

Benefits Advantage



Choose your benefits DESTINATION

Open Enrollment 2023

Open enrollment time is approaching, and PEBA wants to help you choose your destination, so you are ready to select your insurance coverage for 2024. Start thinking now about what changes you might want to make to your insurance coverage. Visit peba.sc.gov/oe to learn more about this year's open enrollment.

Open enrollment is October 1-31, 2023. If you are satisfied with your elections, you don't need to do anything. Your current coverage will continue in 2024. If you are unsure what insurance coverage you have, you can review your current elections by logging in to your MyBenefits account at mybenefits.sc.gov.

Below are the changes you can make during open enrollment this year. Any coverage changes you make will take effect January 1, 2024. Log in to MyBenefits at mybenefits.sc.gov to make your coverage selections. If you would like to make a change with an immediate effective date, such as an address update, you should do so before submitting your open enrollment changes in October.

2024 Monthly premiums

Funded retiree health insurance premiums will not increase in 2024. Partially and non-funded retiree, COBRA subscriber, survivor and former spouse health insurance premiums will increase in 2024. Dental Plus and vision premiums will also increase. Be sure to review the 2024 monthly premiums at peba.sc.gov/monthly-premiums. If you worked for an optional employer, verify your rates with your former employer.

Choose your health plan

- Change from one health plan to another:
 - Medicare primary members:
 - Medicare Supplemental Plan; or
 - Carve-out Plan.
 - Non-Medicare primary members:
 - Standard Plan;
 - Savings Plan; or
 - TRICARE Supplement Plan for eligible military members.
- Enroll yourself or any eligible dependents in health coverage.
- Drop health coverage for yourself or any dependents.

If you are changing health plans, review the chart on Page 2. Be sure to note differences in copayments, deductibles and coinsurance.

Choose your dental coverage

- Change from one dental plan to another:
 - Dental Plus; or
 - Basic Dental.
- Enroll yourself or any eligible dependents in dental coverage.
- Drop dental coverage for yourself or any dependents.

Changes to existing dental coverage can be made during open enrollment only in odd-numbered years. If you don't make changes this year, your next opportunity to make a change will be in October 2025.

Choose your vision coverage

Enroll in or drop State Vision Plan coverage for yourself and/or any eligible dependents.

Health plans offered for 2024

The following chart is an overview of available plans and is for comparison only. The *Plan of Benefits*, which includes a complete description of the Plan, governs the three plans offered by PEBA. It is available at peba.sc.gov/publications.

Option for Medicare primary members

	Medicare Supplemental Plan
Availability	Same as Medicare and available to retirees and covered dependents/survivors who are eligible for Medicare.
Annual deductible	Plan pays Medicare Part A and Part B deductibles.
Coinsurance	Plan pays Part B coinsurance of 20%. There is no coinsurance maximum.
Physician's office visits	Plan pays Part B coinsurance of 20%.
Inpatient hospitalization¹	Plan pays Medicare deductible and coinsurance for days 61-150. Medicare benefits may end sooner than day 150 if members have previously used any of their 60 lifetime reserve days. Plan pays 100% beyond 150 days.
Prescription drugs² (30-day supply/90-day supply at network pharmacy)	Tier 1 (generic): \$13/\$32 Tier 2 (preferred brand): \$46/\$115 Tier 3 (non-preferred brand): \$77/\$192 You pay up to \$3,000 in prescription drug copayments. Then, you pay nothing.

