Benefits Administrator Manual

2016

south carolina peba SM

state health plan | retirement systems

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General information

General information

This manual will help you prepare insurance benefits paperwork and documentation required by the S.C. Public Employee Benefit Authority (PEBA). It outlines rules, regulations, policies and procedures.

When determining benefits, the *Plan of Benefits Document* supersedes all other publications. This document contains a complete description of the State Health Plan. Its terms and conditions govern all health benefits under the Plan. The *Plan of Benefits Document* is available on PEBA's website. For other benefits, the respective contract with PEBA supersedes all other publications.

The *Insurance Benefits Guide* provides summaries of the various insurance programs offered by PEBA. The guide is mailed to retirees, survivors, and COBRA subscribers. The *Insurance Benefits Guide* is also available online.

All participating employers must offer their benefits-eligible subscribers all of the insurance programs that PEBA offers:

- Health insurance benefits (State Health Plan and the GEA TRICARE Supplement Plan)
- Health and wellness programs
- Dental insurance (State Dental Plan and Dental Plus)
- Life insurance (Basic, Optional Life and Dependent Life)
- MoneyPlus (all plans, as eligible)
- Long Term Disability (Basic and Supplemental)
- State Vision Plan
- Vision Care Discount Program

Employers may offer some additional products and plans, but premiums for additional products and plans may not be paid on a pretax basis and are, therefore, not eligible for MoneyPlus. No incentives (such as employer-paid premiums) may be offered to encourage subscribers to enroll in benefits and plans other than those PEBA offers.

BENEFITS ADMINISTRATORS AND OTHERS CHOSEN BY YOUR 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.
THIS PUBLICATION CONTAINS AN ABBREVIATED DESCRIPTION OF INSURANCE BENEFITS OFFERED BY OR THROUGH THE S.C. PUBLIC EMPLOYEE BENEFIT AUTHORITY. THE *PLAN OF BENEFITS* DOCUMENTS AND BENEFITS CONTRACTS CONTAIN COMPLETE DESCRIPTIONS OF THE HEALTH AND DENTAL PLANS AND ALL OTHER INSURANCE BENEFITS. THEIR TERMS AND CONDITIONS GOVERN ALL BENEFITS OFFERED BY OR THROUGH THE S.C. PUBLIC EMPLOYEE BENEFIT AUTHORITY. IF YOU WOULD LIKE TO REVIEW THESE DOCUMENTS, CONTACT THE S.C. PUBLIC EMPLOYEE BENEFIT AUTHORITY.
THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE 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 which address the types of subscribers you assist. The manual's Table of Contents is combined to make it easier to locate the information you need. Each section of the manual also includes a Contents page.

The *Benefits Administrator Manual* is available on the PEBA website at www.peba.sc.gov.

Search the manual using Adobe® Reader®

Adobe Reader is a free software program you can use to open and view the *Benefits Administrator Manual* and any other PDF document. It also has a built-in search feature. This feature makes it easy for you to look through documents to find a word or phrase.

When you open a PDF document using Adobe Reader, you should notice a small pair of binoculars (or a larger and smaller pair) on the Adobe Reader menu bar. This is Adobe Reader's *search* or *find* tool.

When you click on the search tool, a window will appear that allows you to type in a word or phrase describing what you want to search for, such as "Optional Life" or "special eligibility situation." In this window, you also have search options: whole words only, case sensitive, etc. How the search tool looks and works depends on which version of Adobe Reader you have.

Also, by clicking on the Bookmarks tab in Adobe Reader, you open an interactive Table of Contents for the manual. You can expand (+) and collapse (-) the list of contents. Clicking on an entry will jump you to that section in the manual.

You can also get a simple bar that will enable you to search for words in the document by keying Control/F.

Quick access tip

Open the *BA Manual* and minimize it on your Task bar on the bottom of your computer monitor so you can access it with one click. You can even save a copy of the manual to your desktop for offline access.

Forms on the web

The forms mentioned in this manual are included on PEBA's website, www.peba.sc.gov. To find those specifically for employers select Insurance Benefits (or Retirement Benefits) then Employers. Some also may be under Insurance Benefits/Forms. If you do not know your group ID number or if you do not have Internet access, call PEBA at 888.737.6800 or 888.260.9430.

EBS website

The Employee Benefits Services (EBS) website at https://ebs.eip.sc.gov gives you instant online access to insurance enrollment information, reporting data and billing reports. PEBA recommends you sign up and take advantage of EBS right away, if you have not already done so. Through EBS, you can:

- Access subscriber and spouse and/or children record information.
- Enroll new employees and make coverage changes online.
- Review and approve changes your employees make using MyBenefits.
- Receive statements and reports online.
- Update SLTD salary information online.

Refer to Using the Online Enrollment System chapter for information on EBS, how to sign up, and how to use online enrollment and subscriber data management features of EBS.

Contact PEBA

Address:

202 Arbor Lake Drive

Columbia, SC 29223

Website:

www.peba.sc.gov

Email:

Select Contact us at the bottom of www.peba.sc.gov and select a form for insurance or retirement inquiries.

Telephone:

Customer Contact Center:

803.737.6800

888.260.9430

Benefits Administrator Call Center:

803.734.2352

888.260.9430

When you call PEBA on behalf of a subscriber:

Be sure the subscriber has already attempted to resolve the question by contacting the third-party claims processor, plan administrator or PEBA. There are excellent online resources available to subscribers, and they should be encouraged to take advantage of them.

Have the SSN or Benefits ID Number (BIN) of the individual ready.

Have your question ready, and please be specific.

Remember the 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 his 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 is glad to provide these letters. However, **it may take up to 10 working days to process these requests**. Please encourage subscribers to request proof of insurance as soon as they know they need it.

PEBA departments

Legal

The Legal Department is responsible for developing PEBA's policies relating to compliance with plan documents and state laws and federal laws, such as HIPAA. This department also addresses and resolves legal matters and processes appeals from subscribers and dependents who are denied benefits or coverage changes.

Healthcare Policy

The **Healthcare Policy Department** plays several key roles related to PEBA's insurance programs.

The **Analytics Unit** analyzes data and statistics from all third-party claims processors' reports. The data, along with enrollment statistics, are compiled into reports that identify key elements for analysis and trends in the insurance plans. These trends allow PEBA to determine the cost of insurance benefits on an annual basis and facilitate the experience rating of health premiums process for local subdivisions.

This unit manages PEBA's Medicare Part D prescription drug program, which PEBA provides creditable drug coverage for Medicare Part D eligible retirees and their eligible dependents.

The unit receives and processes National Medical Support Notices, which help ensure children receive health coverage when it is available and required as part of a child support order.

It also develops special publications involving key issues relating to data and analyses. You may access the *50-State Survey*, *Trends* newsletter and other information on the PEBA website at www.peba.sc.gov.

Through Health and Wellness Programs, the Health Initiatives Unit provides activities, programs and services designed to educate covered employees, retirees and their covered spouses and children on leading healthier, happier lives. This unit's focus is on disease prevention, early detection of disease and disease management. From Preventive Worksite Screenings to Chronic Disease Workshops to weight management and beyond, Health and Wellness Programs coordinates a variety of resources for health at the workplace.

For more information about preventive programs offered by PEBA, please check the Health and Wellness section of the PEBA website at www.peba.sc.gov. On the homepage, click on Insurance Benefits/Health and wellness. Subscribers can register online for group, regional and Web-based training online. Under "Upcoming events" click on "See more." Then click on the event you wish to attend.

The Contracts and Procurement Unit develops, solicits and manages contracts for all benefits plans offered by PEBA in accordance with the terms of the state Procurement Code. It answers contractual questions received from subscribers, vendors and other concerned parties.

Employer Services

Employer Services and the Field Services team at PEBA is committed to supporting employers. Staff is available to assist employers with training, webinars, benefit fairs and field visits.

The **Field Services Unit** works directly with the benefits administrators of each of the approximately 670 participating employers. Staff works one-on-one with benefits administrators to ensure they are processing enrollments and changes to files appropriately and trains them to use the EBS website, https://ebs.eip.sc.gov, including the Online Enrollment System. Group training is conducted at the employer's location, on site at PEBA and via the Internet (live and prerecorded). Benefits administrators can register for training online at www.peba.sc.gov. Under "Upcoming events," click on "See more." Then click on the event you wish to attend. The Field Services staff also enrolls new employer groups, conducts employee orientation and preretirement sessions, facilitates enrollment meetings for active and retiree subscribers and attends benefits fairs. Contact this unit to arrange for a representative to participate in these types of sessions.

Employers are invited to participate in the **Employer Advisory Group**. As part of it, they meet, in groups of eight, with the director of Employer Services to discuss their concerns and questions about PEBA's programs. 2016 dates for the sessions will be announced in *PEBA Update*.

Held each August, the **Benefits at Work** is a training conference for benefits administrators and their staff. The workshops focus on the changes in the state group insurance and retirement benefits for the next year. Employers are notified during the summer of the dates, hotel accommodations and topics for the workshops. This training keeps benefits administrators and their staff informed of plan changes and prepares them for the upcoming October insurance open enrollment period. It is also an excellent opportunity to meet the PEBA staff and vendor representatives.

The **Insurance Benefits Training Program** is a series of classes which explain the benefit plans and procedures. The classes are designed to help benefits administrators better inform and counsel employees about their insurance coverage and benefits. BAs and personnel/payroll staff are encouraged to attend. This training is offered by PEBA at no charge. Class size is limited, so sign up early**,** and please be sure to notify PEBA if you must cancel so that someone else may have the opportunity to attend.

All classes are listed on the PEBA website at www.peba.sc.gov. Under "Upcoming events" click on "See more." You may browse several different months. When you find a class you wish to attend, click on it. You will see a description of the class and whether space is available. When you decide on a class you wish to attend click "Register." Complete the registration form in its entirety, then click "Submit Registration" at the bottom of the form. A confirmation screen will appear, and you will receive confirmation by email.

PEBA has developed helpful PowerPoint presentations for your insurance benefits training needs. They may be downloaded and used as presentations for your employees or printed as black and white handouts. They are available on a variety of topics.

To access these training tools, go to the PEBA at Select Insurance www.peba.sc.gov. Select Insurance Benefits/Resources/Presentations. You will see these presentations provided with and without accompanying audio and with printable scripts, so you can train your employees by reading from the scripts while showing the PowerPoint presentation.

Customer Intake

The **Customer Intake Unit** receives and answers all incoming correspondence and emails from subscribers and benefits administrators. Representatives of the unit also meet with subscribers who come to PEBA for services. Representatives of the unit work directly with subscribers to resolve unique and complex service and claims issues.

The **Customer Contact Center** provides information and assistance related to state insurance and retirement programs to subscribers. Help also is provided to benefits administrators through the **BA Call Center**. Representatives answer telephone inquiries from subscribers and benefits administrators who have enrollment and coverage questions, including those that need immediate action or attention.

This unit also serves as the benefits office for retirees of state agencies and school districts, as well as their spouses and children, survivor subscribers and COBRA subscribers.

Insurance Finance

A major responsibility of this department is billing and collecting the premiums for health, dental, life, long-term disability and vision benefits with annual revenue exceeding $1.8 billion. The unit maintains individual accounts for approximately 81,000 retired, survivor and COBRA subscribers and approximately 680 group accounts with an enrollment of approximately 200,000 active employees.

Account representatives are responsible for answering questions about each participating employer's monthly billing statement. They answer billing questions about the individual accounts for retired, survivor and COBRA subscribers. They also perform dependent eligibility audits.

The Audit Unit is responsible for ensuring that all state-covered employers are complying with rules and regulations of PEBA insurance benefits and PEBA retirement benefits through on-site or desk reviews. For the insurance audit, the auditor reviews employer personnel and payroll records to verify enrollee insurance coverage and eligibility, payroll deductions, MoneyPlus reporting, the timeliness of payment of the monthly bill and the review of the initial COBRA letters. For the retirement audit, the auditor verifies eligibility, proper forms are on file, contributions are being withheld and employers are remitting and reporting retirement contributions timely.

The Audit Unit performs third-party claims processor reviews to ensure payment and procedural accuracy of claims processing as well as to identify areas of cost savings and abnormal provider practices.

The **Eligibility Determination team** determines eligibility for all individual subscribers — retirees, survivors, COBRA participants and their spouses and children. This team handles all appeals of

enrollment and eligibility issues. Team members also assist Subscriber Services representatives with complex subscriber files that may require further review by an experienced team member.

The **Enrollment** team examines and inputs data into new and existing subscriber files. The team ensures the accuracy and completeness of data submitted by benefits administrators and subscribers.

The **Imaging/postal Center** receives all incoming mail. Staff is responsible for imaging all paper and electronic documents and responsible for indexing/filing documents for all subscribers through our up-front imaging process.

The **Quality Assurance Unit** ensures the integrity of the data transmitted from PEBA insurance benefits to the insurance carriers and how it is applied to their systems. In addition, the unit works with the PEBA's information technology staff to identify and resolve information technology issues. This unit also tests and implements system changes related to new and existing plans.

Communications

The **Communications Unit** develops materials and publications that describe PEBA's plans, policies and procedures. These publications may be in print or in electronic form and available on PEBA's website. Major insurance publications are listed below. The staff also coordinates and reviews materials and information for other PEBA units and departments, as well as vendor-produced communications.

Part of the role of the benefits administrator is to inform employees of their benefits. Please take advantage of these publications, which are all on the PEBA website at www.peba.sc.gov.

Benefits Advantage

The *Benefits Advantage* is an annual newsletter, published before the October enrollment period, for all benefits-eligible subscribers and describes any plan changes for the next year. You are responsible for distributing the *Benefits Advantage* to all employees eligible for benefits. PEBA sends the *Benefits Advantage* directly to retirees, survivors and COBRA participants. The *Benefits Advantage* addresses plan changes for the next year and October enrollment information **only** and should not be given out after December 31.

Insurance Benefits Guide

The *Insurance Benefits Guide* (IBG) is an annual publication for all benefits-eligible subscribers. Every insurance plan PEBA offers is described in this guide. It will arrive by January 1, and you are responsible for giving one to all benefits-eligible employees. Be sure to keep enough copies of this guide on hand to distribute to new employees. Copies are sent directly to all retirees, survivors and COBRA subscribers.

***PEBA Update* (for benefits administrators)**

PEBA Update is a weekly email newsletter for benefits administrators. It contains information, particularly policy and procedural changes and clarifications that require benefits administrators' immediate attention.

When You Become Eligible for Medicare

This handbook explains insurance options and the benefits available to those who become eligible for Medicare. It also covers how the available health insurance plans coordinate with Medicare and includes a comparison chart of the plans, as well as the rates. This handbook is updated yearly.

Using the online enrollment system

Using the online enrollment system

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Online enrollment system terms

Employee Benefits Services

Employee Benefits Services (EBS) is an online software application through which you can access PEBA's insurance enrollment database. EBS gives you instant access to your subscribers' insurance enrollment information and your group's reporting data and billing reports. If you register for EBS's Online Enrollment System, you can enroll your subscribers, view their benefits, make changes to their coverage and approve changes your subscribers make using MyBenefits. The Online Enrollment System will allow you to submit enrollment changes for your subscribers using two methods. One method, Current EBS, generates enrollment forms that must be signed by you and your subscriber and submitted to PEBA. The other method, MyBenefits, is paperless. It uses electronic signatures and does not require you to send forms to PEBA unless documentation is required.

MyBenefits

MyBenefits is an online software application that allows active subscribers, retirees, survivors and COBRA subscribers to access their own enrollment information on PEBA insurance benefits' enrollment database. Through MyBenefits they 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, unless documentation is required.

BA Console

The BA Console is the tool in the middle section of the EBS homepage that allows you to manage changes to your subscribers' coverage. The results of all enrollment transactions, whether initiated by you or initiated by your subscribers, will appear on this console. The console consists of four tabs: Suspended, Acknowledgement, Approval, and Current EBS. All transactions you initiate and submit will generate a signature and/or barcode.

Summary of Enrollment (SOE)

This document is generated when a new enrollment is completed online. The SOE is an official document that replaces the NOE.

Summary of Change (SOC)

This document is generated when an enrollment change is completed online. The SOC is an official document that replaces the NOE.

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 his final choices because he can make multiple changes online throughout October. After midnight on October 31, PEBA accepts the last change the subscriber submitted.

Summary of Termination

This document is generated when a termination is completed online. This is an official document that replaces the Active Termination Form.

Employee Benefits Services (EBS)

PEBA recommends all benefits administrators sign up for Employee Benefits Services (EBS). EBS gives you instant online access to insurance enrollment information, reporting data and billing reports. You can also enroll your subscribers and make changes to their coverage. You can even review and approve changes your subscribers make using MyBenefits if you have access to EBS's Online Enrollment System. Below are some of the things you can see and do on EBS:

Subscriber inquiry menu:

- ID data (name, salary, address, date of birth, etc.)
- Coverage, including premiums
- Coverage history for your employees

- Spouse and children information
- Beneficiary information
- Subscriber changes (SSN, name, marital status, etc.)

Dependent inquiry menu:

- ID data
- Coverage
- Historical changes

Manage subscribers function:

- Enroll subscribers
- Make coverage changes
- Change spouse, children and beneficiary information
- Change ID data
- Terminate coverage

Submit refund requests online
Receive enrollment reports

- Weekly Dependent Eligibility Audit Report
- Health plan subscriber roster
- Children turning age 19/25
- Terminated subscribers
- Children older than 1 year without a Social Security Number

Receive accounting reports

- EBS recertification
- SLTD subscriber roster
- Active billing files for subscribers, spouses and children
- Premium data file
- Active Subscriber roster

Update your group's contact information
Update SLTD salary information online (non-Comptroller General groups)
BA Console function:

- Follow up and complete suspended transactions
- Review and acknowledge beneficiary and contact information changes by subscribers
- Review, edit and approve annual and open enrollment changes made by subscribers

To sign up for EBS

You will need:

Internet access
A compatible browser:

- PEBA web applications support the current and previous major releases of the following browsers: 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.

A valid EBS User ID:

- 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.

To complete and forward to PEBA the following forms:

- EBS Confidentiality Agreement
- EBS Authorizing Agent Designation Form
- EBS Designated Employee Confidentiality Agreement.
- If your group uses a third-party enroller (TPE), these forms must also be completed and sent to:
    - Memo of Understanding (for Third-Party Enrollers)
    - TPE Designated Employee Confidentiality Agreement.

These EBS documents are on PEBA website at http://www.peba.sc.gov/iemployers.html. Send all EBS forms from your office to PEBA in one envelope. Once approved, a confidential user ID will

be sent to you in the mail. A PIN number will follow in a separate mailing.

Once you are approved, if you have any problems accessing the EBS website or using your password and PIN number, call PEBA's BA Call Center at 803.734.2352.

PEBA will send a letter to your group's authorizing agent to complete and return by June 30 each year to recertify employees' access to EBS. To change an employee's access or add a new EBS user, the authorizing agent must submit a new EBS Designated Employee Confidentiality Agreement. You will use your same login and password after you recertify.

EBS homepage

The EBS homepage is a great tool to help benefits administrators and other users registered on EBS perform their duties.

The buttons on the left side of the homepage (Inquiry, Refunds, Reports, etc.) are accessible to you based on your Confidentiality Agreement with PEBA. If your user ID does not allow access to a function, the tab for that function will be grayed out.

The **BA Console**, in the middle section of the homepage, allows you to manage changes to your subscribers' coverage. The results of all enrollment transactions, whether initiated by you or initiated by your subscribers, will appear on this console. Each transaction will remain on your console until it is approved by PEBA, approved by you or acknowledged by you, whichever is applicable. The console consists of four tabs: Suspended, Acknowledgement, Approval and Current EBS.

All transactions that you or your designee initiate and submit using the Current EBS method, which generates printed enrollment forms requiring signatures in ink, will appear under the Current EBS tab.

All transactions that you or your designees initiate or that your subscribers initiate and submit using the MyBenefits method will appear under either the Acknowledgement tab or the Approval tab.

For more information, see BA Console on page 35.

The **Manage Subscribers** section on the right of the homepage allows you to perform functions based on your Confidentiality Agreement with PEBA. Only the functions allowed under the agreement will appear in the drop-down menu.

The **Group Statistics** section lists the number of employees enrolled in the various benefits at the time the EBS site is accessed. The number will be refreshed each session (each time you log back in after logging off the system).

The update **Email Address** function (lower right corner of the homepage) allows you to advise PEBA of any changes to your email address. Click on Update My Email Address and follow the prompts.

Explanation of EBS homepage buttons

From the homepage, the registered user (the benefits administrator or his designee) will see buttons on the left side of the screen. These buttons give access to information or areas for which you have user rights. Sections that are unavailable to you are grayed out and will not respond when clicked.

- **Inquiry** – This function allows you to view detailed insurance information about a subscriber within your group(s). A user may search by SSN# or last name. You may also view suspense records for your group.
- **Manage** – This function allows you to enroll a new subscriber, make changes to current subscribers or terminate coverage for a subscriber. You must have access to EBS's Online Enrollment System to be able to use this function.

- **Enroll. Reports** – This function allows you to view your group's enrollment reports online.
- **Acct. Reports** – This function allows you to view your group's billing statements and reports online.
- **Balance** – This function allows you to view your group's accumulated balance.
- **Contacts** – This function allows you to view and change your group's contact information.
- **SLTD Salary Entry** – This function allows you to enter SLTD salary updates online and is available for yearly updates during the open enrollment period. (This does not apply to CG agencies.)
- **PEBA Ins. Home** – This function links you to PEBA's website.
- **Download Forms** – This function links you to forms on PEBA's website.
- **Carrier Links** – This function links you to vendor links.
- **Contact Us** – This function allows you to view PEBA's contact information and includes a link to PEBA's Customer Contact Center's email.
- **Browser Support** – This function links you to information regarding Internet browser requirements to use PEBA's online applications.
- **Change Password** – This function allows you to change your password.
- **Log Out** – This function logs you out of the system.

The **Back** button on the tool bar line will always return you to the previous screen. The **Home** button will return you to the EBS Homepage.

Manage subscribers

From the Manage Subscribers section on the homepage, you can indicate the type of transaction to be processed or initiate a subscriber or suspense inquiry by selecting the action desired from the drop-down menu beside Action.

Enrollment

Enrolling a new employee or an employee transferring from another group

- Select Enroll as the action by keying E or selecting Enroll from the drop-down menu.
- Enter the SSN of the employee.
- Enter your Group ID if it does not automatically populate the field.
- Tab to Go and press Enter or click on the Go button.

The Enrollee Data tab will then populate the field.

Enrollee data tab

System edits will prompt the required data and return error messages and help text where applicable.

- Select the Status from the drop-down (only available status types will populate, based on your group ID).
- Complete the name section.
- Complete the address section. There are drop-down selections for state, county and country. You may select from the drop-down or key the first letter of the state, county or country until the system populates the field.
- Enter the date of birth of the subscriber.
- Gender and marital status both have drop-down lists, or you may key the first letter until the system populates the field.
- Enter the phone number and email address.
- Medicare eligibility defaults to No. If the employee is Medicare eligible, change to Yes by keying Y or use the drop-down to select Yes. If Yes is selected, the system will require additional information. Complete the Medicare information as required.

- Enter the yearly contract salary in whole dollars.
- Enter the date of hire (first day on the job).
- You may enter the effective date (if left blank, the system will automatically calculate the effective date).
- MoneyPlus defaults to Yes. You may key N or select No from the drop-down if the employee is not a participant in the MoneyPlus Pretax Group Insurance Premium Feature.

Tab to the Next button at the bottom of the screen and press Enter to move to the Dependents tab, or click on the Next button at the top or bottom of the screen to move to the Dependents tab.

Dependents tab

- *If the subscriber is married*, the spouse must be listed, regardless of whether the spouse is covered.
- *If the subscriber is not married and has no eligible children* for whom he is electing benefits, move to the Coverage tab by clicking on that tab at the top of the screen or by clicking on one of the Next buttons.
- *If the subscriber was enrolled previously* with a spouse or child, the spouse or child may be selected from the Reactivate Dependent List.
- Enter the number of the covered spouse and children in the field beside Add, or select from the drop-down list. The system will bring forward the number of selections you entered.
- Complete the required information for the spouse and each child (an SSN is required for any child age 1 or older).
- Enter the relationship to the *subscriber* by keying the first letter of the relationship or selecting the relationship from the drop-down list.
- Enter the gender of the spouse or child by keying the first letter or by selecting from the drop-down list.
- Enter Active beside each coverage type or leave the status blank if you are not adding the spouse or child to the benefits. The system will show the Dependent Life choice based on the relationship entered above. You may key an A or select from the drop-down list.
- Enter Other Coverage information, when applicable, if the spouse or child is enrolling in health coverage. The system defaults to No. If changed to Yes, complete the required information. (The requested date of birth is that of the policyholder of the other plan.)
- Medicare coverage question defaults to No. Change to Yes and complete the required information, if applicable.
- After completing the data for the spouse or the first child, complete the data for each additional family member to be covered. You may Add More Rows of Dependents by entering a number in the field beside Add, or by selecting from the drop-down. The system will add the additional number of fields indicated.
- You may select Delete under the number of the spouse and children (left side of the screen) to be deleted if you wish to clear the information and start over.

Tab to the Next button at the bottom of the screen and press Enter to move to the Coverage tab; or click on the Next button at the top or bottom of the screen to move to the Coverage tab.

Coverage tab

Benefit election choices for the Coverage tab will populate based on the information entered on the Dependents tab. *Examples:* If no spouse or children are listed, you will not see a choice for Dependent

Life. Also, if health coverage is selected for both a spouse and a child on the Dependents tab, the health plan category will default automatically to *full family*.

- Select a health plan by keying the first letter of the name of the plan or by selecting the plan from the drop-down list next to Plan. The Plan Category field will populate automatically, based on the information entered on the Dependents tab.
- The Dental Plan Category field will populate automatically, based on the information entered on the Dependents tab. Dental Plus will default to No, but can be changed to Yes.
- Complete the State Vision Plan field by indicating No or Yes.
    - The State Vision Plan field will populate automatically, based on the information entered on the Dependents tab. If no spouse or children are entered, select the plan from the drop-down (Vision Coverage or Refused).
- Complete the Tobacco Use field. The field will default to Tobacco Coverage, but can be changed to Refused.
- Complete the Optional Life choice by indicating Optional Life Coverage or Refused.
    - If electing the benefit, choose the level from the drop-down list. For an employee, the maximum amount of coverage that may be keyed into the system is three times salary (rounded down). If the employee wants a higher level of coverage, the employee must complete and submit an Evidence of Insurability form for Securian to review and submit a paper NOE.
    - The Dependent Life-Child field will populate automatically, based on the elections made on the Dependents tab. *(This field will not appear if there are no eligible children; this election will appear as Refused on the Review tab.)*
    - For the Dependent Life-Spouse field, enter a coverage level of either $10,000 or $20,000, based on whether a spouse was entered on the Dependents tab. If the *subscriber* wants a higher level of coverage, he must complete and submit an Evidence of Insurability form for Securian to review and submit a paper NOE. *(This field will not appear if there is no eligible spouse; this election will appear as Refused on the Review tab.)*
- Choose or refuse SLTD. If choosing SLTD, elect the coverage type from the drop-down list. The system will pull the salary from the Enrollee Data tab.

Tab to the Next button at the bottom of the screen and press Enter to move to the Beneficiaries tab, or click on the Next button at the top or bottom of the screen to move to the Beneficiaries tab or click on the Beneficiaries tab.

Beneficiaries tab

- Choose the number of beneficiaries by keying the number in the box beside Add or choose the number of beneficiaries from the drop-down list.
- *If the desired beneficiary is a spouse or child listed on the Dependents tab*, click on the Add button beside Add from Existing Dependent List. Choose (highlight) the spouse or child from the list and click on Add Selected Dependents to Beneficiaries. The personal information and relationship of the spouse or child will populate those fields automatically.
- Complete the beneficiary information as applicable to the type of beneficiary.

- Indicate the life insurance program by clicking on the box beside the elected programs.
- Indicate the percentage if not equally divided.
- Indicate primary or contingent by keying a P or C; or choose from the drop-down list.
- Complete all required information for each beneficiary listed.

Access the Beneficiary Coverage Help box by clicking on Coverage Help at the bottom of the Coverage/Percentage/Primary/Contingent box.

Tab to the Next button at the bottom of the screen and press Enter to move to the Review tab; or click on the Next button at the top or bottom of the screen to move to the Review tab.

Review tab

The Review tab is a complete list of all information entered on the previous tabs. The type of action taken and the effective date will be at the top of the page.

From this page you may return to any tab by clicking on the tab at the top of the page if adjustments to the information are needed.

You may Suspend, Cancel or Apply the transaction by clicking on the desired button (top right of the page).

- **Suspend** will allow you to keep what has already been processed and you may retrieve it at a later date. It will be retrievable using the Suspended tab on the BA Console on the homepage and will be listed as Incomplete. You will receive a SUSPEND message box, inside which you enter the reason for suspending the file.
- **Cancel** will remove the entire transaction. Once a transaction has been canceled, it cannot be recovered.
- **Apply** will remain grayed out until the transaction is completed and has passed all system edits. Once you hit Apply you will have to choose either Current EBS to generate a printed SOE as explained below or MyBenefits to generate a paperless SOE (explained later).

Summary of Enrollment (SOE)

The Summary of Enrollment (SOE) document is a complete list of the *subscriber's* elected benefits, ID data, spouse and children information and beneficiary information. The SOE is an official document that replaces the NOE.

The effective date of the transaction will be shown at the top, along with a description of any documentation that may be required.

Current EBS (generates printed SOE)

This method generates a printed/paper SOE which both the benefits administrator and the subscriber must sign within 31 days of the hire date and forward to PEBA. Staple any required documentation to the SOE.

- The benefits administrator and subscriber must initial and date each page.
- The benefits administrator signature and date and the subscriber's signature and date are required on the last page of the document.
- Make a copy of the signed SOE for the group files and another copy for the subscriber.
- Attach any required supporting documentation to the original signature page and/or barcode page. You may want to place a copy in the subscriber's file.
- Forward the entire signature page and/or barcode page and any required documentation to. *Do NOT delay in sending in the signature page and/or barcode page. The subscriber's file is locked until the signature page and/or barcode page is received, processed and the transaction is released by PEBA.*

NOTE: If entering enrollments electronically from a signed, paper NOE, be sure to double check the data you entered against the NOE. *Since the NOE has the subscriber's signature and will be attached to the SOE, the information on the NOE and SOE must match.*

The transaction will appear on the BA Console on the EBS homepage under the Current EBS tab. This transaction will be listed as Pending EIP Approval. Once PEBA receives the signature page and/or barcode page, along with any required documentation, the transaction will be released into production and will disappear from the Current EBS tab.

Reviewing and editing the Summary of Enrollment

Once you have entered a transaction on EBS and have created the Summary of Enrollment (SOE), select Review to review or reprint the SOE.

If you do need to edit a subscriber's file after creating the SOE, use the edit function. Print the new SOE with the signature page with barcode.

MyBenefits (generates paperless SOE)

This method creates an electronic SOE that is sent automatically to the employee's MyBenefits account. You must then notify the employee (by email or by phone) to log in to MyBenefits, review the transaction and electronically sign it to complete it. If there is an error, he can return it to you through MyBenefits for correction. Remind the subscriber to provide any needed documentation. The pending transaction is sent directly to the subscriber's MyBenefits system.

The transaction will appear on the BA Console on the EBS homepage under the Approval tab, waiting for the subscriber to approve it.

- **The subscriber must log into MyBenefits and review the transaction.** If the subscriber is a first-time user of MyBenefits, he would first choose the button Get My BIN on the login screen. He would then follow the registration procedures and answer the security questions to complete the registration process. Remind your employees to print the registration information for future reference and put it in a safe place.
    - Once the subscriber is logged in, the pending transaction will appear immediately. The subscriber may then choose to Approve or Return the transaction.
- **If approved**, the transaction will move from the Approval tab to the Acknowledgement tab on the BA Console on the EBS homepage if no documentation is required. PEBA records will be updated automatically. Once you acknowledge the transaction you can print a copy of the SOE for the employee's file, or, if you maintain personnel records electronically, you can save the SOE to your computer records (as a pdf file). **Do *not* mail a copy to PEBA. The SOC will be electronically imaged into the PEBA insurance imaging system. The process is the same for Current EBS transactions.**
    - **If documentation is required**, you must notify the subscriber that documentation is required and remind him to provide it promptly; otherwise the transaction cannot be completed. The transaction will remain on the Approval tab on the BA Console with a Yes for documentation, and a status of Pending BA approval. When you receive the documentation, you may then approve the transaction. A barcoded cover sheet is generated automatically, which you print and attach to the documentation to be mailed to

PEBA. More information on the BA Console is on Page 35.

- **If returned due to an error or change**, the transaction will remain on the Approval tab on the BA Console, 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.

Changes

You may process most family status changes using the Online Enrollment System. The system is designed to assist in the process by providing policy-driven edits. Choices and elections are restricted, based on the reason(s) for change selected initially. Certain change reasons will result in some fields being populated automatically. Other fields and tabs will be hidden or grayed out.

The effective dates are calculated automatically based on the information entered on the Define Your Change screen. Changes can be viewed on the Review tab and on the Summary of Change (SOC).

Required documentation notices are based on the change reason and/or the spouse or child's eligibility status.

The system will restrict you to specific capabilities based on the change reason you selected.

- From the homepage, choose Change as the Action by keying a C or selecting Change from the drop-down list.
- Enter the subscriber's SSN.
- Tab to the Go button and press enter, or click on the Go button.
- Select the Reason for Change by keying the first letter of the reason or by selecting from the drop-down list. The reasons are listed in most frequently used order.
- You will be prompted to enter a sub-reason from the drop-down list, if applicable.
- The current date is the default date; change it, if necessary.
- The reason and/or sub-reason will generate instructions and basic requirements, as applicable. If the change is due to a special eligibility situation, a new field, Date of Request, will sometimes appear. The Date of Request field is automatically filled with the current date. Adjust this date only if you are keying the transaction from an NOE that an employee signed on a different date. For example, if the reason selected is Marriage, the system will request the date of marriage, the date of request and will include a note stating that the request must be made within 31 days of the date of marriage.
- Move from one tab to the next by clicking on the Next button at the top or bottom of the screen or by tabbing to the Next button at the bottom and pressing enter; or by clicking on the desired tab at the top of the screen.

Enrollee Data tab

- The Enrollee Data information (address, phone numbers, email address, spelling of name) may be updated with any change type. Note: Address changes processed using the Current EBS method do not require the subscriber's signature; only the benefit administrator's.
- Changes to the subscriber's SSN or date of birth must be made on a paper NOE. Documentation must be attached to the NOE.

Dependents tab

You may change the status of the coverage for the existing spouse and children, based on the change reason.

- **Ineligible dependent child** – Selecting ineligible terminates all coverage benefits for the child.
- **Dependent deceased** – The Deceased button terminates all coverage benefits for the deceased spouse or child.
- **Dependent gain of other coverage** (state or non-state)
    - Use the drop-down list to *terminate only those benefits gained elsewhere*.
- **Dependent loss of other coverage** (state or non-state)
    - Use the drop-down list to add only those benefits lost elsewhere. Loss of state benefits for a spouse will allow adding Dependent Life-Spouse coverage.
- **Family status changes** – Previously covered children may be chosen from the Reactivate Dependent List and their benefits activated.

Coverage tab

Based on the change reason, fields will be populated automatically on the Coverage tab. Only those fields with a white background may be edited.

- **Marriage, newborn, adoption, custody** – Optional Life benefits may be selected or increased, and a new coverage level may be chosen from the drop down menu where the maximum amount available without evidence of insurability is displayed.
- **Elections or increases of Optional Life coverage levels with evidence of insurability:**
    - A Statement of Health form must be completed and sent to Securian for review.
    - *For those who are MoneyPlus participants* – action must be requested within 31 days of a family status change or during enrollment periods in which participants can select or increase coverage, without evidence of insurability, above the amount available. Approvals from Securian should be forwarded directly to PEBA with an NOE and supporting documentation.
    - *For those who are not MoneyPlus participants* – request may be processed through EBS and forwarded to PEBA with the SOC, approval letter from Securian and supporting documentation. This request may be made throughout the year.

Beneficiaries tab

The benefits administrator may make changes as desired. Use the Delete button beside Type to remove a beneficiary.

- Choose the number of beneficiaries by keying the number in the box beside Add or choose the number of beneficiaries from the drop-down list.
- Click on the Add button beside Add from Existing Dependent List if the desired beneficiary is listed on the Dependent page.
    - Choose (highlight) the spouse and/or children from the list, and click on Add Selected Dependents to Beneficiaries.
- Complete the beneficiary information as applicable.
- Indicate the life insurance program by clicking on the box beside the elected programs.
- Indicate the percentage if proceeds are not to be divided equally among the beneficiaries.
- Indicate primary or contingent by keying a P or C; or choose from the drop-down list.
- Complete all required information for each beneficiary listed.

Review tab

The Review page is a complete list of all information entered. The type of action taken and the effective date will be at the top of the page.

- From this page you may return to any tab by clicking on the tab at the top of the page if adjustments to the information are needed.
- You may Suspend, Cancel or Apply the transaction by clicking on the desired button (top right of the page).
- **Suspend** will allow you to keep what has already been processed and you may retrieve it at a later date. It will be retrievable from the Suspended tab on the BA Console on the homepage and will be listed as Incomplete. You will receive a SUSPEND message box, inside which you enter the reason for suspending the file.
- **Cancel** will remove the entire transaction. Once a transaction has been canceled, it cannot be recovered.
- **Apply** will remain grayed out until the transaction is completed and has passed all system edits. Once you hit Apply you will have to choose either Current EBS to generate a printed SOE as explained below or MyBenefits to generate a paperless SOE.

Summary of Change

The Summary of Change (SOC) document is a complete list of the subscriber's elected benefits, ID data, spouse and children information and beneficiary information.

- The change reason will be shown at the top of the form.
- The effective date of the transaction will also be shown at the top, along with a description of any documentation that may be required.
- Both the old values and the new values, created by the transaction, will be displayed.

Current EBS (generates printed SOC)

- The benefits administrator's signature and date and the subscriber's signature and date are required on the signature page and/or barcode page. If the employee is not available to sign, have him complete and sign an NOE and attach it. Note: An address change processed through the Current EBS method does not require the subscriber's signature, only the benefits administrator's. Disregard the space that requests the subscriber's signature on the printed SOC.
- Make a copy of the signed SOC for the group files and another copy for the subscriber.
- Attach any required supporting documentation to the original, signed SOC. You may want to place a copy in the subscriber's file.
- Mail any documentation to PEBA.

NOTE: If entering changes electronically from a signed, paper NOE, be sure to double check the data you entered against the NOE.

The transaction will appear on the BA Console on the EBS homepage under the Current EBS tab. This transaction will be listed as Pending BA Review-Print, Pending EIP Approval or EIP Rejected. Once PEBA receives the SOC, along with any required documentation, the transaction will be released into production and will disappear from the Suspended tab.

MyBenefits (generates paperless SOC)

This method creates an electronic SOC that is sent automatically to the employee's MyBenefits account. You must then notify the employee (by email or by phone) to log in to MyBenefits, review the transaction and electronically sign it to complete it. If there is an error, he can return it to you through MyBenefits for correction. Remind the subscriber to provide any needed documentation. The pending transaction is sent directly to the subscriber's MyBenefits system.

The transaction will appear on the BA Console on the EBS homepage under the Approval tab, waiting for the subscriber to approve it.

- The subscriber must log into MyBenefits and review the transaction. If the subscriber is a first-time user of MyBenefits, he would first choose the button Get My BIN on the login screen. He would then follow the registration procedures and answer the security questions to complete the registration process. Remind your employees to print the registration information for future reference and put it in a safe place.
- Once the subscriber is logged in, the pending transaction will appear immediately. The subscriber may then choose to Approve or Return the transaction.
    - **If approved**, the transaction will move from the Approval tab to the Acknowledgement tab on the BA Console on the EBS homepage if no documentation is required. PEBA's records will be updated automatically. Once you acknowledge the transaction you can print a copy of the SOC for the employee's file, or, if you maintain personnel records electronically, you can save the SOC to your computer records (as a pdf file). **Do *not* mail a copy to PEBA. The SOC will be electronically imaged into PEBA's imaging system.**
    - *If documentation is required*, you must notify the subscriber that documentation is required and remind him to provide it promptly; otherwise the transaction cannot be completed. The transaction will remain on the Approval tab on the BA Console with a Yes for documentation, and a status of Pending BA approval. When you receive the documentation, you may then approve the transaction. A barcoded cover sheet is generated automatically, which you print and attach to the documentation to be forwarded to PEBA. More information on the BA Console is on Page 35.
    - **If returned due to an error or change**, the transaction will remain on the Approval tab on the BA Console, 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.

Termination

You may process most terminations using the Online Enrollment System.

Unlike the enrollment/change process, terminations are entered directly into the PEBA's database system without going through the suspense process. PEBA's insurance files are updated immediately for billing and transmission to the carriers. **Exceptions:** these types of terminations must still be sent to PEBA for processing:

- Terminations with an effective date that is more than three months past.
    - From the homepage choose Terminate by keying T beside action or selecting Terminate from the drop-down list.
    - Enter the SSN.
    - Tab to Go and press enter or click on Go to advance to the Terminate Coverage tab.
    - Check the coverages to be terminated. A Terminate All button is available.
    - Choose the termination reason by keying the first letter of the reason

or by selecting from the drop-down list.
  - The reason chosen will prompt a request for an effective date (and will prompt the need for additional information if an employee is transferring without a break in coverage to another covered employer group).
  - Tab to the Next button at the bottom of the screen and press enter or click on the Next button at the bottom of the screen to move to the Review and Finish tab.
  - The Review and Finish page will have reminders about COBRA notification, continuation, conversion and MoneyPlus. Mark any items applicable.
  - Apply and Print will populate the termination document. Make copies for your files and for the subscriber.
  - Do *not* mail a copy to PEBA. The termination form will be electronically imaged into the PEBA imaging system.

Manual transactions

Although you can enroll subscribers and/or change their enrollment and personal information, there are some transactions that must be processed manually, using paper NOEs:

Programs

- MoneyPlus program enrollment and changes other than for the Pretax Group Insurance Premium Feature—Medical Spending, Dependent Care and Health Savings accounts. (Employees can enroll online in a Medical Spending Account and a Dependent Care Spending Account during October enrollment only.) See Page 56 for MoneyPlus enrollment information and procedures.

Enrollments/re-enrollments

- Retirees returning to work for a participating employer
- NOEs from new hires, changing their minds within 31 days, if the first request has already been applied by PEBA.
- Open enrollment changes that may require *two* transactions (such as family status changes with effective dates in October, November or December).

Changes

- Social Security Numbers
- Dates of Birth

Dependents

- Adding incapacitated children

Terminations

- Terminations due to military leave
- Terminations of coverage when Supplemental Long Term Disability is in a waiver of premium status
- Terminations effective more than 31 days retroactive

Administrative approvals

- Including those for effective dates that are more than three months retroactive.

MyBenefits

MyBenefits allows subscribers of participating employers to access their insurance information using the Internet and to make some changes on their own. MyBenefits is also paperless, unless follow-up documentation is required.

Changes made using MyBenefits are sent electronically to PEBA, and the benefits office is notified daily of these changes through EBS.

Throughout the year, all subscribers can:

- Get their BIN
- Update contact information

- Review benefits and print a summary of their coverage (similar to a benefits statement)

Active employees can also:

- Change beneficiaries.
- Approve changes made as a result of a special eligibility situation.

When contact or beneficiary information is changed, you will receive an acknowledgement notice through the EBS BA Console. See Page 35 for more information.

During open enrollment, *your subscribers can make their own coverage changes* for the next year. Depending on the type of change an employee makes, you will receive an approval notice on the BA Console. See Page 36 for more information.

How to register on MyBenefits

Go to PEBA's website at www.peba.sc.gov and select the MyBenefits button. You will be taken to the MyBenefits homepage, where you and other subscribers will log in. First-time users must register.

Select Register and you will be asked to enter:

- A security code you will see on the screen (Enter it exactly as it appears, capitalizing the same letters that are capitalized in the box on the screen.)
- Your first and last names
- Your date of birth
- Your Social Security number
- Your eight-digit Benefits Identification Number (BIN). Subscribers can get this from their health ID cards or their latest benefits statements, or you can click on Get My BIN and follow the prompts to retrieve it.

Next you will be asked to create a password for MyBenefits. To protect your privacy, you must go through a few steps to create a password.

- The password must have eight characters. At least one must be a number and one must be one of these special characters: ! : # $ % * { } [ ] @.
- After you create your password, verify it.
- You will be asked four security questions that will help identify you if you ever forget your password. A summary of your registration information, including the answers to the security questions, will appear. This is the only time it will be displayed. *You may want to print this screen and keep it in a safe place.*

Once registered, you may log in by entering your BIN, the last four digits of your SSN and your password. This will take you to the main menu of MyBenefits.

- If you forget your password, you will be given three chances to answer correctly at least one of the four security questions and create a new password.
- If you are unable to correctly answer a security question after three tries, your account information will be removed and you will be redirected to the Register as New User page.
- Register as a first-time user to regain access to MyBenefits.

Using MyBenefits

After logging in, the subscriber will see any transactions you submit for his approval or he may choose:

- **Review Benefits** to see his benefits. He may print them, but he cannot change any of the information in the Review Benefits view.
- **Contact Information**. Here the subscriber can review his address, phone numbers and email address and update them.
- **Beneficiary**. Here the subscriber can review and change his beneficiaries. He can add a new beneficiary, delete a beneficiary, or he

can correct a beneficiary by overwriting or adding the information in the appropriate fields.

- **Open Enrollment.** The open enrollment function of MyBenefits is available only during the fall enrollment period.

When a subscriber makes a change (Submits a transaction) using MyBenefits, a Summary of Change (SOC) will be generated, similar to those a benefits administrator generates in the EBS online enrollment system. Only changes and updated information will appear in the New Value fields on the right side of the SOC.

- To accept the change(s), the subscriber clicks on the Approve button.
- A certification, authorization and disclaimer statements appear, which require an electronic signature. The subscriber then enters the last four digits of his SSN for the electronic signature. This authorizes and processes the transaction/change.

A final SOC is generated that the subscriber can print for his records.

Making open enrollment changes using MyBenefits

During open enrollment, your subscribers can make their own coverage changes when they log in to MyBenefits. Links to instructions appear in blue throughout the enrollment screen, and a link to a tutorial is at the top of the enrollment screen. These links help the subscriber navigate the enrollment screen and guide him through his enrollment choices.

Your Current Coverage

This section shows the subscriber's coverage and coverage levels.

Make Coverage Changes

In this section, the subscriber can enroll, change and cancel coverage for the various programs based on the changes allowed during the enrollment period. Built-in edits prevent the subscriber from enrolling in a program for which he, his spouse or his child is not eligible or from selecting a level of coverage above what is available to him.

Dependents

In this section, the subscriber can review his spouse and/or children and their coverage, add a spouse and/or children or add or cancel coverage for his spouse and/or each child by program (health, dental, vision, Dependent Life), based on the options allowed during the enrollment period.

Beneficiaries

This section shows the subscriber's current beneficiaries. Here, he can add or delete beneficiaries, designate them as primary or contingent and change the percentages they would receive for Basic Life and Optional Life.

Completing open enrollment changes

Once subscribers have completed their enrollment changes, they will be prompted to review the screen before electronically authorizing and submitting those changes. An SOI is generated that the subscriber can print for his records. The enrollment change data will then be sent to the BA Console in EBS for review and approval.

If the subscriber changes his mind during enrollment

If a subscriber changes his mind about his elections:

- The subscriber may go back into MyBenefits and edit and/or delete his enrollment changes until 11:59 p.m. October 31, regardless of whether the transaction has been approved by the benefits office. If the benefits office has approved a previous transaction, a new status will appear on the BA Console Pending BA Approval Subscriber Changed under the Approval tab.
- **Changes must be submitted by October 31.**

BA Console

The middle section on the homepage consists of four tabs. The Suspended tab, Acknowledgement tab, Approval tab and Current EBS tab. Here you will follow up on transactions initiated by you in EBS as well as transactions initiated by subscribers using MyBenefits.

Suspended Tab

The data on this tab shows transactions processed using the Online Enrollment System, and only shows incomplete transactions that you have suspended. You can change the number of transactions displayed on this tab — 10, 25, 50 or 100.

- The first column lists the SSNs of the subscribers.
- The second column lists the names of the subscribers.
- The third column lists the status of each transaction — Incomplete.

An **Incomplete** status indicates you have suspended the record. You can suspend a transaction for any number of reasons. For example, you are waiting for needed documentation, the transaction has not been completely processed, etc. The status will change from Incomplete to Complete and move to the Approval or Current EBS tab for completion once you finish processing the transaction.

Incomplete transactions may be edited or deleted.

The **Color Map** helps you follow up on the transactions appearing on the Suspended tab.

- Transactions more than 30 days old are highlighted in yellow.

At 60 days, a suspended transaction is canceled automatically, and it is deleted from the system. The changes are not applied. If the change is still valid, you would need to send a Request for Review Form to PEBA for approval.

Click anywhere on the row of a transaction to open a new window with the subscriber's transaction in it. The Edit and Delete buttons will be on the right side of the new screen once you have opened the transaction.

