south carolina peba SM
state health plan | retirement systems

FALL 2018

benefits ADVANTAGE

What's new for 2019?

Funded retiree premiums will not increase in 2019. This includes:

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

The employer premiums for the three plans will increase by 7.4 percent. Premiums for non-funded retirees, survivors and COBRA subscribers also increased. See Pages 9-12 for premiums.

Patient cost-sharing increases

Some patient cost-sharing features, such as copayments and deductibles, will increase for Standard Plan members. Learn more on Page 8.

Adult well visits

Adult well visits will be a covered benefit under the Standard Plan, subject to copayments, deductibles and coinsurance in covered years. Learn more on Page 4.

Continued on Page 2

Inside

It's time to make choices for 2019

The 2018 *Benefits Advantage* details your insurance options for 2019. The newsletter includes changes you can make during open enrollment. This takes place October 1-31, 2018.

The 2019 *Insurance Benefits Guide* (IBG) contains descriptions of all PEBA-sponsored insurance benefits. The guide is available online at www.peba.sc.gov/iresources.html.

Reminders

- Satisfied with your current coverage? You do not need to do anything during open enrollment.
- Any changes that you make during open enrollment take effect January 1, 2019.

What's new for 2019?

Continued from Page 1

Naturally Slim®

This 10-week, online program will teach the behavioral skills necessary to lose weight and keep it off long-term. Learn more on Page 6.

Express Script's Preferred90 retail maintenance network for Medicare members

Medicare primary members enrolled in the Express Scripts Medicare drug plan can fill their 90-day supply of medication at a participating Preferred90 maintenance network pharmacy for a reduced copayment. Learn more on Page 5.

Insurance Benefits Guide

The 2019 *Insurance Benefits Guide* will be available online at www.peba.sc.gov/iresources.html.

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

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

Here's what you can do during 2018 open enrollment

Open enrollment is October 1-31, 2018. Any coverage changes that you make will take effect January 1, 2019. Happy with your current coverage? You do not need to do anything. You will be re-enrolled for 2019, and your coverage will continue.

Health options

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

If you change to the Savings Plan during October, the change will go into effect January 1, 2019. You may also sign up for a Health Savings Account (HSA). You can enroll in an HSA through any institution that offers an HSA.

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

No Dental changes for 2019

Changes to dental coverage may only be made during open enrollment in odd-numbered years. Your next opportunity to make changes in dental coverage is October 2019 for January 1, 2020.

State Vision Plan

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

Follow up on your changes

In January, log in to MyBenefits at MyBenefits.sc.gov. Select Review Benefits from the drop-down list to see your 2019 benefits. If you notice any discrepancies, contact PEBA or, if you retired from a local subdivision, your former employer immediately.

Open enrollment made easy – MyBenefits is the quickest, simplest way to make changes

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

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

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

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

To allow your changes, you will need to enter the last four digits of your Social Security number and click Sign. Your changes are not complete until you submit your electronic signature. You should also print a copy of the Summary of Change for your records. Some coverage changes need supporting documentation. PEBA must receive the documents by December 1 to approve the changes.

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

Reminders

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

Important reminders when you qualify for Medicare

- Be sure to enroll in Medicare Part A and Part B. If you do not enroll in Part B, you will have to pay the part of your health care costs that Part B would have paid.
- If you or one of your dependents qualify for Medicare because of a disability, you should enroll in the Medicare Supplemental Plan. To enroll, submit a *Notice of Election* form within 31 days of eligibility. Be sure to include a copy of your Medicare card with your form.
- PEBA enrolls Medicare-eligible retirees and Medicare-eligible dependents in the State Health Plan Medicare Prescription Drug Program. Subscribers may be better served if they remain enrolled in this prescription program.
- Benefits offered by the Standard Plan and Medicare Supplemental Plan vary. This is especially true in how each plan coordinates with Medicare. For more information, see the *Insurance Coverage for the Medicare-eligible Member* handbook at www.peba.sc.gov/iresources.html.

Standard Plan covers adult well visits beginning January 1, 2019

Well visits may be a key part of preventive care. They can reassure you that you are as healthy as you feel, or prompt you to ask questions about your health. Evidence-supported services, based on United States Preventive Services Task Force (USPSTF) A and B recommendations, are included as part of an adult well visit under the State Health Plan. After talking with your doctor during a visit, the doctor can decide which services you need and build a personal care plan for you. Learn more about adult well visits at www.peba.sc.gov/wellvisits.html.

How the benefit works

Adult well visits are subject to copayments, deductibles and coinsurance in covered years. If you have not met your deductible, you will pay the $14 copayment plus the remaining allowed amount for the visit. If you have met your deductible, you will pay the $14 copayment plus your 20 percent coinsurance for the visit.

Who is eligible?

The benefit is available to all non-Medicare primary adults age 19 and older who are covered by the Standard Plan. Adult members can take advantage of this benefit at an eligible network provider. Eligible female members may use their well visit at their gynecologist or their primary care physician, but not both, in a covered year. If a female visits both doctors in the same covered year, only the first routine office visit received will be allowed. See the Cervical cancer screening section on Page 5 for information about how a Pap test is covered.

Frequency of visits

The Plan will only cover one visit in covered years, based on the following schedule:

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

Savings Plan members

Beginning January 1, 2019, Savings Plan member's covered well visits will include evidence-supported services based on USPSTF A and B recommendations at an eligible network provider. The Plan will cover a well visit every year for Savings Plan members at no member cost.

