

When You Become Eligible for Medicare

2016



Launching January 1, 2016 ... a new PEBA website experience!

The screenshot displays the PEBA website layout. At the top left is the PEBA logo with the text 'south carolina peba state health plan | retirement systems'. To the right are social media icons for Facebook, Twitter, and LinkedIn, and a search bar with the placeholder 'Enter Search Term(s)'. A 'Customer Service CHAT NOW' button is also present.

Below the header is a large image of an elderly couple smiling. Underneath this image is a navigation bar with icons and labels for 'Insurance Benefits', 'Retirement Benefits', 'Deferred Compensation', and 'PEBA Board'.

The main content area is divided into three columns:

- Upcoming events:**
 - NOV 3 FAAC Committee:** Wednesday, November 3 3:15 p.m.
 - NOV 18 Health Care Policy Committee:** Wednesday, November 18 10:30 a.m.
 - Board of Directors:** Wednesday, November 18 1:30 p.m.
 - NOV 19 "Diabetes and You" workshop:** Canal Room - Edventure Museum Thursday, November 19 11:30 a.m.
 - NOV 20 Darlington regional screening:** Darlington County School Districts Administration building Friday, November 20 10 a.m.
- Latest news:**
 - Blue Cross BlueShield of South Carolina awarded dental contract:** October 28, 2015
 - Changes to prescription benefits effective January 1, 2016:** October 16, 2015
 - PEBA extends open enrollment period due to recent flooding:** October 12, 2015
- Member Access:**
 - MyBenefits
 - EBS Website
 - EES Website

At the bottom of the main content area are three image-based sections: 'New employees' (a woman at a laptop), 'Employers' (a group of five people), and 'Facts and figures' (a document with a pen).

The footer contains the PEBA logo, contact information (202 Arbor Lake Drive, Columbia, SC 29223, 803.737.6800 | 888.260.9430, Monday-Friday, 8:30 a.m.-5 p.m.), and navigation links for 'About us', 'Contact us', 'Press room', 'Archives', 'Index', 'HIPAA', 'Privacy statement', 'Legal disclaimer', 'Links', 'Report fraud', 'State of South Carolina', 'S.C. Code of Laws', and 'Transparency'. It also includes 'Social Media' links for Facebook, Twitter, and LinkedIn.

Beginning January 1, PEBA's insurance website (www.eip.sc.gov) and retirement website (www.retirement.sc.gov) will be combined into one agency site.

Members can find all the information they need about their benefits at www.peba.sc.gov!

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Disclaimer

Benefits administrators and others chosen by your employer who may assist with insurance enrollment, changes, retirement or termination and related activities are not agents of the S.C. Public Employee Benefit Authority (PEBA) and are not authorized to bind the S.C. Public Employee Benefit Authority.

The *When You Become Eligible for Medicare* handbook contains an abbreviated description of insurance benefits provided by or through the S.C. Public Employee Benefit Authority. The Plan of Benefits Documents and benefits contracts contain complete descriptions of the health and dental plans and all other insurance benefits. Their terms and conditions govern all benefits offered by or through the S.C. Public Employee Benefit Authority. If you would like to review these documents, contact your benefits administrator or the S.C. Public Employee Benefit Authority.

The language in this document does not create an employment contract between the employee and the S.C. Public Employee Benefit Authority. This document does not create any contractual rights or entitlements. The S.C. Public Employee Benefit Authority reserves the right to revise the content of this document, in whole or in part. No promises or assurances, whether written or oral, which are contrary to or inconsistent with the terms of this paragraph create any contract of employment.

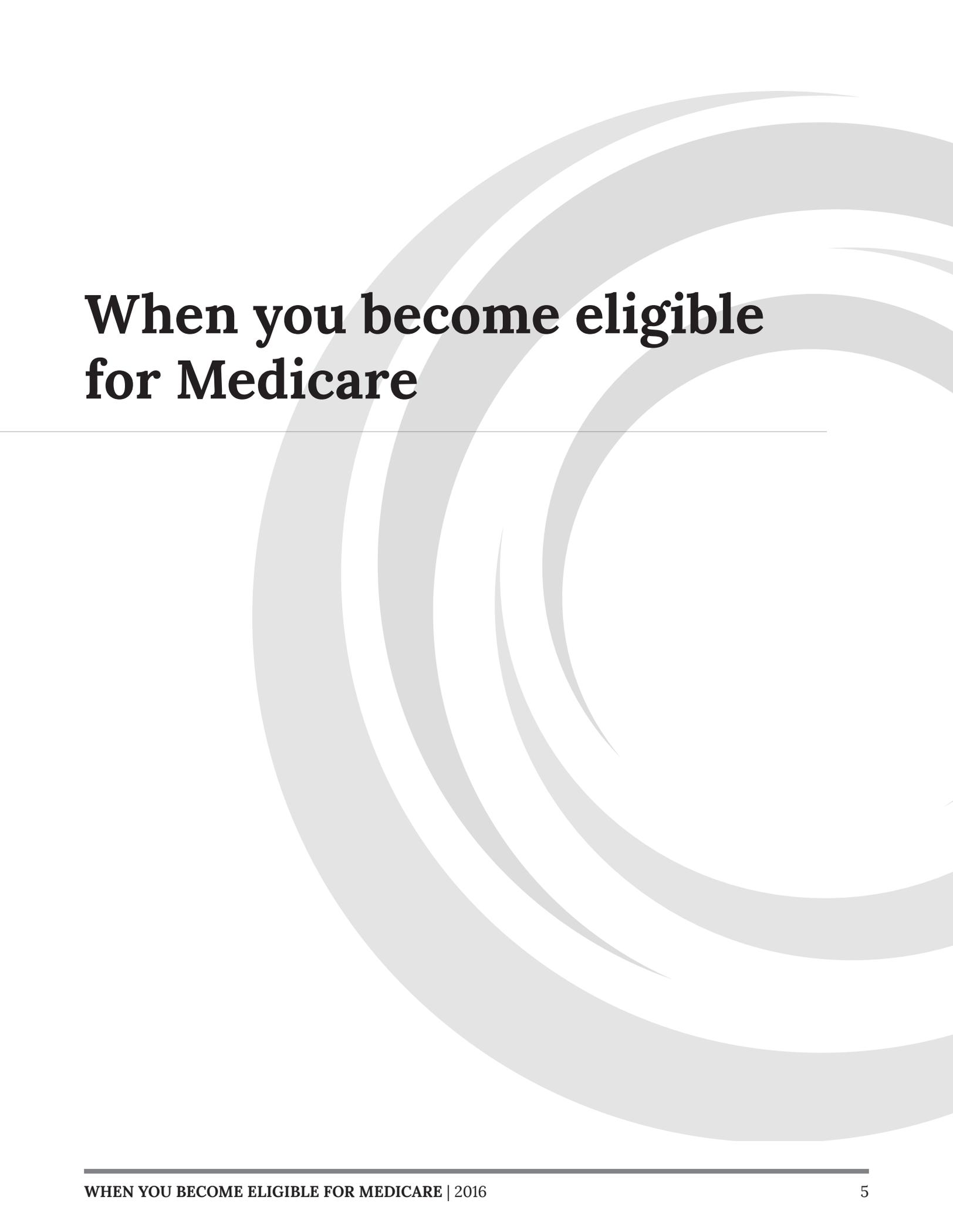
About this handbook

This handbook is for participants in a state health insurance plan and their covered family members who are eligible for Medicare or who soon will be. It provides information about how the Medicare Supplemental Plan and the Standard Plan, health insurance offered through the S.C. Public Employee Benefit Authority (PEBA), work with Medicare. For more information about your health plan, refer to the Health Insurance chapter in the 2016 *Insurance Benefits Guide*.

Express Scripts is the pharmacy benefits manager for the State Health Plan (SHP). The SHP includes the Medicare Supplemental Plan, the Standard Plan and the Savings Plan. Call Express Scripts at 855.612.3128 for information about prescription drug coverage, including Express Scripts Medicare, the SHP's Medicare Part D prescription drug program.

The Retirement and Disability chapter in the *Insurance Benefits Guide* offers information on topics such as eligibility, enrollment and when coverage begins and ends. It also discusses how other insurance offered through PEBA is affected by retirement. Please continue to refer to the Retirement and Disability chapter of the IBG, as well as to the chapters on specific insurance programs under which you are covered.

If you have questions or need additional information, contact PEBA through its website, www.peba.sc.gov, or call 803.737.6800 or 888.260.9430.



When you become eligible for Medicare

Medicare Part A

Medicare Part A is hospital insurance. Most people do not pay a premium for Part A because they or their spouse paid Medicare taxes while they were working. Part A helps cover inpatient care in hospitals, in critical access hospitals in rural areas and in skilled nursing facilities. Part A has an inpatient hospital deductible for each benefit period.

For 2016, it is \$1,288. Part A also covers hospice care and some home health care. You must meet certain requirements to be eligible for Part A. If you are not eligible for free Part A coverage, you may buy it. Contact Medicare for more information.

If you or your spouse or child gains Medicare coverage, the family member who gains coverage may drop health coverage through PEBA within 31 days of the date Part A is effective. Attach a photocopy of the Medicare card to a Notice of Election form and give it to your benefits administrator within 31 days of the date you gain Part A. Coverage will be canceled on the date Part A coverage is effective.

If you or someone you cover becomes eligible for Medicare before age 65, please notify PEBA within 31 days of eligibility. If you do not notify PEBA of your Medicare eligibility, and PEBA continues to pay benefits as if it were your primary insurance, PEBA may seek reimbursement for overpaid claims back to the date you or your family member(s) became eligible for Medicare.