- The **Edit** button allows you to make changes or corrections to the subscriber's data. Once you have made changes, review them and then apply them to generate a revised SOC. This revised SOC must be printed and submitted to PEBA, along with any required documentation. For more information about making changes to subscribers' records using EBS, refer to Page 28.
- The **Delete** button removes the transaction. Deleting a transaction before it is applied by PEBA will cancel the transaction, and it will disappear from the Suspended tab.
- The **Cancel** button at the top right of the screen takes you back to the homepage.

Tips

- You may Edit (make corrections and changes) any transaction on the Suspended tab. *If you edit a completed transaction, another signature page and/or barcode page must be mailed to PEBA***.** The latest edited transaction must be signed and dated by you and the subscriber before mailing it to PEBA.

Acknowledgement tab

The Acknowledgement tab shows transactions that have been initiated by the subscriber using MyBenefits or initiated by you and sent to the subscriber to approve electronically in MyBenefits. These transactions do not require documentation. Examples are:

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

PEBA's files are updated electronically and a copy of the SOE or SOC is automatically imaged at PEBA.

Click anywhere on the row of the transaction to open it.

- The first column lists the SSNs of the subscribers.
- The second column lists the names of the subscribers.
- The third column lists the change reasons (such as contact information or beneficiary).
- The fourth column lists the dates and times of the transactions.

The Color Map helps you follow up.

- Transactions more than 30 days old are highlighted in yellow.

Transactions that are 60 days old are deleted from the Acknowledgement tab automatically. However, these transactions were applied at the time the subscribers made them.

When you acknowledge the transaction, a new window opens with the SOC in it. You can then print it. You should put this transaction copy in the subscriber's file and notify other applicable parties of the change. Do NOT send a copy to PEBA.

Tips

- Enrollments for new hires and changes must be initiated within the 31-day window.
- You may print copies of the SOEs/SOCs, or you may save them electronically to your computer.
- Acknowledging these transactions will remove them from the Acknowledgement tab. Notify any other applicable parties of the address changes.

Approval tab

Note: *Do not delay reviewing and processing transactions on the Approval tab, especially during open enrollment. You must process (or reject) these transactions in time to allow your subscribers to correct their changes or to change their minds (either through MyBenefits or by completing a paper NOE) before the end of the enrollment period on October 31.*

The transactions on this tab are initiated by subscribers using MyBenefits or initiated by you using the MyBenefits method and sent to the subscriber to approve electronically.

You must print a copy of these SOEs/SOCs for the subscribers' files and update payroll files as needed. These changes are not applied by PEBA or sent to the third-party claims processors until after you approve them.

- The first column lists the SSNs of the subscribers.
- The second column lists the names of the subscribers.
- The third column gives the status of each transaction.
- The fourth column indicates whether supporting documentation is required.
- The fifth column lists the dates and times of the transactions.

The Status and Support Documents columns are vital in handling the electronically submitted transactions.

The Color Map helps you follow up on records listed on the Approval tab.

- Records that have been rejected by PEBA are highlighted in green and appear at the top of the list for your immediate attention.
- Transactions more than 30 days old are highlighted in yellow.

At 60 days, a pending transaction is canceled automatically, and it is deleted from the Approval tab. The changes are not applied.

Current EBS tab

The Current EBS tab shows transactions that have been initiated by you and printed for signature.

- The first column lists the SSNs of the subscribers.
- The second column lists the names of the subscribers.
- The third column gives the status of each transaction.
- The fourth column indicates whether supporting documentation is required.
- The fifth column lists the dates and times of the transactions.

After selecting a transaction, click the Review/Print button and print any copies of the SOE/SOC you need for your files or for the employee. After clicking Back, you will be ready for the final approval. Let the employee review the SOE/SOC and click Edit to make changes or Approve to complete the transaction.

Once you approve a transaction, PEBA's files are updated electronically and a copy of the SOE or SOC is automatically imaged at PEBA. You will only be required to mail in the one-page signature page showing the subscriber has reviewed and accepts the transaction, a barcode page and any supporting documents.

Status

The nine possible statuses are explained below.

1. **Pending Subscriber Approval.**
   No documentation required (Support Documents is No). (Example: John Smith)

- This indicates transactions you initiated using MyBenefits and sent to the subscriber to approve electronically.
- Notify the subscriber to log into his MyBenefits account and electronically sign the SOE/SOC. Once signed, the transaction will move to the Acknowledgement Tab for you to print or save a copy for your records.
- The transaction will update PEBA's records when the subscriber signs the transaction in MyBenefits.

2. **Pending Subscriber Approval. Documentation required**
   (Support Documents is Yes). (Example: Joe Public)

- This indicates transactions that you initiated using MyBenefits and sent to the subscriber to approve electronically.
- Notify the subscriber to log into his MyBenefits account and electronically sign the SOE/SOC. Once signed, the transaction will move to the Approval tab for you to print or save a copy for your records.
- You must approve the transaction when the subscriber submits the required documentation. You will be given the option to Review and Print the SOE/SOC. Once you approve the transaction requiring documentation, a bar-coded cover sheet will be generated. Be sure to print this cover sheet. You will send only this cover sheet with the documentation attached to PEBA. Do NOT send a copy of the SOE/SOC to PEBA. You may print a copy of the SOE/SOC by accessing it using the Review and Print button.

3. **Pending BA Approval. No documentation required**
   (Support Documents is No). (Example: Jane L. Smith)

- This indicates transactions subscribers initiated in MyBenefits during open enrollment that may or may not require supporting documentation. You may Review and Print, Approve or Delete a transaction. You must select Review and Print before you will be able to click on Approve. You must Click anywhere on the row to access the desired transaction. Review the transaction, make a copy of the SOC for the subscriber's file and update the payroll as needed.
- The Review and Print button allows you to look at and print a copy of the SOC without making any changes to the document. You must review the transaction before

approving. Your electronic approval updates the file automatically at PEBA and sends a copy of the transaction to the appropriate third-party claims processors.

- The approve button electronically sends the transaction to PEBA. The option to print the SOC will be available. Be sure to print or save a copy for your files. The transaction will then disappear from the Approval tab if no documentation is required. If documentation is required, do not approve the transaction until you have received the documentation from the subscriber and have reviewed it.
- The delete button removes the transaction completely. All changes made by the subscriber are canceled.
- The cancel button at the top right of the screen returns you to the homepage.

4. **Pending BA Approval. Documentation required.**
(Support Documents is Yes). (Example: James Doe)

- This indicates transactions you initiated using MyBenefits and sent to the subscriber to approve electronically.
- Notify the subscriber to log into his MyBenefits account and electronically sign the SOE/SOC. Once logged in, the subscriber will see the transaction and will also get a message that documentation must be provided to complete the transaction.
- Once signed, the transaction status will change to Pending BA Approval on the Approval tab.
- You will need to approve the transaction *when the subscriber submits the required documentation*. You will be given the option to Review and Print the SOE/SOC.
- Once you approve the transaction requiring documentation, a bar-coded cover sheet will be generated. Be sure to print this cover sheet. You will send only this cover sheet with the documentation attached to PEBA. *Do NOT send a copy of the SOE/SOC to PEBA.* You may print a copy of the SOE/SOC by accessing it using the Review and Print button.
- The cover sheet (example at right) will include the subscriber's name, date the transaction was processed and a list of the required documentation. A bar code at the bottom of the cover sheet enables PEBA to match the required documentation to the SOE/SOC that has already been submitted electronically to PEBA. Attach the documentation to the cover sheet and mail them to PEBA *Do NOT send the SOE/SOC.*
- Once approved, the status will change to Pending EIP Approval. When PEBA receives the documentation, the transaction will be reviewed and applied, if correct.

5. **Pending EIP Approval**.
(Example: James Doe)

- This indicates transactions you have already approved and for which you have already mailed the supporting documentation to PEBA. These are the transactions that were previously shown as Pending BA Approval and Yes for supporting documentation before you received the documentation and approved these transactions.
- You will have the option to Review and print a copy of the SOEs/SOCs until PEBA approves the transactions. These transactions will disappear from the BA console when PEBA verifies the supporting documentation. *If the documentation submitted is not complete or sufficient, PEBA will reject or remove the transaction.*

6. **Subscriber Returned. Documentation may or may not be required**
(Support Documents can be Yes or No). (Example: India Crinkle)

- This indicates transactions you initiated in MyBenefits and sent to the subscriber via MyBenefits, but the subscriber returned the

transaction to you because of an error or change.

- Open the transaction and read the subscriber's note to find out what corrections he is requesting.
- You can then edit the transaction and send it back to the subscriber to review and approve in MyBenefits.
- You can select the Review button, which allows you to view and print a copy of the SOC without making any changes to the document. You must review the transaction before approving. Your electronic approval updates the file automatically at PEBA and sends a copy of the transaction to the appropriate third-party claims processors.
- You can select the Delete button, which removes the transaction completely. You may go back into EBS and initiate a new transaction.

7. EIP Rejected.

(Example: India Crinkle)

- This indicates transactions that PEBA has returned to the BA Console because the supporting documentation was not complete or not sufficient. *These transactions will be highlighted in green at the top of the Approval tab.* These transactions were previously shown as EIP Approval Pending.
- Click anywhere on the row to access the reason for the rejection, as shown in the example above. You will also see the same options for a transaction with the status Subscriber Approved with documentation required.
- Print a copy of the rejection and contact the subscriber to obtain the additional or corrected documentation. You may also need a copy of the original SOC as verification of the date the subscriber tried initially to make the change. It may be necessary to submit this copy, along with a paper NOE, if the open enrollment period has passed. The copy of the SOC verifies the initial change request was made in a timely manner.
- Once you receive the new/corrected documentation and approve the transaction, again, the status will change back to EIP Approval Pending. Be sure to print a new barcoded cover sheet, attach the new documentation and mail them to PEBA.
- If you determine that the transaction is not valid, you have the option of deleting the transaction.

8. Pending BA Review-Print. Documentation required

(Support Documents is Yes). (Example: Benny Fits)

- This indicates transactions you initiated using the Current EBS method.
- Click Review/Print and print any copies you need for your records or for the subscriber.
- If the subscriber reviews the transaction and wants to make a change, click Edit.
- If you determine that the transaction is not valid, you have the option of deleting the transaction.
- After the subscriber has reviewed and approved the transaction, click Approve.
- The transaction will update PEBA's records, and a PDF file will open containing a signature page and/or barcode page. These two pages, along with supporting documentation, are all that must be mailed to PEBA.

9. Pending BA Review-Print. No documentation is required

(Support Documents is No). (Example: Benny Fits)

- This indicates transactions you initiated using the Current EBS method.
- Click Review/Print and print any copies you need for your records or for the subscriber.
- If the subscriber reviews the transaction and wants to make a change, click Edit.

- If you determine that the transaction is not valid, you have the option of deleting the transaction.
- After the subscriber has reviewed and approved the transaction, click Approve.
- The transaction will update PEBA's records, and a PDF file will open containing a signature page and/or barcode page. These two pages are all that must be mailed to PEBA.

Tips

- If you need to print an SOE or 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 reprint SOEs and SOCs done through MyBenefits by going to Manage Subscribers in EBS. Log in using your EBS User ID and password, then select SOC Lookup and enter the subscriber's SSN. The most recent transaction will appear first. Click on the link next to an SOE/SOC to view it.
- If documentation is required for transactions generated in MyBenefits, you will get a cover sheet when you verify the accuracy of the required document and approve the transaction. Print the cover sheet and staple the required documentation to it. Mail only the cover sheet and required documentation to PEBA.
- Send signature pages and/or barcode pages to PEBA as soon as possible, so the transactions can be released. If the employee is not available to sign the SOE or SOC, have him complete and sign an NOE and attach it to the SOE/SOC.
- Do not write additional instructions on an SOC; PEBA cannot key handwritten changes. Instead, log on to EBS and modify or delete and re-enter the transaction.
- Make or save copies of SOEs/SOCs for your records and for your subscribers.
- Notify your payroll department of the changes that affect premiums.
- Make copies of any transactions you reject and notify the subscriber of the rejection. Likewise, make copies of any transaction PEBA rejects and notify the subscriber.
- Make copies of any transaction PEBA removes and notify the subscriber.
- If an NOE is required because of a rejection, attach a copy of the original SOE/SOC and attach it to the NOE. This will verify the original requests for enroll, change or open enrollment transactions were made within 31 days.
- Transactions involving incapacitated children cannot be done through EBS. A paper NOE must be used for these transactions.

SLTD salary updates using EBS

To update SLTD premiums correctly for the next plan year, PEBA needs updated salary information for your employees who are enrolled in SLTD.

- If your employer is not a part of the Comptroller General (CG) payroll group, submit your updated salaries as of October 1 of each year through the Employee Benefits Services (EBS).
- Please submit this information to PEBA no later than October 31.
- You should include data for those who have had a salary change since the previous October 1.
    - *Example*: If an employee was hired March 2014 with a salary of $25,000, and he has received a salary increase of $3,000, and his salary as of October 1 includes this increase, you must submit this updated salary information to PEBA.
    - The maximum annual salary for calculating SLTD benefits and premiums is $147,684. If PEBA

receives any salary updates that exceed this amount, the amount entered into the system will default to $147,684.

- Groups affected by furloughs should use employees' non-furlough salaries to calculate premiums.

You may begin entering the salaries on EBS on September 15.This system is available through October 31.

Submit your updated employee salaries to PEBA no later than October 31. **You may not submit SLTD salary information by email or on a disk**. SLTD salaries need to be reported through EBS. Log into EBS and select SLTD Salary Entry from the menu under Manage Groups. Please use one of the methods listed below.

- Select SLTD Salary Browse to add employee salaries individually, if you have a small number of employee salaries to update. The fields are set up for you. Type the data into each field, and click on the button at the bottom of the screen to submit the information for each employee.
- You may also upload SLTD Data from a diskette or from a text file saved on your computer.
- You may 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.
- You may select Batch Entry Screen which allows you to enter 10 employee salaries at a time.
- You may select Current SLTD Coverage List to receive a list of all employees currently enrolled in SLTD.
- You must Review and Confirm all SLTD salary entries when you have completed updates for your group.

If you have any questions, contact Chuck Wilson, PEBA insurance benefits Operations Manager at chuck.wilson@peba.sc.gov or via phone at 803.734.1787 or 888.260.9430

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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. If an Employer elects to obtain other health insurance coverage for its persons employed on a nonpermanent, Full-Time basis, such persons do not constitute Employees under this paragraph. 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 State-Covered Entity that has qualified for, 2016 SHP Plan of Benefits Document 9 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*:

With regard to an Employee shall mean an Employee who is credited with an average of at least 30 hours of service per week. Provided, however, 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 Insurance Benefits. Full-Time status for purposes of eligibility to participate in the Plan is determined in accordance with the process set out in paragraphs 3.19, 3.20, and 3.21 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 substantially all full-time employees or pay a penalty to the IRS.

To accommodate this requirement, PEBA has amended its Plan of Benefits to allow participating employers to 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 his 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 his 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 period of time 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 2017, the Standard Measurement Period runs from October 4, 2015, and ends on October 3, 2016.

Administrative Periods

The Administrative Period is the period of time (immediately after the measurement period) when the employer notifies an employee of his eligibility for benefits and the plan processes the employee's enrollment documents.

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 his Initial Measurement Period may enroll during an Initial Administrative Period, which begins the day after the end of his 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.

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 2017 is October 3, 2016-December 31, 2016. Employers must offer coverage to eligible employees during the plan's open enrollment period, which ends October 31, 2016. All enrollment forms must be submitted to PEBA according to the open enrollment submission deadline (refer to page 78 open enrollment). PEBA will use the remainder of the Standard Administrative Period to process enrollments to ensure employees have access to coverage at the beginning of the Stability Period (January 1, 2017).

The Standard Administrative Period is also the period of time an employer must notify an employee of his loss of eligibility for the next plan year. If an eligible employee is not credited with an average of 30 hours per week during the Standard Measurement Period, the employee will lose eligibility at the end of his stability period.

- If the employee is an ongoing employee and he does not qualify for benefits in the next plan year, the employee will lose eligibility at the end of the current plan year. The employer should:
    - Notify the employee he 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 his covered dependents an 18-month COBRA Notice. The COBRA Qualifying Event

will be the employee's reduction of hours effective January 1.
    - If the employee is enrolled in life insurance, send the employee the PEBA Coverage Verification Notice of Group Life Insurance.
    - Send PEBA the Active Termination form and check box T5—Not Eligible (Not in stability period) box indicating the employee is no longer eligible at the end of the stability period.
- If the employee is a new variable-hour, part-time or seasonal employee and he does not qualify for benefits based on the Standard Measurement Period, the employee will lose eligibility at the end of his Initial Stability Period. During the Standard Administrative Period, the employer should notify the employee he will not be eligible for benefits when his Initial Stability Period ends. At the end of the employee's Initial Stability Period, the employer should:
    - Notify the employee of his loss of eligibility.
    - If the employee is enrolled in health, dental or vision, send the employee and his covered dependents an 18-month COBRA Notice. The COBRA Qualifying Event will be the employee's reduction of hours effective the end of his Initial Stability Period.
    - If the employee is enrolled in life insurance, send the employee the PEBA Coverage Verification Notice of Group Life Insurance.
    - Send PEBA the Active Termination form and check box T5, indicating the employee is no longer eligible at the end of the stability period.

Stability Periods

The Stability Period is the period of time 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 that begins 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 Reporting Requirements 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, the employee can choose from which employer to accept coverage. See the Affordable Care Act Reporting Requirements Frequently Asked Questions.

- An employee who works for two participating employers is considered working for one employer or the other employer for insurance purposes. His insurance coverage and premiums *cannot* be split between the two employers, nor may he combine his two salaries for Optional Life/Dependent Life Insurance purposes. See page 87, Transfers and Terminations, for additional information.
- There are other special provisions regarding calculating hours of service and eligibility for benefits, especially for academic employers. PEBA strongly encourages employers to consult with their legal counsel for guidance in calculating hours of service.
- An employee who participates in the TERI program remains under the active group insurance program and is entitled to the same benefits and enrollment rules as a non-TERI employee. No paperwork needs to be submitted to PEBA regarding TERI employees.

Note: PEBA does not verify the eligibility of employees for employers. Neither does it classify employees.

Procedures to elect 20-hour threshold

Any participating employer, including a local subdivision, 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 group must send a letter to, 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 14).
- PEBA will send back 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** full-time 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

Prepare an information packet as outlined below. Use the Newly Eligible Employee Checklist on page 246to ensure that you have covered all benefit information.

Information packet

When an employee becomes eligible for insurance benefits, the employer should provide the employee with the following items (all of these items are available online www.peba.sc.gov*):

- Active Notice of Election (NOE) (unless the benefits administrator is enrolling through EBS, in which case direct the employee to the PEBA website and the MyBenefits homepage)
- Certification Regarding Tobacco Use
- Marketplace Exchange Notice (under the ACA heading)
- *Insurance Benefits Guide* (IBG)
- Notice of Special Enrollment Rights (under Other forms heading)
- Preventive Worksite Screening flyer
- MoneyPlus Information (*available to full-time benefits-eligible employees*)
    - *MoneyPlus Reference Guide*, formerly the *MoneyPlus Tax-Favored Accounts Guide*
    - MoneyPlus Enrollment Form, along with Custodial Agreement.

**During October-December, include a copy of the* Benefits Advantage *so the new employee will be aware of benefit changes for the next plan year.*

Review benefits available

Explain the following benefits are available to all eligible employees. The new employee must choose or refuse one or all of the following, based on eligibility:

Health insurance:

State Health Plan (includes prescription drugs and mental health/substance abuse; includes an additional preventive benefit for Savings Plan only — a physical).

- No-pay Copay
- Well Child Care benefit
- Pap Test benefit
- Mammography Testing benefit
- Maternity Management benefit
- Colonoscopy screening benefit
- Tobacco Cessation benefit (Quit for Life® offered through SHP)
- GEA TRICARE Supplement Plan
- Explain premium surcharge for tobacco users. Surcharge is automatic for State Health Plan subscribers, unless subscriber certifies no one he covers uses tobacco or covered individuals who use tobacco have completed a tobacco cessation program approved by PEBA. See Page 55.
- PEBA Perks and other value-based benefits available to members.

Dental insurance:

- State Dental Plan
- Dental Plus

Vision care:

- State Vision Plan
- Vision Care Discount Program

Additional benefits are available to **full-time employees**. If eligible, the new employee must choose or refuse one or all of the following:

Life insurance:

- Basic Life and AD&D
- Dependent Life-Child(ren) (a child age 19-24 must be a full-time student or certified as incapacitated to be eligible for coverage; a child older than 24 must be certified as incapacitated to be eligible for coverage)
- Dependent Life-Spouse and accidental death and dismemberment (AD&D)
- Optional Life and AD&D

Long Term Disability insurance:

- Basic Long Term Disability (BLTD)
- Supplemental Long Term Disability (SLTD)
- Explain there is a 12-month pre-existing condition exclusion period related to BLTD and SLTD benefits.
- Explain any applicable late entrant procedures and the pre-existing exclusion period is 18 months for late entrants to SLTD.

MoneyPlus:

- Pretax Group Insurance Premium Feature for health (with or without tobacco surcharge), dental, Dental Plus, State Vision Plan and for up to $50,000 in Optional Life coverage

Please note: Effective January 1, 2016, an employees who covers an ex-spouse on any benefit is not eligible for the Pretax Group Insurance Premium Feature. This does not affect the employee's eligibility to participate in an MSA or a DCSA.

- Medical Spending Account (MSA)
- myFBMC Card®
- Dependent Care Spending Account (DCSA)
- Health Savings Account (HSA)
- Optional limited-use Medical Spending Account

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, he forfeits Basic Life and Basic LTD coverage.**

To refuse coverage, the employee must complete the following sections of the NOE:

- Administrative Information (ACTION): check **New Hire**;
- Enrollee Information (ENROLLEE INFO): complete Blocks 1-19;
- Benefits/Coverage Information (COVERAGE): Check **Refuse** for each benefit refused; and
- Sign and date the Certification and Authorization statement at the bottom of the NOE.
- The BA should:
    - Complete the **BA Use Only** section at the top of the NOE;
    - Sign and date the NOE;
    - Keep a copy for your file and give a copy to the employee; and
    - Mail the original NOE to PEBA, even if the employee refused all coverage.
- Make sure the employee signs an NOE and any other benefit enrollment forms.

Explain enrollment

Explain how to enroll (if not enrolling the employee using EBS).

- Enrollment forms for all benefits must be completed and signed within 31 days of date of hire or a special eligibility situation (birth, marriage, adoption or placement for adoption or loss of coverage).
- If not completed within 31 days, must wait until the next open enrollment period or a special eligibility situation to enroll in health, dental and/or vision coverage. Full-time employees must provide evidence of insurability to enroll in Optional Life and Dependent Life-Spouse and medical evidence of good health to enroll in SLTD coverage.

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, he begins 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 children 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.

Review network, preauthorization, claims requirements

Explain the SHP requirements for Medi-Call, mental health and substance abuse benefits, Maternity Management benefits, Pap Test benefit, advanced radiology scans (such as, but not limited to, CT, MRI, MRA, PET scans), the hospital and physician networks, the Prescription Drug Program networks and the Well Child Care benefit.

Explain the claims processing steps for benefits, including how to file manual claims, and that completed claim forms should be submitted as services are rendered. Forms are also available on the PEBA website.

Explain how to request reimbursements from MoneyPlus accounts for unreimbursed expenses.

Assisting a new full-time employee with enrollment

All new full-time employees must complete an Active NOE to elect or refuse benefits within 31 days of their date of hire. The new employee is allowed to change his mind about an original selection within 31 calendar days of his date of hire (*not* the effective date of coverage). To make a new selection, a new NOE must be signed within the 31-day window and submitted to PEBA for processing.

If an employee is already enrolled as a dependent on his parent's coverage through PEBA, he may continue coverage as a dependent or enroll in coverage as an active employee. If the employee chooses to remain enrolled as a dependent, he may not enroll in any benefits as an employee, including SLTD and Optional Life.

- The benefits administrator should have the employee complete and sign an NOE refusing all coverage and an Active Group Benefits Refusal. Under Type of Change on the NOE, he should write, Enrolled as a child of PEBA subscriber next to Other.
    - Keep a copy for your file and give a copy to the employee.

Assisting a new nonpermanent full-time employee

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 may not be eligible for retiree coverage if they retire from a nonpermanent position. See Page 112 for retiree eligibility requirements, including that the last five years of active employment must be full-time, permanent and consecutive.

Completing the Active NOE

NOE forms are available on the PEBA website. NOE forms may be completed online and then printed and signed.

- The NOE sent to PEBA must have the subscriber's original signature.
- Do not use highlighters on NOEs.
- The employee is solely responsible for the information on the form(s) he signs.
- Use the correct NOE for the subscriber type. For example, do not use the Active NOE for a retiree, COBRA or survivor subscriber.
- The online NOE form has a Clear Form button to clear all entries on the form and start over.

Administrative information (ACTION)

- Check New Hire.
- Skip Type of Change, since you are enrolling a new hire.
- Benefits administrator should complete BA Use Only section.
- Check whether the employee is enrolling in the MoneyPlus Pretax Group Insurance Premium Feature.

Enrollee information (ENROLLEE INFO)

Enter all available information requested.

1. The SSN (verify with SSN card)

2-5. Full name (enter name as it appears on the employment record)

6-8. Personal information

9-10. Phone numbers (home and work)

11. Email address (work or home)

12-16. Mailing address: current and complete

17. County code: the county where the mailing address is located (see county code listing on Page 196).

18. Annual salary: per year, not hourly wages or monthly salary

19. Date of hire: date employee reports to work, not contract or signature date

Medicare coverage information (MEDICARE)

20. Medicare information, including number, if applicable. Indicate reason for eligibility. Parts A and B: the dates Medicare coverage went into effect (dates on Medicare card)

Benefits/coverage information (COVERAGE)

(No alterations in this section)

21. **HEALTH**: Must elect a health plan and level of coverage or check **Refuse**.

- The carrier generates the health ID card and sends it directly to the subscriber. This card has the subscriber's BIN printed on it (exceptions are noted above).
- **Spouse and children must be listed on the NOE to be covered.**
- Basic Life Insurance and Basic Long Term Disability are included automatically with State Health Plan and TRICARE Supplement Plan coverage.

22-23. **DENTAL**: Must elect a level of dental coverage or check **Refuse**. Must indicate **Refuse** or **Yes** under Dental Plus.

- Must elect the State Dental Plan to participate in the Dental Plus benefit.
- The level of coverage selected for the State Dental Plan and Dental Plus must be the same.
- **Spouse and children must be listed on the NOE to be covered.**
- Issue a State Dental Plan ID card to the employee. Tell the employee to write his BIN on the card when he receives his BIN in the mail. The employee uses his BIN or SSN to file covered spouse and children's claims.
- The carrier mails Dental Plus ID cards, with BINs printed on them, directly to subscribers.

24. **DEPENDENT LIFE - Child(ren):** An employee can purchase Dependent Life/Child(ren) for any of his eligible children. Children ages 19-24 must be full-time students or certified as incapacitated to be eligible for Dependent Life. Children older than 24 must be certified as incapacitated to be eligible for Dependent Life. Must **Refuse** or enroll for $15,000 coverage. Proof of eligibility, at the time of enrollment and at the time of the claim, will be required before any benefit will be paid on a child age 19-24.

- Children must be listed on the NOE to be covered.
- If both husband and wife are state employees, only one can carry coverage for eligible children.
- The employee is the beneficiary for all covered children.

25. **DEPENDENT LIFE - Spouse**: The employee is the beneficiary. Must **Refuse** or enter a coverage level ($10,000 or $20,000). If the subscriber is enrolled in Optional Life, he may elect more than $20,000 in Dependent Life/Spouse coverage with medical evidence, but no more than $100,000 and not to exceed 50 percent of subscriber's level of coverage.

- Follow the same procedures as outlined under Optional Life, below, for submitting evidence of insurability.
- **The spouse must be listed on the NOE to be covered.**
- An employee may not cover his former spouse for Dependent Life - Spouse coverage.

26. **OPTIONAL LIFE:** Must elect a level of Optional Life coverage or check **Refuse** ($10,000 - $500,000, in $10,000 increments, not to exceed three times salary, rounded down)

- The new hire may request a level greater than three times the annual salary, up to the maximum, by submitting evidence of insurability.
    - The employee should submit the original new hire NOE with the maximum guaranteed issue amount allowed by salary.
    - A second NOE for the total amount of coverage requested (with medical evidence) should be completed and held for the approval from Securian.
- Employees participating in the pretax premium feature (MoneyPlus) must make the medical underwriting request within 31 days of the date of hire. The NOE must be signed within 31 days of the date of hire. An Evidence of Insurability form must be completed and submitted to Securian within 31 days of the date of hire of an employee participating in the MoneyPlus pretax premium feature. The effective date for the higher level will be the first of the month after approval.
- Employees NOT participating in the pretax premium feature (MoneyPlus) may apply for additional coverage, up to the maximum, throughout the year by submitting a completed Evidence of Insurability form to Securian. The effective date for the higher level will be the first of the month after approval.
- For employees age 70 and older, mark the NOE for the coverage amount as if the employee were younger than age 70. The system will convert the amount and the premium to the age 70 level.
- Premiums are based on the employee's age as of the previous December 31.
- Employees participating in the pretax premium feature (MoneyPlus) can increase, decrease or drop Optional Life coverage only during each October enrollment period or within 31 days of a special eligibility situation. Employees NOT participating in the pretax premium feature may drop or

decrease Optional Life coverage throughout the year.

27. **SUPPLEMENTAL LONG TERM DISABILITY:** Must refuse or enroll.

- Premiums are based on an employee's age as of the previous January 1 and salary as of the date of hire. Groups affected by furloughs should use employees' non-furlough salaries to calculate premiums. (Salary is updated each year, and premiums are adjusted each January 1 based on salary as of the previous October 1.)

28. **VISION CARE**: Must elect a level of coverage for the State Vision Plan or check **Refuse**.

Beneficiaries information (BENEFICIARIES)

29. Do not make any alterations in this section. If a mistake is made, complete a new NOE.

- List a beneficiary for Basic Life, if health coverage is elected.
- List a beneficiary for Optional Life, if this coverage is elected.
- List each beneficiary's full name (for example: Jane Doe, not Mrs. John Doe or Mrs. Doe or Mrs. J. Doe), SSN, relationship to the subscriber and date of birth.
- If the number of beneficiaries exceeds the allotted space on the NOE, the employee should indicate on the bottom of the NOE that beneficiaries are continued on an attachment. On the attachment, indicate employee's name, SSN and the life insurance benefit with necessary beneficiary information. **The attachment must be signed and dated by the employee and stapled to the NOE.**
- List relationship as wife, husband, daughter, son, etc. Do not list spouse or child. An estate or trust has no relationship.
- Indicate percentages (not dollar amounts) when multiple beneficiaries are listed (percentages must total 100 percent and must be whole numbers — no decimals); otherwise, the benefits will be divided equally among the beneficiaries.
- Indicate whether each beneficiary is a primary or contingent beneficiary. Otherwise, all listed beneficiaries will be considered primary.
- For an estate, the employee must write ESTATE in block 30 on the NOE.
- For a trust, the employee must list the name and address of the trust institution and the date the trust was signed.

Dependent information (DEPENDENTS)

30. List the information on the spouse first. (Because of coordination of benefits, this information is required even if the spouse is not covered.)

- Indicate whether the spouse is also an employee covered by a participating employer.
- All requested information is required.
- List the given legal name as it will appear on a claim.
- Relationship: list as wife, husband, ex-wife, ex-husband to indicate gender. **Do not enter spouse.**
- Spouse's birth date.
- Any supporting documentation must be attached to the NOE. See Page 241for charts of documentation requirements.

List all children to be covered. If not listed, they will not be covered.

- Follow the same procedure for children as for the spouse.
- List the given legal name as it will appear on a claim.
- Relationship: list as son, daughter, niece, nephew, etc., to indicate gender. **Do not enter child.**
- If child is older than 19 and enrolled in Dependent Life-Child, indicate whether a full-time student or incapacitated. If

incapacitated, see Page H-13 for information on certification process.

- If child is age 26 or older, child can only be covered if incapacitated. Indicate incapacitated on form and see page 140 for information on certification process.
- Any supporting documentation must be attached to the NOE. See page 241for charts of documentation requirements.

Certification and authorization (CERTIFICATION & AUTHORIZATION)

31-32. Must be signed and dated by both the employee and the benefits administrator.

- Each employee should read the conditions and authorizations at the bottom of the NOE. The second page of the NOE contains step-by-step instructions on completing the NOE.
- The employee is solely responsible for what he signs.
- If an employee is unable to sign the NOE, a witness should verify the employee's signature X.

Tobacco certification

To avoid paying the surcharge on State Health Plan premiums, new employees must certify that neither they nor any of their covered spouse and/or children use tobacco. The tobacco-use surcharge may also be waived if a tobacco user completes a tobacco cessation program through the SHP's Quit for Life Program.

- If completing a paper NOE or an SOE through EBS, they should also complete and attach a Certification Regarding Tobacco Use form. Make sure the tobacco-user status entered in EBS matches the selection made on the Tobacco Certification form. Attach the Tobacco Certification form to the enrollment form before sending the forms to PEBA for processing. If the Tobacco Certification form is attached to the enrollment form, the effective date for the waiver (or surcharge if certifying as tobacco user) will be the effective date of coverage on the enrollment form.
- If completing a paperless enrollment through MyBenefits, there is no SOE to send to PEBA. In this situation, send the completed Tobacco Certification form to PEBA by itself. The effective date for the waiver (or surcharge if certifying as tobacco user) will be the first of the month after PEBA receives the form.
- Subscribers may also follow up and certify later by completing the Certification Regarding Tobacco Use form and submitting it to the benefits administrator. If the Tobacco Certification form is NOT attached to the enrollment form and is sent later, the effective date for the waiver (or surcharge if certifying as tobacco 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 smoke, marries and enrolls his new spouse who does smoke), have the subscriber complete a new Tobacco Certification form, and attach it to the NOE or SOC, so the effective date for the tobacco certification will be the same as the effective date for the coverage change on the NOE or SOC. Otherwise, the effective date for the tobacco certification will be the first of the month after PEBA receives the form.

Subscribers may apply to remove the surcharge once they and their covered spouse and/or children are tobacco-free for six months or if all covered individuals who use tobacco completed the Quit for Life smoking cessation program. They may certify by completing the paper Certification Regarding Tobacco Use form and submitting it the benefits administrator (or to PEBA if a retired, COBRA or survivor subscriber of a state agency, higher education institution or public school district). The

surcharge will be removed the first of the month after PEBA receives the form.

Tobacco Certification forms should not be held. They should be sent 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 WageWorks, 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 Dependent Care Spending Account (DCSA), the Medical Spending Account (MSA) and the Health Savings Account (HSA) (with or without a *limited-use* MSA) for Savings Plan subscribers. Participants in MSA and DCSA accounts must re-enroll each year during October enrollment. Refer to the IBG for eligibility rules and information regarding these features.

Note: In 2016, the Dependent Care Spending Account (DCSA) is capped at $1,500 for highly compensated employees. However, the $1,500 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 2016, the Internal Revenue Code defines a highly compensated employee as someone who earned $120,000 or more in calendar year 2015.

Effect of MoneyPlus on other retirement plans

State Retirement Plan

Contributions to or benefits from the retirement systems administered by PEBA are based on 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 may contribute to a MSA or HSA for many years, and the amounts contributed may vary significantly, year to year.

The Tax Analysis Calculation software on WageWorks' website may help estimate the effect of MoneyPlus participation on future Social Security benefits. Employees should consult their tax preparer/advisor to discuss their options.

If both spouses are eligible

- If both spouses are eligible employees, each may participate in MoneyPlus.
- Either spouse may 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. Refer to

the MoneyPlus Change in Status Form for eligible changes and their effective dates.

Eligible employees may enroll in a MoneyPlus Health Savings Account (HSA) at any time. They may change their HSA elections on a monthly basis. HSA changes become effective the first of the month following the change.

Assisting an employee with MoneyPlus enrollment

Pretax Group Insurance Premium Feature

- To participate, check Yes in the MoneyPlus box on the NOE. To decline, check Refuse.
- 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

- Provide a copy of the *MoneyPlus Reference Guide* from WageWorks.
- Provide a copy of the MoneyPlus Worksheets.
- Refer the employee to the Tax Analysis Calculation software on WageWorks' website.
- To participate in either account, the employee completes a MoneyPlus Enrollment Form. He must re-enroll each October to continue participating the following year. The myFBMC Card® is provided to MSA participants at no charge.
- The deduction amount entered on the form should be PER PAYCHECK, not per month. If the annual deduction amount is not evenly divisible by the number of payroll deductions, round down so that the participant will not exceed his annual election.
    - Example: If the annual election is $1,000 and the employee has 24 payroll deductions, the per-pay-period amount would be rounded down to $41.66, or $999.84 annually. WageWorks will make this adjustment if you do not.
- Refer to the MoneyPlus COBRA section for employees who are retiring or otherwise terminating employment.
- The benefits administrator must complete the portions indicated and sign the bottom of the form, verifying eligibility.
- Make copies as needed. Give a copy to your employee and forward a copy to WageWorks. If WageWorks makes a change to the enrollment form, a copy will be sent to you for correction in your system.
- If the employee participates in one of the spending accounts, be sure to provide a Direct Deposit Authorization Form.

Comptroller-General Agencies only

If your payroll is processed through the CG's office, complete a P-4 payroll change form and return it to the benefits office for all changes to existing deductions or additions of new deductions.

Dependent Care Spending Account and Medical Spending Account Rules

Refer to the IBG and the *MoneyPlus Reference Guide* from WageWorks for the eligibility information regarding these accounts.

- Participants may not 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.
- By IRS regulations, an employee has until March 15 to spend any remaining funds deposited in his Medical Spending Account or Limited-Use Medical Spending Account 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 plan year. Amounts not claimed by March 31 cannot be returned to the employee or carried forward to a new plan year.
    - WageWorks sends statements to participants who have an account balance, have had activity in their account during the period or who have outstanding myFBMC Card® transactions. The statements are mailed quarterly.
    - WageWorks includes a reminder of the 90-day run-out period in the statements they receive November-February.
    - All participants, regardless of account activity, will receive a final statement after the run-out period ends for the previous plan year.

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 daycare) must be incurred prior to reimbursement.
- By IRS regulations, an employee has until March 31 to submit claims for eligible Dependent Care Spending Account expenses from January through December of the previous year. Amounts not claimed by March 31 cannot be returned to the employee or carried forward to a new plan year.

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

- is not someone else's qualifying child;
- is a U.S. citizen, national or resident of the U.S., Mexico or Canada;
- has a specified family-type relationship to the employee; and
- spends at least eight hours per day in the employee's home.

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;
- **i**s physically and/or mentally incapable of self-care;
- **i**s not someone else's qualifying child;
- **l**ives in the employee's household for more than half of the tax year;
- **s**pends at least eight hours per day in the employee's home; and
- receives more than half of his support from the employee during the tax year.

Note: If the employee is the tax dependent of another person, he 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 Dependent Care Spending Account.

Medical Spending Accounts Only

- Generally, the expense must be incurred prior to reimbursement.
- MSA participants have a *grace period* of two months and 15 days following the end of the calendar year. If participants have money remaining in their MSAs when the plan year ends on December 31, they may continue to incur eligible expenses until March 15 and pay them with any unspent funds from the previous year. This is not to be confused with the *run-out period*.
    - During the grace period, employees should send their MSA claims and documentation for the previous year to WageWorks as soon as possible, particularly if they have begun to file new claims for expenses incurred in the current year. When WageWorks receives MSA claims during the grace period (both manual claims and myFBMC Card® claims), WageWorks will pay those claims first from any funds remaining from the previous year (if any funds are remaining) and then from current-year funds. If employees wait to submit claims from the previous year, those claims could be rejected if remaining funds are used to pay more recent claims incurred during the grace period.
- If the employee has a myFBMC Card®, requested documentation should be submitted using a MoneyPlus Claim Form, the same form used for manual MSA claims and DCSA claims. The account must be reimbursed for any ineligible expenses that were paid with the card.
- Documentation is required for certain types of transactions, as explained in the IBG and the *MoneyPlus Reference Guide*.
- Monthly statements indicate in blue ink when to submit supporting documentation.
- **If the required documentation is not received by WageWorks within 60 days of the card transaction date**, the account is then subject to *automatic substitution*. Automatic substitution allows WageWorks to reimburse the account by applying all or a portion of a subsequent, eligible manual/paper claim.
- **If the documentation is not received by the time the second quarterly statement is sent** and no automatic substitution has occurred to satisfy the amount in question, the participant's myFBMC Card® *will be suspended* until:
    - WageWorks receives the documentation
    - Automatic substitution occurs
    - The participant pays back his account by check. WageWorks will reinstate the card automatically once the transaction in question is cleared by one of these methods.
- Any 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:
    - A contract is required to verify the procedure is not for cosmetic reasons.
    - The initial service (banding) must have occurred before reimbursements may begin.
    - The contract payment schedule will need to be reviewed before reimbursements may begin.

Whose expenses are eligible under an MSA?

- Employee
- Employee's spouse
- Employee's qualifying child or
- Employee's qualifying relative

An individual is a **qualifying child** if he is 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 his own support during the tax year.

An individual is a **qualifying relative,** if he is 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 his 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 his support from the employee during the tax year.

Note: There is no age requirement for a qualifying child if he is 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.

Refer the employee to the *MoneyPlus Reference Guide* **for more information.**

Health Savings Account

Provide a copy of the *MoneyPlus Reference Guide* and Health Savings Account flyer from WageWorks.

To participate, the employee must:

- Enroll in the SHP Savings Plan
- Complete a MoneyPlus Enrollment Form for pretax, payroll deductions of HSA contributions.
- Open an HSA bank account online with Wells Fargo that will receive those contributions.

Completing the MoneyPlus enrollment form

- Complete all available identification and contact information in the top section of the form.
- The deduction amount entered on the form should be PER PAYCHECK, not per month. If the annual deduction amount is not evenly divisible by the number of payroll deductions, round down so that the participant will not exceed his annual election.
    - Example: If annual election is $1,000 and the employee has 24 payroll deductions, the per-pay-period amount would be rounded down to $41.66, or $999.84 annually. WageWorks will make this adjustment if you do not.
- Be sure the employee does *not* sign up for a regular Medical Spending Account also (Section C of the form). However, the employee may sign up for a limited-use Medical Spending Account (Section B) and/or a Dependent Care Spending Account (Section D). If enrolling in the Savings Plan, he may also enroll in the Health Savings Account (Section A).
- **The benefits administator must complete the portions indicated and sign the bottom portion, verifying eligibility.**
- Make copies as needed. Give a copy to your employee and forward a copy to WageWorks.

- If WageWorks makes a change to the enrollment form, a copy will be sent to you for correction in your system.
- WageWorks charges a $1.50 monthly administrative fee, which is collected from the employer's payroll center and submitted to WageWorks, along with other MoneyPlus account fees.

Opening an HSA Bank Account Online

Direct employees to open their HSA accounts online with Wells Fargo. Here's the link. The Employer HSA ID number is 00247 followed by 10 zeros, and the name of the carrier is BCBSSC.

Wells Fargo charges HSA participants an administrative fee of $1.75 monthly. Wells Fargo will charge the monthly administrative fee automatically, and it is deducted from the account at Wells Fargo.

Comptroller-General Agencies Only

If your payroll is processed through the CG's office, complete a P-4 payroll change form and return it to the benefits office for all changes to existing deductions or additions of new deductions.

Health Savings Account 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 single coverage (employee-only coverage), each may 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 or checks to get funds directly out of their accounts for eligible expenses; they do *not* request reimbursement through WageWorks.
- Participants may not 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.
- Wells Fargo sends monthly statements 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, so long as the eligible expenses were incurred after the HSA was established and the employee is keeping sufficient records to document the eligible expenses.
    - Wells Fargo will send the tax forms for income tax reporting directly to participants.

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 his NOE and supporting documentation.

- PEBA will process the NOE and send enrollment 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 him a GEA TRICARE Supplement Plan enrollment packet.

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 his Initial Measurement Period may enroll during an Initial Administrative Period, which begins the day after the end of his 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 his Initial Stability Period regardless of the number of hours the employee works.

Example: An employee hired on December 5, 2014, would not have been employed for the entire Standard Measurement Period (October 4, 2014-October 3, 2015); therefore, the employee will have his own Initial Measurement Period, Administrative Period and Stability Period:

- Initial Measurement Period January 1, 2015-December 31, 2015
- Initial Administrative Period January 1, 2016-January 31, 2016
- Initial Stability Period February 1, 2016-January 31, 2017

During the Administrative Period, the employer would review the hours worked by the employee during his Initial Measurement Period. If the employee is deemed eligible for benefits, the employer would offer coverage and submit a Notice of Election form to PEBA electing or refusing coverage by January 31, 2016. If the employee was deemed eligible for benefits, he would remain eligible for the duration of his Stability Period regardless of the number of hours he works.

In accordance with the ACA and as defined in paragraphs 3.19, 3.20, and 3.21 of the Plan of Benefits document, variable-hour, part-time and seasonal employees who are eligible for benefits are eligible for all benefits.

Assisting an eligible variable-hour, part-time or seasonal employee with enrollment

- Eligible employees must elect or refuse coverage within the employee's designated Administrative Period by completing an Active NOE or by enrolling through EBS/MyBenefits.
- Coverage is effective the first of the month after the end of the Administrative Period.
- Employees enrolling in a health plan must also complete their tobacco certifications to avoid the premium surcharge.
- The employee is allowed to change his mind about an original selection within the administrative period. To make a new selection, a new NOE must be signed within the 31-day window and submitted to PEBA for processing.

Completing the Active NOE

The same procedures apply for completing the different sections of an Active NOE with the following exception:

Coverage Information (COVERAGE)

20. **CATEGORY**: Employer should 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 112 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 2.56 of the Plan of Benefits document, permanent, part-time teachers of South Carolina public schools, the South Carolina Department of Corrections, the South Carolina 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)
- State Dental Plan and Dental Plus
- MoneyPlus
- State Vision Plan and Vision Care Discount Program.

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

- Basic Life Insurance
- Basic LTD or Supplemental LTD
- Dependent Life Insurance for children or spouses
- Optional Life Insurance.

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 may 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. Contact 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, may elect coverage as a permanent, part-time teacher or as 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 his 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 112 for retiree eligibility requirements, including that the last five years of active employment must be full-time and continuous.

Assisting a permanent, part-time teacher with enrollment

- Eligible employees must enroll within 31 days of date of hire by completing an Active Part-time Teachers NOE or by enrolling through EBS/MyBenefits.
- 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 complete their tobacco certifications to avoid the premium surcharge.

Completing the NOE

The same procedures apply for completing the different sections of a permanent Part-Time Teacher NOE as for an Active NOE, with the following exceptions:

Coverage information (COVERAGE)

20. **CATEGORY**: Must select one category based on the number of hours worked each week. The benefits administrator should 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 Section B, Using the Online Enrollment System, for more information.

- After the transaction is complete and you have the documentation, if any, call PEBA's BA Contact Center. You will be given a number to use to fax the documentation to PEBA. 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.
- If the subscriber's file is in suspense because of a rejection, call PEBA's BA Contact Center. The call center representative will delete the suspended transaction so that you can complete the transaction in EBS. After the fax is received, the call center representative will release it and update the third-party claims processors.

A subscriber can obtain medical services before he has an insurance card by giving his member ID to his provider.

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

A subscriber can obtain prescription drugs before he has an insurance card.

- **After January 1, 2016,** State Health Plan subscribers should tell the pharmacist they are now with Express Scripts. The pharmacist may only need the member's name and his eight-digit claim. If the pharmacist needs more information from the card:
    - **All active employees and their covered dependents** should provide the RxGroup: SCPEBAX; RxPCN: A4; and RxBIN: 003858.
    - **Retirees not enrolled in Medicare** should provide the RxGroup: SCPEBAX; RxPCN: A4; and RxBIN: – 003858.
    - **Retirees enrolled in Medicare** should provide the 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 his child. Timely completion helps ensure children have the required coverage.

If you receive a NMSN, fax it to PEBA as soon as possible. The format of the notice may vary, but it will always say National Medical Support Notice at the top of the first page, and 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.
- Please note: The information on the custodial parent and child contained on the NMSN should not be shared with the employee. If the employee has questions concerning the coverage requirements and plan choice, please 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 may not make changes to their benefits other than those specified in the NMSN, which PEBA will determine.

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

Rules and procedures for late entrants

Health insurance

- The employee must wait until the next October enrollment period to enroll as a late entrant or to add a spouse or child as a late entrant. Someone who enrolls due to a special eligibility situation is not considered a late entrant.
- No medical evidence of good health is required for subscribers, their spouses or children.
- There are no pre-existing condition exclusions under any of the health plans offered through PEBA.

Dental insurance

- 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 as a late entrant.
- There is no dental underwriting for subscribers, their spouses or children.
- There are no pre-existing condition exclusions under the State Dental Plan or Dental Plus.

Vision insurance

(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 as a late entrant.
- There is no medical evidence of good health for subscribers, their spouses or children.
- There are no pre-existing condition exclusions under the State Vision Plan.

Life insurance

Optional Life

(Policy number 34407)

- 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 evidence of insurability 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 evidence of insurability and be approved.