How to get the most out of your State Health Plan benefits

The State Health Plan offers many value-based benefits at no member cost to primary members through PEBA Perks. You may continue to take advantage of these services. Learn how the preventive screening and cervical cancer screening benefits work with your adult well visit below.

Preventive screening

You can receive a biometric screening at no cost to you, and the screening includes comprehensive blood work with lipid panels, as well as:

- A health risk appraisal;
- Blood pressure screening; and
- Height and weight measurements.

You will receive a confidential report, and we recommend you share it with your doctor to eliminate the need for retesting at a well visit. Doing this will minimize cost to you, since only a lipid panel and a glucose panel are covered as part of a well visit.

Continued on Page 5

State Health Plan covers Shingrix vaccine at no cost

State Health Plan primary members age 50 and older can receive the Shingrix vaccine for a $0 copayment. Shingrix is a new vaccine to prevent shingles. The Centers for Disease Control and Prevention (CDC) recommends adults age 50 and older receive the vaccine to prevent shingles and the complications of the disease.

Shingrix is a two dose vaccination. After the initial shot is administered, a second shot will be required within two to six months to complete the vaccination process. Even if you received the Zostavax vaccination, you are encouraged to get the Shingrix vaccine. You should talk to our healthcare provider to determine the best time to get the Shingrix vaccine.

The State Health Plan covers adult vaccinations as recommended by the CDC at no cost to the member through PEBA Perks. You can receive a vaccination at a network pharmacy without a prescription. Medicare primary members should receive the vaccination from a network pharmacy since it is included in their Part D coverage. If you receive the shot in a network doctor's office, coverage includes the cost of the vaccine and administration fee. Any associated office visit charges will follow regular Plan coverage rules. Learn more at www.PEBAPerks.com.

Adult well visits

Continued from Page 4

Cervical cancer screening

If you are a female ages 18-65, you can receive a routine Pap test each calendar year. In years in which Standard Plan members are not eligible for an adult well visit, the Standrad Plan will cover the cost of the Pap test and the part of the office visit associated with it. You will be responsible for the remainder of the cost for the well visit in those years. You can receive an HPV test in combination with a Pap test once every five years at no member cost if you are ages 30-65.

Services not included as part of an adult well visit

Services not included as part of the adult well visit are those without an A or B recommendation by the USPSTF. Find these at www.USPreventiveServicesTaskForce.org. Other services, including a complete blood count (CBC), EKG, PSA test and basic metabolic panel, if ordered by your physician to treat a specific condition may still be covered. These services are subject to copayment, deductible and coinsurance, as well as normal Plan provisions. Follow-up visits and services as a result of your well visit are also subject to normal Plan provisions.

Preferred90 network now available to Medicare members

As a Medicare primary member enrolled in the Express Scripts Medicare drug plan, you can fill a 90-day supply of your long-term medication for a reduced copayment under the State Health Plan. You will pay less when you ask your doctor to write your prescription for a 90-day supply and fill it at one of the participating Preferred90 network pharmacies.

You can continue to pay the three full copayments for a 90-day supply at a non-participating Preferred90 network pharmacy. You may also continue to fill a 30-day prescription at any participating pharmacy.

To find a participating retail maintenance pharmacy call Express Scripts at 855.612.3128 or search for a pharmacy online by logging into express-scripts.com. First-time visitors will need to register and should have their member ID number handy.

Get connected with PEBA

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

To add yourself to PEBA's insurance email list, register for MyBenefits. To add yourself to PEBA's retirement email list, register for Member Access.

Social media

Get access to other resources via PEBA's social media pages. Search for SCPEBA on Facebook and Twitter. On YouTube, search for PEBA TV.

On-the-go health info

Text messages are a great way to keep up with kids, friends and appointments. And now they can help you stay on top of your health.

Sign up for secure State Health Plan mobile messages. You'll get benefits information, health and wellness reminders and cost-saving tips.

Two easy ways to sign up

1. Call 844.284.5417 from your mobile phone.
2. Text PERKS to 735-29.

Data rates may apply.

New weight management program available

Learn the skills to lose weight and keep it off while still eating your favorite foods in this clinically proven online program. Naturally Slim will teach you it's not what you eat, but when and how you eat that will help you lose weight. Plus, you will reduce your risk for chronic diseases like diabetes and heart disease while increasing your chances of living a longer, healthier life. Naturally Slim is available at no cost to you. Learn more at www.naturallyslim.com/PEBA.

Who is eligible?

State Health Plan members age 18 and older can apply to participate. Medicare primary members are also eligible to apply. Some medical conditions or body mass indexes (BMIs) may prevent you from participating.

How it works

Naturally Slim is a 10-week, online program that uses weekly video lessons and interactive tools to teach the behavioral skills necessary to lose weight and keep it off long-term. Each week, you will watch lessons at your convenience on your computer, smartphone or tablet through the iPhone or Android apps. You will receive a full year of support after the first 10 weeks.

The program will help you create changes in your behavior by:

- Helping you develop a lifestyle of eating your favorite foods while still improving your health and losing weight.
- Teaching you to identify personal eating habits, recognize the difference between true hunger and psychological hunger, understand how hydration habits influence hunger and practice ways to minimize fat storage.
- Addressing how exercise, stress and your environment affect weight loss.

Scheduled program start dates

- November 5, 2018
- February 4, 2019
- May 6, 2019
- July 8, 2019
- September 23, 2019

How to participate

Visit www.naturallyslim.com/PEBA to apply.

Call ahead to get the green light for your care

Some medical and behavioral health services need preauthorization for the State Health Plan to provide coverage. This means you or your provider need to make a phone call. Not calling for preauthorization may lead to a $490 penalty. Preauthorization does not guarantee payment.

