2018 Insurance Summary

for South Carolina's public employees

south carolina peba SM

state health plan | retirement systems

Welcome

South Carolina public employees help make the Palmetto State a better place — and PEBA helps make life better for public employees. PEBA offers several insurance programs to more than 483,000 people, including spouses and dependents.

The *Insurance Summary* provides a concise overview of your 2018 insurance benefits. Eligible employees are those who:

- Work for the state, a higher education institution, a public school district or a participating local subdivision like a county government or municipality; and
- Receive compensation from the state, a higher education institution, a public school district or a participating local subdivision.

Learn more at **www.peba.sc.gov**.

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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 My Health Toolkit.

Learn more about your coverage

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

Check medical claims

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

Check dental claims

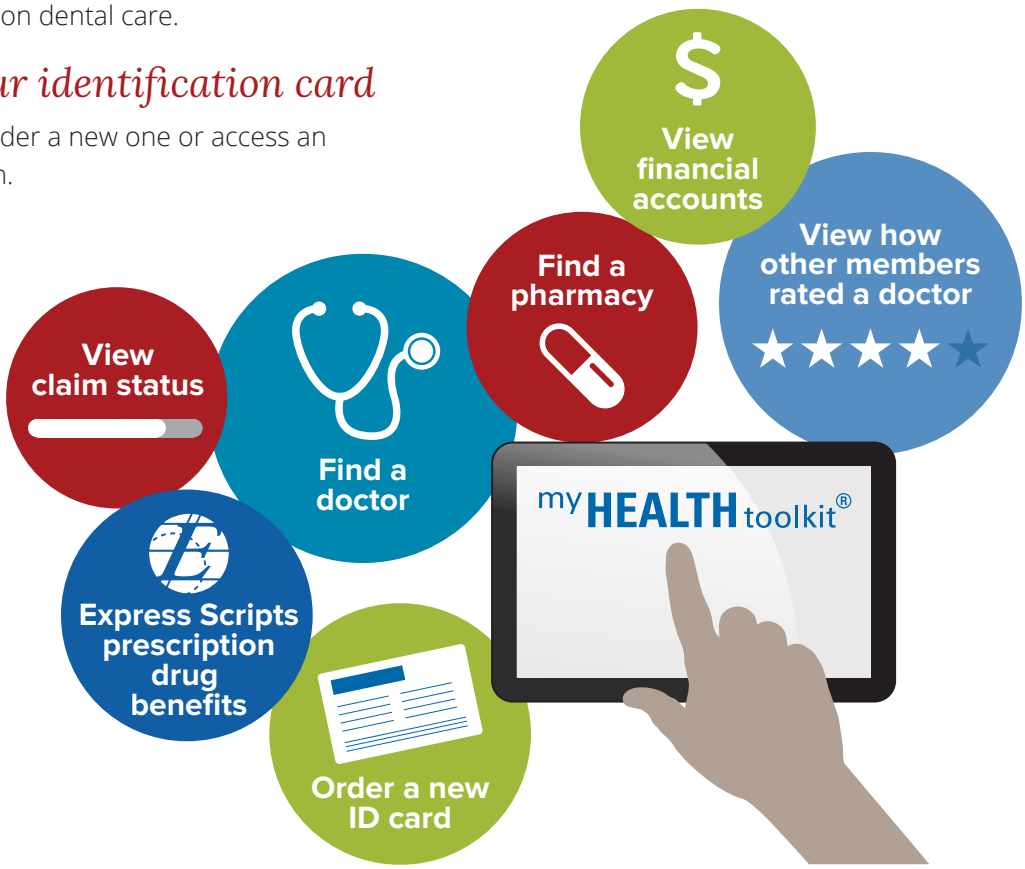
Look up your dental coverage, deductible and out-of-pocket spending on dental care.

Replace your identification card

You can easily order a new one or access an electronic version.