Options for non-Medicare primary members

	Standard Plan ³	Savings Plan
Annual deductible	You pay up to \$515 per individual or \$1,030 per family.	You pay up to \$4,000 per individual or \$8,000 per family. ⁴
Coinsurance⁵	In network, you pay 20% up to \$3,000 per individual or \$6,000 per family.	In network, you pay 20% up to \$3,000 per individual or \$6,000 per family.
Physician's office visits⁶	You pay a \$15 copayment plus the remaining allowed amount until you meet your deductible. Then, you pay the copayment plus your coinsurance.	You pay the full allowed amount until you meet your deductible. Then, you pay your coinsurance.
Outpatient facility/emergency care^{7,8}	You pay a \$115 copayment (outpatient services) or \$193 copayment (emergency care) plus the remaining allowed amount until you meet your deductible. Then, you pay the copayment plus your coinsurance.	You pay the full allowed amount until you meet your deductible. Then, you pay your coinsurance.
Inpatient hospitalization⁹	You pay the full cost until you meet your deductible. Then, you pay your coinsurance.	You pay the full allowed amount until you meet your deductible. Then, you pay your coinsurance.
Prescription drugs² (30-day supply/90-day supply at network pharmacy)	Tier 1 (generic): \$13/\$32 Tier 2 (preferred brand): \$46/\$115 Tier 3 (non-preferred brand): \$77/\$192 You pay up to \$3,000 in prescription drug copayments. Then, you pay nothing.	You pay the full allowed amount until you meet your annual deductible. Then, you pay your coinsurance. Drug costs are applied to your coinsurance maximum. When you reach the maximum, you pay nothing.

¹Medi-Call or Companion Benefit Alternatives approval required if hospital stay exceeds 150 days.

²Prescription drugs are not covered at out-of-network pharmacies. Specialty medications are limited to a 30-day supply per fill.

³Standard Plan is the Carve-out Plan for Medicare primary members. Learn more in the *Insurance Coverage for the Medicare-eligible Member* handbook.

⁴If more than one family member is covered, no family member will receive benefits, other than preventive benefits, until the \$8,000 annual family deductible is met.

⁵Out of network, you will pay 40% coinsurance, and your coinsurance maximum is different. An out-of-network provider may bill you more than the Plan's allowed amount. Learn more about out-of-network benefits and about surprise billing protections at peba.sc.gov/health.

⁶The \$15 copayment is waived for routine mammograms, adult well visits, well woman visits and well child visits. Standard Plan members who receive in-person care at a BlueCross-affiliated patient-centered medical home (PCMH) will not be charged the \$15 copayment for a physician office visit. After Savings Plan and Standard Plan members meet their deductible, they will pay 10% coinsurance, rather than 20%, for care at a PCMH.

⁷The \$115 copayment for outpatient facility services is waived for dialysis services, partial hospitalizations, intensive outpatient services, electro-convulsive therapy and psychiatric medication management.

⁸The \$193 copayment for emergency care is waived if admitted.

⁹Inpatient hospitalization requires prior authorization for the State Health Plan to provide coverage. Not calling for prior authorization may lead to a \$515 penalty.

Open enrollment made easy

Use MyBenefits to make your changes

MyBenefits is the fastest, most convenient way for subscribers covered by PEBA-administered insurance programs to manage their benefits. Log in to MyBenefits at mybenefits.sc.gov to make your coverage changes during open enrollment and ensure prompt transmission of your coverage changes. If you are a first-time user, select Register to create an account.

How to make changes

- 1 Log in to your account and select Open Enrollment to view your current coverage and premiums.
- 2 Select Make Changes. Here you will see the coverage options available to you during open enrollment. The 2024 premiums for the coverage options will also be listed. Former employees of optional employers should contact their former employer to verify their premiums.
- 3 Select the changes you want and choose Next. You will then see a summary page comparing your current coverage to your new choices.
- 4 If you are happy with your elections, choose Apply. To submit your changes, you must enter the last four digits of your Social Security number and select Sign. Your changes are not complete until you submit your electronic signature.

You should also download or print a copy of the *Summary of Change* for your records. If you change your mind about your coverage selections, you have until 11:59 p.m. on October 31, 2023, to log back in to MyBenefits to make additional changes.

Some coverage changes, including enrolling a dependent who is not covered under any benefit, require supporting documentation. You can upload documents through MyBenefits. Keep in mind that PEBA must receive the documents by December 1 to approve the changes.

Follow up on your changes

In December 2023, log in to MyBenefits at mybenefits.sc.gov to review your changes. Select Review Benefits from the drop-down list to see your 2024 benefits.

If you notice any discrepancies, contact PEBA if you retired from a state agency, public higher education institution, public school district or charter school that participates in insurance and retirement. If you retired from an optional employer or charter school that participates in insurance only, contact your former employer.