Medical services

To preauthorize your medical treatment, call Medi-Call at 800.925.9724. Contact Medi-Call at least two business days before:

- Inpatient care in a hospital, including admission to a hospital to have a baby.
- An outpatient service that results in a hospital admission.
- Outpatient surgery for a septoplasty (surgery on the septum of the nose).
- Outpatient or inpatient surgery for a hysterectomy.
- Sclerotherapy (vein surgery).
- Chemotherapy or radiation therapy.
- Admission to a long-term care facility or nursing facility.
- Ordering durable medical equipment.
- In vitro fertilization or other infertility procedures.
- An organ transplant.
- Inpatient rehabilitation services and related outpatient physical, speech or occupational therapy.

Pregnancy

You should contact Medi-Call within the first three months of a pregnancy.

Emergencies

In a hospital emergency, you should contact Medi-Call within 48 hours of admission.

Behavioral health services

To preauthorize your behavioral services, call Companion Benefit Alternatives at 800.868.1032.

- Inpatient hospital care.
- Intensive outpatient hospital care.
- Partial hospitalization care.
- Outpatient electroconvulsive therapy.
- Repetitive transcranial magnetic therapy.
- Applied behavioral analysis therapy.
- Psychological/neuropsychological testing.

Radiology services

To preauthorize your radiology services, call National Imaging Associates at 866.500.7664.

- CT scan.
- MRI.
- MRA.
- PET scan.

Have you moved? Let us know!

It is particularly important that you keep your address up to date with PEBA. This ensures that you receive benefits information, including Internal Revenue Service Form 1095. You will receive Form 1095 by January 31. The form shows you have minimum essential health insurance coverage which the federal Affordable Care Act requires. You can use MyBenefits to change your address in our system.

Health benefits offered for 2019

The following chart illustrates how your deductible, copayments and coinsurance work together, as well as other features of the Standard, Savings and Medicare Supplemental plans. This overview is for comparison only. The *Plan of Benefits*, which includes a complete description of the plan, governs the Standard, Savings and Medicare Supplemental plans offered by the state. It is available at www.peba.sc.gov/assets/planofbenefits.pdf.

Plan	Standard Plan	Savings Plan
Annual deductible	You pay up to **$490** per individual or **$980** per family.	You pay up to **$3,600** per individual or **$7,200** per family.[1]
Coinsurance[2] Maximum excludes copayments and deductible.	In network, you pay **20%** up to **$2,800** per individual or **$5,600** per family.	In network, you pay **20%** up to **$2,400** per individual or **$4,800** per family.
Physicians' office visits[3]	You pay a **$14** copayment plus the remaining allowed amount until you meet your deductible. Then, you pay the copayment plus your coinsurance.	You pay the full cost until you meet your deductible. Then, you pay your coinsurance.
Blue CareOnDemand[SM]	You pay a **$14** copayment plus the remaining allowed amount until you meet your deductible. Then, you pay the copayment plus your coinsurance.	You pay the full cost until you meet your deductible. Then, you pay your coinsurance.
Outpatient facility/ emergency care[4,5]	You pay a **$105** copayment (outpatient services) or **$175** copayment (emergency care) plus the remaining allowed amount until you meet your deductible. Then, you pay the copayment plus your coinsurance.	You pay the full cost until you meet your deductible. Then, you pay your coinsurance.
Inpatient hosipitalization	You pay the full cost until you meet your deductible. Then, you pay your coinsurance	You pay the full cost until you meet your deductible. Then, you pay your coinsurance.
Chiropractic	**$2,000** limit per covered person	**$500** limit per covered person
Prescription drugs[6] 30-day supply/90-day supply at network pharmacy	• Tier 1 (generic): **$9/$22** • Tier 2 (preferred brand): **$42/$105** • Tier 3 (non-preferred brand): **$70/$175** You pay up to **$3,000** in prescription drug copayments.	You pay the allowed amount until you meet your annual deductible. Then, you pay your coinsurance. Drug costs are applied to your coinsurance maximum. When you reach the maximum, you can obtain medications at no cost.
	Medicare Supplemental Plan	
	In-network	
Availability	Same as Medicare and available to retirees and covered dependents/survivors who are eligible for Medicare.	
Annual deductible	Plan pays Medicare Part A and Part B deductibles.	
Coinsurance	Plan pays Part B coinsurance with no maximum.	
Physician's office visits	Plan pays Part B coinsurance of 20%.	
Inpatient hospitalization/ nursing facility care	**Inpatient hospital stays** Plan pays Medicare deductible, coinsurance for days 61-150 (Medicare benefits may end sooner if the member has previously used any of his 60 lifetime reserve days); Plan pays 100% beyond 150 days (Medi-Call approval required). **Skilled nursing facility care** Plan pays coinsurance for days 21-100; Plan pays 100% of approved days beyond 100 days, up to 60 days/year.	
Prescription drugs[6] 30-day supply/90-day supply at network pharmacy	• Tier 1 (generic): **$9/$22** • Tier 2 (preferred brand): **$42/$105** • Tier 3 (non-preferred brand): **$70/$175** You pay up to **$3,000** in prescription drug copayments	

Footnotes listed on Page 12

2019 monthly premiums for funded retirees[7, 8]

Retiree eligible for Medicare/spouse eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[9]	TRICARE Supp[8]	Dental	Dental Plus[10]	Vision
Retiree	$79.68	N/A	$97.68	N/A	$0	$27.12	$8.00
Retiree/spouse	$217.36	N/A	$253.36	N/A	$7.64	$54.80	$16.00
Retiree/children	$125.86	N/A	$143.86	N/A	$13.72	$63.20	$17.16
Full family	$270.56	N/A	$306.56	N/A	$21.34	$82.10	$25.16