Refer to page 72 for the procedures for adding and changing Optional Life Insurance coverage outside of a new hire situation.

Dependent Life-Spouse

(Policy number 34407)

- Eligible spouses may be added throughout the year.
- Evidence of insurability is required for spouses enrolled as late entrants.

Refer to page 75 for the procedures for adding and increasing Dependent Life Insurance coverage with evidence of insurability.

Dependent Life-Child(ren)

(Policy number 34407)

- Eligible dependent children may be added throughout the year.
- No evidence of insurability is required for children enrolled as late entrants.

Supplemental Long Term Disability

(Policy number 621144A)

- Have the employee complete the SLTD Medical History Statement.
- Send the completed original to Standard Insurance Company.
- When an approval is received from The Standard, have the employee complete an NOE to select the coverage for which he was approved. This may be done earlier and held for the approval from Standard.
- Send the NOE to PEBA. The approval must be stapled to the NOE.
- Premiums start with the effective date of coverage (first of the month after approval).

Changes in status and special eligibility situations

(Health, State Dental Plan/Dental Plus, State Vision Plan, Dependent Life)

Enrollment changes must be requested within 31 days of the changes in status that follow, and any supporting documentation must be attached to the NOE or SOC. 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.

- Employees can enroll themselves and/or their covered dependents in the State Vision Plan during the next October enrollment period or due to a special eligibility situation if they miss their 31-day window of opportunity.
- If the change in status or special eligibility situation changes the tobacco use status for the subscriber (i.e., the subscriber was certified as a non-tobacco user, and he is enrolling a new spouse who *is* a tobacco user), have the subscriber complete a new Certification Regarding Tobacco Use form and attach it to the NOE enrolling the new spouse.

More information on changes related to a spouse or a child can be found in beginning on Page 130.

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

(*Exceptions*: Medicare and Medicaid--see effective dates below.)

- *Exception to 31-day rule:* 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 he gains other group coverage. He can drop only the type of coverage he gained.
- An employee may drop a spouse or child from coverage if his spouse or child gains other group coverage. Only the spouse or children who gained other coverage may be dropped. The spouse or child can be dropped only from the type of coverage he gained.
    - However, if the spouse is gaining coverage as an employee of a participating employer, the subscriber must drop the spouse within 31 days; he cannot wait until the open enrollment period.
    - If a spouse or child 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 must be terminated from the other coverage first. If the spouse or child's coverage as a dependent is not terminated within 30 days, PEBA will make the adjustments and send a letter to the employers and the subscriber who is losing the dependent to let them know that the spouse or child has been dropped as a dependent and is enrolled in his own coverage.
- A gain of other group coverage letter is required only if the group is not participating with PEBA insurance benefits. The letter must be attached to the NOE.
    - The gain of coverage letter must be on company letterhead.
    - The letter must include the company's name, the effective date of coverage, the type(s) of coverage (health, dental and/or vision) and list all individuals who gained coverage.
    - The letter 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 letter, and the deadline to enroll in PEBA insurance coverage is nearing, complete and 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 only make a change in coverage through PEBA 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 he gains Medicare.
- An employee may drop a spouse or child from health coverage if his spouse or child gains Medicare. Only the spouse or children 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 employee signs up for Part D, PEBA will *not* be able to drop his 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 call PEBA's BA Call Center for more information.
    - *When an individual begins dialysis for end-stage renal disease*, he becomes eligible for Medicare typically three months after beginning dialysis. At this point, he begins a coordination period of 30 months. During this time, his coverage through the SHP remains primary. When the coordination period ends, Medicare becomes primary. 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, he 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 his 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 he was notified by Medicaid, no changes are allowed.
- An employee may terminate health, dental and/or vision coverage if he gains Medicaid.
- An employee may drop a spouse or child from coverage if his spouse or child gains Medicaid. Only the spouse or children who gained Medicaid may be dropped.
- A copy of the Medicaid approval letter must be attached to the NOE.
- 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 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 DHHS (contact information will be on the Medicaid approval letter).

Loss of other group coverage

(Includes Medicare and Medicaid)

- *Effective date:* date of the loss of coverage
- *Exceptions to the 31-day rule:* If the subscriber and his 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 he is not already enrolled in health through PEBA, he can enroll himself, his spouse and his children in health, dental, Dental Plus and vision. The subscriber must enroll in coverage he is adding for his spouse or children. He cannot drop or change his current coverage.
    - If the subscriber is already enrolled in health through PEBA, he cannot make changes.
- If the subscriber loses other dental coverage, he can enroll in dental or in dental and Dental Plus.
- If the subscriber loses other vision coverage, he can enroll in vision.
- If the subscriber's spouse or child loses other health coverage, he can enroll himself and the spouse or child who lost coverage in health, dental, Dental Plus and vision. The subscriber must enroll in coverage he is adding for his spouse or children. If the subscriber is already enrolled in health, he may change plans if he adds the spouse or child who lost coverage. He cannot drop his current coverage.
- If the subscriber's spouse or child loses other dental coverage, he can enroll himself and the spouse or child who lost coverage in dental or in dental and Dental Plus. The subscriber must enroll in coverage he is adding for his spouse or children.
- If the subscriber's spouse or child loses other vision coverage, he can enroll himself and the spouse or child who lost coverage in vision. The subscriber must enroll in coverage he is adding for his spouse or children.
- 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 evidence of insurability 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 evidence of insurability.
- Documentation of dependent eligibility should be attached to the NOE.
    - A marriage license or page 1 of the employee's federal tax return is required to add a spouse.
    - The Continuing Marriage Affidavit can be used instead of page 1 of the federal tax return. The completed form must be notarized as proof that the subscriber and spouse are married.
    - A birth certificate (long form) showing the subscriber as the parent is required to add a child.
- **Documentation of loss of coverage should be attached to the NOE.** Acceptable documentation is a creditable coverage letter or a letter, on company letterhead, that includes the employer's name, the effective date of the loss of coverage, the type of coverage lost (health, dental and/or vision), the names of all individuals who lost coverage.
    - If the coverage that was lost was through a PEBA insurance benefits-

participating employer, please 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 he is not already enrolled in health through PEBA, his spouse and children can be added to health, dental, Dental Plus 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 him to enroll in those coverages.
    - If the subscriber's spouse or child loses other health coverage, the loss of coverage letter does not need to say spouse or child lost dental or vision for the spouse or child to enroll in dental, Dental Plus or vision.
- If the subscriber has not received the loss of coverage letter, and the deadline to enroll in PEBA coverage is nearing, complete and 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 an 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 that are allowed by the IRS. Refer to the appropriate IRS Publication regarding the Medical Spending Account (IRS Publication 502) or the Dependent Care Spending Account (IRS Publication 503) 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. These publications are available on the IRS website at www.irs.gov.

Eligible employees have 31 days to enroll or to make a change when a qualifying change in status occurs. Refer to the MoneyPlus Change in Status form for eligible changes and their effective dates. 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 your Medical Spending Account contributions when your adult child gets a job and coverage elsewhere is consistent with the gain of other coverage; increasing your 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, he may also enroll in or drop his Pretax Group Insurance Premium Feature. This election is made on the NOE.

- **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 only submit expenses incurred through the date of termination.
- **Health Savings Account** — Change in status rules do not apply to HSAs. HSA contributions may be started at any time and stopped or changed monthly, regardless of the situation. Use the MoneyPlus Enrollment form for HSA enrollment *and* changes.

Refer to the Transfers and Terminations section and the COBRA section of this manual for more information on continuation of Medical Spending and Health Savings accounts at termination.

Completing the Change in Status Form

Use the MoneyPlus Change in Status form when an employee wants to change his MoneyPlus account(s) due to a change in status.

- Enter the date of the event, not the effective date of the change.
- For changes to Dependent Care Spending Accounts (change existing, start or terminate) the Tax Filing Status box under Qualified Change Events must be completed.
- Complete the Payroll Calculation Summary for each account that will change, calculating the new payroll deduction amount based on the pay periods remaining in the year.
- Deductions for any accounts which the employee has, but does not wish to change as a result of the change in status, will remain the same.
- The employee must sign and date the form.
- The benefits administrator must complete the last section to confirm the eligibility of the change in status, including the group number and name of the employer, employer address and contact information. The benefits administrator must also sign the form. This signature verifies the employee is eligible to change his account. WageWorks does not request supporting documentation, nor does WageWorks make decisions as to the employee's eligibility. It is the benefit administrator's responsibility to verify change in status eligibility.
- Some payroll centers cannot handle before- and after-tax deduction changes during the year. All changes must then be made during the open enrollment period.

Return the completed form to WageWorks by fax or by mail. The fax number and mailing address are at the bottom of the form.

- If WageWorks does not receive the form before the participant submits claims related to the change in status, those claims may be rejected.
- If WageWorks does not receive adjusted payroll data that matches the payroll effective date or payroll amount on the form, related claims may 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 apply also 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:

- Complete and send an Active Termination form to PEBA, 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., he enrolled in Category III working 26 hours and the contract changes to 23 hours), he may decrease or increase his coverage.
- If the increase in hours places the employee in a higher category (e.g., he enrolled in Category I working 17 hours and the contract changes to 23 hours), he may select and/or increase his benefits.
- If the increase in hours reaches 30 hours per week, classifying him as a permanent, full-time employee, he is eligible to make all new selections. Treat him as a new hire and offer all benefits to him, effective the first of the month after he reaches permanent, full-time status.

Other coverage changes

Optional Life

Use an NOE to change Optional Life coverage. The benefits administrator must mark the NOE indicating **Yes** or **Refuse** in the MoneyPlus section at the top right of the NOE to indicate whether the employee participates in the MoneyPlus Pretax Premium Feature.

Not participating in MoneyPlus

Subscribers NOT participating in the MoneyPlus Pretax Premium Feature may (the 31-day rule does not apply if NOT participating in the Pretax Premium Feature):

- Add or increase coverage, with evidence of insurability:
    - Complete an Evidence of Insurability form and submit it to Securian for review. The benefits administrator completes the For Benefits Administrator Use Only section at the bottom of the first page of the form. Be sure to include your employer name and group number at the top of the form, and include the amount of Optional Life/Dependent Life amount

requiring evidence of insurability and the total amount of Optional Life/Dependent Life coverage the employee has elected. The subscriber faxes or mails the completed form to Securian. If additional information or medical data is needed, Securian will send a letter to the subscriber or medical provider.
    - Securian allows 60 days to respond. A reminder letter is sent if no response is received within 30 days. If no response is received in another 30 days, the file is closed.
    - Securian subcontracts for a paramedical exam, if an exam is necessary to make a determination. If required, this step also follows the same 30- and 60-day process.
    - Once Securian receives all needed information, a decision will be made within 10 business days.
    - Securian emails a Notification Statement to the subscriber and the benefits administrator.
    - As the benefits administrator, you will need to attach a copy of the Notification Statement from Securian, showing the approval, to the NOE that shows the increase in coverage, and send them to PEBA so the subscriber's file can be updated and the billing statement adjusted.
    - The effective date will be the first of the month after approval from Securian.
- Add or increase coverage, without evidence of insurability, due to a special eligibility situation:
    - The change must be made within 31 days of the special eligibility situation (marriage, birth, adoption or placement for adoption).
    - The effective date of the change will be the first of the month after the change is requested on an NOE.
    - If the subscriber refused Optional Life as a new hire, he may add coverage, up to $50,000 (in increments of $10,000). If the subscriber is already enrolled in Optional Life, he may increase coverage, up to an additional $50,000 (in increments of $10,000 and not to exceed the maximum amount allowed).
- Decrease coverage (effective the first of the month after the change is requested on an NOE).
- Cancel coverage (effective the first of the month after the change is requested on an NOE).

Participating in MoneyPlus

Subscribers participating in the MoneyPlus Pretax Premium Feature may (changes must be made within 31 days of the special eligibility situation or the employee must wait until the next enrollment period):

- Add coverage. The Optional Life request must be consistent with the special eligibility situation (such as to add Optional Life coverage due to marriage).
    - The effective date of the change will be the first of the month after the change is requested on an NOE.
    - If the subscriber refused Optional Life as a new hire, he may:
    - Add coverage, up to $50,000 (in increments of $10,000), without evidence of insurability.
    - The effective date will be the first of the month after the change is requested on an NOE.
    - Add coverage, more than $50,000 (in increments of $10,000 and not to exceed the maximum amount

allowed), with evidence of insurability.
    - Complete an Evidence of Insurability form and submit it to Securian for review.
    - Complete two NOEs. Complete the first NOE, requesting the level for which he is eligible without medical evidence ($50,000), effective the date of the event. Complete the second NOE for the *total amount* of coverage (with medical evidence) and hold until approval is received from Securian.
    - Once approved, send the second NOE, with the Notification Statement attached, to PEBA for processing.
    - The effective date will be the first of the month after approval from Securian. The process, once Securian receives the Evidence of Insurability form, is explained below.
- Increase coverage, up to an additional $50,000, without evidence of insurability.
    - The effective date will be the first of the month after the change is requested on an NOE.
- Increase coverage, more than $50,000, with evidence of insurability.
    - Complete an Evidence of Insurability form and submit it to Securian for review. Keep a copy to hold in the pending file.
    - Complete two NOEs:
    - Complete the first NOE, requesting the level for which he is eligible without evidence of insurability ($50,000), effective the first of the month after the change is requested on an NOE.
    - Complete the second NOE for the *total amount* of coverage (with medical evidence) and hold, with the copy of the Evidence of Insurability form, until approval is received from Securian.
    - Once approved, the second NOE should be sent to PEB for processing with the Notification Statement and the copy of the Evidence of Insurability form attached.
- Decrease coverage. The Optional Life request must be consistent with the special eligibility situation (such as to decrease Optional Life coverage due to death of a spouse or child).
    - The effective date will be the first of the month after the change is requested on an NOE. *Exception*: The effective date for the death of a spouse will be the day after death, as with other benefits.
- Cancel coverage. The Optional Life request must be consistent with the special eligibility situation (such as to cancel Optional Life coverage due to death of a spouse or child).
    - The effective date will be the first of the month after the change is requested on an NOE. *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 his Optional Life selection becomes effective (add Optional Life coverage or increase in the level of Optional Life), the effective date will be the first of the month after the employee returns to work for one full day. Actively at work is defined in the Terms to know section at the end of the IBG's Life insurance chapter.

If request for additional coverage is denied

If Securian denies additional coverage, based on evidence of insurability:

- The employee may request from Securian, in writing, additional information regarding the denial.
- Do not forward denials to PEBA.
- If denied, the employee may reapply by submitting a new Evidence of Insurability form.

Dependent Life

Dependent Life-Child(ren)

- 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; an NOE must be submitted to continue coverage beyond 31 days.
- Coverage may 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).
- Certification of student status or incapacitation is required for ages 19-24 to be covered. No claims will be paid without this documentation.
- 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 himself or increase his 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 IBG and below, will apply, *except for newborns.*

Dependent Life-Spouse

- Coverage up to $20,000 may be added within 31 days of date of marriage or within 31 days of loss of other coverage with a participating employer, without providing evidence of insurability.
- Coverage may be added, increased, decreased or canceled throughout the year.
- Evidence of insurability (medical underwriting) is required for late entry and to increase Dependent Life-Spouse coverage beyond $20,000, up to the maximum allowed.
- Evidence of insurability procedures:
    - Complete an NOE, listing the spouse to be added to coverage or to have coverage increased.
    - Complete an Evidence of Insurability form and submit it to Securian for review. Keep a copy to hold in the pending file.
    - Once approved, the NOE should be sent to PEBA for processing, along with the Notification Statement from Securian and the copy of the Evidence of Insurability form.
    - Securian will notify the subscriber of the approval/denial. As the benefits administrator, you will need to forward the approval from Securian to PEBA so the subscriber's file can be updated and the billing statement adjusted.
    - The effective date will be the first of the month after approval from Securian.

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 his 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 Securian denies coverage, refer to the Optional Life Insurance denial information on page 75.

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 — medical evidence of good health is required.
    - Effective the first of the month following approval.
- Add coverage if late entrant — medical evidence of good health is required.
    - Effective the first of the month following approval.

All changes must be made using an NOE. The form must be signed and dated by both the subscriber and the benefits administrator.

For late entrants, a Medical History Statement must also be completed and sent to Standard Insurance Company for review. A copy of the approval from The Standard must be attached to the NOE. If approved, a copy of the approval will be mailed to the employee and the benefits administrator. The approval letter from The Standard must be attached to the NOE.

MoneyPlus

Flexible Spending Accounts

Medical Spending and Dependent Care Spending accounts can be changed during the year only if an approved change in status occurs (See page 70).

Health Savings Accounts (HSAs)

- Contributions can be started at any time and stopped or changed on a monthly basis.
- Pretax contribution changes to HSAs must be made on a prospective basis. **Employees cannot make retroactive changes.**
- To change an HSA, active employees should complete a MoneyPlus Enrollment Form. Enter the new per-pay period deduction under Part A on the MoneyPlus Enrollment Form. To stop HSA contributions, enter $0. As the benefits administrator, when you sign and date the form, you are also certifying the employee's eligibility to continue contributing to an HSA. To close the account with Wells Fargo, please follow the steps below.
- Each employer's payroll center may specify when the enrollment form must be received to allow enough time to change the payroll withholding.
- Changes become effective the first of the month following the change.
- Employees may also contribute directly to their HSAs, through Wells Fargo, on an after-tax basis, according to IRS guidelines.

To close an HSA account with Wells Fargo:
Step 1. The employee must stop contributing to his account. He must complete and submit a MoneyPlus Enrollment Form, entering $0 in Section A of the form to stop the payroll deductions. Both the employee and benefits administrator must sign this form before sending it to WageWorks.

However, completing the MoneyPlus enrollment form does not close the HSA account at Wells Fargo.

Step 2. To close the HSA account with Wells Fargo, the employee must contact the Wells Fargo HSA Account Holder customer service line at 866.884.7374.

Do not advise employees to leave their HSA accounts open with a $0 balance. If the employee does not close his account with Wells Fargo, the monthly $1.75 service charge will continue, resulting in an overdraft, compounded by additional charges. If there is money remaining in the HSA account, the employee may continue to use the money for qualified medical expenses. When the account balance drops below $25, he should use the rest and contact Wells Fargo to close the account.

For information on changing from an MSA to an HSA, refer to page 78.

Beneficiary changes

Basic Life/Optional Life

- Complete an NOE to change a beneficiary designee for Basic Life and/or Optional Life.
- An attachment is acceptable when the number of designated beneficiaries exceeds the spaces on the NOE.
    - Indicate on the NOE that beneficiaries are continued, or may be listed entirely, on an attachment.
    - On the attachment, indicate the employee's name, SSN and the life insurance benefit with the same beneficiary information that is requested on the NOE. The attachment must be signed and dated by the subscriber and stapled to the NOE.
- When multiple beneficiaries are listed, indicate percentages (not dollar amounts); otherwise, the money will be divided equally among beneficiaries. The percentages must total 100 percent and must be whole numbers — no decimals.
- The effective date will be the subscriber's signature date on the NOE.
- Send PEBA the original and keep a copy for your files.

See page 156 for information on how benefits are paid to beneficiaries.

Open enrollment for active subscribers

Open enrollment for health and vision occurs each year during October. Changes become effective the following January 1.

- Employees may enroll themselves, their eligible spouse and/or their eligible children in health and/or dental insurance without providing medical evidence of good health:
- Employees may cancel health coverage or drop their spouse and/or children 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 children.
- Employees may enroll or re-enroll in MoneyPlus features as follows.
    - Employees remain on the MoneyPlus Pretax Premium Feature and do not need to re-enroll.
    - Permanent full-time employees must re-enroll in the MoneyPlus Medical Spending Account and/or Dependent Care Spending Account each year.
    - Medical Spending Account participants receive the myFBMC

Card at no charge. Note that a new card is not sent to the participant each year; *the card is valid for three years.*

  - Employees do not need to re-enroll in the Health Savings Account each year, if they wish to continue contributing the same amount. If they wish to change the amount they contribute, they can indicate a new amount on the MoneyPlus Enrollment Form. (They should enter $0 if they wish to stop contributions or are no longer eligible to contribute. To close the HSA account with Wells Fargo, see page 76.)
  - Employees enrolling in an HSA and who currently have a full (not a limited-use) Medical Spending Account (MSA) 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). Otherwise, they must wait until April 1 or later in the year to begin making contributions to their HSA. This is due to the grace period for Medical Spending Accounts and the fact that they are considered *other health insurance*. They will still be able to contribute the full annual amount to their HSA, as long as they remain eligible through the end of the plan year and continue to be eligible for a full 12 months after that.
- Employees participating in the MoneyPlus Pretax Premium Feature may elect, make changes or cancel Optional Life. Evidence of insurability may be required. Please note: Effective January 1, 2016, an employee who covers an ex-spouse on any benefit is not eligible for the Pretax Group Insurance Premium Feature. This does not affect the employee's eligibility to participate in an MSA or a DCSA.
- Changes to other benefits may be made as announced.

Dental Coverage

- Employees may enroll in, cancel or add or drop spouse and/or children from the State Dental Plan or Dental Plus 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 wish.
  - 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.
  - Contact PEBA's Field Services team early (as early as July 1) if you'd like to schedule an open enrollment meeting for your group.
- Only the requested changes need to be marked on the NOE. If anything else is marked, be sure it is marked correctly to avoid unnecessary rejections or unintended changes.
- Any changes requested must be submitted on an NOE.
  - The revised NOE must include all changes the subscriber wishes to make for the new year, because this NOE will replace any NOEs submitted previously.

    - When in doubt, if more than one NOE is submitted, PEBA will process the NOE with the latest signature date as the final, enrollment NOE.
    - After October 31, the employee's enrollment decision is final; he does not have 31 days to change his mind.
- NOEs must be signed by October 31.
- Check the box Enrollment under TYPE OF CHANGE in the Administrative Information section of the NOE.
- Do not hold enrollment NOEs. Send them to PEBA as they are completed.
- All enrollment NOEs must be received by PEBA by November 15 — no exceptions!
- The SSN or BIN and name of the subscriber must be on the NOE.
- The effective date, group number and group name must also be on the NOE, under For BA Use Only.
- When making health and/or dental plan changes, any spouse or children to be added or deleted must be listed.
- If there is also a change of address, complete a Universal Name/Address Change Form and submit it to PEBA immediately.
- Staple any required documentation to the NOE.
- The NOE must be signed by the benefits administrator and by the employee.
- MoneyPlus — Send all MoneyPlus enrollment forms directly to WageWorks by November 15 — no exceptions!
    - New or current participants may re-enroll in a Medical Spending Account or Dependent Care Spending Account online at www.myFBMC.com. They may also add a Dependent Care Spending Account.

New employees or transfers hired October 2-December 31

New employees

If the health plan the new employee selected for the remainder of the year will not be available to the employee on January 1, or if he wishes to enroll in a plan that won't be available until then, he may change his health plan election for the coming year. The employee will need to complete two NOEs; one for the remainder of the year, and the other one for the next year.

Transfers

Employees who transfer from one participating employer to another with no break in coverage must make their enrollment elections as usual: during October, while still employed with the previous employer.

- The subscriber must advise the new employer of his October elections at the time of the transfer. The employee will need to complete an NOE with his new employer.
- If the health plan selected is not available to the employee as a result of moving/relocation, he may change his health plan.

Unpaid leave or reduction in hours

General leave policies

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

This section describes how eligibility for insurance benefits is affected when an employee goes on an employer-approved leave of absence that is not associated with military leave or FMLA. See the Unpaid leave quick reference on page 245 for more information.

Employees whose unpaid leave or reduction of hours began on or after January 1, 2015

Ongoing employees

Any employee employed during the Standard Measurement Period (October 4, 2014-October 3, 2015) is an ongoing employee. Eligibility for benefits in 2016 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, he is 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, his eligibility for benefits continues for the remainder of 2016 (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, the benefits administrator should submit an NOE or SOC with the supporting documentation.
- The employee intends to enroll in coverage through the Health Insurance Marketplace. In this case, the benefits administrator should submit the Active Termination Form to PEBA. Check the box in the Reduction of hours section and sign. Because the employee is voluntarily terminating coverage, neither the employee nor his covered dependents are eligible for COBRA. Once the employee cancels his active coverage, the employee may not re-enroll 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, he is 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, the PEBA Coverage Verification Notice of Group Life Insurance. Submit the Active Termination form to PEBA. 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, the PEBA Coverage Verification Notice of Group Life Insurance.

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

If the employee averaged 30 hours per week during his Initial Standard Measurement Period, he is in his 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 his employer, the employee remains eligible for benefits through the end of his 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, the benefits administrator should submit an NOE or SOC with the supporting documentation.
- The employee intends to enroll in coverage through the Health Insurance Marketplace. In this case, the benefits administrator should complete the Active Termination Form

Once the employee's Initial Stability Period ends, he becomes an ongoing employee and continued eligibility should be based on his hours worked during the Standard Measurement Period (October 4-October 3). Refer to Ongoing Employees section above.

Premiums while on unpaid leave

Effective January 1, 2015, 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. The benefits administrator should submit the Active Termination Form to PEBA.

Eligible employees are only responsible for paying 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 his employer by the first of the month, the employer can cancel his coverage due to nonpayment by submitting an Active Termination form to PEBA.

If an employer fails to submit an Active Termination form to terminate coverage due to nonpayment within the month payment is due, coverage will be terminated the first of the month after request.

There is a 30-day grace period for employees to make payment and have coverage reinstated. If the employee makes payment before the end of the grace period, the benefits administrator can submit a Request for Review form to PEBA requesting 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 non-payment is not a COBRA qualifying event. No COBRA notice should be sent to the employee or his covered dependents. The employee may not re-enroll in benefits until the next open enrollment period, if eligible, or within 31 days of a special eligibility situation. **Please note: Returning to work is not a special eligibility situation that allows an employee to re-enroll in benefits.**

SLTD and Life Insurance benefits while on unpaid leave

- SLTD benefits will end 30 days after last day worked. Complete an Active Termination Form to terminate employee's SLTD coverage. Under Section C, Plan and Dates, mark SLTD only and list the effective date.

- Life Insurance benefits end 12 months after last day worked. Complete an Active Termination Form to terminate employee's life coverage. Under Section C, Plan and Dates, mark, as appropriate, Dependent Life/Child, Dependent Life/Spouse and/or Optional Life. List the effective date.

Continuing MoneyPlus while on unpaid leave

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

1. **Prepay**. The employee is given the opportunity to prepay his contributions on a pretax basis.

- **Health Savings Account** — the same rules apply to contributions to the employee's HSA.

2. **Pay-as-you-go**. The employee is given the opportunity to 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 checks and participant remittances to WageWorks at PO Box 603244, Charlotte, NC 28260-3244 written notification, including the employee's SSN, name, type of account, collection amount and the payroll date(s) collected.
- **Health Savings Account** — Employees may also contribute directly to their HSAs through Wells Fargo on an after-tax basis. If they choose to do this, there is nothing for the employer to report.

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.

- **Health Savings Account** — the same rules apply to contributions to the employee's HSA.

Note: If the employee has an MSA and is using the myFBMC Card®, the card will not work while he is on unpaid leave.

If the employee remains eligible for benefits and he decides not to continue his MoneyPlus contributions:

- Notify WageWorks' that the person is on unpaid leave and will not be continuing his contributions. The address is WageWorks, P.O. Box 14766, Lexington, KY 40512-4766.
- Notify WageWorks at the same address when the person returns from leave if his contributions will resume.

If the employee's unpaid leave makes his ineligible for benefits, refer to page 97 regarding the procedures for terminating participation in MoneyPlus accounts.

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.

- At the beginning of military leave (regardless of whether leave is paid or

unpaid), an employee may continue or drop all of his coverage.

  - 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 he is enrolled in life insurance, the Coverage Verification Notice of Group Life Insurance.

- When the employee returns from military leave, the employee may re-enroll in coverage within 31 days of returning to work.
  - If the employee terminated coverage and he returns to work within 15 calendar days or does not experience a break in coverage, the employee may re-enroll in the same benefits he was enrolled in prior to military leave.
  - If the employee terminated coverage and he returns to work more than 15 calendar days later or he experiences a break in coverage, the employee may make elections as a new employee.
  - An employee returning from military leave may reinstate his life insurance at the same level he had prior to going on military leave without evidence of insurability regardless of when he returns to employment as long as he is 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 he did not continue his coverage through PEBA, he may add the newly eligible spouse and/or children when he returns 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 he does wish 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 child
- 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
- 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 pre-existing conditions, etc. See §825.212(c).

During FMLA leave, an employee remains eligible for benefits even if his 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 his 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 30-day grace period on premium payments**. If the employee fails to make a timely payment within 30 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.
    - Send an Active Termination Form marked non-payment. If the employee returns to work before FMLA leave is exhausted, the employee may reinstate coverage the first of the month following his 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 81 to determine if the employee is eligible to continue benefits based on his status (ongoing employee, new full-time, new variable-hour, etc.).
- The employer may terminate employment.
- The employer offers the employee and his 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 87) and COBRA Subscribers (Page 101) 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 evidence of insurability.
- 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 end of FMLA leave, the employer should send the employee and his covered dependents the 18-month COBRA Notice. The date of the COBRA qualifying event should be listed 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 may 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 his share of the premiums, the employer may continue the coverage and request repayment of the employee's share once he returns to work.
    - If the employer does not wish to continue the employee's coverage because he has stopped paying his share of the premiums, the employer should consult with its legal counsel before terminating the employee's coverage.
    - To terminate the coverage, the employer should send an Active Termination Form marked nonpayment. The employee may reinstate coverage within 31 days of his return to work. Otherwise, he may enroll within 31 days of a special eligibility situation or during open enrollment.

Transfers and terminations

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 to another 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 through the summer.

Generally, when he transfers, an employee will remain enrolled in the same insurance benefits.

Transferring OUT (losing employer)

After the employee notifies you of his intention to transfer to another participating employer without a 15-day break in employment or with no break in insurance coverage:

- Notify PEBA by checking TRANSFER in Section A of the Active Termination Form and list the group number and group name.
    - PEBA will produce a transfer form that will be sent to the benefits administrator at the new employer. The transfer form is similar to the benefits statement and lists an employee's benefits and his covered spouse and/or children. The form includes an area for the employee to change his address, telephone number, Basic Life and Optional Life beneficiaries.
- If the employee is contributing to a MoneyPlus account (Medical Spending, Dependent Care Spending or Health Savings) notify WageWorks immediately of the transfer.
    - Notify WageWorks by fax at 866.672.4781. Include this information:
    - The employee's name, SSN and the date benefits coverage ends with your employer
    - Your employer name, group number, your name and your phone number
    - Do not send a copy of the Active Termination Form to WageWorks for a transferring employee.
    - If you receive a discrepancy report that includes the employee who transferred, contact WageWorks immediately to confirm the transfer and effective date.

COBRA Applies to Transfers

COBRA notification for continuation of health, dental and vision coverage must be sent to transferring employees, their spouses and their children.

When an employee transfers, COBRA notification is not required for MoneyPlus accounts. Follow the procedures above to notify the MoneyPlus administrator of any transferring employee who has a MoneyPlus account.

Academic Transfers

Employees of public school districts, universities, colleges and technical colleges (participating academic employers) are considered academic employees and are subject to the termination and transfer rules below. *These rules apply, regardless of when the benefits administrator receives the resignation.*

- Academic employees, who complete a school term and move to another participating academic employer, are considered academic transfers, even though they may not work during the summer.

- The losing employer (the employer the employee is *leaving*) must continue to cover academic transfer employees during the summer, pay the employer share of premiums, collect premiums from the employee and terminate coverage at the beginning of the fall term (September 1) to avoid a break in coverage.
    - Exceptions may be made for academic positions that begin employment during the summer, such as, but not limited to, coaches, principals and superintendents. Be sure to write the employee's position at the top of the NOE so that the 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, should be terminated effective the first of the month following the last day worked. If an academic employee terminated employment at the start of summer, but returns to an academic setting in the fall, he is still considered a transfer. The employee must pay the back premiums for the summer months to his former employer to avoid a break in coverage.
    - If the academic employee was planning to return to an academic setting in the fall, **but decided to retire retroactively**, he should be terminated effective the first of the month following the last day worked. If the employee is eligible for retiree coverage, but has missed the 31-day window to enroll, he should contact PEBA.
    - Academic employees who work during the summer session, **but who are not transferring to another academic setting in the fall,** should be terminated from coverage effective the first of the month following the last day worked.
    - 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.
- The termination effective date from the losing academic employer should 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 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. He may make changes based on the increase or decrease in hours as explained in the Active Subscribers section of this manual, under Coverage changes for permanent, part-time teachers.

Change in status during the transfer

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

- If 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 edit the system and 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 his new employer to complete an NOE for the change.
- Do not make coverage changes or add/drop a spouse and/or children on the transfer form.

Transferring IN (gaining employer)

- Confirm that the subscriber is a transfer from another participating employer:
  - You may have received a transfer form from PEBA if the losing employer completed the Active Termination Form in a timely manner.
  - The subscriber may give you a copy of his termination form and/or creditable coverage letter.
  - Contact PEBA if you have any questions about the status and eligibility of the transferring employee.
  - Contact WageWorks or the previous BA if you have questions about the transferring employee's MoneyPlus status.
  - If the employee is contributing to a MoneyPlus account- — Medical Spending, Dependent Care Spending or Health Savings — *notify WageWorks immediately* of the transfer. Notify WageWorks by mail WageWorks, P.O. Box 14766, Lexington, KY 40512-4766 or fax at 866.672.4781. Include this information:
  - The employee's name, SSN and the effective date of the transfer.
  - The continuing per-pay-period deduction amount(s). The annual election amount may not be changed, unless a qualified change in status has occurred within 31 days. Refer to Section C, Active Subscribers, for information on allowed MoneyPlus changes.
  - Your employer name, group number, your name and your phone number.
- Transferring employees may be enrolled using EBS instead of a transfer form. Refer to Enrolling the transferring employee through EBS below.
- Be sure that the transferring employee is offered the same orientation given to new employees with your group.
  - Review the COBRA regulations with each employee.
  - Orientation may be simpler, since the transferring employee should already be familiar with the benefits.
- 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 effective date from the losing employer, reflecting no break in coverage.
  - If the effective date of 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 or on an NOE as the effective date of loss under the losing employer.

Academic transfers

- The termination effective date from the losing academic employer should coincide with the effective date of the gaining academic employer, **reflecting no break in coverage.**
- He must be enrolled in the same coverage he had previously.
- His previous employer must:
  - Pay the employer share for his 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 89.
  - 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 a transfer form from PEBA, you can complete the transfer transaction on EBS instead of using the transfer form. All of the employee's information and coverage levels will be prepopulated in the fields. Refer to page 23 for more information.

Completing the transfer form

The system-generated transfer form will already have your group name and number listed under A, BA USE ONLY section. Have the employee review the form and make any necessary and/or allowed changes. **Do not** make coverage changes or add/drop a spouse and/or children on the transfer form.

A. BA USE ONLY:

- **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 with your group. 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 figure the premium for SLTD if the transfer has SLTD coverage.
- **Employment Date:** First day physically at work.
- **MoneyPlus Indicator:** System will reflect Y, N or Leave Blank. You may need to confirm this with WageWorks or the previous benefits administrator.

B. ENROLLEE INFORMATION:

Make any mailing address, email address or telephone number changes necessary in this section. The employee should mark a single line through any information that needs to be updated and print the new information.

C. MEDICARE AND OTHER COVERAGE INFORMATION:

Coverage through Medicare or another policy for a subscriber, a spouse or child will be shown here

D. COVERAGE:

Coverage and levels will be printed on the form. The employee may make limited changes to his life and SLTD coverage by completing an NOE. See Using an NOE Instead of EBS or a transfer form on page 92.

E. DEPENDENTS:

- The spouse and/or children on file at the time of the transfer from the previous participating employer will be shown in this section. The insurance benefits under which each spouse or child is covered will be indicated beside the spouse or child's name. An X under the benefit will indicate the spouse or child is covered.
- The subscriber will need to 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 children 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.

F. BENEFICIARIES:
The transfer form will list the beneficiaries for benefits as reflected in PEBA's records. **Changes are allowed in this section.** If the subscriber wishes to make a beneficiary change:

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

If the transfer employee has health coverage, a beneficiary for Basic Life must be indicated. If you see that this field on the transfer form is blank, please have the employee fill it in.

G. AUTHORIZATION:

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

Change in status during transfer

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

- If 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 edit the system and 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 his new employer to complete an NOE for the change.
- Do **not** make coverage changes or add/drop a spouse and/or children on the transfer form.

Using an NOE Instead of EBS or a transfer form

Use an NOE instead of EBS or a transfer form when:

- A transfer form is not available.
- The losing employer has not terminated the transferring employee.
- The employee wants to make the following changes to his coverage:
    - **Dependent Life**: The transfer employee wants to add, increase or drop Dependent Life coverage on a spouse and/or child. Evidence of insurability is required to add or increase coverage on a spouse.
    - **Optional Life**: The transfer employee NOT participating in the MoneyPlus Pretax Group Insurance Premium feature wants to increase, decrease or drop coverage. Evidence of insurability is required to increase coverage. Employees currently enrolled in OL, but who are participating in the MoneyPlus Pretax Group Insurance Premium feature, can increase, decrease or drop coverage only during annual

enrollment or within 31 days of a change in status.
    - **SLTD**: The transfer employee wants to enroll or decrease to a 90-day waiting period with medical evidence of good health. He may also drop SLTD coverage.
    - **No changes** may be made for health, State Dental Plan, Dental Plus or State Vision Plan coverage**.**
- A change in status or special eligibility situation has occurred. If you have a transfer form, be sure to attach the completed NOE and any required documentation to the transfer form and send them to PEBA for processing. See Change In status above.

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

- Check **Transfer** at the top of the NOE, in the Administrative Information (ADM INFO) section.
- The benefits administrator may call PEBA to obtain previous levels of coverage.
- Be sure to complete the SLTD selection under the Benefits section.
- Remember to attach any required documentation listed in Transferring IN, beginning on page 90.

Transfers — new group Created or lateral transfer

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

- Group 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/agency reorganizations.
- The same policies and procedures govern employees who are laterally transferred from one employer group to another. This occurs when employees are moved from one agency to another without a break in coverage or employment because of a management decision within employer groups.
- Each employee affected by the transfer will be terminated from the old group and added to the new group, with no break in coverage and with the same coverage. PEBA insurance benefits' computer transfer function will terminate and add the employees automatically.
- Other coverage changes are permitted only if a special eligibility situation occurs. Documentation may be required.

Old employer group 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 that occur before the effective date of transfer.
- If the employee is contributing to a MoneyPlus account (Medical Spending, Dependent Care Spending or Health Savings) notify WageWorks immediately of the transfer. Notify WageWorks by fax at 866.672.4781. Include this information:
    - The employee's name, SSN and the date benefits coverage ends with your employer
    - Your employer name, group number, your name and your phone number
    - Do not send a copy of the Active Termination Form to WageWorks for a transferring employee.
    - If you receive a discrepancy report that includes the employee who

transferred, contact WageWorks immediately to confirm the transfer and effective date.

- The employees' names, SSNs, old group ID number and new group ID number with effective date of transfer must be sent to PEBA (address on page A-9). The computer transfer function will be used to transfer this information.
- Give all benefits documentation, including COBRA notification letters, to the new employer at the time of transfer.

New employer group procedures (gaining employer)

- Prepare a letter of notification to PEBA with the following information:
    - Departing employer and group number
    - New employer and group number
    - Effective date of change
    - SSN and name of each employee being transferred
- Send the letter of notification to PEBA for processing.
- Send a copy of the notification letter to the losing employer group (to the employer that the employees are leaving/have left).
- Place a copy of the notification letter in each employee's file.
- If the employee is contributing to a MoneyPlus account (Medical Spending, Dependent Care Spending or Health Savings) notify WageWorks immediately of the transfer. Notify WageWorks by fax at 866.672.4781. Include this information:
    - The employee's name, SSN and the effective date of the transfer.
    - The continuing per-pay-period deduction amount(s). The annual election amount may not be changed, unless a qualified change in status has occurred within 31 days. Refer to the Active subscribers section for information on allowed MoneyPlus changes.
    - Your employer name, group number, your name and your phone number.

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, he is considered working for one employer or the other for insurance purposes. He cannot be considered working for both employers.

The employee **cannot** have his insurance coverage and premiums split between the two employers, nor may he combine his two salaries for Optional Life/Dependent Life Insurance purposes**.**

If an employee starts working for a second participating employer and wants his insurance coverage to be with the new employer, he is considered a transfer. He has 31 days to complete an NOE as a transferring employee or to have his transfer processed. If the 31-day window is missed, his 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

- Complete and send an Active Termination Form to PEBA immediately.

- Be sure to enter the last day worked in Section A of the form.
- CHECK ONLY ONE REASON for the termination.
- If the employee was contributing to a MoneyPlus Medical Spending Account, check the MoneyPlus box on the Active Termination Form and send a copy to WageWorks immediately.
    - Mail the form to WageWorks, P.O. Box 14766, Lexington, KY 40512-4766 or fax it to 866.672.4780.
    - Be sure to notify WageWorks of all MoneyPlus terminations, by mail at WageWorks, P.O. Box 14766, Lexington, KY 4-012-4766 or fax at 866.672.4781, unless your employer group sends termination information on an electronic eligibility/payroll file. Timely notification will avoid exceptions on the discrepancy reports you receive.
- All changes in employment or special eligibility situations resulting in a termination of coverage must be processed within 31 days.

Retroactive terminations

Maximum 31 days retroactive

(To be calculated from the date received by PEBA)

Terminations may be no more than 31 days retroactive. *Exception*: If PEBA receives an Active Termination Form that is 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) that shows the subscriber is continuing coverage, and with no break in his 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, should be terminated the first of the month following the last day worked.
- If an academic employee terminated employment at the start of summer, but returns to an academic setting in the fall, he is still considered a transfer. Refer to Academic Transfers on page 88 for additional information.
- Academic employees who work during the summer session, **but who are not transferring to another academic setting in the fall**, should be terminated from coverage the first of the month following the last day worked.
- 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 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, you should notify the employee and spouse, if applicable, of continuation of coverage as a COBRA participant. Refer to the

COBRA section for information on COBRA notification procedures.

Termination due to unpaid leave or a reduction in hours

Refer to the Active Subscribers section.

Termination due to non-payment of premiums

- Termination is 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 his premiums, submit an Active Termination Form to PEBA as soon as possible. **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 30-day grace period, follow the procedures for completing a Request for Review on page 164. Otherwise, the employee and any eligible spouse and/or children must wait until the next October enrollment or until a special eligibility situation occurs and enroll as late entrants.
- Local subdivisions should complete the appropriate NOE to terminate coverage for retiree, COBRA and survivor subscribers.
- If the subscriber is terminated due to non-payment 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 children must wait until the next open enrollment period or until a special eligibility situation occurs and enroll as late entrants.

(*Exception*: **State Vision Plan.** Employees can enroll themselves and/or their covered spouse and/or children during the next October enrollment period if they miss their 31-day window of opportunity.)

Other termination information

Life Insurance

If terminating employment, the employee may convert his Basic Life, Optional Life, Dependent Life-Spouse and/or Dependent Life-Child coverage to an individual whole life policy. To do so, the benefits administrator would provide the employee with the Coverage Verification Notice of Group Life Insurance form. The employee should follow the instructions on the form and contact Securian if he is interested in converting coverage. Note that the conversion notice is not an application for insurance — the employee must speak with a Securian agent to complete an application within 31 days of the date group coverage ends.

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.

- If the employee wants to convert some or all of his life insurance coverage:
    - You, as the benefits administrator, must complete the entire Coverage Verification Notice of Group Life Insurance form and provide it to the employee. Do NOT delay in providing this form to the employee.
    - Be sure to complete all sections of the form for the employee, including the applicable coverage amounts in the Coverage Information section of the form. Be

sure to sign and date the form at the bottom.
    - It is the employee's responsibility to contact Securian regarding conversion.
- If the employee **does not want to convert his coverage**, give him a copy of the Coverage Verification Notice of Group Life Insurance form and let him know he has 31 days from the date of termination to contact Securian if he changes his mind.

Long Term Disability

Basic Long Term Disability may not 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 will not be eligible for coverage with another employer.
- The individual is not disabled.
- The individual is not a retiree.

A Request for Long Term Disability Conversion Materials is available on the PEBA website.

MoneyPlus

When an employee participating in MoneyPlus terminates employment, the benefits administrator **must notify WageWorks' Deduction Management Department immediately**, by mail at WageWorks, P.O. Box 14766, Lexington, KY 40512-4766 or fax at 866.672.4781. Provide the employee's SSN, date of termination (last day on payroll), the employer name, employer group number, your name and your number. Timely notification will minimize the number of exceptions on the discrepancy reports you receive.

- If you report payroll and eligibility information to WageWorks electronically, include terminations on the file, if the option is available.

If the employee had a Medical Spending Account, send a copy of the Active Termination Form (or the SOC if using EBS) to WageWorks Benefits Continuation Department, by mail at WageWorks, P.O. Box 14766, Lexington, KY 40512-4766 or fax to 866.672.4780 within 30 days of termination or any other COBRA qualifying event (address on back of form). WageWorks is required to send timely COBRA notification to terminating employees who had Medical Spending Accounts (notification is not required for Dependent Care Spending or Health Savings Accounts).

- **Medical Spending Account** — A terminated participant has 90 days from the date of termination to submit expenses incurred through the date of termination, unless he is continuing participation on an after-tax basis through COBRA. See page 108 in Section E, COBRA Subscribers, for more information.
    - If the employee is continuing a Medical Spending Account after termination (through COBRA), and the employee has a myFBMC Card®, the card will be canceled as of the date of termination shown on the Active Termination Form.
    - If the termination is due to the death of the participating employee, the employee's eligible spouse and/or children may elect to continue the MSA coverage through the end of the plan year. In this case, eligible spouse and/or children mean IRS qualified tax dependents as defined in IRS Publication 502. Otherwise, the spouse and/or children have 90 days after the termination date (date of death) to submit any eligible claims incurred through the date of death.
    - Terminations of employees participating in the Medical Spending Account should be

reported to WageWorks immediately to avoid any overpayments.

- **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 incurred through the date of termination.
- **Health Savings Account** — Health Savings Account participants may continue to contribute to their accounts after terminating employment, so long as they are covered by a high deductible health plan, whether it is the SHP 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 Wells Fargo or other Health Savings Account trustee. They can then include these after-tax contributions on their tax returns according to the IRS guidelines.
    - **If the employee decides to close his HSA account.** Closing a MoneyPlus HSA account with Wells Fargo is a two-step process. Besides the benefits administrator notifying WageWorks of the termination from employment, the employee must contact the Wells Fargo HSA Account Holder customer service line at 866.884.7374. **Do not advise employees to leave their HSA accounts open with a $0 balance.** If the employee does not close his account with Wells Fargo, the monthly $1.75 service charge will continue, resulting in an overdraft, compounded by additional charges. When the account balance drops below $25, he should use the rest and contact Wells Fargo to close the account.

Reinstating coverage after termination

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

- If coverage was terminated within the past 15 days:
    - Send a letter to PEBA, including reason for reinstatement of coverage. Be sure to include the employee's name, SSN, and the effective date for coverage to be reinstated. **Do NOT send an Active NOE or the termination form with Reinstate written on it.**
- If coverage was terminated more than 15 days ago:
    - The employee is considered a new hire, and coverage cannot be reinstated. Complete an Active NOE for the new hire.

Exception: Academic transfers. Send a letter to PEBA, explaining the employee is an academic transfer and including the employee's name, SSN, and effective date of transfer. Be sure to follow the academic transfer procedures explained on page 91.

COBRA

COBRA

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What is COBRA? (Consolidated Omnibus Budget Reconciliation Act)

COBRA is designed to protect only those individuals (called qualified beneficiaries) who lose their group health, dental and/or vision insurance due to certain qualifying events outlined in the federal law. **Under COBRA, it is the responsibility of the covered employee, spouse or other family member to notify the benefits office within 60 days of a qualifying event.**

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 Qualifying Event Notices that address 18-, 29- and 36-month COBRA continuation.

The following coverage may be continued under COBRA:

- State Health Plan
- State Dental Plan and Dental Plus
- State Vision Plan
- 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 and vision coverage. *Go to page E-10 for COBRA instructions and procedures relating to Medical Spending Accounts.*

Who is the COBRA administrator?

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

- For *a former employee of a local subdivision*, the COBRA Administrator is the **local subdivision**.
- For *any other COBRA participant*, the COBRA Administrator is **PEBA.**

Assisting a terminating employee

If the employee is not eligible to retire

- You must offer the employee and his covered spouse and/or children COBRA enrollment information by letter, except:
  - If the termination was due to gross misconduct or non-payment of premiums, the benefits administrator does not need to send COBRA notification letters, since the employee, his spouse and children are not eligible.
  - You may want to consult your legal counsel before making a determination of gross misconduct.
- An employee, whose spouse is also a covered employee or retiree, may apply for health, dental, vision and/or Dependent Life* on his spouse's coverage within 31 days of termination.

**If the spouse is a retiree, Dependent Life coverage is not available.*

If the employee is eligible to retire

- You must still offer the retiring employee and his covered spouse and/or children COBRA enrollment information by letter, even though he is eligible for retiree insurance benefits.