Appointments for benefits consultations available

We offer appointments for one-hour phone consultations and video consultations, as well as in-person consultations. You will receive the same service regardless of the type of consultation you choose.

You may also contact us any time from 8:30 a.m. to 5 p.m., Monday through Friday, at 803.737.6800 or 888.260.9430. Calls are answered in the order in which they are received.

To learn more and schedule an appointment, visit peba.sc.gov/visit-us. You will receive a confirmation email with more details about your appointment.

Returning to work in an insurance-eligible job after retirement

If you return to work for a participating employer and are eligible to enroll in insurance benefits, and you, your spouse or your children are covered under retiree group insurance, you must elect active coverage or refuse all PEBA-sponsored coverage. There is one exception to this rule.

Retirees who are not eligible for Medicare and who retired from an employer that does not participate in the state's Retiree Health Insurance Trust Fund can remain on retiree coverage if they return to work in an insurance-eligible position. Contact your previous employer if you are unsure if it participates in the Retiree Health Insurance Trust Fund. When you stop working and your active group coverage ends, you may re-enroll in retiree group coverage within 31 days of the date you leave active employment by submitting a *Retiree Notice of Election* to PEBA.

Learn more in the Retiree group insurance chapter of the *Insurance Benefits Guide*.

Important reminders when you qualify for Medicare

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

- Be sure to enroll in Medicare Part A and Part B. If you do not enroll in Part B, you will have to pay the part of your health care costs that Part B would have paid.
- You or one of your dependents may qualify for Medicare because of a disability. If so, you should enroll in the Medicare Supplemental Plan. To enroll, submit a *Retiree Notice of Election* form. You need to submit the form within 31 days of Medicare Part A eligibility. Be sure to include a copy of your Medicare card with your form.
- PEBA automatically enrolls Medicare-eligible retirees in the State Health Plan Medicare Prescription Drug Program. PEBA also enrolls Medicare-eligible dependents in this program.
- For Medicare primary members, Part B prescriptions covered under the medical benefit might require prior authorization by CMS. Medicare primary members should use a network pharmacy that accepts Medicare.

The benefits offered by the Medicare Supplemental Plan and Carve-out Plan vary. This is especially true in how each plan coordinates with Medicare. The *Insurance Coverage for the Medicare-eligible Member* handbook includes a plan comparison. This handbook, available at peba.sc.gov/publications, is also useful in determining which plan best suits your needs. Additionally, you can learn about how the Medicare Supplemental Plan coordinates with traditional Medicare in the *Traditional Medicare and the Medicare Supplemental Plan* flyer, available at peba.sc.gov/nyb.

Avoid costs by getting the green light for your care

State Health Plan primary members must receive prior authorization for some medical and behavioral health services for the Plan to provide coverage. This means you or your provider needs to make a phone call. **Not calling for prior authorization may lead to a \$515 penalty.** Prior authorization does not guarantee payment.

- Medical services** :
- For prior authorization of your medical treatment, call Medi-Call at **800.925.9724** at least two business days before:
 - Non-emergent inpatient care in a hospital, including admission to a hospital to have a baby.
 - Admission to a long-term care facility or nursing facility.
 - An outpatient service that results in a hospital admission.
 - Ordering durable medical equipment.
 - Outpatient surgery for a septoplasty (surgery on the septum of the nose).
 - In vitro fertilization or other infertility procedures.
 - Outpatient or inpatient surgery for a hysterectomy.
 - An organ transplant.
 - Sclerotherapy (vein surgery).
 - Inpatient rehabilitation services and related outpatient physical, speech or occupational therapy.
 - Chemotherapy or radiation therapy.

- Pregnancy** : You should contact Medi-Call at **800.925.9724** within the first three months of a pregnancy.

- Emergencies** : In a hospital emergency, you should contact Medi-Call at **800.925.9724** to report your admission within 48 hours or the next business day.

- Radiology services** :
- For prior authorization of your radiology services, call National Imaging Associates at **866.500.7664**:
 - CT scan.
 - MRA.
 - MRI.
 - PET scan.