Retiree eligible for Medicare/spouse not eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[9]	TRICARE Supp[8]	Dental	Dental Plus[10]	Vision
Retiree/spouse	$235.36	N/A	$253.36	N/A	$7.64	$54.80	$16.00
Full family	$281.54	N/A	$299.54	N/A	$21.34	$82.10	$25.16

Retiree not eligible for Medicare/spouse eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[9]	TRICARE Supp[8]	Dental	Dental Plus[10]	Vision
Retiree/spouse	$235.36	$77.40	$253.36	N/A	$7.64	$54.80	$16.00
Full family	$281.54	$113.00	$299.54	N/A	$21.34	$82.10	$25.16

Retiree not eligible for Medicare/spouse not eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[9]	TRICARE Supp[8]	Dental	Dental Plus[10]	Vision
Retiree	$97.68	$9.70	N/A	$62.50	$0	$27.12	$8.00
Retiree/spouse	$253.36	$77.40	N/A	$121.50	$7.64	$54.80	$16.00
Retiree/children	$143.86	$20.48	N/A	$121.50	$13.72	$63.20	$17.16
Full family	$306.56	$113.00	N/A	$162.50	$21.34	$82.10	$25.16

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

Plan	Standard Plan	Savings Plan	Medicare Supp[9]	TRICARE Supp[8]	Dental	Dental Plus[10]	Vision
Retiree/children	$143.86	$20.48	$161.86	N/A	$13.72	$63.20	$17.16
Full family	$306.56	$113.00	$324.56	N/A	$21.34	$82.10	$25.16

Footnotes listed on Page 12

2019 monthly premiums for non-funded retirees[7, 8]

Retiree eligible for Medicare/spouse eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[9]	TRICARE Supp[8]	Dental	Dental Plus[10]	Vision
Retiree	$482.38	N/A	$500.38	N/A	$13.48	$27.12	$8.00
Retiree/spouse	$1,015.04	N/A	$1,051.04	N/A	$21.12	$54.80	$16.00
Retiree/children	$743.92	N/A	$761.92	N/A	$27.20	$63.20	$17.16
Full family	$1,269.28	N/A	$1,305.28	N/A	$34.82	$82.10	$25.16

Retiree eligible for Medicare/spouse not eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[9]	TRICARE Supp[8]	Dental	Dental Plus[10]	Vision
Retiree/spouse	$1,033.04	N/A	$1,051.04	N/A	$21.12	$54.80	$16.00
Full family	$1,280.26	N/A	$1,298.26	N/A	$34.82	$82.10	$25.16

Retiree not eligible for Medicare/spouse eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[9]	TRICARE Supp[8]	Dental	Dental Plus[10]	Vision
Retiree/spouse	$1,033.04	$875.08	$1,051.04	N/A	$21.12	$54.80	$16.00
Full family	$1,280.26	$1,111.72	$1,298.26	N/A	$34.82	$82.10	$25.16

Retiree not eligible for Medicare/spouse not eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[9]	TRICARE Supp[8]	Dental	Dental Plus[10]	Vision
Retiree	$500.38	$412.40	N/A	$62.50	$13.48	$27.12	$8.00
Retiree/spouse	$1,051.04	$875.08	N/A	$121.50	$21.12	$54.80	$16.00
Retiree/children	$761.92	$638.54	N/A	$121.50	$27.20	$63.20	$17.16
Full family	$1,305.28	$1,111.72	N/A	$162.50	$34.82	$82.10	$25.16

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

Plan	Standard Plan	Savings Plan	Medicare Supp[9]	TRICARE Supp[8]	Dental	Dental Plus[10]	Vision
Retiree/children	$761.92	$638.54	$779.92	N/A	$27.20	$63.20	$17.16
Full family	$1,305.28	$1,111.72	$1,323.28	N/A	$34.82	$82.10	$25.16

2019 monthly premiums for former spouses[1, 2]

Plan	Standard Plan	Savings Plan	Medicare Supp[9]	Dental	Dental Plus[10]	Vision
Not eligible for Medicare	$550.66	$462.68	N/A	$21.12	$32.54	$8.00
Eligible for Medicare	$$532.66	N/A	$550.66	$21.12	$32.54	$8.00
COBRA (18 or 36 months)	$561.68	$471.94	$561.68	$21.54	$33.20	$8.16
COBRA (29 months)	$826.00	$694.02	$826.00	$21.54	$33.20	$8.16

Footnotes listed on Page 12

2019 monthly premiums for non-funded survivors[7, 8]

Spouse eligible for Medicare/children eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[9]	TRICARE Supp[8]	Dental	Dental Plus[10]	Vision
Spouse	$482.38	N/A	$500.38	N/A	$13.48	$27.12	$8.00
Spouse/children	$743.92	N/A	$779.92	N/A	$27.20	$63.20	$17.16
Children only	$261.54	N/A	$279.54[11]	N/A	$13.72	$36.08	$9.16

Spouse eligible for Medicare/children not eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[9]	TRICARE Supp[8]	Dental	Dental Plus[10]	Vision
Spouse	$482.38	N/A	$500.38	N/A	$13.48	$27.12	$8.00
Spouse/children	$743.92	N/A	$761.92	N/A	$27.20	$63.20	$17.16
Children only	$261.54	$226.14	N/A	N/A	$13.72	$36.08	$9.16

