# 2019 *Insurance Education and Orientation* script

**Slide 1**

Hello, and welcome to PEBA's 2019 *Insurance Orientation and Education* presentation.

We're going to walk you through the insurance benefit options you have available to you as an active employee. We'll also show you key resources that can help you use your benefits effectively.

**Slide 2**

First let's talk quickly about eligibility. To be eligible for insurance benefits through PEBA, you must work for the state, a higher education institution, a public school district or another participating entity, like a county government or municipality, as a full-time employee; and receive compensation from the state, a higher education institution, a public school district or other entity allowed by law to participate.

Spouses and children may also be eligible to be covered as dependents. To be eligible for coverage in retirement, retirees must meet certain eligibility requirements. More information about eligibility is available in the *Insurance Benefits Guide*.

**Slide 3**

Deciding on your insurance coverage doesn't have to be overwhelming. While some information can get quite complex, consider these basic factors when trying to decide what coverage to elect – premiums, deductibles, copayments, coinsurance and prescription costs.

**Slide 4**

It's easy to get lost in all the information about available benefits, but we'll go over your options in six steps: health plans, dental plans, vision coverage, additional life insurance, supplemental long term disability and MoneyPlus, which is a tax-favored accounts program. We'll also show you the deductibles, copayments, coinsurance, premiums, fees and coverage schedules you should know.

**Slide 5**

It's important to remember that this presentation is just an introduction, not a comprehensive description of PEBA's insurance benefits.

While you're making decisions, review our publications to see which benefits best meet your needs. The *Insurance Summary* gives an overview of the available benefits and includes a worksheet to help you plan your insurance coverage. You may want to have your copy handy during this presentation. The *Insurance Benefits Guide* provides a more detailed look at the insurance benefits. Both of these publications are on our website, www.peba.sc.gov, too.

**Slide 6**

The *Navigating Your Benefits* series includes flyers and videos, which give you plain-language explanations of your benefits. Check out these resources at www.peba.sc.gov/nyb.html.

**Slide 7**

The first choice is the big one, so we'll spend the most time on it – choosing your health plan. Your selection may affect the other decisions you make, too.

Your insurance needs are as unique as you are. Maybe you meet your deductible every year or maybe you can't remember the last time you saw a doctor. No matter your situation, the State Health Plan gives you two options to cover your expenses: the Standard Plan or the Savings Plan. PEBA also offers the TRICARE Supplement Plan to eligible members of the military community. Details about the health plan options are on Pages 2-3 of the *Insurance Summary*.

**Slide 8**

The State Health Plan is a self-funded plan. This means the premiums you pay as an employee and those your employer pays on your behalf do not go to an insurance company, but are instead placed in a trust fund. PEBA pays member claims and the Plan's administrative expenses from this fund.

If you're wondering how BlueCross BlueShield of South Carolina fits into the equation, it is the third-party administrator of the State Health Plan. BlueCross processes medical claims and provides other support.

The State Health Plan is a great value to South Carolina's public workforce. If you want to see how it stacks up to other plans, you can check out the benchmarks found on our website. Proactive health management is a key way to maintaining low costs. We'll talk about the many health and wellness benefits available to you later.

**Slide 9**

The State Health Plan has worldwide coverage. You are responsible for paying copayments, deductibles and coinsurance. When you use a network provider, the provider files the claim and accepts the allowed amount as payment in full. The allowed amount is the maximum amount you may pay a network provider for a covered service.

The Plan also provides some coverage if you use out-of-network providers. However, you may have to file your own claims and the provider may bill you for the difference between the allowed amount and the provider's actual charge. You'll pay a higher coinsurance, too.

You can find network providers near you at StateSC.SouthCarolinaBlues.com.

**Slide 10**

The annual deductible is the amount you pay for covered services before the Plan begins to pay. The Standard Plan deductible is $490 per individual or $980 per family. The Savings Plan, which is a high deductible plan, has much higher deductibles. It's $3,600 per individual or $7,200 per family.

Don't make your health plan choice too quickly though. Let's compare the other features of the two plans first.