Manage your prescriptions

You're just a click away from all your medication details. Select the **Benefits** link on your My Health Toolkit homepage to access your Express Scripts account. From there, select **Express Scripts**. You can see 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.



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.

Find a doctor or hospital

Use the **Doctor and Hospital Finder** 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.

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**.
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® BlueShield® of South Carolina at **877.274.1715**.

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 a provider can be reimbursed for a covered service.

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 $112 and the member has met his deductible. After a Standard Plan member pays the $12 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.

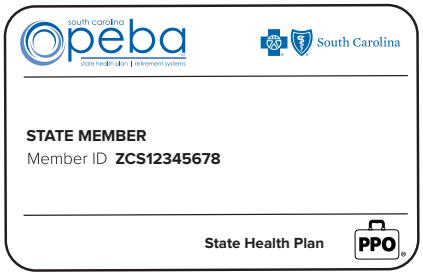
Preauthorization A decision that a service, prescription drug or piece of equipment is medically necessary. Certain services and medications require preauthorization before you receive them except in an emergency. You may also hear this referred to as precertification or prior authorization.

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.

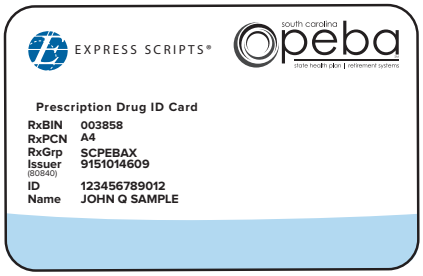
You're covered with membership ID cards

You receive insurance cards for health, prescription, dental and vision benefits. Be sure to keep your cards with you at all times and show them to your provider or pharmacy as necessary. Only the subscriber's name will be on the cards, but all covered family members can use them.



State Health Plan

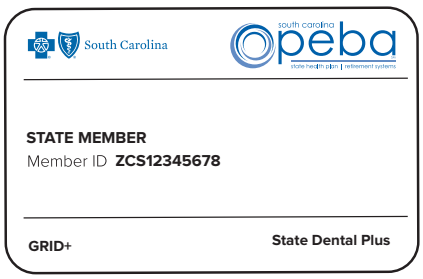
To order a replacement card, call BlueCross BlueShield of South Carolina at **800.868.2520** or visit **www.StateSC.SouthCarolinaBlues.com**.



Prescription drug

To order a replacement card, call Express Scripts at **855.612.3128** or visit **www.Express-Scripts.com**.

You also have digital access to your card by downloading the Express Scripts app on your mobile device.



Dental Plus

To order a replacement card, call BlueCross BlueShield of South Carolina at **888.214.6230** or visit **www.StateSC.SouthCarolinaBlues.com**.

If you need a State Dental Plan card, contact your benefits administrator.

Vision care

To order a replacement card, call EyeMed at **877.735.9314** or visit **www.EyeMed.com**.

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).