Spouse not eligible for Medicare/children eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[9]	TRICARE Supp[8]	Dental	Dental Plus[10]	Vision
Spouse	$500.38	$412.40	N/A	N/A	$13.48	$27.12	$8.00
Spouse/children	$761.92	$638.54	$779.92[11]	N/A	$27.20	$63.20	$17.16
Children only	$261.54	N/A	$279.54[11]	N/A	$13.72	$36.08	$9.16

Spouse not eligible for Medicare/children not eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[9]	TRICARE Supp[8]	Dental	Dental Plus[10]	Vision
Spouse	$500.38	$412.40	N/A	$62.50	$13.48	$27.12	$8.00
Spouse/children	$761.92	$638.54	N/A	$121.50	$27.20	$63.20	$17.16
Children only	$261.54	$226.14	N/A	$61.00	$13.72	$36.08	$9.16

2019 monthly premiums for COBRAs[7, 8]

18 and 36 months

Plan	Standard Plan	Savings Plan	Medicare Supp[9]	Dental	Dental Plus[10]	Vision
Subscriber	$510.40	$420.66	$510.40	$13.76	$27.66	$8.16
Subscriber/spouse	$1,072.06	$892.58	$1,072.06	$21.54	$55.90	$16.32
Subscriber/children	$777.16	$651.32	$777.16	$27.74	$64.46	$17.50
Full family	$1,331.40	$1,133.96	$1,331.40	$35.52	$83.74	$25.66
Children only	$266.76	$230.66	$266.76	$14.00	$36.80	$9.34

29 months

Plan	Standard Plan	Savings Plan	Medicare Supp[9]	Dental	Dental Plus[10]	Vision
Subscriber	$750.58	$618.60	$750.58	$13.76	$27.66	$8.16
Subscriber/spouse	$1,576.56	$1,312.62	$1,576.56	$21.54	$55.90	$16.32
Subscriber/children	$1,142.88	$957.82	$1,142.88	$27.74	$64.46	$17.50
Full family	$1,957.92	$1,667.58	$1,957.92	$35.52	$83.74	$25.66
Children only	$392.30	$339.22	$392.30	$14.00	$36.80	$9.34

Footnotes listed on Page 12

2019 monthly premiums for partially-funded retirees[7, 8, 12]

Retiree eligible for Medicare/spouse eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[9]	TRICARE Supp[8]	Dental	Dental Plus[10]	Vision
Retiree	$281.02	N/A	$299.02	N/A	$6.74	$27.12	$8.00
Retiree/spouse	$616.20	N/A	$652.20	N/A	$14.38	$54.80	$16.00
Retiree/children	$$434.88	N/A	$452.88	N/A	$20.46	$63.20	$17.16
Full family	$769.92	N/A	$805.92	N/A	$28.08	$82.10	$25.16

Retiree eligible for Medicare/spouse not eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[9]	TRICARE Supp[8]	Dental	Dental Plus[10]	Vision
Retiree/spouse	$634.20	N/A	$652.20	N/A	$14.38	$54.80	$16.00
Full family	$780.90	N/A	$798.90	N/A	$28.08	$82.10	$25.16

Retiree not eligible for Medicare/spouse eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[9]	TRICARE Supp[8]	Dental	Dental Plus[10]	Vision
Retiree/spouse	$634.20	$476.24	$652.20	N/A	$14.38	$54.80	$16.00
Full family	$780.90	$612.36	$798.90	N/A	$28.08	$82.10	$25.16

Retiree not eligible for Medicare/spouse not eligible for Medicare

Plan	Standard Plan	Savings Plan	Medicare Supp[9]	TRICARE Supp[8]	Dental	Dental Plus[10]	Vision
Retiree	$299.02	$211.04	N/A	$62.50	$6.74	$27.12	$8.00
Retiree/spouse	$652.20	$476.24	N/A	$121.50	$14.38	$54.80	$16.00
Retiree/children	$452.88	$329.50	N/A	$121.50	$20.46	$63.20	$17.16
Full family	$805.92	$612.36	N/A	$162.50	$28.08	$82.10	$25.16

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

Plan	Standard Plan	Savings Plan	Medicare Supp[9]	TRICARE Supp[8]	Dental	Dental Plus[10]	Vision
Retiree/children	$452.88	$329.50	$470.88	N/A	$20.46	$63.20	$17.16
Full family	$805.92	$612.36	$823.92	N/A	$28.08	$82.10	$25.16

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

[1] If more than one family member is covered, no family member will receive benefits, other than preventive benefits, until the $7,200 annual family deductible is met.

[2] Out of network, you will pay 40 percent coinsurance. An out-of-network provider may bill you more than the Plan's allowed amount. Learn more about out-ofnetwork benefits at www.peba.sc.gov/healthplans.html.

[3] The $14 copayment is waived for routine mammograms and well-child visits. Standard Plan members who receive care at a BlueCross-affiliated patient-centered medical home provider will not be charged the $14 copayment for a physician office visit. After Savings Plan and Standard Plan members meet their deductible, they will pay 10 percent coinsurance, rather than 20 percent, for care at a PCMH.

[4] The $105 copayment for outpatient facility services is waived for physical therapy, speech therapy, occupational therapy, dialysis services, partial hospitalizations, intensive outpatient services, electro-convulsive therapy and psychiatric medication management.

[5] The $175 copayment for emergency care is waived if admitted.

[6] Prescription drugs are not covered at out-of-network pharmacies.

[7] Premiums for optional employers may vary. To verify your rates, contact your benefits office.