Required COBRA notices

The required COBRA notices are available on the PEBA's website, www.peba.sc.gov in the Forms section under the Insurance Benefits tab.

Each COBRA notice includes an instruction sheet that summarizes the notification procedures for that particular notice. These instruction sheets are very helpful, so please be sure to read them before you proceed. These notices are available in MS Word format. You can download the forms to your

computer and enter the subscriber and COBRA information where prompted.

Benefits administrators are responsible for completing and mailing these COBRA notices:

- Initial COBRA Notice (send when health/dental/vision coverage begins or when beginning a MoneyPlus Medical Spending Account)
- 18-month COBRA Notice
- 36-month COBRA Notice.

Mailing requirements for all COBRA notices

- Address the notice to the covered employee and to the spouse for children (if spouse and/or children are covered).
- The first and last names of the covered employee, covered spouse and the covered children MUST be listed in the body of the notification letter. The phrase covered children may be used for children ONLY in the address and salutation portions of the letter.
- Send it to the last known address.
- One notice to the home satisfies the requirement if the spouse and all children live at the same address as the employee.
- Send a separate notice to the spouse and/or children if they live at a different address from the employee.
- Send first class mail.
- Hand delivery to the employee is ***not*** considered notice to a covered spouse or child. A separate notice should be mailed to the spouse and children if a notice is hand-delivered to an employee.

Initial COBRA Notice (First required notice)

(Benefits administrator sends this notice)

Notice of the right to purchase temporary extension of group health/dental/vision coverage when coverage is lost due to a qualifying event

The intent of the initial notification is to provide a broad summary of the COBRA law, procedures and obligations to all covered individuals and outline notification responsibilities, including the 60-day notification requirement.

- When coverage begins, send an Initial COBRA Notice to:
    - A new employee who elects health, dental or vision coverage or a Medical Spending Account for himself and/or his spouse and children
    - A newly covered spouse or a child of a covered employee, enrolled due to a special eligibility situation
    - Anyone newly covered at open enrollment.
- Send the initial, written notice to the newly covered employee, spouse or child.
    - Notification is NOT required if the employee, his spouse and children do NOT enroll in a health, dental or vision plan or a Medical Spending Account.
    - After distribution, place a copy of this entire letter in your employee's file.
- If this notice has not been provided to your covered employees, his spouse and children, send a notice immediately.

It is your responsibility to:

- Check the employee file for coverage. If the employee is covered:
    - Check the enrollment for a spouse and children.
    - If the employee has single coverage, address the notification to the employee only.
    - If the employee has family coverage, address the notification

to the employee and spouse by name (John and Mary Doe).
  - If no spouse is named, address the notification to John Doe and covered children.

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 his 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 notification should be sent.
- The spouse and children are notified of this 60-day requirement in the initial COBRA notice they receive.

Procedures for determining COBRA eligibility

- Determine if a COBRA-qualifying event has occurred.
- Document the date the benefits administrator is 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; if not, DO NOT OFFER COBRA.
- Document the file. If eligible, send Notice of COBRA Qualifying Event; if ineligible, use the COBRA Ineligibility Form for Dependents. The forms are on www.peba.sc.gov in the Forms section under the Insurance Benefits tab.

Example

Qualifying event — ineligible child (child turns 26)

Date of qualifying event	September 15, 2014
Date BA notified of event	January 20, 2015
Date initial COBRA notice mailed	November 20, 1997
60-day notification language included in notice?	Yes
Date of coverage loss if reported timely	October 1, 2014
60 calendar days from date of coverage loss	November 29, 2014 (60 days from October 1, 2014)
Qualifying event reported within this period?	No
Action	Do not offer COBRA; document file, using the COBRA Ineligibility Form for Dependents.

COBRA Qualifying Event Notice

(Second required notice)

(Benefits administrator sends this notice)
Notice to eligible qualified beneficiaries 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 the group health, dental and/or vision plan to continue coverage under COBRA. Each individual (including spouses and children) covered under the plan is a qualified beneficiary and has independent election rights. COBRA should **not** be offered to spouses or children who were dropped because of the Dependent Eligibility Audit.

After a qualifying event has occurred, eligible individuals should be notified of their rights to continue health/dental/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 his covered spouse and/or children is 36 months from the date the employee became eligible for Medicare. This is known as the *Medicare Entitlement Rule*.

Depending on the tobacco use status before and whether that status has changed for the new COBRA subscriber, a new Certification Regarding Tobacco Use form may need to be completed and attached to the COBRA NOE.

Who is a qualified beneficiary?

A qualified beneficiary:

- Must have been covered (under Health, Dental, Dental Plus, State Vision Plan and/or MoneyPlus Medical Spending Account) on the day before the qualifying event; AND
- Must be a **covered employee**, the **covered spouse** of the covered employee or a **covered child** of the covered employee.

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 is considered a qualified beneficiary.
- 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, is considered a qualified beneficiary.

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 his new wife to his coverage, she is *not* a qualified beneficiary and would not be eligible to extend her 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.

18-Month COBRA qualifying events

- Leaves employment
- Transfers
- Retires
- Has a reduction of hours (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 81.

Extending COBRA overage 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, he is 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 (who may be the covered employee or his spouse or child) 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 the 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 termination of employment or reduction of hours);
    - The date which the qualified beneficiary loses (or would lose) coverage as a result of the qualifying event
    - The date which 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 termination of employment or reduction of hours).
- The extension of coverage to 29 months is not limited to just 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 percent** 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 percent.
- A qualified beneficiary, whose coverage is extended, must notify the plan administrator within 30 days if a final determination is made that he is no longer disabled. He should complete and submit to his COBRA administrator a Notice to Terminate COBRA Continuation Coverage, which is on the PEBA website at Insurance Benefits/Forms/COBRA along with the documentation requested on the form. He does not need to complete a COBRA NOE.

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 on page E-8.*
- **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 his COBRA administrator a Notice to Extend COBRA Continuation Coverage, along with

the documentation requested on the form. He does 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, except for military leave.

Second qualifying events are:

- Death of former employee
  - The covered spouse and covered child are eligible for up to 36 months of continuation coverage.
- Divorce/legal separation
  - The covered spouse and covered child are eligible for up to 36 months of continuation coverage.
- Child becomes ineligible
  - The covered child 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 may complete a Notice to Extend COBRA Continuation Coverage if there has been a second qualifying event that may extend COBRA coverage. He should attach any documentation requested on the form.
- The completed form should be returned to his COBRA administrator.

COBRA Termination Notice

(Third required notice)

(PEBA sends this notice)
This notice is sent 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).

The benefits administrator **does not** send this notice. PEBA sends this required notice directly to the qualified beneficiaries**.**

- A Certificate of Coverage is mailed upon termination.
- This notice is sent via first class mail to the last known address.

Other coverage may end COBRA eligibility

Eligibility for health, vision and/or dental 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 enrolls in Medicare (Part A, Part B or both) *after* COBRA coverage is elected. If the individual has Medicare *and then elects* COBRA, he 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 pre-existing condition that the individual may have. If the individual *already* has the other coverage when he elects COBRA, he can have both. The plan that covers the subscriber as an employee will be primary to the plan that covers him as a spouse.

The loss of COBRA eligibility applies only to the person who enrolls in Medicare or other coverage. Covered persons who do not enroll in Medicare or other group coverage may continue their COBRA coverage as long as they are otherwise eligible.

To end COBRA coverage, the subscriber completes and submits to his COBRA administrator a Notice to Terminate COBRA Continuation Coverage, along with the documentation requested on the form. He does not need to submit a COBRA NOE.

COBRA election period

- Once the qualifying event notification has been sent, each qualified beneficiary has a period of time in which to make the decision to elect COBRA continuation coverage.
    - The 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 hurry an election or a waiver of COBRA coverage.
    - An election is deemed made on the date postmarked on the NOE that is 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.
    - However, once a qualified beneficiary has elected COBRA coverage, he 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. *Exceptions* are:
    - A qualified beneficiary may change *from* the SHP Standard Plan *to* the SHP 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.

Initial premium payment period

The qualified beneficiary is allowed 45 days, from the date of election, to make his initial payment as explained below. 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. For example, assume the following:

- Qualifying event: Divorce
- Qualifying event date: May 28
- COBRA start date: June 1
- COBRA election date: July 22
- First payment due: September 5 (if this falls on a weekend or Labor Day, the next business day).

In this example, the first payment must include 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*: Local subdivisions 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 30-day grace period to pay.

- Following the example used 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 30-day grace period, his coverage is terminated, and he loses all continuation rights under the plan.

Administrative fee for local subdivisions

PEBA charges local subdivision employers a $3-per-month administrative fee for COBRA subscribers. This administrative fee may not be passed along to the COBRA subscriber. By law, the maximum premium the COBRA administrator can charge the subscriber is 102 percent of the total premium (employer and employee shares) charged to an active employee. *Exception*: When 18-month COBRA coverage is extended to 29 months, the COBRA administrator can charge 150 percent of the total premium for active employees (see page 105).

Benefit changes

Qualified beneficiaries are entitled to the same rights as active employees. These rights include participating in enrollment periods, changing plans, special eligibility situations and adding a newly acquired spouse or children.

Open Enrollment

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

COBRA procedures for the MoneyPlus Medical Spending Account

IRS Code Section 125 allows an employee to continue his Medical Spending Account under COBRA. The Medical Spending Account can only be continued for the rest of the plan year; employees may not re-enroll for the next year.

- The subscriber must be enrolled in the Medical Spending Account at termination.
- The subscriber must elect to maintain continuous contributions, on an after-tax basis, to the Medical Spending Account.
- The administrative fee for continuing the Medical Spending Account under COBRA can only be two percent of the monthly amount in all cases, except disability. The fee is calculated and included with the payment.

Procedures at termination

- The benefits administrator completes and sends a copy of the Active Termination Form to WageWorks.
    - Be sure to check the Medical Spending Account box on the form.
    - Send the form to the attention of WageWorks' Benefits Continuation Department.
    - Send the form within 31 days of the qualifying event (termination of employment).
- WageWorks will then notify the participant of his COBRA rights and include a COBRA Continuation Coverage Election Form.
    - The monthly contribution amount will be already filled in on the form.
    - The notification will include information regarding when and how payments should be made.
- When WageWorks receives the election form from the participant, WageWorks will process the application and send a coupon to the participant for future payments. Remember that participants may only continue 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 he makes his initial payment.
    - The monthly contribution amount and the amount of the initial payment will be included in the confirmation statement and coupon 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 must be postmarked 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 30-day grace period for payment. If WageWorks does not receive payment by the end of the grace period, coverage will end as of the last paid-through date.**

Benefit administrators with MoneyPlus COBRA questions may call WageWorks at 877.502.6272. Employees should be directed to call WageWorks' Customer Care number at 800.342.8017.

COBRA quick reference

Action type	Required COBRA notice
New hire	Initial Notification
Special eligibility situations *(adding someone to coverage):* • Marriage • Birth • Adoption/placement for adoption • Gaining custody • Loss of other coverage	Initial Notification
Open enrollment *(adding someone to coverage):* • Employee • Spouse • Child(ren)	Initial Notification
Open enrollment *(dropping someone from coverage):* • 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 should send the 18-month Qualifying Event Notice. Gaining employer should send the Initial Notification
Leaves employment (for reasons other than gross misconduct or non-payment of premiums)	18-month Qualifying Event Notice
Retires	18-Month Qualifying Event Notice
Working hours reduced	18-Month Qualifying Event Notice
MoneyPlus Medical Spending Account (if enrolled)	Send a copy of the Active Termination Form to WageWorks (be sure to check the MoneyPlus Medical Spending Account box)

Retiree subscribers

Retiree subscribers

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Requirements for retiree insurance

Eligibility for ***retirement*** is not the same as eligibility for ***retiree group insurance***. PEBA's insurance benefits program and PEBA's retirement benefits program have different requirements. PEBA recommends an employee review the requirements for retiree group insurance in the Retirement and Disability chapter of the *Insurance Benefits Guide* before he confirms his retirement date. Please remember that in addition to qualifying for retirement, an employee's last five years of employment must be served consecutively in a full-time, permanent position with an employer that participates in the state insurance program to qualify for retiree insurance.

PEBA insurance benefits **cannot** confirm eligibility over the telephone. If an employee's anticipated retirement date is **within 90 days**, please direct him to submit an Employment Verification Record with a Retiree NOE.

If an employee's anticipated retirement date is **three to six months away**, he may submit an Employment Verification Record, along with his anticipated retirement date, and PEBA insurance benefits will give him a written confirmation of his eligibility. PEBA will **not** confirm eligibility for retiree insurance more than six months before an employee's retirement date.

Assisting an eligible retiree

Administrative information

- PEBA acts as the benefits administrator for retirees, except retirees of local subdivisions. Benefits administrators of local subdivisions serve as the main contact for their retirees.
- Retirees do not have to be receiving a retirement check from PEBA to be eligible for retiree insurance. However, they must be eligible for a retirement check and must meet the retiree insurance eligibility requirements explained in the Retirement and Disability chapter of the IBG.
    - *Example*: An employee, with 20 years of service credit with a PEBA insurance benefits-participating employer, leaves work. He is a Class Two member with at least five years of earned service credit, so when he turns age 60, he is eligible for retirement benefits with PEBA . He may then enroll in retiree insurance with PEBA even if he delays his retirement check until age 65.
- 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 local subdivisions only

A local subdivision *does not* have to participate in PEBA's retirement program for its qualifying retirees to be eligible to participate in the State Health Plan.

Benefits administrators for local subdivisions remain the main point of contact for their retirees.

Local subdivisions determine whether they will pay the employer share of contributions for retirees and survivors. Regardless of funding, retirees must be offered retiree coverage if they meet the eligibility requirements (see the Retirement and Disability chapter of the IBG).

- Local subdivisions are billed for all retirees and survivors.
- Local subdivisions collect all premiums for their subscribers.

Benefits administrators for local subdivisions must verify eligibility for their retirees.

- The Employment Verification Record (verification of service credit for retirement eligibility) must be attached to the Retiree NOE. Both must be signed by the benefits administrator and returned to PEBA for retirement eligibility verification.
- Local subdivision benefits administrators must always sign the Retiree NOEs, whether the retiree is new or is changing coverage, changing beneficiaries, address, etc.

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.

Retiree packet information

These forms are on the PEBA website at www.peba.sc.gov:

- Retiree NOE
- Employment Verification Record Form (This form must be signed by the local subdivision benefits administrator and attached to the NOE.)
- PEBA Coverage Verification Notice of Group Life Insurance (This form must be completed and signed by the benefits administrator if the employee wants to continue or convert his life insurance coverage.)
- Retiree Life Continuation Election (to continue Optional Life)

Important retirement information

Health insurance

The same certification and documentation required of active subscribers, spouses and children applies also to retirees, spouses and children (i.e., eligibility documentation, spouse is a state group employee/retiree, spouse lost coverage, incapacitated child, etc.).

- If the subscriber's tobacco use status has changed, complete a Certification Regarding Tobacco Use form and attach it to the Retiree NOE.

If both the retiree and spouse are covered retirees (or one is a covered employee and the other is a covered retiree) and both persons are enrolled in the same health plan, the family deductible will apply.

- Eligible state 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 cover the child under dental.

When the retiree becomes eligible for Medicare

(Applies also to covered spouses and children)

Due to age:

- PEBA insurance benefits will notify the retiree, in advance of his 65th birthday, to complete the appropriate paperwork and make elections. If the retiree is enrolled in the Standard Plan or Savings Plan, his coverage will change automatically to the Medicare Supplemental Plan when he turns age 65 and becomes eligible for Medicare, unless he completes and returns the

paperwork, within 31 days of Medicare eligibility, to stay on his current plan.

- Advise your retirees to enroll in Medicare Parts A and B when they become eligible so that they will have optimal coverage.
- Eligibility for the GEA TRICARE Supplement Plan will end.

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 his Medicare card to verify eligibility.
- *Note on end-stage renal disease.* When an individual begins dialysis for end-stage renal disease, he becomes eligible for Medicare three months after beginning dialysis. At this point, he begins a "coordination period" of 30 months. During this time, his coverage through the SHP 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 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, he will be changed to the Standard Plan during the 30-month coordination period.
- Eligibility for the GEA TRICARE Supplement Plan will end.

Medicare Part D

State Health Plan members enrolled in Medicare are eligible for Express Scripts Medicare, a group-based, Medicare Part D Prescription Drug Plan (PDP). PEBA has determined that most subscribers covered by the Medicare Supplemental Plan or the Standard 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 his eligible spouse or child enrolls in a Medicare Part D plan not sponsored by PEBA, he will lose his prescription drug coverage through his plan with PEBA, and his 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. 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 Medicare Supplemental coverage, even if the yearly deductible under the previous plan (Standard Plan, etc.) has already been met.

Dental insurance

- The retiree group dental coverage is the same as the active group dental coverage.
- The retiree may elect dental coverage, even if he refuses health coverage.
- The retiree must be covered under the State Dental Plan to enroll in Dental Plus.

Vision insurance

- The State Vision Plan benefits are the same as for the active group.
- The retiree may elect the State Vision Plan, even if he refuses health coverage.
- The retiree is also eligible for the Vision Care Discount Program.

Life insurance

If retiring, the employee may continue or convert Optional Life. He may only convert his Basic Life, Dependent Life-Spouse and/or Dependent Life-Child coverage to an individual whole life policy. To do so, the benefits administrator would complete the Coverage Verification Notice of Group Life Insurance form and give the employee a copy. The employee should contact Securian if he is interested in converting coverage. Note that the conversion notice is not an application for insurance — the employee must speak with a Securian agent to complete an application within 31 days of the date group coverage ends.

Death benefits within 31 days after retirement

- If an employee/retiree, his spouse or his child dies within the 31-day period in which he is entitled to have a conversion and/or continuation policy issued, the amount of group life insurance the employee, his spouse or his child was eligible to continue or convert will be paid to the designated beneficiary. The benefits administrator completes and submits the claim form to Securian. 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 employee 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 IBG for information on the living benefit and continuation of life insurance in retirement.
- Premiums for continued or converted coverage are due by the payment due date.
    - If the individual is billed monthly, his 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, Securian will bill again. The due date will be 21 days later. If neither of these bills are paid in full, the individual's coverage will cancel on the 60th day.
    - If the individual is billed quarterly, semi-annually or yearly, his 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.

Basic Life

Basic Life coverage may be converted within 31 days of retirement to an individual policy through Securian.

- The benefits administrator completes t Coverage Verification Notice of Group Life Insurance form and gives it to the employee.
- The employee should contact Secuian if he is interested in converting coverage.

Optional Life

Coverage may be *continued* (continued into retirement as a term policy with no cash value) or *converted* within 31 days of retirement to an individual whole life policy through Securian.

(**Note:** accidental death and dismemberment coverage is available only to active employees; it cannot be continued into retirement.) The subscriber 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 retiree does not continue his coverage, he *cannot* re-enroll later (e.g., during open enrollment or if a special eligibility situation occurs). You may want to make a note in his file if he does not want to continue or convert this coverage.

Retirees with questions about their life insurance coverage may call Securian at 866.293.6047.

To continue OL coverage as term insurance:

- The minimum amount of coverage that can be continued is $10,000.
- The benefit administrator completes the Coverage Verification Notice of Group Life Insurance form and gives it to the employee.
- The employee must complete and sign the Retiree Life Continuation Election form and send it and the Coverage Verification Notice of Group Life Insurance form to Securian. Securian must receive the two forms within 31 days of the date coverage is lost due to approved retirement or approved disability retirement.

To convert to an individual policy:

- The benefits administrator completes the Coverage Verification Notice of Group Life Insurance form and gives it to the employee.
- The employee should contact Securian at 866.365.2374 to discuss the conversion option. Securian will send the employee a Conversion of Group Life Insurance Enrollment form.
- The employee completes the Conversion of Group Life Insurance Enrollment form and mails it, along with Coverage Verification Notice of Group Life Insurance form and the first premium payment, to Securian. Securian must receive the forms within 31 days of the date the employee's group life insurance coverage ends.

Dependent Life

Dependent Life coverage may be *converted* to an individual policy through Securian. If the retiree does not continue coverage, he *cannot* re-enroll his spouse or children later (e.g., during open enrollment). He also cannot add a new spouse or child to DL coverage later if a special eligibility situation occurs. You may want to make a note in his file if he does not want to convert this coverage.

- The spouse or child must be covered when the employee leaves employment.
- The 31-day rule applies to continuing life insurance into retirement.
- The benefits administrator completes Coverage Verification Notice of Group Life Insurance form and gives it to the employee.
- The employee should contact Securian at 866.365.2374 to discuss the conversion option. Securian will send the employee a Conversion of Group Life Insurance Enrollment form.
- The employee completes the Conversion of Group Life Insurance Enrollment form and mails it, along with Coverage Verification Notice of Group Life Insurance form and the first premium payment, to Securian. Securian must receive the forms within 31 days of the date the Dependent Life coverage ends.

Long Term Disability

Basic Long Term Disability and Supplemental Long Term Disability may not 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 explained in COBRA chapter). Otherwise, the retiree cannot use his Medical Spending Account after he leaves employment and cannot access any remaining funds.
- Refer to the IBG 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, he may continue to contribute to his Health Savings Account (HSA). Refer to the IBG for more information on HSA eligibility.

- A retiree cannot contribute to his HSA on a pretax basis through MoneyPlus.
- He can contribute directly to Wells Fargo, trustee for the MoneyPlus HSA, or to another HSA trustee.

Assisting a new retiree with enrollment

Retirees may enroll in and add or drop their spouse or children from health, vision and/or dental coverage within 31 days of the date of retirement. Many of the procedures for completing a Retiree NOE are the same as those outlined in the Active Subscribers chapter. Below are some reminders for completing the Retiree NOE.

Completing the Retiree NOE

Refer to the instructions on the back of the NOE. Be sure to use this form when enrolling a retiree. **Do NOT use an Active NOE,** regardless of whether you write "Retiree" across the top of it.

Eligibility

- Check type of retiree (regular, disability, police, etc.).
- Provide years, months and days of service. Must attach a completed Employment Verification Record.
- If applicable, check whether a 5-10-year, age 55/25-year or TERI retiree and corresponding ending date.
- Employers other than state agencies and school districts: Benefits administrator *must* sign verification of retirement eligibility.
- Benefits administrators of local subdivisions must verify retirement eligibility for their employees, both on the NOE and on the Employment Verification Record. Benefits administrator *must* sign verification of retirement eligibility.

Action:

- Indicate type of action requiring NOE. Select only one

Enrollee information

- Retiree completes blocks #1-16, including **County Code**.

Coverage

- Retiree completes blocks #17-20. If refusing coverage, must check Refuse.

Medicare

- Retiree completes block if any family members to be covered are eligible for Part A or B of Medicare.

Dependents

- #22 — Indicate whether spouse is also a covered employee or retiree. List spouse and all children to be covered and whether they are full-time students or incapacitated.

Certification and Authorization

- #23 — Have retiree read this section. Be sure the retiree signs and dates this section.

NOE Reminders

- Altered NOEs are not acceptable (no strike-throughs, etc.).
- Make sure Dental Plus block is marked **Refuse** or **Yes**.
- Photocopies of NOEs are not acceptable.
- Do not use highlighters on NOEs.
- The retiree is wholly responsible for the information on the form(s) he signs.
- Forward original to PEBA with employment record.

Changing coverage in retirement

Regular rules for coverage changes during open enrollment apply.

If a retiree does not pay his complete bill, **all of his coverage** will be canceled effective the last day of the month in which he paid his premiums in full. This includes all premiums for health insurance (including the tobacco-user surcharge, if applicable), the State Dental Plan, Dental Plus and the State Vision Plan. Benefits that require no retiree contribution (i.e. State Dental Plan) are included in this cancellation policy. The retiree may re-enroll in coverage within 31 days of a special eligibility situation or during an open enrollment period.

Retiree returns to work

If an employee, who is covered under the state retiree group, returns to a benefits-eligible **position**:

- Offer the active group employee benefits. If the employee, his eligible spouse or any of his children are eligible for Medicare, he must be offered active group coverage. See "Medicare" on page 120 for additional information.
- If the returning employee decides to continue his retiree group insurance coverage, he must complete and sign an Active Group Benefits Refusal form, which is on the PEBA website. Under Insurance Benefits, select Notice of Election. Keep a copy for your records. Advise the returning employee that if he refuses to enroll as an active employee, he also refuses:
    - $3,000 Basic Life benefit
    - Basic and Supplemental Long Term Disability
    - Optional Life
    - MoneyPlus
    - However, if eligible and enrolled in the Savings Plan, the retiree can contribute directly to his HSA through Wells Fargo or other HSA trustee.
- If the returning employee elects active group coverage, *and* he is returning to work with no more than a 15-calendar-day break in service, or with no break in coverage:
    - He must be treated as a transfer employee and must continue the same active coverage as would any other transferring employee.
    - If he is continuing employment in a full-time position with the same agency or school district, there is no need to send an Active Termination NOE.
    - If the returning employee elects active group coverage, and he is returning to work with more than a 15-calendar-day break in service, or with a break in coverage:
    - Complete an Active NOE. The retiree coverage will be terminated

effective when the active employee coverage begins.

- Optional Life (OL)
  - If the retiree has continued OL coverage, he must decide whether to keep his 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, he must contact Securian to cancel his continued retiree coverage due to his return to active status. Otherwise, he will continue to receive a bill for retiree coverage and possibly double what he is paying for the same amount of coverage. If a retiree has converted OL coverage, he 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.
  - Since Dependent Life (DL) coverage must be converted at retirement, if the retiree returns to work and enrolls as an active employee, he is not required to drop any converted DL coverage to enroll his spouse and/or children in DL as an active employee.
  - Retirees returning to work should review their current life insurance coverage and needs carefully before deciding how much coverage they need.

Working retiree transfers

If the working retiree transfers to a new employer group and continues coverage as a retiree, the new benefits administrator must complete the Active Benefits Refusal form. Keep the form in the employee's file. Do not send it to PEBA.

Exception: Gain of Medicare benefits – If an employee (including a part-time teacher), his eligible spouse or any of his children are eligible for Medicare, the employee cannot remain on retiree group coverage while employed. See the Medicare section below.

If the working retiree transfers to a new employer group and elects active group benefits, the new benefits administrator will treat the retiree as a new hire.

Medicare

If an employee (including a part-time teacher), his eligible spouse or any of his children are eligible for Medicare, the employee cannot remain on retiree group coverage while employed.

- He can change to one of the active group plans. Medicare will be secondary payer to the active group coverage. The employee must notify Social Security that Part B will be the secondary payer to his active coverage.
- He can refuse PEBA health insurance coverage altogether (he must disenroll) and keep his Medicare coverage. However, you cannot offer an incentive for the employee to refuse active group coverage.

When the employee leaves active employment and his active group coverage is terminated, he will be eligible to return to retiree group coverage. He must file an enrollment form to return to the state retiree group within 31 days of termination.

- In addition, he must notify Social Security that he is no longer covered under an active group, so Medicare can become his primary payer or so he can re-enroll in Medicare Part B during the special enrollment period, if Part B was canceled. The cost of Part B will not go up. Call the Social Security Administration at 800.772.1213 for questions.

Teacher and Employee Retention Incentive Program (TERI)

- As long as the TERI participant continues employment in an eligible position, he should continue insurance benefits as an active employee. When the TERI period ends, he should file for retiree insurance benefits within 31 days of termination of his active insurance benefits.
- If an employee terminates employment at the end of his TERI period and returns to work with no more than a 15-calendar-day break in service, follow the rules above as for a regular retiree with no break in service.

Survivors

Survivors

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General rules about survivor coverage

A survivor is a spouse or child 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 he is 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.
- Refer to the IBG and to Section H, Spouses and children, for additional information.

If survivor was not covered at the time of death

Survivors must be enrolled in health, dental and/or vision (State Vision Plan) coverage at the time of death to be eligible to continue that coverage as a survivor.

- A surviving spouse or child who is not covered when the covered employee or retiree dies is not eligible for coverage as a survivor.
- The survivor will not be eligible to enroll later during open enrollment, nor will he be eligible to enroll due to a special eligibility situation.

If survivor was covered at the time of death

A surviving spouse or child, who *is* enrolled in health, dental and/or vision (State Vision Plan) coverage when the covered employee or retiree dies, is eligible to continue that coverage as a survivor. The survivor can only continue the coverage he had at the time of covered employee or retiree's death. He may change health plans within 31 days of gain of coverage as a survivor. The survivor may add other coverage during open enrollment.

- If the covered surviving spouse or covered child terminates health, dental and vision coverage, he loses his eligibility for coverage as a survivor. He will no longer be eligible to re-enroll during open enrollment, nor will he be eligible to enroll otherwise due to a special eligibility situation.
- If the covered surviving spouse or covered child terminates health, dental or vision coverage later, but he still retains at least one of the other coverages he keeps his eligibility for coverage as a survivor. He will then be able to re-enroll in the other coverage during open enrollment or when a special eligibility situation occurs.
- A surviving spouse may add an eligible child to coverage during open enrollment or when a special eligibility situation occurs.
- A surviving child may add an eligible spouse or child 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

- If applicable, notify PEBA retirement benefits regarding the death and any refund or monthly benefit that may be due.
- Complete an Active Termination Form, Retiree NOE or Survivor NOE (depending upon the status of the deceased) to terminate the coverage as soon as the death is confirmed, and forward it, along with a copy of the death certificate/documentation, to PEBA insurance benefits immediately.
    - If the deceased was killed in the line of duty, attach this verification to the NOE.

If the deceased was an active subscriber

- If the deceased was enrolled in SLTD 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(s) 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.
- If the deceased was enrolled in Optional Life and/or enrolled in a health plan, file for life Insurance with Securian, using the Notice of Death. See page 127 for more information.
- If the deceased had a MoneyPlus Health Savings Account (HSA), advise the survivor/beneficiary to call Wells Fargo to settle the account. Wells Fargo will require proof of death for the deceased and identification for the beneficiary.
- MoneyPlus Medical Spending Accounts (MSAs) and Dependent Care Spending Accounts (DCSAs) are NOT refundable to the survivor. These accounts are terminated effective the date of death of the employee, unless the IRS-qualified spouse, children or beneficiaries elect to continue the MSA under COBRA through the end of the plan year.
    - Follow the same procedures for notifying WageWorks as you would for a termination of employment. WageWorks will then advise the qualified beneficiaries of their right to continue the MSA through the end of the year under COBRA.
    - Benefit administrators with MoneyPlus COBRA questions may call WageWorks' Benefits Continuation Team at 877.502.6272. Employees should be directed to call WageWorks' Customer Service number at 800.342.8017.

Procedures to continue coverage as a survivor

Benefits administrators must notify survivors about enrollment, cost of premiums, premium collection, coverage changes and terminations.

- When PEBA receives the termination form or NOE, PEBA will notify any covered survivors 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 use status for the survivor has changed, complete and attach a Certification Regarding Tobacco Use form. On PEBA's website under Insurance Benefits, select Forms/Health insurance.
- Since the original subscriber is deceased, the survivor will receive new ID cards from the carriers that will show a new BIN. See also "Which SSN/BIN to Use for Claims" on page 127.
- PEBA will bill for continuation of dental and vision coverage if the survivor was covered.
- Local subdivisions are responsible for premium collection.
- The survivor may pay premiums:

    - Through deduction from a monthly PEBA annuity check
    - By automatic bank draft
    - By direct billing.
- For any children covered by the deceased subscriber, if both parents were covered as active employees or retirees:
    - Health: Remember to add children to the surviving parent's health plan within 31 days of the ending date of the premium waiver.
    - Dental: Add children to the surviving parent's dental plan within 31 days of the loss of coverage under the deceased's plan.
    - Vision: Add children to the surviving parent's State Vision Plan coverage within 31 days of the loss of coverage under the deceased's plan.

Premium waiver rules

- A spouse and/or child 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.
    - 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. Local subdivision 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 IBG for additional information on survivor coverage.
    - Survivors of deceased permanent, part-time teachers are not eligible for the premium waiver.
- The waiver of health premium is effective the day after the date of death.
- A surviving spouse is not entitled to a premium waiver if he feloniously or intentionally kills his 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 a participating employer, the surviving spouse or child may continue coverage, as long as he is eligible, at the employer-funded rate after the waiver ends. (Local subdivision 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.)
- There is no premium waiver for State Dental Plan, Dental Plus or the State Vision Plan. However, the survivors can continue coverage by paying survivor premiums.
    - *Exception:* If the deceased was killed in the line of duty while working for a participating employer, the dental premiums of a surviving spouse or child 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. The benefits

administrator receives a copy of the notification sent to survivors of participating local subdivisions.

- Survivors may drop health coverage within 31 days of the waiver end date. Otherwise, they must wait until open enrollment or a special eligibility situations allows them to do so.

Which SSN/BIN to use for claims

- Continue to file claims for services provided to the deceased employee or retiree under his SSN or BIN.
- Effective the day after the date of death, the subscriber ID number for the surviving spouse and children is the surviving spouse's SSN or BIN (if the surviving spouse is covered). A BIN will be generated for the surviving spouse.
    - If coverage is for children only, the subscriber ID number is the SSN or BIN of the youngest child, unless Medicare covers one of the children. Then, the subscriber ID number 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 on them will be issued by the carriers.
- For any children covered by the deceased subscriber, if both parents were covered as active employees or retirees:
    - **Health**: During the waiver period (if applicable), claims for the covered children should be filed using the SSN or BIN of the child (if there is more than one child, this would be the ID number 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.

Notes regarding Optional Life benefits for survivors

Once Securian receives the completed Notice of Death, a certified death certificate, and copies of the NOEs to establish a history of coverage increases, Securian 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)
- Dependent Child Education Benefit (paid to qualified beneficiaries).
- When Securian receives the Notice of Death, Securian staff will mail the beneficiary a condolence letter, a Beneficiary Statement and a request for a certified death certificate.
- Securian also offers legacy planning resources and beneficiary financial counseling. The subscriber may assign benefits to a third party, such as a funeral home. However, Securian 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 Securian's home office, and Securian sends the subscriber an acknowledged copy. For

more information, contact Securian or see the IBG.

- More information on life insurance claims is in Claims and appeals, beginning on page 153.

When survivor coverage ends

- The surviving spouse's eligibility to continue health/dental/vision coverage as a survivor ends upon remarriage. Survivor coverage ends the first of the following month. 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 his COBRA administrator (PEBA or the benefits administrator, if a local subdivision). *Example*: Surviving spouse remarries, but fails to notify his COBRA administrator for 12 months. He is eligible for COBRA coverage for the remaining 24 months (36 months - 12 months = 24 months).
- Eligibility for survivor coverage also ends if a surviving spouse or child becomes eligible for coverage as an active employee with a participating employer.
- He cannot remain on survivor coverage; he must enroll as an active employee.
    - Even if the survivor is still on waiver status, he must enroll as an active employee and pay the employee share of the premium unless he is the survivor of an employee who was killed in the line of duty. However, any covered children who are not employed with a PEBA insurance benefits-participating employer may remain on the waiver until it ends. For additional information and enrollment/payroll instructions, call PEBA's BA Call Center at 803.737.6800 or at 888.260.9430.
    - He may return to survivor coverage when he leaves employment or continue coverage as a retiree, if eligible. He must enroll in survivor or retiree coverage within 31 days of when his active coverage ends. The remainder of the waiver period would not apply.
- A child may continue coverage until no longer eligible. Coverage ends the first of the following month after he becomes ineligible.
    - Children who become ineligible must be offered COBRA. The 36-month COBRA continuation period starts when eligibility for survivor coverage ends, regardless of when the survivor notifies his COBRA administrator (PEBA or the benefits administrator, if a local subdivision). *Example*: Surviving child becomes eligible for employer-sponsored group health coverage, but fails to notify his COBRA administrator for 12 months. He is eligible for COBRA coverage for the remaining 24 months (36 months - 12 months = 24 months).

Spouses and children

Spouses and children

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Spouses: Special eligibility requirements and changes in status

Documentation is required to cover a spouse. Any document provided as proof of dependent eligibility (such as a marriage certificate or a birth certificate) that is in a language other than English must be completely translated into English and should be certified with a letter of accuracy from the translator. If a subscriber does not have a translation and wishes to submit a copy of the document, PEBA will try to provide a translation. If PEBA cannot adequately translate the document, the subscriber will be mailed a letter advising him that he is responsible for providing an acceptable English translation.

The eligibility of spouses and children is subject to review. The subscriber will be required to submit documentation proving eligibility of his covered spouse and children. If he fails to submit the required documentation the dependents will be removed from coverage.

Changes in coverage should be consistent with the change event.

Example: An employee who gets married would normally ADD his new spouse to his coverage, NOT terminate his own coverage unless he is gaining other coverage through his new spouse.

The type of change entered on the NOE should be specific, such as Divorce vs. Drop Spouse.

In general, eligible spouses must be added to coverage within 31 days of the special eligibility situation. Otherwise, spouses and children may be added to coverage during open enrollment. The subscriber must be on the plan or added with the spouse and/or child.

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.

Both spouses employed by participating employers

- If a husband and wife are employed by participating employers and eligible for coverage as employees neither may be covered as a spouse once he gains eligibility as an employee. When a spouse gains eligibility for benefits with a participating employer (even if the spouse refuses coverage), he may not continue to be covered under his spouses insurance. When PEBA receives an NOE for a covered spouse, PEBA will notify the benefits administrator to submit an NOE to terminate the spouse's coverage. If the employee fails to submit the NOE promptly, PEBA will automatically terminate coverage for the spouse.
- A husband and wife are not required to carry the same health coverage. However, family deductibles will not apply unless they elect the same health plan.
- Two employees cannot cover the same child under the same benefit (health, dental, vision, Dependent Life).

Spouse gains coverage as an employee of a participating employer

If a spouse gains state benefits as an employee, he is not eligible to be on the subscriber's coverage and must be dropped from coverage.

- *Effective date to drop spouse from subscriber's coverage:* the date spouse's employee coverage with PEBA insurance benefits begins.
- *Exception*: If a spouse goes to work as a part-time teacher with a participating employer, he may be covered as an employee or a spouse, but not both.

Spouse is retiree subscriber

A spouse who is also an employer-funded retiree is not eligible for coverage as a spouse; a spouse who is not an employer-funded retiree is eligible.

Spouse gains coverage as a retiree subscriber

If a spouse gains state benefits as a retiree, he is not eligible as a spouse and must be dropped from the subscriber's coverage.

- Effective date to drop spouse from subscriber's coverage: the date the spouse's retiree coverage begins.
- Exception: A spouse covered as a retiree subscriber may be covered as an active employees spouse under Dependent Life within 31 days of the date he retires or during a specified enrollment period.

Marriage

- *Effective date of coverage:* date of marriage for health, dental and vision coverage. Optional Life and Dependent Life-Spouse coverage begins on the first of month following date of request if employee is actively at work (if not actively at work, effective date is first of month following return to work). Dependent Life-Child coverage begins the first of the month after the date of request.
- The eligible employee may enroll himself and/or enroll any eligible spouse and stepchildren in health, vision and/or dental coverage within 31 days of date of marriage. If the employee is already enrolled in health, he may change plans if he is adding his spouse or stepchild to health. The employee may also add Dependent Life-Child, Dependent Life-Spouse ($10,000 or $20,000 without evidence of insurability) and Optional Life (up to $50,000 without evidence of insurability). The employee also may be able to make changes to his Medical Spending Account or Dependent Care Spending Account.
    - A marriage license or page 1 of the employee's federal tax return is required to add a spouse.
    - The Continuing Marriage Affidavit can be used instead of page 1 of the federal tax return. (The form is on the PEBA website. Under Insurance Benefits, select Forms/Other forms.) The completed form must be notarized as proof that the subscriber and spouse are married.
    - A birth certificate (long form) showing the name of the natural parent plus proof natural parent and subscriber are married are required to add a stepchild.
- The employee must be on the plan or added with the spouse and/or children.
- *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.

Common law spouse

- *Effective date of coverage for the new spouse:* date of the marriage as shown on the completed Common Law Marriage Affidavit. The form is on the PEBA website.
- A completed, notarized Common Law Marriage Affidavit must be attached to the NOE to add a common law spouse:
    - During initial enrollment in PEBA insurance coverage
    - During open enrollment
    - As a result of a special eligibility situation, such as loss of other coverage.

- The eligible employee may enroll himself and/or enroll any eligible spouse and/or children in health, vision and/or dental coverage within 31 days of date of the marriage, or other special eligibility situation, or during initial or open enrollment.
    - A birth certificate (long form) showing the subscriber as the parent is required to add a child.
    - A birth certificate (long form) showing the name of the natural parent plus proof natural parent and subscriber are married are required to add a stepchild.
- The employee must be on the plan or added with the spouse and/or children. If the employee is already enrolled in health, he may change plans if he is adding his spouse and/or children to health.

A common law spouse is a legal spouse, and the rules for dropping a spouse's coverage below would apply.

Spouse of foreign national employee

- *Effective date:* first of the month after arrival in the U.S. to *add*; first of the month after departure from U.S. to *drop*
- A spouse of an eligible foreign national employee, working for a participating employer, 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 a marriage license are required to add the spouse.
- A spouse of an eligible foreign national employee, working for a participating employer, 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.

Separated spouse

Subscribers who are enrolled in MoneyPlus **may not drop coverage** for a separated spouse during the plan year, regardless of court order. However, a court could order the separated spouse to pay the subscriber for his share of the premiums instead. Subscribers enrolled in MoneyPlus must wait until open enrollment, until the divorce is finalized or until another special eligibility situation occurs to drop a separated spouse.

For subscribers who are not enrolled in MoneyPlus:

- Effective date to drop spouse: the first of the month after the date the NOE is submitted.
- To drop a spouse (including a common law spouse) at separation, a copy of a court order signed by the judge is required. The order must state that the divorce is in progress and be attached to the NOE.
- The subscriber has 31 days from the date of the court orders date stamp from the Clerk of Court to drop the separated spouse.
- If the subscriber is dropping the separated spouse from health-related coverage (health, dental or vision), he must drop the separated spouse from all three programs. The subscriber may drop or keep Dependent Life-Spouse.
- 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, until the divorce is finalized or until another special eligibility situation occurs to drop the separated spouse.
- The employee may enroll in or increase Optional Life coverage up to $50,000 without evidence of insurability or cancel or decrease his Optional Life coverage. To do so, an employee must submit an NOE to his

benefits administrator within 31 days of the court order date. Changes to Optional Life coverage begin on the first of month following date of request if employee is actively at work (if not actively at work, effective date is first of month following return to work).

- The separated spouse may remain on health, dental, vision and/or Dependent Life-Spouse until the divorce is final. No documentation is required to continue coverage during separation.

Reconciliation

Reconciliation is NOT a special eligibility situation. If a separated couple reconciles:

- The deleted spouse and/or children must wait until the next open enrollment period to be reinstated for health insurance and State Vision Plan coverage.
- The spouse may re-enroll in Dependent Life-Spouse year-round by providing evidence of insurability and being approved. Dental coverage may be reinstated only during the next open enrollment period of an odd-numbered year or within 31 days of a special eligibility situation.

Former spouse/divorce

When a divorce is final, the subscriber must drop the former spouse (including a former common law spouse) from all benefits, unless a divorce decree or court order requires him to continue to cover the former spouse.

- Effective date to drop spouse from subscribers coverage: first of the month after the divorce becomes final
- Exception to 31-day rule: If the subscriber fails to drop the ex-spouse within 31 days of the divorce, the effective date will be the first of the month after the request is made (subscribers signature date on the NOE).
- **To drop the ex-spouse,** a copy of the entire divorce decree must be attached to the NOE.
- The eligible employee may enroll in or increase Optional Life (up to $50,000 without evidence of insurability). The employee also may be able to make changes to his Medical Spending Account or Dependent Care Spending Account.

Required to cover ex-spouse by divorce decree or court order

- *Effective date of ex-spouses coverage:* first of the month after the divorce becomes final.
- *Exception to 31-day rule:* If the subscriber fails to add the ex-spouse within 31 days of the date the court order or divorce decree is signed, the effective date will be the first of the month after the request is made (subscribers signature date on the NOE).
- A copy of the entire divorce decree or court order must be attached to the NOE.
- The divorce decree or court order must state what insurance the employee is directed to provide (i.e., health, dental, vision). It must also list the name(s) of those to be covered. Only the coverage listed in the document may be provided.
    - The spouse and/or children to be covered as directed by the divorce decree or court order must also be listed on the accompanying NOE and will be added only to the coverage stated in the court document.
    - A subscriber cannot cover his ex-spouse for Dependent Life insurance. If a court order directs a subscriber to provide life insurance on his ex-spouse, he will need to get a private policy.
- A divorce decree or court order, directing an employee to cover his former spouse, does *not* generally constitute a special

eligibility situation for that employee if he declined coverage previously and is not currently enrolled.

- A divorce decree or court order does not create a special eligibility situation for the subscriber to add anyone else to coverage who is not specified in the decree or order or to add additional coverage which is not specified in the decree or order.
- A covered employee cannot cover both the current spouse and a former spouse under a particular plan at the same time; only one or the other. For example, an employee cannot cover his former spouse and current spouse for health insurance. However, if the court order specifies health insurance coverage for a former spouse, but not dental insurance, the employee may cover the former spouse for health insurance while covering his current spouse for dental insurance.

Death of covered spouse

- Effective date to drop spouse: the day after date of death.
- Exception to 31-day rule: If the subscriber fails to make the request to drop the spouse within 31 days, 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 his Optional Life coverage within 31 days of his 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 must enroll the spouse in Dependent Life-Spouse coverage within 31 days of first eligibility or within 31 days of loss of other coverage through a participating employer, or evidence of insurability will be required. Evidence of insurability is required if:

- Requested coverage is greater than $20,000
- The spouse is not added within 31 days of initial eligibility, which is:
    - Date of hire, if spouse is not an eligible employee
    - Date of marriage
    - 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 he retires or during a specified enrollment period.)
- Follow the same procedures as outlined under Optional Life on pages 72-75 for submitting evidence of insurability.
- The Actively at Work requirement and the Dependent Non-confinement provision, as explained in the IBG, apply.

Children: Special eligibility requirements and changes in status

Documentation is required to enroll a child. Any document provided as proof of dependent eligibility (such as a marriage certificate or a birth certificate) that is in a language other than English must be completely translated into English and should be certified with a letter of accuracy from the translator. If a subscriber does not have a translation and wishes to submit a copy of the document, PEBA will try to provide a translation. If

PEBA cannot adequately translate the document, the subscriber will be mailed a letter advising him that he is responsible for providing an acceptable English translation.

The eligibility of spouses and children is subject to review. The subscriber will be required to submit documentation proving eligibility of his covered spouse and children. If he fails to submit required documentation the dependents will lose coverage.

Changes in coverage should be consistent with the change event.

Example: An employee who has a baby would normally ADD his new baby to his coverage, NOT terminate his own coverage.

The type of change entered on the NOE should be specific, such as Child gains employment with coverage vs. Ineligible child.

Special eligibility situations allowing an employee or retiree to enroll himself only (if not already enrolled) or enroll himself and his eligible child(ren) in health, vision and/or dental insurance: **marriage, birth, adoption/placement for adoption, placement of a foster child, gaining of legal custody, other court order** or **loss of other coverage**.

Eligible children must be added to coverage within 31 days of the special eligibility event. Otherwise, they may be added during the next open enrollment period. They can be added to State Vision Plan coverage during the next October enrollment period.

Child younger than age 26

A child who is younger than age 26 is eligible if either:

1. The child is the *employee's* natural or adopted child, stepchild, foster child or child for whom the *employee* has legal custody.
2. 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

A newborn may be added to coverage within 31 days of the date of birth.

- *Effective date*: date of birth of the newborn for health, dental, vision and Dependent Life-Child coverage. Optional Life and Dependent Life-Spouse coverage begins on the first of month following request if employee is actively at work (if not actively at work, effective date is first of month following return to work). Newborns are covered under Dependent Life-Child automatically for 31 days from live birth; an NOE must be submitted to continue Dependent Life-Child coverage beyond 31 days.
    - 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 this 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.

- The eligible employee may enroll himself only or any eligible spouse and/or newborn in health, vision and/or dental coverage. If the employee is already enrolled in health, he may change plans if he is adding his spouse or newborn to health. The employee may also add Dependent Life-Child, Dependent Life-Spouse ($10,000 or $20,000 without evidence of insurability) and Optional Life (up to $50,000 without evidence of insurability). The employee also may be able to make changes to his Medical Spending Account or Dependent Care Spending Account.
    - A birth certificate (long form) 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 subscriber's current federal tax return is required to add the spouse.

The subscriber must be on the plan or added with the spouse and/or newborn.

Adoption/placement for adoption (child younger than age 18)

A child younger than 18 may be added to coverage within 31 days of the date of adoption/date of placement for adoption.

- *Effective date:* date of birth for health, dental, vision and Dependent Life-Child coverage if baby is adopted or placed for adoption within 31 days of birth (if adopted or placed for adoption after 31 days of birth, effective date is date of adoption or placement for adoption). Optional Life and Dependent Life-Spouse coverage begins on the first of month following date of request if employee is actively at work (if not actively at work, effective date is first of month following return to work).
- *Exception: International adoptions.* The effective date of coverage on the NOE must be either:
    - The date of adoption on the adoption paperwork (this documentation is required). Attach the documentation to the NOE.
    - 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, please see Birth above for additional requirements if the 31-day window to add the child is missed.
- The eligible employee may enroll himself only or any eligible spouse and/or newly adopted child in health, vision and/or dental coverage. If the employee is already enrolled in health, he may change plans if he is adding his spouse or newly adopted child to health. The employee may add Dependent Life-Child, Dependent Life-Spouse ($10,000 or $20,000 without evidence of insurability) and Optional Life (up to $50,000 without evidence of insurability). The employee also may be able to make changes to his Medical Spending Account or Dependent Care Spending Account.
    - Acceptable documentation to add the newly adopted child includes a copy of a birth certificate (long form) listing 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 subscriber's current federal tax return is required to add the spouse.

