

2019 Insurance Summary

for South Carolina's public employees

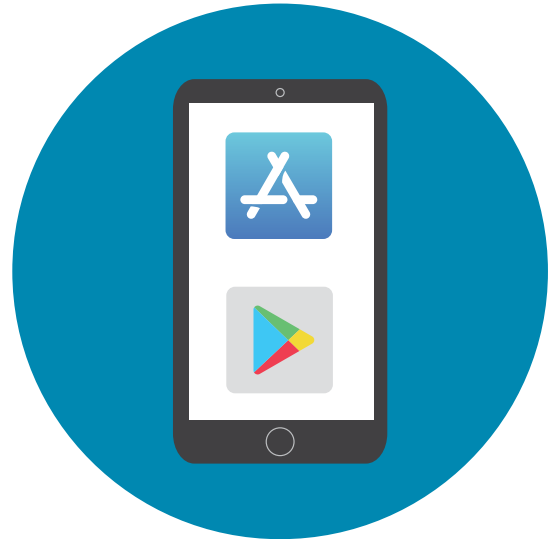


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Your benefits on-the-go

Make your phone your go-to resource for accessing your insurance benefits information. Mobile apps are available for your health, dental, prescription, vision and flexible spending benefits. Learn more about these apps on Page 10.



Look for this icon throughout the summary; visit the App Store (iOS) or Google Play (Android) and use the search term above each icon.

Welcome

There are certain times throughout the year when you may enroll in insurance coverage or make changes to your coverage. Review this summary and use the foldout worksheet in the back to plan the 2019 health coverage and additional benefits that are best for you and your family.

Open enrollment | October 1-31, 2018

During open enrollment, eligible employees may change their coverage for the following year. If you are satisfied with your current coverage, the only thing you need to do is re-enroll in MoneyPlus accounts. All open enrollment changes take effect January 1, 2019. Log in to **MyBenefits** (mybenefits.sc.gov) to make your coverage selections during open enrollment.



New hires

From the date you become eligible, you have 31 days to enroll in your health insurance and other available insurance benefits. Once you are ready to make your coverage selections, contact your benefits administrator for the next steps to enroll.

Eligibility

Eligible employees are those who:

- Work for the state, a higher education institution, a public school district or another entity allowed by law to participate, like a county government or municipality, as a full-time employee; and
- Receive compensation from the state, a higher education institution, a public school district or other entity allowed by law to participate.

What's new for 2019

Patient cost-sharing increases

Some patient cost-sharing features, such as copayments and deductibles, will increase for Standard Plan members. Learn more on Page 2.

Adult well visits

Adult well visits will be a covered benefit under the Standard Plan, subject to copayments, deductibles and coinsurance in covered years. Learn more on Page 16.

Naturally Slim

This 10-week, online program will teach the behavioral skills necessary to lose weight and keep it off long-term. Learn more on Page 20.

MoneyPlus changes

- ASIFlex is the new flexible spending accounts administrator.
- No fee to participate in the Pretax Group Insurance Premium feature.
- Carry over up to \$500 of unused Medical Spending Account funds into 2020.
- Use Dependent Care Spending Account funds for expenses incurred through March 15, 2020.
- Central Bank is the new custodian bank for Health Savings Accounts.

Step 1: Choose your health plan



Your insurance needs are as unique as you are. You may meet your deductible each year or maybe you can't remember the last time you saw a doctor. No matter your situation, the State Health Plan gives you two options to cover your expenses: the Standard Plan or the Savings Plan.

The Standard Plan has higher premiums and lower deductibles. The Savings Plan has lower premiums and higher deductibles. Learn more about the plans at www.peba.sc.gov/healthplans.html.

	Standard Plan	Savings Plan
Annual deductible	You pay up to \$490 per individual or \$980 per family.	You pay up to \$3,600 per individual or \$7,200 per family ¹ .
Coinsurance²	In network, you pay 20% up to \$2,800 per individual or \$5,600 per family.	In network, you pay 20% up to \$2,400 per individual or \$4,800 per family.
Physician's office visits³	You pay a \$14 copayment plus the remaining allowed amount until you meet your deductible. Then, you pay the copayment plus your coinsurance.	You pay the full cost until you meet your deductible. Then, you pay your coinsurance.
Blue CareOnDemandSM (More details on Page 15)	You pay a \$14 copayment plus the remaining allowed amount until you meet your deductible. Then, you pay the copayment plus your coinsurance.	You pay the full cost until you meet your deductible. Then, you pay your coinsurance.
Outpatient facility/ emergency care^{4,5}	You pay a \$105 copayment (outpatient services) or \$175 copayment (emergency care) plus the remaining allowed amount until you meet your deductible. Then, you pay the copayment plus your coinsurance.	You pay the full cost until you meet your deductible. Then, you pay your coinsurance.
Inpatient hospitalization	You pay the full cost until you meet your deductible. Then, you pay your coinsurance.	You pay the full cost until you meet your deductible. Then, you pay your coinsurance.
Prescription drugs⁶ (30-day supply/90-day supply at network pharmacy)	Tier 1 (generic): \$9/\$22 Tier 2 (preferred brand): \$42/\$105 Tier 3 (non-preferred brand): \$70/\$175 You pay up to \$3,000 in prescription drug copayments. Then, you pay nothing.	You pay the allowed amount until you meet your annual deductible. Then, you pay your coinsurance.
Tax-favored accounts (More details on Page 8)	Medical Spending Account	Health Savings Account Limited-use Medical Spending Account

The TRICARE Supplement Plan provides secondary coverage to TRICARE. For eligible employees, it provides an alternative to the State Health Plan.