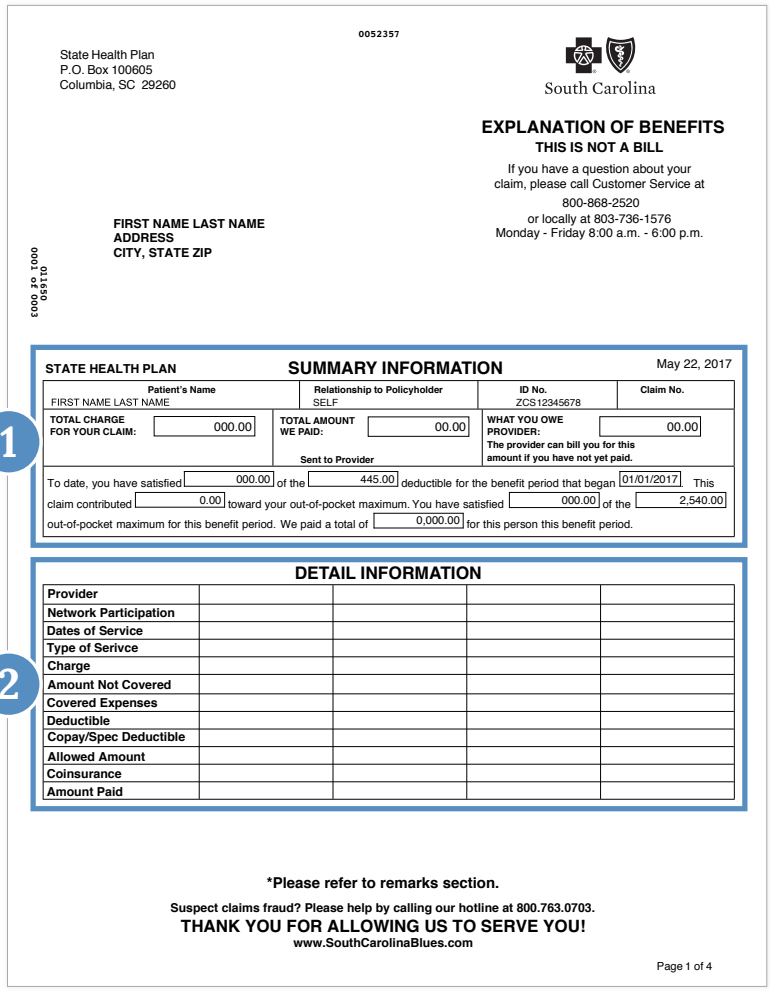
EOB: Page 1

1. Summary information

This is a view of the total amount of charges from all health care providers, the amount the State Health Plan paid and the amount you may owe or have already paid to providers. Your deductible is the amount of charges that you are responsible for paying before insurance will pay for covered expenses. Your out-of-pocket maximum is the amount you could pay for covered services per benefit period.

2. Detail information

Here you'll see the provider's name and network affiliation, the type of service provided, the service date and the claim number. You'll also find the total charges for the claim(s) from providers and the amount covered by the State Health Plan. There is also an itemized list of charges you will be responsible for, such as your copayment, deductible and coinsurance.



0052357

State Health Plan
P.O. Box 100605
Columbia, SC 29260

South Carolina

EXPLANATION OF BENEFITS
THIS IS NOT A BILL

If you have a question about your claim, please call Customer Service at
800-868-2520
or locally at 803-736-1576
Monday - Friday 8:00 a.m. - 6:00 p.m.

FIRST NAME LAST NAME
ADDRESS
CITY, STATE ZIP

0015690 0001 of 0003

1

STATE HEALTH PLAN **SUMMARY INFORMATION** May 22, 2017

Patient's Name	Relationship to Policyholder	ID No.	Claim No.
FIRST NAME LAST NAME	SELF	ZCS12345678	

TOTAL CHARGE FOR YOUR CLAIM:	TOTAL AMOUNT WE PAID:	WHAT YOU OWE PROVIDER:
000.00	00.00 Sent to Provider	00.00 The provider can bill you for this amount if you have not yet paid.

To date, you have satisfied 000.00 of the 445.00 deductible for the benefit period that began 01/01/2017. This claim contributed 0.00 toward your out-of-pocket maximum. You have satisfied 000.00 of the 2,540.00 out-of-pocket maximum for this benefit period. We paid a total of 0,000.00 for this person this benefit period.

2

DETAIL INFORMATION

Provider				
Network Participation				
Dates of Service				
Type of Serivce				
Charge				
Amount Not Covered				
Covered Expenses				
Deductible				
Copay/Spec Deductible				
Allowed Amount				
Coinsurance				
Amount Paid				

***Please refer to remarks section.**

Suspect claims fraud? Please help by calling our hotline at 800.763.0703.
THANK YOU FOR ALLOWING US TO SERVE YOU!
www.SouthCarolinaBlues.com

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Go green!

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.