The employee must be on the plan or added with the spouse and/or newly adopted child.

Custody or guardianship

A subscriber who gains custody or guardianship over a child may add the child within 31 days.

- Effective date: date of custody or guardianship for health, dental, vision and Dependent Life-Child coverage.
- The eligible employee may enroll himself only or any eligible spouse and/or child with new legal custody in health, vision and/or dental coverage. The employee may add Dependent Life-Child for eligible children (**a foster child is not eligible for Dependent Life coverage**). The employee also may be able to make changes to his Medical Spending Account or Dependent Care Spending Account.
    - 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 subscriber's current federal tax return is required to add the spouse.
- The employee must be on the plan or added with the spouse and/or newborn. If the employee is already enrolled in health, he may change plans if he is adding his spouse or child with new legal custody to health.
- 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.

- *Effective date:* 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).
- A copy of the entire divorce decree or court order must be attached to the NOE.
    - The document should state what insurance the employee is directed to provide (i.e., health, dental, vision), and it must list the name(s) of those to be covered. Only the coverage listed in the document may be provided for the child.
    - Former stepchildren may not be added to Dependent Life, even if it is specified in the court order. If a court order directs a subscriber to provide life insurance on his former stepchild, the employee must get a private policy.

- Special eligibility rules do not apply to National Medical Support Notices (NMSNs). See page 64 for more information about NMSNs.

Child of foreign national employee

- *Effective date:* first of the month after arrival in the U.S. to *add*; first of the month after departure from U.S. to *drop.*
- A child of an eligible foreign national employee, working for a participating employer, 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 a birth certificate (long form) showing the subscriber as the parent are required to add a child.
    - A copy of the visa/visa stamp, showing the arrival date, a copy of a birth certificate (long form) showing the name of the natural parent and proof that the natural parent and subscriber are married are required to add a stepchild.
- A child of an eligible foreign national employee, working for a participating employer, 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.

Child gains employment with coverage

A child who becomes eligible for other employer-sponsored group health coverage as an employee or as a spouse can continue his coverage through the subscriber. The subscriber may drop the child within 31 days of when the child becomes eligible for coverage through his employer or his spouses employer.

- *Effective date to drop child:* first of the month after gaining coverage.
- If the child loses his insurance coverage through his employer — *and the child is otherwise eligible for coverage through the subscriber,* the child may be re-enrolled within 31 days of the event or during the next open enrollment period.

A subscriber may cover a child who is eligible for state benefits because he works for an employer that participates in PEBA. However, if the child is covered under his parents insurance, he is only eligible for benefits offered to children. The child is not eligible for Basic Life, Optional Life, Dependent Life-Child or Long Term Disability insurance.

A child who is eligible for benefits because he works for a participating employer must choose to be covered by his parents as a child or he may be covered on his own as an employee. He cannot be covered as a child on one insurance program, such as health, and then enroll for coverage as an employee on another, such as vision.

If the child wants to continue coverage as a dependent, he should complete an Active Benefits Refusal Form, **not** an NOE refusing coverage. (If he completes an NOE refusing coverage, he will be removed from his parent's coverage.)

The benefits administrator should keep the Active Benefits Refusal Form on file. It does not need to be sent to PEBA. If the child later decides to enroll in coverage as an employee, rather than as a dependent, he should complete an Active NOE.

Death of covered child

- Effective date to drop child: the day after date of death.
- Exception to 31-day rule: If the subscriber fails to make the request to drop the child within 31 days 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.

Incapacitated child

An incapacitated, unmarried child who is incapable of self-sustaining employment because of mental illness, retardation or physical handicap 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 his 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 his 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.
- 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: (The form is on the PEBA website. Under Insurance Benefits, select Forms/Other forms.)
    - A copy of the letter of withdrawal from the educational institution, verifying full-time student status up to the date of incapacitation
    - 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.

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 age 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 due to loss of student status for Dependent Life-Child coverage, attach a copy of the letter of withdrawal from the educational institution, verifying full-time student status up to the date of incapacitation, to the Incapacitated Child Certification form.
- Be sure to 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).

Note: The Authorized Representative Form is on the PEBA website.

1. PEBA will forward the completed form to Standard Insurance Company for a review of the medical information provided, as well as the terms of the plan of benefits, and a recommendation.
2. The Standard may request additional information from the subscriber and/or the child's health care providers.
3. The Standard will forward its recommendation to PEBA, which makes the final determination based on the recommendation and documentation provided.
4. PEBA will then issue a written approval or denial to both the benefits administrator and the subscriber. (Under HIPAA, no personal health information is disclosed to the benefits administrator.) This minimal notification to the benefits administrator is for the purpose of any potential payroll adjustment.
5. 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.

Completing the Incapacitated Child Certification form

This form is available on the PEBA website at www.peba.sc.gov.

- Fill in the subscriber's name, BIN or SSN, employer name and number.
- The subscriber must complete and sign Section A. If the child is age 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, to the Incapacitated Child Certification form.
- The attending physician must complete and sign Section B.
- The subscriber returns the completed form to PEBA for review, approval/denial and processing. The subscriber should also complete and attach an Authorized Representative Form, signed by the incapacitated child. *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).*
- PEBA will notify you and the subscriber of its decision.
- If eligibility as an incapacitated child is denied, the subscriber has 30 days to submit additional medical records and documentation to The Standard for review and reconsideration.
- 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 Insurance.

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.

Effective date to drop child: first of the month after the child's 26th birthday. The child will be dropped from the system automatically, and any ineligible claims will not be paid.

Dependent Life-Child coverage

Eligibility requirements

The employee pays one premium to insure all covered children listed on the NOE, and the employee is the beneficiary for all covered children. There are no accidental death or dismemberment benefits for Dependent Life-Child(ren). Newborns are covered under Dependent Life-Child automatically for 31 days from live birth; an NOE 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)
- 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 incapacitated (certification of incapacitation is required).
- A child who is age 19-24 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 coverage within 31 days of when he becomes a full-time student. *Effective date:* first of the month after attaining full-time student status.
    - For students already covered, 90 days before a covered child's 19th birthday PEBA will send a letter addressing the child's insurance coverage. The letter will be sent to the benefits administrator via EBS for him to print and mail to the subscriber. The child's coverage will continue unless the subscriber notifies the benefits administrator that the child is no longer a full-time student or incapacitated child. No Dependent Life claims will be paid for children ages 19-24 who were not eligible as full-time students.

Children may be added or dropped throughout the year, effective the first of the month after request or effective the date of the event if added within 31 days of birth, adoption, etc. No evidence of insurability is required.

- If both husband and wife are state employees, only one can carry Dependent Life coverage for eligible children.
- The Dependent Non-Confinement Provision applies.

Dependent Non-Confinement Provision

If a dependent is hospitalized or confined because of illness or disease on the date his insurance would otherwise become effective, his effective date shall be delayed until he is 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 subscribers insurance is effective.

Eligibility for MoneyPlus spending accounts

A list of who qualifies for reimbursement from a Dependent Care or Medical Spending account is in the MoneyPlus Reference Guide, which is on the PEBA website, www.peba.sc.gov. For more information, consult with a tax advisor.

When spouse and children eligibility ends

For a spouse

- A spouse's eligibility ends upon divorce, unless a court order requires continued coverage. Coverage ends the first of the month after the divorce becomes final.
- A surviving spouses eligibility ends at remarriage or if he becomes eligible as an employee of a participating employer. Coverage ends effective the first of the month after the date of marriage or the first of the month after the date of hire with a participating employer.
    - If starting work with a participating employer, the benefit administrators should coordinate when coverage as a spouse ends and coverage as an employee begins to avoid overlapping coverage.
- The subscriber must notify PEBA within 31 days of the event.

For a child

- A child's eligibility for health, dental and vision coverage ends the first of the month after he turns age 26, unless he is covered as an incapacitated child.
- A child's eligibility for Dependent Life-Child coverage ends the first of the month after he turns age 19, unless he is certified as an incapacitated child or is a full-time student. Full-time students are eligible for Dependent Life-Child coverage until they turn age 25.
- If a child is covered as a full-time student and loses full-time student status, eligibility for Dependent Life coverage ends the first of the month after he loses that status.
- The subscriber must notify his benefits office or PEBA within 31 days of the event.

COBRA notification by subscriber required

COBRA notification by the subscriber, spouse or other family member is required within 60 days for spouses and children when eligibility for health, dental and/or vision coverage ends.

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 *special needs child* or other *child*. This program is administered through PEBA.

Qualified applicants will receive:

- Actual adoption expenses, not to exceed $5,000 for a non-special needs child or $10,000 for a special needs child.
- When there are not enough funds available or authorized to meet every qualified applicant's expenses, funds will be divided evenly among the applicants (with those who adopted a special needs child receiving twice the amount as those who adopted a non-special needs child).

To be eligible, the adopting employee must be covered by insurance offered by PEBA and must be employed when the adoption is finalized, when the application is submitted and when the payment is made.

Applications must be submitted July 1 - 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.*

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.

For the purpose of the Adoption Assistance program, a **special needs child**, means a child, as defined above, and who meets other specific requirements set forth in the S.C. Code of Laws. For information on these requirements, contact Traci Rish with PEBAs Insurance Finance department at trish@peba.sc.gov or at 803.734.1628.

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
- 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 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 individuals 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 transfer the employers FICA match from the STARS account. SCEIS will then forward the employee and employer FICA taxes to the IRS and report the adoption benefit and withholdings on the employees 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 call Insurance Finance at 803.737.6800 or at 888.260.9430.

Disability subscribers

Disability subscribers

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Disability subscribers

An employee may be eligible for retiree group insurance if he is approved for disability retirement benefits through one of the defined benefit plans administered by PEBA.

Disability retirement eligibility for South Carolina Retirement System members is based on entitlement to Social Security benefits. Police Officers Retirement System 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 meet the retirement eligibility requirement for retiree group insurance through approval through The Standard for Basic Long Term Disability and/or Supplemental Long Term Disability.

Employees of local subdivisions that do not participate with PEBA's retirement benefits may meet the disability retirement eligibility requirement for retiree group insurance through approval through The Standard for Basic Long Term Disability and/or Supplemental Long Term Disability.

For more information about disability retirement, see Chapter 7 of the *Covered Employer Procedures Manual*. For more information about retiree disability insurance see the Disability Retirement section in the Retirement and Disability chapter of the *Insurance Benefits Guide*. You also may contact PEBA.

Applying for disability benefits

An employee should file an application for disability benefits as soon as he becomes disabled and *before leaving covered employment.*

1. Complete and submit an Application for Disability Retirement to PEBA retirement benefits, if applicable. Call PEBA at 803.737.6800 (Greater Columbia area) or 888.260.9430 (toll free) for details on disability retirement.
2. Complete and submit a Long Term Disability Claim Form packet (available on PEBA's website) for BLTD/SLTD benefits.
3. If the employee is unable to file, the employer may file on his behalf.
4. The process may always be canceled, if the employee recovers.

Assisting a disabled employee

If an employee is leaving due to disability:

- Follow the procedures for Terminations. Refer to the Termination Checklists in Section D, Transfers and Terminations.
- The COBRA notification rules apply. Refer to Section E, COBRA Subscribers, for information and procedures for notifying subscribers of their COBRA rights.
- If eligible for disability retirement, refer the employee to PEBA for assistance and information. This could include filing for disability retirement and establishing any additional service credit. Additional information may be found in the Retiree Subscribers chapter.
    - If the employee applied for disability retirement with PEBA before he left covered employment and he is terminated from employment before he receives approval, he may continue coverage through COBRA. (*Note:* The employee has 31 days from the date he leaves employment to convert his life insurance with Securian). If the employee is later

approved for disability retirement, he may apply for retiree insurance within 31 days of the date of notification from PEBA. If eligible, the retiree may choose to enroll in retiree coverage effective the first of the month following the date of notification or the first of the month following the date of retirement. If the employee does not apply within 31 days of the date of notification, he 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 he receives disability approval, he 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 his termination from active coverage provided he is terminated from active coverage on or after the date of retirement. (*Note:* The employee has 31 days from the date of notification from PEBA retirement benefits to apply for continuation or conversion of his life insurance with Securian). If the employee does not apply within 31 days of the date of notification, he must wait for a special eligibility situation or open enrollment to enroll as a retiree.
- Employees who are approved for BLTD/SLTD disability benefits cannot use that approval to apply for retiree insurance. *Exceptions*: Disabled employees who participate in the State Optional Retirement Program or who work for an employer that does NOT participate in PEBA retirement benefits may use BLTD/SLTD approval to apply for retiree insurance, if otherwise eligible.

- Explain that the effective date for insurance purposes will be the first of the month following the date on the approval letter from PEBA (disability retirement), or from The Standard (BLTD/SLTD) as explained in the above bullet. 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 IBG.
- If the employee becomes eligible for Medicare as a disability retiree through Social Security, advise the disabled employee he will need to enroll in Medicare Parts A and B. *He must also notify PEBA within 31 days of eligibility.* He will no longer be able to contribute to an HSA if he enrolls in Medicare.
  - If the individual has end-stage renal disease, please read page 1155 in the Retiree Subscribers section for additional information about Medicare's coordination period.
- If the employee does not qualify for retiree insurance benefits, but enrolls under COBRA, he must notify PEBA when he is approved for Social Security disability benefits so that PEBA can determine his 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), his Optional Life coverage will be continued for up to 12 months by paying the premiums, beginning the first of the month after the *last day worked*.

- If employee retires while on the leave of absence, he can choose to continue or convert his coverage within 31 days of leaving active employment, as explained below.
- If the employee dies while on a leave of absence, complete the Notice of Death and send it with the coverage verification (an NOE, SOE or SOC) and beneficiary information to Securian.
- If the employee has not returned to work at the end of 12 months, terminate his OL coverage. He should choose to continue or convert his coverage within 31 days of leaving active employment, depending on whether he is eligible to retire. Read Continuation/Conversion below for more information and instructions.
- The employee can be considered eligible for Dependent Life coverage on his spouse's insurance when his eligibility for OL coverage as an employee ends or if he converts coverage. He is not eligible if he chooses to continue his coverage.

Continuation/Conversion

- Explain the Optional Life continuation or conversion options, if enrolled. Emphasize the 31-day window.
- If the employee is approved for PEBA retirement benefits disability retirement and/or BLTD/SLTD, but does *not* qualify for retiree insurance benefits, he can still *continue* or convert Optional Life coverage because he is approved for one or more of these disability programs. The subscriber 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 retirement benefits disability retirement or BLTD/SLTD, he can only *convert* Optional Life Insurance coverage.
- The procedures for continuing and converting Optional Life Insurance coverage are explained on pages 116-117.

Basic Long Term Disability/Supplemental Long Term Disability

Eligibility for benefits

Eligibility for BLTD and SLTD benefits is based on the criteria for:

- Own occupation disability (first 24 months)
- Any occupation disability (after 24 months)
- Partial disability.

Note regarding partial disability

An employee may work in another occupation while he meets his own occupation's definition of disability. If the employee is disabled from his own occupation, there is no limit on his 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. The entire claim packet must be completed. This packet is on the PEBA website, www.peba.sc.gov.

Time limits for filing and substantiating claims —

- An employee should submit a completed claim packet to Standard Insurance Company (The Standard) as soon as possible, but within 90 days after the end of the benefit waiting period. The Standard will review the *completed claim* upon receipt.

- In situations in which the employee is unable to obtain the information to submit a completed claim to The Standard within the timeframe 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, the benefits administrator should 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 60 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 60 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 he qualifies for benefits. The payment should be received by the first of the month for the previous month.
- Any BLTD and/or SLTD benefits remaining unpaid at an employee's death will be paid to the person(s) eligible to receive the survivor benefit. If there is no eligible survivor, any remaining BLTD and/or SLTD benefits will 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 IBG.
- These offsets are applied against BLTD and SLTD benefits, according to an individual's eligibility to receive them, regardless of whether he actually does receive them.
- Eligibility for any benefits (Social Security, PEBA retirement benefits disability, 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 Standard will contact PEBA, the benefits administrator and the employee when the disability claim is approved. The waiver ends when the employee returns to work. At that time, notify The Standard and complete the SLTD Premium Waiver Form.

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.
- Standard prepays the employer share, and bills the employer at the end of the year for reimbursement of these amounts. 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, please call Jeri Elsasser at The Standard at 971.321.5387.

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 as soon as possible. The Standard's Stay at Work program may be able to help your disabled employee remain productive. For more information on the Stay at Work program contact The Standard's local Workplace Possibilities consultant, Hollie Hoadwonic, at 803.665.5259 or at Hollie.Hoadwonic@standard.com.

When the benefits administrator 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:

- Employee receives deductible income/offsets (PEBA retirement benefits disability or retirement benefits, Social Security disability or retirement benefits, 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
- Employee is terminated.

MoneyPlus

- If on leave due to disability, the employee can continue his MoneyPlus accounts as explained on page 82 under Unpaid Leave or Reduction in Hours.
- If the employee is eligible for disability retirement through PEBA, his options are explained in the Retiree Subscribers chapter.

Claims and appeals

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.

SHP 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 Appendix of the IBG.

Tips for filing claims

The name on the claim form (if filed manually) should match the name on the NOE.

Allow about three weeks to receive an Explanation of Benefits (EOB) before calling BCBSSC or PEBA 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 should notify their benefits office immediately of any address change. Subscribers can also change their addresses online using MyBenefits.

SHP claims for services outside the U.S.

Claims outside the U.S. are filed for subscribers through the BlueCard Worldwide Program's network providers. However, to receive benefits when a hospital or doctor does not file subscribers can file the BlueCard Worldwide International Claim Form manually. The BlueCard Worldwide International Claim Form is on the PEBA website at www.peba.sc.gov.

Coordination of benefits

SHP benefits for health and prescription drug coverage are coordinated with other coverage that a subscriber, his covered spouse or his covered children 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 SHP is the secondary payer for prescription drug benefits when coordination of benefits applies, the covered person should present the primary insurance card first.

The person would then file a manual claim for any SHP benefits due as the secondary payer. The SHP prescription drug program's manual claim form is on the PEBA website at www.peba.sc.gov.

A person with a MoneyPlus myFBMC Card® is advised not to use the card at the pharmacy when the SHP is the secondary payer because the manual SHP 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 group, unless the employee, spouse or child is enrolled in Medicare solely due to end-stage renal disease.)

When an active employee, his spouse or his child is enrolled in Medicare, claims are filed with BCBSSC first. Once the employee receives the EOB, he should send an itemized bill and a copy of the SHP Explanation of Benefits 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. SHP (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 SHP is the primary payer.

A retiree, who is not eligible for Medicare by his own employment record, but who may become eligible on a spouse's employment record, must enroll for Medicare when the spouse enrolls. If either refuses Medicare coverage, the SHP 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, he will be required to pay the portion of his health care costs that Part A and Part B would have covered.

Accident questionnaires

For accident-related claims, BCBSSC may need information about the event. BCBSSC 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 Terms to Know in the General Information chapter of the *Insurance Benefits Guide*.

- Questionnaires are sent to subscribers when there is a claim filed for treatment of an injury or diagnosis that has been established by BCBSSC's staff of physicians as likely to be an accident or work-related.
- Questionnaires are generated once per week. Subscribers can receive multiple questionnaires related to the same event, due to any of the following:
    - BCBSSC 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 BCBSSC receives a completed one.
    - Subscribers may 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 BCBSSC 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 BCBSSC identify any subsequent accidents that may 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 BCBSSC. This will update the subscriber's file for another six months.

Mental health and substance abuse claims

Office visit services for psychological/neuropsychological testing and applied behavior analysis and all hospital inpatient, partial and intensive outpatient program admissions must be preauthorized by CBA.

In-network claims

The provider files claims when the subscriber, his covered spouse or his covered children use a provider that participates in the mental health and substance abuse 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 abuse claims. The subscriber can file a claim manually as outlined in the IBG.

State Dental Plan and Dental Plus claims

Most dental offices can file claims directly with BCBSSC. However, to receive benefits when a dentist does not file directly, subscribers can file a claim manually as outlined in the Appendix of the IBG. The dental claim form is on the PEBA website.

Tips for filing claims

- The name on the dental claim form (if filed manually) should match the name on the NOE.
- A Pretreatment Estimate from BCBSSC must be returned with the claim after the services are rendered. These estimates are valid for one year.
- Allow about three weeks to receive an EOB before calling BCBSSC or PEBA 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 dental claim form cannot be used to make an address change; subscribers should notify their benefits office immediately of any address change or update their address online through MyBenefits.

State Vision Plan claims

In-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 pre-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. This form is on the PEBA website at www.peba.sc.gov.

- EyeMed will accept only itemized, paid receipts that list the services and the amount charged for each service. Handwritten receipts must be on the provider's letterhead.
- Attach itemized receipts to the completed claim form and mail to EyeMed's Out-of-Network Claims department at the address on the claim form's instructions page.

Life insurance claims

Policy Number 34407

Complete the Active Termination Form, canceling life insurance coverage.

Completing the Claim Form

You must complete the Notice of Death. This form is on the PEBA website at www.peba.sc.gov. .

1. Complete parts 1, 2 and 4 if the employee dies.

- In Part 1, the employer/policyholder name is South Carolina PEBA; the group ID number is your employer's PEBA Group ID number and the plan/policy number is 34407.
- For Part 2, attach a copy of the subscriber's NOE, SOE or SOC showing his coverage; for date employer's unit entered group insurance plan, list 01/14/15 or the date your employer began participating with PEBA, if later than January 1, 2015; for address and telephone number of beneficiary, provide whatever information you have and a copy of the form naming the beneficiary; and for amount of insurance, list the amount of Basic Life and Optional Life separately.

- Complete parts 1, 3 and 4 if the dependent dies.
  - In Part 1, the employer/policyholder name is South Carolina PEBA; the group ID number is your employer's PEBA Group ID number and the plan/policy number is 34407.
  - For Part 2, attach a copy of the subscriber's NOE, SOE or SOC showing his coverage; for marital status of employee and duration of final illness, list the information if you have it (the form can be processed without it).

2. After the Notice of Death is complete, send it, along with coverage verification and beneficiary information, to Securian.
   - Fax the information to 651.665.7106 or
   - Mail the information to Securian
     Claims
     P.O. Box 64114
     St. Paul, MN 55164-0114
3. Securian will send a condolence letter and beneficiary statement to the beneficiary. In the condolence letter, Securian will request a certified death certificate.
4. After Securian receives the completed beneficiary statement and certified death certificate, the claim will either be approved, and payment will be made to the beneficiary, or the claim will be denied, and Securian 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 — may require an in-depth investigation. Securian 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, he may call Securian at 888.658.0193.

Retirees

If the claim is for a deceased retiree, the beneficiary should call Securian at 888.658.0193. The necessary claim form will be sent to the correct party for completion.

Claims payments

Securian will pay life insurance benefits to the beneficiary or beneficiaries as indicated on the NOE.

Exceptions:

- 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.
- In these situations, 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, Securian will send a payment notice to the beneficiary.
- You may go to Life Benefits Extra to check the status of a claim.

Assignment

Securian 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
- The right to increase coverage, as applicable.
- No assignment will be binding on Securian until Securian receives a completed Absolute Assignment to Trust form, records and acknowledges it. This form is available from Securian by calling 800.638.9696.
- 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

The same procedures for completing and filing a Notice of Death should be used in cases of accidental death. 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, whether sane or insane, 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 benefits administrator, employee and his physician must complete the Notice of Accidental Dismemberment and Loss of Sight Claim form and submit it to Securian. Dismemberment benefits are not available to retirees or dependent children.

Accelerated benefits option (Living Benefit option)

When a physician diagnoses an employee or his covered dependents as terminally ill with a life expectancy of no more than 12 months, the employee may request that Securian pay up to 100 percent of his Optional Life or Dependent Life benefit prior to death. The benefits administrator, employee and his physician must complete the Notice of Claim for Accelerated Benefit form and submit it to Securian.

If terminating employment, refer to the Transfers and Terminations chapter for additional information and procedures.

Dependent Life

Policy Number 34407

Follow the claims procedures explained on page 157.

- Give the employee an NOE to complete. 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 the claim is denied, Securian 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;
- An explanation of the review procedure.

The claimant may request an appeal in writing.

- Eligibility appeals should be sent to PEBA.
- All other appeals should be sent to Securian.

Long Term Disability claims

Basic Long Term Disability

(BLTD Policy #627284-B)

Supplemental Long Term Disability

(Policy #621144-B)

The claim packet for both BLTD and SLTD is 16 pages; the latest version is always available on the PEBA website www.peba.sc.gov. It should be completed as soon as the employee is absent from work for more than 30 days or when modified duties have exceeded 30 days. Employees may work part-time or have modified duties and still be eligible for benefits. Detailed instructions are printed on the first two pages of the packet. If the employee is not able to apply for benefits, the benefits administrator may apply on behalf of the employee.

- Give employees applying for LTD benefits the latest LTD Certificate(s) of Coverage(s). Both certificates of coverage, for BLTD and SLTD, are available on the PEBA website.
- The employee completes the Employee's Statement (Pages 3-6) and signs and dates it where indicated.
- The employee signs and dates the next section, Authorization to Obtain Information (Pages 7-8).
- The employee should also sign and date the next section, Authorization to Obtain Psychotherapy Notes, if applicable (Pages 9-10).
- The employee should forward the Employee's Statement and both authorizations to Standard Insurance Company (The Standard) at the address on the form.

- The employee completes only Part A of the Attending Physician's Statement (Pages 11-13) and forwards it to his 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 (Pages 14-16) and forward it to his benefits administrator. The benefits administrator should complete this section and forward it directly to The Standard at the address on the form.

Documentation

Satisfactory written proof that the employee is disabled and entitled to BLTD and/or SLTD benefits must be provided. The entire claim packet must be completed. This packet is available on the PEBA Insurance Benefits website at www.peba.sc.gov.

Time limits for filing and substantiating claims:

- An employee should submit a completed claim packet to Standard Insurance Company (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 timeframe above, The Standard will accept completed claims up to one year after the 90-day period following the respective benefit waiting period (see above).
- If a completed claim is not filed within this time period, the employee's claim will be denied.
- These time limits do not apply while the employee lacks legal capacity. In this situation, the benefits administrator should contact The Standard for additional information and instructions.

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 the claim.

- 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 benefits administrator 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 benefits administrator, requesting the benefits administrator notify PEBA immediately if the employee ever 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
- 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 180 days 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.

If The Standard upholds its decision on a claim—BLTD only:

- 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.

Please 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/Reimbursement

Dependent Care Spending Account and Medical Spending Account reimbursements

The employee files claims for reimbursement directly with WageWorks, administrator for the MoneyPlus program. Instructions for completing the MoneyPlus claim form are on the back of the form.

During the plan year, the minimum reimbursement amount is $5. At the end of the plan year, the minimum reimbursement amount is waived so an employee can submit claims sufficient to clear his balance.

The employee completes the form and attaches copies of explanation of benefits and/or itemized receipts; the employee should keep the original receipts for his records. The employee can fax or mail the form and receipts to WageWorks as indicated on the form. Claims can also be submitted online through the WageWorks website. Here's how.

- Scan your completed claim form and supporting documents. Refer to your scanner's instruction manual for information on saving documents in the proper format and within the file size limit:
    - *Acceptable scanned document formats are .pdf, .jpg, .bmp or .gif.*
    - *Individual file sizes of scanned documents cannot exceed 3 megabytes. Total submission cannot exceed 8 megabytes.*
- Log in to your account at www.myFBMC.com.

- Once you have logged in, click on the Claims tab at the top of the screen, then choose Online Claims Submission from the drop-down menu.
- From here, follow the instructions:
    - Choose the account type for which you are submitting a claim (Medical Spending Account, limited-use Medical Spending Account or Dependent Care Spending Account).
    - Enter the total dollar amount of the claim in the appropriate box. This should match the total amount on your completed claim form.
- Follow the instructions on the next page:
    - Attach your scanned, completed and signed claim form (.jpg, .bmp or .gif format, not to exceed 3 megabytes).
    - Attach your scanned supporting documents (receipts, invoices, etc.).
    - Click Submit.
- Write down the confirmation number for future reference.

If you receive any error messages or if the confirmation page does not appear, check to be sure the file sizes of your scanned documents do not exceed 3 megabytes and that they are in the correct document format (.jpg, .bmp or .gif). Make any adjustments by rescanning the documents and resubmit your claim. Contact WageWorks' Customer Care Center at 800.342.8017 if you have any questions.

Special notes on Medical Spending Account (MSA) reimbursements

Only the eligible expenses an employee must pay may be claimed. Any medical expenses that are already covered by health, dental or vision insurance are not reimbursable.

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 a 90-day run-out period to submit claims incurred during his period of coverage while he was an employee. Refer to Section D, Transfers and Terminations, and Section F, Retiree Subscribers, for more information.

myFBMC Card® reimbursements

The MoneyPlus myFBMC 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
- Pharmacies and any other stores that use Inventory Information Approval Systems (IIAS) (they have coded their prescriptions and eligible over-the-counter items so they can be identified electronically by the myFBMC Card® and other Medical Spending Account card programs). Only the items that are coded into the IIAS may be purchased with the card. *Example*: If you go to Walgreens (this chain uses IIAS) and buy a prescription, some aspirin, eye drops and a magazine, the charge for the magazine will not go through on the card. You would have to pay for that item separately.

Persons with a MoneyPlus myFBMC 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 in order to determine the amount of *unreimbursed* expense before filing a Medical Spending Account reimbursement.

Documentation

Card transactions that require documentation from the employee will show up in blue on their quarterly statements and in red on the WageWorks website, on the Payment Card tab, under Card Transactions. Employees should use the MoneyPlus

claim form for submitting this documentation. This form is on the PEBA website, www.peba.sc.gov.

- If WageWorks does not receive the documentation after the transaction has appeared on two quarterly statements, the next time the employee submits an approved paper claim, enough money will be kept in his account to make up for the card transaction he has not documented., This is called *automatic substitution*.
- If documentation is not received and processed by WageWorks by the end of the month after the second statement is mailed, and the undocumented claim has not been satisfied through automatic substitution, the card will be suspended until:
    - WageWorks receives the documentation
    - Automatic substitution occurs, or
    - The employee pays back his account by check.
- WageWorks will reinstate the card once the transaction is cleared by one of these methods.
- Employers will receive periodic reports on uncleared card transactions.
- Card transactions that remain uncleared by March 31 after the end of the plan year are taxable as income, and WageWorks will send a report to employers listing all uncleared 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 a receipt for the DCSA.
- There must be sufficient funds in the account balance to reimburse DCSA expenses. Payroll deduction data from the employer is submitted to WageWorks after payroll processing. If an employee submits a day care reimbursement request before WageWorks receives and posts the payroll data, the request is suspended and then paid within five working days after the payroll data arrives. A suspended request results also when an employee incurs day care expenses for more than the account balance. A check for the balance is issued. Additional reimbursements are issued as the payroll data arrives and the funds become available.

Special Notes on Health Savings Account Reimbursements

- There must be sufficient funds in the account balance to reimburse eligible HSA expenses.
- MoneyPlus HSA contributions are transferred from the employer to WageWorks. WageWorks processes the payrolls and transfers the funds to Wells Fargo, the trustee for the MoneyPlus HSA accounts. Wells Fargo then posts the funds to each account.
- Generally, deposits are sent from WageWorks to Wells Fargo twice each week.
- The participant is responsible for reimbursing himself from his HSA by writing a check or by using his HSA debit card. He can also use the debit card at an ATM to reimburse himself for out-of-pocket expenses. Any withdrawals must be for medical expenses that qualify under IRS guidelines. If they do not qualify, they may be subject to taxes and penalties.
- The participant is responsible for ensuring that he reimburses himself *only for eligible expenses*.
- The participant is responsible for retaining documentation and providing it to the IRS if requested.

Administrative error (Request for Review)

Requests for Review must be requested from the benefits administrator and should be submitted to PEBA, using a Request for Review Form. The form is on PEBA's website, www.peba.sc.gov.

- A Request for Review addresses an error or mistake made by the benefits office, such as misplacing and failing to send in an employee's NOE within 31 days of a change in status.
    - As explained on page 165, a Level II Departmental Review in the Administrative or Eligibility Appeals process addresses a denial for a subscriber to enroll, add/drop a spouse, etc., for a reason other than benefits office error. Administrative or Eligibility Appeals are explained on page 165.
- Use the Request for Review Form when the benefits office has made a clerical or delay error, has misinformed the enrollee or has misplaced a completed NOE.
    - The Request for Review Form can also be used when a subscriber is requesting a Level II Departmental Review in the Administrative or Eligibility Appeals process.
    - The benefit administrator's signature is required, certifying the error was caused by the agency, school district or local subdivision and was not the fault of the employee (such as the employee failed to submit an NOE within 31 days).
    - Include complete details, and attach all relevant documentation. Attach an additional explanation sheet, if necessary.
    - Always include the group name, employee's name, BIN and date of request.
    - If making a change to coverage, attach an original NOE, completed and signed by the employee and the benefits administrator, to the Request for Review Form. The NOE must correct the error addressed on the form. The Request for Review cannot be completed without an NOE showing the requested change.
- If the request is denied, the benefits administrator *must* send a copy of the denied Request for Review Form to the subscriber, notifying him that he has 90 days to appeal to PEBA's Level III Eligibility and Enrollment Appeals Committee.
- If the request is approved, a change made due to an administrative error can be made retroactively, up to one year. The effective date for the change must be retroactive (up to one year), back to the actual effective date, and any premiums due must be paid. *Changes cannot be made proactively or for the date the request is made.*
    - *Example*: New employee hired March 1, 2015, but NOE was not submitted due to administrative error. PEBA receives Request for Review Form and NOE to add employee on July 1, 2016. PEBA cannot add employee effective July 1, 2016. Employee will be added effective July 1, 2015 (one year retroactive from receipt of request, as request was received more than one year after the actual effective date of March 1, 2015). Premiums are due from July 1, 2015, forward.
- A Request for Review Form must be attached to an NOE whenever an effective date correction is more than 90 days retroactive.

- A Request for Review Form is not required for retroactive terminations 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.

Subscriber negligence is not considered an administrative error. If the subscriber feels the matter is not due to negligence, but due to other circumstances, he may submit a request for a Level II Departmental Review through his benefits administrator (see below).

Administrative or Eligibility Appeals

If PEBA denies eligibility for coverage for an employee, retiree, survivor, spouse or child the subscriber has the right to a review of that decision.

Examples include, but are not limited to:

- Eligibility for coverage as an incapacitated child
- Subscriber fails to add/drop a spouse or child to/from his coverage within 31 days of a special eligibility situation or change in status
- Eligibility for coverage as a funded or non-funded retiree

The individual or subscriber must submit his request to his benefits administrator. The benefits administrator then sends a written request to PEBA.

There are several levels of review at PEBA. Each level must be exhausted before the benefits administrator or subscriber may request review at the next level. The following is a brief overview of that process.

Level I Review

The Level I Review consists of the subscriber making a request to PEBA for a change in coverage or other eligibility request and the request is denied.

- A rejected NOE is an example of a Level I request.

Level II Review

Active subscribers must submit Level II written requests through their benefits administrators. *Note: Retirees should write directly to PEBA in most Level II situations.*

- The benefits administrator will complete a Request for Review (RFR) form, attaching the denied NOE if applicable, and an explanation indicating which changes and effective dates are requested. If the rejection was due to benefits administrator error, please mark the FRF to show that fact. Please be detailed in your explanation on the RFR.
- The benefits administrator must submit the request and all supporting documentation, including a completed NOE, regardless of whether he supports the employee's request. The completion of an NOE does not guarantee PEBA will approve the request.
- PEBA will then review the request and communicate its decision to the benefits administrator.
- If the request is approved, PEBA will process the NOE and notify the benefits administrator of any other needed documentation.
- If the request is denied, a benefits counselor will send the benefits administrator a letter explaining the denial. **The benefits administrator must send the denial letter to the subscriber**. The benefits administrator may not initiate a Level III appeal. The letter will explain to the subscriber that he has 90 days to appeal to

PEBA's Level III Eligibility and Enrollment Appeals Committee at the following address:

PEBA Insurance Benefits Appeals Committee
Attn: Appeals Coordinator
202 Arbor Lake Drive
Columbia, SC 29223

Level III Review

All Level III written requests must be submitted directly to PEBA.

- The subscriber may submit the written request for a Level III review to PEBA only after receiving
  - A denied Request for Review Form due to benefits office error (discussed on page 164) through his benefits administrator or
  - A denied Level II Departmental Review decision through his benefits administrator (often called a 90-day letter).
- The denied Request for Review Form or Level II Departmental Review letter will explain to the subscriber that he has 90 days to request an appeal.
- The subscriber must explain the reason for the Level III appeal in his letter, and any additional information and supporting documents must be attached. The request must be made within 90 days of receiving the denied Request for Review Form or the Level II denial letter.
- If the Level I and Level II appeals were denied because of lack of documentation, please have the subscriber attach the required documentation to the appeal letter.
- Once a written request is submitted, the Eligibility and Enrollment Appeals Committee must review the request.
  - If the Eligibility and Enrollment Appeals Committee approves the request, PEBA will process the NOE and notify the subscriber and his benefits administrator of any other needed documentation.
  - If the Eligibility and Enrollment Appeals Committee denies the request, PEBA will send the subscriber a detailed decision letter explaining the reason for denial. The subscriber then has 30 days from receipt of the Level III Eligibility and Enrollment Appeals Committee denial letter from PEBA to seek judicial review as provided by S.C. Code Ann. § § 1-11-710 and 1-23-380.

Judicial Review

The Level III denial letter will contain information on contacting the Administrative Law Court to proceed with the judicial review process as provided by S.C. Code Ann. § § 1-11-710 and 1-23-380.

- The subscriber must submit his appeal to the appropriate court within 30 days of receiving a Level III Eligibility and Enrollment Appeals Committee denial letter from PEBA.

Accounting, billing and reports

Accounting, billing and reports

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General information

This section gives instructions on how to use the information found on the monthly billing statement and in various reports. This is only a guide; it will not cover every situation. If you have any questions after reading these instructions, call the PEBA Insurance Finance account representative for your group at 803.734.1696 or at 888.260.9430.

Accounting definitions

Payroll Center: The office or area of a participating employer that processes the payrolls of its employees, including premiums for insurance coverage.

Retroactivity (RETRO): A charge or credit of premiums that occurred because an NOE was processed with an effective date prior to the current billing statement month.

Key: A description of codes on the Group Address page of the billing statement.

General accounting rules

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.
- An exception: If the employee or other subscriber dies *on the 15th of the month*, coverage will be terminated on the 16th of the month. (This is to make sure all claims for the month are paid.) 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

(Applies to all employers)

For more information and policies regarding unpaid leave, refer to the Active subscribers chapter under unpaid leave or reduction in hours, which begins on page 80.

- Participating employers are responsible for collecting all premiums and submitting them to PEBA Insurance Finance. In relation to this responsibility, an employee authorizes his employer to collect his portion of the premiums for the coverage selected on the NOE.
- The employer will be billed and is required to pay all outstanding premiums to PEBA Insurance Finance.
- In an unpaid leave situation, the employer should 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 non-payment of premiums, but only up to 31 days retroactive.
- See Submitting premiums for employees on unpaid leave on page 181 for more information.

Issuing credits

(Applies to all employers, except CG agencies)

PEBA Insurance Finance does not issue individual refunds. Instead, a credit is applied to the billing statement through processing an NOE, 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 his W-2 records. It is not PEBA Insurance Finance's responsibility to make sure this adjustment is made.

Active accounting system

Billing statement

You may view your bill through the Employee Benefits Services (EBS) website (https://ebs.eip.sc.gov). Groups without EBS access will receive paper copies in the mail.

Active group billing statement (applies to all groups)

Frequency: Monthly

On or before the first of each month, PEBA Insurance Finance sends each group a billing statement. This billing statement enables each group to maintain the accounting records of each employee. If the group verifies the information printed on the billing statement and communicates with PEBA Insurance Finance whenever there are questions about the data, the financial process for employees' benefits should work smoothly.

This section of the manual includes descriptions of the billing system for the following insurance programs and plans:

- State Health Plan*
- Dependent Life-Spouse
- GEA TRICARE Supplement Plan
- Dependent Life-Child(ren)
- State Dental Plan
- BLTD
- Dental Plus Plan
- SLTD
- Basic Life
- State Vision Plan
- Optional Life

**The tobacco surcharge will appear separately from the health premium on the billing statement.*

Group address page

This page contains the group identification number, along with the name and complete address of the group. This page also lists the name of the person PEBA Insurance Finance will contact if there are any questions. Your group's contact person should be the individual responsible for remitting payment for insurance premiums. If there is a change in the contact person or address, the Authorizing Agent for your group should update this information through EBS. In the middle of the page is the section that lists the account representative for each group and PEBA Insurance Finance's return address. At the bottom of the page, there is a key/legend that refers to the Coverage Processing section of the billing statement.

Account summary pages

These two pages summarize the prior month's activity, ending with the net premium outstanding from the prior month and the billing for the current month. The first page lists information for the employer share, health, dental, Optional Life and Dependent Life-Spouse. The second page pertains to Dependent Life-Child, SLTD, vision and the tobacco surcharge.

Below is a description of each section on these pages. If you have any questions about the Account Summary, call PEBA Insurance Finance department at 803.734.1696 or at 888.260.9430.

- 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 and returned checks.
- 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: one type is for a subscriber and the other type is an adjustment to the group account. *For example*, 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 last four digits of the SSN will be listed on the Account Summary page and an Adjustment form will be mailed to the group. 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 Billing Summary lists the totals of the current month's billing found on the Billing Summary page.
- The Administrative Fee is applied to local subdivisions (counties, disabilities and special needs boards, water and sewer districts, alcohol and drug abuse agencies, special hospital districts, special purpose districts, recreation districts and municipalities).
- Total Net Balance is the total of the Net Premium Outstanding and the current Billing Summary.
- The Employer Share for health, dental, Basic Life and LTD is rolled into one total. Separate totals are provided for the Employee Share for health, dental, Dental Plus, State Vision Plan, Optional Life, Dependent Life-Spouse, Dependent Life-Child, SLTD and the tobacco surcharge. In addition, a grand total is provided by adding the total employer and employee shares together.

Billing Summary pages

The Billing Summary pages show a breakdown of the amount of the current month's bill for all state benefits plans. The health insurance plans are itemized by level of coverage within each plan. The tobacco surcharge will not be included in the health premium amounts; it will appear separately.

This summary itemizes the monthly premium, showing the amount of the employer share and the employee share for each plan. In addition, separate totals are provided for the current month's figures and for retroactive figures. Also, a current month's figure is provided for the total number of subscribers enrolled in each of the benefit programs.

If you have any questions about the Account Summary, call PEBA Insurance Finance at 803.734.1696 or at 888.260.9430.

Coverage processing pages

Coverage Processing provides a detailed list of all NOEs processed since the completion of the last bill. These changes are listed in alphabetical order by the subscriber's last name, with the information displayed only for the state benefits plan(s) affected by the change. If no NOEs are processed, the group will not receive this section.

- Check each transaction listed on the billing statement against the copy of the NOE to make certain the change was processed correctly. If there is a discrepancy in enrollment processing, contact the BA Call Center at 803.734.2352 or at 888.260.9430.

- The first column lists the subscriber's name and date of birth displayed across the page on the same row.
- The second column shows which insurance program is affected by the coverage processing entry. The alpha and numeric characters for the various state plans are located in the key on the Group Address page of the bill.
- The third column lists which plan and coverage level the subscriber elected for each type of insurance.
- The fourth column shows the effective date for each type of insurance.
- 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 indicates which type of entry is completed for each type of insurance program.
- The grand total for all retroactive figures for each of the state plans can be found after the last employee listed in the Coverage Processing pages and on the Billing Summary page of the billing statement for the employer and employee shares.

Remittance advice page

Use this page to report the monthly payment of your bill to PEBA Insurance Finance for the employer and employee shares. The Grand Total is the total amount due for the current month. These figures are the same figures located at the bottom of the Account Summary page in the Total Net Balance column.

Follow these procedures when completing this page:

- For each payment submitted, identify the document by listing the check, the date and the total amount.
- List the amount paid for each benefit down the page starting with the employer share and ending with SLTD.
- Verify each payment submitted by adding the amount listed for each state benefits plan to provide a grand total. The grand total should equal the figure listed for the document total.
- Sign, date and provide a telephone number in the appropriate spaces for the person in each office to contact for questions.

Advance deposit billing statement

Frequency: Annually

Every participating employer is required to make an advance deposit of at least one month's premium for employer contributions. At the beginning of each fiscal year in July, PEBA Insurance Finance bills all participating employers for the advance deposit. Payment is due to PEBA Insurance Finance by July 15.

- This bill lists insurance programs for which the employer contributes to the monthly premium and the subscriber count enrolled in each of these plans at the end of June. The subscriber count is multiplied by the current employer rate to arrive at the deposit amount.
    - On the last page, check one-month deposit or 12-month deposit in the appropriate space and fill in the figure in the Total Remitted space. Sign, date and list a telephone number in the space provided for the contact person in your office.
- Those employers that make the one month's advance deposit receive credit to their group account on their bill for the following June, which may result in a balance due or overpayment.
- Those employers that make a yearly deposit receive credit to their group account immediately. This advance deposit for total employer contributions is composed of

premiums for these programs according to PEBA Insurance Finance's enrollment files for July:

- State Health Plan
- State Dental Plan
- Basic Life
- Basic LTD.

Active Billing File

All employers, except for CG agencies, are responsible for reconciling their employer and employee records on a monthly basis. Upon request, PEBA Insurance Finance can provide you with an Active Billing File as an electronic text file. The text file may be provided in one of two formats:

1. A text file that is easily downloaded into Microsoft Excel
2. A text file that may be downloaded and used in other programs, such as CSI Payroll Services payroll program.

Contact your PEBA Insurance Finance accounting representative to request an Active Billing File.

Reports

In addition to your billing statements, PEBA Insurance Finance generates and sends you regular reports to help you notify employees of changes and to help identify errors. Groups receiving reports through the EBS website will not receive paper copies in the mail. Following is a brief summary of those reports.

Active Subscriber Roster (HAC500)

Frequency: Monthly via EBS

A list of all employees on file with each group is printed monthly for those without EBS access. If you have EBS access, you can access a roster at any time. The month for which it is printed appears directly below the title. Use this to update your records and to verify PEBA Insurance Finance's records. The list provides information on each employee's coverage and the monthly employee premium for each of these programs:

- State Health Plan (the tobacco surcharge will be listed separately) and the GEA TRICARE Supplement Plan
- State Dental Plan
- Dental Plus
- State Vision Plan
- Dependent Life-Spouse
- Dependent Life-Child
- Optional Life
- SLTD.

Subscriber rosters are listed in alphabetical order by the subscriber's last name. Each subscriber is listed by last name, first name and middle initial, and the last four digits of his SSN. The total number of subscribers and the total amount of employee premiums for each program are on the page following the list of active subscribers. No roster will include the complete SSN.

If there is a discrepancy in enrollment on the membership rosters, call the BA Call Center at 803.734.2352 or at 888.260.9430.

Subscriber/Dependent Roster (HIS539)

Frequency: Monthly via EBS

This list shows the type and level for each employee's coverage:

- Health plan (the tobacco surcharge will be listed separately from health coverage)
- State Dental Plan
- Dental Plus
- State Vision Plan
- Dependent Life-Child
- Optional Life
- Dependent Life-Spouse
- SLTD.

This list also shows each employee's spouse and children, the last four digits of their SSNs and the benefits for which each spouse and child is covered, including:

- Health plan
- State Dental Plan
- Dental Plus
- State Vision Plan
- Dependent Life-Child
- Dependent Life-Spouse.

Dependents Terminated due to Eligibility Audit (HIS630NP)

Frequency: Monthly via EBS (if applicable)

A list of all dependents who were dropped the previous month because acceptable documentation was not received. If a dependent was dropped and reinstated within the same month, the dependent will not appear on the report.

PEBA will adjust the level of coverage as needed after dependents have been dropped. Groups whose payroll is not processed through SCEIS should use this report to make adjustments to payroll.

Subscribers in SLTD Waiver Status (HAC555)

Frequency: Monthly (if applicable)

Each group will receive a monthly report listing employees in premium waiver status for SLTD. This report will list the subscriber's name, the last four digits of the SSN, effective date of waiver status and the premium waived. This report will not include the SSN if you receive your reports in the mail.

Optional Life, Dependent Life-Spouse (HAC502) and SLTD Age Group Change (HAC515)

Frequency: Annually (if applicable)

In November of each year, each group receives two reports that list the subscribers who are enrolled in Optional Life, Dependent Life-Spouse and SLTD and who will have a premium adjustment effective the following January due to a change in age bracket. The Optional Life report displays the coverage level and premium amounts for these employees. Subscribers are listed in alphabetical order with full name and birthday. The SLTD report will display only the subscriber's name and the last four digits of the SSN; premiums will not be listed. This report will not include the SSN if you receive your reports in the mail.