2019 Premiums^{7,8}

	Employee	Employee/spouse	Employee/children	Full family
Standard Plan	\$97.68	\$253.36	\$143.86	\$306.56
Savings Plan	\$9.70	\$77.40	\$20.48	\$113.00
TRICARE Supplement	\$62.50	\$121.50	\$121.50	\$162.50

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

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

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

⁴ The \$105 copayment for outpatient facility services is waived for physical therapy, speech therapy, occupational therapy, dialysis services, partial hospitalizations, intensive outpatient services, electroconvulsive therapy and psychiatric medication management.

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

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

⁷ Premiums for local subdivisions may vary. To verify your rates, contact your benefits office.

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



Step 2: Choose your dental plan



Changes to existing dental coverage can only be made during open enrollment in odd-numbered years. **Only new hires will complete this step.**

Basic dental coverage with the State Dental Plan offers four classes of treatment:

- I. Diagnostic and preventive** Exams; cleaning and scaling of teeth; fluoride treatment; space maintainers (child); X-rays;
- II. Basic** Fillings; extractions; oral surgery; endodontics (root canals); periodontal procedures;

III. Prosthodontics Onlays; crowns; bridges; dentures; implants; repair of prosthodontic appliances; and

IV. Orthodontics Limited to covered children ages 18 and younger. Correction of malocclusion consisting of: diagnostic services (including models, X-rays); active treatment (including necessary appliances).

Dental Plus gives you even more coverage, with the added benefit of a higher allowed amount. It also offers deeper discounts and lower out-of-pocket expenses. To participate in Dental Plus, you must enroll in basic coverage and cover the same family members under both plans. Learn more about the plans at www.peba.sc.gov/dental.html.

	Plan	Annual deductible ¹	Percent covered of allowed amount	Maximum payment ²
I. Diagnostic and preventive	Basic Dental	None	100%	\$1,000 per person each year for Classes I, II and III
	With Dental Plus	None	100%	\$2,000 per person each year for Classes I, II and III
II. Basic benefits	Basic Dental	You pay up to \$25 per person.	80%	\$1,000 per person each year for Classes I, II and III
	With Dental Plus	No additional deductible	80%	\$2,000 per person each year for Classes I, II and III
III. Prosthodontics	Basic Dental	You pay up to \$25 per person.	50%	\$1,000 per person each year for Classes I, II and III
	With Dental Plus	No additional deductible	50%	\$2,000 per person each year for Classes I, II and III
IV. Orthodontics³	Basic Dental	None	50%	\$1,000 lifetime benefit for each covered child
	With Dental Plus	None	No additional benefits	No additional benefits

¹ If you have services in Classes II and III, you pay only one deductible. Deductible is limited to three per family per year.

² \$2,000 is the maximum yearly payment for benefits when a member is enrolled in basic dental coverage and Dental Plus.

³ A subscriber must submit a letter from his provider for a covered child, ages 18 and younger, stating that the child's orthodontic treatment is not for cosmetic purposes for it to be covered by the State Dental Plan.

2019 Premiums

	Employee	Employee/spouse	Employee/children	Full family
Basic Dental	\$0.00	\$7.64	\$13.72	\$21.34
With Dental Plus	\$27.12	\$62.44	\$76.92	\$103.44

Step 3: Choose your vision coverage



Good vision is crucial for work and play. It is also a significant part of your health. An annual eye exam can help detect serious illnesses. You will pay the full premium without an employer contribution.

You can have an exam once a year and get either frames/lenses or contacts once a year. Learn more about your vision coverage at www.peba.sc.gov/vision.html.

	In-network member cost	Out-of-network reimbursement
	You pay:	You receive:
Exam, with dilation if necessary	A \$10 copay.	Up to \$35.
Retinal imaging	Up to \$39 .	No reimbursement.
Frames	80% of balance over \$150 allowance.	Up to \$75.
Standard plastic lenses	A \$10 copay.	Up to \$55.
Standard progressive lenses	A \$35 copay.	Up to \$55.
Premium progressive lenses	\$35–\$80 for Tiers 1–4. For Tier 4, you pay copay and 80% of cost less \$120 allowance.	Up to \$55.
Standard contact lenses fit & follow-up	A \$0 copay.	Up to \$40.
Premium contact lenses fit & follow-up	A \$0 copay and receive 10% off retail price less \$55 allowance.	Up to \$40.
Conventional contact lenses	A \$0 copay and 85% of balance over \$130 allowance.	Up to \$104.
Disposable contact lenses	A \$0 copay and balance over \$130 allowance.	Up to \$104.

2019 Premiums

	Employee	Employee/spouse	Employee/children	Full family
Vision	\$8.00	\$16.00	\$17.16	\$25.16



Step 4: Choose your additional life insurance coverage



You are automatically enrolled in Basic Life insurance at no cost if you enroll in the State Health Plan. This policy provides \$3,000 in coverage. You'll also get a matching amount of Accidental Death and Dismemberment (AD&D) insurance. You may elect more coverage for yourself, spouse and/or children. Learn more about your life insurance options at www.peba.sc.gov/life.html.

	Coverage level	Coverage details
Optional Life with AD&D	Elect in \$10,000 increments up to a maximum of \$500,000.	<ul style="list-style-type: none"> • Lesser of three times annual earnings or \$500,000 of coverage guaranteed within 31 days of initial eligibility. • Includes matching amount of AD&D insurance. • Coverage reduces to 65% at age 70, to 42% at age 75 and to 31.7% at age 80 and beyond.
Dependent Life-Spouse with AD&D	Elect in \$10,000 increments up to a maximum of \$100,000 or 50% of your Optional Life amount, whichever is less.	<ul style="list-style-type: none"> • If you are not enrolled in Optional Life, spouse coverages of \$10,000 or \$20,000 are available. • \$20,000 of coverage guaranteed within 31 days of initial eligibility. • Includes matching amount of AD&D insurance.
Dependent Life-Child	\$15,000 per child.	<ul style="list-style-type: none"> • Coverage guaranteed. • Children are eligible from live birth to ages 19 or 25 if a full-time student. • Child can only be covered by one parent.