When you become eligible for Medicare, it is advised you enroll in Medicare Part A and Part B if you are covered as a retiree or as a spouse or child of a retiree. Medicare becomes your primary insurance. If you are not covered by Part A and Part B, you will be required to pay the portion of your health care costs that Parts A and B would have paid.

Medicare Part B

Medicare Part B is medical insurance. Most people pay a premium through the Social Security Administration for Part B. It helps cover doctors' services, durable medical equipment and outpatient hospital care. It also covers some medical services that Part A does not cover, such as some services of physical and occupational therapists and home health care. Part B pays for these covered services and supplies when they are medically necessary.

In 2016, the standard Part B premium is \$121.80 (or higher depending on your income). However, most people who receive Social Security benefits will continue to pay a Part B premium of \$104.90 a month. You will pay a different premium in 2016 if:

- You enroll in Part B for the first time in 2016
- You don't receive Social Security benefits
- You have Medicare and Medicaid, and Medicaid pays your premiums
- Your modified adjusted gross income, as reported on your federal tax return from two years ago, is above a certain amount. You can get more information about your Part B premium from Social Security.
- In 2016, the Part B deductible is \$166 a year.

It is important that Medicare-eligible retirees, spouses and children be covered by Medicare Part A and Part B. Medicare becomes your primary insurance, and your retiree group insurance becomes the secondary payer. If you are not covered by Part A and Part B, you will be required to pay the portion of your health care costs that Part A and Part B would have paid.

Medicare's preventive benefits include a free yearly Wellness visit, in addition to the Welcome to Medicare preventive visit. For detailed information, see *Medicare & You 2016* or *Your Guide to Medicare's*

Preventive Services, which are available online at www.medicare.gov or by contacting Medicare.

Medicare Part D

What does Express Scripts Medicare mean to you?

When you become eligible for Medicare, you will automatically be enrolled in Express Scripts Medicare, the State Health Plan's (SHP) Medicare prescription drug program. The program is a group-based, Medicare Part D Prescription Drug Plan. Express Scripts, the SHP's pharmacy benefits manager, will send you information that will include a letter about how you can opt out of the Medicare prescription drug program and remain covered by the SHP Prescription Drug Program. The pharmacy benefits manager is required to give you 21 days to opt out. If you opt out, you remain out of the program unless you decide to re-enroll in it. You do not have to opt out every year.

Most subscribers covered by the Medicare Supplemental Plan or the Standard Plan will be better served if they remain covered by the Medicare Part D plan sponsored by PEBA. Because you have this coverage, your drug benefits will continue to be paid through your health insurance. PEBA charges no additional premium for drug coverage.

You may have heard that if you do not sign up for Part D when you are first eligible — then later do so — you will have to pay higher premiums for Part D. For most PEBA subscribers, this is not true. According to Medicare rules, Medicare recipients who have “creditable coverage” (drug coverage that is as good as, or better than, Part D) and who later sign up for Part D, will not be penalized by higher Part D premiums. Subscribers to the health plans offered through PEBA have creditable coverage.

When you turn 65 and become eligible for Medicare, you will receive a Notice of Creditable

Coverage from PEBA. (If you become eligible for Medicare before age 65, the letter will not be sent to you. You must notify PEBA of your Medicare eligibility.) Please save your Notice of Creditable Coverage from PEBA in case you need to prove you had this coverage when you became eligible for Part D. Please note: if a member joins a plan that does not provide creditable coverage and then joins a Medicare plan, he will have to pay a late enrollment penalty if he goes 63 continuous days or more without creditable coverage.

If you enroll in a Medicare Part D prescription drug plan other than the one offered through PEBA, you will not be eligible for drug benefits through the State Health Plan. Your health insurance premium will remain the same.

Medication Therapy Management

Express Scripts Medicare has a Medication Therapy Management (MTM) program that helps ensure SHP members receive the most effective medications while reducing side effects and out-of-pocket costs. To participate, a member must meet all of the following criteria: have two or more of the following diseases: asthma, COPD, depression, diabetes, high cholesterol, heart failure, HIV, high blood pressure, osteoporosis and rheumatoid arthritis; have filled four or more Part D maintenance or chronic condition drug prescriptions; and be likely to spend \$3,507 or more yearly on drugs in 2016.

Medicare requires that members who qualify automatically be enrolled in the program. However, they may opt out at any time.

Eligible members will receive a letter and will be contacted by a specially trained pharmacist to review their medications and answer questions. After the consultation, members will receive material about their medications. MTM pharmacists work closely with members and their doctors to solve drug-related problems.

For more information, call Express Scripts Medicare at 855.612.3128.

No pay-the-difference policy

Under Express Scripts Medicare, a brand-name drug will be covered for the appropriate copayment, even if a generic drug is available. There is no pay-the-difference under Express Scripts Medicare.

Out-of-network coverage

You must use a network pharmacy, either a local retail pharmacy or the Express Scripts PharmacySM, a home delivery service, to fill prescriptions.

Low-income subsidies

Some people with limited income and resources may be able to get extra help to pay costs, such as copayments, related to a Medicare prescription drug plan. To see if you qualify, call Medicare at 800.633.4227 (TTY users should call 877.486.2048). You also may call Social Security at 800.777.1213. (TTY users should call 800.325.0778.) You also may call the S.C. Lieutenant Governor's Office on Aging at 803.734.9900 or 800.868.9095 and ask for contact information for your regional State Health Insurance Assistance Program (SHIP). If you live in a state other than South Carolina and you would like to speak with the SHIP in the state where you live, contact Medicare. If you qualify, Medicare will tell the plan how much assistance you will receive. Express Scripts will send you information on the amount you will pay once you enroll in the plan.

Income-Related Monthly Adjustment Amounts (IRMAA)

High-income earners enrolled in a Medicare Part D plan may be required to pay a monthly fee to the Social Security Administration (SSA). For information about income thresholds and amounts of the fees, go to www.socialsecurity.gov/n/ssa-44.pdf. If you will pay an IRMAA fee, you should

determine if the additional benefits of the Medicare Part D plan are worth the additional fee you will pay to the SSA.

For more information

For detailed information about Express Scripts Medicare, see the welcome kit package you will receive from Express Scripts Medicare.

If you have questions about your prescription drug benefit, call Express Scripts at 855.612.3128.

Please remember that Medicare Part D does not affect your need to be covered by Medicare Part B (medical insurance). As a retiree covered under PEBA, you must be covered by Part A, and it is strongly advised that you enroll in Part B when you become eligible for Medicare. If you are not covered by Parts A and B of Medicare, you will be required to pay the portion of your health care costs that Parts A and B would have paid.

When you or someone you cover becomes eligible for Medicare

Medicare before age 65: Disability retirees

If you or your eligible spouse or child becomes eligible for Medicare before age 65 due to disability, including end-stage renal disease, you must notify PEBA within 31 days of Medicare eligibility by sending PEBA a copy of your Medicare card.

Because Medicare is primary (pays first) over your retiree health insurance (except during the 30-month end-stage renal disease coordination of benefits period), when you become eligible for Medicare, you must enroll in Medicare Part A, and it is strongly advised that you enroll in Part B. If you are not covered by Parts A and B, you will be required to pay the portion of your health care costs that Parts A and B would have paid.

A chart showing how the Medicare Supplemental Plan and the Standard Plan pay with Medicare is on Page 13. To enroll in the Medicare Supplemental Plan, you must complete a Retiree Notice of Election form. Send it to PEBA if you worked for a state agency, a college or university or a public school district. If you worked for a local subdivision, send it to the benefits administrator in your former employer's personnel office. Coverage will begin the first of the month after PEBA is notified you are covered by Medicare.

End-stage renal disease

If you have end-stage renal disease you will become eligible for Medicare three months after beginning dialysis. At this point, a 30-month coordination period begins. During this period, your health coverage through PEBA is primary, which means it pays your medical claims first. After 30 months, Medicare becomes your primary coverage. Please notify PEBA within 31 days of the end of the coordination period. If you are covered as a retiree, you will then have the option of changing to the Medicare Supplemental Plan. (The Medicare Supplemental Plan is not available to active employees or their covered family members.) A chart showing how the Medicare Supplemental Plan and the Standard Plan pay with Medicare is on Page 13.

The coordination period applies whether you are an active employee, a retiree, a survivor or a covered spouse or child and whether you were already eligible for Medicare for another reason, such as age. If you were covered by the Medicare Supplemental Plan, your claims will be processed under the Standard Plan for the 30-month coordination period.

If you choose not to enroll in Medicare Parts A and B, but you are eligible to participate in Medicare, the SHP will limit coverage to coordinate benefits with what would have been paid by Parts A and B

of Medicare if you were enrolled after the 33 month from the first date of dialysis.

Medicare at 65 if you are retired

At age 65, Medicare is primary (pays first) over your retiree health insurance. You must be covered by Medicare Part A, and it is strongly advised that you be covered by Part B. If you are not covered by Medicare Part A and Part B, you will be required to pay the portion of your health care costs Parts A and B would have paid.

Medicare's Initial Enrollment Period starts three months before your 65th birthday, includes the month of your birthday and extends three months past the month you turn 65. If you are not receiving Social Security benefits, you should ask about enrolling in Medicare three months before you turn age 65 so your Medicare coverage can start the month you turn 65.

If you are receiving Social Security benefits, you should be notified of Medicare eligibility by the Social Security Administration three months before you reach age 65. Medicare Part A starts automatically. It is strongly advised that you enroll in Part B. If you are not notified, contact your local Social Security office immediately.

If you decide not to receive Social Security benefits until you reach your full Social Security retirement age, you must still be covered by Medicare Part A and Part B. We recommend you contact the Social Security Administration within three months of your 65th birthday to enroll. The Social Security Administration will bill you quarterly for the premium for Part B.