Dependent Turning 19/25 within 90 Days (HIS501) (With Letter [HIS600])

Frequency: Monthly (if applicable)

This report and letter give advance notice to an employee within 90 days of when a child turns age 19 and 25 (for Dependent Life) and age 26 (for all other coverage).

- Send the letter to the employee and include an NOE and necessary COBRA information.
- The employee should complete the NOE and return it to you so you can make the necessary payroll changes and send it to PEBA for processing.
- If the child is incapacitated:
    - Complete the necessary Incapacitated Child Certification Form and send it to PEBA for review and a determination.
    - PEBA will notify you of approval or denial.
    - If denied, provide COBRA information.

Dependent Age 1 and Over with No SSN (HIS534)

Frequency: Monthly (if applicable)

This report lists subscribers with eligible spouses or children on file without Social Security numbers. The spouse or child will be listed on this report each month until a SSN is provided.

Terminated Subscriber Listing (HIS512)

Frequency: Monthly (if applicable)

This report lists any subscribers who are terminated from the current month's billing.

- Make sure the proper notification is sent to each listed employee.

- If the termination is in error, submit a corrected Active NOE to PEBA immediately to reinstate the employee's benefits or to correct an incorrectly keyed late entrant date.
- Refer to the key (reminder) at the bottom of the report for proper notification.

Temporary Coverage on Adoptions Ending within 90 Days (With Letters) (HIS507)

Frequency: Monthly (if applicable)

This report and letter give advance notice to an employee who has added a child to his coverage and is waiting for completion of the one-year final adoption. They are also used to notify you of those employees who failed to furnish the needed final placement agreement at the end of the one-year temporary placement.

- Send the letter to the employee; keep a copy for your files.
- Send an NOE for corrections if the child is no longer 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 no longer is 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.

Health Subscriber and/or Spouse's TEFRA/DEFRA Letter

(Tax Equity and Fiscal Responsibility Act/Deficit Reduction Act)

This letter is for your files only. This letter notifies subscribers of their insurance options once they become eligible for Medicare.

- Employees and spouses reaching age 65 are mailed a letter from PEBA 90 days prior to their 65th birthday.
- Letters are mailed the first of each month to the subscriber and/or his spouse.
- A copy is sent to you for your files.

Subscriber Premium Data File (HAC470)

Frequency: Daily

This report is a daily snapshot of all benefits and premiums for your group's subscribers. It is in a text file format so the data can be manipulated and used to update your payroll without keying the data changes.

For Comptroller General (CG) agencies only

Definitions

Comptroller General (CG) agency: An agency that uses the South Carolina Enterprise Information System (SCEIS) to process its payroll for the employee and employer deductions. SCEIS is the statewide enterprise system used to standardize and streamline business processes within the government of South Carolina. Services include finance, material management, human resources and payroll.

Canceled Warrant (Cnx Warr): The cancellation of a payroll check.

Reconciliation: The comparison of the enrollment files at PEBA and the SCEIS payroll deductions for a subscriber.

Refund: A reimbursement of overpaid insurance premiums to the employee, or to the employer in certain situations.

Submitting premiums for employees on unpaid leave

- Collect the total premium due for unpaid leave employees.
- Submit the personal checks from the employees on unpaid leave, along with an itemized list of the plans/coverage each check includes each employee's BIN. A Personal Checks form is available on the PEBA website at www.peba.sc.gov. Select Insurance Benefits/Forms/Accounting.
- See pages 170 and 182 for more information on unpaid leave rules.

Payroll reconciliation report

PEBA provides a monthly computer reconciliation for all CG agencies. The reconciliation is for the employee share of the monthly premium. The reconciliation for the previous month is forwarded to the agency with the current month's billing statement. Each CG agency receives a printout of differences for the following state benefits plans:

- State Health Plan (the tobacco surcharge will be listed separately) and the GEA TRICARE Supplement Plan
- State Dental Plan
- Dental Plus
- State Vision Plan
- Optional Life
- Dependent Life Spouse
- Dependent Life-Child
- SLTD.

Reconciliation for all of these plans follows the same basic format. The reconciliation report lists the subscriber(s) who is being billed a different amount than the deducted premium. Under the Insurance Master section is the amount of the coverage on the PEBA computer system. Under the SCEIS Deduction section is the amount that is payroll deducted. Listed in the next column is the difference between the two. At the end of each type of insurance are the totals for the Insurance Master section, the SCEIS Deduction section and the Difference column.

Investigate each exception and take proper action to correct the problem.

PEBA sends an enrollment file to SCEIS on a daily basis. 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.

SCEIS payroll process

- SCEIS collects and remits to PEBA the employer and employee premiums based on the daily files. Your group will continue to receive a bill; however, your group should not remit payments for the monthly employer premiums or the Advance Deposit.
- Contact the SCEIS Help Desk with questions concerning which account the employer premiums are taken from or the funding source for the employer premiums.
- SCEIS does not recognize exceptions listed on the Accumulator for months prior to the date that your group went live for SCEIS payroll. For outstanding balances, you should collect and remit a personal check to PEBA. For refunds, you should send a Refund Request Form to PEBA.
- SCEIS does not recognize effective dates prior to the date that your group went live for SCEIS payroll and will not collect premiums for those months. For example: if a subscriber is a new-hire effective June and your group went live July, SCEIS will not collect the premiums for June. You should collect and remit a personal check to PEBA. If a subscriber terminates effective June and your group went live July, SCEIS will not refund June premiums. You should send a Refund Request Form to PEBA.

- SCEIS will not process a refund check for amounts less than a $1; therefore, an adjustment must be requested to zero out the employee's balance.
- For a new hire or coverage change that results in a large balance due, your group may decide to collect premiums due over several pay periods. You should contact the SCEIS Help Desk to change the amount of the deduction and the number of pay periods.
- You may continue to send personal checks for the employee premiums for subscribers in unpaid leave status. If you do not collect the monthly premium from a subscriber while he is in unpaid leave status, SCEIS will collect the total amount due from the first payroll check the subscriber receives once he is no longer in unpaid leave status. If you remit the monthly premiums, you should 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 he is in unpaid leave status.
- If you discover an enrollment error on the billing statement, you should contact PEBA to resolve the enrollment error, which should correct the deduction. If the coverage is correct but the payroll deductions are not, you should contact the SCEIS Help Desk to resolve the problem.
- PEBA will continue to provide the Reconciliation and the Accumulator reports for all SCEIS groups. PEBA will also provide the Reconciliation and Accumulator reports for the employer share. Contact the account representative for your group at 803.734.1696 for more information.

Unclaimed Refund Checks

If the U.S. Postal Service returns a refund check to your group 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 http://treasurer.sc.gov/.

For local subdivisions only

Definitions

Administrative fee: A monthly fee charged by PEBA to alcohol and drug abuse agencies, community action agencies, councils on aging, county governments, disabilities and special needs boards, hospital districts, municipalities, recreation districts and special purpose districts. This fee is charged per employee, retiree, survivor and COBRA participant.

Experience rating: A method under which a group's recorded health care costs (claims) are analyzed and the group's premium is calculated partly or completely according to the group's claims experience.

Experience rating health premiums for local subdivisions and other optional employers

When new employers enroll in the State Health Insurance Program, they are categorized by size — by the number of covered lives (number of individuals insured under the program). Health insurance premiums for these employers are experience-rated according to the average claims experience of other employers in their category. This rate, or load factor, is applied to the current premiums and remains in effect until they have incurred enough claims to be rated using the same formula as other employers in their category. Experience rating applies only to the State Health Plan.

PEBA calculates the experience rating of all local subdivisions annually. The experience rating formulas for each category are described below. Be aware that rate changes due to experience rating are separate and are in addition to any annual, across-the-board rate increases.

Employers subject to the experience rating of health premiums are separated into three categories for determining rates.

- Small groups (fewer than 100 covered lives). Rated according to average claims experience of all of the small groups.
- Medium groups (100-500 covered lives). Once 24 months of claims are incurred for a group, medium groups are rated using a formula that gives 50 percent weight to the average claims experience of all medium groups combined and 50 percent weight to the claims experience of the individual group.
- Large groups (more than 500 covered lives). Once 12 months of claims are incurred for a group, the experience rating is based solely on the claims experience of that group.

PEBA will notify employers of their new rates. The notification will include the load factor — the percentage increase in premium. Both the employer and employee shares of the total premium will change, and an employer may choose to absorb some or all of any increase in the employee share. However, an employer may NOT pass along any of its share of the increase to the employee.

Notification

- PEBA will notify the payroll center, in writing, of any change in the experience rating before it goes into effect and will provide rate tables for both employee and employer premiums.
- It is important that you share this information with all benefits and payroll staff in your employer group.
- The employer is responsible for notifying its subscribers of any rate changes.

The retiree/COBRA/survivor billing statement

The billing statement for retiree, COBRA and survivor subscribers is the same as that for active subscribers (described earlier in this section), except for the differences noted below. This guide includes descriptions of the billing system for the following state benefits plans:

- State Health Plan (the tobacco surcharge will be listed separately)
- GEA TRICARE Supplement Plan
- State Dental Plan
- Dental Plus
- State Vision Plan.

Group address page

Same as for active subscribers on Page 171.

Account summary pages

The administrative fee applies only to local subdivisions (counties, disabilities and special needs boards, water and sewer districts, alcohol and drug abuse agencies, special hospital districts, special purpose districts, recreation districts and municipalities).

Billing summary pages

Each subscriber type is listed: Regular Retirees, Retiree Buy-Ins, etc. Within each subscriber type the health insurance plans are listed and are itemized by level of coverage within each plan. The tobacco surcharge is listed separately. Separate line totals are listed for the total dental amounts for each subscriber type section.

Coverage processing pages

Same as for active subscribers on Page 172.

Remittance advice page

The instructions for the remittance advice page are the same as for active subscribers on Page 173,but note that the layout is different for retiree, COBRA and survivor subscribers. Note that some programs are not listed because they are not available to these subscribers.

Subscriber roster (HRA500)

Frequency: Monthly via EBS; Monthly via mail

This list provides information on each subscriber's coverage and the monthly employee premium for each of the following state benefits plans:

- State Health Plan (the tobacco surcharge will be listed separately)
- State Dental
- Dental Plus
- State Vision Plan.

The subscriber roster is divided into sections based on subscriber type (18-month COBRA, 29-month COBRA, 36-month COBRA, regular retiree, etc.). In each of the sections, the subscribers' names are printed in alphabetical order. Each subscriber is printed by last name, first name and middle initial, with the last four digits of the SSN listed in the next column. This roster will not include the SSN.

Automated Subscriber Coverage Changes Report (HRA615)

Changes to regular retiree coverage due to age (turning 65) or spouse and/or children becoming ineligible are made automatically to the billing statement. Whenever applicable, the Automated Subscriber Coverage Changes Report is sent with the billing statement. The Automated Subscriber Coverage Changes Report lists those subscribers whose premiums have been changed.

- The effective date of the change is listed directly below the title of the report.
- The subscriber's name is displayed last name, first and middle initial.
- The next column lists the last four digits of the SSN, the third and fourth columns show the health and dental current and previous premiums respectively.
- The last column gives the reason for the change.

Collecting premiums for mid-month changes

Same as for active subscribers on Page 170.

Submitting premium payments to PEBA

- 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 section of the bill, please call the BA Call Center at 803.734.2352 or at 888.260.9430. 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.
- All payments should be made payable to PEBA. If your office also pays for retiree, survivor and COBRA subscriber coverage, submit one check for these premiums. See also Submitting premiums for employees on unpaid leave on Page 182.
    - 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 Insurance Finance Department.
- Street address: 202 Arbor Lake Drive, Columbia, SC 29223.
- Mailing address: P.O. Box 11661, Columbia, SC 29211
- Employers also have the option to pay their monthly premiums through Electronic Funds Transfer (or automatic draft). This

payment method gives PEBA authorization to automatically deduct your monthly premium balance from your designated bank account. You will continue to receive a monthly billing statement, which gives the amount that will be drafted from your bank account on the 10th of the following month. Note: If the 10th falls on a weekend or holiday, the draft will occur on the next business day.

- To enroll, please complete an Authorization Agreement for Electronic Funds Transfer. This form is on PEBA's website at www.peba.sc.gov. Submit it with a voided check from your designated bank account. After we receive your authorization, it will take about 30 days for the automatic draft to begin. If you have any questions, please contact Insurance Finance unit at 803.734.1696 or toll-free at 888.260.9430.

Premiums for active employees

School districts, higher education institutions and local subdivisions

- A single check from the employer, for the total premiums for active employees and matching the total amount due on the monthly Active Group Billing Statement, should be sent to PEBA.
- The check must also include premiums for any covered employees on unpaid leave as noted in the statement.
- Do not submit individual checks from your employees. See also Submitting premiums for employees on leave without pay below.

CG agencies

CG agencies may forward to PEBA individual checks received from covered employees on LWOP. See Submitting premiums for employees on leave without pay below.

Premiums for retiree, survivor and COBRA subscribers

CG agencies, school districts and higher education institutions

- Since PEBA becomes the benefits administrator for these subscribers, they will receive a bill from PEBA. *Note*: Retirees, who have their premiums deducted from their retirement checks or auto-drafted from a bank account, do not receive a bill.
- These subscribers submit their personal checks, payable to PEBA, with their bill.
- Any questions about the premium amounts or billing should be directed to the Insurance Finance unit at 803.734.1696 or at 888.260.9430.

Local subdivisions

- Since the employer continues to serve as the benefits administrator for these subscribers, the employer will receive the retiree/COBRA/survivor billing statement from PEBA, which will include the premiums for these subscribers.
- A single check from the employer, for the amount of premiums for these subscribers that matches the total amount due on the monthly retiree/COBRA/survivor billing statement, should be included in the check remitted for active employees.
- Collect the premiums for covered retirees, survivors and COBRA subscribers and deposit their checks into your group account. Their checks should be made payable to the employer, *not* PEBA. Do not submit personal checks to PEBA.
- Subscriber questions regarding the premium amounts or billing should be directed to the employer. Employers with questions should contact PEBA's Insurance

Finance department at 803.734.1696 or at 888.260.9430.

for more information on the Remittance Advice page.

Submitting premiums for employees on unpaid leave

School districts, higher education institutions and local subdivisions

- Premiums billed for employees on unpaid leave are included on the monthly active group billing statement (see Page 171). Include the amount of premiums for employees on unpaid leave in your check for active employees.
- Collect the premiums due for covered employees on unpaid leave. Their checks should be made payable to the employer, *not* PEBA. Do not submit personal checks to PEBA.
- Deposit the collected unpaid leave premiums into your group account.

CG agencies only

- Premiums billed for employees on unpaid leave are included on the monthly Active Group Billing Statement. Only CG agencies may send employees' personal checks to PEBA while they are on unpaid leave.
- Collect the total premiums due for covered employees on unpaid leave. Their checks may be made payable to PEBA or to the employer, depending on how the employer and employee arranged to submit premiums during unpaid leave.
- Submit the personal checks received from employees on unpaid leave, along with an itemized list of the amounts paid for each plan/coverage and the last four digits of the employees' SSNs. These personal checks should be made payable to PEBA
- A Personal Checks form is on the PEBA website at www.peba.sc.gov. A copy of the Remittance Advice page may be used as long as the BIN is provided. See Page 173

Premium checks quick reference

Type of employer	Submitting insurance checks to PEBA Insurance Finance		
	Active employee	Unpaid leave	Retiree/COBRA/ survivor
Local subdivision	Single check from employer to include all active employee premiums as billed by PEBA Insurance Finance	Single check from employer; include with active group as billed No personal checks to PEBA Insurance Finance	Include all premiums for these subscribers in the check for active employees No personal checks to PEBA Insurance Finance
CG agency	Employee and employer premiums are payroll-deducted by SCEIS and sent directly to PEBA Insurance Finance.	Submit personal 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
School district	Single check from employer to include all active employee premiums as billed by PEBA Insurance Finance	Single check from employer; include with active group as billed No personal 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
Higher ed institution	Single check from employer to include all active employees premiums as billed by PEBA Insurance Finance	Single check from employer; include with active group as billed No personal 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

Annual SLTD salary updates

All salaries must be reviewed and updated annually during open enrollment. (There is a separate process for CG payroll groups.)

To update SLTD premiums correctly for the next plan year, PEBA needs updated salary information for your employees who are enrolled in SLTD.

If your employer is not a part of the Comptroller General (CG) payroll group, submit your SLTD updated salaries as of October 1 of each year through the Employee Benefits Services (EBS).

Please note: If you do not update the salary information, premiums will be based on the most recent information submitted to PEBA Insurance Finance. Any benefits paid also will be based on the most recent information submitted to PEBA Insurance Finance.

You should include data for those who have had a salary change since the previous October 1.

- *Example*: If an employee was hired March 2015 with a salary of $25,000, and he has received a salary increase of $3,000, and his salary as of October 1 includes this increase, you must submit this updated salary information to PEBA.
- The maximum annual salary for calculating SLTD benefits and premiums was $147,684 in 2015. If the amount changes, you will be notified. If PEBA receives any salary updates that exceed this amount, the amount entered into the system will default to the maximum annual salary for calculating SLTD benefits and premiums.
- Groups affected by furloughs should use employees' non-furlough salaries to calculate premiums.

Please submit this information to PEBA no later than October 31, using EBS. See Page 40 for more information and procedures.

If you have any questions or problems regarding submitting SLTD salary information, please contact the BA Call Center at 803.734.2352 or 888.260.9430.

MoneyPlus payrolls and accounting

This information is provided to you on behalf of WageWorks, administrator for the MoneyPlus program. Please contact WageWorks at 646.839.3198 with any questions about MoneyPlus.

Your payroll office must report to WageWorks on all features of the MoneyPlus program. This includes identification of employees participating in the Pretax Group Insurance Premium Feature, spending accounts and HSAs, including detailed information on amounts deducted for administrative fees, spending accounts, HSAs and pretax health, dental, vision and life insurance premiums. *Comptroller General agencies do not have to send reports on administrative fees to WageWorks.*

Administrative Fees

The monthly administrative fees charged to each MoneyPlus enrollee and submitted to WageWorks are:

Pretax Group Insurance Premium Feature	$0.28*
Dependent Care Spending Account	$3.14**
Medical Spending Account.	$3.14**
Health Savings Account	$1.50***

** This feature allows premiums for health (with or without the tobacco surcharge), dental, Dental Plus, State Vision Plan and up to $50,000 in Optional Life coverage to be deducted on a pretax basis. Dependent Life and SLTD premiums cannot be paid pretax.*

*** A subscriber who is enrolled in both a Dependent Care Spending Account and a Medical Spending Account will pay one administrative fee of $3.14 a month.*

**** Additional administrative fees for the Health Savings Account (HSA) are charged and deducted directly from the account by Wells Fargo, trustee for the MoneyPlus HSA.*

These fees must be remitted to WageWorks with each payroll. Remit two checks to WageWorks for each payroll: one for the payroll deductions and another for the fees.

Pay dates/pay frequency

If you have a change in pay dates and/or pay frequency, notify WageWorks immediately. *Examples*: change from a monthly pay cycle (12 times per year) to bi-weekly (26 times per year) or semi-monthly (24 times per year).

Setting up your MoneyPlus payroll file

Only the state-sanctioned plans shown in columns N through T of the payroll chart on Page 186 can be offered pretax through MoneyPlus. If your employer group had a qualified cafeteria plan in place when your group enrolled in the state insurance benefits program, your old cafeteria plan must be replaced with the state's MoneyPlus plan.

(Groups with 50 or more employees)

If your group has 50 or more employees, you should use an electronic file to submit your payrolls. WageWorks will set up and send you a standard, electronic file layout to use. If your group is unable to provide the MoneyPlus payroll deductions in that format, WageWorks will work with you in customizing the file layout.

(Groups with fewer than 50 employees)

If your group has fewer than 50 employees, WageWorks recommends you use the file layout on the next page for setting up and submitting your monthly MoneyPlus payroll files. This information must be provided on all payroll files, whether provided on paper or using Microsoft Excel or other spreadsheet software.

Column	Field *(complete these fields for each employee participating in pretax premiums, MSA, DCSA or HSA)*	Payroll Code*
A	New Hire? *(Enter Y for new hires only. No entry needed for existing employees)*	
B	SSN *(with dashes. For example: 123-45-6789)*	
C	First Name	
D	Middle Initial	
E	Last Name	
F	Work Location Code (your work location code, issued by WageWorks)	
G	Status (A = Active; T= Termination)	
H	Number of Payrolls Per Year (12, 24, 16, etc.)	
I	Date of Birth (mm/dd/yyyy)	
J	Date of Hire (for verifying eligibility) (mm/dd/yyyy)	
K	Termination Date (if employee has terminated)	
L	Gender (M = Male; F = Female)	
M	Annual Salary *(with dollar signs, commas and decimals; i.e., $35,456.98)*	
N	Pretax state Health and Dental (total premium amount per pay period, including the tobacco surcharge, if applicable)	111
O	MoneyPlus Dependent Care Spending Account (deduction amount per pay period)	211
P	MoneyPlus Medical Spending Account (deduction amount per pay period)	311
Q	MoneyPlus administrative fees (total per-pay-period pretax premium and spending accounts)	511
R	Pretax state Optional Life (premium amount per pay period)	611
S	MoneyPlus Health Savings Account (deduction amount per pay period)	460
T	MoneyPlus Health Savings Account (*employer contributions per pay period*, if applicable)	461

**These codes apply to all employers, except those under the Comptroller General (CG) payroll group.*

Payroll/processing

The following are required to process MoneyPlus payrolls:

- A payroll file and/or listing (identified by group number, payroll date, filename)
- Checks for MoneyPlus deductions
- A completed Deposit of MoneyPlus Contributions form.

Please note: ACH is the preferred method for all remittances.

Submitting your checks

Please send two separate checks: one for the MSA, DCSA and HSA account contributions; and the other for the administrative fees for these accounts. Make checks payable to WageWorks South Carolina MoneyPlus. These payments may be submitted by mail or electronically. See below for details.

A completed Deposit of MoneyPlus Contributions form must be included with the check for account contributions. This form is available on the PEBA website. Complete the entire form, including the payroll date — *not the paid-through date* (very important) — and attach it to the checks.

PARTICIPANT CONTRIBUTIONS

1a. Electronic Remittance of Participant's Contributions:

Account Name: WageWorks, Inc. as Agent for South Carolina MoneyPlus

Bank Name: Wells Fargo

Bank Address: 1201 North Monroe Street, Tallahassee, FL 32303

ABA Routing #: For ACH: 063107513 for Wires*: 121000248

Account #: 2000015717687

Reference: South Carolina [Agency Name] Contributions

**Please only send wire if there is no other available alternative.*

1b. Check Remittance of Participant's Contributions *via Mail*:

Mail ONLY Participant Contribution checks to:

South Carolina MoneyPlus
PO Box 603244
Charlotte, NC 28260-3244
NOTE: Please send administrative fees in a separate check to the address below.

ADMINISTRATIVE FEES

2a. Electronic Remittance of Administrative Fees:

Account Name: WageWorks, Inc.

Bank Name: Union Bank

Bank Address: 445 South Figueroa Street, Los Angeles, CA 90071

ABA Routing #: 122000496

Account #: 0580025358

Reference: South Carolina [Agency Name] Admin Fees

2b. Check Remittance of Administrative Fees *via Mail*:

Mail ONLY Administrative Fee checks to:

WageWorks, Inc. PO Box 45584, San Francisco, CA 94145-0584

NOTE: Please send payroll funds in a separate check to the address above for participant contributions

Submitting Your Payroll

Include this contact information with your payroll file:

- Contact name
- Contact phone number
- Agency name.

Include this information in your payroll file/list:

- File name (for example, 294#####.ELP). Fill in the numbers with your payroll center number provided to you by WageWorks at start up.

- Group ID number (assigned by PEBA insurance benefits)
- Pay date associated with file/list and check

Total deduction amounts for Medical Spending, Dependent Care Spending and Health Savings accounts. WageWorks uses these amounts to verify payroll totals.

If data is being transferred via WageWorks' FTP (file transfer protocol) site or via encrypted email, separate documentation of the process will be communicated to the appropriate personnel. Email electronic files and notifications to xfer@fbmc.com. If transferring data via the FTP site, WageWorks will provide you with the site and login information at startup. Each group's information will be different to ensure security of the data.

Submit the Deduction Tracking/Control forms and checks, made payable to WageWorks South Carolina MoneyPlus, for the account deductions and administrative fees to:

WageWorks, Inc.
P.O. Box 45584
San Francisco, CA 94145-0584

Payroll discrepancy reports

After each payroll is submitted to WageWorks' Deduction Management department, WageWorks will generate and fax a discrepancy report to the employer. This report shows those participants whose actual payroll deductions do not match their expected deductions.

- Review the report and follow the directions on the cover sheet. The cover sheet will instruct you on what to do and how to adjust your payroll file.
- If WageWorks received a deduction, but did not expect it, WageWorks does not have the enrollment form. Fax or mail it to WageWorks, attention Enrollment Processing (fax number and address are on the cover sheet).
- If the deduction amount for a participant varied in any way from what was expected (i.e., a lesser or greater amount, a Medical Spending Account deduction instead of a Dependent Care Spending Account deduction), please correct it on the next payroll file. If what WageWorks has set up in its system is incorrect, please forward the corrected enrollment form.
- If a participant has missed two consecutive deductions, the participant has been terminated in WageWorks' system. If a deduction should have been made, please make up the missed deduction(s) on the next payroll file, so WageWorks can reactivate the participant's account.
- If a deduction was made in error, refund the amount on the next payroll file. Do this by entering a negative amount that offsets the deduction.
- If a participant has terminated employment, fax a copy of the Active Termination Form to WageWorks' Deduction Management Department at 866.672.4780.

You can ignore:

- A discrepancy marked OK. These are typically discrepancies of a penny more or less due to rounding.
- A recurring discrepancy which you have already addressed. In some cases, the discrepancy may continue to show an exception for various reasons. You can ignore the discrepancy if you have already responded to it and know that it will be resolved.
- If additional information is needed, please respond by attaching your comments to the original discrepancy report and returning the report and comments to Deduction Management. If you need assistance, contact WageWorks' Customer Service at 800.342.8017.

Sample error messages on discrepancy reports

Here are several common error messages that appear on the discrepancy reports. Resolve any errors quickly to minimize any problems for your employees and to prevent errors from showing up on subsequent reports.

- Waiting on account number - Funds will be held in suspense -- Employee has not yet opened HSA bank account. Contact employee and remind him to open it.
- 1st-5th missed deduction -- Payroll deductions for an employee were expected, but not received. Advise WageWorks why the deductions were missed.
- 6th missed deduction -- HSA will be terminated and refund processed -- Stop payroll deductions immediately and refund the amount to the employee.
- Employee has met or exceeded annual election amount -- Stop payroll deductions immediately. WageWorks will forward the deductions to Wells Fargo, until the annual limit has been reached.
- HSA rate should be $X per pay period -- Advise WageWorks why a different amount is being deducted from what was expected. Adjustments may be necessary.
- Suspended funds -- Send WageWorks a copy of the enrollment form. HSA deductions will be held in suspense until the enrollment issue is resolved.
- Verify pay schedule -- The deduction cycle is different from what WageWorks expected (i.e., account set up for bi-weekly deductions, but deductions are monthly). Advise WageWorks of the payroll cycle.
- Verify transfer date and recalculate -- Employee has transferred, and deductions from old employer to new employer do not match or there is a gap in deductions. Verify the date of transfer and contact WageWorks to determine whether an adjustment may be necessary.

Refunds and adjustments

Refunds through payroll are typically issued due to an administrative or enrollment error or other instances that are allowed by the IRS. These refunds are then sent to WageWorks as negative amounts on a payroll file/listing. However, some payroll systems do not have this capability. In this situation, write a note to WageWorks' Deduction Management Department, describing the error, and include it with the payroll file.

The refund process applies to Medical Spending Accounts, Dependent Care Spending Accounts and Health Savings Accounts.

- Medical Spending Account and Dependent Care Spending Account refunds are processed and paid through your office/payroll center. Any refunds should be reflected on the payroll file and/or listing as a negative amount so that WageWorks may reconcile the account.
- Before refunding an employee, check with WageWorks to be sure he has not already submitted a claim and received reimbursement.
- Health Savings Account (HSA) refunds are processed similarly.
- *Examples* of HSA refunds:
    - The employee signs up for an HSA, the account with Wells Fargo is not yet opened, and the employee is not eligible to contribute.
    - The employee terminates employment; the employer has already forwarded HSA contributions to WageWorks, but the account with Wells Fargo is not yet opened.
    - The employee signed up for an HSA, the employer has forwarded contributions to WageWorks, but the employee failed to return the signed application and ID to Wells Fargo to open the account within

90 days of the start of HSA deductions.

- The refund should be reflected on the payroll file and/or listing as a negative amount and forwarded to WageWorks. As long as the account with Wells Fargo has not been opened (the employee has not signed up online, submitted his authorization and Wells Fargo has not received and processed everything to open the account) and the deductions have not been forwarded to Wells Fargo for deposit into the account, WageWorks will accept the refund on the payroll.
- Once the account with Wells Fargo is set up, opened and funds are deposited into the account, WageWorks cannot issue refunds, as the funds are then considered to be the employee's.
- Wells Fargo will refund its administrative and monthly maintenance fees if the account was set up in error and no contributions were deposited into the account and the account was never used.
- Remember: If the employee changes his mind about having an HSA, he may stop contributing to his account (contribution changes are allowed monthly) and withdraw the funds from his HSA account according to IRS guidelines. The change in contributions must be made on a prospective basis; he cannot make retroactive changes.

Late entrant adjustments may be made only if your payroll center can accommodate before- and after-tax adjustments. Some payroll centers are not equipped to handle mid-year late entrants; therefore, late entrants can be added only during an enrollment period (with a January 1 effective date).

If your adjustments to MoneyPlus deductions are produced as a separate file or report, please send a paper listing for these adjustments, identifying it clearly as an adjustment listing.

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 percent Average Benefits Test, requires that all eligible employees' gross compensation be collected.
- This test is vital in determining the South Carolina MoneyPlus plan's compliance with Internal Revenue Service (IRS) nondiscrimination rules.
- The test is performed within the first 60 days of any given plan year.
- This is for your information only, since WageWorks performs these tests. WageWorks staff members will contact you directly if they need any information for the purpose of nondiscrimination testing.

Imputed Income (Taxable Portion of OL Premiums)

Optional Life (OL) 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 OL 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 OL coverage will always be the amount over $50,000 of the total coverage, regardless of any employer contributions.

Imputed income rate table (2015 tax year)

Age category	Rate per $1,000 in coverage beyond $50,000
Younger than 25	.05
25-29	.06
30-34	.08
35-39	.09
40-44	.10
45-49	.15
50-54	.23
55-59	.43
60-64	.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 OL coverage beyond $50,000 is multiplied by the monthly rate for the applicable age group. The employer is responsible for reporting the imputed income amounts on employees' W-2 forms.

PEBA provides WageWorks with monthly enrollment data for employees participating in OL. This data includes the employee's name, SSN, effective date, level of coverage, age group, status and date of birth. Then, during the first week of December, WageWorks sends an imputed income report to each employer's benefits administrator. You can then adjust employees' W-2 forms accordingly.

If your employer group chooses to deduct the taxable and non-taxable premium amounts separately each pay period, your group determines and accounts for the taxable portion of the OL premiums for employees throughout the year on all payrolls. You will only need to use the year-end OL/imputed income report from WageWorks for comparison purposes.

Important reminders in calculating imputed income

- Each $1,000 of coverage beyond $50,000 should be multiplied by the monthly rate for the applicable age group in the IRS rate table on the previous page. This monthly amount may be multiplied by 12 to get an annual amount. 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. For example, for the 2016 tax year, if an employee turns age 50 in September, his IRS-imputed income for 2016 is based on the rate for the 50-54 age category in the IRS rate table, even though his 2016 OL premium is based on the age 45-49 category in the OL premiums table in the IBG.
- Instead of one age category in the OL premiums table in the IBG for those younger than 35, there are three age categories in the IRS imputed income rate table for those younger than 35: younger than 25, 25-29 and 30-34. Also, the last category in the imputed income rate table is for those age 70 and older; the last age category for OL premiums is 80 and older.

Example: An employee, who elected $180,000 in OL coverage, turns age 50 in October 2016. His monthly OL premium on $180,000 in coverage is $28.04, 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. $130,000/1,000 = $130 (the per-thousand amount)
3. 130 X 0.23 (the rate for the age-50-54 category from the IRS imputed income rate table) = $29.90 per month. This is the taxable monthly amount of imputed income.

Contact David Hanley with WageWorks at David.Hanley@wageworks.com or at 646.839.3198 for any questions about calculating imputed income.

Reclassification of outstanding myFBMC Card® transactions

Payback report

Each fall, WageWorks will send benefits administrators a payback report that lists any employees with outstanding myFBMC Card® transactions. This report includes a summary and detail. The summary shows the total amount due. The detail portion of the report shows each individual transaction (by SSN and name).

If an employee is on this report:

- The employee has been notified about the outstanding transaction(s) at least twice
- The outstanding transaction(s) is at least 70 days old
- His card has been suspended.

The employee has until the end of the run-out period (March 31 following the end of the plan year) to clear up any outstanding expenses and reinstate the card.

You are encouraged to use this report to communicate with any employees listed on it and remind them:

- To submit their documentation or they will face tax consequences (see Reclassification as follows)
- Their card will be suspended if there are any transactions that have not been cleared up by the end of the run-out period.

Reclassification

If the employee does not clear up the outstanding transactions, the unsubstantiated amounts must be reclassified as taxable income and that employee's W-2 must be amended to reflect that amount.

Example: For the 2015 plan year, an employee has an outstanding card transaction of $50. That employee has until March 31, 2016, to clear up the expense by:

- Submitting the necessary documentation to substantiate the claim
- Filing a manual (paper) claim or claims that will offset the outstanding card transaction amount (called automatic substitution)
- Writing a check made payable to the State of South Carolina and mailing it to WageWorks, South Carolina MoneyPlus, PO Box 603244, Charlotte, NC 28260-3244. This check will repay his MSA for the amount of the outstanding card transaction amount.

If the outstanding transaction amount is not cleared up by one of these methods, the $50 is taxable as income. Since this amount cannot be confirmed until after the end of the tax-reporting period (April 15, 2015), the amount will be reported for the 2016 tax year. In November 2016 the benefits administrator will receive a list from WageWorks that will include this employee's name and the amount ($50) to be added to his taxable income on his 2016 W-2, which will be issued to him early 2017. For CG agencies, WageWorks 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.

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Acronyms Used in this Manual

Acronym	Explanation
AD&D	Accidental Death & Dismemberment
BA	Benefits Administrator
BCBS	Blue Cross and Blue Shield
BCBSSC	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
EIP	Employee Insurance Program
ERISA	Employee Retirement Income Security Act
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
IBG	*Insurance Benefits Guide*
LTC	Long Term Care
LTD	Long Term Disability
MSA	Medical Spending Account (MoneyPlus)
NOE	Notice of Election form
PEBA	Public Employee Benefit Authority
PCP	Primary Care Physician
PPACA (ACA)	Patient Protection and Affordable Care Act
RETRO	Retroactivity
SCEIS	South Carolina Enterprise Information System
SHP	State Health Plan (also referred to as Plan)
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
TERI	Teacher and Employee Retention Incentive Program
URT	Unrequested Refund Transfer
USERRA	Uniformed Services Employment and Reemployment Rights Act

County Codes

1	Abbeville
2	Aiken
3	Allendale
4	Anderson
5	Bamberg
6	Barnwell
7	Beaufort
8	Berkeley
9	Calhoun
10	Charleston
11	Cherokee
12	Chester
13	Chesterfield
14	Clarendon
15	Colleton
16	Darlington
17	Dillon
18	Dorchester
19	Edgefield
20	Fairfield
21	Florence
22	Georgetown
23	Greenville
24	Greenwood
25	Hampton
26	Horry
27	Jasper
28	Kershaw
29	Lancaster
30	Laurens
31	Lee
32	Lexington
33	McCormick
34	Marion
35	Marlboro
36	Newberry
37	Oconee
38	Orangeburg
39	Pickens
40	Richland
41	Saluda
42	Spartanburg
43	Sumter
44	Union
45	Williamsburg
46	York
99	Out-of-state

State Insurance Benefits Program History

Health Insurance Benefits

JULY 1, 1972 The SHP is initiated under the auspices of the State Personnel Division. Only state agencies are under the program. BCBS is the carrier at risk for the Plan.

SEPT. 1, 1974 A majority of the public school districts join the Plan.

JULY 1, 1975 The remaining public school districts are added.

OCT. 1, 1975 Plan C is added to the health contract. It is designed as a catastrophic plan for people with other group coverage.

JULY 1, 1977 The first HMO, Piedmont Healthcare, is offered as an alternative to State Health Plan coverage. Piedmont Healthcare is available to state agencies and public school districts within a 30-mile radius of Greenville, South Carolina.

JULY 1, 1978 Plan C is eliminated.

APRIL 29, 1979 A minimum of five years of state service is required for retirees to be eligible for health insurance.

JULY 1, 1980 The state begins to pay the retiree health insurance premium in full. Drug and nursing and/or major medical coverage changes from optional to automatic.

The health contract changes to a modified administrative services only contract.

The active health program changes the maximum lifetime benefit from $50,000 to $250,000.

Chiropractors become covered providers for the health plan.

JULY 1, 1981 A pre-existing condition provision is added to the state health contract.

FEB. 1, 1982 The state policy adds Plan B, expanded coverage, to the retiree policy. Retirees entitled to Medicare cannot enroll in Plan B.

JULY 1, 1982 The lifetime maximum for major medical for active employees is raised from $250,000 to $500,000.

The state-sponsored wellness program, Carolina Healthstyle, begins in Richland and Lexington counties on a pilot basis.

JULY 1, 1983 TEFRA (Tax Equity and Fiscal Responsibility Act) regulations are introduced.

An optional second opinion service, mandatory pre-certification on 25 surgical procedures and pre-admission testing for outpatient surgery are established for the State Health Plan.

The Plan A Medicare Supplement becomes the only available coverage for retirees eligible for Medicare.

JULY 1, 1984 The State Health Plan becomes fully self-insured, meaning that the state is liable for the health plan.

The State Treasurer begins controlling claim reserve funds and investment functions.

Eligibility rules for retirees become effective. Eligibility is predicated on the retiree having been formerly employed by an agency or school district for a minimum of five years.

Health Insurance Association of America screens are applied to professional charges under the State Health Plan.

JAN. 1, 1985 Medicare is made secondary on dependents of active employees, ages 65 through 69, while covered as dependents under the state group.

Licensed clinical/counseling psychologists are recognized as providers of service when rendering care under their scope of practice.

OCT. 1, 1985 In addition to HealthAmerica (Piedmont Healthcare), offered in the Greenville, South Carolina, area since 1977, options to select HMOs are made available to agencies and school districts in most areas statewide during the open enrollment period. HMOs offered include Companion, HealthAmerica, Hospital Corporation of America and Physicians Health Plan (PHP). HMO coverage becomes effective December 1, 1985.

FEB. 1, 1986 Retirees are granted an open enrollment period to select HMOs if desired.

APRIL 1, 1986 A federal mandate eliminates the age limit of 69 in TEFRA (Tax Equity and Fiscal Responsibility Act) and DEFRA (Deficit Reduction Act) regulations. These regulations remain in effect during active employment.

JULY 1, 1986 Enrollment in Physicians Health Plan (PHP) proves more than the HMO can handle, and approximately 18,000 employees are transferred back to the State Health Plan.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 mandated that employers with 20 or more employees allow extended coverage for 18 months for terminated or Reduction in Force (RIF) employees and for 36 months for widowed or divorced spouses or ineligible dependent children. A rate of at least 100 percent of premium must be paid monthly to extend coverage.

JULY 1, 1987 State-approved HMOs are required to have an affiliated general or family practice provider located within a 30-mile radius of subscribers in each county of the service area they apply to serve.

JAN. 1, 1989 The Mammography Testing Program, with a network of 22 participating facilities, is introduced as part of the State Health Plan.

An employee drug card program is incorporated into the State Health Plan. Copayments are $7 for brand name drugs and $4 for generic drugs. Participating pharmacies bill the state directly for the remaining costs.

A voluntary employee advocacy and case management program (Medi-Call) is introduced as part of the State Health Plan.

SEPT. 1, 1989- An open enrollment is held during which eligible employees can join the State Health Plan

OCT. 31, 1989 as late entrants without providing medical evidence of good health.

JAN. 1, 1990 The State Health Plan changes from a basic plan with major medical benefits to a comprehensive benefits plan. The comprehensive plan requires coinsurance for services, with reimbursement based on allowable charges for the balance. The out-of-pocket maximum for individuals is $1,500 and $3,000 for the family. Once the out-of-pocket limit is met, the Plan pays 100 percent of the allowable charges.

The employee drug card program is discontinued. The program, expected to be revenue neutral, exceeded cost expectations by more than $12 million in 1989. Prescription drugs are, once again, treated as regular medical expenses subject to reimbursement after satisfying the deductible.

The comprehensive plan's lifetime maximum benefit is raised from $500,000 to $1 million.

Medi-Call, administered by Crawford and Company, becomes mandatory. If a subscriber fails to consult Medi-Call, the out-of-pocket maximum does not apply and the employee is responsible for an additional $200 hospitalization deductible.

The Medicare Supplemental plan is discontinued. The State Health Plan continues to pay benefits, secondary to Medicare, according to the carve-out payment method.

Late entrants are required to provide medical evidence of good health when applying to join the State Health Plan.

All employees and retirees are re-enrolled in order to bring records up to date.

JAN. 1, 1991 Plan A is renamed the Economy plan, and Plan B is renamed the Standard plan.

The Mammography Testing Program is expanded to pay fully for routine mammograms for female employees and retirees and their eligible dependents, ages 35 through 74, who are State Health Plan subscribers.

The Pap test benefit is introduced.

The list of eligible providers for psychiatric, drug and alcohol abuse is expanded to include licensed professional counselors, licensed marital and family therapists and licensed independent social workers. A psychiatrist or physician must make referrals.

The Medicare Supplemental Plan for retirees is reintroduced.

Late entrants are allowed to enroll in the State Health Plan, the Medicare Supplemental plan or an HMO throughout the year by providing medical evidence of good health and being approved.

Retirees with Medicare are no longer required to pay a monthly premium for the Standard Plan.

JAN. 1, 1992 The State Health Plan Hospital Network is established. All general hospitals in the state participate in the plan and are paid a fixed price for most inpatient admissions.

The Maternity Management Program, an extension of Medi-Call, is established.

JAN. 1, 1993 The State Health Plan Physician Network is established. Participating physicians agree to accept the State Health Plan allowable charge as payment-in-full.

BCBS becomes the new Medi-Call program administrator.

JAN. 1, 1994 The State Health Plan Ambulatory Surgical Center Network is established with 20 ambulatory surgical centers participating in the network. The centers are paid a fixed price for their services.

Physicians Health Plan returns as an HMO alternative to the State Health Plan.

Dependents become eligible for coverage through age 24 if they are full-time students.

Expenses for services received from a licensed, independent, certified nurse/midwife become covered expenses.

JULY 1, 1994 The State Health Plan Transplant Network is established. Three hospitals, the Medical College of Georgia, Medical University of South Carolina and Duke University Medical Center, sign on as participants.

OCT. 1, 1994 Richland Memorial Hospital joins the Transplant Network for the transplantation of allogeneic bone marrow.

JAN. 1, 1995 A penalty of $200 is added to the State Health Plan for failure to notify Medi-Call during the first trimester of pregnancy or for refusing to participate in the Maternity Management Program.

The State Health Plan Prescription Drug Program is created. Medco Containment Services, Inc., administers the program. An additional and separate claim form is required for prescription reimbursement.

Second surgical opinion is revised to second opinion. Second opinions are no longer limited to surgical cases.

Definition of nurse/midwife is expanded to include definition of extended role nurse.

Partial hospitalizations are allowed by the SHP if Medi-Call approves.

JAN. 1, 1996 The Well Child Care benefit is added to the State Health Plan. The new program provides first-dollar benefits for routine well child office visits and recommended childhood immunizations as outlined in the *Insurance Benefits Guide* and the *Plan of Benefits Document*.

MAY 1, 1996 The State Health Plan Appeals Process is formalized. The procedure is described in a brochure sent to all employees.

OCT. 1997 Open enrollment is initiated for the 1998 plan year. Subsequent open enrollment periods will occur in years ending in an odd number, with coverage effective the following January 1. Annual enrollment will be held every year, during which only a change in health carrier may be made. Both annual and open enrollment periods may have announced additions and changes to programs other than health or dental (for example, an announced guaranteed issue for the Optional Life Insurance program).

Definitions and procedures of *late entrant* and *pre-existing condition* are changed to comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

JAN. 1998 The special annual and lifetime dollar limits for mental health benefits are removed effective January 1, 1998. Day and visit limits remain. Substance abuse treatment is still subject to a benefit year and lifetime maximum limit.

Effective January 1, 1998, preventive worksite health screenings are offered for a cost of $10 to active employees.

Effective January 1, 1998, EIP expands its transplant contracting arrangements to include the Blue Cross and Blue Shield Association (BCBSA) National Transplant Network, which includes more than 50 institutions nationwide.

All changes related to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) become effective January 1, 1998.

JAN. 1, 2000 The State Health Plan Prescription Drug Program is initiated. Merck-Medco Managed Care administers this drug card plan.

JULY 1, 2000 Legislation passed offering health benefits to permanent part-time teachers (working 19 to 29 hours per week) employed with South Carolina school districts, the Department of Corrections or the Department of Juvenile Justice. The health benefit does not include basic life or long term disability insurance.

JAN. 1, 2001 TERI effective date.

JAN. 1, 2002 Effective January 1, 2002, CIGNA Healthcare and HMO Blue are no longer providers.

The State Health Plan implements Mental Health Parity, with APS Healthcare, Inc., administering the program.

Upstate PARTNERS HMO is available in the upstate to employees who work or live in the service area.

JULY 2002 Merck-Medco Managed Care becomes Medco Health Solutions, Inc.

JAN. 1, 2003 Upstate PARTNERS is no longer a provider.

CIGNA HealthCare Network's traditional HMO and HMO with POS option are available to those who work or live in the service area.

Companion HealthCare's traditional HMO and HMO with POS option are available to those who work or live in the service area.

JAN. 1, 2004 SHP annual deductibles increase to $500/$1,000 (Economy Plan) and $350/$700 (Standard Plan). Out-of-pocket maximums increase to $2,000/$4,000. Per-occurrence deductibles increase to $75 (outpatient) and $125 (emergency room visit). A $10 per-visit deductible for all physician office visits is added. A 20 percent out-of-network differential is added.

SHP Prescription Drug Program adds a new category for non-preferred brand name drugs. Drug copayments are now $10 (generic), $25 (preferred brand) and $40 (nonpreferred brand). The copayment maximum increases to $2,500. The SHP also begins using Medco Health's pharmacy network (Select Network™) and formulary (Rx Selections™).

CIGNA HealthCare Network's HMO with POS option is no longer available. CIGNA HMO per-occurrence copayments increase to $500 (inpatient), $250 (outpatient) and $100 (emergency care). Copayments increase to $20 (PCP) and $40 (OB/GYN and specialist). Coinsurance rates decrease to 80 percent, and the coinsurance maximum increases to $3,000/6,000. Nonpreferred brand name drug copayments increase to $50 (retail) and $100 (mail order).

Companion HealthCare HMO and HMO with POS option add a pay-the-difference policy to their prescription drug benefits. A new specialty pharmaceuticals category with a $75 copayment is added.

MUSC Options increases per-occurrence copayments to $300 (inpatient), $100 (outpatient) and $100 (emergency care). A pay-the-difference policy is added to the prescription drug coverage.

TRICARE Supplement Plan is offered to eligible employees as an alternative to the SHP or an HMO. Association & Society Insurance Corp. (ASI) is the administrator for this plan.

JAN. 1, 2005 The SHP Economy Plan is eliminated and replaced with the SHP Savings Plan, a high deductible health plan. The annual deductibles are $3,000 single/$6,000 family (no individual, imbedded deductible). The coinsurance rate is 80 percent in-network and 60 percent out-of-network. The out-of-pocket maximum is $2,000 single/$4,000 family in-network. (There is no out-of-pocket maximum for services out-of-network.) The annual deductible also applies to covered prescription drug purchases; afterward, participants are reimbursed for drug purchases at the coinsurance rate. The Savings Plan provides additional preventive benefits, including annual flu shots and physicals, but it limits chiropractic visits to $500 per year and certain prescription drugs are not covered (non-sedating antihistamines and erectile dysfunction drugs). Savings Plan subscribers who have no other health coverage, including Medicare, can also contribute to a Health Savings Account for qualified health care expenses, according to IRS guidelines. Retirees who are eligible for Medicare are not eligible for the Savings Plan.

The SHP implements coordination of benefits for covered prescription drug purchases.

The SHP eliminates coverage for gastric bypass surgery.

The SHP Standard Plan coinsurance maximum for out-of-network services increases to $4,000 single/$8,000 family.