2019 Monthly premiums

Optional Life and Dependent Life-Spouse

Premiums are determined by the employee or spouse's age as of the previous December 31 and the coverage amount. Rates shown per \$10,000 of coverage.

Age	Employee	Age	Employee
Under 35	\$0.58	60-64	\$6.00
35-39	\$0.78	65-69	\$13.50
40-44	\$0.86	70-74	\$24.22
45-49	\$1.22	75-79	\$37.50
50-54	\$1.94	80 and over	\$62.04
55-59	\$3.36		

Dependent Life-Child

\$1.26 per month; you only pay one premium for all eligible children.

Step 5: Choose your supplemental long term disability coverage



You are automatically enrolled in Basic Long Term Disability at no cost if you enroll in the State Health Plan. The maximum benefit is \$800 per month. You may elect more coverage for added protection. Learn more about long term disability coverage at www.peba.sc.gov/longtermdisability.html.

Supplemental Long Term Disability

Supplemental Long Term Disability (SLTD) is a voluntary benefit for which you pay. The benefit provides:

- Competitive group rates;
- Survivor's benefits for eligible dependents;
- Coverage for injury, physical disease, mental disorder or pregnancy;
- Return-to-work incentive;
- SLTD conversion insurance;
- Cost-of-living adjustment; and
- Lifetime security benefit.

SLTD benefits summary

	Benefit
Benefit waiting period	90 or 180 days
Monthly SLTD benefit¹	65% of your predisability earnings, reduced by your deductible income
Minimum benefit	\$100 per month
Maximum benefit	\$8,000 per month

¹ Basic Long Term Disability and Supplemental Long Term Disability benefits are subject to federal and state income taxes. Check with your accountant or tax adviser about your tax liability.

2019 Monthly premium factor

Multiply the premium factor for your age and plan selection by your monthly earnings to determine your monthly premium.

Age preceding January 1	90-day waiting period	180-day waiting period
Under 31	0.00065	0.00052
31-40	0.00090	0.00070
41-50	0.00179	0.00136
51-60	0.00361	0.00277
61-65	0.00434	0.00333
66 and older	0.00530	0.00407

Step 6: Choose your MoneyPlus elections



Don't leave money on the table. MoneyPlus is a tax-favored accounts program, which allows you to save money on eligible medical and dependent care costs. You fund the accounts with money deducted pretax from your paycheck. Learn more about your MoneyPlus options¹ at www.peba.sc.gov/moneyplus.html.

Standard Plan members

Medical Spending Account

If you are a Standard Plan member, you can use a Medical Spending Account (MSA) to pay for eligible medical expenses, including copayments and coinsurance. As you have eligible expenses, you can use a debit card for your account or submit claims for reimbursement. You can carry over into 2020 up to \$500 in unused funds from your account. You must re-enroll each year.



Savings Plan members

Health Savings Account

If you are a Savings Plan member, a Health Savings Account (HSA) is essential to help you prepare for your health expenses.

- Carry over all funds from one year to the next.
- You own the account and keep it if you leave your job or retire.
- While there is an annual contribution limit, there's no limit to how much you can save in your account.
- You can invest funds to earn investment income tax-free.

Limited-use Medical Spending Account

If you have a Health Savings Account, you can also use a Limited-use Medical Spending Account to pay for those expenses the Savings Plan does not cover, like dental and vision care.

Account type	Plan	Funds available	Medical expenses	Dental, vision expenses	Balance carries from year-to-year	Invest funds	Re-enroll each year
MSA	Standard	January 1	✓	✓	Up to \$500		✓
HSA	Savings	As deposited	✓	✓	✓	✓	
Limited-use MSA	Savings	January 1		✓	Up to \$500		✓

¹ Contributions made before taxes lower your taxable earned income. The lower your earned income, the higher the earned income tax credit. See IRS Publication 596 or talk to a tax professional for more information.

All members

Pretax Group Insurance Premium feature

This feature allows you to pay insurance premiums before taxes for health, vision, dental and up to \$50,000 of Optional Life coverage. You do not need to re-enroll each year.

Dependent Care Spending Account

You can use a Dependent Care Spending Account to pay for daycare costs for children and adults. It cannot be used to pay for dependent medical care. You submit claims for reimbursement as you have eligible expenses. The funds can be used only for expenses incurred January 1, 2019, through March 15, 2020. You forfeit funds left in your account after the reimbursement deadline. You must re-enroll each year.

2019 Administrative fees

Monthly fees	
Medical Spending Account	\$2.32
Limited-use Medical Spending Account	\$2.32
Dependent Care Spending Account	\$2.32
Central Bank (HSA)	
Maintenance fee (balances less than \$2,500)	\$1.25
Paper statements	\$3.00
Annual fees	
Health Savings Account	\$12.00

2019 Contribution limits

Account	Limit
Medical Spending Account ²	\$2,650
Health Savings Account	\$3,500 (self-only coverage) \$7,000 (family coverage) \$1,000 (catch-up for age 55 or older)
Limited-use Medical Spending Account ²	\$2,650
Dependent Care Spending Account ^{2,3}	\$2,500 (married, filing separately) \$5,000 (single, head of household) \$5,000 (married, filing jointly)

² These are 2018 limits; contribution limits for 2019 will be released by the IRS at a later date. ³ Contribution limit for highly compensated employees is \$1,700.

