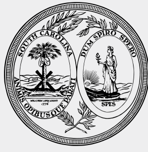

PEBA[SM]
SC Retirement Systems
and State Health Plan

Insurance Coverage for the Medicare-eligible Member

2024

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Disclaimer

Benefits administrators and others chosen by your employer to assist you with your participation in the employee benefit programs administered by the South Carolina Public Employee Benefit Authority (PEBA) are not agents or employees of PEBA and are not authorized to bind PEBA or make representations on behalf of PEBA.

The *Insurance Benefits Guide* contains an abbreviated description of insurance benefits provided by or through the South Carolina Public Employee Benefit Authority. The *Plan of Benefits* documents and benefits contracts contain complete descriptions of the health and dental plans and all other insurance benefits. Their terms and conditions govern all benefits offered by or through the South Carolina Public Employee Benefit Authority. If you would like to review these documents, contact your benefits administrator or the South Carolina Public Employee Benefit Authority.

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

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.

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, 888.260.9430 (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 1.888.260.9430.

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 1.888.260.9430

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.888.260.9430

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.888.260.9430 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.888.260.9430.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.888.260.9430.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.888.260.9430.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.888.260.9430.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1.888.260.9430.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.888.260.9430.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1.888.260.9430.

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。1.888.260.9430 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 1.888.260.9430.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1.888.260.9430 पर कॉल करें।

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1.888.260.9430

When you or a covered dependent becomes eligible for Medicare

Signing up for Medicare Parts A and B

To receive full benefits with PEBA's retiree group health plan when you become eligible for Medicare, you will need to be covered by both Part A (hospital coverage) and Part B (medical coverage). If you are not, you will be required to pay the portion of your health care costs Parts A and B would have paid. You can learn more about Medicare at **www.medicare.gov**.

Medicare's initial enrollment period begins three months before your 65th birthday, includes the month of your birthday, and then continues for three months past the month in which you turn 65. Those who are not receiving Social Security benefits should ask about enrolling in Medicare three months before turning 65, so Medicare coverage can start during the month they turn 65.

If you are receiving Social Security benefits, the Social Security Administration should notify you of Medicare eligibility three months before you reach age 65. Medicare Part A starts automatically.

If you decide to put off receiving Social Security benefits until you reach your full Social Security retirement age, you must still be covered by Medicare Part A and Part B. Contact the Social Security Administration within three months of your 65th birthday to enroll. The Social Security Administration will bill you quarterly for the Part B premium.

Automatic enrollment in PEBA's Medicare Supplemental Plan

If you are a retiree, and you are covered by the State Health Plan Standard Plan or Savings Plan before you become eligible for Medicare, PEBA will mail you a letter when you become Medicare-eligible because of age, which indicates that you will be automatically enrolled in the Medicare Supplemental Plan.

If you prefer another PEBA-sponsored health plan, you will need to inform PEBA within 31 days of Medicare Part A eligibility. If you are covered by a health plan offered through PEBA and you become Medicare-eligible for any reason, not just age, you will be able to change to the Medicare Supplemental Plan within 31 days of eligibility. After this 31-day period, you can change from the Carve-out Plan to the Medicare Supplemental Plan during the annual October open enrollment period. Plan changes made during open enrollment become effective the following January 1. If you move out of the United States permanently, you may be eligible to change from the Medicare Supplemental Plan to the Carve-out Plan.

More information on Medicare Supplemental Plan coverage and Carve-out Plan coverage begins on Page 12.

What happens when you turn down Part B

If you turn down Medicare Part B when you are first eligible, you must wait until Medicare's general enrollment period to sign up, unless you are covered as an active employee. This period is from January 1 to March 31 of each year, and coverage begins on July 1. For every 12-month period you were not covered by Part B after you were first eligible, your Medicare premium will be 10% higher, and the increase might be permanent. Contact Medicare to learn more about enrollment and for premium information that applies to you.

Your insurance cards

When you become eligible for Medicare, you will receive new identification cards for the Medicare Supplemental Plan. Your Benefits Identification Number (BIN) will not change, though, and your dental cards will remain valid.

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

Moving to prescription drug coverage with Express Scripts Medicare

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

Most subscribers covered by the Medicare Supplemental Plan or the Carve-out Plan will be better served if they remain covered by Express Scripts Medicare. Because you have this coverage, your drug benefits will continue to be paid through your health insurance. PEBA charges no additional premium for drug coverage.

The program is a group-based, Medicare Part D Prescription Drug Plan. Express Scripts will send you information that will include a letter about how you can opt out of the Medicare prescription drug program and remain covered by the State Health Plan Prescription Drug Program. Express Scripts is required to give you 21 days to opt out. If you opt out, you remain out of the program unless you decide to re-enroll; you will not need to opt out every year. You can re-enroll in Express Scripts Medicare at any time; however, if you enroll initially, you cannot opt out until Medicare's open enrollment period, which is from October 15 to December 7 each year.

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

When you turn 65 and become eligible for Medicare, you will receive a *Notice of Creditable Coverage* from PEBA.[1] Please save your *Notice of Creditable Coverage* from PEBA in case you need to prove you had this coverage when you became eligible for Part D. Please note that if a member joins a plan that does not provide creditable coverage, and then joins a Medicare plan, they will have to pay a late enrollment penalty if they go 63 continuous days or more without creditable coverage.

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

For more details on prescription drug coverage, see the Using Express Scripts Medicare for prescription drug coverage section on Page 18.

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1 If you become eligible for Medicare before age 65, PEBA will not send you the *Notice of Creditable Coverage*. You need to notify PEBA of your Medicare eligibility.

Coverage in active employment situations

Medicare at age 65 for active employees

Employees who are actively working and/or are covered under a state health insurance plan for active employees may delay enrollment in Part B because in these cases, insurance as an active employee remains the primary payer. This means that the Plan pays first toward your medical expenses, and Medicare pays second. If you remain an active employee, but your spouse is eligible for Medicare, your spouse should enroll in Part A but may delay enrollment in Part B until you retire and your active health coverage ends.

If you or your spouse defers Part B coverage and then decides to enroll in Part B at a later time while you are still actively at work, a gain of Part B will not be considered a special eligibility situation that would permit you to immediately drop health coverage with PEBA. You will be required to wait until an open enrollment period, which occurs annually in October, or until the 31-day period after a special eligibility situation, such as divorce or a gain of other coverage, to drop your health coverage.

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

Working in an insurance-eligible job after retirement

If you, your spouse or your child is covered under the retiree group insurance program, and you return to work for an employer participating in the state insurance program in a way that makes you eligible for enrollment in the State Health Plan, you may not remain on retiree coverage.

Federal law will not allow a person in an insurance-eligible position, or any person they cover, to use Medicare as their primary insurance and coverage through PEBA as their secondary insurance. This means that even if you are eligible for PEBA-sponsored coverage as a retiree, if you return to work in an insurance-eligible position, you may not be covered as a retiree. As a result, you will need to do one of these things:

- Enroll as an active employee with Medicare as the secondary payer; or
- Refuse all PEBA-sponsored health coverage[1] for you, your spouse and your children and have Medicare coverage only.

As an active employee, you are also eligible for these benefits:

- Dental Plus and Basic Dental;
- State Vision Plan;
- Basic, Optional and Dependent Life insurance (with the exception of part-time teachers, who are eligible for the State Health Plan according to S.C. Code 59-25-45);
- Basic and Supplemental Long Term Disability (with the exception of part-time teachers, who are eligible for the State Health Plan according to S.C. Code 59-25-45);
- MoneyPlus; and
- Health Savings Account if enrolled in the Savings Plan.[2]

Should you enroll in active group coverage, you will still need to notify the Benefits Coordination & Recovery Center at 855.798.2627 so that Medicare will be correctly established as secondary insurance.