The SHP Standard Plan increases mail-order pharmacy copayments to $25 for generic, $62 for preferred brand and $100 for non-preferred brand drugs.

Companion CHOICES POS is no longer available.

JULY 1, 2005 Companion HealthCare is renamed BlueChoice HealthPlan.

JAN. 1, 2006 SHP offers free tobacco treatment program, Free & Clear®. Offered through APS Healthcare, Inc., this program addresses all types of tobacco use — cigarettes, cigars, pipes and smokeless tobacco. Enrollment is voluntary.

BlueChoice HealthPlan prescription drug copayments increase, for preferred brands, to $30 (retail) and $50 (mail order) and, for non-preferred brands, to $50 (retail) and $100 (mail-order).

MAY 1, 2006 SHP establishes retail maintenance network. Participating local pharmacies can fill 90-day prescriptions at mail-order prices.

JAN. 1, 2007 SHP Well Child Care immunizations expanded to include Hepatitis A and Human Papillomavirus (HPV).

CIGNA HMO's coinsurance maximums decrease to $2,000 single/$4,000 family coverage.

MUSC Options plan undergoes several changes. Obesity surgery is no longer covered. The annual deductible for out-of-network services increases to $500 single/$1,500 family coverage. Office visit copayments for in-network services increases to $25 for a primary care physician, $25 for an OB/GYN well woman exam, $55 for a specialist and $50 for urgent care. The copayment for emergency care increases to $150 per occurrence. A $100 annual deductible (per person) is introduced for prescription drug purchases. Retail prescription drug copayments increase to $30/preferred brand and $50/non-preferred brand (generic copayment remains $10). The specialty pharmaceutical copayment increases to $100. Mail-order prescription drug copayments increase to $25/generic, $75/preferred and $125/non-preferred.

MARCH 2007 SHP begins to cover routine colonoscopies — one colonoscopy every 10 years for subscribers ages 50 and older.

AUG. 1, 2007 BlueChoice HealthPlan and MUSC Options offer the Free & Clear® tobacco treatment program. Enrollment is voluntary.

JAN. 1, 2008 The United States Department of Defense issued regulations prohibiting employers from offering, or funding, any TRICARE Supplement that makes the employer plan primary to TRICARE. As a result, EIP is no longer able to offer the TRICARE Supplement Plan.

SHP routine mammograms become available to women, ages 40-49, on an annual basis.

SHP Well Child Care checkups become payable on an annual basis for covered children through age 18. (Multiple checkups per year for children ages 1 and younger are still payable.)

SHP establishes an ambulance network within S.C. Network providers do not balance bill.

BlueChoice HealthPlan prescription drug copayments decrease for generics to $7 (retail) and $14 (mail order); increase for preferred brands to $35 (retail) and $70 (mail order) and for non-preferred brands, to $55 (retail) and $110 (mail order).

BlueChoice outpatient hospital copayment increases to $100.

BlueChoice physical, speech and occupational therapy is covered after a deductible and is subject to 10 percent coinsurance, up to 20 visits per year for each type of therapy.

BlueChoice lifetime maximum benefit for human organ transplants increases to $350,000.

CIGNA HMO office visit copayments for PCP and OB/GYN well-woman exam decrease to $15; copayments for network specialists decrease to $30.

CIGNA HMO short-term rehabilitation therapy and chiropractic services covered for $30 copayment and limited to 20 visits per plan year.

CIGNA HMO offers the Quit Today℠ tobacco treatment program. Enrollment is voluntary.

MUSC Options specialist copayment decreases to $50.

JAN. 1, 2009 MUSC Options is no longer available.

Autism Spectrum Disorders are covered by all plans offered by EIP, up to a maximum yearly benefit of $50,000. The covered child must be diagnosed by age 8, and coverage ends at age 16.

BlueChoice lifetime maximum benefit for human organ transplants decreases to $250,000

BlueChoice covers these additional transplants: bone marrow/stem cell ($250,000 maximum); cornea ($25,000 maximum); and Lung, double ($250,000 maximum).

JAN. 1, 2010 For all health plans, subscribers who use tobacco, or who cover family members who use tobacco, pay a $25 surcharge on their health insurance premiums. To avoid the surcharge, subscribers must certify that no one they cover has used tobacco within the past six months.

The lifetime maximum benefit for all health plans offered by EIP increases to $2 million.

SHP begins offering out-of-network mental health and substance abuse benefits, provided they are preauthorized.

SHP begins requiring preauthorization for advanced radiology services, such as CT, MRI, MRA or PET scans.

SHP Standard Plan limits chiropractic benefits to $2,000 per covered person per year.

SHP Standard Plan and Medicare Supplemental Plan prescription drug copayments change. Tier 1 (generics) copayments decrease to $9. Tier 2 (brand) increase to $30. Tier 3 (brand) increase to $50.

Both HMOs (BlueChoice and CIGNA) no longer offer routine vision care benefits, as EIP begins offering the State Vision Plan.

BlueChoice coinsurance increases to 15 percent, and the coinsurance maximums increase to $2,000/single and $4,000/family.

BlueChoice specialist copayment increases to $40.

BlueChoice has several changes in its prescription drug copayments. Generic drug copayments are split into two tiers: the lower-cost generic copayment is $8, and the higher-cost generic copayment is $15. Specialty pharmaceuticals are split into two tiers: Copayments are $80 and $125. Mail-order copayments also change: generics are split into two tiers at $20 and $37.50; preferred brands are $87.50; non-preferred brands are $137.50.

JAN. 1, 2011 The tobacco-user surcharge increases to $40-per-month for subscriber-only coverage and $60-per-month for those with subscriber-spouse, subscriber-child or full family coverages. To avoid the surcharge, subscribers must certify that no one they cover has used tobacco within the past six months.

The lifetime maximum benefit for all health plans offered by EIP is abolished.

Pre-existing condition exclusions no longer apply to subscribers or covered family members younger than 19.

Preauthorization is no longer required for medically necessary mental health and substance abuse office visits except those involving Dialectic Behavior Therapy (DBT), Applied Behavior Analysis Therapy (ABA) and Psychological/Neuropsychological testing.

SHP begins offering Wellness Incentive Program. Eligible SHP enrollees may receive generic drugs that treat diabetes, cardiovascular disease and congestive heart failure at no cost for 12 months after completing the program.

SHP offers a one-year Obesity Treatment Pilot Program, designed to help treat and manage obesity and related conditions through various methods, including bariatric surgery. The program is limited to 100 non-Medicare eligible participants who have been enrolled in the SHP, either as a subscriber or spouse, for at least two years. Participants must meet other requirements to be eligible for the program.

JAN. 1, 2012 Companion Benefit Alternatives becomes the new mental health/substance abuse manager for the SHP.

Preauthorization is no longer required for Dialectic Behavior Therapy (DBT).

The tobacco-use surcharge may be waived if a tobacco user provides a letter from his physician saying that it is unreasonably difficult for him to stop using tobacco due to a medical condition or that it is medically inadvisable for him to attempt to stop using tobacco.

APRIL 2, 2012 Express Scripts takes over as the State Health Plan's pharmacy benefit manager after purchasing Medco Health Solutions.

JAN. 1, 2013 CIGNA HMO is no longer available.

BlueChoice HealthPlan HMO becomes a fully insured plan.

BlueChoice no longer covers members who are eligible for Medicare as their primary insurance.

BlueChoice copayment for Doctors Care and Minute Clinic decreases to $5. The copayment for specialty care office visits, maternity care and chiropractic care increases to $45. The copayment for ambulatory surgical centers decreases to $45, then HMO will pay 100 percent.

BlueChoice has several changes in its prescription drug copayments. The lower-cost generic copayment is $4, and the higher-cost generic copayment is $20. Preferred brand-name copayment is $40. Nonpreferred brand-name copayment is $60. Mail-order copayments also change: generics are $10 and $50; preferred brands are $100; non-preferred brands are $150.

JUNE 30, 2013 BlueChoice HealthPlan HMO ends its Away From Home Care program.

JAN. 1, 2014 SHP annual deductibles increase to $420/$840 (Standard Plan) and $3,600/$7,200 (Savings Plan). Coinsurance maximums under the Standard Plan and Savings Plan increase to $2,400/$4,800 (network services) and $4,800/$9,600 (out-of-network services). Copayments under the Standard Plan increase to $12 (physician office visit), $90 (outpatient facility services) and $150 (emergency room visit).

SHP prescription drug copayments increase to $36 for Tier 2 and $60 for Tier 3. Mail-order copayments increase to $90 for Tier 2 and $150 for Tier 3.

Catamaran becomes the new pharmacy benefit manager for the State Health Plan.

The State Health Plan Medicare Prescription Drug Program is launched.

The AMRA TRICARE Supplement Plan is offered to eligible employees as an alternative to the SHP or BlueChoice HealthPlan HMO. Association & Society Insurance Corp. (ASI) is the administrator for this plan.

Pre-existing condition exclusions no longer apply to subscribers or covered family members.

APRIL 1, 2014 Selman & Company buys ASI and assumes management of the TRICARE Supplement Plan.

JAN. 1, 2015 BlueChoice HealthPlan HMO is no longer available.

SHP annual deductibles increase to $445/$890 under the Standard Plan. Coinsurance maximums under the Standard Plan increase to $2,540/$5,080 (network services) and $5,080/$10,160 (out-of-network services). Copayments under the Standard Plan increase to $95 (outpatient facility services) and $159 (emergency room visit).

SHP prescription drug copayments increase to $38 for Tier 2 and $63 for Tier 3. Mail-order copayments increase to $95 for Tier 2 and $158 for Tier 3.

The Government Employees Association (GEA) replaces the American Military Retirees Association (AMRA) as the sponsor of the TRICARE Supplement Plan.

The State Health Plan no longer financially penalizes a member for failure to notify Medi-Call during the first trimester of a pregnancy. Members are still required to preauthorize any hospital admission, include those related to having a baby, and will be financially penalized for failure to do so.

Dental Insurance Benefits

FEB. 15, 1985 Dental coverage begins. All active and retired employees with health coverage are enrolled automatically in dental coverage, with the exception of the Public Service Authority (Santee Cooper). Enrollment for dependent coverage is at the option of the employee/retiree.

JAN. 1, 1986 Premiums increase 8 percent. Premiums remain unchanged until 1996.

JULY 1, 1989 Dental fee allowances increase 5 percent for 21 procedures in classes I and II. The South Carolina Dental Association, as a recommendation to the state, identified the 21 procedures needing change.

JAN. 1, 1990 Allowances for the same 21 procedures from classes I and II increase an additional 5 percent.

JAN. 1, 1991 The fee schedule amounts for some allowable charges in the State Dental Plan increase. The procedures in class I, not increased in 1990, increase by 5 percent. Procedures in class II, not increased in 1990, increase 10 percent. Class III procedures increase 10 percent. Class IV orthodontic procedures remain unchanged for 1991.

JAN. 1, 1992 Dental enrollment periods become biannual instead of annual.

The allowable charges increase for selected procedures in classes I, II and III, based on the recommendations of the South Carolina Dental Association, or to the Health Insurance Association of America mean. Those procedures remaining in classes II and III increase an additional 6.7 percent. Class IV orthodontic benefits remain unchanged for 1992.

JAN. 1, 1993 The allowable charges in classes I and II increase 3 percent. Class III allowances increase 10 percent. Class IV orthodontic benefits remain unchanged for 1993.

JAN. 1, 1994 The allowable charges increase for several State Dental Plan procedures. Dental fee allowances increase 3 percent across the board for classes I, II and III. Class IV orthodontic benefits remain unchanged for 1994. The premium remains unchanged for 1994.

Dependents become eligible for coverage through age 24 if they are full-time students.

JAN. 1, 1995 Dental fee allowances increase 3 percent across the board for classes I, II and III. Class IV orthodontic benefits remain unchanged for 1995. The premium remains unchanged for 1995. Harrington Benefit Services, Inc., is selected as the third-party claims processor (TPCP) for dental claims.

JAN. 1, 1996 The State Dental Plan fee schedule is revised to delete obsolete procedure codes and to update or add revised codes based on the American Dental Association-approved Current Dental Terminology CDT-2 manual.

JAN. 1, 1997 The employer share of the dental premium increases from $9.80 to $11.71.

OCT. 1997 Open enrollment is initiated for the 1998 plan year. Subsequent open enrollment periods will occur in years ending in an odd number, with coverage effective the following January 1. Annual enrollment will be held every year, during which no State Dental Plan changes may be made.

JULY 1, 2000 Legislation passed allowing qualified permanent part-time academic personnel (working 15 to 29 hours per week) to enroll in state dental benefits, with the premium based on the number or hours worked.

Dental benefits are offered to permanent part-time teachers employed with South Carolina school districts, the Department of Corrections or the Department of Juvenile Justice.

JAN. 1, 2002 The Dental Plus benefit, administered by R.E. Harrington, is added.

JAN. 1, 2004 BlueCross BlueShield of South Carolina becomes the new claims administrator for the State Dental Plan and Dental Plus.

JAN. 1, 2008 The total annual benefit an individual may receive when enrolled in both the State Dental Plan and Dental Plus increases from $1,500 to $2,000.

JAN. 1, 2013 The State Dental Plan and Dental Plus begin to cover dental implants as a Class III procedure.

Life Insurance/AD&D

OCT. 1, 1982 The voluntary optional term life insurance program is offered, with the initial contract with Metropolitan Life effective on this date. Premiums are based on age requirements and salary levels.

NOV. 1, 1982 Optional Life coverage becomes effective for public school districts.

JAN. 1, 1983 Optional Life coverage becomes effective for state agencies.

NOV. 1, 1984 Optional Life Insurance coverage amounts increase 15 percent at no cost to those insured.

NOV. 1, 1985 United of Omaha is awarded the Optional Life contract. Rates are reduced, benefits are increased and a maximum level of $80,000 coverage is added.

JULY 1, 1986 Year-round enrollment with medical evidence is instituted for Optional Life.

JUNE 19, 1988 The Hartford is awarded the Optional Life contract, succeeding United of Omaha. The effective date of coverage is November 1, 1988.

OCT. 31, 1988 The Hartford agrees to provide continuation of coverage to former state employees and retirees covered by United of Omaha under the portability option.

NOV. 1, 1990 The Hartford cancels the portability policy extended to former United of Omaha policyholders, effective October 31, 1988. Members of the portability group are given the option of purchasing a new Optional Supplemental Life Insurance Plan, effective November 1, 1990, in increments of either $15,000 or $25,000. This coverage is also made available to retirees who had retired since November 1, 1988, and had Optional Life at the time of retirement.

JAN. 1, 1991 Optional Supplemental Life becomes available to active employees.

JAN. 1, 1992 Optional Life and Optional Supplemental Life premiums increase, with rates guaranteed not to increase for 22 months.

Employees purchasing Dependent Life insurance are offered $5,000 of coverage for a spouse and $2,500 for each eligible child age 14 days through 22 years. Those employees already covered under Dependent Life may keep their current coverage of $1,000 for a spouse and $1,000 for each child age 5 years through 22 years.

JAN. 1, 1994 The Optional Life Plan is enhanced to allow continuation of 50 percent of coverage at retirement and to include a living benefit option, a seat belt rider and a premium waiver in the event of a disability. The Optional Supplemental Life Plan is no longer offered as an enrollment option.

Dependents become eligible for Dependent Life coverage through age 24 if they are full-time students.

Employees with $1,000 of Dependent Life coverage are allowed to increase their coverage level year-round by providing medical evidence of good health.

JAN. 1, 1996 The $1,000 level of Dependent Life coverage is eliminated.

OCT.-NOV. 1996 During the annual enrollment period, an open enrollment for the Optional Life and Dependent Life programs is held. New enrollees can apply for the basic level of Optional Life coverage (based on their salary) and can select Dependent Life coverage of $5,000/$2,500 without providing medical evidence of good health.

JAN. 1, 1997 New Dependent Life coverage levels of $10,000/$5,000 are introduced, in addition to the $5,000/$2,500 coverage levels already available.

Retiring employees can continue their Optional Life Insurance coverage at 100 percent of the final face value of coverage, rather than the current 50 percent.

New maximum coverage for two salary brackets is added to the Optional Life program — $115,000 for salaries $70,000 to $79,999, and $125,000 for salaries $80,000 and higher. All other coverage levels increase $5,000.

OCT. 1998 Those currently enrolled in Optional Life may select new benefit levels and options during the annual enrollment period.

Active employees already enrolled in the Dependent Life program may increase coverage by one level during the annual enrollment period without providing medical evidence of good health. Coverage will become effective January 1, 1999.

JAN. 1, 1999 The maximum insurance amount increases one level for each salary bracket. New salary brackets take effect for upper salary levels. The same premium rate per $1,000 of coverage applies.

An employee retiring on or after January 1, 1999, may continue his Optional Life coverage into retirement at either 100 or 50 percent of the final face value of coverage.

An employee retiring on or after January 1, 1999, can maintain his Optional Life coverage to age 75, after which he may convert the coverage to a whole life policy.

The new option of $20,000 spouse/$10,000 child coverage is available, in addition to the $10,000/$5,000 and $5,000/$2,500 coverage levels.

JAN. 1, 2001 Dependent Life benefit is divided into two separate programs; one for dependent children with the coverage level of $10,000 and a separate benefit for the spouse that allows $10,000 or $20,000 level of coverage without providing medical evidence of good health, if requested within 31 days of first eligibility. The spouse's coverage level may be increased to 50 percent of enrollee's Optional Life coverage (the spouse's maximum level is 50 percent of the employee's Optional Life level, not to exceed $100,000) with medical evidence of good health.

Optional Life coverage tiers are deleted. Optional Life levels which are not evenly divisible by 10 are rolled up to the next $10,000 increment. The new maximum level is $300,000. The level of eligibility is no longer based on salary, except as a new hire without medical evidence of good health (the maximum is three times annual salary, rolled down to the nearest $10,000). The Living Benefit Option is now available for any amount, up to 80 percent of face value.

An employee retiring on or after January 1, 2001, may continue his Optional Life coverage in $10,000 increments, up to the final face value of coverage.

JULY 1, 2001 Additional benefits are added to Optional Life Accidental Death and Dismemberment (AD&D) at no additional cost: increased seat belt benefit from 10% to 25%; daycare benefit added; education benefit added; felonious assault benefit added. The same Optional Life AD&D benefits are added to the Dependent Life-Spouse program at no additional cost.

NOV. 1, 2001 No medical evidence of good health is required to add eligible dependent children to the Dependent Life-Child(ren) benefit. Subscribers may elect to add Dependent Life-Child(ren) coverage throughout the year, or they may add eligible dependent children to the benefit. The 31-day rule no longer applies to this benefit.

JAN. 1, 2003 The maximum level of employee coverage increases to $400,000.

OCT. 2003 During enrollment, new enrollees can apply for $10,000, $20,000 or $30,000 Optional Life coverage without providing medical evidence of good health. Enrolled employees can increase their coverage by these same amounts without providing medical evidence.

JAN. 1, 2004 The maximum level of employee coverage increases to $500,000.

The Travel Assistance Program (provided through The Hartford by Worldwide Assistance Services, Inc.) is introduced.

OCT. 2004 During enrollment, new enrollees can apply for $10,000, $20,000 or $30,000 Optional Life coverage without providing medical evidence of good health. Enrolled employees can increase their coverage by these same amounts without providing medical evidence.

JAN. 1, 2005 The Beneficiary Assist® Program (provided through The Hartford by ComPsych) is introduced.

OCT. 2005 During enrollment, new enrollees can apply for $10,000, $20,000 or $30,000 Optional Life coverage without providing medical evidence of good health. Enrolled employees can increase their coverage by these same amounts without providing medical evidence. Spouses can be enrolled for Dependent Life-Spouse coverage for $10,000 or $20,000 without medical evidence. Coverage for spouses already enrolled may be increased by these same amounts without medical evidence.

JAN. 1, 2006 The suicide exclusion is extended to apply to Dependent Life-Spouse coverage.

OCT. 2006 During enrollment, new enrollees can apply for $10,000, $20,000 or $30,000 Optional Life coverage without providing medical evidence of good health. Enrolled employees can increase their coverage by these same amounts without providing medical evidence. Spouses can be enrolled for Dependent Life-Spouse coverage for $10,000 or $20,000 without medical evidence. Coverage for spouses already enrolled may be increased by these same amounts without medical evidence.

OCT. 2007 During enrollment, new enrollees can apply for up to $50,000 Optional Life coverage without providing medical evidence of good health. Enrolled employees can increase their coverage, up to an additional $50,000, without providing medical evidence. Spouses can be enrolled for Dependent Life-Spouse coverage for $10,000 or $20,000 without medical evidence. Coverage for spouses already enrolled may be increased by these same amounts without medical evidence.

JAN. 1, 2008 Dependent Life coverage for children increases to $15,000.

OCT. 2008 During enrollment, new enrollees can apply for up to $50,000 Optional Life coverage without providing medical evidence of good health. Enrolled employees can increase their coverage, up to an additional $50,000, without providing medical evidence.

AUG. 17, 2009 MetLife is awarded the Optional Life/Dependent Life contract, succeeding The Hartford. The effective date is January 1, 2010.

OCT. 2009 During enrollment, employees can enroll for up to $50,000 Optional Life coverage without medical evidence of good health. Enrolled employees can increase their coverage, up to an additional

$50,000, without medical evidence. Spouses can be enrolled for Dependent Life-Spouse coverage for $10,000 or $20,000 without medical evidence. Coverage for spouses already enrolled may be increased by these same amounts without medical evidence.

JAN. 1, 2010 The Beneficiary Assist® Program, offered by The Hartford, is not available through MetLife. A repatriation benefit of up to $5,000 is available through MetLife. MetLife also offers will preparation and estate resolution services at no charge for participants in Optional Life insurance.

OCT. 2010 During enrollment, employees can enroll for up to $50,000 Optional Life coverage without medical evidence of good health. Enrolled employees can increase their coverage, up to an additional $50,000, without medical evidence. Spouses can be enrolled for Dependent Life-Spouse coverage for $10,000 or $20,000 without medical evidence. Coverage for spouses already enrolled may be increased by these same amounts without medical evidence.

OCT. 2011 During enrollment, employees can enroll for up to $50,000 Optional Life coverage without medical evidence of good health. Enrolled employees can increase their coverage, up to an additional $50,000, without medical evidence.

OCT. 2012 During enrollment, employees can enroll for up to $50,000 Optional Life coverage without medical evidence of good health. Enrolled employees can increase their coverage, up to an additional $50,000, without medical evidence.

OCT. 2013 During enrollment, employees can enroll for up to $50,000 Optional Life coverage without medical evidence of good health. Enrolled employees can increase their coverage, up to an additional $50,000, without medical evidence.

OCT. 2014 During enrollment, employees can enroll for up to $50,000 Optional Life coverage without medical evidence of good health. Enrolled employees can increase their coverage, up to an additional $50,000, without medical evidence.

OCT. 31, 2014 Securian is awarded the Optional Life/Dependent Life contract, succeeding MetLife. The effective date is Jan. 1, 2015.

DEC. 2014 An enrollment for Optional Life and Dependent Life-Spouse is held for active employees. Coverage becomes effective Jan. 1, 2015. Employees are allowed to increase their Optional Life up to $50,000 more than what they had before open enrollment. Employees are allowed to reinstate the Dependent Life-Spouse coverage they had before open enrollment.

MoneyPlus

JAN. 1, 1989 A qualified pretax flexible benefits plan (MoneyPlus) becomes available. Benefits include insurance premiums, dependent care and out-of-pocket medical expenses.

JAN. 1, 1990 The out-of-pocket Medical Spending Account feature of the MoneyPlus is discontinued due to federal tax legislation increasing the employer's liability for the benefit.

JAN. 1, 1991 The Medical Spending Account is restored with a maximum benefit of $1,800. New employees and employees with less than one year of service cannot participate until they have been employed for one year.

JAN. 1, 1994 LTC premiums become ineligible for deduction through the Pretax Group Insurance Premium Feature.

The Medical Spending Account limit increases to $2,400.

JAN. 1, 1998 An employee no longer has to participate in the Pretax Group Insurance Premium feature to participate in the Dependent Care or Medical Spending Accounts. An employee must be eligible to participate, but does not have to enroll, in a health plan to participate in MoneyPlus.

JAN. 1, 2000 Optional Life premiums for Optional Life coverage up to $50,000 are now tax exempt for those who participate in the MoneyPlus Pretax Group Insurance Premium feature.

Medical Spending Account limit increases to $3,000.

JAN. 1, 2003 Fringe Benefits Management Company becomes the new administrator for the MoneyPlus program and offers new enhancements/features.

OCT. 1, 2003 Reimbursement is allowed from Medical Spending Accounts for certain over-the-counter medicines purchased on or after this date.

JAN. 1, 2004 Medical Spending Account limit increases to $5,000.

JAN. 1, 2005 FBMC introduces the EZ REIMBURSE® Card, a debit card that can be used to pay eligible Medical Spending Account expenses up front. Follow-up documentation is not required for some transactions, such as prescription drug expenses and fixed copayments. Medical Spending Account participants may sign up for this card at their option, for an annual fee.

FBMC introduces an optional, pretax Health Savings Account (HSA) for employees who enroll in the SHP Savings Plan, which was also introduced this same year. HSA participants can contribute up to the maximum allowed by the IRS, each year, for eligible expenses. NBSC, an affiliate of Synovus Financial Corp., serves as the trustee for HSAs. Once an HSA reaches $3,500, additional investment options are available.

JAN. 1, 2006 New grace period for Medical Spending Accounts goes into effect, per IRS Revenue Notice 2005-42. Participants who have funds remaining in their MSAs at the end of the plan year (December 31) have until March 15 of the following year to incur eligible expenses and pay them with the remaining funds.

JAN. 1, 2007 The EZ REIMBURSE® Card may now be used at any drugstore that accepts MasterCard®. The card may now be used for prescription drug purchases by mail through any of the health insurance plans offered by EIP. The card may also be used to purchase eligible OTC items. Documentation still required for some transactions.

JAN. 1, 2008 The EZ REIMBURSE® Card may no longer be used at any general merchandise store pharmacy or at any grocery store pharmacy that has not coded eligible prescriptions and OTC items to meet IRS Inventory Information Approval System (IIAS) system requirements so that these purchases may be automatically adjudicated without follow-up documentation. This does not affect how

the card is used at regular pharmacies, mail-order pharmacies and other eligible health care providers.

JUNE 2009 The EZ REIMBURSE® MasterCard® Card is replaced with the myFBMC Card® Visa® Card.

JULY 1, 2009 All pharmacies (independent, chain or mail-order) must be IIAS (inventory information approval system) compliant. To comply with the new IRS regulations, every pharmacy in the U.S. must implement a point-of-sale system that processes IIAS-eligible expenses or stop accepting FSA (flexible spending account) credit and debit cards.

DEC. 6, 2010 WageWorks, Inc., buys FBMC and assumes management of the MoneyPlus program. The company is referred to as Fringe Benefits Management Company, a division of WageWorks (FB-WW).

JAN. 1, 2011 Over-the-counter medicines and drugs are no longer reimbursable through a Medical Spending Account or Health Savings Account unless they are prescribed by a doctor.

JAN. 1, 2013 Wells Fargo replaces National Bank of South Carolina as the trustee for HSAs. Medical Spending Account limit decreases to $2,500.

JULY 1, 2013 FB-WW is referred to as WageWorks.

JAN. 1, 2015 Medical Spending Account limit increases to $2,550.

Long Term Care

SEPT. 1, 1988 LTC coverage is offered to active employees and their spouses, with an effective date of January 1, 1989. They are not required to provide medical evidence of good health. The employees may pay premiums on a pretax basis through MoneyPlus.

JUNE 1, 1990 - An enrollment period for retirees is held. They are required to provide medical evidence of

JULY 31, 1990 good health. The effective date for retiree coverage is January 1, 1991.

JULY 1, 1990 Parents become eligible for coverage, subject to providing medical evidence of good health.

JAN. 1, 1994 LTC premiums no longer can be deducted pretax through MoneyPlus. EIP assumes responsibility for the billing and collection of LTC premiums.

Enhancements to the LTC plan include: an increase in the daily benefit options; modification of the pre-existing condition limitation; a two-year instead of five-year opportunity to purchase additional coverage (known as a guaranteed issue); and the right of spouses, parents and parents-in-law to enroll (with medical evidence of good health) even if the employee or retiree does not.

OCT. 1994 A guaranteed issue is held in fall 1994, for a coverage effective date of January 1, 1995.

OCT. 1996 Aetna offers an opportunity to purchase an additional benefit unit of coverage on a guaranteed issue basis in October 1996, for a coverage effective date of January 1, 1997.

JAN. 1, 1997 The daily benefit maximum coverage available increases to $140.

JAN. 1, 1999 New lower rates take effect for those currently enrolled.

MARCH 1999 LTC open enrollment period is held for active employees.

LTC guaranteed issue period is held for all LTC subscribers. All current subscribers may increase their coverage by $10 without providing medical evidence of good health.

APRIL 1, 1999 The maximum daily benefit amount increases from $140 to $150.

JAN. 1, 2001 Guaranteed issue for all current LTC subscribers and spouses. Maximum daily benefit amount increases from $150 to $160.

APRIL 2001 LTC open enrollment held for active employees. New benefit effective June 1, 2001.

JUNE 1-15, 2003 Guaranteed issue period is held for all current LTC subscribers and spouses. Current subscribers may increase coverage by $10 without medical evidence. New coverage levels effective July 1, 2003.

OCT. 2003 New LTC plans offered during open enrollment: a disability plan (DBA of $50-$250) and two optional service reimbursement plans (DBA of $50-350). Current subscribers may remain on the existing LTC plan or choose one of the new offerings. Open enrollment includes all eligible employees. Retirees, spouses, parents, and parents-in-law may also enroll with medical evidence. A new 10 percent discount for spouses who both enroll in a service reimbursement plan is also offered. Coverage becomes effective January 1, 2004.

SEPT. 22, 2008 Aetna LTC insureds have the opportunity to transfer to Prudential coverage (January 1, 2009 effective date).

JAN. 1, 2009 The Prudential Insurance Company of America becomes the new insurer for the LTC program.

JAN. 14, 2009 Opportunity for accepted Aetna transferees to purchase additional coverage with Prudential.

FEB. 16, 2009 LTC open enrollment for eligible employees and family members.

AUG. 1, 2012 The Prudential Insurance Company of America stops selling LTC coverage to new groups.

JUNE 30, 2013 The Prudential Insurance Company of America stops accepting new applications for enrollment in LTC coverage.

$3,000 Basic Life/AD&D and Basic Long Term Disability

JULY 1, 1972 The Life and LTD insurance program is initiated. Pilot Life is the insurer for the LTD and $2,000 life insurance policy. The maximum benefit for LTD is $500.

JULY 1, 1974 The LTD maximum benefit increases to $600.

JULY 1, 1975 The carrier for life and LTD changes from Pilot Life to Liberty Life of Greenville, South Carolina.

JULY 1, 1977 A two-year waiting period is added to LTD for conditions for which treatment is received within six months prior to beginning employment.

JULY 1, 1978 The LTD waiting period for pre-existing conditions is changed from two years to one year.

NOV. 1, 1979 The age limit on the life and LTD program for active employees, as required by law, is changed from 65 to 70 for payment of benefits.

JULY 1, 1984-JUNE 20, 1997 The life, accidental death and dismemberment and LTD contract is re-bid and awarded to Liberty Life Insurance Company. The maximum LTD benefit increases to 62.5 percent, or $800 per month.

JULY 1, 1987 The South Carolina Retirement Systems begins administration of the Basic Life insurance, Dependent Life and LTD coverage. In the past, the state contracted with an outside insurance company to insure this risk.

Basic Life benefits for employees reaching age 70 on or after July 1, 1987, are reduced by half. Basic Life benefits are not reduced for employees who reached age 70 before July 1, 1987.

NOV. 1, 1988 Dependent Life is made a part of the Optional Life program underwritten by The Hartford.

JAN. 1, 1997 Management of the Basic Life and Basic LTD insurance programs is transferred from the South Carolina Retirement Systems to EIP.

Standard Insurance Company of Portland, Oregon, the SLTD insurer, becomes the administrator of the $3,000 Basic Life and the Basic LTD programs.

JAN. 1, 2002 The Hartford becomes the insurer for the $3,000 Basic Life Insurance program.

JAN. 1, 2010 MetLife becomes the insurer for the $3,000 Basic Life Insurance Program.

JAN. 1, 2015 Securian becomes the insurer for the $3,000 Basic Life Insurance Program.

Supplemental Long Term Disability

JULY 1995 The SLTD program begins. This employee-pays-all program is introduced to address a perceived gap in the state's benefits program. The bid for this insured program is awarded to the Standard Insurance Company of Portland, Oregon. The initial enrollment is for employees of state agencies and local subdivisions for a September 1, 1995, coverage effective date.

SEPT. 1, 1995 The SLTD program becomes effective for enrolled employees of state agencies and local subdivisions.

NOV. 1995 An enrollment period is held for employees of school districts and higher education institutions for a January 1, 1996, coverage effective date.

JAN. 1, 1996 The SLTD program becomes effective for enrolled employees of school districts and higher education institutions.

JAN. 1, 1997 The first premium increase based on salary and age takes effect.

SEPT. 1, 2000 Standard Insurance Company of Portland, Oregon, is re-awarded the contract. The benefits increase, and the rates decrease.

APRIL 2001 An SLTD open enrollment is held for active employees. Coverage becomes effective June 1, 2001.

SEPT. 1, 2005 Lifetime Security Benefit is added to SLTD coverage for all new and current enrollees.

OCT. 2005 An SLTD open enrollment is held for active employees. Coverage becomes effective January 1, 2006.

SEPT. 1, 2010 Standard Insurance Company of Portland, Oregon, is re-awarded the contract. The rates decrease.

OCT. 2010 An SLTD open enrollment is held for active employees. Coverage becomes effective January 1, 2011.

Vision Care

JAN. 1, 1993 The Vision Care Discount program begins. Participating ophthalmologists and optometrists agree to charge no more than $44 for a routine, comprehensive eye examination. Participating vision care providers, including opticians, also agree to give a 20 percent discount on eyewear. There are no claims to file and no reimbursements.

JAN. 1, 1999 The 20 percent discount no longer applies to disposable contact lenses.

JAN. 1, 2001 Routine, comprehensive eye examination charges increase to $50.

JAN. 1, 2005 Routine, comprehensive eye examination charges increase to $60.

JAN. 1, 2010 The State Vision Plan begins. EyeMed is awarded the contract. Subscribers and covered dependents may receive comprehensive eye examinations, frames, lenses and lens options, and contact lens services and materials. The plan also offers discounts on additional pairs of eyeglasses and contact lenses and discounts on LASIK and PRK vision correction.

JAN. 1, 2015 EyeMed is re-awarded the contract. The eyeglass frame allowance increased, some lens costs decreased and the diabetic plan, which allows for a second follow-up exam for Type 1 and Type 2 diabetics within the same plan year.

General Administration

JULY 1, 1980 The eligibility ruling for health, life and LTD under the state program changes from a permanent, full-time employee working five months for 30 hours per week to a permanent, full-time employee working more than six months for at least 30 hours per week.

JULY 1, 1984 A rule change allows academic employees who completed a full school term to remain on the state group insurance until the beginning of the next academic year (August 31), provided they

continue employment in an academic setting and make appropriate payment of their share of the premium. This affects health, State Life, LTD and Optional Life coverage.

AUG. 1984 The state Personnel Division's name changes to the Division of Human Resource Management (DHRM). The Insurance unit becomes the Insurance Benefits Section.

MAY 14, 1985 The South Carolina Retirement Systems assumes the responsibility of administering insurance benefits and the Insurance Benefits section is transferred from DHRM to the Retirement Systems.

JULY 1, 1987 The State Dental Plan and HMOs are included along with the State Health Plan in the continuation of coverage package offered to active state employees and/or their dependents who qualify for COBRA.

The South Carolina Retirement Systems begins the process of changing the health, dental and HMO contracts from a fiscal year basis (July 1 - June 30) to a calendar year basis (January 1 - December 31). To accomplish that, the contracts are extended from 12 to 18 months, to run from July 1, 1987, to December 31, 1988. Benefits and rules are unchanged.

JAN. 1, 1989 Counties become eligible for state insurance benefits. Participation by counties is voluntary, and the state does not contribute toward premiums.

JUNE 5, 1989 The Division of Insurance Services is created. It brings together the Insurance Benefits Section from the South Carolina Retirement Systems and the Insurance Reserve Fund from the Division of General Services. All insurance contracts are transferred to the new division, except the state Life and LTD coverage, which remains at the Retirement Systems.

JUNE 1992 The Risk Management section is added to the existing Insurance Benefits Management and Insurance Reserve Fund sections of the Division of Insurance Services.

JULY 1992 Existing legislation is consolidated to make the following entities eligible for state insurance benefits: counties; regional tourism promotion commissions funded by the Department of Parks, Recreation and Tourism; county mental retardation boards; regional councils of government; regional transportation authorities; alcohol and other drug abuse planning agencies; and special purpose districts created by acts of the General Assembly to provide gas, water or sewer service or any combination of such services. Participation is voluntary, and the state does not contribute toward the premiums.

JULY 1994 Effective July 1, 1994, the Division of Insurance Services becomes the Office of Insurance Services.

Legislation is passed to include recreation districts and hospital service districts as special purpose districts. Municipalities, councils on aging and community action agencies also may participate in the state's plan of benefits. The state does not contribute toward the premiums.

JAN. 1995 The definition of eligible employee is amended to allow members of municipal councils to be considered employees for purposes of the Plan if they receive a salary and participate in the South Carolina Retirement Systems.

MARCH 1996 Municipal and county council members of participating employers with at least 12 years of council service are allowed to enroll as retirees, at full cost, provided the participating employer elects to allow coverage for former members.

FEB. 1997 The Risk Management section is discontinued and the wellness program is incorporated into the Insurance Benefits Management section.

JUNE 1997 Transfer procedures are implemented, through which a transferring employee is no longer considered a new hire for insurance program purposes.

JAN. 1, 1998 New student certification procedures take effect. The Office of Insurance Services sends a letter notifying the employee of a dependent turning age 19. The employee is responsible for certifying that the dependent is a full-time student and for notifying the Office of Insurance Services when the dependent is no longer a full-time student. The Office of Insurance Services conducts random audits to verify compliance.

JULY 1, 2000 Legislation is passed to include permanent part-time teachers as eligible for health and dental benefits (eligibility based on job description; premiums based on number of hours worked per week).

JAN. 1, 2001 The Teacher and Employee Retention Incentive Program (TERI) allows South Carolina Retirement Systems members to retire and begin accumulating retirement benefits without terminating employment.

JULY 2001 OIS becomes the Employee Insurance Program (EIP).

JUNE 2002 The Employee Benefits Division becomes a part of the newly created Division of Insurance and Grants Services (DIGS).

APRIL 2004 Employee Insurance Program launches Employee Benefits Services (EBS) website, enabling benefits administrators to view their employee enrollment information and receive their reports and billing statements online.

JAN. 1, 2004 Employers who participate in the Employee Insurance Program have the option of reducing the threshold for insurance eligibility for permanent employees from 30 hours per week to at least 20.

JULY 1, 2004 Experience rating for optional employers goes into effect. Participants whose premiums increase five percent or more are given the option to change or drop coverage.

JAN. 1, 2005 The Prevention Partners Worksite Screening Program is expanded. All active employees and retirees who are enrolled in the SHP or one of the HMOs as their primary coverage are eligible. Dependents and retirees eligible for Medicare are not eligible.

SEPT. 2005 Employee Benefits Services (EBS) website is enhanced to allow benefits administrators to enroll employees and make changes/terminate their coverage online.

JUNE 1, 2007 Employee Insurance Program launches MyBenefits website, enabling employees to view their enrollment information and to change their contact and beneficiary information online.

OCT. 1, 2007 MyBenefits website is expanded to allow employees to make their annual and open enrollment changes online.

MAY 2, 2008 Legislation passed that changes the requirements for retiring employees to be eligible for state retiree health and dental insurance. These new requirements apply to new employees hired on or after May 2, 2008.

OCT. 1, 2008 MyBenefits website is expanded to allow retirees, survivors and COBRA subscribers to make their annual and open enrollment changes online. Throughout the year they can also view their enrollment information and change their contact information online.

FEB. 17, 2009 The COBRA Premium Assistance Program, part of the American Recovery and Reinvestment Act of 2009, provides a 65 percent subsidy to help pay COBRA continuation premiums for up to nine months for assistance eligible individuals whose employment is/was *terminated involuntarily* between September 1, 2008, and December 31, 2009.

DEC. 19, 2009 The COBRA Premium Assistance Program is extended to provide a 65 percent subsidy to help pay COBRA continuation premiums for up to 15 months for assistance eligible individuals whose employment is/was *terminated involuntarily* between September 1, 2008, and February 28, 2010.

JAN. 1, 2010 Michelle's Law goes into effect. Passed October 2008, this law ensures dependent students taking a medically necessary leave of absence do not lose their health insurance.

The Genetic Information Nondiscrimination Act (GINA) of 2008 prohibits health insurance providers from denying coverage or charging a higher premium to an otherwise healthy individual found to have a potential genetic condition or genetic predisposition toward a disease or disorder. GINA also bans an employer from using an employee's genetic information when making hiring, firing, placement or promotion decisions.

The Mental Health Parity and Addiction Equity Act of 2008 requires group health plans to provide mental health and substance abuse benefits at the same level as other health and medical benefits.

MARCH 2, 2010 The COBRA Premium Assistance Program is extended to provide a 65 percent subsidy to help pay COBRA continuation premiums for up to 15 months for assistance eligible individuals whose employment is/was *terminated involuntarily* between September 1, 2008, and March 31, 2010. The program is also expanded to include assistance eligible individuals whose *working hours were reduced* between September 1, 2008, and March 31, 2010, **and** whose employment is/was *terminated involuntarily* between March 2, 2010, and March 31, 2010.

APRIL 15, 2010 The COBRA Premium Assistance Program is extended to provide a 65 percent subsidy to help pay COBRA continuation premiums for up to 15 months for assistance eligible individuals whose employment is/was *terminated involuntarily* between September 1, 2008, and May 31, 2010. The program also includes assistance eligible individuals whose *working hours were reduced* between September 1, 2008, and May 31, 2010, **and** whose employment is/was *terminated involuntarily* between March 2, 2010, and May 31, 2010.

JAN. 1, 2011 Children younger than 26 become eligible for coverage on their parents' insurance regardless of student status, residency, financial dependency or marital status. Certification of student status or incapacitation is still required for children ages 19-24 to be enrolled in Dependent Life-Child coverage.

APRIL 20, 2011 The dependent eligibility project is launched. EIP requires current subscribers who cover a spouse or child to submit copies of documents that verify their family members are eligible for coverage. Subscribers who enroll a spouse or child in coverage have to provide copies of documents that verify their family members are eligible for coverage.

JULY 1, 2012 The Employee Insurance Program and the South Carolina Retirement Systems become part of the newly created Public Employee Benefit Authority (PEBA). The Employee Insurance Program begins operations as PEBA. The Retirement Systems begins operations as PEBA Retirement Benefits.

JAN. 1, 2014 Open enrollment becomes a yearly occurrence. Every October, eligible employees, retirees, COBRA subscribers and survivors may enroll in or drop their own health coverage and add or drop their eligible spouse and/or children. Eligible subscribers also may change health plans. Subscribers may add or drop the State Dental Plan and Dental Plus only in October of odd-numbered years.

Children younger than 26 who begin working for a participating employer can enroll as an active employee or remain a dependent on their parents' coverage through PEBA.

NOV. 18, 2014- PEBA holds open enrollment for subscribers who have valid, out-of-state same-sex marriages

DEC. 19, 2014 to add insurance coverage for their same-sex spouses and children of their same-sex spouses. Subscribers who enter in a valid, same-sex marriage in South Carolina or another state after Nov. 18, 2014, will have the usual 31 days from the date of marriage in which to add coverage for spouses or stepchildren.

JAN. 1, 2015 Nonpermanent full-time, variable-hour, part-time and seasonal employees and their dependents may be eligible for health, dental and vision insurance.

Quick reference charts

Active NOE quick reference

This information refers to the active NOE (additions and changes).

Type of Action: NOE Section:	New Hire	Open Enrollment	Marriage	Divorce/ Separation
TYPE OF CHANGE	New Hire; Specify Enrollment	Change; Specify Enrollment	Change; Other (Marriage); Date of Change Event. ***Must provide documentation.***	Change; Other (Divorce or Separation); Date of Change Event. *Must provide documentation.*
BA USE ONLY	Effective Date; Group ID#; Group Name; if 20-hour employee	Effective Date; Group ID#; Group Name	Effective Date; Group ID#; Group Name	Effective Date; Group ID#; Group Name
MONEYPLUS PRETAX PREMIUMS	Refuse or Yes	Complete if changing election	Complete if changing election	Complete if changing election
ENROLLEE INFO	#1-19	#1-5	#1-5; #8-17	#1-5; #8-17
MEDICARE	Complete all, if applicable	Complete all, if applicable	Complete all, if applicable	Complete all, if applicable
COVERAGE*	#21-28	#21-23, 25-26, 28, if applicable	#21-26, 28 if changing coverage level	#21-26, 28 if changing coverage level
BENEFICIARIES*	Complete all. List relationship as wife, husband, daughter, son, etc. (Do not list spouse or child.) An estate or trust has no relationship.	Employee option to change; complete all, if applicable. List relationship as wife, husband, daughter, son, etc. (Do not list spouse or child.) An estate or trust has no relationship.	Employee option to change; complete all, if applicable. List relationship as wife, husband, daughter, son, etc. (Do not list spouse or child.) An estate or trust has no relationship.	Employee option to change; complete all, if applicable. List relationship as wife, husband, daughter, son, etc. (Do not list spouse or child.) An estate or trust has no relationship.
DEPENDENTS	Complete all, if applicable. List relationship as wife, husband, daughter, son, etc. (Do not list spouse or child.)	Complete all, if applicable. List relationship as wife, husband, daughter, son, etc. (Do not list spouse or child.)	Add; complete all, listing spouse and/or children to add. List relationship as wife, husband, daughter, son, etc. (Do not list spouse or child.)	Delete; list spouse and/or children to delete. List relationship as wife, husband, daughter, son, etc. (Do not list spouse or child.)
CERTIFICATION & AUTHORIZATION	#31-32	#31-32	#31-32	#31-32

*Absolutely no alterations are allowed in this section.

Active NOE quick reference

Type of Action: NOE Section:	Ineligible Child/ Coverage Change	Last Ineligible Child/Coverage Change	Returning Student	Dependent Life-Spouse Coverage with Medical Approval
TYPE OF CHANGE	Change; Other (ineligible child; give reason)	Change; Other (ineligible child; give reason)	Change; Other (returning student). ***Must provide documentation.***	Change; Other (Dependent Life and increase with medical approval). ***Must provide approval from Securian.***
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
MONEYPLUS PRETAX PREMIUMS	Complete if changing election	Complete if changing election	Complete if changing election	N/A
ENROLLEE INFO	#1-5	#1-5	#1-5	#1-5
MEDICARE	Complete all, if applicable	Complete all, if applicable	Complete all, if applicable	Complete all, if applicable
COVERAGE*	#21-23 and 24 if decreasing coverage level	#21-23 and 24 if decreasing coverage level	#21-23 and 24 if decreasing coverage level	#25
BENEFICIARIES*	Employee option to change; complete all, if applicable. List relationship as wife, husband, daughter, son, etc. (Do not list spouse or child.)An estate or trust has no relationship.	Employee option to change; complete all, if applicable. List relationship as wife, husband, daughter, son, etc. (Do not list spouse or child.)An estate or trust has no relationship.	Employee option to change; complete all, if applicable. List relationship as wife, husband, daughter, son, etc. (Do not list spouse or child.)An estate or trust has no relationship.	Employee option to change; complete all, if applicable. List relationship as wife, husband, daughter, son, etc. (Do not list spouse or child.)An estate or trust has no relationship.
DEPENDENTS	Delete; list child to delete. List relationship as daughter, son, etc. (Do not list spouse or child.)	Delete; list child to delete. List relationship as daughter, son, etc. (Do not list spouse or child.)	Add; complete all, listing child to add. List relationship as wife, husband, daughter, son, etc. (Do not list spouse or child.)	Add; list spouse. List relationship as wife, husband, etc. (Do not list spouse or child.)
CERTIFICATION & AUTHORIZATION	#31-32	#31-32	#31-32	#31-32

*Absolutely no alterations are allowed in this section.