2019 Reimbursement deadlines

Account	Grace period	Deadline
Medical Spending Account	None	March 31, 2020
Limited-use Medical Spending Account	None	March 31, 2020
Dependent Care Spending Account	March 15, 2020	March 31, 2020



Your benefits on-the-go

Make your phone your go-to resource for accessing your insurance benefits information. Mobile apps are available for your health, dental, prescription, vision and flexible spending benefits.



BlueCross BlueShield of South Carolina

Search for My Health Toolkit®

Health and dental benefits

- Learn about your coverage.
- Check status of claims.
- Access your identification card.
- Find a doctor or hospital.



Express Scripts

Search for Express Scripts.

Prescription benefits

- Check if a drug requires prior authorization and compare drug prices.
- Refill and renew mail order prescriptions.
- Access your identification card.
- Locate a network pharmacy.



EyeMed

Search for EyeMed Members.

Vision benefits

- Learn about your coverage.
- Set eye exam and contact lens change reminders.
- Access your identification card.
- Search for network providers.



ASIFlex

Search for ASIFlex Self Service.

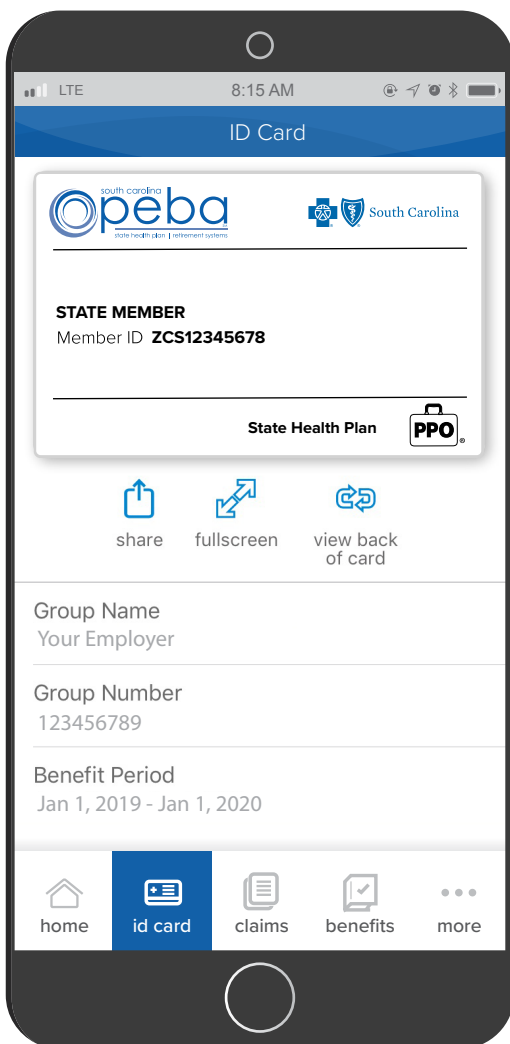
Flexible spending accounts

- Submit and view status of a claim.
- Submit documentation.
- View account statement.
- Find information about your account.



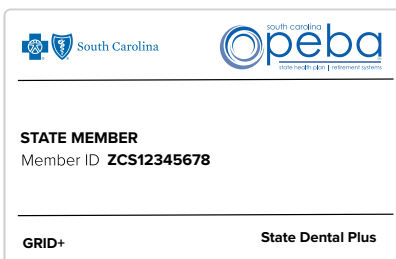
You're covered with membership ID cards

You receive insurance cards for health, prescription, dental and vision benefits. You can also access your digital identification cards from the BlueCross, Express Scripts and EyeMed apps. Only the subscriber's name will be on the cards, but all covered family members can use them.



State Health Plan

For help accessing your card, call BlueCross at **800.868.2520** or visit www.StateSC.SouthCarolinaBlues.com.



Dental Plus

For help accessing your card, call BlueCross at **888.214.6230** or visit StateSC.SouthCarolinaBlues.com.

If you need a basic dental card, contact your benefits administrator.



Prescription drug

For help accessing your card, call Express Scripts at **855.612.3128** or visit www.Express-Scripts.com.



Vision care

For help accessing your card, call EyeMed at **877.735.9314** or visit www.EyeMed.com.

You can also contact vendors to order a replacement card.

Your health and pharmacy benefits at your fingertips

When you're a member of the State Health Plan, you have one convenient place to find answers about your benefits. My Health Toolkit is a one-stop destination for managing your health benefits. You can also access your Express Scripts account directly from the My Health Toolkit website.

My Health Toolkit app

1. Learn more about your coverage

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

2. 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.