- Behavioral health services** :
- For prior authorization of your behavioral services, call Companion Benefit Alternatives at **800.868.1032**.
 - Inpatient hospital care.
 - Repetitive transcranial magnetic therapy.
 - Intensive outpatient hospital care.
 - Applied behavioral analysis therapy.
 - Partial hospitalization care.
 - Psychological/neuropsychological testing.
 - Outpatient electroconvulsive therapy.
 - Some outpatient behavioral health services may not be covered by the Plan if you do not receive prior authorization.

Adult well visits

Well visits may be a key part of preventive care. They can reassure you that you are as healthy as you feel, or prompt you to ask questions about your health. Learn more about adult well visits and when they are covered at peba.sc.gov/well-visits.

How the benefit works

State Health Plan primary members are eligible for one well visit each year at no member cost. Beginning in 2024, eligible female members may take advantage of the annual adult well visit at no cost and can also receive an annual well woman visit at no cost. Evidence-supported services, based on United States Preventive Services Task Force (USPSTF) A and B recommendations, are included as part of an adult well visit and well woman visit under the State Health Plan. After talking with your doctor during a visit, the doctor can decide which services you need and build a personal care plan for you.

Who is eligible?

The benefit is available to all non-Medicare primary adults ages 19 and older who are covered by the Standard Plan or Savings Plan. Adult members can take advantage of this benefit at a network provider specializing in general practice, family practice, pediatrics, internal medicine, gerontology, and obstetrics and gynecology.

Women ages 18-65 can also receive a Pap test each calendar year at no member cost through PEBA Perks.

Services not included in an adult well visit

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

How to get the most out of your benefits

The State Health Plan offers many value-based benefits at no member cost to its primary members through PEBA Perks. Learn how to coordinate your PEBA Perks benefits with your adult well visit below.

Step 1

Get your preventive screening. You can receive a biometric screening at no cost, which will minimize cost to the Plan at your adult well visit.

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Step 2

Have your adult well visit or well woman visit after your preventive screening. USPSTF A and B recommendations are included as part of a well visit. After talking with your doctor during a visit, the doctor can decide which services you need and build a personal care plan for you.

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Step 3

Share your preventive screening results with your doctor. You will receive a confidential report with your screening results, and we recommend you share it with your doctor to eliminate the need for retesting at a well visit. Sharing your results will minimize the cost of your well visit to the Plan.

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Step 4

Follow your doctor’s recommendations and stay engaged with your health. We encourage you to take advantage of the other PEBA Perks available to you. If you’re eligible, sign up for No-Pay Copay to receive certain generic drugs at no cost to you. Learn more at www.PEBAPERKS.com.

Save money and get the care you need

Your primary care physician should be your first call for routine medical care. 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.

Primary care physician

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

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

Your primary care physician may offer telehealth services, too. Contact your provider for more information.

Telehealth

If your doctor's office is closed, you're traveling or you feel too sick to drive, use a video visit for non-emergency health issues, such as:

- Cold and flu symptoms.
- Pinkeye.
- Rashes and other skin irritations.
- Seasonal allergies.
- Sinus or respiratory infections.
- Urinary tract infections.

Blue CareOnDemand Search for Blue CareOnDemand in your app store. You can see a doctor who can diagnose your symptoms and call in a prescription to your local pharmacy, if needed.

MUSC Health Virtual Care Visit www.MUSChealth.org/virtual-care to start a visit. A doctor will diagnose your symptoms and call in a prescription to your local pharmacy, if needed. You must be in South Carolina at the time of the visit.

Emergencies

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

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

• You pay a \$15
• copayment,¹ plus the
• remaining allowed
• amount until you meet
• your deductible. Then,
• you pay the copayment
• plus your coinsurance.

• For Blue CareOnDemand,
• you pay a \$15
• copayment,¹ plus the
• remaining allowed
• amount until you meet
• your deductible. Then,
• you pay the copayment
• plus your coinsurance.
• MUSC visits are available
• at no cost for all State
• Health Plan members,
• including Medicare
• primary members.

• You pay a \$193
• copayment,¹ plus the
• remaining allowed
• amount until you meet
• your deductible. Then,
• you pay the copayment
• plus your coinsurance.