Better health in your hands

Rally gives you an easier way to improve and maintain your health. Based on your responses to its quick health survey, Rally will offer personalized recommendations to help you move more, eat better and feel great. Rally is available to you at no additional cost as part of your State Health Plan benefits.

Use Rally on the web or download the app for the convenience of Rally on the go. The Rally Health app is available in the App Store (iOS) or on Google Play (Android).

Inside Rally

- See all your **Missions** at a glance.
- Track your progress.
- Earn and redeem **Rally Coins.**
- Join **Challenges** and go for the gold.

It's easy to get started

1. Visit **www.StateSC.SouthCarolinaBlues.com**.
2. Log in to your My Health Toolkit account.
3. Select Wellness, then Rally.

Already a Rally user? Search **Rally Health** to download the mobile app.

Download on the App Store

GET IT ON Google Play

RALLY®

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.

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.

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.

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. This program allows members with certain conditions to receive generic drugs at no cost. 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 our maternity management program, Coming Attractions.

For more details about PEBA Perks, including eligibility, visit ***www.PEBAperks.com****.*

On-the-go health info

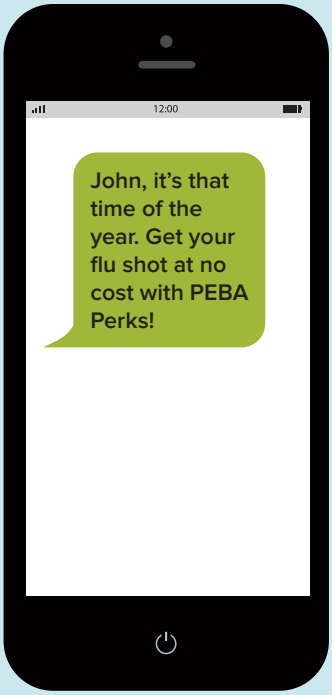
Sign up for State Health Plan mobile messaging.

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.

Get care when you need it with video visits

Blue CareOnDemand is a faster, easier way to see a doctor. State Health Plan primary members can consult licensed health care professionals 24/7/365 through the convenience of video visits.

Blue CareOnDemand is a network service, even if you are out of the state. Therefore, it is covered as a traditional office visit under the State Health Plan.

For example, if you have the Standard Plan, a visit before you meet your deductible can total $59, and after you meet your deductible, your visit can cost as little as $21.40.

BLUE CareOnDemand℠

When to use it

Blue CareOnDemand is a great solution when:

- You need to see a doctor, but can't fit it into your schedule.
- Your doctor's office is closed.
- You or your child feel too sick to leave the house.
- You're traveling.

Licensed health care professionals can treat many of the most common health conditions through video visits, including:

- Allergies
- Bronchitis and other respiratory infections
- Cold and flu symptoms
- Migraines
- Sinus problems
- Skin irritations
- Urinary tract infections
- And more!

The doctor can even write prescriptions if needed.

How to register

There are two easy ways to access Blue CareOnDemand:

- Visit **www.BlueCareOnDemandSC.com**.
- Download the Blue CareOnDemand mobile app for your Apple or Android device.

Register and create a patient profile today. That way, the next time you need care, the doctor is only a few clicks away.

*Go to **www.peba.sc.gov/bluecareondemand.html** to learn more about Blue CareOnDemand.*

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 becoming familiar with your health care options.

Primary care physician

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

- Managing your chronic condition
- Health screenings, immunizations
- Prescription refills

Your regular doctor is also the best choice for unexpected health issues, such as:

- 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

Blue CareOnDemand

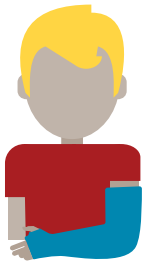
If your doctor's office is closed, you're traveling or you feel too sick to drive, a Blue CareOnDemand video visit is a great option.

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.