3. Check dental claims

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

4. View or replace your identification card

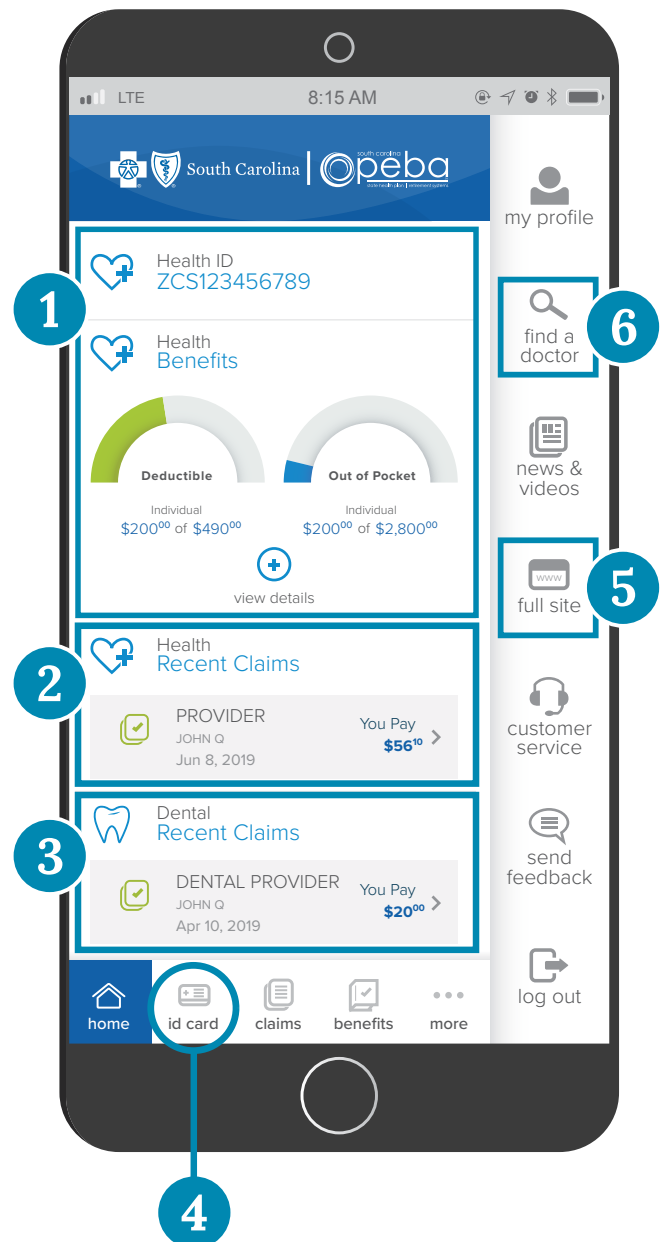
You can access an electronic version of your card or order a replacement card by visiting the full site.

5. 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.

6. Find a doctor or hospital

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



Improve your health with Rally®

Sign up for Rally, a digital health platform that makes it easier for you to improve and maintain your overall health. Based on your responses to a quick health survey, you'll get personalized recommendations to help you move more, eat better and feel great.

Search Rally Health and look for this icon:



Get started today

It's easy to sign up for **My Health Toolkit**. In just a few clicks, you'll have everything you need at your fingertips.

1. Go to www.StateSC.SouthCarolinaBlues.com and select **Register Now**. In the app, select **Sign Up**.
2. Enter your member identification number 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 **877.274.1715**.

Manage your benefits on-the-go

Search My Health Toolkit® and look for this icon:



Explanation of Benefits

Be a smart health care consumer. Look at your Explanation of Benefits (EOB) after you receive services. To make sure you don't pay more than you should, compare your doctor's bill to the amount listed on your EOB.

What's an EOB?

This is a report that's created whenever the State Health Plan processes a claim. An EOB shows you:

- How much your provider charged for services.
- How much the State Health Plan paid.
- The amount you will be responsible for, such as your copayment, deductible and coinsurance.
- The total amount you may owe the provider (does not include any amount you've already paid).

EOB

1. Summary information

This is a view of the status of your claim and the amount you may owe or have already paid to providers.

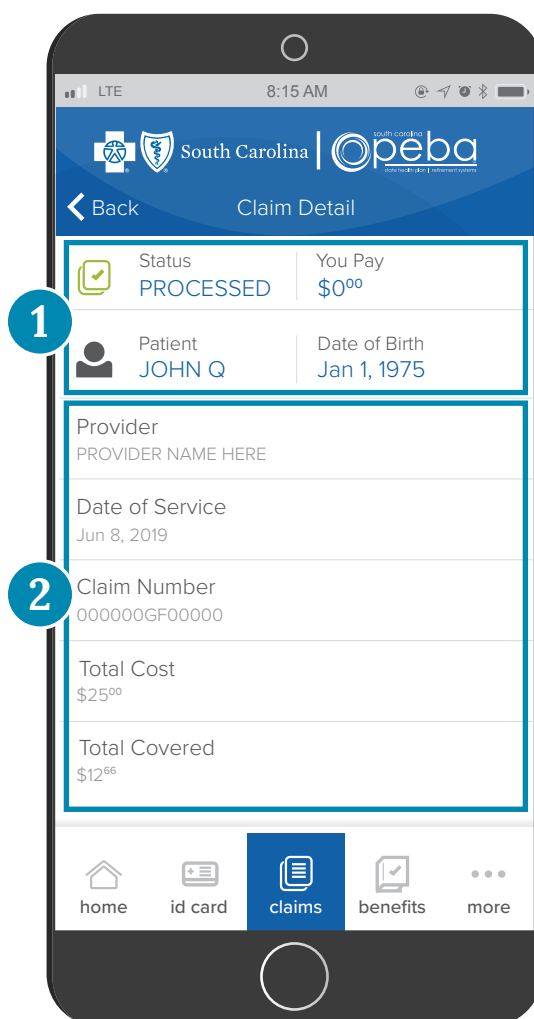
2. Detail information

Here you'll see the provider's name, the service date and the claim number. You'll also find the total charge for the claim from the provider and the amount covered by the State Health Plan.

Go green!



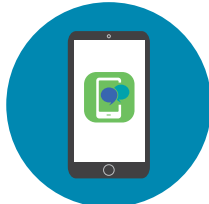

Now you can view your EOBs on the My Health Toolkit app! Plus, you can choose paperless notifications and we'll email you whenever a new EOB is ready to view.

1. Log in to **My Health Toolkit** at www.StateSC.SouthCarolinaBlues.com.
2. Select the **Profile** tab.
3. Select **Change Notifications**.
4. Select **Online** as your preference.



Where should you go when you need care?