¹Standard Plan members who receive in-person care at a PCMH will not pay a copayment. Savings Plan members do not pay copayments for any visits, but pay the full allowed amount until meeting their deductible.

Manage your health and pharmacy benefits with My Health Toolkit

When you're a member of the State Health Plan, you have one convenient place for managing your health and pharmacy benefits. My Health Toolkit is your one-stop destination.

Learn more about your coverage.

Look up your medical coverage, deductible and out-of-pocket spending.

Check medical claims.

View the status of a current or previous medical claim, the date of service, the amount charged by your provider and the amount you may owe.

Check dental claims.

Look up your dental coverage, deductible and out-of-pocket spending on dental care.

View or replace your identification card.

Access an electronic version of your card or order a replacement card by visiting the full site.

Manage your prescriptions.

You're just a click away from all your medication details. Select the **Full Site** link to access your Express Scripts account. You can see prescription drug claims and payment history, find and compare drug prices, check to see if a medication is subject to clinical rules, see your prescription order status, order a temporary ID card and much more.

Find a provider.

Use the **Find Care** link to view a list of network doctors and medical facilities or dentists in your area. Filter your search and compare results side by side. You can even view feedback from other members about a specific provider.

Get started today

It's easy to sign up for My Health Toolkit. Follow these steps to have everything you need at your fingertips.

- 1** Search for **My Health Toolkit®** in your app store.
In the app, select **Sign Up**.
- 2** Or, visit www.StateSC.SouthCarolinaBlues.com and select **Create An Account**.
Enter your member identification number that's on your State Health Plan identification card and your date of birth.
- 3** Choose a username and password.
- 4** Enter your email address and choose to go paperless.

If you have not created an Express Scripts account, you'll be prompted to create one the first time you access your pharmacy benefits through My Health Toolkit.

If you have any questions about your My Health Toolkit account, call BlueCross at **800.868.2520**.

Coordination of benefits

All State Health Plan benefits are subject to coordination of benefits, a process that is used to make sure a person covered by more than one insurance plan will not be reimbursed more than once for the same expenses. With coordination of benefits, the primary plan pays first. The secondary plan pays after the primary plan. To ensure benefits are paid correctly, members must complete a coordination of benefits questionnaire every year. BlueCross will not process or pay claims until it receives your information. Log in to your [My Health Toolkit account](#) to update this information.

2024 Insurance vendor contact information

BlueCross BlueShield of South Carolina

State Health Plan

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

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

Medi-Call (medical prior authorization)

AF-650 | I-20 Alpine Road | Columbia, SC 29219

- 803.699.3337 or 800.925.9724
- Fax: 803.264.0183

Companion Benefit Alternatives

Behavioral health

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

- Customer Service: 803.736.1576 or 800.868.2520
- Precertification: 800.868.1032
- Case management, behavioral health coaching: 800.868.1032, ext. 25835
- www.CompanionBenefitAlternatives.com

National Imaging Associates

Advanced radiology prior authorization

A subsidiary of Magellan Health Services

- 866.500.7664
- www.RadMD.com

Dental Plus, Basic Dental

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

- Customer Service: 888.214.6230 or 803.264.7323
- Fax: 803.264.7739
- StateSC.SouthCarolinaBlues.com

Express Scripts

State Health Plan Prescription Drug Program, Express Scripts Medicare®

Claims: Attn: Commercial Claims | P.O. Box 14711
Lexington, KY 40512-4711

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

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

EyeMed

State Vision Plan

Group No.: 9925991

Claims: OON Claims

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

- Customer Care Center: 877.735.9314
- www.eyemedvisioncare.com/pebaoe

MetLife

Basic, Optional and Dependent Life

Policy No.: 200879-1-G

MetLife Recordkeeping and Enrollment Services

P.O. Box 14401 | Lexington, KY 40512-4401

- Claims: 800.638.6420, Option 2
- Continuation for retirees: 888.507.3767
- Conversion: 877.275.6387
- Conversion Fax: 866.545.7517
- www.metlife.com/scpeba

Selman & Company

TRICARE Supplement Plan

P.O. Box 29151 | Hot Springs, AR 71903

- Customer Service: 866.637.9911, Option 1
- <https://info.selmanco.com/peba>

The Standard

Long term disability

Group No.: 621144

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

- Customer Service: 800.628.9696
- Continued benefits (conversion): 800.378.4668
- www.standard.com/mybenefits/scpeba

Learn more in the IBG

The 2024 *Insurance Benefits Guide* (IBG) describes the insurance programs in detail and contains information about all PEBA-sponsored insurance benefits. The guide will be available online by October 1, 2023, at peba.sc.gov/publications.