If you are an active employee at age 65

If you are actively working and/or covered under a state health insurance plan for active employees, you may delay enrollment in Part B because your

insurance as an active employee remains primary. If you are an active employee but your spouse is eligible for Medicare, your spouse should enroll in Part A but may delay enrollment in Part B until you retire and your active coverage ends.

If you or your spouse defer Part B coverage and later elect to enroll in Part B while you are still actively at work, a gain of Part B is not a special eligibility situation that would permit you to drop health coverage with PEBA. You must wait until open enrollment, which occurs yearly in October, or until within 31 days of a special eligibility situation, to drop your health coverage.

If you are an active employee, you cover your spouse under a state health insurance plan for active employees and your spouse is eligible for Medicare due to disability, your spouse may delay enrollment in Part B because your insurance as an active employee remains primary. If your spouse's eligibility is due to end-stage renal disease, contact PEBA.

When you leave active employment after age 65

Social Security has a special enrollment rule for employees ending active employment after age 65. You should contact the Social Security Administration at least 90 days before you retire to ensure that you or your covered spouse or child's Medicare Part A and Part B coverage begins on the same date as your retiree coverage.

Please check with the Social Security Administration to make sure you are covered by Medicare Part A. It is advised that you be covered by Part B because Medicare becomes your primary coverage.

A chart showing how the Medicare Supplemental Plan and the Standard Plan pay with Medicare is on Page 13. You may enroll in the Medicare Supplemental Plan within 31 days of the date your active coverage ends. To do so, complete a

Retiree Notice of Election form and send it to PEBA if you are retiring from a state agency, a college or university or a public school district. If you are retiring from a local subdivision, give the RNOE to your benefits administrator.

If your spouse or child is eligible for Medicare

If you are a retiree and your spouse or child is eligible for Medicare and you are not, they can enroll in the Medicare Supplemental Plan. Family members who are not eligible for Medicare will be covered under the Standard Plan provisions.

Sign up for Parts A and B of Medicare

You must be covered by both Part A and Part B of Medicare to receive full benefits with any state-offered retiree group health plan. If you are not covered by both parts, you will be required to pay the portion of your health care costs Parts A and B would have paid.

How turning down Part B affects Medicare coverage

Unless you are covered as an active employee at the time, if you turn down Medicare Part B when you are first eligible, you must wait until Medicare's General Enrollment Period. This period is from January 1 to March 31 of each year, and coverage begins on July 1. Your Medicare premium will be 10 percent higher for each full 12-month period you were not covered by Part B after you were first eligible. Contact Medicare for enrollment details and for premium information that applies specifically to you.

If you are retired, age 65 or older and not eligible for Medicare

If, when you retire, you are age 65 or older and not eligible for Medicare, contact the Social Security Administration. They will send you a letter of denial of Medicare coverage. Give a copy of the letter

to your benefits administrator. You may enroll in health insurance as a retiree within 31 days of loss of active coverage or within 31 days of a special eligibility situation or during open enrollment. You may also enroll your eligible family members.

Medicare eligibility and TRICARE

If, as an active employee, survivor or retiree, you become eligible for Medicare Part A, you must purchase Medicare Part B to remain eligible for TRICARE. Your TRICARE health benefit changes to TRICARE for Life, a Medicare supplement, and your TRICARE Supplement Plan coverage ends. You may continue the supplement plan coverage for your eligible dependents by making premium payments directly to Selman & Company. Contact Selman & Company for details.

If a dependent becomes eligible for Medicare before the active employee, survivor or retiree, the dependent is no longer eligible for the GEA TRICARE Supplement Plan.

For more information about the TRICARE Supplement Plan, contact the Selman & Company at 866.637.9911 and select option 1, email memberservices@selmanco.com or online at www.selmantricareresource.com/SC. For more information about TRICARE for Life, call 866.773.0404 or go to www.tricare4u.com.

Working in a benefits-eligible job after retirement

If you or your spouse or child is covered under the retiree group insurance program and you return to work for an employer participating in the state insurance program and you are eligible for enrollment in the SHP, you will need to make decisions about your coverage.

If you or a member of your family is covered by Medicare

Medicare cannot be the primary insurance and coverage through PEBA cannot be secondary insurance for you, or for anyone you cover, while you are employed, according to federal law. To comply with this requirement, you must suspend your retiree group coverage and enroll as an active employee with Medicare as the secondary payer, or refuse all PEBA-sponsored health coverage for yourself, your spouse and your children and have Medicare coverage only. (You may keep your dental and vision coverage.) Beginning January 1, 2016, employees who are eligible for the SHP (the Savings Plan and the Standard Plan) are also eligible for these benefits:

- State Dental Plan and Dental Plus
- State Vision Plan
- Basic and Supplemental Long Term Disability (with the exception of part-time teachers, who are eligible for the SHP according to S.C. Code 59-25-45)
- Basic, Optional and Dependent Life Insurance (with the exception of part-time teachers, who are eligible for the SHP according to S.C. Code 59-25-45)
- MoneyPlus benefits

If you enroll in active group coverage, you must notify the Medicare coordination of benefits contractor at 855.798.2627. Medicare will become secondary for active employees.

You may remain covered by Medicare Part B and continue paying the premium, and Medicare will be the secondary payer. You may also delay or drop Part B without a penalty while you have active group coverage. For more information, contact the Social Security Administration at 800.772.1213.

When you stop working and your active group coverage ends, you may re-enroll in retiree group coverage within 31 days of your active termination date. You also may enroll during open enrollment or within 31 days of a special eligibility situation. In addition, you must notify the Social Security Administration that you are no longer covered under an active group so that you can re-enroll in Medicare Part B, if you dropped it earlier.

If your new job does not make you eligible for benefits, your retiree group coverage continues, and Medicare remains the primary payer.

Retirees hired in a benefits-eligible job who continued life insurance

If you continued your Optional life insurance as a retiree, you may keep the policy if you continue your retiree group benefits. However, you must cancel the policy if you choose active benefits. You may then enroll as an active employee. Contact Securian within 31 days of returning to work and cancel your continued coverage before enrolling in active coverage.

If you are considered a new hire, see the Life Insurance chapter in the *Insurance Benefits Guide*.

How Medicare affects COBRA coverage

If you or your eligible spouse or child has continued coverage under COBRA and becomes eligible for Medicare Part A, Part B or both, please notify PEBA. Your COBRA coverage will end.

A subscriber or eligible spouse or child who is covered by Medicare and then becomes eligible for continued coverage under COBRA can generally use the continued coverage as secondary insurance. Medicare will be his primary coverage.

For more information about continued coverage under COBRA, see the General Information chapter of the 2016 *Insurance Benefits Guide* or contact your benefits office.

Your health insurance options with Medicare

When you and/or your eligible spouse or children are covered under retiree group health insurance and become eligible for Medicare, Medicare becomes the primary payer, and your health insurance options change. Plans available to you and your eligible family members are:

- The Medicare Supplemental Plan
- The Standard Plan

You automatically will be enrolled in the Medicare Supplemental Plan if you become eligible for Medicare due to age and you are covered by the Standard Plan or the Savings Plan unless you respond to the notification letter from PEBA by choosing the Standard Plan. Coverage changes must be made within 31 days of the date you become eligible for Medicare.

You have the option to change to the Medicare Supplemental Plan:

- If you or someone you cover becomes eligible for Medicare due to a disability.
- At the end of the end-stage renal disease coordination period if you are covered as a retiree.
- When you leave active employment after age 65.

To make a change, attach a copy of your Medicare card to your Notice of Election form and give it to your benefits administrator with 31 days of Medicare eligibility.

How PEBA health plans pay with Medicare

Medicare Supplemental Plan	Standard Plan (carve-out method)
Medicare is primary. The hospital bill for a January admission is \$7,500. If you are covered by the Medicare Supplemental Plan and Medicare, your Medicare claim will be processed like this:	Medicare is primary. The hospital bill for a January admission is \$7,500. If you are covered by the Standard Plan and Medicare, your Medicare claim will be processed like this:
\$7,500 Medicare-approved amount	\$7,500 Medicare-approved amount
- 1,288 Part A deductible for 2016	- 1,288 Part A deductible for 2016
\$6,212 Medicare payment	\$6,212 Medicare payment
\$1,288 Remaining bill	\$1,288 Remaining bill
Next, the Medicare Supplemental Plan benefits are applied:	Next, Standard Plan benefits are applied to the Medicare-approved amount:
\$1,288 Remaining bill	\$7,500 SHP allowed amount
-\$1,288 Medicare Supplemental Plan pays Medicare Part A deductible	- 445 Standard Plan deductible for 2016
\$0 You pay nothing	\$7,055 Standard Plan's allowance after deductible
	x 80% Standard Plan coinsurance
	\$5,644 Standard Plan payment in the absence of Medicare
	- 6,212 Medicare payment is "carved out" of the Standard Plan payment.
	\$ 0 Standard Plan pays nothing.
	\$1,288 Remaining bill – amount you pay.

If you or your covered spouse or child is covered by the Medicare Supplemental Plan, the claims of covered family members without Medicare are paid through the Standard Plan provisions.

How the Medicare Supplemental Plan pays with Medicare

If a provider accepts Medicare assignment, the provider accepts Medicare's payment plus the Medicare Supplemental Plan's payment as payment in full for covered services. If the provider does not accept Medicare assignment, the provider may charge more than what Medicare and the Medicare Supplemental Plan pay combined. You pay the difference.