**Slide 11**

After you meet your deductible, the Plan begins to pay a percentage of your costs. This is known as coinsurance. No matter which plan you choose, you'll pay 20 percent coinsurance at a network provider. Your coinsurance goes up to 40 percent if you use out-of-network providers.

There's also a coinsurance maximum. If you pay that amount in a given year, you no longer pay coinsurance. For the Standard Plan, the maximum is $2,800 per individual or $5,600 per family. For the Savings Plan, it's $2,400 per individual or $4,800 per family. Keep this in mind because the coinsurance maximum may become important if you have a major medical issue.

**Slide 12**

Copayments are the fixed amounts you pay for a covered service or drug, and you pay them in addition to your coinsurance. You will also continue pay a copayment even if you meet your coinsurance maximum.

Copayments vary depending on the type of service. For the Standard Plan, a visit to a doctor's office has a $14 copayment. Before you meet your deductible, you pay the $14 copayment plus the remaining allowed amount for the service. After you meet your deductible, you pay the $14 copayment plus your coinsurance.

The Savings Plan does not have copayments. Before you meet your deductible, you pay the full cost of services. After you meet your deductible, you only pay your coinsurance.

Blue CareOnDemand offers video visits to State Health Plan members as an alternative to a traditional office visit. A video visit is covered just like a traditional office visit. You can learn more at www.BlueCareOnDemandSC.com.

**Slide 13**

The Standard Plan also has copayments for other services. For an outpatient service, it's $105 and for emergency care, it's $175. Again, if you haven't met your deductible, you pay the copayment plus the remaining allowed amount. Once you meet your deductible, you pay the copayment plus your coinsurance. Remember, copayments don't apply to the Savings Plan.

Inpatient hospitalization works the same for both the Standard Plan and Savings Plan. You pay the full cost until you meet your deductible. Then, you only pay your coinsurance.

**Slide 14**

Prescription drugs are only covered at network pharmacies. The Standard Plan provides prescription drug payments for the copayment only with no coinsurance amount. Drugs are categorized into tiers.

The copayment for a Tier 1 generic 30-day supply is $9. For a Tier 2 preferred-brand, the copayment is $42 for a 30-day supply. It's $70 for a 30-day supply of a Tier 3 non-preferred brand drug.

For a 90-day supply, copayments are $22 for Tier 1, $105 for Tier 2 and $175 for Tier 3. The most you'll pay for prescription drug copayments is $3,000. Once you reach that maximum, you pay nothing.

Under the Savings Plan, you pay the allowed amount for prescriptions until you meet your annual deductible. Then, you only pay your coinsurance.

**Slide 15**

In addition to the State Health Plan, PEBA offers the TRICARE Supplement Plan to those eligible for TRICARE through the military. The Plan, administered by Selman & Company, provides secondary coverage to TRICARE. Members of this plan don't pay deductibles, coinsurance or out-of-pocket expenses for covered services.

PEBA does not confirm eligibility for the TRICARE Supplement Plan. Instead, the individual must register with the Defense Enrollment Eligibility Reporting System. Eligibility requires that the person isn't eligible for Medicare and doesn't have State Health Plan coverage.

**Slide 16**

Your monthly premium is determined by your plan and coverage level. You have four coverage level options: yourself; yourself and your spouse; yourself and your children; and your full family. If you work for an optional employer, your premiums may vary.

**Slide 17**

State Health Plan subscribers who use tobacco or cover dependents who use tobacco are charged an additional monthly premium. For subscriber-only coverage, the premium is $40 per month. It's $60 per month for other levels of coverage.

To avoid this charge, you must certify that neither you nor any covered dependents have used tobacco in the last six months, or that all covered tobacco users have completed the Quit For Life tobacco cessation program.

**Slide 18**

After you've figured out coverage for your health plan, you can move on to your dental coverage.

Keep in mind you can only change your dental coverage once every two years during open enrollment in odd-numbered years. Let's take a look at your options. Details about the dental coverage options are on Page 4 of the *Insurance Summary*.