Have you moved?

If you have recently moved or you plan to move soon, be sure to log in to MyBenefits to update your address on file with PEBA. *If you would like to make this address change have an immediate effective date, you should submit the change before submitting your open enrollment changes in MyBenefits.* It is particularly important that you keep your address up to date. This ensures you receive benefits information, including Internal Revenue Service Form 1095. You will receive Form 1095 by January 31, 2024. The form shows you have minimum essential health insurance coverage. The federal Affordable Care Act requires you to have this coverage.

Keep in mind that updating your address in MyBenefits does not update your address for retirement benefits administered by PEBA. Log in to Member Access to update your address for retirement benefits.

How much health insurance do you need?

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

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

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

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

Federally mandated notices

Grandfathered notice

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

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

Summaries of Benefits and Coverage

The 2024 *Summaries of Benefits and Coverage* for the Standard and Savings Plans are available at peba.sc.gov/publications. To request a copy, call PEBA at 803.737.6800 or 888.260.9430.

Notice of Privacy Practices

Effective: April 14, 2003 | Revised: July 1, 2020

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

The South Carolina Public Employee Benefit Authority (PEBA) is committed to protecting the privacy of your protected health information. PEBA may access your medical claims information and related protected health information in order to provide you with health insurance

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

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

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

How PEBA may use and disclose protected health information

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

- **For treatment.** PEBA may use and disclose your protected health information to coordinate and manage your health care-related services by one or more of your health care providers. For example, a representative of PEBA, a case manager and your doctor may discuss the most beneficial treatment plan for you if you have a chronic condition, such as diabetes.
- **For payment.** PEBA may use and disclose your protected health information to bill, collect payment and pay for your treatment/ services from an insurance company or another third party; to obtain premiums; to determine or fulfill its responsibility for coverage or provision of benefits; or to provide reimbursement for health care. For example, PEBA may need to give your protected health information to another insurance provider to facilitate the coordination of benefits or to your employer to facilitate the employer's payment of its portion of the premium.
- **For health care operations.** PEBA may use and disclose protected health information about you for other PEBA operations. PEBA may use protected health information in connection with conducting quality assessment and improvement activities; reviewing the competence or qualifications of health care professionals; evaluating practitioner, provider and health plan performance; underwriting, premium rating and other activities relating to health plan coverage; conducting or arranging for medical review, legal services, audit services and fraud and abuse detection programs; business planning and development, such as cost management; and business management and general administrative activities. For example, PEBA may disclose your protected health information to an actuary to make decisions regarding premium rates, or it may share your protected health information with other business associates that, through written agreement, provide services to PEBA. These business associates, such as consultants or third-party administrators, are required to protect the privacy of your protected health information.
- **Business Associates.** PEBA may contract with individuals or entities known as Business Associates to perform various functions on PEBA's behalf or to provide certain types of services. For example, PEBA may disclose your protected health information to a Business Associate to process your claims for Plan benefits, pharmacy benefits, or other support services, but the Business Associate must enter into a Business Associate contract with PEBA agreeing to implement appropriate safeguards regarding your protected health information.
- **Treatment alternatives and health-related benefits and services.** PEBA may use and disclose your protected health information to contact you about health-related benefits or services that may be of interest to you. For example, you may be contacted and offered enrollment in a program to assist you in handling a chronic disease, such as high blood pressure.
- **Individuals involved in your care or payment for your care.** PEBA may, in certain circumstances, disclose protected health information about you to your representative, such as a friend or family member who is involved in your health care, or to your representative who helps pay for your care. PEBA may disclose your protected health information to an agency assisting in disaster relief efforts so that your family can be notified about your condition, status and location.
- **Research.** PEBA may use and disclose your de-identified protected health information for research purposes, or PEBA may share protected health information for research approved by an institutional review board or privacy board after review of the research rules to ensure the privacy of your protected health information. For example, a research project may compare the health/recovery of patients who receive a medication with those who receive another medication for the same condition.