How the Standard Plan pays with Medicare: The carve-out method

When a retired subscriber is covered by Medicare, Medicare pays first, and the Standard Plan pays second. If your provider accepts the amount Medicare allows as payment in full, the Standard Plan will pay the lesser of:

1. The amount Medicare allows, minus what Medicare reported paying or
2. The amount the SHP would pay in the absence of Medicare, minus what Medicare reported paying.

If your provider does not accept the amount Medicare allows as payment in full, the Standard Plan pays the difference between the amount the SHP allows and the amount Medicare reported paying. The Standard Plan will never pay more than the SHP allows. If the Medicare payment is more than the amount the SHP allows, the Standard Plan pays nothing.

As shown in the example, under the carve-out method, you pay the Standard Plan deductible and coinsurance or the remainder of the bill, whichever is less. In this example, the \$445 deductible and your 20 percent coinsurance is \$1,856. However, the remainder of the bill is \$1,288, so you pay the lesser amount, \$1,288.

Once you reach your \$2,540 coinsurance maximum, all claims will be calculated at 100 percent of the allowed amount based on the carve-out method of claims payment. All of your Medicare deductibles and your Medicare Part B 20 percent coinsurance should be paid in full for the rest of the calendar year after you reach your \$2,540 coinsurance maximum.

Your prescription drug coverage with Medicare

When you become eligible for Medicare, you will automatically be enrolled in Express Scripts Medicare, the State Health Plan's Medicare prescription drug program, whether you are covered by the Medicare Supplemental Plan or the Standard Plan.

Health insurance coverage overseas

The Standard Plan offers access to doctors and hospitals outside the United States through the BlueCard Worldwide program. The Medicare Supplemental Plan, which follows Medicare, does not.

If you move abroad, you can switch to the Standard Plan. Please provide your benefits administrator with proof of residency and travel documents showing your date of departure. If you will have dual residency, you will need to decide whether the Standard Plan or the Medicare Supplemental Plan best suits your needs. You cannot change plans except during the annual October open enrollment.

Prescription Drug Coverage

If you are enrolled in the SHP Prescription Drug Program, you have limited prescription drug coverage outside the U.S. If you are traveling abroad, you may wish to buy travel health insurance for coverage during the trip. Such policies are available through most travel agencies.

Your insurance cards when you become eligible for Medicare

Keep your identification cards if you do not change plans when you become eligible for Medicare. Your Benefits ID Number will not change, and your health and dental cards will still be valid. You will receive a new card if you enroll in the SHP, a dental plan or the State Vision Plan for the first time.

If you or your dependents are covered under Express Scripts Medicare each member will receive a prescription drug card issued in his own name. Each family member who is not covered under the Medicare prescription drug program will receive a card, issued in the subscriber's name, showing he is covered under the SHP Prescription Drug Program.

Medicare assignment: How Medicare shares the cost of your care

When you choose a provider, you may wish to determine if:

- He accepts assignment
- He may accept assignment on an individual claim or
- He has opted out of Medicare.

Medicare assignment is a yearly agreement between Medicare and individual providers. After you meet your deductible and pay your coinsurance, if it applies, some doctors and suppliers, called participating providers, will accept the Medicare-approved amount as payment in full for services payable under Medicare Part B. This is called accepting assignment. A provider who accepts assignment also submits his claims directly to Medicare, so you don't have to pay the full amount and wait for reimbursement.

A provider also may choose whether to accept assignment on each individual claim. Before you receive services from a physician, ask if he accepts assignment. If a doctor does not accept assignment, you may pay more for his services.

If a doctor decides to accept assignment from Medicare, he cannot drop out in the middle of the year. Independent laboratories and doctors who perform diagnostic laboratory services and non-physician practitioners must accept assignment.

For a list of physicians, suppliers of medical equipment and other providers who accept assignment, visit www.medicare.gov. For more information, call 800.633.4227. TTY/TDD users should call 877.486.2048.

Opting out: If a provider does not accept Medicare

Some providers choose not to accept any payment from Medicare. If a provider has made this decision, Medicare covers none of that provider's services, and no Medicare payment can be made to him. If Medicare doesn't pay anything, neither will the Medicare Supplemental Plan.

If you are covered under the Standard Plan and your physician has opted out of Medicare, call PEBA at 803.737.6800 or 888.260.9430 for information.

A provider who opts out of Medicare signs a two-year contract. The contract can be renewed.

Immunization benefits through Medicare or the SHP's Medicare Part D prescription drug program

The immunizations in the chart on Page 16 are offered through Medicare Part B or Express Scripts Medicare, the State Health Plan's Medicare Part D prescription drug program. Please note that some benefits are available only at Express Scripts Medicare participating pharmacies.

Coverage schedule for adult immunizations

Immunization ¹	Primary coverage	
	State Health Plan ²	Medicare ³
Flu <i>Ages 19 years and up</i>	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part B for these immunizations. Medicare supplement members: Your medical plan will pay remaining Medicare deductible and coinsurance if Medicare pays. Medicare carve-out members: Your medical plan will coordinate with Medicare to determine if any secondary benefits are available.
Hepatitis A <i>Ages 19 years and up</i>	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part D for these immunizations. Benefits available only at participating pharmacies. Pays at 100% of allowed amount with no member cost share at pharmacy.
Hepatitis B <i>Ages 19 years and up</i>	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part B for these immunizations. Medicare Supplement Members: Your medical plan will pay remaining Medicare deductible and coinsurance if Medicare pays. Medicare Carve-Out Members: Your medical plan will coordinate with Medicare to determine if any secondary benefits are available.
Hib (Haemophilus Influenzae B) <i>Ages 19 years and up</i>	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part D for these immunizations. Benefits available only at participating pharmacies. Pays at 100% of allowed amount with no member cost share at pharmacy.
HPV (Human papillomavirus) <i>Adults ages 19 through 26 years</i>	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part D for these immunizations. Benefits available only at participating pharmacies. Pays at 100% of allowed amount with no member cost share at pharmacy.
Meningococcal <i>Ages 19 years and up</i>	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part D for these immunizations. Benefits available only at participating pharmacies. Pays at 100% of allowed amount with no member cost share at pharmacy.
MMR (Measles, Mumps, Rubella) <i>Ages 19 years and up</i>	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part D for these immunizations. Benefits available only at participating pharmacies. Pays at 100% of allowed amount with no member cost share at pharmacy.
Pneumococcal <i>Ages 19 years and up</i>	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part B for these immunizations. Medicare supplement members: Your medical plan will pay remaining Medicare deductible and coinsurance if Medicare pays. Medicare carve-out members: Your medical plan will coordinate with Medicare to determine if any secondary benefits are available.
Polio <i>Ages 19 years and up</i>	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part D for these immunizations. Benefits available only at participating pharmacies. Pays at 100% of allowed amount with no member cost share at pharmacy.

Continued on next page

Immunization ¹	Primary coverage	
	State Health Plan ²	Medicare ³
Tetanus, Diphtheria, Pertussis <i>Ages 19 years and up</i>	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part D for these immunizations. Benefits available only at participating pharmacies. Pays at 100% of allowed amount with no member cost share at pharmacy.
Varicella <i>Ages 19 years and up</i>	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part D for these immunizations. Benefits available only at participating pharmacies. Pays at 100% of allowed amount with no member cost share at pharmacy.
Zoster (shingles) <i>Ages 60 years and up</i>	Pays at 100% of allowed amount with no member cost share amounts.	Medicare benefits are available under Medicare Part D for these immunizations. Medicare supplement and carve-out members: If you receive this vaccine at your pharmacy, Medicare Part D will cover the cost. If you receive this vaccine at your medical provider's office, the State Health Plan will cover the vaccine at 100% of the allowed amount with no member cost share.

¹Benefits are available only when performed by a medical or pharmacy network provider. Any associated office visit costs are not covered.

²Members who have another coverage primary to a state plan other than Medicare will have their claims coordinated with the other carrier to determine if benefits are available. Routine office visits and related services that may be given on the same day for Standard Plan members are not covered. See Plan descriptions for more information on which routine services are covered and not covered under each Plan to understand your benefits and potential member costs.

³Medicare may pay for some adult immunization services normally covered under Part D under your Part B benefit if the service was given as a treatment of an injury or direct exposure to a disease or condition instead of as a vaccination. If this occurs, the deductible and coinsurance amounts for services covered under Medicare Part B will be paid by the Medicare Supplement Plan. For Medicare carve-out members, your plan will coordinate with Medicare to determine if any secondary benefits are available.

The Medicare Supplemental Plan

If you are a retiree covered by the Standard Plan or the Savings Plan and become eligible for Medicare due to your age, you will receive a letter from PEBA stating that you will be enrolled automatically in the Medicare Supplemental Plan. If you prefer another health plan, you need to inform PEBA within 31 days of Medicare eligibility. If you are covered by a health plan offered through PEBA, you may change to the Medicare Supplemental Plan within 31 days of Medicare eligibility. During the yearly October enrollment period, you can change from the Standard Plan to the Medicare Supplemental Plan. Plan changes are effective on January 1 after the enrollment period. If you move out of the

United States permanently you may be eligible to change from the Medicare Supplemental Plan to the Standard Plan.

This section explains the Medicare Supplemental Plan, which is available to a retiree and his spouse or children who are covered by Medicare Parts A and B. This plan coordinates benefits with the original Medicare plan only. No benefits are provided for coordination with Medicare Advantage plans (Part C). For more information, visit www.medicare.gov or call 800.633.4227.

General information

The Medicare Supplemental Plan is similar to a Medigap policy — it pays the portion of Medicare-approved charges that Medicare does not, such as Medicare's deductibles and coinsurance. The

Medicare Supplemental Plan payment is based on the Medicare-approved amount. Except as specified on Pages 19-21, charges that are not covered by Medicare will not be payable as benefits under the supplemental plan.