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

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

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

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

[12] Partially-funded retirees who left employment after reaching retirement eligibility and have at least 15, but less than 25, years of earned service credit. And those who leave employment before retirement eligibility and have at least 20, but less than 25, years of earned service.

2019 insurance vendor contact information

BlueCross BlueShield of South Carolina

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

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

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

Medi-Call (medical preauthorization)

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

- 803.699.3337 or 800.925.9724
- Fax: 803.264.0183

Companion Benefit Alternatives (behavioral health)

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

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

Health coaching

- 855.838.5897
- Fax: 803.264.4204

National Imaging Associates (advanced radiology preauthorization)

- 866.500.7664
- www.RadMD.com

State Dental Plan, Dental Plus

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

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

Express Scripts

State Health Plan Prescription Drug Program, Express Scripts Medicare®

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

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

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

EyeMed

State Vision Plan (Group No.: 9925991)

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

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

Metropolitan Life Insurance Company

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

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

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

Selman & Company

TRICARE Supplement Plan

6110 Parkland Boulevard | Cleveland, OH 44124

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

The Standard Insurance Company

Long term disability (Group No.: 621144)

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

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

Federally mandated notices

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

Grandfathered notice

The S.C. Public Employee Benefit Authority believes the State Health Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

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

Summaries of Benefits and Coverage

The 2019 *Summaries of Benefits and Coverage* for the Standard Plan and Savings Plan are available online at www.peba.sc.gov/iresources.html. To request a copy at no charge, call PEBA at 803.737.6800 or 888.260.9430.

Notice of Privacy Practices

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

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

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

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

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

How PEBA may use and disclose protected health information

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

- **For treatment**. PEBA may use and disclose your protected health information to coordinate and manage your health

care-related services by one or more of your health care providers. For example, a representative of PEBA, a case manager and your doctor may discuss the most beneficial treatment plan for you if you have a chronic condition such as diabetes.

- **For payment**. PEBA may use and disclose your protected health information to bill, collect payment and pay for your treatment/services from an insurance company or another third party; to obtain premiums; to determine or fulfill its responsibility for coverage or provision of benefits; or to provide reimbursement for health care. For example, PEBA may need to give your protected health information to another insurance provider to facilitate the coordination of benefits or to your employer to facilitate the employer's payment of its portion of the premium.
- **For health care operations**. PEBA may use and disclose protected health information about you for other PEBA operations. PEBA may use protected health information in connection with conducting quality assessment and improvement activities; reviewing the competence or qualifications of health care professionals; evaluating practitioner, provider and health plan performance; underwriting, premium rating and other activities relating to health plan coverage; conducting or arranging for medical review, legal services, audit services and fraud and abuse detection programs; business planning and development such as cost management; and business management and general administrative activities. For example, PEBA may disclose your protected health information to an actuary to make decisions regarding premium rates, or it may share your protected health information with other business associates that, through written agreement, provide services to PEBA. These business associates, such as consultants or third-party administrators, are required to protect the privacy of your protected health information.
- **For purposes of administering the plan**. PEBA may disclose your protected health information to its Plan sponsor, the South Carolina Public Employee Benefit Authority, for the purpose of administering the Plan. For example, PEBA may disclose aggregate claims information to the Plan sponsor to set Plan terms.
- However, consistent with the Genetic Information Nondiscrimination Act (GINA), PEBA will not use or disclose, for underwriting purposes, protected health information that is genetic information.
- **Business associates**. PEBA may contract with individuals or entities known as Business Associates to perform various functions on PEBA's behalf or to provide certain types of services. For example, PEBA may disclose your protected health information to a Business Associate to process your claims for Plan benefits, pharmacy benefits, or other support services, but the Business Associate must enter into a Business Associate contract with PEBA agreeing to implement appropriate safeguards regarding your protected health information.
- **Treatment alternatives and health-related benefits and services**. PEBA may use and disclose your protected health information to contact you about health-related benefits or services that may be of interest to you. For example, you may be contacted and offered enrollment in a program to assist you in handling a chronic disease such as disabling high blood pressure.
- **Individuals involved in your care or payment for your care**. PEBA may, in certain circumstances, disclose protected health information about you to your representative such as a friend or family member who is involved in your health care, or to your representative who helps pay for your care. PEBA may disclose your protected health information to an agency assisting in disaster relief efforts so that your family can be notified about your condition, status and location.
- **Research**. PEBA may use and disclose your de-identified protected health information for research purposes or PEBA may share protected health information for research approved by an institutional review board or privacy board after review of the research rules to ensure the privacy of your protected health information. For example, a research project may compare the health/recovery of patients who receive a medication with those who receive another medication for the same condition.
- **As required by law**. PEBA will disclose protected health information about you when it is required to do so by federal or South Carolina law. For example, PEBA will report any suspected insurance fraud as required by South Carolina law.
- **To avert a serious threat to health or safety, or for public health activities**. PEBA may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety, or to the health and safety of the public, or for public health activities.