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	Blue CareOnDemand	Emergency room
 <p>Your primary care physician, or regular doctor, is the best option for routine medical care, such as:</p> <ul style="list-style-type: none">• Managing your chronic condition.• Health screenings, immunizations.• Prescription refills. <p>Your regular doctor is also the best choice for unexpected health issues, such as:</p> <ul style="list-style-type: none">• Cold and flu symptoms, including fever, coughing, sore throat and mild nausea.• Migraines.• Minor cuts and bruises.• Pinkeye.• Rashes, insect bites, sunburn and other skin irritations.• Seasonal allergies.• Sinus or respiratory infections.• Sprained muscles.• Urinary tract infections.	 <p>If your doctor's office is closed, you're traveling or you feel too sick to drive, a Blue CareOnDemand video visit is a great option.</p> <p>Using your computer or mobile device, you can see a doctor who can diagnose your symptoms and call in a prescription to your local pharmacy if needed.</p> <p>Use Blue CareOnDemand for non-emergency health issues, such as:</p> <ul style="list-style-type: none">• Cold and flu symptoms, including fever, coughing, sore throat and mild nausea.• Migraines.• Pinkeye.• Rashes, insect bites, sunburn and other skin irritations.• Seasonal allergies.• Sinus or respiratory infections.• Urinary tract infections. <p>Search Blue CareOnDemand and look for this icon:</p> 	 <p>Go to the ER or call 911 for very serious or life-threatening conditions, such as:</p> <ul style="list-style-type: none">• Coughing up or vomiting blood.• Heavy, uncontrolled bleeding.• Loss of consciousness or sudden dizziness.• Major injuries such as broken bones or head trauma.• Severe allergic reactions.• Signs of a heart attack, such as chest pain that lasts more than two minutes.• Signs of stroke, such as numbness, sudden loss of speech or vision.

Adult well visits covered by Standard Plan beginning January 1, 2019

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

How the benefit works

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

Who is eligible

The benefit is available to all non-Medicare primary adults ages 19 and older who are covered by the Standard Plan. Adult members can take advantage of this benefit at an eligible network provider.

Eligible female members may use their well visit at their gynecologist or their primary care physician, but not both, in a covered year. If a female visits both doctors in the same covered year, only the first routine office visit received will be allowed. See the [Cervical cancer screening](#) section on Page 17 for information about how a Pap test is covered.

Frequency of visits

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

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

Savings Plan members

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

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

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

Preventive screening

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

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

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

Cervical cancer screening

If you are a female ages 18-65, you can receive a Pap test each calendar year at no cost. This benefit also covers the cost of the part of the office visit associated with the Pap test. In years when you are not eligible for an adult well visit, you can still receive a Pap test at no cost. You can also receive an HPV test in combination with a Pap test once every five years at no cost if you are ages 30-65.

Services not included as part of an adult well visit

Services not included as part of the adult well visit are those without an A or B recommendation by the USPSTF. Find these recommendations 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.



Value-based benefits at no cost to you

It's always better to address a health issue before it becomes a health crisis. Take advantage of these value-based benefits at no cost to you. These benefits can help make it easier for you and your family to stay healthy. For more details about PEBA Perks, including eligibility, visit www.PEBAperks.com.

Preventive screening

Identifying health issues early can prevent serious illness and help save you money. This benefit, worth more than \$300, allows you to receive a biometric screening at no cost. Share your results with your network provider at a well visit to eliminate the need for retesting.

Flu vaccine

The flu affects between 5 and 20 percent of the U.S. population each year. An annual flu vaccine is the best way to reduce your risk of getting sick and spreading it to others.

Adult vaccinations

Vaccines are one of the safest ways to protect your health and the health of those around you. The State Health Plan covers adult vaccinations based on age, interval and medical history recommendations from the Centers for Disease Control.

Receive Shingrix vaccine at no cost

Shingrix, a two-dose vaccination, is a new vaccine to prevent shingles. The CDC recommends adults ages 50 and older receive the vaccine to prevent shingles and complications of the disease.

Even if you received the Zostavax vaccine in the past, you are encouraged to get the Shingrix vaccine.

Well-child benefits (exams and immunizations)

This benefit aims to promote good health and prevention of illness in children. Covered children through age 18 are eligible for this benefit. The State Health Plan covers recommended doctor visits and immunizations at network providers.



Colorectal cancer screening

Colorectal cancer is the second-most common cause of cancer deaths in the U.S. The State Health Plan covers the cost for both diagnostic and routine screenings based on age ranges recommended by the United States Preventive Services Task Force.

Cervical cancer screening

Cervical cancer deaths have decreased since the implementation of widespread cervical cancer screenings. The State Health Plan allows women ages 18-65 to receive a Pap test each calendar year at no cost. For women ages 30-65, the Plan covers the HPV test in combination with a Pap test once every five years at no cost.

No-Pay Copay

No-Pay Copay encourages members to be more engaged in their health — and saves them money. By completing certain activities in Rally each quarter, members can receive certain generic drugs the next quarter at no cost. Covered conditions include:

- High blood pressure and high cholesterol.
- Cardiovascular disease, congestive heart failure and coronary artery disease.
- Diabetes.

Mammography

A mammogram is an important step in taking care of yourself. This benefit provides one baseline routine mammogram (four views) for women ages 35-39. Women ages 40 and older can receive one routine mammogram (four views) each calendar year. The State Health Plan also covers diagnostic mammograms.

Diabetes education

Managing your diabetes can help you feel better. It can also reduce your chance of developing complications. This benefit provides diabetes education through certified diabetes educators.

Tobacco cessation

This benefit provides enrollment in the Quit For Life® program at no cost. It also includes a \$0 copay for some tobacco cessation drugs to eligible participants.

Breast pump

This benefit provides members with certain electric or manual breast pumps at no cost. Members can learn how to get a breast pump by enrolling in the maternity management program, Coming Attractions.