**Slide 19**

You have two options for dental coverage. Your first option is the State Dental Plan. It has four classes of treatment, and pays different percentages of the allowed amount for each class, ranging from 50 to 100 percent.

Each covered person has a maximum $1,000 benefit each year for Classes I, II and III. Each covered child has a $1,000 lifetime benefit for Class IV. Details about the types of services in each class are on Page 4 in the *Insurance Summary*.

**Slide 20**

You can also elect Dental Plus, which provides more coverage with the added benefit of a higher allowed amount. It also gives you deeper discounts and lower out-of-pocket expenses. To participate, you must enroll in basic coverage and cover the same family members under both plans.

With Dental Plus, the maximum benefit goes up to $2,000 each year for Classes I, II and III. There is no additional benefit for Class IV.

**Slide 21**

Just like with health coverage, your monthly premium is determined by your plan and coverage level. You'll notice there is no premium for employee-only basic coverage. If you elect Dental Plus, you must cover the same family members as you do for Basic Dental. You will pay the premium for both plans.

**Slide 22**

Good vision is crucial for work and play, but it's also a significant part of your health. An annual eye exam can help detect serious illnesses. Let's take a look at vision coverage available to you. More details are also available on Page 5 of the *Insurance Summary*.

**Slide 23**

If you elect to enroll in the State Vision Plan, you'll pay the full premium without an employer contribution. The Plan's coverage includes comprehensive eye exams, frames, lenses and lens options, and contact lens services and materials.

You can also receive discounts on extra pairs of eyeglasses, contact lenses and LASIK and PRK vision correction. The Plan also offers coverage for diabetics, including office service visits and retinal imaging. If needed, you may choose either to get frames and lenses or contact lenses each year. You cannot get both in the same plan year.

**Slide 24**

You can receive an annual comprehensive eye exam under the State Vision Plan. If you use a network provider, you won't have to file claims for the Plan to pay. You'll pay a $10 copayment for an eye exam at a network provider and up to $39 for retinal imaging.

Visit www.EyeMed.com to find a network provider.

**Slide 25**

If you opt for frames and lenses, you have a $150 allowance at a network provider. Then, you'll pay 80 percent of remaining balance. You can obtain standard plastic lenses for a $10 copayment or standard progressive lenses for a payment of up to $35.

For premium progressive lenses, you'll pay a set amount from $35 to $80, depending on the tier. Tier 4 you'll pay 80 percent of the remaining cost over a $120 allowance.

For out-of-network providers, you may receive some reimbursement for your expenses.

**Slide 26**

There are no copayments if you opt for contact lenses. A standard contact lens fit and follow-up visit at a network provider has no cost. For a premium contact lenses fit and follow-up, you'll receive 10 percent off the retail price less a $55 allowance.

As for the lenses themselves, conventional contact lenses offer a $130 allowance and you will pay 85 percent of the remaining cost. For disposable contact lenses, you also have a $130 allowance, but you will pay the full balance over this amount.

Just like with frames, you may be reimbursed for some of your expenses at out-of-network providers.

**Slide 27**

Again, your monthly premium is determined by your coverage level. Here are the 2019 monthly premiums for the State Vision Plan.

**Slide 28**

Next up, you need to decide whether you want additional life insurance coverage. We say "additional" because when you enroll in the State Health Plan, you are automatically enrolled in Basic Life insurance at no cost.

You can choose more coverage for yourself, your spouse and your children. Details about the life insurance are on Page 6 of the *Insurance Summary*, but let's take a look at your options now.

**Slide 29**

This basic policy offers $3,000 in term life insurance coverage with a matching amount of Accidental Death and Dismemberment, or AD&D, insurance. As mentioned earlier, you are automatically enrolled in Basic Life insurance at no cost if you enroll in the State Health Plan.

**Slide 30**

Beyond the basic coverage, you can choose Optional Life insurance for yourself in increments of $10,000 up to a maximum of $500,000.