For example, in an outpatient setting, such as an emergency room, Medicare does not cover self-administered drugs (drugs that a person usually takes on his own). This means that if a patient receives pain pills in an emergency room, the hospital will bill him for the drugs. Because Medicare does not pay for the pills, the Medicare Supplemental Plan will not pay for them either.

If your medical provider does not accept Medicare assignment, and charges you more than Medicare allows, you pay the difference. Contact Medicare for more information.

Using Medi-Call and Companion Benefit Alternatives for preauthorization

You will call Medi-Call or Companion Benefit Alternatives only when Medicare benefits are exhausted for inpatient hospital services and for extended care services, such as skilled nursing facilities, private duty nursing, home health care, durable medical equipment and Veterans Administration hospital services.

Filing claims for covered family members who are not eligible for Medicare

Claims for covered family members who are not eligible for Medicare, but who are insured through the Medicare Supplemental Plan, are paid according to the Standard Plan provisions. Remember that some benefits require preauthorization by Medi-Call, National Imaging Associates, Express Scripts or Companion Benefit Alternatives.

Medicare deductibles and coinsurance

Deductibles

Medicare Part A has an inpatient hospital deductible for each benefit period. That deductible for 2016 is \$1,288. A Medicare benefit period begins the day you go to a hospital or skilled nursing facility and ends when you have not received any hospital or skilled care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. The Medicare Supplemental Plan will pay the Part A deductible each time it is charged.

Medicare Part B has a deductible of \$166 a year in 2016. Part B, for which you pay a monthly premium, covers physician services, supplies and outpatient care. Contact Medicare for more information. As a retiree, you need to enroll in Part B as soon as you are eligible for Medicare, since Medicare is your primary coverage. If you are not covered by Part B, you will be required to pay the portion of your health care costs that Part B would have paid. The Medicare Supplemental Plan pays the Part B deductible.

Coinsurance

Medicare Part B pays 80 percent of the Medicare-approved amount for medical services, including outpatient mental health care. The Medicare Supplemental Plan pays the remaining 20 percent.

Medicare Supplemental Plan deductibles and coinsurance

The Medicare Supplemental Plan benefit period is January 1- December 31 and includes a \$200 deductible each calendar year that applies to private duty nursing services only. If you enroll in Medicare and change to the Medicare

Supplemental Plan during the year, you will need to meet a new \$200 deductible for private duty nursing services.

What the Medicare Supplemental Plan covers

Hospital admissions

The Medicare Supplemental Plan pays for these services during a benefit period after Medicare has paid:

- Medicare Part A inpatient hospital deductible
- The Medicare coinsurance amount for days 61 through 90 of a hospital stay in each Medicare benefit period
- The Medicare coinsurance amount for days 91 through 150 of a hospital stay for each of Medicare's 60 lifetime reserve days (lifetime reserve days can be used once.)
- After all Medicare hospital benefits are exhausted, 100 percent of the Medicare Part A-eligible hospital expenses, if medically necessary*
- The coinsurance for durable medical equipment up to the Medicare-approved amount.

*Must call Medi-Call or Companion Benefit Alternatives for approval.

If you exhaust the inpatient hospital days Medicare allows

If you are covered by the Medicare Supplemental Plan and you exhaust all Medicare-allowed inpatient hospital days, you need to call Medi-Call or Companion Benefit Alternatives for approval of any additional inpatient hospital days. Also, if you are covered by the Medicare Supplemental Plan, and you think that a hospital stay may exceed the number of days allowed under Medicare, you should choose a hospital within the SHP networks or BlueCard Program so that any days beyond

what Medicare allows will be covered as a network benefit by the Medicare Supplemental Plan.

You need to also call Medi-Call or Companion Benefit Alternatives for preauthorization for services related to home health care, hospice, durable medical equipment and Veterans Administration hospital services.

Skilled nursing facilities

The Medicare Supplemental Plan will pay these benefits after Medicare has paid benefits during a benefit period (preauthorization by Medi-Call is required):

- The coinsurance, after Medicare pays, up to the Medicare-approved amount for days 21-100 (Medicare pays 100 percent for the first 20 days)
- 100 percent of the approved days beyond 100 days in a skilled nursing facility, if medically necessary. (Medicare does not pay beyond 100 days.) The maximum benefit under the plan per year for covered services beyond 100 days is 60 days.

Physician charges

The Medicare Supplemental Plan will pay these benefits related to physician services approved by Medicare:

- The Medicare Part B deductible
- The coinsurance for the Medicare-approved amount for physician's services for surgery, necessary home and office visits, inpatient hospital visits and other covered physician's services
- The coinsurance for the Medicare-approved amount for physician's services provided in the outpatient department of a hospital for treatment of accidental injuries and medical emergencies; minor surgery; and diagnostic services.

Home health care

The Medicare Supplemental Plan will pay these benefits for medically necessary home health care services:

- The Medicare Part B deductible
- The coinsurance for any covered services or costs Medicare does not cover (Medicare pays 100 percent of Medicare-approved amount), up to 100 visits per benefit year. The plan does not cover services provided by a person who ordinarily resides in the home, is a member of the family or a member of the family of the spouse of the covered person.
- 20 percent of Medicare-approved amount for durable medical equipment.

Private duty nursing services

Private duty nursing services are services that are provided by a registered nurse or a licensed practical nurse and that have been certified in writing by a physician as medically necessary. Services must be preauthorized by Medi-Call. A \$200 annual deductible that applies, regardless of when you enroll in the plan. Medicare does NOT cover this service. Once the deductible is met, the Medicare Supplemental Plan will pay 80 percent of covered charges for private duty nursing in a hospital or in the home.

Coverage is limited to no more than three nurses per day, and the maximum annual benefit per year is \$5,000. The lifetime maximum benefit under the Medicare Supplemental Plan is \$25,000.

Prescription drug program

The Medicare Supplemental Plan covers prescription drugs when purchased from a participating pharmacy. For more information, see the 2016 *Insurance Benefits Guide*. For information about how PEBA coverage relates to Medicare Part D, see Page 7 of this handbook.

Pap test benefit

Medicare covers a Pap test, pelvic exam and clinical breast exam every 24 months. These tests are covered yearly if you are at high risk. There is no patient liability if you receive the tests from a doctor who accepts assignment. Check with Medicare for more information.

Filing claims as a retiree with Medicare

If you are retired and covered by Medicare, Medicare is primary. In most cases, your provider will file your Medicare claims for you.

Claims filed in South Carolina

The Medicare claim should be filed first. Claims for Medicare-approved medical charges incurred in South Carolina should be transferred automatically from Medicare to the SHP. If you or your doctor have not received payment or notification from the plan within 30 days after the Medicare payment is received, one of you must send BCBSSC, claims processor for the SHP, a claim form and a copy of your Medicare Summary Notice (MSN) with your Benefits ID Number or Social Security number written on it.

Your mental health and substance abuse claims also should be filed with BCBSSC and should include your MSN with your Benefits ID Number or Social Security number written on it. See the 2016 *Insurance Benefits Guide* for more information.

Claims filed outside South Carolina

If you receive services outside South Carolina, your provider will file its claim to the Medicare carrier in that state. Medicare will send you claim to BCBSSC.

When traveling outside the U.S.

Medicare does not cover services outside the United States and its territories. Because the Medicare Supplemental Plan does not allow

benefits for services not covered by Medicare (other than private duty nursing), Medicare Supplemental Plan members do not have coverage outside the U.S. if Medicare is their primary coverage.

Limited prescription drug coverage is available outside the U.S. to members enrolled in Express Scripts Medicare. For more information, see the 2016 *Insurance Benefits Guide* or call Express Scripts at 855.612.3128.

The Standard Plan

The Standard Plan offers worldwide coverage. It requires Medi-Call (800.925.9724) approval for inpatient hospital admissions, including admission to a hospital to have a baby; outpatient surgical services in a hospital or clinic; the purchase or rental of durable medical equipment; skilled nursing care; hospice care; and home health care. You are encouraged to call Medi-Call during the first trimester of your pregnancy. Preauthorization by National Imaging Associates (NIA) (866.500.7664) is required for office-based or outpatient advanced radiology services, such as CT, MRI, MRA and PET scans. You must call Companion Benefit Alternatives (800.868.1032), the SHP's mental health/substance abuse manager, for preauthorization before you receive some mental health or substance abuse benefits. For more information, see the 2016 *Insurance Benefits Guide*.

The plan has deductibles and coinsurance. Once you are covered by Medicare, Medicare becomes your primary insurance. The Standard Plan uses a carve-out method to pay claims. It is described on Pages 13-14.

How the Standard Plan and Medicare work together

Using Medi-Call and CBA preauthorization as a retiree with Medicare

You still need to call Medi-Call or Companion Benefit Alternatives (CBA) when Medicare benefits are exhausted for inpatient hospital services (including hospital admissions outside South Carolina or the U.S.), and for extended care services, such as skilled nursing, home health care, durable medical equipment and Veterans Administration hospital services. Medicare has its own program for reviewing use of its benefits.

Covered family members who are not eligible for Medicare and whose claims are processed under the Standard Plan must call Medi-Call or CBA. Remember that while your physician or hospital may call Medi-Call or CBA for you, it is your responsibility to see that the call is made.

Hospital network

When you are covered by Medicare, Medicare is the primary payer, and you may go to any hospital you choose. Medicare limits the number of days of a hospital stay that it will cover. If you are enrolled in the Standard Plan and your hospital stay exceeds the number of days allowed under Medicare, it may be important to you that you are admitted to a hospital within the SHP network or BlueCard Program so that you will not be charged more than what the Standard Plan allows.