Even with active employee insurance through PEBA, you may still remain covered by Medicare Part B as a secondary payer and continue paying the Part B premium. You can also delay or drop Part B without a penalty while you have active group coverage.

For more information, contact the Social Security Administration at 800.772.1213.

When you stop working and your active group coverage ends, you may re-enroll in retiree group coverage within 31 days of the date your active coverage is terminated. You also may enroll during open enrollment or within 31 days

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1 You may keep your dental and vision coverage offered through PEBA.
2 When an active subscriber who is enrolled in the Savings Plan turns age 65, they remain eligible to contribute to an HSA if they delay enrollment in Medicare Part A by delaying Social Security benefits. Once they enroll in Social Security, and therefore Medicare Part A, they can no longer make contributions to an HSA.

of a special eligibility situation. In addition, you must notify the Social Security Administration that you are no longer covered under an active group so you can re-enroll in Medicare Part B, if you dropped it earlier.

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

Retirees hired in an insurance-eligible job who continued life insurance

If you continued your Optional Life insurance as a retiree, you will have the option to keep your continued policy and pay premiums directly to MetLife, or to enroll in Optional Life as a newly hired active employee with a limit of three times your annual salary without medical evidence, up to a maximum of $500,000. You cannot do both. If you choose to cancel your continued coverage, contact MetLife, the insurer for the Optional Life program, within 31 days of returning to work.

If you are considered a new hire, see the Life insurance chapter in the *Insurance Benefits Guide* to learn about your options during employment and when you leave employment.

Coverage in retirement situations

Eligible retirees who turn age 65

When a retiree reaches age 65 and is eligible for Medicare, Medicare serves as the primary payer.

Ineligible retirees who turn age 65

If, when you retire, you are age 65 or older and not eligible for Medicare, you should contact the Social Security Administration. It will send you a letter of denial of Medicare coverage, and you should provide a copy of this to your benefits administrator. You may enroll in health insurance as a retiree within 31 days of loss of active coverage, within 31 days of a special eligibility situation or during an annual open enrollment period. You may also enroll your eligible family members.

Retirees who leave active employment after age 65

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

Check with the Social Security Administration to make sure you are covered by Medicare Part A. PEBA encourages you to enroll in Part B because Medicare becomes your primary coverage.

A chart showing how PEBA's Medicare Supplemental Plan and Carve-out Plan coordinate with traditional Medicare is on Page 13. You may enroll in the Medicare Supplemental Plan within 31 days of the date your active coverage ends. If you are leaving a state agency, public higher education institution, public school district or charter school that participates in both insurance and retirement, attach a copy of your Medicare card to a completed *Retiree Notice of Election* and send them to PEBA. If you are leaving an optional employer or charter school that participates in insurance only, give a completed *Retiree Notice of Election* with a copy of your Medicare card to the benefits administrator for your former employer's personnel office.

Ineligible retirees whose spouses or children are eligible for Medicare

If you are a retiree who is not eligible for Medicare, but your dependent spouse or child is, you have the option to enroll in the Medicare Supplemental Plan. Family members who are not eligible for Medicare will be covered under the Standard Plan provisions. See the Health insurance chapter of the *Insurance Benefits Guide* for more information.

Coverage in disability situations

Before age 65

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

Generally, when you become eligible for Medicare, it serves as the primary payer for your coverage. This is not the case for those who are still actively working for an employer participating in the State Health Plan or those who are in the 30-month end-stage renal disease coordination of benefits period. If this is the case for you, PEBA health insurance will remain primary.

A chart showing how PEBA's Medicare Supplemental Plan and Carve-out Plan coordinate with traditional Medicare is on Page 13. To enroll in the Medicare Supplemental Plan, complete a *Retiree Notice of Election* and attach a copy of your Medicare card. If you worked for a state agency, public higher education institution, public school district or charter school that participates in both insurance and retirement, you should send them directly to PEBA. If you worked for an optional employer or charter school that participates in insurance only, you should send them to the benefits administrator for your former employer's personnel office. Coverage will begin the first day of the month after PEBA receives notification that you are covered by Medicare.

End-stage renal disease

If you have end-stage renal disease, you will become eligible for Medicare three months after beginning dialysis. A 30-month coordination period will then begin. During this period, your health coverage through PEBA is primary, which means it pays your medical claims first. At the end of the 30-month end stage renal disease coordination period, Medicare will become your primary insurance regardless of your employment status. If you are covered as a retiree, you should contact PEBA within 31 days to change from the Carve-out Plan to the Medicare Supplemental Plan.[3] A chart showing how PEBA's Medicare Supplemental Plan and Carve-out Plan coordinate with traditional Medicare is on Page 13.

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

If you are eligible for Medicare but choose not to enroll in Parts A and B, and 33 months have passed from the time you started dialysis, the State Health Plan will limit its coverage as if it were coordinating benefits with what Parts A and B would have paid.

The coordination period may be different for covered dependent children with ESRD or who have had a kidney transplant. Learn more on the Medicare website.

3 The Medicare Supplemental Plan is not available to active employees or their covered family members.

Your health insurance options with Medicare

When you and/or your eligible spouse or children are covered under PEBA's retiree group health insurance and become eligible for Medicare, Medicare becomes the primary payer. The following PEBA health insurance plans are available to you as secondary coverage:

- Medicare Supplemental Plan.
- Carve-out Plan.

You will receive a letter from PEBA if you are covered by the Standard Plan or Savings Plan and you become eligible for Medicare because of age. When you receive this notification, you can take no action, and PEBA will automatically enroll you in the Medicare Supplemental Plan. Note, you will need to contact PEBA to choose the Carve-out Plan within 31 days of the date you become eligible for Medicare. For coverage details about the Carve-out Plan, see Page 16.

Several other events will provide you the option to change to the Medicare Supplemental Plan if you want:

- You or someone you cover becomes eligible for Medicare due to a disability.
- The end-stage renal disease coordination period concludes, and you are covered as a retiree.
- You leave active employment after age 65.

To make a change, attach a copy of your Medicare card to a completed *Retiree Notice of Election* and give it to your benefits administrator or mail it to PEBA within 31 days of Medicare eligibility.

If you or your covered spouse or child is covered by the Medicare Supplemental Plan, claims for covered family members without Medicare will still be paid through the Standard Plan provisions. See the Health insurance chapter of the *Insurance Benefits Guide* for more information.

How the Medicare Supplemental Plan and Carve-out Plan coordinate with Medicare

Medicare assignment

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

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

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

Some providers choose not to accept any payment from Medicare. If a provider has made this decision, Medicare covers none of that provider's services, and no Medicare payment can be made to them. If Medicare does not pay anything, neither will the Medicare Supplemental Plan. If you are covered under the Carve-out Plan and your physician has opted out of Medicare, call PEBA at 803.737.6800 or 888.260.9430 for information. When you choose a provider, you may want to determine if:

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

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

How the Medicare Supplemental Plan coordinates with Medicare

If a provider accepts Medicare, they will accept Medicare's payment, plus the Medicare Supplemental Plan's payment, as full compensation for covered services. If the provider does not accept Medicare, they may charge more than what Medicare and the Medicare Supplemental Plan will pay combined, and you will need to pay the difference.