When you first become eligible, you are guaranteed an amount of coverage within the first 31 days. This means you don't have to provide medical evidence of insurability. The guaranteed amount is three times your annual earnings or $500,000, whichever is less. Medical evidence is required for additional coverage and if you decide to add coverage after your initial eligibility.

With Optional Life, you also get a matching amount of AD&D insurance. It's important to note that your coverage will automatically reduce once you reach certain ages, beginning at age 70.

**Slide 31**

Dependent Life-Spouse insurance is available in increments of $10,000 up to a maximum of $100,000 or 50 percent of your Optional Life coverage amount, whichever is less.

You can get spouse coverage even if you aren't enrolled in Optional Life. In this case, it's available in the amounts of $10,000 or $20,000. Medical evidence is required for additional coverage and if you decide to add coverage after your initial eligibility.

At initial eligibility, you are guaranteed Dependent Life-Spouse coverage up to $20,000. This means you do not have to provide medical evidence for this coverage when you enroll.

Dependent Life-Spouse also has a matching amount of AD&D insurance.

**Slide 32**

Dependent Life-Child insurance is available in the set amount of $15,000 per child. You can add eligible children at any time without evidence of insurability. Children are eligible from live birth until age 19. The limit extends to age 25 if the child is a full-time student who is primarily dependent on you for financial support.

If both parents are eligible to provide coverage through PEBA, each child can only be covered by one parent.

**Slide 33**

For Optional Life and Dependent Life-Spouse coverage, the premium is based on yours or your spouse's age as of the previous December 31 and the coverage amount. You will pay the rates seen here for each $10,000 in coverage.

The premium for Dependent Life-Child coverage, is $1.26 per month and covers all children for which you have a policy.

**Slide 34**

Only two more steps to go. Let's talk about long term disability, which helps protect a portion of your income if you become disabled. As with life insurance, when you enroll in the State Health Plan, you are automatically enrolled in Basic Long Term Disability at no cost. You can opt for supplemental long term disability protection for added protection. We'll take a look at your options and you can find more information about the disability coverage on Page 7 of the *Insurance Summary*.

**Slide 35**

As a reminder, you are automatically enrolled in Basic Long Term Disability, or BLTD, at no cost if you enroll in the State Health Plan. This plan has a 90-day benefit waiting period and offers a monthly benefit equal to 62.5 percent of your predisability earnings, up to a maximum of $800.

**Slide 36**

Supplemental Long Term Disability, or SLTD, is a voluntary benefit for which you pay, and is available with competitive group rates.

You have a choice of two plans if you wish to add SLTD coverage. Those plans offer a 90-day or 180-day benefit waiting period, which is the time you must be disabled before benefits become payable. If you begin receiving a benefit, it will be 65 percent of your predisability earnings, reduced by any deductible

income you receive. A SLTD monthly benefit will not be less than $100 or greater than $8,000. Your maximum benefit period is determined by your age when your disability begins.

**Slide 37**

As with life insurance premiums, SLTD premiums take into account your age. To calculate your monthly premium, find the premium factor for the plan you elected that applies to your age group and multiply it by your monthly earnings.

**Slide 38**

Finally, we've made it to your last decision, which are the options available through the MoneyPlus tax-favored accounts program. Don't leave money on the table. With MoneyPlus accounts, you can save money on eligible medical and dependent care costs. You fund the accounts with money deducted pretax from your paycheck. More information is available on Pages 8-9 of the *Insurance Summary*, but we'll review a few details next.

**Slide 39**

Some of your choices for MoneyPlus depend on whether you elected the State Health Plan Standard Plan or Savings Plan in Step 1.

If you are eligible to enroll in the State Health Plan, you are also eligible for a Medical Spending Account, or MSA. Standard Plan members will find it particularly useful to pay for eligible medical expenses, copayments and coinsurance. It's easy to use your funds, too. As you have eligible expenses, you can use a debit card for your account or submit claims for reimbursement. A new feature in 2019 is the ability to carry over up to $500 of unused funds into the next plan year. Keep in mind you will forfeit any unused funds over $500 though, and that you must re-enroll in your MSA each year.