You must also call Medi-Call or CBA for approval of any additional inpatient hospital days beyond the number of days approved under Medicare and for services related to home health care, hospice, durable medical equipment and Veterans Administration hospital services.

Coverage outside the U.S.

You are not generally covered outside the United States under Medicare. However, if you are covered by the Standard Plan, you have worldwide access to doctors and hospitals through the BlueCard Worldwide program.

Emergency hospital admissions outside South Carolina or the U.S.

If you are admitted to a hospital outside the state or the country as a result of an emergency, notify Medi-Call or CBA and follow the BlueCard guidelines. For more information see the 2016 *Insurance Benefits Guide*.

Prescription drug coverage

Limited prescription drug coverage is available outside the U.S. to members enrolled in Express Scripts Medicare. For more information, see the 2016 *Insurance Benefits Guide*.

Prescription drug program

The Standard Plan covers prescription drugs when purchased from a participating pharmacy. For more information, see the 2016 *Insurance Benefits Guide*.

Outpatient facility services

Outpatient services may be provided in the outpatient department of a hospital or a freestanding facility. If you are covered by Medicare, there is no need to call Medi-Call for preauthorization, nor do you need to select a center that participates in the network.

Transplant contracting arrangements

As part of this network, you have access to the leading transplant facilities in South Carolina and throughout the nation. If you are covered

by Medicare, there is no need to call Medi-Call for preauthorization, nor do you need to select a facility that participates in the network.

Mammography benefit

The SHP pays for routine mammograms for covered women ages 35-74. You may have one baseline mammogram if you are age 35-39 and one routine mammogram every calendar year if you are age 40-74. There is no charge if you use a facility that participates in the program's mammography network. Medicare covers a screening mammogram every 12 months for women age 40 and older. Medicare pays 100 percent of its allowance for covered routine mammograms. You pay nothing if you receive the test from a doctor who accepts assignment.

Pap test program

The SHP will pay for the portion of the office visit associated with the Pap test, and the lab services for the Pap test each year, without any requirement for a copayment, deductible or coinsurance, for covered women ages 18-65. See the 2016 *Insurance Benefits Guide* for more information. Medicare covers a Pap test, pelvic exam and clinical breast exam every 24 months. If you are at high risk, you may have one every 12 months. You pay nothing if you receive the test from a doctor who accepts assignment. Check with Medicare for more information.

Maternity Management and Well Child Care benefits

The SHP offers two programs geared toward early detection and prevention of illness among children. The Maternity Management benefit helps mothers-to-be receive necessary prenatal care. (This benefit applies to covered retirees and their spouses. It does not apply to covered children.) Covered

children are eligible for Well Child Care checkups until they turn age 19. The plan pays 100 percent for routine immunizations when a network doctor provides the services. If your covered child has delayed, or missed, receiving immunizations at the recommended time, the plan will pay for catch-up immunizations for some vaccines until the child turns age 19. Check with BCBSSC or your network pediatrician to determine which immunizations are covered.

Filing claims as a retiree with Medicare

If you are retired and covered by Medicare, Medicare is primary. In most cases, your provider will file your Medicare claims for you.

Claims filed in South Carolina

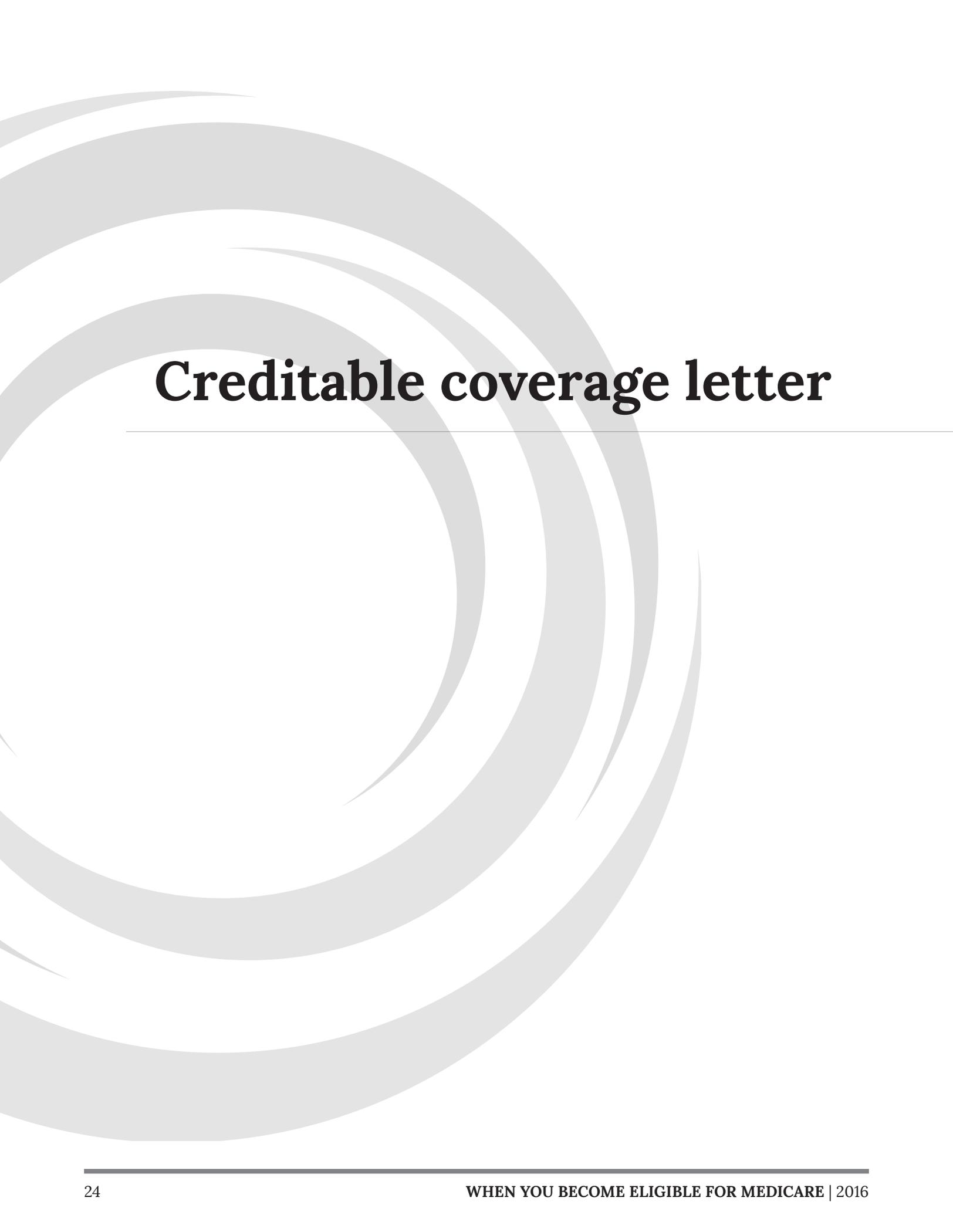
The Medicare claim should be filed first. Claims for Medicare-approved medical charges incurred in South Carolina should be transferred automatically from Medicare to the SHP. If you or your doctor have not received payment or notification from the plan within 30 days after the Medicare payment is received, one of you must send BCBSSC, claims processor for the SHP, a claim form and a copy of your Medicare Summary Notice (MSN) with your Benefits ID Number or Social Security number written on it. Your mental health and substance abuse claims should also be filed with BCBSSC and should include your MSN with your Benefits ID Number or Social Security number on it. See the *Insurance Benefits Guide* if you need to file your own claim.

Claims filed outside South Carolina

If you receive services outside South Carolina, but in the U.S., your provider will file the claim with the Medicare carrier in the state where you received services. Medicare will send your claim to BCBSSC. If you or your doctor have not received payment or notification from the SHP within 30 days after the Medicare payment is received, one of you must send BCBSSC, claims processor for the SHP, a claim form and a copy of your MSN, with your Benefits ID Number or Social Security number written on it.

If Medicare denies your claim

If Medicare denies your claim, you are responsible for filing the denied claim with BCBSSC. You may use the same SHP claim forms active employees use. These forms are on the PEBA's website, www.peba.sc.gov, or from PEBA or BCBSSC. Please attach your MSN and an itemized bill to your claim form.



Creditable coverage letter

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 an HMO or PPO) 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 (SEP) 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. Be aware 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.

Call your regional State Health Insurance Assistance Program (see Page 27 of this handbook for information about how to get the program's telephone number) for personalized help. You may also 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 below 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.

South Carolina Public Employee Benefit Authority

202 Arbor Lake Drive

Columbia, SC 29223

803.737.6800

888.260.9430

www.peba.sc.gov

Medicare Part D: Frequently asked questions

Q: I received a notice recently about Medicare Part D from PEBA. What is this?

A: Even though the Medicare prescription drug benefit went into effect on January 1, 2006, PEBA will continue to provide you and your covered dependents with your state prescription drug coverage. The notice tells you this coverage is at least as good as the Medicare prescription drug benefit, and it is proof of such coverage. Please keep this notice where you can easily find it.

Q: Do I need to do anything right now?

A: No. There is nothing you need to do if you plan to keep your state coverage through PEBA.

Q: What do I need to do if I want to switch to a Medicare plan?

A: If you switch to a Medicare prescription drug plan other than the one sponsored by PEBA, you need to enroll within the seven-month initial enrollment period of your Medicare eligibility. More information is available by calling Medicare at 800-MEDICARE (800.633.4227) or at 877.486.2048 (TTY). However, enrolling in a Medicare prescription drug plan will disqualify you from prescription drug coverage under your PEBA plan. If you enroll in a Medicare prescription drug plan other than the one sponsored by PEBA, you will lose your PEBA drug coverage, and there will be no reduction in your health insurance premium.