On-the-go health info

Sign up for State Health Plan mobile messaging.

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

How can you avoid catching a cold? Do you know about benefits available at no cost to you? Are you missing out on healthy lifestyle programs, health coaching and value-based benefits?

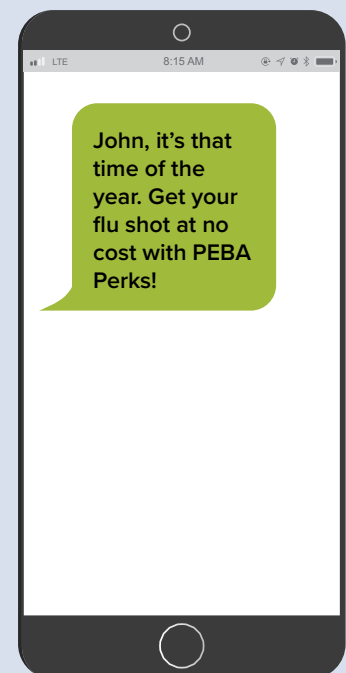
Sign up for secure State Health Plan mobile messages. You'll get benefits information, health and wellness reminders and cost-saving tips.

Mobile messaging is completely optional, but we encourage you to sign up! It's a simple and secure way to get information you can use.

Two easy ways to sign up

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

Data rates may apply.



Find your happy plates

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

Who is eligible

State Health Plan members ages 18 and older can apply to participate.

How it works

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

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

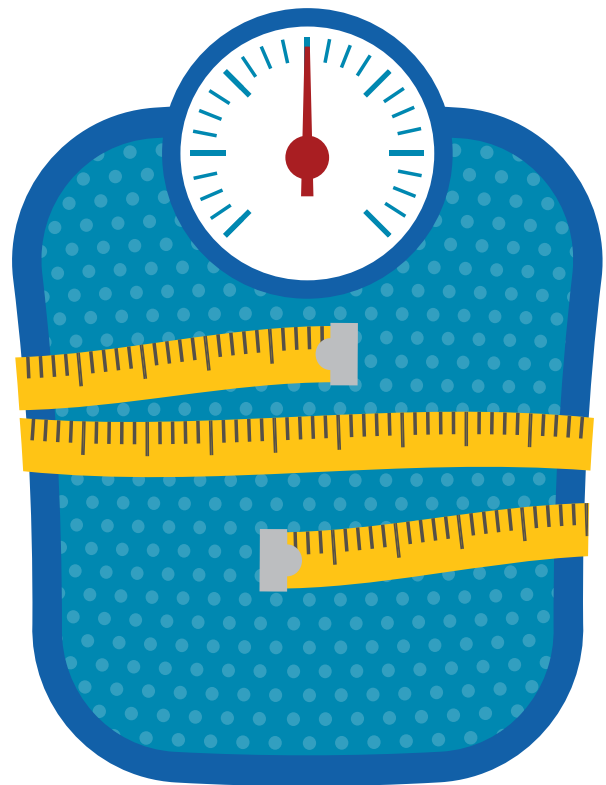
- Helping you develop a lifestyle of eating your favorite foods while still improving your health and losing weight.
- Teaching you to identify personal eating habits, recognize the difference between true hunger and psychological hunger, understand how hydration habits influence hunger and practice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

Scheduled programs

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

How to participate

Visit www.naturallyslim.com/PEBA to apply.



n a t u r a) (y s l i m[®]

A team approach to care

The patient-centered medical home (PCMH) approach to care helps you reach your goals for better health. Visit www.StateSC.SouthCarolinaBlues.com to find a PCMH near you.

What is a PCMH?

If you have a chronic medical condition, coordinating your health services is important. You might have many doctors and lots of different medications. A patient-centered medical home, or PCMH, can make things easier.

PCMHs use a team approach to deliver care. This approach promotes ongoing, personal relationships between you, your primary care physician and a dedicated care team. The goal is true partnership between patients and providers.

State Health Plan members have access to BlueCross BlueShield of South Carolina's PCMH practices across the state. A PCMH is a regular doctor's office that has met special criteria.

PCMHs are helpful for people who have high blood pressure, heart failure or diabetes. But anyone can go to a PCMH. With a medical "home," you can count on a trusted team to provide coordinated care. Care includes basic preventive care to acute care needed in urgent situations.

Benefits of the PCMH approach

- Your health care providers coordinate care to help you reach your health goals.
- You receive personalized, consistent care. You will see a member of your care team who knows you and your history.
- Your PCMH team coordinates results of all your procedures. That way, they have a complete picture of your health.
- Your team can help you manage your health conditions, including getting the preventive and follow-up care you need.
- PCMHs have extended office hours and same-day visits, when necessary.
- You can talk to an on-call physician after hours.

Savings for you

Standard Plan members do not pay the \$14 copayment for a PCMH office visit. Plus, Savings Plan and Standard Plan members pay a 10 percent coinsurance, rather than 20 percent, after meeting their deductible.



Call ahead to get the green light for your care

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

Medical services

To preauthorize your medical treatment, call Medi-Call at **800.925.9724**.

Contact Medi-Call at least two business days before:

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

Pregnancy

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

Emergencies

In a hospital emergency, you should contact Medi-Call to report your admission as soon as possible.

Behavioral health services

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

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

Radiology services

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

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

Helpful terms

Insurance lingo can be confusing. But it's important to understand your benefits and how they work. Here are some terms you may need to know.

Allowed amount The maximum amount you may pay a network provider for a covered service. Network providers have agreed to accept the allowed amount as their total fee.

Benefits The items or services covered by your insurance plan.

Claim A request for payment that you or your provider submits after you receive services.