**Slide 40**

If you elected the Savings Plan, you can make the most out of your high-deductible plan with a Health Savings Account, or HSA. An HSA is essential to help you prepare for your health expenses. Funds carry over year to year, and you can even take the account with you if you leave your job. While there's an annual contribution limit, there's no limit to how much you can save over time. This allows you to build up your savings to pay for eligible expenses in retirement. Once your balance reaches $1,000, you can invest the funds to earn investment income tax-free. To contribute pretax from your paycheck, you must open a health savings bank account with Central Bank, the custodian bank for HSAs.

**Slide 41**

If you open an HSA, you are also eligible to enroll in a Limited-use MSA. You can use this account to pay for expenses not covered by the Savings Plan, like dental or vision care expenses. This account works the same way as the traditional MSA we talked about a few minutes ago.

**Slide 42**

There are some MoneyPlus options available no matter which health plan you chose. The Pretax Group Insurance Premium feature lets you pay premiums before taxes for health, vision, dental and up to

$50,000 of Optional Life insurance coverage each year. Once you enroll in the feature, you don't have to re-enroll each year.

**Slide 43**

Everyone is also eligible for a Dependent Care Spending Account. This account can be used for child and adult daycare costs, but not for dependent medical care. You submit claims for reimbursement as you have eligible expenses. The funds you put into it for 2019 can only be used for expenses incurred between January 1, 2019, and March 15, 2020. You will forfeit any unused funds and you must re-enroll in the account each year.

**Slide 44**

MoneyPlus charges monthly fees for its accounts, including $2.32 each for an MSA, a Limited-use MSA and a Dependent Care Spending Account. You will pay a fee for each account in which you enroll, and the fees will be deducted from your paycheck.

Fees work a little differently for an HSA. You'll pay an annual fee, which is deducted monthly from your paycheck. You'll also pay a maintenance fee to Central Bank if your balance is less than $2,500. There is an additional monthly fee if you choose paper statements, too. The Central Bank fees are deducted from your actual account.

**Slide 45**

The IRS sets limits on how much you can contribute to the MoneyPlus accounts each year. Some of the limits are based on your health plan coverage level and some are based on your tax filing status.

**Slide 46**

You'll need to remember deadlines when using any kind of account other than an HSA.

You can only incur expenses for the MSA and Limited-use MSA through December 31, 2019, but you can carry over up to $500 of unused funds into the next plan year. You forfeit any funds left in your account over $500 after the reimbursement deadline of March 31, 2020.

For the Dependent Care Spending Account, you can incur expenses through March 15, 2020, but the reimbursement deadline is still March 31, 2020.

**Slide 47**

Now that we've reviewed your insurance options, it's time to enroll.

**Slide 48**

To help plan your coverage, use the worksheet in the back of your *Insurance Summary*. While the worksheet is not an election of benefits, it will help you to complete the enrollment process.

**Slide 49**

If you're a new hire and enrolling for the first time, you have 31 days from your date of hire to make your elections. Special eligibility situations are life events, such as marriage, childbirth or adoption. You

may be able to make changes to your coverage within 31 days of these situations. To actually enroll, contact your benefits administrator for your next steps.

**Slide 50**

Open enrollment takes place every year from October 1 to October 31. The changes you make during open enrollment take effect the following January 1. If you are happy with your current coverage, the only thing you need to do during this time is re-enroll in Money Plus accounts. You can change most of your coverage each year, but can only make changes to dental coverage during open enrollment odd-numbered years.

To make the actual changes, log in to MyBenefits at mybenefits.sc.gov. Your benefits administrator can help you, if needed.

**Slide 51**

Now, let's talk about some of the tools that can help you make the best use of your benefits.

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Mobile apps give you access to your benefits no matter where you are. The My Health Toolkit® app is for your health and dental coverage. The Express Scripts app shows you details about your prescription benefits. The EyeMed app shows you your State Vision Plan coverage, and you can manage your MoneyPlus accounts with the ASIFlex app. Learn more about what you can do in each of the apps on Page 10 of the *Insurance Summary*.