Use Blue CareOnDemand for non-emergency health issues, such as:

- 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

Emergency room



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

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

You've got a health coach in your corner

Ready to get on track with your health but not sure where to start? You don't have to figure it out on your own. Adults age 18 and older can get one-on-one coaching from a health care professional at no cost.

Chronic conditions

Managing a chronic condition can be difficult. A health coach can help you better understand your condition and the steps you can take to achieve your best health.

- Asthma[1]
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure
- Coronary artery disease
- Diabetes
- Hyperlipidemia (high cholesterol)
- Hypertension (high blood pressure)
- Migraine

Healthy lifestyles

A health coach can help you achieve a healthier lifestyle. Your coach will help you create a personalized action plan for meeting your goals.

- Back health
- Metabolic health
- Stress management
- Weight management[1]

Maternity

Coming Attractions supports mothers throughout their pregnancy and postpartum care. Expectant mothers will connect with a maternity care nurse and receive educational materials throughout their pregnancy and the baby's first year of life. Participants also learn how to receive a breast pump at no cost. We encourage mothers to enroll during their first trimester.

Behavioral health

A health coach will work one-on-one and offer you support. Your coach will encourage you to follow your treatment plan, help you set goals and teach you how to handle symptoms.

- Addiction recovery
- Attention deficit hyperactivity disorder (ADHD)
- Bipolar disorder
- Depression

To connect with a health coach, call **855.838.5897**.

[1]Health coaching for asthma and weight management is also available for children under age 18.

Patient-centered medical home

A team approach to care helps you reach your goals for better health.

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.

BlueCross BlueShield of South Carolina has 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.

*Visit **www.StateSC.SouthCarolinaBlues.com** to find a PCMH near you.*

Savings for you

Standard Plan members do not pay the $12 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.

Comparison of health plans

Plan[1]	Standard Plan		Savings Plan	
	In-network	Out-of-network[2]	In-network	Out-of-network[2]
Availability	Coverage worldwide		Coverage worldwide	
Annual deductible	Single: $445 Family: $890		Single: $3,600 Family: $7,200[3]	
Coinsurance[4]	Plan pays 80% You pay 20%	Plan pays 60% You pay 40%	Plan pays 80% You pay 20%	Plan pays 60% You pay 40%
Coinsurance maximum	Single: $2,540 Family: $5,080 Excludes deductible and copayments	Single: $5,080 Family: $10,160 Excludes deductible and copayments	Single: $2,400 Family: $4,800 Excludes deductible	Single: $4,800 Family: $9,600 Excludes deductible
Physician's office visits[4]	$12 copayment Plan pays 80% You pay 20%	$12 copayment Plan pays 60% You pay 40%	No copayment Plan pays 80% You pay 20%	No copayment Plan pays 60% You pay 40%
Blue CareOnDemand	$12 copayment Plan pays 80% You pay 20%		No copayment Plan pays 80% You pay 20%	
Hospitalization/emergency care[5,6]	Outpatient facility services: $95 copayment Emergency care: $159 copayment Plan pays 80% You pay 20%	Outpatient facility services: $95 copayment Emergency care: $159 copayment Plan pays 60% You pay 40%	No copayments for outpatient facility services or emergency care	
Chiropractic	$2,000 limit per covered person		$500 limit per covered person	
Prescription drugs[7]	**Retail pharmacies (up to 30-day supply)** • Tier 1 (generic): $9 • Tier 2 (brand): $38 • Tier 3 (brand): $63 **Retail maintenance network and mail-order pharmacies (up to 90-day supply)** • Tier 1: $22 • Tier 2: $95 • Tier 3: $158 Copay maximum: $2,500		**Retail pharmacies and mail order** You pay the State Health Plan's allowed amount until your annual deductible is met. Afterward, the Plan will pay 80% of the allowed amount; you pay 20% in coinsurance. Drug costs are applied to your coinsurance maximum. When you reach the maximum, the Plan will pay 100% of the allowed amount, and you can obtain medications at no cost.	
Tax-favored medical accounts	Medical Spending Account		Health Savings Account Limited-Use Medical Spending Account	