How the Carve-out Plan coordinates with Medicare

If your provider accepts the amount Medicare allows as payment in full, the Carve-out Plan will pay the lesser of:

- The amount Medicare allows, minus what Medicare reported paying; or
- The amount the State Health Plan would pay in the absence of Medicare, minus what Medicare reported paying.

This is known as the carve-out method. If your provider does not accept the amount Medicare allows as payment in full, the Carve-out Plan pays the difference between the amount the State Health Plan allows and the amount Medicare reported paying. The Carve-out Plan will never pay more than the State Health Plan allows. If the Medicare payment is more than the amount the State Health Plan allows, the Carve-out Plan pays nothing.

As shown in the example on Page 13, under the carve-out method, you pay the Carve-out Plan deductible and coinsurance or the remainder of the bill, whichever is less. In this example, the $515 deductible and your 20% coinsurance is $1,912. However, the remainder of the bill is $1,632, so you pay the lesser amount, which is $1,632.

Once you reach your $3,000 coinsurance maximum, all claims will be calculated at 100% of the allowed amount based on the carve-out method of claims payment. All of your Medicare deductibles and your Medicare Part B 20% coinsurance should be paid in full for the rest of the calendar year after you reach your $3,000 coinsurance maximum.

How PEBA health plans coordinate with Medicare Parts A and B

Medicare Supplemental Plan

Medicare is primary. The hospital bill for a January admission is $7,500. If you are covered by the Medicare Supplemental Plan and Medicare, your Medicare claim will be processed like this.

Medicare-approved amount	$7,500.00
Part A deductible for 2024	- $1,632.00
Medicare payment	$5,868.00
Remaining bill	$1,632.00

Next, Medicare Supplemental Plan benefits are applied.

Remaining bill	$1,632.00
Medicare Supplemental Plan pays Medicare Part A deductible	- $1,632.00
Your total payment	$0.00

Carve-out Plan

Medicare is primary. The hospital bill for a January admission is $7,500. If you are covered by the Carve-out Plan and Medicare, your Medicare claim will be processed like this.

Medicare-approved amount	$7,500.00
Part A deductible for 2024	- $1,632.00
Medicare payment	$5,868.00
Remaining bill	$1,632.00

Next, Carve-out Plan benefits are applied to the Medicare-approved amount.

State Health Plan allowed amount	$7,500.00
Carve-out Plan deductible for 2024	- $515.00
Carve-out Plan allowance	$6,985.00
Carve-out Plan coinsurance	× 80%
Carve-out Plan payment in absence of Medicare	$5,588.00
Medicare payment is "carved out" of Carve-out Plan payment	- $5,868.00
Carve-out Plan payment	$0.00
Your total payment	$1,632.00

Medicare Supplemental Plan coverage

The Medicare Supplemental Plan is available to a retiree and their spouse or children who are eligible for Medicare Parts A and B. This plan coordinates benefits with the traditional Medicare plan only (Parts A and B). No benefits are provided for coordination with Medicare Advantage plans (Part C). For more information, visit **www.medicare.gov** or call Medicare at 800.633.4227.

The Medicare Supplemental Plan is similar to a Medigap policy in that it pays the portion of Medicare-approved charges that Medicare does not, such as Medicare's deductibles and coinsurance. The Medicare Supplemental Plan payment is based on the Medicare-approved amount. Charges not covered by Medicare will not be payable as benefits under the Medicare Supplemental Plan, except as specified on Pages 14-16.

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

Medicare deductibles and coinsurance

Deductibles

Medicare Part A includes an inpatient hospital deductible for each benefit period. That deductible for 2024 is $1,632. A Medicare benefit period begins the day you go to a hospital or skilled nursing facility and ends when you have not received any hospital or skilled care for 60 consecutive days. If you go into the hospital after one benefit period has ended, a new benefit period begins. The Medicare Supplemental Plan will pay the Part A deductible each time it is charged.

Medicare Part B has a deductible of $240 a year in 2024. Part B, for which you pay a monthly premium, covers physician services, supplies and outpatient care. Contact Medicare for more information. As a retiree, you need to enroll in Part B as soon as you are eligible for Medicare, since Medicare is your primary coverage. If you are not covered by Part B, you will be required to pay the portion of your health care costs that Part B would have paid. The Medicare Supplemental Plan pays the Part B deductible.

Coinsurance

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

Medicare Supplemental Plan deductibles and coinsurance

The Medicare Supplemental Plan benefit period is January 1 to December 31 and includes a $200 deductible each calendar year that applies to private duty nursing services only. If you enroll in Medicare and change to the Medicare Supplemental Plan during the year, you will need to meet a new $200 deductible for private duty nursing services.

Prior authorization

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

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

Claims for covered family members who are not eligible for Medicare, but who are insured through the Medicare Supplemental Plan, are paid according to the Standard Plan provisions. Some benefits require prior authorization by Medi-Call, National Imaging Associates, Express Scripts or Companion Benefit Alternatives. Learn more in the Health insurance chapter of the *Insurance Benefits Guide*.

Health insurance coverage overseas

The Medicare Supplemental Plan, which follows Medicare, does not offer access to doctors and hospitals outside the United States through the BlueCross BlueShield Global® Core program. The Carve-out Plan does, and as a result, you are eligible to switch to the Carve-out Plan if you move abroad.

When making this change, you should provide your benefits administrator with proof of residency and travel documents showing your date of departure. Once you switch, you can change plans again only during PEBA's annual open enrollment period in October.

Services covered by the Medicare Supplemental Plan

Home health care

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

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

Hospital admissions

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

- Medicare Part A inpatient hospital deductible.

- The Medicare coinsurance amount for days 61 through 90 of a hospital stay in each Medicare benefit period.
- The Medicare coinsurance amount for days 91 through 150 of a hospital stay for each of Medicare's 60 lifetime reserve days.[1]
- After all Medicare hospital benefits are exhausted, 100% of the Medicare Part A-eligible hospital expenses, if medically necessary.[2]
- The coinsurance for durable medical equipment up to the Medicare-approved amount.

If you are covered by the Medicare Supplemental Plan and you exhaust all Medicare-allowed inpatient hospital days, you need to call Medi-Call or Companion Benefit Alternatives for approval of any additional inpatient hospital days. Also, if you are covered by the Medicare Supplemental Plan, and you think that a hospital stay might exceed the number of days allowed by Medicare, be sure to choose a hospital within the State Health Plan networks or BlueCard Program so that any days beyond what Medicare allows will be covered as a network benefit by the Medicare Supplemental Plan.

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

Pap test benefit

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

Physician charges

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

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

Prescription drug coverage

The Medicare Supplemental Plan covers prescription drugs when purchased from a network pharmacy. For more information, see the Prescription benefits chapter of the *Insurance Benefits Guide*. For information about how PEBA coverage relates to Medicare Part D, see Page 7 of this handbook. 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. Some specialty medications administered in a provider's office may require prior authorization.

Private duty nursing services

Private duty nursing services are services provided by a registered nurse or a licensed practical nurse and have been certified in writing by a physician as medically necessary. Medi-Call prior authorization is required for these services.

A $200 annual deductible applies regardless of when you enroll in the Plan. Medicare does not cover this service. Once the deductible is met, the Medicare Supplemental Plan will pay 80% of covered charges for private duty nursing in a hospital or in the home.