Q: If I keep my current coverage, can I switch to a Medicare plan later?

A: Yes. Open enrollment for Medicare coverage is held yearly between October 15 and December 7.

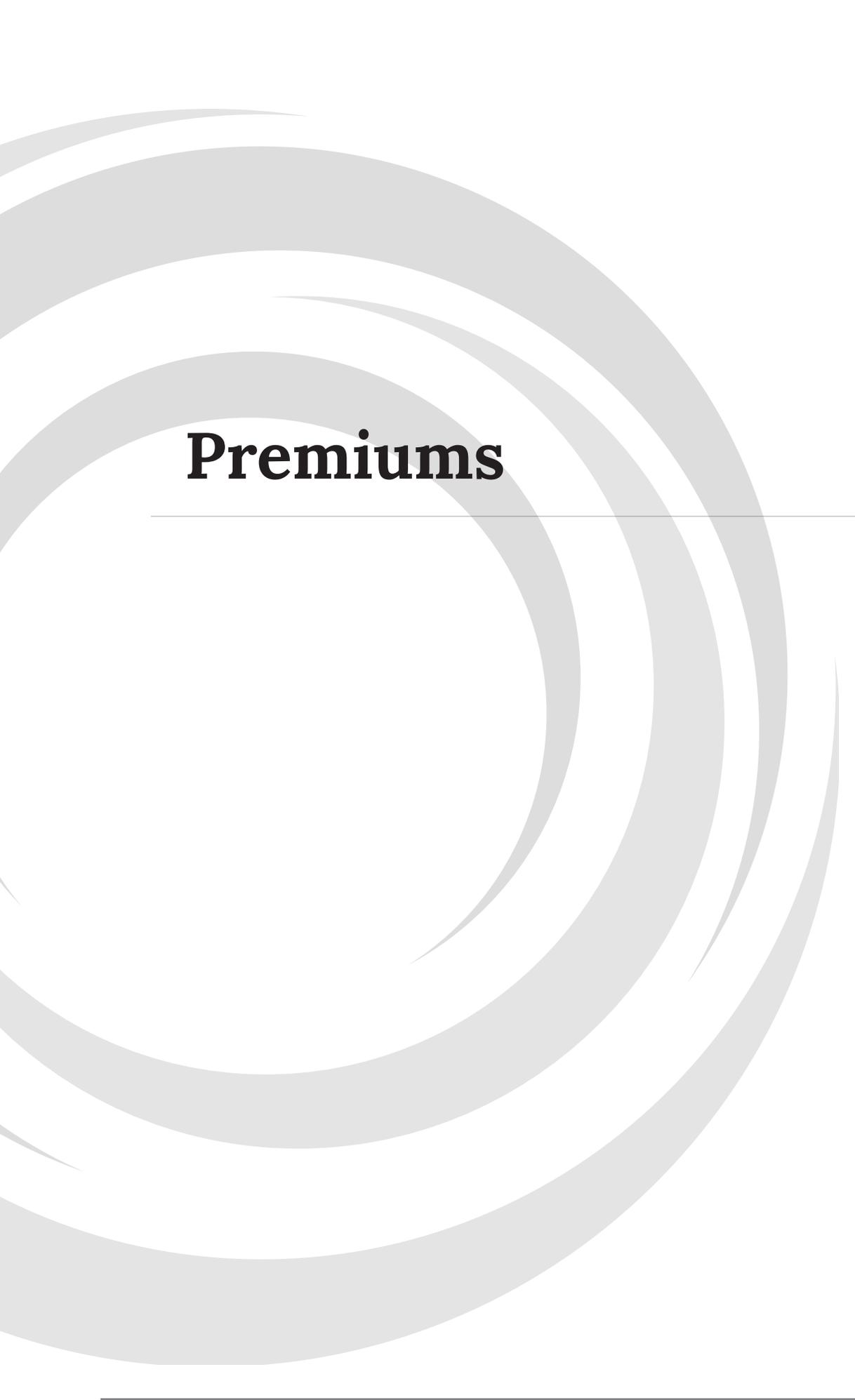
Q: Will I pay higher premiums for a Medicare prescription drug plan if I keep my state coverage through PEBA and switch later?

A: No. Since Medicare recognizes your current state coverage through PEBA is at least as good as the standard Medicare plan, you will not pay more if you later enroll in a Medicare plan. Remember that you may only enroll in a Medicare prescription drug plan during:

- Open enrollment for Medicare, which is October 15 to December 7 of each year; or
- If your PEBA coverage ends.

Q: Is extra help or limited-income assistance available for prescription drug coverage?

A: Under Medicare Part D, the federal government offers Extra Help, a program to help pay costs of a Medicare prescription drug plan for people with limited income and resources. If you think you may qualify, you can apply for assistance by filling out an application online at www.socialsecurity.gov or by calling the Social Security Administration at 800.772.1213 or 800.325.0778 (TTY). You also may call the S.C. Lieutenant Governor's Office on Aging at 803.734.9900 or 800.868.9095 for contact information for your regional State Health Insurance Assistance Program (SHIP).



Premiums

Benefits at a glance

Comparison of health plans for retirees and family members eligible for Medicare

Plan	Medicare	Medicare Supplemental	SHP Standard Plan ¹	
Availability	United States (Contact Medicare about any services outside the U.S.)	Same as Medicare	Coverage worldwide	
Cancellation policy	Call Medicare for details	Canceled for failure to pay premiums	Canceled for failure to pay premiums	
Annual deductible	Part A: \$1,288 (per benefit period) Part B: \$166	Pays Medicare Part A and Part B deductibles	\$445 (single) / \$890 (family) Carve-out method applies	
Copayments	Inpatient hospital: Part A deductible (\$1,288 per benefit period)	Pays Medicare Part A deductible (Call Medi-Call for hospital stays over 150 days, skilled nursing, private duty nursing, home healthcare, durable medical equipment and VA hospital services)	Outpatient hospital, outpatient surgery centers: \$95 copay; Emergency care: \$159 copay (Call Medi-Call for hospital stays over 150 days, skilled nursing, home healthcare, durable medical equipment and VA hospital services)	
Coinsurance	Part A: 100% Part B: 80% (You pay 20%)	Pays Part B coinsurance of 20%	Carve-out method applies Plan allows 80%	
Coinsurance maximum	None	None	Network \$2,540 (single) \$5,080 (family)	Out-of-network \$5,080 (single) \$10,160 (family)
			Excludes deductible and copays	
Physician visits	Medicare pays 80% You pay 20% Medicare covers a "Welcome to Medicare" preventive visit and a yearly "Wellness" visit. No charge if they are from a doctor who accepts assignment.	Plan pays Part B coinsurance of 20%	Carve-out method applies; \$12 copay; Plan allows 80% in-network, 60% out-of-network Well Child Care visits and immunizations paid at 100% in-network until the child turns age 19.	
Prescription Drugs (Express Scripts Medicare and SHP Prescription Drug Program)	Covered under Medicare Part D. Most subscribers to health plans offered through PEBA will be better served if they remain covered by the Part D plan sponsored by PEBA.	Participating pharmacies only (up to 31-day supply): \$9 Tier 1 (generic — lowest cost), \$38 Tier 2 (brand — higher cost), \$63 Tier 3 (brand — highest cost) Mail order and Retail Maintenance Network (up to 90-day supply): \$22 Tier 1, \$95 Tier 2, \$158 Tier 3 Copay max: \$2,500	Participating pharmacies only (up to 31-day supply): \$9 Tier 1 (generic — lowest cost), \$38 Tier 2 (brand — higher cost), \$63 Tier 3 (brand — highest cost) Mail order and Retail Maintenance Network (up to 90-day supply): \$22 Tier 1, \$95 Tier 2, \$158 Tier 3 Copay max: \$2,500	
Mental health/substance abuse	Inpatient: Medicare pays 100% for days 1-60 (Part A deductible applies); You pay \$322/day for days 61-90; You pay \$644/day for days 91-150 (subject to 60 lifetime reserve days); You pay all costs after 150 days. Outpatient: Medicare pays 80% (Part B deductible applies)	Inpatient: Plan pays Medicare deductible; \$322 coinsurance for days 61-90; \$644 coinsurance for days 91-150; After 150 days CBA approval required. Outpatient: Plan pays Medicare deductible, 20% coinsurance	Carve-out method applies Plan allows 80% in-network	
Lifetime maximum	None	None	None	

Plan	Medicare	Medicare Supplemental	SHP Standard Plan ¹
Inpatient hospital days	Medicare pays 100% for days 1-60 (Part A deductible applies); You pay \$322 /day for days 61-90; You pay \$644 for days 91-150 (subject to 60 lifetime reserve days); You pay all costs beyond 150 days	Plan pays Medicare deductible; coinsurance for days 61-150 (Medicare benefits may end sooner than day 150 if the member has previously used any of his 60 lifetime reserve days) Pays 100% beyond 150 days. (Medi-Call or CBA approval required).	Carve-out method applies Plan allows 80% (Call Medi-Call if hospital stay exceeds 150 days)
Skilled nursing facility	Medicare pays 100% for days 1-20; You pay \$161 for days 21-100	Plan pays \$161 for days 21-100; With Medi-Call approval, Plan pays 100% of approved days beyond 100 days (limited to 60 days)	Carve-out method applies. Plan allows 80%, up to 60 days. (Call Medi-Call or CBA if hospital stay exceeds 100 days)
Private duty nursing	Not covered	\$200 annual deductible Plan pays 80% if Medi-Call approved You pay 20% \$5,000 annual maximum \$25,000 lifetime maximum	Not covered.
Home health care	Medicare pays 100%	Medi-Call available to assist with referrals Up to 100 visits.	Carve-out method applies Plan allows 80% You pay 20% Up to 100 visits.
Hospice care	Medicare pays 100%	Medi-Call available to assist with referrals	Medi-Call available to assist with referrals
Durable medical equipment	Medicare pays 80% of Medicare-approved amount (Medicare approval required) You pay 20%	Plan pays 20% coinsurance (Medi-Call required)	Carve-out method applies Plan allows 80% (Medi-Call approval required)
Routine mammography screening	No charge if the doctor accepts assignment; guidelines apply.	Plan pays 20% coinsurance	Ages 35-74 at participating facilities only; guidelines apply
Pap test	Routine every 24 months (yearly if high risk) No patient liability if the doctor accepts assignment.	Plan pays 20% coinsurance. Otherwise, plan pays yearly for one routine Pap test for covered women ages 18-65. Diagnostic only age 66 and older.	Routine yearly, ages 18-65; Diagnostic only, age 66 and older; Plan allows 100% for Pap test (Carve-out method applies when Medicare pays)
Ambulance	Medicare pays 80% You pay 20%	Plan pays 20% coinsurance	Carve-out method applies Plan allows 80%
Eyeglasses	None, except for prosthetic lenses from cataract surgery.	None, except for prosthetic lenses from cataract surgery.	None, except for prosthetic lenses from cataract surgery.