[1]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 per month for other levels of coverage. The tobacco-use premium does not apply to TRICARE Supplement subscribers.
[2]An out-of-network provider may bill you for more than the Plan's allowed amount for services.
[3]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.
[4]The $12 copayment is waived for routine Pap tests, routine mammograms and well-child visits. Standard Plan members who receive care at a BlueCross-affiliated patient-centered medical home provider will not pay the $12 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.
[5]$95 copayment for outpatient facility services is waived for emergency room, physical therapy, speech therapy, occupational therapy, oncology and dialysis services, routine mammograms and Pap tests, clinic visits, partial hospitalizations, intensive outpatient services, electro-convulsive therapy and psychiatric medication management.
[6]$159 copayment for emergency care is waived if admitted.
[7]Prescription drugs are not covered at out-of-network pharmacies.

2018 monthly premiums[1,2]

Active employees

	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
Dental	$0.00	$7.64	$13.72	$21.34
Dental Plus[3]	$27.12	$ 54.80	$63.20	$82.10
Vision	$8.00	$16.00	$17.16	$25.16

Former spouses[4]

	Not eligible for Medicare	Eligible for Medicare
Standard Plan	$523.44	$505.44
Savings Plan	$435.46	N/A
Dental	$21.12	$21.12
Dental Plus[3]	$32.54	$32.54
Vision	$8.00	$8.00

Tobacco-use premium

If you are a State Health Plan subscriber with single coverage and you use tobacco, 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, the additional premium will be $60 monthly.

The premium is automatic for all State Health Plan subscribers unless the subscriber certifies no one he covers uses tobacco or covered individuals who use tobacco have completed the Quit For Life tobacco cessation program.

To certify no one covered by his health insurance uses tobacco and no one has used it during the past six months, or all covered individuals who use tobacco have completed the tobacco cessation program, the subscriber must complete a *Certification Regarding Tobacco Use* form. If you have not certified or need to change your certification, go to **www.peba.sc.gov/iforms.html** 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.

[1]Premiums for local subdivisions may vary. To verify your rates, contact your benefits office.
[2]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 per month for other levels of coverage. The tobacco-use premium does not apply to TRICARE Supplement subscribers.
[3]If you enroll in Dental Plus, you must also be enrolled in the State Dental Plan. You will pay the combined premiums for both plans.
[4]A former spouse must have his own policy under the Plan. Coverage for a former spouse can include health, dental and vision as required by the court order. The cost of coverage is the full premium amount.

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 $200 penalty. And your health care coinsurance maximum may not apply to your treatment, which means there may be no cap on the amount you may pay out of pocket. 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

Get your prescription for savings

The State Health Plan includes prescription drug benefits. Prescription drugs are a major benefit to you and a major part of the cost of our self-insured health plan.

Prescription copayments

Standard Plan

	Retail (30-day supply)	Retail maintenance pharmacy (90-day supply)	Mail order (90-day supply)
Tier 1 (generic)	$9	$22	$22
Tier 2 (brand – preferred[1])	$38	$95	$95
Tier 3 (brand – non-preferred[1])	$63	$158	$158

Savings Plan

Savings Plan members do not pay a copayment when filling prescriptions. You pay the full allowed amount for drugs until you meet your annual deductible. Afterward, the Plan will pay 80 percent of the allowed amount; you pay 20 percent in coinsurance.

Formulary

The formulary is the list of preferred drugs, including some brand drugs and generics. After review, some safe and effective drugs become "preferred" (Tier 2) and other alternatives may become "non-preferred" (Tier 3). Talk to your doctor if you currently use a drug that is not on the preferred list. Doing this can save you money, and using generic drugs may save you even more. Log in to the Express Scripts website, **www.Express-Scripts.com**, to see if a drug is on the formulary.