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

Self-administered medications during an outpatient hospital observation stay

Outpatient hospital observation services are services received at a hospital while the doctor decides whether to admit a patient as inpatient or discharge them from the hospital. Patients can receive observation services in the emergency department or another area of the hospital. Observation can last for up to a 72-hour period. Medicare covers observation services under Medicare Part B. For safety reasons, many hospitals have policies that do not allow patients to bring prescription medications or other

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1 Lifetime reserve days can be used once.
2 You need to call Medi-Call or Companion Benefit Alternatives for approval.

drugs from home. These medications are considered self-administered drugs and Medicare defines these medications as drugs a patient would take by mouth or administer to themself and include, but are not limited to: oral medications, insulin, eye drops and topical treatments. Self-administered drugs are not covered under Medicare Part B.

A Medicare-eligible member who has had a hospital observation stay may have self-administered medication charges denied under Medicare Part B. Self-administered medications may be covered under the prescription benefit for Express Scripts Medicare members and Medicare primary retirees covered under the State Health Plan Commercial Plan. If self-administered medications are denied by Medicare as not covered under Medicare Part B during a hospital observation stay, members can submit a paper claim for reimbursement under the prescription benefit. The claim will be paid at the pharmacy network rate (allowed amount), and might not cover the full amount billed to the member.

Skilled nursing facilities

The Medicare Supplemental Plan will pay these benefits after Medicare has paid benefits during a benefit period:[3]

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

3 Prior authorization by Medi-Call is required.

Carve-out Plan coverage

While you are not generally covered outside the United States under Medicare, the Carve-out Plan offers worldwide coverage, giving you access to doctors and hospitals through the BlueCross BlueShield Global Core program.

The Plan has deductibles and coinsurance, although when Medicare is your primary insurance, the Carve-out Plan uses a carve-out method to pay claims, as described on Page 12.

Prior authorization

When you are covered by Medicare and the Carve-out Plan, you will still need to call Medi-Call or Companion Benefit Alternatives when Medicare benefits are exhausted for inpatient hospital services (including hospital admissions outside South Carolina or the United States), and for extended care services. Medicare has its own program for reviewing the use of its benefits.

You must call Medi-Call at 800.925.9724 for approval for inpatient hospital admissions, including:

- Admission to a hospital to have a baby;
- Outpatient surgical services in a hospital or clinic;
- Veterans Administration hospital services;
- Purchase or rental of durable medical equipment;
- Skilled nursing care;
- Hospice care; and
- Home health care.

You are also encouraged to call Medi-Call during the first trimester of your pregnancy.

Prior authorization by National Imaging Associates (866.500.7664) is required for office-based or outpatient advanced radiology services, such as CT, MRI, MRA and PET scans. You must call Companion Benefit Alternatives (800.868.1032), the State Health Plan's mental health/ substance abuse manager, for prior authorization before you receive some mental health or substance abuse benefits.

For more information, see the *Insurance Benefits Guide*.

How State Health Plan services work with Medicare

Hospital admissions

When Medicare is the primary payer, you may go to any hospital you choose, although Medicare limits the number of days of a hospital stay it will cover. If you are a Carve-out Plan member whose hospital stay exceeds the number of days allowed under Medicare, you might want to consider using a hospital within the State Health Plan network or BlueCard Program so you will not be charged more than what the Carve-out Plan allows, following the prior authorization guidelines above.

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

Outpatient facility services

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

Mammography benefit

The State Health Plan uses the BlueCross mammography network for routine mammograms. Routine mammograms are covered at 100% as long as you use a provider in the BlueCross mammography network and meet eligibility requirements. A doctor's order is not required for plan coverage of a routine mammogram, but some centers might ask for one. Mammography benefits include:

- One baseline mammogram (four views) for women ages 35 through 39; and
- One routine mammogram (four views) every year for women ages 40 and older.

Medicare covers a screening mammogram every 12 months for women ages 40 and older. Medicare pays 100% of its allowance for covered routine mammograms. You will pay nothing if you receive the test from a doctor who accepts Medicare assignment.

Maternity management and well child care benefits

The State Health Plan offers two programs geared toward early detection and prevention of illness among children. The Coming Attractions maternity management program helps mothers-to-be receive necessary prenatal care. This benefit applies to covered retirees and their spouses. It does not apply to covered children.

Covered children are eligible for well child care checkups until they reach age 19. The Plan pays 100% of the allowed amount for approved routine exams, Centers for Disease Control-recommended immunizations, American Academy of Pediatrics-recommended services specific to certain ages and lab tests when a network doctor provides the checkup. If your covered child has delayed or missed receiving immunizations at the recommended time, the Plan will pay for catch-up immunizations for some vaccines until the child reaches age 19. Check with BlueCross or your network pediatrician to determine which immunizations are covered.

Pap test benefit

Beginning in 2024, eligible female members may take advantage of the annual adult well visit at no cost, and can also receive an annual adult well woman visit at no cost. Women ages 18-65 can receive a Pap test each calendar year at no member cost through PEBA Perks. See the Health insurance chapter of the *Insurance Benefits Guide* for more information. Medicare covers a Pap test, pelvic exam and clinical breast exam every 24 months. If you are at high risk, you may have one every 12 months. You pay nothing if you receive the test from a doctor who accepts Medicare assignment. Check with Medicare for more information.

Prescription drug coverage

The Carve-out Plan covers prescription drugs when purchased from a network pharmacy. For more information, see the Prescription benefits chapter of the *Insurance Benefits Guide*.

Limited prescription drug coverage is available outside the United States to members enrolled in prescription drug coverage under the Carve-out Plan. Medicare drug plans do not cover prescription drugs purchased outside the United

States. For more information, see the *Insurance Benefits Guide*.

Self-administered medications during an outpatient hospital observation stay

Self-administered drugs are not covered under Medicare Part B. Learn more about self-administered medications during an outpatient hospital observation stay on Page 15.

Transplant contracting arrangements

As part of the State Health Plan network, you have access to the leading transplant facilities in South Carolina and throughout the nation. If you are covered by Medicare, there is no need to call Medi-Call for prior authorization, nor do you need to select a facility that participates in the State Health Plan network.

Using Express Scripts Medicare for prescription drug coverage

Pharmacy network

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

To find a pharmacy in your area, call Express Scripts at 855.612.3128 or visit **www.express-scripts.com**, select Help, then Frequently Asked Questions.

No pay-the-difference policy for medication

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

Medication Therapy Management

Express Scripts Medicare provides a Medication Therapy Management program that helps ensure State Health Plan members receive the most effective medications while reducing side effects and out-of-pocket costs. To participate, a member must meet all of the following criteria:

- Have two or more of the following diseases:
  - Asthma,
  - COPD,
  - Depression,
  - Diabetes,
  - High cholesterol,
  - Heart failure,
  - HIV,
  - High blood pressure,
  - Osteoporosis, or
  - Rheumatoid arthritis;
- Have filled four or more Part D maintenance or chronic condition drug prescriptions; and
- Be likely to spend $5,330 or more yearly on drugs in 2024.

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

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

For more information, call Express Scripts Medicare at 855.612.3128.

Low-income subsidies

Some subscribers with limited income and resources may be able to get extra help to pay costs, such as copayments, related to a Medicare prescription drug plan. To see if you qualify, call Medicare at 800.633.4227 (TTY users may call 877.486.2048) or the Social Security Administration at 800.777.1213 (TTY users may call 800.325.0778).

You also may call the South Carolina Lieutenant Governor's Office on Aging at 803.734.9900 or 800.868.9095 to ask for contact information for your regional State Health

Insurance Assistance Program. If you live in a state other than South Carolina and you would like to speak with the State Health Insurance Assistance Program in the state where you live, contact Medicare. If you qualify, Medicare will tell the Plan how much assistance you will receive. Express Scripts will send you information on the amount you will pay once you enroll in the Plan.