- **Organ and tissue donation**. If you are an organ donor, PEBA may disclose your protected health information to organizations that handle organ, eye or tissue procurement, transplantation or donation.
- **Coroners, medical examiners and funeral directors**. PEBA may share your protected health information with a coroner/medical examiner or funeral director as needed to carry out their duties.
- **Military and veterans**. If you are a member of the armed forces, PEBA may disclose protected health information about you after the notice requirements are fulfilled by military command authorities.
- **Workers' compensation**. PEBA may disclose protected health information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
- **Health oversight activities.** PEBA may disclose your protected health information to a health oversight agency for authorized activities such as audits and investigations.
- **Lawsuits and disputes**. PEBA may disclose your protected health information in response to a court or administrative order, a subpoena, discovery request, or other lawful process if PEBA receives assurance from the party seeking the information that you have either been given notice of the request, or that the party seeking the information has tried to secure a qualified protective order regarding this information.
- **Law enforcement**. PEBA may disclose information to a law enforcement official in response to a court order, subpoena, warrant, summons, or similar process.
- **National security, intelligence activities and protective services**. PEBA may disclose your protected health information to authorized officials for intelligence, counterintelligence and other national security activities; to conduct special investigations; and to provide protection for the President, other authorized persons or foreign heads of state.
- **Inmates**. If you are an inmate of a correctional institution or are in the custody of a law enforcement official, PEBA may disclose your protected health information if the disclosure is necessary to provide you with health care, or to protect your health and safety or the health and safety of others.
- **Fundraising**. PEBA will not use or release your protected health information for purposes of fund-raising activities.
- **Sale or marketing**. Your authorization is required for PEBA's use or disclosure of any PHI for marketing purposes, or for any disclosure by PEBA that constitutes the sale of PHI.

Your rights regarding your protected health information

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

- **Right to inspect and copy**. You have the right to request to see and receive a copy of your protected health information or, if you agree to the preparation cost, PEBA may provide you with a written summary. If PEBA maintains an electronic health record containing your protected health information, you have the right to request that PEBA send a copy of your protected health information in an electronic format to you. Some protected health information is exempt from disclosure. To see or obtain a copy of your protected health information, send a written request to: S.C. Public Employee Benefit Authority, Attn: HIPAA Privacy Officer, 202 Arbor Lake Drive, Columbia, SC 29223. PEBA may charge a fee for the costs associated with your request. In limited cases, PEBA may deny your request. If your request is denied, you may request a review of the denial.
- **Right to amend**. If you believe that your protected health information is incorrect or incomplete, you may ask PEBA to amend the information by sending a written request to: S.C. Public Employee Benefit Authority, Attn: HIPAA Privacy Officer, 202 Arbor Lake Drive, Columbia, SC 29223, stating the reason you believe your information should be amended. PEBA may deny your request if you ask it to amend information that was not created by PEBA , the information is not part of the protected health information kept by or for PEBA , the information is not part of the information you would be permitted to inspect and copy or your protected health information is accurate and complete. You have the right to request an amendment for as long as PEBA keeps the information.
- **Right to an accounting of disclosures**. You have the right to request a list of the disclosures of your protected health

information PEBA has made. This list will NOT include protected health information released to provide treatment to you, to obtain payment for services or for health care operations; releases for national security purposes; releases to correctional institutions or law enforcement officials as required by law; releases authorized by you; releases of your protected health information to you; releases as part of a limited data set; releases to representatives involved in your health care; releases otherwise required by law or regulation and releases made prior to April 14, 2003. You must submit your request for an accounting of disclosures in writing to: S.C. Public Employee Benefit Authority, Attn: HIPAA Privacy Officer, 202 Arbor Lake Drive, Columbia, SC 29223, indicating a time period that may not go back beyond six years. Your request should indicate the form in which you want the list (for example, by paper or electronically). The first list that you request within a 12-month period will be provided free of charge; however, PEBA may charge you for the cost of providing additional lists within a 12-month period.

- **Right to request restrictions of use and disclosure**. You have the right to request a restriction on the protected health information that PEBA uses or discloses. You also have the right to request a limit on the protected health information that PEBA discloses about you to someone who is involved in your care or the payment for your care. Please note that the protected health information collected by PEBA is not used for any other purpose than as necessary for the administration of your benefits as described above and is kept confidential pursuant to the requirements of state and federal law, including the protections under HIPAA and HITECH. PEBA is not required to agree to your request(s). If PEBA does agree, PEBA will comply with your request(s) unless the information is needed to provide you with emergency treatment. In your request, you must specify what information you want to limit and to whom you want the limits to apply. You must make these request(s), in writing, to: S.C. Public Employee Benefit Authority, Attn: HIPAA Privacy Officer, 202 Arbor Lake Drive, Columbia, SC 29223
- **Right to request confidential communications**. You have the right to request that PEBA communicate about your protected health information by alternative means or to an alternative location to avoid endangering you. PEBA will accommodate your request if (a) it is reasonable, (b) you state clearly that failure to communicate your protected health information by the alternative means or to the alternative location could endanger you, and (c) you provide reasonable alternative means or location for communicating with you. You must make these request(s), in writing, to: S.C. Public Employee Benefit Authority, Attn: HIPAA Privacy Officer, 202 Arbor Lake Drive, Columbia, SC 29223.
- **Right to restrict release of information for certain services**. Unless the disclosure is required by law, you have the right to restrict the disclosure of information regarding services for which you have paid in full or on an out-of-pocket basis. This information can be released only upon your written authorization.
- **Right to a paper copy of this notice**. You have the right to request a paper copy of this notice at any time by contacting PEBA's HIPAA Privacy Officer at: S.C. Public Employee Benefit Authority, Attn: HIPAA Privacy Officer, 202 Arbor Lake Drive, Columbia, SC 29223. You may obtain a copy of this notice at PEBA's website at www.peba.sc.gov
- **Right to breach notification**. You have the right to be notified of any breach of your unsecured protected health information.

Complaints

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

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

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

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

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

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

Changes to this notice

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

Other uses of protected health information

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

HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after our or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, contact your benefits administrator.

Women's Health and Cancer Rights Act

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 803.737.6800 or 888.260.9430 for more information.