Member resources

Helpful information about your State Health Plan prescription drug benefits is just a click away at **www.Express-Scripts.com** and on the Express Scripts mobile app[2].

- Refill and renew your prescriptions
- See your order status, claims and payment history
- Find in-network pharmacies near you

Coverage reviews

Express Scripts may need more information than the prescription to determine your coverage. Coverage reviews rely on medical experts and research, and aim to provide drug safety. There are three types of coverage reviews:

- Prior authorizations
- Drug quantity management
- Step therapy

You can log in to the Express Scripts website, **www.Express-Scripts.com**, to see if a prescription needs a coverage review. To begin a coverage review, call Express Scripts at **855.612.3128**.

*Learn more about how to manage your medicine at **www.peba.sc.gov/prescription.html**.*

Note: Beginning January 1, 2018, members who fill prescriptions for specialty medications must use the Plan's custom credentialed specialty network. The network will include Accredo, Express Scripts' specialty pharmacy, and accredited locally-owned pharmacies.

[1]If you obtain a brand-name drug when a generic equivalent is available, you are responsible for the generic copayment plus the cost difference between the brand-name drug and the generic drug.

[2]The app is available for iPhone®, Android™, Windows Phone®, Amazon and BlackBerry® mobile devices.

Care for your pearly whites

Selecting the right dental coverage for you and your family has never been easier. To participate in Dental Plus, you must enroll in the State Dental Plan and cover the same family members under both plans.

The State Dental Plan offers four classes of treatment:

I. Diagnostic and preventive
II. Basic
III. Prosthodontics
IV. Orthodontics

Dental Plus gives you even more coverage with the added benefit of a higher allowed amount.

- Deeper discounts
- Lower out-of-pocket expenses
- Your annual maximum payment goes further toward necessary treatment

Dental benefits at a glance

	Plan	Covered benefits	Annual deductible	Percent covered	Maximum payment
I. Diagnostic and preventive	State Dental Plan	Exams, cleaning and scaling of teeth, fluoride treatment, space maintainers (child), X-rays	None	100% of allowed amount	$1,000 per person each year, combined for Classes I, II and III
	State Dental Plan w/ Dental Plus				$2,000[2] per person each year, combined for Classes I, II and III
II. Basic benefits	State Dental Plan	Fillings, extractions, oral surgery, endodontics (root canals), periodontal procedures	$25 per person. If you have services in Classes II and III, you pay only one deductible. Limited to three per family per year.	80% of allowed amount	$1,000 per person each year, combined for Classes I, II and III
	State Dental Plan w/ Dental Plus		No additional deductible		$2,000[2] per person each year, combined for Classes I, II and III
III. Prosthodontics	State Dental Plan	Onlays, crowns, bridges, dentures, implants, repair of prosthodontic appliances	$25 per person. If you have services in Classes II and III, you pay only one deductible. Limited to three per family per year.	50% of allowed amount	$1,000 per person each year, combined for Classes I, II and III
	State Dental Plan w/ Dental Plus		No additional deductible		$2,000[2] per person each year, combined for Classes I, II and III
IV. Orthodontics[1]	State Dental Plan	Limited to covered children age 18 and younger. Correction of malocclusion consisting of: diagnostic services (including models & X-rays) and active treatment (including necessary appliances)	None	50% of allowed amount	$1,000 lifetime benefit for each covered child
	State Dental Plan w/ Dental Plus		No additional benefits	No additional benefits	No additional benefits

Learn more about dental benefits at ***www.peba.sc.gov/dental.html.***

[1]A subscriber must submit a letter from his provider for a covered child, age 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.
[2]$2,000 is the maximum yearly payment for benefits when a member is enrolled in State Dental Plan and Dental Plus.

Maximize your paycheck with MoneyPlus

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.

Pretax Group Insurance Premium feature

This feature allows you to pay premiums from your paycheck before taxes for health, vision, dental and Optional Life. Once you enroll in the pretax premium feature, you don't need to re-enroll each year.