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

Your rights regarding your protected health information

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

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

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

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

Complaints

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

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

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

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

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

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

Changes to this notice

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

Other uses of protected health information

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

However, PEBA will not be able to take back any disclosure that it made with your permission.

HIPAA Notice of Special Enrollment Rights

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

Women's Health and Cancer Rights Act

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

Newborn's and Mother's Health Protection Act

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

New Health Insurance Marketplace coverage options and your health coverage

PART A: General information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2023 for coverage starting as early as January 1, 2024.

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

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

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

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

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

How can I get more information?

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

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your state for more information on eligibility.

ALABAMA - Medicaid Website: http://myalhipp.com Phone: 1-855-692-5447	ALASKA - Medicaid The AK Health Insurance Premium Payment Program Website: http://myakhipp.com Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS - Medicaid Website: http://myarhipp.com Phone: 1-855-MyARHIPP (855-692-7447)	CALIFORNIA - Medicaid Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+) Health First Colorado Website: https://www.healthfirstcolorado.com Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com HIBI Customer Service: 1-855-692-6442	FLORIDA - Medicaid Website: https://www.flmedicaidtprecovery.com flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA - Medicaid GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	INDIANA - Medicaid Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid Phone 1-800-457-4584

IOWA - Medicaid and CHIP (Hawki) Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	KANSAS - Medicaid Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY - Medicaid Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIP.PPROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	LOUISIANA - Medicaid Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) 1-855-618-5488 (LaHIPP)
MAINE - Medicaid Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	MASSACHUSETTS - Medicaid Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA - Medicaid Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	MISSOURI - Medicaid Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA - Medicaid Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov	NEBRASKA - Medicaid Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA - Medicaid Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	NEW HAMPSHIRE - Medicaid Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll-free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY - Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	NEW YORK - Medicaid Website: https://www.health.ny.gov/health_care/medicaid Phone: 1-800-541-2831
NORTH CAROLINA - Medicaid Website: https://medicaid.ncdhhs.gov Phone: 919-855-4100	NORTH DAKOTA - Medicaid Website: http://www.nd.gov/dhs/services/medicalserv/ medicaidPhone: 1-844-854-4825
OKLAHOMA - Medicaid and CHIP Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	OREGON - Medicaid Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075

PENNSYLVANIA - Medicaid and CHIP Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 1-800-986-KIDS (5437)	RHODE ISLAND - Medicaid and CHIP Website: http://www.eohhs.ri.gov Phone: 1-855-697-4347 or 401-462-0311 (Direct Rite Share Line)
SOUTH CAROLINA - Medicaid Website: https://www.scdhhs.gov Phone: 1-888-549-0820	SOUTH DAKOTA - Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS - Medicaid Website: http://gethipptexas.com Phone: 1-800-440-0493	UTAH - Medicaid and CHIP Medicaid Website: https://medicaid.utah.gov CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT - Medicaid Website: https://dvha.vermont.gov/members/medicaid/hipp-program Phone: 1-800-250-8427	VIRGINIA - Medicaid and CHIP Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON - Medicaid Website: https://www.hca.wa.gov Phone: 1-800-562-3022	WEST VIRGINIA - Medicaid and CHIP Website: https://dhhr.wv.gov/bms or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN - Medicaid and CHIP Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	WYOMING - Medicaid Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1.866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1.877.267.2323, Menu Option 4, Ext. 61565

Medicare Part D creditable coverage letter

Important notice from PEBA about your prescription drug coverage and Medicare

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

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

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (such as a health maintenance organization or preferred provider organization) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. PEBA offers Express Scripts Medicare and the State Health Plan Prescription Drug Program to members enrolled in Medicare. It has determined that the prescription drug coverage offered through the Standard Plan or the Medicare Supplemental Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays. It is, therefore, considered creditable coverage. Because your existing coverage is creditable coverage, you can keep this coverage and

not pay a higher premium (a penalty) if you later decide to join a Medicare prescription drug plan.