¹The carve-out method is used to pay claims for retired subscribers covered by the Standard Plan and Medicare.

Please note: This chart is a summary of your benefits. For details, please see the previous sections of this handbook, the Retirement/Disability chapter and the Health Insurance chapter of the *Insurance Benefits Guide*, your health insurance claims processor or Medicare.

The chart for subscribers and covered family members who are not eligible for Medicare is in the Retirement/Disability chapter of the *Insurance Benefits Guide*.

No health plan offered through PEBA has a lifetime maximum benefit.

2016 monthly premiums for funded retirees^{1,2}

Retiree eligible for Medicare/spouse eligible for Medicare

	Retiree	Retiree/spouse	Retiree/children	Full family
Savings Plan	N/A	N/A	N/A	N/A
Standard Plan	\$79.68	\$217.36	\$125.86	\$270.56
Medicare Supplement⁴	\$97.68	\$253.36	\$143.86	\$306.56
TRICARE Supplement	N/A	N/A	N/A	N/A
Dental	\$0.00	\$7.64	\$13.72	\$21.34
Dental Plus³	\$25.96	\$52.46	\$60.50	\$78.60
Vision	\$7.00	\$14.00	\$14.98	\$21.98

Retiree eligible for Medicare/spouse not eligible for Medicare

	Retiree/spouse	Full family
Savings Plan	N/A	N/A
Standard Plan	\$235.36	\$281.54
Medicare Supplement⁴	\$253.36	\$299.54
TRICARE Supplement	N/A	N/A
Dental	\$7.64	\$21.34
Dental Plus³	\$52.46	\$78.60
Vision	\$14.00	\$21.98

Retiree not eligible for Medicare/spouse eligible for Medicare

	Retiree/spouse	Full family
Savings Plan	\$77.40	\$113.00
Standard Plan	\$235.36	\$281.54
Medicare Supplement⁴	\$253.36	\$299.54
TRICARE Supplement	N/A	N/A
Dental	\$7.64	\$21.34
Dental Plus³	\$52.46	\$78.60
Vision	\$14.00	\$21.98

Retiree not eligible for Medicare/spouse not eligible for Medicare

	Retiree	Retiree/spouse	Retiree/children	Full family
Savings Plan	\$9.70	\$77.40	\$20.48	\$113.00
Standard Plan	\$97.68	\$253.36	\$143.86	\$306.56
Medicare Supplement⁴	N/A	N/A	N/A	N/A
TRICARE Supplement	\$62.50	\$121.50	\$121.50	\$162.50
Dental	\$0.00	\$7.64	\$13.72	\$21.34
Dental Plus³	\$25.96	\$52.46	\$60.50	\$78.60
Vision	\$7.00	\$14.00	\$14.98	\$21.98

Footnotes listed on Page 34

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

	Retiree/children	Full family
Savings Plan	\$20.48	\$113.00
Standard Plan	\$143.86	\$306.56
Medicare Supplement ⁴	\$161.86	\$324.56
TRICARE Supplement	N/A	N/A
Dental	\$13.72	\$21.34
Dental Plus ³	\$60.50	\$78.60
Vision	\$14.98	\$21.98

2016 monthly premiums for non-funded retirees^{1,2}

Retiree eligible for Medicare/spouse eligible for Medicare

	Retiree	Retiree/spouse	Retiree/children	Full family
Savings Plan	N/A	N/A	N/A	N/A
Standard Plan	\$439.78	\$930.62	\$678.54	\$1,163.60
Medicare Supplement ⁴	\$457.78	\$966.62	\$696.54	\$1,199.60
TRICARE Supplement	N/A	N/A	N/A	N/A
Dental	\$11.72	\$19.36	\$25.44	\$33.06
Dental Plus ³	\$25.96	\$52.46	\$60.50	\$78.60
Vision	\$7.00	\$14.00	\$14.98	\$21.98

Retiree eligible for Medicare/spouse not eligible for Medicare

	Retiree/spouse	Full family
Savings Plan	N/A	N/A
Standard Plan	\$948.62	\$1,174.58
Medicare Supplement ⁴	\$966.62	\$1,192.58
TRICARE Supplement	N/A	N/A
Dental	\$19.36	\$33.06
Dental Plus ³	\$52.46	\$78.60
Vision	\$14.00	\$21.98

Retiree not eligible for Medicare/spouse eligible for Medicare

	Retiree/spouse	Full family
Savings Plan	\$790.66	\$1,006.04
Standard Plan	\$948.62	\$1,174.58
Medicare Supplement ⁴	\$966.62	\$1,192.58
TRICARE Supplement	N/A	N/A
Dental	\$19.36	\$33.06
Dental Plus ³	\$52.46	\$78.60
Vision	\$14.00	\$21.98

Footnotes listed on Page 34

Retiree not eligible for Medicare/spouse not eligible for Medicare

	Retiree	Retiree/spouse	Retiree/children	Full family
Savings Plan	\$369.80	\$790.66	\$573.16	\$1,006.04
Standard Plan	\$457.78	\$966.62	\$696.54	\$1,199.60
Medicare Supplement ⁴	N/A	N/A	N/A	N/A
TRICARE Supplement	\$62.50	\$121.50	\$121.50	\$162.50
Dental	\$11.72	\$19.36	\$25.44	\$33.06
Dental Plus ³	\$25.96	\$52.46	\$60.50	\$78.60
Vision	\$7.00	\$14.00	\$14.98	\$21.98

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

	Retiree/children	Full family
Savings Plan	\$573.16	\$1,006.04
Standard Plan	\$696.54	\$1,199.60
Medicare Supplement ⁴	\$714.54	\$1,217.60
TRICARE Supplement	N/A	N/A
Dental	\$25.44	\$33.06
Dental Plus ³	\$60.50	\$78.60
Vision	\$14.98	\$21.98

2016 monthly premiums for non-funded survivors^{1,2}

Spouse eligible for Medicare/children eligible for Medicare

	Spouse	Spouse/children	Children only
Savings Plan	N/A	N/A	N/A
Standard Plan	\$439.78	\$678.54	\$238.76
Medicare Supplement ⁴	\$457.78	\$714.54	\$256.76 ⁵
TRICARE Supplement	N/A	N/A	N/A
Dental	\$11.72	\$25.44	\$13.72
Dental Plus ³	\$25.96	\$60.50	\$34.54
Vision	\$7.00	\$14.98	\$7.98

Footnotes listed on Page 34

Spouse eligible for Medicare/children not eligible for Medicare

	Spouse	Spouse/children	Children only
Savings Plan	N/A	N/A	\$203.36
Standard Plan	\$439.78	\$678.54	\$238.76
Medicare Supplement⁴	\$457.78	\$696.54	N/A
TRICARE Supplement	N/A	N/A	N/A
Dental	\$11.72	\$25.44	\$13.72
Dental Plus³	\$25.96	\$60.50	\$34.54
Vision	\$7.00	\$14.98	\$7.98

Spouse not eligible for Medicare/children eligible for Medicare

	Spouse	Spouse/children	Children only
Savings Plan	\$369.80	\$573.16	N/A
Standard Plan	\$457.78	\$696.54	\$238.76
Medicare Supplement⁴	N/A	\$714.54 ⁸	\$256.76 ⁵
TRICARE Supplement	N/A	N/A	N/A
Dental	\$11.72	\$25.44	\$13.72
Dental Plus³	\$25.96	\$60.50	\$34.54
Vision	\$7.00	\$14.98	\$7.98

Spouse not eligible for Medicare/children not eligible for Medicare

	Spouse	Spouse/children	Children only
Savings Plan	\$369.80	\$573.16	\$203.36
Standard Plan	\$457.78	\$696.54	\$238.76
Medicare Supplement⁴	N/A	N/A	N/A
TRICARE Supplement	\$62.50	\$121.50	\$61.00
Dental	\$11.72	\$25.44	\$13.72
Dental Plus³	\$25.96	\$60.50	\$34.54
Vision	\$7.00	\$14.98	\$7.98

Footnotes for comparison and premium charts on Pages 31-34:

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

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

³If you enroll in Dental Plus, you must also be enrolled in the State Dental Plan. You will pay the combined premiums for both plans.

⁴If the Medicare Supplemental Plan is elected, claims for covered subscribers not eligible for Medicare will be based on the Standard Plan provisions.

⁵This premium applies only if one or more children are eligible for Medicare.



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CHANGE SERVICE REQUESTED