Active NOE quick reference

Type of Action: / 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	Change; Other (OL add or increase); give reason	Change; Other (OL add or increase with medical approval) ***Must provide approval from Securian.***	Change; Other (OL decrease or refuse); give reason for change if on MoneyPlus	Change; Other (DL add or increase with medical approval) ***Must provide approval from Securian.***	Change; Other (SLTD add or wait period decrease) ***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
MONEYPLUS PRETAX PREMIUMS	Complete if changing election	Complete if changing election	Complete if changing election	N/A	N/A
ENROLLEE INFO	#1-5; 18	#1-5; 18	#1-5	#1-5; 18	#1-5
MEDICARE	Complete all, if applicable	Complete all, if applicable	Complete all, if applicable	Complete all, if applicable	Complete all, if applicable
COVERAGE*	#26 (enter new amount)	#26 (enter new amount)	#26 (enter new amount or refuse)	#25 (enter new amount)	#27
BENEFICIARIES*	Employee option to change; complete all, if applicable. List relationship as wife, husband, daughter, son, etc. (Do not list spouse or child.) An estate or trust has no relationship.	Employee option to change; complete all, if applicable. List relationship as wife, husband, daughter, son, etc. (Do not list spouse or child.) An estate or trust has no relationship.	Employee option to change; complete all, if applicable. List relationship as wife, husband, daughter, son, etc. (Do not list spouse or child.) An estate or trust has no relationship.	Employee option to change; complete all, if applicable. List relationship as wife, husband, daughter, son, etc. (Do not list spouse or child.) An estate or trust has no relationship.	Employee option to change; complete all, if applicable. List relationship as wife, husband, daughter, son, etc. (Do not list spouse or child.) An estate or trust has no relationship.
DEPENDENTS	N/A	N/A	N/A	N/A	N/A
CERTIFICATION & AUTHORIZATION	#31-32	#31-32	#31-32	#31-32	#31-32

*Absolutely no alterations are allowed in this section.

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.

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	☐ Employee alone ☐ Employee and newborn child ☐ Employee and spouse ☐ Employee, spouse and newborn child	☐ Enroll in health (if employee already enrolled in health, may change plans if adding spouse or child to health) ☐ Enroll in State Dental ☐ Enroll in State Dental and Dental Plus ☐ Add Dental Plus to existing State Dental coverage ☐ Enroll in State Vision ☐ Enroll in Dependent Life-Child ☐ Enroll in or increase Dependent Life-Spouse ($10,000 or $20,000 without evidence of insurability; more than $20,000 with evidence of insurability) ☐ Enroll in or increase Optional Life (up to $50,000 without evidence of insurability; more than $50,000 with evidence of insurability) ☐ Review changes available with MSA/DCSA	**Health, dental and vision:** Date of birth **Optional Life and Dependent Life-Spouse:** For amounts available without evidence of insurability, first of month following date of request. For amounts requiring evidence of insurability, first of month following date of approval. **Dependent Life-Child:** Date of birth	Long-form birth certificate of newborn baby **and** If adding spouse, marriage license or Page 1 of most recent tax return
	Notes			
	A. No other children may be added due to this event. B. May not drop any coverage; may only change or add coverage. C. For Optional Life, if employee is not actively at work on the expected effective date, then the effective date will be first of the month following return 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.			

Special eligibility situations quick reference

Event	This person/these people *(select one)*	Can do one or more of these actions *(select as many as apply)*	Effective date	Documentation required
Adoption of child (or placement for adoption)	☐ Employee alone ☐ Employee and newly adopted child ☐ Employee and spouse ☐ Employee, spouse and newly adopted child	☐ Enroll in health (if employee already enrolled in health, may change plans if adding spouse or child to health) ☐ Enroll in State Dental ☐ Enroll in State Dental and Dental Plus ☐ Add Dental Plus to existing State Dental coverage ☐ Enroll in State Vision ☐ Enroll in Dependent Life-Child ☐ Enroll in or increase Dependent Life-Spouse ($10,000 or $20,000 without evidence of insurability; more than $20,000 with evidence of insurability) ☐ Enroll in or increase Optional Life (up to $50,000 without evidence of insurability; more than $50,000 with evidence of insurability) ☐ Review changes available with MSA/DCSA	**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 **Optional Life and Dependent Life-Spouse:** For amounts available without medical evidence, first of month following date of request. For amounts requiring evidence of insurability, first of month following date of approval. **Dependent Life-Child:** Date of birth for newborns. First of the month after date of request for other children.	A copy of a birth certificate (long form) 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 **and** if adding spouse, marriage license or Page 1 of most recent tax return
	Notes			
	A. No other children may be added due to this event. B. May not drop any coverage; may only change or add coverage. C. For Optional Life, if employee is not actively at work on the expected effective date, then the effective date will be first of the month following return 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.			

Special eligibility situations quick reference

Event	This person/these people *(select one)*	Can do one or more of these actions *(select as many as apply)*	Effective date	Documentation required
Placement of Foster Child (with court order) *If you have gained legal custody of your foster child, see Gains custody of child*	☐ Employee alone ☐ Employee and new foster child ☐ Employee and spouse ☐ Employee, spouse and new foster child	☐ Enroll in health (if employee already enrolled in health, may change plans if adding spouse or new foster child to health) ☐ Enroll in State Dental ☐ Enroll in State Dental and Dental Plus ☐ Add Dental Plus to existing State Dental coverage ☐ Enroll in State Vision ☐ Review changes available with MSA/DCSA	**Health, dental and vision** Date of placement (usually date of court order) *If enrolled in MoneyPlus Pretax Premium Feature, premiums must be paid post-tax for retroactive coverage back to the date of gaining child. Premiums may be paid through the Pretax Premium Feature beginning first of the month following date of request.*	Court order placing child in foster care with the employee **and** if adding spouse, marriage license or Page 1 of most recent tax return
	Notes			
	A. No other children may be added due to this event. B. May not drop any coverage; may only change or add coverage.			

Special eligibility situations quick reference

Event	This person/these people *(select one)*	Can do one or more of these actions *(select as many as apply)*	Effective date	Documentation required
Gains custody of child (with court order)	☐ Employee alone ☐ Employee and child for whom he gained legal custody ☐ Employee and spouse ☐ Employee, spouse and child for whom he gained legal custody	☐ Enroll in health (if employee already enrolled in health, may change plans if adding spouse or child to health) ☐ Enroll in State Dental ☐ Enroll in State Dental and Dental Plus ☐ Add Dental Plus to existing State Dental coverage ☐ Enroll in State Vision ☐ Enroll in Dependent Life-Child ☐ Review changes available with MSA/DCSA	**Health, dental and vision** Date of court order **Dependent Life-Child** Date of birth for newborns. First of the month after date of request for other children. *If enrolled in MoneyPlus Pretax Premium Feature, premiums must be paid post-tax for retroactive coverage back to the date of gaining child. Premiums may be paid through the Pretax Premium Feature beginning first of the month following date of request.*	Court order granting custody of the child to employee **and** if adding spouse, marriage license or Page 1 of most recent tax return
	Notes			
	A. No other children may be added due to this event. B. May not drop any coverage; may only change or add coverage. 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.			

Special eligibility situations quick reference

Event	This person/these people *(select one)*	Can do one or more of these actions *(select as many as apply)*	Effective date	Documentation required
Marriage	☐ Employee alone ☐ Employee and spouse ☐ Employee, spouse and any new stepchild ☐ Employee and any new stepchild	☐ Enroll in health (if employee already enrolled in health, may change plans if adding spouse or stepchild to health) ☐ Enroll in State Dental ☐ Enroll in State Dental and Dental Plus ☐ Add Dental Plus to existing State Dental coverage ☐ Enroll in State Vision ☐ Enroll in Dependent Life-Spouse ($10,000 or $20,000 without medical evidence; more than $20,000 with evidence of insurability) ☐ Enroll in Dependent Life-Child ☐ Enroll in or increase Optional Life (up to $50,000 without evidence of insurability; more than $50,000 with evidence of insurability) ☐ Review changes available with MSA/DCSA	**Health, dental and vision:** Date of marriage **Optional Life and Dependent Life-Spouse:** For amounts available without evidence of insurability, first of month following date of request. For amounts requiring evidence of insurability, first of month following date of approval. **Dependent Life-Child:** First of the month after date of request *If enrolled in MoneyPlus Pretax Premium Feature, premiums must be paid post-tax for retroactive coverage back to the date of marriage. Premiums may be paid through the Pretax Premium Feature beginning first of the month following date of request*	Marriage license **and** if adding step-children, also need long-form birth certificates for each child
	Notes			
	A. No other children may be added due to this event. B. May not drop any coverage; may only change or add coverage. C. For Optional Life, if employee is not actively at work on the expected effective date, then the effective date will be first of the month following return 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.			

Special eligibility situations quick reference

Event	This person/these people *(select one)*	Can do one or more of these actions *(select as many as apply)*	Effective date	Documentation required
Divorce	☐ Former spouse and any former stepchildren	☐ Unless the divorce decree or other court order requires the employee to continue coverage for former dependents, he must drop former spouse and stepchildren from health, dental and vision. ☐ If not already enrolled and divorce decree or other court order requires the employee to continue coverage for former dependents, he may add former spouse or stepchildren in accordance with court order. ☐ Must drop Dependent Life for former spouse or stepchild, even if court ordered to continue	**Health, dental and vision:** First of month following divorce **Exception to 31-day rule:** If dropping ineligible spouse or stepchildren and PEBA is notified more than 31 days after divorce, first of month following notification. *Exception to 31-day Rule does not apply in the case of adding a former spouse or stepchild. To add a former spouse or former stepchild, he must notify PEBA within 31 days of court order*	Entire divorce decree
	☐ Employee	☐ Enroll in or increase Optional Life up to $50,000 without evidence of insurability ☐ Cancel or decrease Optional Life ☐ Review changes available with MSA	**Optional Life:** If employee is actively at work, first of month following date of request. If not actively at work, first of month following return to work.	
	Notes			
	A. May not drop coverage for himself or any dependents who remain eligible for coverage. B. For Optional Life, if employee is not actively at work on the expected effective date, then the effective date will be first of the month following return to work.			

Special eligibility situations quick reference

Event	This person/these people *(select one)*	Can do one or more of these actions *(select as many as apply)*	Effective date	Documentation required
Employee loses other health coverage (includes Medicare)	If employee is not already enrolled in PEBA's health coverage: ☐ Employee ☐ Employee and spouse ☐ Employee and children ☐ Employee, spouse and children	☐ Enroll in health ☐ Enroll in State Dental ☐ Enroll in State Dental and Dental Plus ☐ Add Dental Plus to existing State Dental coverage ☐ Enroll in State Vision	**Health, dental and vision:** Date of loss of health coverage *If enrolled in MoneyPlus Pretax Premium Feature, premiums must be paid post-tax for retroactive coverage back to the date of loss. Premiums may be paid through the Pretax Premium Feature beginning first of the month following date of request*	Letter (on company letterhead) stating employee lost health coverage and date of loss **and** Long-form birth certificate if adding child; marriage license or Page 1 of most recent 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			
	A. Letter does NOT have to state employee lost dental or vision to add dental or vision. B. Letter does not have to state spouse or children lost coverage to add them. C. May not drop any coverage but may add coverage.			

Special eligibility situations quick reference

Event	This person/these people *(select one)*	Can do one or more of these actions *(select as many as apply)*	Effective date	Documentation required
Spouse or child loses other health coverage (includes Medicare)	☐ Employee and spouse/child who lost health coverage	☐ Enroll in health (if employee already enrolled in health, may change plans if adding spouse or child to health) ☐ Enroll in State Dental ☐ Enroll in State Dental and Dental Plus ☐ Add Dental Plus to existing State Dental coverage ☐ Enroll in State Vision	**Health, dental and vision:** Date of loss of health coverage *If enrolled in MoneyPlus Pretax Premium Feature, premiums must be paid post-tax for retroactive coverage back to the date of loss. Premiums may be paid through the Pretax Premium Feature beginning first of the month following date of request*	Letter (on company letterhead) stating employee lost health coverage and date of loss **and** Long-form birth certificate if adding child; marriage license <u>or</u> Page 1 of most recent tax return if adding spouse
	Notes			
	A. Letter does NOT have to say spouse/child lost dental or vision to add dental or vision B. Employee may not make changes to coverage unless he adds spouse/child who lost health coverage. C. May not drop any coverage but may add coverage. D. If the spouse/child lost coverage through PEBA and he 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.			

Special eligibility situations quick reference

Event	This person/these people *(select one)*	Can do one or more of these actions *(select as many as apply)*	Effective date	Documentation required
Employee loses other dental coverage only (not health)	☐ Employee	☐ Enroll in State Dental ☐ Enroll in State Dental and Dental Plus ☐ Add Dental Plus to existing State Dental coverage	**Dental:** Date of loss of dental coverage *If enrolled in MoneyPlus Pretax Premium Feature, premiums must be paid post-tax for retroactive coverage back to the date of loss. Premiums may be paid through the Pretax Premium Feature beginning first of the month following date of request*	Letter (on company letterhead) stating employee lost dental coverage and date of loss
Employee loses other vision coverage only (not health)	☐ Employee	☐ Enroll in State Vision	**Vision:** Date of loss of vision coverage *If enrolled in MoneyPlus Pretax Premium Feature, premiums must be paid post-tax for retroactive coverage back to the date of loss. Premiums may be paid through the Pretax Premium Feature beginning first of the month following date of request*	Letter (on company letterhead) stating employee lost vision coverage and date of loss
Spouse or child loses other dental coverage only (not health)	☐ Employee and spouse/child who lost health coverage	☐ Enroll in State Dental ☐ Enroll in State Dental and Dental Plus ☐ Add Dental Plus to existing State Dental coverage	**Dental:** Date of loss of dental coverage *If enrolled in MoneyPlus Pretax Premium Feature, premiums must be paid post-tax for retroactive coverage back to the date of loss. Premiums may be paid through the Pretax Premium Feature beginning first of the month following date of request*	Letter (on company letterhead) stating spouse/child lost dental coverage and date of loss
	Notes			
	If spouse/child not covered by employee for health, vision or life, must also submit dependent documentation.			

Special eligibility situations quick reference

Event	This person/these people *(select one)*	Can do one or more of these actions *(select as many as apply)*	Effective date	Documentation required
Spouse or child loses other dental coverage only (not health)	☐ Employee and spouse/child who lost health coverage	☐ Enroll in State Vision	**Vision:** Date of loss of vision coverage *If enrolled in MoneyPlus Pretax Premium Feature, premiums must be paid post-tax for retroactive coverage back to the date of loss. Premiums may be paid through the Pretax Premium Feature beginning first of the month following date of request*	Letter (on company letterhead) stating spouse/child lost vision coverage and date of loss
	Notes			
	If spouse/child not covered by employee for health, dental or life, must also submit dependent documentation.			
Employee gains other health, dental, or vision coverage	☐ Employee	☐ 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	Letter (on company letterhead) stating subscriber gained coverage and date of gain
	Notes			
	A. Dependents enrolled in the same coverage must also be dropped. B. Cannot just drop dental or Dental Plus — must drop both if enrolled in both.			
Spouse/child gains other health, dental, or vision coverage	☐ Spouse/child who gained other coverage	☐ 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	Letter (on company letterhead) stating spouse/child gained coverage and date of gain
	Notes			
	A. Cannot just drop dental or Dental Plus — must drop both if enrolled in both. B. Only the spouse/child listed on gain of coverage letter may drop.			

Special eligibility situations quick reference

Event	This person/these people *(select one)*	Can do one or more of these actions *(select as many as apply)*	Effective date	Documentation required
Employee gains Medicaid or CHIP coverage	☐ Employee	☐ Drop health ☐ Drop dental and Dental Plus ☐ Drop vision	**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. 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 children enrolled in the same coverage will also be dropped. B. If the employee contacts PEBA later than 60 days after he was notified by Medicaid, no change can be made due to gain of Medicaid.			
Spouse/child gains Medicaid or CHIP coverage	☐ Spouse/child who gained Medicaid or CHIP coverage	☐ Drop health ☐ Drop dental and Dental Plus ☐ Drop vision	**Same as above**	Copy of Medicaid approval letter
	Notes			
	A. Only the spouse/child listed on gain of coverage letter may 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.			

Special eligibility situations quick reference

Event	This person/these people *(select one)*	Can do one or more of these actions *(select as many as apply)*	Effective date	Documentation required
Employee loses Medicaid or CHIP coverage	If employee is not already enrolled in PEBA's health coverage: ☐ Employee ☐ Employee and spouse ☐ Employee and children ☐ Employee, spouse and children	☐ Enroll in health ☐ Enroll in State Dental ☐ Enroll in State Dental and Dental Plus ☐ Add Dental Plus to existing State Dental coverage ☐ Enroll in State Vision	**Health, dental and vision:** **Exception to 31-day rule:** • 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 C below) • *If enrolled in MoneyPlus Pretax Premium Feature, premiums must be paid post-tax for retroactive coverage back to the date of loss. Premiums may be paid through the Pretax Premium Feature beginning first of the month following date of request.*	Copy of Medicaid loss letter **and** Long-form birth certificate if adding child; marriage license or Page 1 of most recent 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			
	A. Letter does not have to state spouse or children lost coverage to add them. B. May not drop any coverage but may add coverage. C. If the employee contacts PEBA later than 60days after he was notified by Medicaid, no change can be made due to gain of Medicaid.			
Spouse/child loses Medicaid or CHIP coverage	☐ Employee and spouse/child who lost health coverage	☐ Enroll in health (if employee already enrolled in health, may change plans if adding spouse or child to health) ☐ Enroll in State Dental ☐ Enroll in State Dental and Dental Plus ☐ Add Dental Plus to existing State Dental coverage ☐ Enroll in State Vision	**Same as above**	Copy of Medicaid loss letter **and** Long-form birth certificate if adding child; marriage license or Page 1 of most recent tax return if adding spouse
	Notes			
	A. May only add the employee with the spouse/child who lost Medicaid. B. May not drop any coverage but may add coverage.			

Special eligibility situations quick reference

Event	This person/these people *(select one)*	Can do one or more of these actions *(select as many as apply)*	Effective date	Documentation required
Employee gains premium assistance through Medicaid or CHIP	If employee is not already enrolled in PEBA's health coverage: ☐ Employee	☐ Enroll in health ☐ Enroll in State Dental ☐ Enroll in State Dental and Dental Plus ☐ Add Dental Plus to existing State Dental coverage ☐ 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. • 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. • *If enrolled in MoneyPlus Pretax Premium Feature, premiums must be paid post-tax for retroactive coverage back to the date of loss. Premiums may be paid through the Pretax Premium Feature beginning first of the month following date of request.*	Copy of Medicaid approval letter
	If employee is already enrolled in PEBA health coverage: Not eligible to change elections	Not eligible to change elections		
	Notes			
	A. May not drop any coverage but may add coverage. B. If the employee contacts PEBA later than 60days after he was notified by Medicaid, no change can be made due to gain of Medicaid premium assistance.			
Spouse/child gains premium assistance through Medicaid or CHIP	☐ Employee and spouse/child who gained Medicaid or CHIP premium assistance	☐ Enroll in health (if employee already enrolled in health, may change plans if adding spouse or child to health) ☐ Enroll in State Dental ☐ Enroll in State Dental and Dental Plus ☐ Add Dental Plus to existing State Dental coverage ☐ Enroll in State Vision	**Same as above**	Copy of Medicaid approval letter **and** Long-form birth certificate if adding child; marriage license or Page 1 of most recent tax return if adding spouse
	Notes			
	A. May only add the employee with the spouse/child who Medicaid gain letter. B. May not drop any coverage but may add coverage.			

Special eligibility situations quick reference

Event	This person/these people *(select one)*	Can do one or more of these actions *(select as many as apply)*	Effective date	Documentation required
Employee loses premium assistance through Medicaid or CHIP	☐ Employee	☐ Drop health ☐ Drop State Dental and Dental Plus ☐ Drop State 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. • 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 children enrolled in the same coverage will also be dropped. B. If the employee contacts PEBA later than 60 days after he was notified by Medicaid, no change can be made due to loss of Medicaid premium assistance.			
Spouse/child loses premium assistance through Medicaid or CHIP	☐ Spouse/child who lost Medicaid or CHIP premium assistance	☐ Drop health ☐ Drop State Dental and Dental Plus ☐ Drop State Vision	**Same as above**	Copy of Medicaid loss letter
	Notes			
	A. Only the spouse/child listed on loss of premium assistance letter may drop B. If the employee contacts PEBA later than 60 days after he was notified by Medicaid, no change can be made due to loss of Medicaid premium assistance			
Employees not enrolled in the MoneyPlus Pretax Group Insurance Premium Feature can also make the following changes:				
Marital separation	☐ Employee's separated spouse	☐ Drop health, dental and vision	First of the month following date of notification	Decree of Separate Maintenance or other order filed with court
	☐ Employee	☐ Enroll in or increase Optional Life up to $50,000 ☐ Cancel or decrease Optional Life	Optional Life: if employee is actively at work, first of month following date of request. If not actively at work, first of month after return 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 may not 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 first of the month following return to work.			

Effective date quick reference

Type of action	Effective date
New Hire	• 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, he begins on the 2nd or 3rd of the month), then the employee may choose when coverage begins: o The first day of that month, OR o 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.
Marriage	See the Special Eligibility Situations Quick Reference chart for effective dates
Separation	See the Special Eligibility Situations Quick Reference chart for effective date
Divorce	See the Special Eligibility Situations Quick Reference chart for effective date
Employee gain of coverage	See the Special Eligibility Situations Quick Reference chart for effective date
Employee gain of Medicaid or CHIP coverage or loss of premium assistance	See the Special Eligibility Situations Quick Reference charts for effective date
Employee loss of coverage	See the Special Eligibility Situations Quick Reference charts for effective date
Employee loss of Medicaid or CHIP coverage or gain of premium assistance	See the Special Eligibility Situations Quick Reference charts on Pages L-44-45 for effective date
Spouse/Child gain of coverage	See the Special Eligibility Situations Quick Reference chart for effective date
Spouse/Child gain of Medicaid or CHIP coverage or loss of premium assistance	See the Special Eligibility Situations Quick Reference charts for effective date
Spouse/Child loss of coverage	See the Special Eligibility Situations Quick Reference charts for effective date
Spouse/Child loss of Medicaid of CHIP coverage or gain of premium assistance	See the Special Eligibility Situations Quick Reference charts for effective date
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) *(no medical evidence of good health)*	Jan. 1 following open enrollment
Birth	See the Special Eligibility Situations Quick Reference chart for effective date

Effective date quick reference

Type of action	Effective date
Adoption	See the Special Eligibility Situations Quick Reference chart for effective date
Foster care/guardianship	See the Special Eligibility Situations Quick Reference chart for effective date
Ineligible spouse or child	First of the month after becoming ineligible
Returning student	First of the month after becoming eligible
Death (health, dental, 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 Jan. 1
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) or The Standard (BLTD/SLTD).

Documentation quick reference

Type of action	Documentation required
Administrative error	Statement explaining error and circumstances on a Request for Review Form, 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.
Common Law Marriage	Common Law Marriage Affidavit signed by both parties
Divorce Decree or Court Order to Insure Ex-spouse or Child(ren)	Copy of the entire divorce decree or court order. Document must stipulate the programs under which the spouse or child must be covered. (Applies also to common law marriages)
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 and not merely financial responsibility.
Death in the line of duty	Verification of death while on duty
Dependent Life (adding or increasing when evidence of insurability is required)	Copy of Notification Statement from Securian
Divorce Decree (drop spouse)	Copy of the entire divorce decree. *(See also Divorce Decree or Court Order to Insure Ex-Spouse or Child(ren) above.)*
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
Enrolling a spouse	Copy of marriage license or Page 1 of federal tax return
Enrolling a stepchild	Copy of the birth certificate (long form) 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 copy of letter on company letterhead 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 age 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

Documentation quick reference

Type of action	Documentation required
Optional Life (adding or increasing when evidence of insurability is required)	Copy of Notification Statement from Securian
Retirement — Disability	Copy of approval letter from the S.C. Retirement Systems or Standard Insurance Company
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. *Cannot be done outside open enrollment or finalized divorce by subscribers with MoneyPlus.*
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

A. Action	B. Enrollee	C. Plan/Dates	D. Certification
LEFT EMPLOYMENT: enter last day worked and check applicable reason	#1-7	Effective date and all plans in which enrolled	COBRA and/or Conversion for OL (if applicable). Sign and date.
TRANSFER TO: new group ID # and group name	#1-7	Effective date and all plans in which enrolled	COBRA and/or Conversion for OL (if applicable). Sign and date.
MILITARY LEAVE	#1-7	Effective date and all plans in which enrolled	COBRA and/or Conversion for OL (if applicable). Sign and date.
NONPAYMENT	#1-7	Effective date and all plans in which enrolled	Conversion for OL (if applicable). Sign and date.
SERVICE RETIREMENT: must meet criteria for PEBA Retirement Benefits annuity payment and retiree insurance (eligibility rules in IBG)	#1-7	Effective date and all plans in which enrolled	COBRA, Retiree and Conversion or Continuation for OL (if applicable). Sign and date.
DISABILITY: approved for BLTD/SLTD and/or PEBA Retirement Benefits disability	#1-7	Effective date and all plans affected by termination (OL can be continued). Do not terminate OL if in waiver; complete OL waiver form	COBRA, Retiree and Conversion or Continuation for OL (if applicable). Sign and date.
DECEASED: enter date of death	#1-7	Effective date and all plans in which enrolled	Sign and date only.

Affordable Care Act 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 his 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	Jan. 1 to Dec. 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. The employer should 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 for 12 months. This is the period of time that an employee cannot lose eligibility for benefits regardless of the number of hours he works. If the employee is deemed eligible for coverage during the Initial Administrative Period, he remains eligible for 12 months as long as he remains employed by the employer.
Applies to all ongoing employees	
Standard Measurement Period	Begins on Oct. 4 and ends 12 months later, on Oct. 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 Oct. 3 and ends Dec. 31. This is the period of time 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 Oct. 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 Jan. 1 and ends 12 months later on Dec. 31. This is the period of time that an ongoing employee cannot lose eligibility for benefits regardless of the number of hours he works. If the employee is deemed eligible for coverage during the Administrative Period, he remains eligible for the entire plan year as long as he remains employed with the employer.

For more information on the Affordable Care Act, including frequently asked questions, go to http://www.peba.sc.gov/aca.html.

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, he becomes an ongoing employee and his hours should be reviewed during the open enrollment period (with all other ongoing employees) to determine his eligibility for benefits in the next plan year.

Month employee began work	Initial measurement period (*12 months*)	Administrative period	Initial stability period (*12 months*)
	Begins the 1st of the month after the date of hire. During this period, an employer would measure the employee's hours.	*Immediately follows the Initial Measurement Period. Employer should review the hours worked during the Initial Measurement Period. If the employee averages 30 hours or more per week, he is eligible for benefits.*	*Immediately follows the Administrative Period. If the employee is deemed eligible for benefits during the Administrative Period, this is the period of time the employee remains eligible for benefits regardless of the number of hours worked.*
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 that is 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)	Eligibility for health, dental and vision continue through the end of the stability period. Employer should send the employee the Your Insurance Benefits When Your Hours are Reduced form.	Employee pays employee's share; employer pays employer's share. If employee fails to pay within the grace period, employer can submit an Active Termination Form to PEBA to terminate coverage. Employee is not eligible for COBRA.	Employee may choose to voluntarily drop coverage to enroll in the Marketplace. If employee elects to drop coverage for this reason, employer should submit the Active Termination form to PEBA.	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 were terminated, employee may enroll with medical evidence.
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	If employee returns to work with same employer as a variable-hour, part-time or seasonal employee: Less than a 13-week break (26-weeks if academic employer), the initial measurement period continues. 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
New full-time employee (Employee is not in a stability period nor on FMLA nor on military leave)	Eligibility for active benefits ends first of the month following employee's last day of paid work or first of the month following his reduction of hours. Employer sends employee the Your Insurance Benefits When Your Hours are Reduced form. Employer submits Active Termination form to PEBA and send the 18-month COBRA notice to employee.	Refer to COBRA rates	Employee and covered dependents may continue coverage through COBRA for up to 18 months (COBRA qualifying event is a reduction of hours)	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.

Newly eligible employee checklist

At your option, you may wish to have new employees sign a statement, confirming that you reviewed all eligible benefits with them as outlined in this checklist. PEBA does not require this; it is only for your information and records.

Review with your new employee

Eligibility rules checklist

- ☐ Employee
- ☐ Spouse
- ☐ Children

Health insurance

- ☐ Plans available
- ☐ Effective date
- ☐ SHP benefits, including Prescription Drug Program, mental health/substance abuse coverage, provider networks, preventive benefits, tobacco cessation
- ☐ Preventive Workplace Screening benefit (if SHP primary coverage) and other health and wellness programs
- ☐ Preauthorization requirements for some services
- ☐ Review rates and tobacco surcharge
- ☐ If employee refuses health coverage, he forfeits Basic LTD and Basic Life
- ☐ *Enrollment*: must wait until next open enrollment period or special eligibility situation if not enrolled within 31 days of date of hire

State Dental Plan and Dental Plus

- ☐ Benefits
- ☐ Fee schedule and allowed amounts
- ☐ Review rates
- ☐ *Enrollment*: must wait until next open enrollment period or special eligibility situation if not enrolled within 31 days

State Vision Plan

- ☐ Benefits
- ☐ Rates
- ☐ *Enrollment*: must wait until next October enrollment period or within 31 days of loss of other vision coverage

Vision Care Discount Program

- ☐ Discount program
- ☐ Cannot combine benefits (double dip) with State Vision Plan benefits, if enrolled in State Vision Plan

Basic Life

- ☐ Benefits, including AD&D
- ☐ Must be enrolled in one of the health insurance plans
- ☐ Enrollment is automatic

Dependent Life-Child(ren)

- ☐ Coverage level: $15,000 each child
- ☐ Children who are not enrolled (not listed on NOE or SOC) will not be covered
- ☐ Monthly premium is $1.10, regardless of number of children covered
- ☐ Eligible children may be added throughout the year without providing evidence of insurability
- ☐ Explain the deferred effective date provision, if applicable.

Dependent Life-Spouse

- ☐ Coverage level options
- ☐ Benefits, including AD&D
- ☐ Review rates (based on subscriber's age)
- ☐ Evidence of insurability is required if the spouse is not added within 31 days of first eligibility, if spouse loses other coverage with a participating employer or for coverage greater than $20,000.
- ☐ Explain the deferred effective date provision, if applicable.

Optional Life

- ☐ Review coverage levels
- ☐ Benefits, including AD&D

If participating in the MoneyPlus pretax premium feature:

- ☐ May select, increase, decrease or cancel coverage within 31 days of a special eligibility situation (depending on the event)
- ☐ Submit evidence of insurability, during an enrollment period, if:
- ☐ Did not enroll within 31 days of hire date
- ☐ Did not enroll or increase coverage within 31 days of a special eligibility situation
- ☐ Cannot decrease or cancel the coverage, except during an enrollment period, if request is not made within 31 days of a special eligibility situation

If not participating in the MoneyPlus pretax premium feature:

- ☐ May select or increase coverage without evidence of insurability within 31 days of a special eligibility situation. Otherwise, may submit evidence of insurability year round to select or increase coverage.
- ☐ May decrease or cancel coverage effective the first of the month after request is made
- ☐ Review rates
- ☐ Rate increase by age category

Supplemental Long Term Disability

- ☐ Review benefits
- ☐ Pre-existing condition exclusion
- ☐ Medical evidence is required if not enrolled within 31 days of eligibility (year-round enrollment) and to reduce the benefit waiting period from 180 to 90 days.
- ☐ Review rates
- ☐ *Provide SLTD certificate of coverage ONLY if employee enrolls* (certificate is available on the PEBA website, under Forms).

Basic Long Term Disability

- ☐ Review benefits
- ☐ Pre-existing condition exclusion

- ☐ Enrollment is automatic if enrolled in a health plan
- ☐ *Provide BLTD certificate if enrolling in a health plan* (certificate is available on the PEBA website, under Forms).

MoneyPlus

For all employees:

- ☐ Review Pretax Group Insurance Premium Feature
- ☐ Review IRS restrictions — Spending Account changes only during enrollment period or within 31 days of a change in status
- ☐ Review administrative fees
- ☐ Review Dependent Care Spending Account (DCSA)
- ☐ Reimbursed through claim to WageWorks with receipt and tax ID of care provider. Sufficient funds must be in account.

If full-time permanent employee has already had one year of continuous employment at a participating employer:

- ☐ Review Medical Spending Account (MSA)
- ☐ Review optional myFBMC Card® and where it may be used
- ☐ Reimbursed through claim to WageWorks (direct deposit option; $5 reimbursement minimum):
- ☐ MSA (full election amount available the first day of the plan year):
  1. With receipts for all services and supplies and Explanation of Benefits forms reflecting deductible and coinsurance amounts.
  2. Through myFBMC Card® (no follow-up documentation required for transactions involving mail-order prescription drug purchases and other fixed, known copayments; otherwise documentation required).

If full-time permanent employee is enrolling in the Savings Plan:

- ☐ Review Health Savings Account (HSA) (changes allowed monthly)
- ☐ Review debit card, checks, fees, account access and future availability of investment options (do *not* give investment advice)
- ☐ Review option of limited-use Medical Spending Account (dental and vision expenses)
- ☐ Direct employee to HSA online enrollment link through PEBA's website at www.peba.sc.gov.

NOE checklist

Newly eligible employee

- ☐ The Active NOE which is sent to PEBA must have the subscriber's original signature.
- ☐ Complete the BA USE ONLY area, sign and date the NOE and attach any appropriate documentation, including the Certification Regarding Tobacco Use form.
- ☐ No alterations appear (strikeovers, correction fluid, multiple checks, etc.) in the coverage areas (blocks #21-28).
- ☐ The employee selected coverage or checked refuse for all programs.
- ☐ No alterations appear in the beneficiary designation area (block #29).
- ☐ SSNs and dates of birth for spouse and/or children are complete and, if applicable, state-covered spouse is indicated.
- ☐ No ditto marks or same as above written in.
- ☐ The NOE is dated and signed by the employee (#31).
- ☐ The NOE is dated and signed by the BA (#32).
- ☐ Any required documents are attached with a paper clip to the NOE:
    - Certification Regarding Tobacco Use form
    - Marriage (copy of marriage license, Page 1 of federal tax return or notarized Continuing Marriage Affidavit)
    - Divorce (divorce decree or court order to cover ex-spouse and/or children)
    - Common law marriage (notarized Common Law Marriage Affidavit signed by both parties)
    - Child (copy of birth certificate [long form] showing the subscriber as the parent)
    - Stepchild (copy of birth certificate [long form] showing name of natural parent plus proof natural parent and subscriber are married)
    - Incapacitated Child Certification Form
    - Custody or guardianship (court order or other legal documentation from a placement agency or DSS, granting custody or guardianship of child/foster child to the subscriber). Documentation must verify guardianship responsibility and not merely financial responsibility.
    - Adoption/placement for adoption (legal adoption documentation from the court or letter of placement verifying the adoption in progress)
- ☐ Each attachment has the employee's name, SSN and the plan designation.
- ☐ Keep a copy of the NOE and any documentation for your file and forward appropriate payroll deduction form(s).
- ☐ Upon enrollment, send the COBRA initial notification to the employee and to the spouse, if the spouse and/or children are covered.

NOE checklist

Part-time employee

- ☐ No alterations appear (strikeovers, correction fluid, multiple checks, etc.) in the coverage areas (blocks #20-24).
- ☐ The Part-Time (NOE) is dated and signed by the employee (block #28).
- ☐ The employee made a coverage selection or checked refuse for health and dental and marked **Refuse** or **Yes** for Dental Plus.
- ☐ Any required documents are attached with a paper clip to the NOE:
    - Certification Regarding Tobacco Use form
    - Marriage (copy of marriage license, Page 1 of federal tax return or notarized Continuing Marriage Affidavit)
    - Divorce (divorce decree or court order to cover ex-spouse and/or children)
    - Common law marriage (notarized statement signed by both parties)
    - Child (copy of birth certificate [long form] showing the subscriber as the parent)
    - Stepchild (copy of birth certificate [long form] showing name of natural parent plus proof natural parent and subscriber are married)
    - Incapacitated Child Certification Form
    - Custody/guardianship (court order or other legal documentation from a placement agency or DSS, granting custody or guardianship of child/foster child to the subscriber). Documentation must verify guardianship responsibility and not merely financial responsibility.
    - Adoption/placement for adoption (legal adoption documentation from the court or letter of placement, verifying the adoption in progress)
- ☐ Each attachment has the employee's name, SSN and the plan designation.
- ☐ The SSN and date of birth for spouse and/or children are complete and, if applicable, indicates whether the employee’s spouse is employed by a participating employer.
- ☐ Complete the BA USE ONLY area, sign and date the NOE and any appropriate documentation. Use a paper clip to attach documentation to the NOE.
- ☐ Keep a copy of the NOE and any documentation for your file and forward appropriate payroll deduction form(s).

Coverage termination checklists

Termination of employment due to resignation, RIF, dismissal, reduction in hours: *not eligible as a retiree* (T5)

- ☐ Complete an Active Termination Form (unless terminating coverage using EBS).
  - *Effective date:* first of the month after the last day worked.
  - **Forward a copy of the form to PEBA immediately. Do NOT delay!**
  - If the employee had a MoneyPlus *Medical Spending Account*, send a copy of the termination form or SOC to WageWorks' Benefits Continuation Department immediately. WageWorks will send the Medical Spending Account COBRA qualifying event letter to the employee.
    - The employee may continue the Medical Spending Account for the rest of the year on an **after-tax basis** through COBRA.
    - The employee may continue the Medical Spending Account for the rest of the year on a **pretax basis** if:
      i. the employee elected in advance, on his last enrollment form, to accelerate his pretax deductions up to the full, annual amount; or
      ii. the remainder of his full, annual election was deducted from his final paycheck(s).
- ☐ Notify WageWorks' Deduction Management Department of *all* MoneyPlus terminations. Provide the employee's name, SSN, termination date, employer name, group number, your name and your number.
- ☐ Offer the employee and his spouse and/or children COBRA enrollment information by letter.
  - Send an 18-month COBRA qualifying event notice to the employee.
  - Send an 18-month COBRA qualifying event notice to the spouse, if the spouse and/or children are
    covered.
  - Put a copy of the COBRA notice in the employee's file.
- ☐ Refer to Section E, COBRA subscribers, for additional information.
- ☐ If the terminating employee's spouse is a covered employee or retiree, the terminating employee may be added to the spouse's coverage and other eligible programs within 31 days.
- ☐ If enrolled within 31 days:
  - The employee may convert Basic Life, Optional Life, Dependent Life-Spouse and/or Dependent Life-Child coverage.
  - The employee may convert SLTD coverage if he meets all the criteria listed in the IBG.
  - The employee may continue to contribute to the Health Savings Account directly through Wells Fargo. To be eligible to contribute, he must be covered under the Savings Plan or other high deductible health plan.

Termination of employment and transferring to another participating employer (TT)

- ☐ Complete an Active Termination Form, indicating the group name and number to which the employee is transferring.
  - **Forward a copy of the form to PEBA immediately. Do not delay.**
- ☐ Offer the employee and his spouse and/or children COBRA enrollment information by letter.

Refer to Transfers in Section D, Transfers and Terminations, for additional information.

Termination of employment due to retirement (service or disability): (T2/disability retirement, T7/service retirement/TERI)

- ☐ Complete an Active Termination (unless terminating coverage using EBS).
  - *Effective date:* first of the month after retirement eligibility has been established. If it is a disability, the effective date will be the first of the month following the date on the approval letter from PEBA Retirement Benefits (disability retirement), or The Standard (BLTD/SLTD) in certain situations. For more information on retirement eligibility, refer to the *Insurance Benefits Guide*.
  - **Forward a copy of the form to PEBA immediately. Do NOT delay!**
  - Attach a copy of the Employment Verification Record form to the Retiree NOE. Attach a Certification Regarding Tobacco Use form, if the subscriber's tobacco use status has changed.
- ☐ If service retirement, also:
  - Offer retiree enrollment information.
  - Document in the employee's file the date you gave or mailed the retiree materials.
- ☐ Offer the employee and his spouse and/or children COBRA enrollment information by letter. Refer to Section E, COBRA Subscribers, for additional information.
  - Send an 18-month COBRA qualifying event notice to the employee.
  - Send an 18-month COBRA qualifying event notice to the spouse, if the spouse and/or children are covered.
  - Put a copy of the COBRA notice in the employee's file.
- ☐ If applicable, notify WageWorks' Deduction Management Department of the termination. Provide the employee's name, SSN, termination date, employer name, group number, your name and your work number.
  - If the employee had a MoneyPlus *Medical Spending Account*, send a copy of the termination form or SOC to WageWorks' Benefits Continuation Department immediately. WageWorks will send the Medical Spending Account COBRA qualifying event letter to the employee.
    - The employee may continue the Medical Spending Account for the rest of the year on an **after-tax basis** through COBRA.
    - The employee may continue the Medical Spending Account for the rest of the year on a **pretax basis** if:
    1. the employee elected in advance, on his last enrollment form, to accelerate his pretax deductions up to the full, annual amount; or
    2. the remainder of his full, annual election was deducted from his final paycheck(s).

Refer to the Retiree Subscribers section of this manual for additional information.

Termination due to death of subscriber (T1)

- ☐ Complete an Active Termination Form (unless terminating coverage using EBS).
  - *Effective date:* day after date of death, except for Optional Life (date of death).
  - **Forward a copy of the form and the death certificate/documentation to PEBA immediately. Do not delay.**
- ☐ Complete the Notice of Death and send it, along with coverage verification and beneficiary information to Securian. If the death was accidental, attach the police/accident report, newspaper article, etc., and write Accidental at the top of the form. For more information, see Page J-7 for procedures on filing the Optional Life claim with Securian.
- ☐ **If the employee had a Medical Spending Account, send a copy of the termination form or SOC to WageWorks' Benefits Continuation Department, by mail or fax to 850.425.6220** (address on back of

form). WageWorks must send timely COBRA notification to IRS-qualifying spouse, children and beneficiaries. Also, notify WageWorks' Deduction Management Department of the death. Provide the employee's name, SSN, date of death, employer name, group number, your name and your work number.

- ☐ **If the employee was receiving disability benefits, send a copy of the Notice of Death to The Standard** so that any potential benefits may be paid to eligible survivors**.**
- ☐ Explain survivor benefits to any covered spouse and/or children.

Refer to Section G, Survivors, for additional information.

Termination due non-payment of premiums (TN)

- ☐ Termination is effective the first of the month following the last month in which premiums were due and paid in full.
- ☐ Local subdivisions should complete the appropriate NOE to terminate coverage for retiree, COBRA and survivor subscribers.
- ☐ If the subscriber is terminated due to non-payment 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 children must wait until the next open enrollment period or until a special eligibility situation occurs and enroll as late entrants. (Exception: **State Vision Plan.** Employees can enroll themselves and/or their covered spouse and/or children during the next October enrollment period if they miss their 31-day window of opportunity.)

Termination during military leave (TM)

- ☐ If not continuing coverage during leave, refer to the information in Military Leave in Section C, Active Subscribers.
- ☐ A copy of the employee's military orders is required.
- ☐ If the employee does not continue coverage during military leave, coverage may be reinstated within 31 days of returning to work.

Termination of covered spouse and/or child

- ☐ Explain to the employee that coverage changes must be made within 31 days of special eligibility situation. *Exception*: **State Vision Plan.** Coverage changes may be made during the next October enrollment period.
- ☐ Complete an Active NOE to terminate coverage and change coverage level, if applicable.
  - o Forward a copy of the form to PEBA.
  - o Attach any supporting documentation, if applicable (divorce decree, proof of other coverage, etc.). If the subscriber's tobacco use status has changed, attach a completed Certification Regarding Tobacco Use form.
- ☐ Complete and send WageWorks a MoneyPlus Change in Status Form if the employee is making a change to his Medical Spending Account or Dependent Care Spending Account.

- ☐ Send COBRA qualifying event letter to covered spouse and/or children. For more information, refer to Section E, COBRA Subscribers.
- ☐ If the spouse or child 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.
- ☐ Complete the Notice of Death and send it, along with coverage verification and beneficiary information to Securian for Dependent Life benefits.
- ☐ If applicable, complete and send WageWorks a MoneyPlus Change in Status Form if the employee is making a change to his Medical Spending or Dependent Care Spending account.

Retiree orientation checklist

- ☐ Verify *before* the employee retires that he meets *all* criteria for retiree insurance eligibility.
- ☐ Explain eligibility rules, based on the employee's original hire date. The eligibility rules are explained in the retirement chapter of the IBG.
- ☐ Explain local subdivision funding, if applicable.
- ☐ Explain that enrollment is not automatic; retirees must enroll within 31 days of eligibility as explained in the IBG.
- ☐ Explain that retirement is a special eligibility situation, allowing the retiree to enroll/drop health, dental and/or vision insurance.

Health Insurance

- ☐ Review health plan options and rates:
  - If not eligible for, or enrolled in, Medicare
    - If the employee and his eligible spouse and/or children are not eligible for Medicare, he cannot choose the Medicare Supplemental Plan.
  - If eligible for, or enrolled in, Medicare
    - When eligible for 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 his BA or PEBA as soon as he becomes eligible.
    - Subscribers covered by the Medicare Supplemental Plan or the Standard 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 he remains enrolled in the Medicare Part D plan sponsored by PEBA. If the retiree enrolls in a separate Part D plan, he loses prescription drug coverage with his plan through PEBA.
    - 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 Use form to the Retiree NOE.
- ☐ Eligible to participate in a Preventive Worksite Screening if enrolled in the SHP as primary coverage.
- ☐ *Enrollment*: must wait until next open enrollment period or special eligibility situation if not enrolled within 31 days of retirement.

State Dental Plan and Dental Plus

- ☐ Review benefits and rates.
- ☐ *Enrollment*: must wait until next open enrollment period of an odd-numbered year or special eligibility situation if not enrolled within 31 days of retirement.

State Vision Plan and Vision Care Discount Program

- ☐ Review State Vision Plan benefits and rates.
- ☐ *Enrollment*: 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.
- ☐ Let retiree know eligibility for the Vision Care Discount Program continues.

Life Insurance

- ☐ Explain the option to continue Basic Life through conversion.

- ☐ Explain the option to continue or convert Optional Life and the option to convert Dependent Life.
  - *If the employee is eligible for retirement benefits through PEBA Retirement Benefits,* he may choose to continue OR convert his Optional Life coverage with Securian.
    - If the employee wants to *continue* coverage, the BA must complete and sign the Notice of Group Life Insurance and give it to the employee. The employee must complete and sign the Retiree Life Continuation Election form and send it and the Notice of Group Life Insurance to Securian. Securian must receive the two forms within 31 days of the date coverage is lost due to approved retirement or approved disability retirement.
    - If the employee wants to *convert* his Optional Life or Dependent Life coverage, the BA must complete and sign the Notice of Group Life Insurance and give it to the employee. The employee should contact Securian at 866-365-2374 to discuss the conversion option. Securian will send the employee a Conversion of Group Life Insurance Enrollment form. The employee completes the Conversion of Group Life Insurance Enrollment form and mails it, along with the Notice of Group Life Insurance form and the first premium payment, to Securian. Securian must receive the forms within 31 days of the date the employee's group life insurance coverage ends.
  - *If the employee is not eligible for retirement benefits through PEBA Retirement Benefits,* his only choice is to convert Optional Life coverage.

Long Term Disability (BLTD and SLTD)

- ☐ BLTD coverage ends at retirement.
- ☐ SLTD coverage ends at retirement.

MoneyPlus

- ☐ Explain that MoneyPlus is not available in retirement (This does not apply to HSAs). Generally, an employee's period of coverage for the flexible spending accounts will end at retirement, with these exceptions.
- ☐ A Medical Spending Account participant may accelerate his pretax deductions, to extend his period of coverage through the end of the plan year. Otherwise, he may continue coverage on an after-tax basis through COBRA as explained in the IBG.
- ☐ A retiree may 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 Wells Fargo or other HSA trustee, not through WageWorks.

Additional Information to Explain

- ☐ The retiree will receive from PEBA:
  - A letter from PEBA, confirming retiree coverage.
  - A Certificate of Creditable Coverage, since active benefits are ending.
  - A COBRA notification letter, since active benefits are ending. (BA to send the Qualifying Event Notice according to procedures in Section E, COBRA Subscribers.)
- ☐ Premiums for health, dental and vision may be paid directly from his PEBA Retirement Benefits annuity payment, if the annuity payment is enough to cover the premiums.
  - *Exception*: PEBA bills local subdivisions 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 processing time, more than one month's premiums may be deducted from the first retirement check.

- ☐ If retiring due to disability, a copy of the disability approval letter from PEBA Retirement Benefits or Standard Insurance Company 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 or The Standard (if retiree is a State ORP participant or if employer is not a covered employer through 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 he is unable to do so.
- ☐ The employee should complete and submit a Long Term Disability Claim Form packet to The Standard. The BA may apply on behalf of the employee if he is unable to do so.
- ☐ 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 may continue MoneyPlus while on disability leave. If the employee does not wish to continue MoneyPlus, notify WageWorks' Deduction Management that the employee is on leave and will not be continuing his 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 Section I, Disability Subscribers.

Claims checklist

- ☐ Make sure you are using the proper claim form for the program as instructed in Section J, Claims and Appeals.
- ☐ Be certain that 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 himself and for his 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 receipts. Note: 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, submit a separate check for these premiums. See also Submitting Premium Payments to PEBA on Page.
- ☐ 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' Financial Services Department, using the mailing address below.
- ☐ If there is a keying error on the coverage processing section of the bill, please call the Customer Contact Center at 803.737.6800 or at 888.260.9430.
- ☐ If you have a question about the Account Summary or Billing Summary, call PEBA' 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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South Carolina Public Employee Benefit Authority

Peggy G. Boykin, CPA, Executive Director

Address:

202 Arbor Lake Drive

Columbia, SC 29223

Phone:

803.737.6800

888.260.9430

Office Hours:

8:30 a.m. - 5 p.m.

www.peba.sc.gov