When can you join a Medicare prescription drug plan?

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

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

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

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

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

If you drop or lose your current coverage with PEBA and don't join a Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (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% 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% higher than the Medicare base beneficiary premium.

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

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

Contact PEBA at the address or telephone number listed below.

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

For more information about your options under Medicare prescription drug coverage

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

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

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

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

Contact PEBA for further information.

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

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

Your rights and protections against surprise medical bills

When you get emergency care or are treated by an out-of-network provider at a network hospital or ambulatory surgical center, you are protected from surprise billing. In these cases, you shouldn't be charged more than the State Health Plan's copayments, deductible and coinsurance.

What is surprise billing?

Surprise billing happens when you receive a bill for a service when you can't control who is involved in your care, like when you have an emergency or when you schedule a visit at a network facility but are unexpectedly treated by an out-of-network provider.

You are protected from surprise billing for the following services:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is the State Health Plan's network cost sharing amount, such as copayments, deductibles and coinsurance. You can't be charged more than the Plan's allowed amount for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections against being charged more than the Plan's allowed amount for these services.

Certain services at a network hospital or ambulatory surgical center

When you get services from a network hospital or ambulatory surgical center, certain providers there may be out of network. In these cases, the most those providers can bill you is the State Health Plan's network cost sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services. These providers can't charge you more than the Plan's allowed amount and may not ask you to give up your protections against surprise billing.

If you get other types of services at these network facilities, out-of-network providers can't charge you more than the Plan's allowed amount unless you give written consent and give up your protections.

You are never required to give up your protections from surprise billing. You also are not required to get out-of-network care. You can choose a provider or facility in the State Health Plan's network.

When you are protected against surprise billing, you also have these protections:

- You're responsible for paying only your share of the cost. This cost includes the copayments, deductibles and coinsurance you would pay if the provider or facility was in network. The State Health Plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, the State Health Plan must:
 - Cover emergency services without requiring you to get approval for services in advance, also known as prior authorization.
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost sharing) on what it would pay a network provider or facility and show that amount in your Explanation of Benefits.
 - Count any amount you pay for emergency or out-of-network services toward your in-network deductible and out-of-pocket coinsurance maximum.

If you think you've been wrongly billed, contact the United States Department of Health and Human Services at 888.393.2789. The toll-free phone number for information and complaints is 800.985.3059.

You may also receive help through an applicable state consumer assistance program. Visit www.dol.gov for contact information by state. Visit www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for more information about your rights under federal law.

Note: If you choose to use an out-of-network provider, the provider may bill you the difference in its cost and the allowed amount. This is known as a balance bill. Learn more about balance billing at peba.sc.gov/nyb.

Health help in the palm of your hand

Text messages are a great way to keep up with kids, friends and appointments. They can help you stay on top of your health, too. Learn how to avoid catching a cold.

Find out about benefits available at no cost. Get information about healthy lifestyle programs, health coaching and value-based benefits.

As a State Health Plan member, you'll automatically receive text messages, but can opt out anytime.

Data rates may apply.



PEBASM

SC Retirement Systems
and State Health Plan

202 Arbor Lake Drive
Columbia, SC 29223

Serving those who serve South Carolina



Choose your benefits
DESTINATION

Open Enrollment 2023

Open enrollment is October 1-31, 2023. During open enrollment, eligible subscribers may change their coverage for the following year. Review your current coverage in MyBenefits (mybenefits.sc.gov).

If you are satisfied with your elections, you don't need to do anything. You will remain enrolled, and your current coverage will continue in 2024. **All open enrollment changes take effect January 1, 2024.**

Follow these steps to learn about open enrollment and make changes:

- 1 Visit the open enrollment webpage, peba.sc.gov/oe, to learn about the changes you can make.
- 2 Download your open enrollment worksheet at peba.sc.gov/oe to plan your coverage for 2024.
- 3 Log in to MyBenefits (mybenefits.sc.gov) to review your coverage and make changes during open enrollment, if necessary.