Income-Related Monthly Adjustment Amounts (IRMAA)

High-income earners enrolled in a Medicare Part D plan may be required to pay a monthly fee to the Social Security Administration. If you will pay an IRMAA fee, you should determine if the additional benefits of the Medicare Part D plan are worth the additional fee you will pay to the Social Security Administration.

More information

For detailed information about Express Scripts Medicare, see the welcome kit package you will receive from Express Scripts Medicare. If you have questions about your prescription drug benefit, call Express Scripts at 855.612.3128.

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

Immunization benefits available through Medicare or Express Scripts Medicare

Adult vaccinations are covered through Medicare Part B or Express Scripts Medicare, the State Health Plan's Medicare Part D prescription drug program, at intervals recommended by the Centers for Disease Control. Contact your network physician or go to **www.cdc.gov/vaccines/schedules** and select Adults (19 years or older) to learn which vaccinations are covered.

Filing claims as a retiree with Medicare

In most cases, your provider will file your Medicare claims for you. Methods will vary based on whether your claim is filed in or out of South Carolina, and whether you are enrolled in the Medicare Supplemental Plan or the Carve-out Plan.

Claims filed in South Carolina

The Medicare claim should be filed first. Claims for Medicare-approved medical charges incurred in South Carolina will be transferred automatically from Medicare to the State Health Plan. If you or your doctor has not received payment or notification from the Plan within 31 days after the Medicare payment is received, one of you must send BlueCross BlueShield of South Carolina (BlueCross), the claims processor for the State Health Plan, a claim form and a copy of your *Medicare Summary Notice* with your BIN or SSN written on it. Your mental health and substance abuse claims should also be filed with BlueCross and should include your *Medicare Summary Notice* with your BIN or SSN on it. Details on how to file your own claim are available in the *Insurance Benefits Guide*.

Claims filed outside South Carolina

If you are a Medicare Supplemental Plan member and you receive services outside South Carolina, your provider will file its claim to the Medicare carrier in that state. This is also the case for Carve-out Plan members who receive services outside South Carolina, but still in the United States. Medicare will send your claim to BlueCross.

If you are a State Health Plan member and the claim was filed, but you or your doctor has not received payment or notification from the State Health Plan within 31 days after the Medicare payment is received, one of you must send BlueCross a claim form and a copy of your *Medicare Summary Notice* with your BIN or SSN written on it.

If Medicare denies your claim as a State Health Plan member

If Medicare denies your claim, you are responsible for filing the denied claim with BlueCross. You may use the same State Health Plan claim forms active employees use. These forms are available on PEBA's website, **peba.sc.gov/forms**, or by contacting PEBA or BlueCross. Please attach your *Medicare Summary Notice* and an itemized bill to your claim form.

How Medicare works with other forms of PEBA coverage

TRICARE

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

If a dependent becomes eligible for Medicare before the active employee, survivor or retiree does, the dependent will not remain eligible for the TRICARE Supplement Plan.

For more information about the TRICARE Supplement Plan, contact Selman & Company at 866.637.9911 and select Option 1, email **memberservices@selmanco.com**, or visit **info.selmanco.com/peba**. For more information about TRICARE for Life, call 866.773.0404 or visit **www.tricare4u.com**.

COBRA

If you or your eligible spouse or child has continued coverage under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) and becomes eligible for Medicare Part A, Part B or both, notify PEBA. Your COBRA coverage will end.

A subscriber or eligible spouse or child who is covered by Medicare and who then becomes eligible for continued coverage under COBRA can generally use the continued coverage as secondary insurance. Medicare will be their primary coverage. For more information about continued coverage under COBRA, see the General information chapter of the *Insurance Benefits Guide*, or contact your benefits office.

Part D Creditable Coverage Letter

Important notice from PEBA about your prescription drug coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with PEBA and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare prescription drug plan other than Express Scripts Medicare, the State Health Plan's Medicare prescription drug program. If you are considering joining another Part D plan, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (such as an HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans might 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 Carve-out Plan or the Medicare Supplemental Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays. It is, therefore, considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare prescription drug plan.

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

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

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium could go up by at least 1% of the Medicare base beneficiary premium per month for every month 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 (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage
Contact PEBA at the address or telephone number listed below.

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

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

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

Call your regional State Health Insurance Assistance Program (see Page 23 of this handbook for information about how to get the program's telephone number) for personalized help. You may also call 800.MEDICARE (800.633.4227). TTY users may call 877.486.2048.

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

Contact PEBA below for further information.

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

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

Medicare Part D: frequently asked questions

I received a notice recently about Medicare Part D from PEBA. What is this?	Even though the Medicare prescription drug benefit went into effect on January 1, 2006, PEBA will continue to provide you and your covered dependents with your state prescription drug coverage. The notice tells you this coverage is at least as good as the Medicare prescription drug benefit, and it is proof of such coverage. Please keep this notice where you can easily find it.
Do I need to do anything right now?	No. There is nothing you need to do if you want to keep your state coverage through PEBA.
What do I need to do if I want to switch to a Medicare plan?	If you switch to a Medicare prescription drug plan other than the one sponsored by PEBA, you need to enroll within the seven-month initial enrollment period of your Medicare eligibility. More information is available by calling Medicare at 800.MEDICARE (800.633.4227) or 877.486.2048 (TTY). Enrolling in a Medicare prescription drug plan will disqualify you from prescription drug coverage through your PEBA plan. If you enroll in a Medicare prescription drug plan other than the one sponsored by PEBA, you will lose your PEBA drug coverage and there will be no reduction in your health insurance premium.
If I keep my current coverage with PEBA, can I switch to a Medicare plan later?	Yes. You can re-enroll in Express Scripts Medicare at any time; however, if you enroll initially, you cannot disenroll until Medicare's open enrollment period. This period is from October 15 to December 7 of each year.
Will I pay higher premiums for a Medicare prescription drug plan if I keep my state coverage through PEBA and switch later?	No. Since Medicare recognizes your current state coverage through PEBA is at least as good as the standard Medicare plan, you will not pay more if you later enroll in a Medicare plan. Remember that you may enroll only in a Medicare prescription drug plan: • During open enrollment for Medicare, which is October 15 to December 7 of each year; or • If your PEBA coverage ends.
Is extra help or limited-income assistance available for prescription drug coverage?	Under Medicare Part D, the federal government offers Extra Help, a program to help pay costs of a Medicare prescription drug plan for people with limited income and resources. If you think you might qualify, you can apply for assistance by filling out an application online at **www.socialsecurity.gov** or by calling the Social Security Administration at 800.772.1213 or 800.325.0778 (TTY). You can also call the S.C. Lieutenant Governor's Office on Aging at 803.734.9900 or 800.868.9095 for contact information for your regional State Health Insurance Assistance Program.

Comparison of 2024 health plans

At network providers for retirees and family members eligible for Medicare

This chart is a summary of how PEBA's Medicare Supplemental Plan and Carve-out Plan coordinate (pays secondary) with traditional Medicare. This chart assumes the member is enrolled in both Part A and B of traditional Medicare. For further details, please see the *Insurance Benefits Guide* or visit Medicare's website at **www.medicare.gov.** Learn more about your options in this handbook, in the Health insurance chapter of the *Insurance Benefits Guide* or from Medicare. The comparison chart for retired subscribers and covered family members who are not eligible for Medicare is in the Health insurance chapter of the *Insurance Benefits Guide*.