Newborn's and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

New Health Insurance Marketplace coverage options and your health coverage

PART A: General information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2018 for coverage starting as early as January 1, 2019.

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

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

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

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

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

How can I get more information?

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

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

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

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1.877.KIDSNOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1.866.444.EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility.

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1.855.692.5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1.877.357.3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1.866.251.4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP) Phone: 404.656.4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1.855.MyARHIPP (855.692.7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1.877.438.4479 All other Medicaid Website: http://www.indianamedicaid.com Phone: 1.800.403.0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1.800.221.3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+: Customer Service: 1.800.359.1991/State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1.888.346.9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1.785.296.3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603.271.5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1.800.635.2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609.631.2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1.800.701.0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1.888.695.2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1.800.541.2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1.800.442.6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919.855.4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1.800.462.1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1.844.854.4825

MINNESOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1.800.657.3739	Website: http://www.insureoklahoma.org Phone: 1.888.365.3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573.751.2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1.800.699.9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1.800.694.3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1.800.692.7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1.855.632.7633	Website: http://www.eohhs.ri.gov/ Phone: 401.462.5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1.800.992.0900	Website: https://www.scdhhs.gov Phone: 1.888.549.0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1.888.828.0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1.800.562.3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1.800.440.0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1.877.598.5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1.877.543.7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1.800.362.3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1.800.250.8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307.777.7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm	Medicaid Phone: 1.800.432.5924 CHIP Phone: 1.855.242.8282

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1.866.444.EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1.877.267.2323, Menu Option 4, Ext. 61565

Medicare Part D creditable coverage letter

Important notice from PEBA about your prescription drug coverage and Medicare

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

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

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (such as a health maintenance organization or preferred provider organization) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. PEBA offers Express Scripts Medicare and the State Health Plan Prescription Drug Program to members enrolled in Medicare. It has determined that the prescription drug coverage offered through the Standard Plan or the Medicare Supplemental Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays. It is therefore considered creditable coverage. Because your existing coverage is creditable coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare prescription drug plan.

When can you join a Medicare prescription drug plan?

You can join a Medicare prescription drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period to join a Medicare prescription drug plan.

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

If you decide to join a Medicare prescription drug plan other than the one sponsored by PEBA, you will lose your prescription drug coverage provided through your health plan with PEBA, and your premiums will not decrease. Please note that you and your dependents will be able to get this coverage back.

Before you decide to switch to other Medicare prescription drug coverage and drop your PEBA coverage, you should compare your PEBA coverage, including which drugs are covered, with the coverage and cost of any plans offering Medicare prescription drug coverage in your area.

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1 percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19 percent higher than the Medicare base beneficiary premium.

You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact PEBA at the address or telephone number listed below.

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

For more information about your options under Medicare prescription drug coverage

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

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

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

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

Contact PEBA for further information.

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

S.C. Public Employee Benefit Authority
202 Arbor Lake Drive
Columbia, SC 29223
803.737.6800 | 888.260.9430
www.peba.sc.gov

How much health insurance do you need?

Do you have more than one Medicare supplement plan? You only need one supplement to traditional Medicare. Having too much health insurance can cost you more. It can also cause claims issues as insurance companies try to determine who the primary payer is.

Are you eligible for Medicare and TRICARE for Life? If so, you don't need the State Health Plan Medicare Supplemental Plan. Open enrollment is the perfect time to drop unneeded insurance. You can still keep your dental and vision coverage even if you don't have the health insurance.

Members enrolled in the Medicare Supplemental Plan do not need to enroll in a Medicare Advantage plan. The two plans do not coordinate and Medicare Supplemental Plan members have prescription drug coverage included in their plan.

If changes occur, you can always re-enroll in the Medicare Supplemental Plan. You may do so within 31 days of the change. You can switch to the Medicare Supplemental Plan during any open enrollment period. Your effective date of coverage would be the following January 1.

south carolina peba
state health plan | retirement systems

202 Arbor Lake Drive
Columbia, SC 29223

Where should you go when you need care?

Primary care physician

Your primary care physician, or regular doctor, is the best option for medical care, such as:

- Managing your chronic condition.
- Health screenings, immunizations.
- Prescription refills.
- Cold and flu symptoms, including fever, coughing, sore throat and mild nausea.
- Migraines.
- Minor cuts and bruises.
- Pinkeye.
- Rashes, insect bites, sunburn and other skin irritations.
- Seasonal allergies.
- Sinus or respiratory infections.
- Sprained muscles.
- Urinary tract infections.

Blue CareOnDemand℠

If your doctor's office is closed, you're traveling or you feel too sick to drive, a Blue CareOnDemand video visit is a great option. Using your computer or mobile device, you can see a doctor who can diagnose your symptoms and call in a prescription to your local pharmacy if needed. Use Blue CareOnDemand for nonemergency health issues, such as:

- Cold and flu symptoms, including fever, coughing, sore throat and mild nausea.
- Migraines.
- Pinkeye.
- Rashes, insect bites, sunburn and other skin irritations.
- Seasonal allergies.
- Sinus or respiratory infections.
- Urinary tract infections.

Emergency room

Go to the ER or call 911 for very serious or life-threatening conditions, such as:

- Coughing up or vomiting blood.
- Heavy, uncontrolled bleeding.
- Loss of consciousness or sudden dizziness.
- Major injuries such as broken bones or head trauma.
- Severe allergic reactions.
- Signs of a heart attack, such as chest pain that lasts more than two minutes.
- Signs of stroke, such as numbness, sudden loss of speech or vision.

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