**Slide 53**

When you have a claim for a service, you'll receive an Explanation of Benefits, or EOB. The EOB shows you how much your provider charged and how much the State Health Plan paid. You'll also see the amount for which you are responsible. Keep in mind that the amount will not include any payments you've already made for the service. To be a smart health care consumer and make sure you don't pay more than you should, always look at your EOB and compare it to your doctor's bill.

You can easily access your EOBs in the My Health Toolkit® app. If you want to go green, log in to My Health Toolkit and select online delivery as your preference.

**Slide 54**

It's important to also know where you should go for care when you need it. Your primary care physician should be your first call for routine medical care or unexpected health issues. But what if your doctor's office is closed? Or it's an emergency? Avoid needless worry, out-of-pocket expenses and hours sitting in the emergency room by knowing your health care options.

Blue CareOnDemand offers 24/7 video visits for State Health Plan primary members. It's a good choice when you have a health issue after hours, when you're traveling or when you feel too sick to drive to an office.

If you have a very serious or life-threatening condition though, you should always go to the ER or call 911.

**Slide 55**

Beginning in 2019, the Standard Plan covers adult well visits. Well visits may be a key part of preventive care and can reassure you that you are as healthy as you feel, or prompt you to ask questions about your health.

Adult well visits are subject to copayments, deductibles and coinsurance. If you haven't met your deductible, you will pay the $14 copayment plus the remaining allowed amount for this visit.

Services included in the well visit are evidence-based services with an A and B recommendation by the United States Preventive Task Force.

**Slide 56**

All non-Medicare primary adults ages 19 and older can take advantage of the benefit at an eligible network provider. The schedule of coverage depends on the age of the member. For those ages 19 to 39, a well visit is available every three years. For ages 40-49, it increases to once every two years, and at age 50 and after, members can have a covered well visit every year.

Eligible females can choose to use their well visit at their gynecologist or with 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.

**Slide 57**

Also beginning in 2019, the covered well visits for Savings Plan members include evidence-supported services based on USPSTF A and B recommendations at an eligible network provider. The Plan covers a well visit every year for these members at no member cost, regardless of the member's age.

**Slide 58**

The State Health Plan offers PEBA Perks to primary members. These are value-based benefits available at no cost to you. See how you can take advantage of these benefits on Pages 18-19 of the *Insurance Summary* and at www.PEBAperks.com.

**Slide 59**

Naturally Slim is a 10-week online program that uses video lessons and interactive tools to teach the behavioral skills necessary to lose weight and keep it off long-term, all while still eating your favorite foods. The program is available to State Health Plan primary members ages 18 and older. Visit www.naturallyslim.PEBA to learn more and apply.

**Slide 60**

Your choice of doctor is, of course, among the most important decisions to make about your health care. A patient-centered medical home, or PCMH, promotes ongoing, personal relationships between you, your primary care physician and a dedicated care team. In a PCMH, your providers coordinate care to make it personalized and consistent. This approach is helpful for people with chronic medical conditions, but anyone can go to a PCMH.

As another benefit, copayments are waived for Standard Plan members who receive care at a PCMH. Plus, Standard and Savings Plan members pay a 10 percent coinsurance rather than 20 percent after meeting their deductible.

You can find PCMH locations near you at www.StateSC.SouthCarolinaBlues.com.

**Slide 61**

Some medical or behavioral health services may require preauthorization for the State Health Plan to provide coverage. This means that either you or your provider needs to make a phone call. Not calling for preauthorization may lead to a $490 penalty. Learn what services require preauthorization and find who to call on Page 22 of the *Insurance Summary*.

**Slide 62**

This ends our presentation, but we recognize it doesn't end your decision-making process. After you dig into coverage details in the *Insurance Summary*, you may still have questions. If so, please reach out to us online or by phone.

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Before we go, we invite you to follow our social media channels for up-to-date information about PEBA benefits. We're on Facebook, Twitter, YouTube, Podbean and LinkedIn.

PEBA—Serving those who serve South Carolina.