Footnotes for the comparison charts on Pages 24-26 are on Page 27.

	Medicare Parts A and B	Medicare Supplemental Plan	Carve-out Plan[1]
Coverage availability	United States (Contact Medicare about any services outside the U.S.)	Same as Medicare	Coverage worldwide
Cancellation policy	Call Medicare for details.	Canceled for failure to pay premiums.	Canceled for failure to pay premiums.
Annual deductible	You pay **$1,632** Part A deductible per benefit period. You pay **$240** Part B deductible per benefit period.	Plan pays Medicare Part A and Part B deductibles.	You pay up to **$515** per individual or **$1,030** per family.
Coinsurance Maximum excludes copayments and deductible	Medicare pays 100% for Part A. Medicare pays 80% for Part B and you pay **20%**. There is no coinsurance maximum.	Plan pays Part B coinsurance of 20%. There is no coinsurance maximum.	You pay **20%** up to **$3,000** per individual or **$6,000** per family.[2]
Physician's office visit	You pay **20%** and Medicare pays 80%. Medicare covers a "Welcome to Medicare" preventive visit and a yearly wellness visit. No charge if from a doctor who accepts assignment.	Plan pays Part B coinsurance of 20%.	You pay a **$15** copayment[3] plus the remaining allowed amount until you meet your deductible. Then, you pay the copayment plus your coinsurance.

	Medicare Parts A and B	Medicare Supplemental Plan	Carve-out Plan[1]
Copayments[4]	You pay the Part A deductible of **$1,632** for inpatient hospital services.	Plan pays Part A deductible. Call BlueCross' Medi-Call for hospital stays over 150 days, skilled nursing, private duty nursing, home healthcare, durable medical equipment and VA hospital services.	You pay a **$115** copayment (outpatient services)[5] or **$193** copayment (emergency care)[6] plus the remaining allowed amount until you meet your deductible. Then, you pay the copayment plus your coinsurance.
Prescription drugs[7] 30-day supply/90-day supply at a network pharmacy	Coverage provided under Medicare Supplemental Plan. Prescription drugs are not covered by Medicare Parts A and B. You do not need to sign up for a Medicare Part D Plan.	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.	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.
Inpatient hospitalization[8]	Medicare pays 100% for days 1-60 (Part A deductible applies). You pay **$408/day** for days 61-90; **$816/day** for days 91-150 (subject to 60 lifetime reserve days); and **all costs** beyond 150 days.	Plan pays Medicare deductible and coinsurance for days 61-150. Medicare benefits may end sooner than day 150 if member has previously used any of their 60 lifetime reserve days. Plan pays 100% beyond 150 days.	You pay the **full cost** until you meet your deductible. Then, you pay your coinsurance.
Mental health, substance abuse	Inpatient: Medicare pays 100% for days 1-60 (Part A deductible applies). You pay **$408/day** for days 61-90; **$816/day** for days 91-150 (subject to 60 lifetime reserve days); and all costs beyond 150 days. Outpatient: Medicare pays 80% (Part B deductible applies). You pay **20%**.	Inpatient: Plan pays Medicare deductible; $408/day coinsurance for days 61-90; and $816/day coinsurance for days 91-150. After 150 days, CBA approval required. Outpatient: Plan pays Medicare deductible and 20% coinsurance.	You pay the **full cost** until you meet your deductible. Then, you pay your coinsurance.

	Medicare Parts A and B	Medicare Supplemental Plan	Carve-out Plan[1]
Skilled nursing facility	Medicare pays 100% for days 1-20. You pay **$204/day** for days 21-100.	Plan pays $204/day for days 21-100. With Medi-Call approval, Plan pays 100% of approved days beyond 100 days, up to a total of 60 days.	You pay **20%** coinsurance, up to 60 days. Call Medi-Call or CBA if stay exceeds 100 days.
Private duty nursing	Not covered	You pay a **$200** annual deductible and **20%** coinsurance if Medi-Call approves. $5,000 annual maximum $25,000 lifetime maximum	Not covered
Home health care	Medicare pays 100%.	Up to 100 visits covered. Medi-Call available to assist with referrals.	Up to 100 visits covered. You pay **20%** coinsurance.
Hospice care	Medicare pays 100%.	Medi-Call available to assist with referrals.	Medi-Call available to assist with referrals.
Durable medical equipment	Medicare pays 80% of Medicare-approved amount. You pay **20%**.	Plan pays 20% coinsurance. Medi-Call approval required.	You pay **20%**. Medi-Call approval required.
Routine mammography	No charge if the doctor accepts assignment; guidelines apply.	Plan pays 20% coinsurance.	Available to women ages 35 and older at participating facilities only; guidelines apply.
Pap test	Routine test every 24 months (annual if high risk) with no patient liability if doctor accepts assignment.	Plan pays 20% coinsurance. Otherwise, Plan pays for one annual routine Pap test for covered women ages 18-65. Diagnostic Pap tests covered only for ages 66 and older.	Routine annual test for covered women ages 18-65; diagnostic Pap tests only for ages 66 and older. Plan pays 100% for Pap test.
Ambulance	Medicare pays 80%. You pay **20%**.	Plan pays 20% coinsurance.	You pay **20%** coinsurance.
Eyeglasses	None, except for prosthetic lenses from cataract surgery.	None, except for prosthetic lenses from cataract surgery.	None, except for prosthetic lenses from cataract surgery.

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

Footnotes for health plan comparison charts
1 The carve-out method is used to pay claims for retired subscribers covered by Medicare and the Carve-out Plan.
2 Out of network, you will pay 40% coinsurance and your coinsurance maximum doubles. An out-of-network provider may bill you more than the State Health Plan's allowed amount.
3 The $15 copayment is waived for routine mammograms, adult well visits, well woman visits and well child visits. Carve-out Plan members who receive in-person care at a BlueCross-affiliated patient-centered medical home (PCMH) provider will not be charged the $15 copayment for a physician's office visit. After Carve-out Plan members meet their deductible, they will pay 10% coinsurance, rather than 20%, for in-person care at a PCMH.
4 For the Medicare Supplemental Plan, must call Medi-Call for hospital stays over 150 days, skilled nursing, private duty nursing, home healthcare, durable medical equipment and VA hospital services.
5 The $115 copayment for outpatient facility services is waived for dialysis services, partial hospitalizations, intensive outpatient services, electroconvulsive therapy and psychiatric medication management.
6 The $193 copayment for emergency care is waived if admitted.
7 Prescription drugs are not covered at out-of-network pharmacies. Specialty medications are limited to a 30-day supply per fill. 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.
8 For the Medicare Supplemental Plan, Medi-Call or CBA approval required if hospital stay exceeds 150 days.

2024 Monthly premiums

Rates may vary for optional employers. Verify rates with your benefits office. Footnotes are available on Page 34.