Coinsurance This is a percentage of the cost of health care you pay after you meet your deductible. For example, say the State Health Plan's allowed amount for an office visit is \$114 and the member has met his deductible. After a Standard Plan member pays the \$14 copayment, his coinsurance payment of 20 percent would be \$20. The health plan pays the rest of the allowed amount, or \$80.

Coinsurance maximum The amount of coinsurance you are required to pay each year before you are no longer required to pay coinsurance.

Copayment The fixed amount you pay for a covered health care service or drug. Standard Plan members pay prescription drug copayments and copayments for office visits, emergency care and outpatient facility services. Savings Plan members do not pay copayments.

Coverage review A blanket term for the different types of processes the State Health Plan uses to ensure the safe and effective use of prescription drugs and to encourage the use of lower-cost alternatives when possible.

Deductible The amount you pay for covered services before your health plan begins to pay.

Dependent An eligible child or spouse covered by your health plan.

National Preferred Formulary The formulary, or list of preferred drugs, used by Express Scripts.

Network A group of facilities, providers and suppliers under contract to provide care for people covered by a health, dental or vision plan.

Out-of-pocket costs These are your costs for expenses that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance and copayments for covered services, plus all costs for services that aren't covered.

Preauthorization A decision that a service, prescription drug or piece of equipment is medically necessary. Certain services and medications require preauthorization before you receive them, except in an emergency. You may also hear this referred to as precertification or prior authorization.

Premium The amount you pay for insurance coverage.

Provider This can refer to the medical professional who delivers care or the location where you receive health care services.





Choose your health plan (Page 2)

- Standard Plan
Consider opening a Medical Spending Account
- Savings Plan
Consider opening a Health Savings Account and Limited-use Medical Spending Account
- TRICARE Supplement Plan

Coverage level

- Employee
- Employee/spouse
- Employee/children
- Full family



Choose your dental plan (Page 4)

Available to new hires only. Changes to existing dental coverage cannot be made during 2018 open enrollment.

- Basic Dental
- With Dental Plus

Coverage level

- Employee
- Employee/spouse
- Employee/children
- Full family



Choose your vision coverage (Page 5)

Coverage level

- Employee
- Employee/spouse
- Employee/children
- Full family



Choose your additional life insurance coverage (Page 6)

- Optional Life
Amount \$ _____
(must be in increments of \$10,000)
- Dependent Life-Spouse
Amount \$ _____
(must be in increments of \$10,000)
- Dependent Life-Child
Amount: \$15,000 per dependent



Choose your supplemental long term disability coverage (Page 7)

Benefit waiting period

- 90 days
- 180 days



Choose your MoneyPlus elections (Page 8)

Standard Plan members

- Medical Spending Account
Amount \$ _____

Savings Plan members

- Health Savings Account
Amount \$ _____
- Limited-use Medical Spending Account
Amount \$ _____

All members

- Pretax Group Insurance Premium feature
- Dependent Care Spending Account
Amount \$ _____

Grandfathered notice

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

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

Summaries of Benefits and Coverage

The 2019 *Summaries of Benefits and Coverage* for the Standard Plan and Savings Plan are available online at www.peba.sc.gov/iresources.html. To request a copy, call PEBA at 803.737.6800 or 888.260.9430.

Insurance Benefits Guide

The 2019 *Insurance Benefits Guide* is available online at www.peba.sc.gov/iresources.html. A very limited supply of printed guides is available on a first-come, first-served basis. To request a copy, call PEBA at 803.737.6800 or 888.260.9430.

Third-party disclosures

These companies provide services on behalf of the South Carolina Public Employee Benefit Authority, which administers the State Health Plan and other insurance benefits. BlueCross BlueShield of South Carolina is the third-party administrator for the State Health Plan. BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association. Rally is a product of Rally Health Inc., and provides a digital health platform. The Quit For Life Program is brought to you by the American Cancer Society and Optum. Optum is a registered trademark of Optum, Inc. The American Cancer Society name and logo are trademarks of the American Cancer Society. Optum administers the Quit For Life Program. Companion Benefit Alternatives, Inc. administers behavioral health services. National Imaging Associates administers radiology services. Express Scripts administers pharmacy benefits. EyeMed administers vision benefits. MetLife administers life insurance benefits. The Standard administers long term disability benefits. ASIFlex administers the MoneyPlus program.

Notice of non-discrimination

The South Carolina Public Employee Benefit Authority (PEBA) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PEBA does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PEBA:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact PEBA's Privacy Officer.

If you believe that PEBA has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: PEBA Privacy Officer, 202 Arbor Lake Dr., Columbia, SC 29223, 803.734.0119 (phone), 803.570.8110 (fax), or at privacyofficer@peba.sc.gov. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, PEBA's Privacy Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.803.734.0119.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.803.734.0119

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.803.734.0119

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.803.734.0119 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.803.734.0119.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.803.734.0119.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.803.734.0119.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.803.734.0119.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1.803.734.0119.

انف، غةلل ركذا تدحتت تنك اذا! فظوحم 1.803.734.0119 . مقرب ل لصتا . ناجم لاب كل رفاوتت قيوغلل ادعاسملا تامدخ

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1.803.734.0119.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1.803.734.0119まで、お電話にてご連絡ください。

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1.803.734.0119.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1.803.734.0119 पर कॉल करें।

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សំរាប់ជំនួយផ្លូវភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់ប្រើអ្នក។ ចូរ ទូរស័ព្ទ

1.803.734.0119 ។

2019 insurance vendors





202 Arbor Lake Drive

Columbia, SC 29223

803.737.6800 | 888.260.9430

www.peba.sc.gov

SCPEBA 082018 | Expires 12312019
Data classification: public information