Funded retirees

Retiree eligible for Medicare, spouse eligible for Medicare

	Retiree	Retiree/spouse	Retiree/children	Full family
Medicare Supplemental[1,2]	$97.68	$253.36	$143.86	$306.56
Carve-out Plan[1]	$79.68	$217.36	$125.86	$270.56
Dental Plus	$28.80	$65.88	$80.92	$108.64
Basic Dental	$0.00	$7.64	$13.72	$21.34
State Vision Plan	$6.30	$12.60	$13.54	$19.84
Tobacco-use premium[1]	$40.00	$60.00	$60.00	$60.00

Retiree eligible for Medicare, spouse not eligible for Medicare

	Retiree/spouse	Full family
Medicare Supplemental[1,2]	$253.36	$299.54
Carve-out Plan[1]	$235.36	$281.54
Dental Plus	$65.88	$108.64
Basic Dental	$7.64	$21.34
State Vision Plan	$12.60	$19.84
Tobacco-use premium[1]	$60.00	$60.00

Retiree not eligible for Medicare, spouse eligible for Medicare

	Retiree/spouse	Full family
Medicare Supplemental[1,2]	$253.36	$299.54
Carve-out Plan[1]	$235.36	$281.54
Dental Plus	$65.88	$108.64
Basic Dental	$7.64	$21.34
State Vision Plan	$12.60	$19.84
Tobacco-use premium[1]	$60.00	$60.00

Retiree not eligible for Medicare, spouse not eligible for Medicare

	Retiree	Retiree/spouse	Retiree/children	Full family
Standard Plan[1]	$97.68	$253.36	$143.86	$306.56
Savings Plan[1]	$9.70	$77.40	$20.48	$113.00
TRICARE Supplement	$62.50	$121.50	$121.50	$162.50
Dental Plus	$28.80	$65.88	$80.92	$108.64
Basic Dental	$0.00	$7.64	$13.72	$21.34
State Vision Plan	$6.30	$12.60	$13.54	$19.84
Tobacco-use premium[1]	$40.00	$60.00	$60.00	$60.00

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

	Retiree/children	Full family
Medicare Supplemental[1,2]	$161.86	$324.56
Carve-out Plan[1]	$143.86	$306.56
Dental Plus	$80.92	$108.64
Basic Dental	$13.72	$21.34
State Vision Plan	$13.54	$19.84
Tobacco-use premium[1]	$60.00	$60.00

Non-funded retirees

Retiree eligible for Medicare, spouse eligible for Medicare

	Retiree	Retiree/spouse	Retiree/children	Full family
Medicare Supplemental[1,2]	$574.68	$1,256.84	$938.54	$1,577.90
Carve-out Plan[1]	$556.68	$1,220.84	$920.54	$1,541.90
Dental Plus	$42.28	$79.36	$94.40	$122.12
Basic Dental	$13.48	$21.12	$27.20	$34.82
State Vision Plan	$6.30	$12.60	$13.54	$19.84
Tobacco-use premium[1]	$40.00	$60.00	$60.00	$60.00

Retiree eligible for Medicare, spouse not eligible for Medicare

	Retiree/spouse	Full family
Medicare Supplemental[1,2]	$1,256.84	$1,570.88
Carve-out Plan[1]	$1,238.84	$1,552.88
Dental Plus	$79.36	$122.12
Basic Dental	$21.12	$34.82
State Vision Plan	$12.60	$19.84
Tobacco-use premium[1]	$60.00	$60.00

Retiree not eligible for Medicare, spouse eligible for Medicare

	Retiree/spouse	Full family
Medicare Supplemental[1,2]	$1,256.84	$1,570.88
Carve-out Plan[1]	$1,238.84	$1,552.88
Dental Plus	$79.36	$122.12
Basic Dental	$21.12	$34.82
State Vision Plan	$12.60	$19.84
Tobacco-use premium[1]	$60.00	$60.00

Retiree not eligible for Medicare, spouse not eligible for Medicare

	Retiree	Retiree/spouse	Retiree/children	Full family
Standard Plan[1]	$574.68	$1,256.84	$938.54	$1,577.90
Savings Plan[1]	$486.70	$1,080.88	$815.16	$1,384.34
TRICARE Supplement	$62.50	$121.50	$121.50	$162.50
Dental Plus	$42.28	$79.36	$94.40	$122.12
Basic Dental	$13.48	$21.12	$27.20	$34.82
State Vision Plan	$6.30	$12.60	$13.54	$19.84
Tobacco-use premium[1]	$40.00	$60.00	$60.00	$60.00

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

	Retiree/children	Full family
Medicare Supplemental[1,2]	$956.54	$1,595.90
Carve-out Plan[1]	$938.54	$1,577.90
Dental Plus	$94.40	$122.12
Basic Dental	$27.20	$34.82
State Vision Plan	$13.54	$19.84
Tobacco-use premium[1]	$60.00	$60.00

Partially funded retirees

Retiree eligible for Medicare, spouse eligible for Medicare

	Retiree	Retiree/spouse	Retiree/children	Full family
Medicare Supplemental[1,2]	$336.18	$755.10	$541.20	$942.24
Carve-out Plan[1]	$318.18	$719.10	$523.20	$906.24
Dental Plus	$35.54	$72.62	$87.66	$115.38
Basic Dental	$6.74	$14.38	$20.46	$28.08
State Vision Plan	$6.30	$12.60	$13.54	$19.84
Tobacco-use premium[1]	$40.00	$60.00	$60.00	$60.00

Retiree eligible for Medicare, spouse not eligible for Medicare

	Retiree/spouse	Full family
Medicare Supplemental[1,2]	$755.10	$935.22
Carve-out Plan[1]	$737.10	$917.22
Dental Plus	$72.62	$115.38
Basic Dental	$14.38	$28.08
State Vision Plan	$12.60	$19.84
Tobacco-use premium[1]	$60.00	$60.00

Retiree not eligible for Medicare, spouse eligible for Medicare

	Retiree/spouse	Full family
Medicare Supplemental[1,2]	$755.10	$935.22
Carve-out Plan[1]	$737.10	$917.22
Dental Plus	$72.62	$115.38
Basic Dental	$14.38	$28.08
State Vision Plan	$12.60	$19.84
Tobacco-use premium[1]	$60.00	$60.00

Retiree not eligible for Medicare, spouse not eligible for Medicare

	Retiree	Retiree/spouse	Retiree/children	Full family
Standard Plan[1]	$336.18	$755.10	$541.20	$942.24
Savings Plan[1]	$248.20	$579.14	$417.82	$748.68
TRICARE Supplement	$62.50	$121.50	$121.50	$162.50
Dental Plus	$35.54	$72.62	$87.66	$115.38
Basic Dental	$6.74	$14.38	$20.46	$28.08
State Vision Plan	$6.30	$12.60	$13.54	$19.84
Tobacco-use premium[1]	$40.00	$60.00	$60.00	$60.00

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

	Retiree/children	Full family
Medicare Supplemental[1,2]	$559.20	$960.24
Carve-out Plan[1]	$541.20	$942.24
Dental Plus	$87.66	$115.38
Basic Dental	$20.46	$28.08
State Vision Plan	$13.54	$19.84
Tobacco-use premium[1]	$60.00	$60.00

Funded survivors

Spouse eligible for Medicare, children eligible for Medicare

	Spouse	Spouse/children	Children only
Medicare Supplemental[1,2]	$97.68	$161.86	$64.18[3]
Carve-out Plan[1]	$79.68	$125.86	$46.18
Dental Plus	$28.80	$80.92	$52.12
Basic Dental	$0.00	$13.72	$13.72
State Vision Plan	$6.30	$13.54	$7.24
Tobacco-use premium[1]	$40.00	$60.00	$60.00

Spouse eligible for Medicare, children not eligible for Medicare

	Spouse	Spouse/children	Children only
Medicare Supplemental[1,2]	$97.68	$143.86	N/A
Carve-out Plan[1]	$79.68	$125.86	$46.18
Savings Plan[1]	N/A	N/A	$10.78
Dental Plus	$28.80	$80.92	$52.12
Basic Dental	$0.00	$13.72	$13.72
State Vision Plan	$6.30	$13.54	$7.24
Tobacco-use premium[1]	$40.00	$60.00	$60.00

Spouse not eligible for Medicare, children eligible for Medicare

	Spouse	Spouse/children	Children only
Medicare Supplemental[1,2]	N/A	$161.86[3]	$64.18[3]
Carve-out Plan[1]	$97.68	$143.86	$46.18
Savings Plan[1]	$9.70	N/A	N/A
Dental Plus	$28.80	$80.92	$52.12
Basic Dental	$0.00	$13.72	$13.72
State Vision Plan	$6.30	$13.54	$7.24
Tobacco-use premium[1]	$40.00	$60.00	$60.00

Spouse not eligible for Medicare, children not eligible for Medicare

	Spouse	Spouse/children	Children only
Standard Plan[1]	$97.68	$143.86	$46.18
Savings Plan[1]	$9.70	$20.48	$10.78
TRICARE Supplement	$62.50	$121.50	$61.00
Dental Plus	$28.80	$80.92	$52.12
Basic Dental	$0.00	$13.72	$13.72
State Vision Plan	$6.30	$13.54	$7.24
Tobacco-use premium[1]	$40.00	$60.00	$60.00

Non-funded survivors

Spouse eligible for Medicare, children eligible for Medicare

	Spouse	Spouse/children	Children only
Medicare Supplemental[1,2]	$574.68	$956.54	$381.86
Carve-out Plan[1]	$556.68	$920.54	$363.86
Dental Plus	$42.28	$94.40	$52.12
Basic Dental	$13.48	$27.20	$13.72
State Vision Plan	$6.30	$13.54	$7.24
Tobacco-use premium[1]	$40.00	$60.00	$60.00

Spouse eligible for Medicare, children not eligible for Medicare

	Spouse	Spouse/children	Children only
Medicare Supplemental[1,2]	$574.68	$938.54	N/A
Carve-out Plan[1]	$556.68	$920.54	$363.86
Savings Plan[1]	N/A	N/A	$328.46
Dental Plus	$42.28	$94.40	$52.12
Basic Dental	$13.48	$27.20	$13.72
State Vision Plan	$6.30	$13.54	$7.24
Tobacco-use premium[1]	$40.00	$60.00	$60.00

Spouse not eligible for Medicare, children eligible for Medicare

	Spouse	Spouse/children	Children only
Medicare Supplemental[1,2]	N/A	$956.54[3]	$381.86[3]
Carve-out Plan[1]	$578.68	$938.54	$363.86
Savings Plan[1]	$486.70	N/A	N/A
Dental Plus	$42.28	$94.40	$52.12
Basic Dental	$13.48	$27.20	$13.72
State Vision Plan	$6.30	$13.54	$7.24
Tobacco-use premium[1]	$40.00	$60.00	$60.00

Spouse not eligible for Medicare, children not eligible for Medicare

	Spouse	Spouse/children	Children only
Standard Plan[1]	$574.68	$938.54	$363.86
Savings Plan[1]	$486.70	$815.16	$328.46
TRICARE Supplement	$62.50	$121.50	$61.00
Dental Plus	$42.28	$94.40	$52.12
Basic Dental	$13.48	$27.20	$13.72
State Vision Plan	$6.30	$13.54	$7.24
Tobacco-use premium[1]	$40.00	$60.00	$60.00

Partially funded survivors

Spouse eligible for Medicare, children eligible for Medicare

	Spouse	Spouse/children	Children only
Medicare Supplemental[1,2]	$238.50	$397.34	$158.84[3]
Carve-out Plan[1]	$238.50	$397.34	$158.84
Dental Plus	$42.28	$94.40	$52.12
Basic Dental	$13.48	$27.20	$13.72
State Vision Plan	$6.30	$13.54	$7.24
Tobacco-use premium[1]	$40.00	$60.00	$60.00

Spouse eligible for Medicare, children not eligible for Medicare

	Spouse	Spouse/children	Children only
Medicare Supplemental[1,2]	$238.50	$397.34	N/A
Carve-out Plan[1]	$238.50	$397.34	$158.84
Savings Plan[1]	N/A	N/A	$158.84
Dental Plus	$42.28	$94.40	$52.12
Basic Dental	$13.48	$27.20	$13.72
State Vision Plan	$6.30	$13.54	$7.24
Tobacco-use premium[1]	$40.00	$60.00	$60.00

Spouse not eligible for Medicare, children eligible for Medicare

	Spouse	Spouse/children	Children only
Medicare Supplemental[1,2]	N/A	$397.34[3]	$158.84[3]
Carve-out Plan[1]	$238.50	$397.34	$158.84
Savings Plan[1]	$238.50	N/A	N/A
Dental Plus	$42.28	$94.40	$52.12
Basic Dental	$13.48	$27.20	$13.72
State Vision Plan	$6.30	$13.54	$7.24
Tobacco-use premium[1]	$40.00	$60.00	$60.00

Spouse not eligible for Medicare, children not eligible for Medicare

	Spouse	Spouse/children	Children only
Standard Plan[1]	$238.50	$397.34	$158.84
Savings Plan[1]	$238.50	$397.34	$158.84
TRICARE Supplement	$62.50	$121.50	$61.00
Dental Plus	$42.28	$94.40	$52.12
Basic Dental	$13.48	$27.20	$13.72
State Vision Plan	$6.30	$13.54	$7.24
Tobacco-use premium[1]	$40.00	$60.00	$60.00

Tobacco-use premium

If you are a State Health Plan subscriber with single coverage and you use tobacco or e-cigarettes, you will pay an additional $40 monthly premium. If you have employee/spouse, employee/children or full family coverage, and you or anyone you cover uses tobacco or e-cigarettes, the additional monthly premium will be $60.

The premium is automatic for all State Health Plan subscribers unless the subscriber certifies no one they cover uses tobacco or e-cigarettes, or covered individuals who use tobacco or e-cigarettes have completed the Quit for Life® tobacco cessation program. The tobacco-use premium does not apply to TRICARE Supplement Plan subscribers.

To certify no one covered by their health insurance uses tobacco or e-cigarettes and no one has used them during the past six months, or all covered individuals who use tobacco or e-cigarettes have completed the tobacco cessation program, the subscriber must complete a *Certification Regarding Tobacco and E-cigarette Use* form. If you have not certified or need to change your certification, go to **peba.sc.gov/forms** to find the form under Health insurance. Give the completed form to your benefits administrator, who will send it to PEBA. The certification will be effective the first of the month after PEBA receives the form.

Subscribers need to pay all premiums, including the tobacco-use premium, if it applies, when they are due. If premiums are not paid, coverage for all plans will be canceled, effective the last day of the month in which the premiums were paid in full.

Footnotes for premium charts

1 State Health Plan subscribers who use tobacco or e-cigarettes or cover dependents who use tobacco or e-cigarettes will pay a $40-per-month premium for subscriber-only coverage. The premium is $60 for other levels of coverage. The premium is automatic for all State Health Plan subscribers unless the subscriber certifies no one they cover uses tobacco or e-cigarettes, or covered individuals who use tobacco or e-cigarettes have completed the Quit For Life® tobacco cessation program.

2 If the Medicare Supplemental Plan is elected, claims for covered subscribers not eligible for Medicare will be based on the Carve-out Plan provisions.

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

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South Carolina Public Employee Benefit Authority

Serving those who serve South Carolina

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