Flexible spending accounts

You authorize deposits from each paycheck to your MoneyPlus account. As you have eligible expenses, you request tax-free withdrawals from your account to reimburse yourself. You can only request reimbursement for expenses incurred during the plan year. Funds left in your account after the reimbursement deadline are forfeited. There are three flexible spending accounts:

- Dependent Care Spending Account
- Medical Spending Account
- Limited-use Medical Spending Account

You must re-enroll in flexible spending accounts each year.

Health savings account

A health savings account is available to Savings Plan participants. You don't have to spend the funds in the year you deposited them. Money from your paycheck accumulates in the account tax-free. You can then use the funds to pay for future qualified medical expenses. An important advantage of a health savings account is that you own it. If you leave your job, you can take the account with you and continue to use it for qualified medical expenses.

You can also invest funds for account balances past a certain threshold. This allows you to earn investment income tax-free. Once you enroll in a health savings account, you don't need to re-enroll each year.

2018 contribution limits	
Medical Spending Account[1]	$2,600
Dependent Care Spending Account[1,2]	$2,500 (married, filing separately) $5,000 (single and head of household or married, filing jointly)
Health Savings Account	$3,450 (single) $6,900 (family) $1,000 catch-up for ages 55 and older
Reimbursement deadlines	
Medical Spending Account	March 31, 2019
Dependent Care Spending Account	March 31, 2019

[1]These are 2017 contribution limits and may change subject to IRS guidelines.
[2]Highly compensated employees have a lower contribution limit for a Dependent Care Spending Account.

Please note that PEBA is currently working to secure a flexible benefits vendor for 2018.

Learn how to maximize your paycheck at ***www.peba.sc.gov/moneyplus.html.***

Set your sight on savings

State Vision Plan

Vision care services	In-network member cost	Out-of-network reimbursement
Exam with dilation as necessary	$10 copay	Up to $35
Retinal imaging	Up to $39	N/A
Frames	$0 copay, $150 allowance, 20% off balance over $150	Up to $75
Standard plastic lenses		
Single vision	$10 copay	Up to $25
Bifocal	$10 copay	Up to $40
Trifocal	$10 copay	Up to $55
Lenticular	$10 copay	Up to $55
Standard progressive lens	$35 copay	Up to $55
Premium progressive lens[1]		
Tier 1	$55	Up to $55
Tier 2	$65	Up to $55
Tier 3	$80	Up to $55
Tier 4	$35 copay, 80% of charge less $120 allowance	Up to $55
Lens options		
UV treatment	$0	Up to $5
Tint (solid and gradient)	$0	Up to $5
Standard plastic scratch coating	$0	Up to $5
Standard polycarbonate – adults	$30 copay	Up to $5
Standard polycarbonate – children under 19	$0	Up to $5
Standard anti-reflective coating	$45	N/A
Premium anti-reflective coating[1]		
Tier 1	$57	N/A
Tier 2	$68	N/A
Tier 3	80% of charge	N/A
Transitions	$60	Up to $5
Photochromic plastic	20% off retail	N/A
Polarized	20% off retail	N/A
Other add-ons and services	20% off retail	N/A

[1]Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Not available in all states. Some provisions, benefits, exclusions or limitations listed herein may vary.

State Vision Plan

Vision care services	In-network member cost	Out-of-network reimbursement
Contact lens fit and follow-up (contact lens fit and follow-up visits are available once a comprehensive eye exam has been completed)		
Standard contact lens fit & follow-up	$0 copay, paid in full and two follow-up visits	Up to $40
Premium contact lens fit & follow-up	$0 copay, 10% off retail price, then apply $55 allowance	Up to $40
Contact lenses (contact lens allowance includes materials only)		
Conventional	$0 copay, $130 allowance, 15% off balance over $130	Up to $104
Disposable	$0 copay, $130 allowance; plus balance over $130	Up to $104
Medically necessary	$0 copay, paid in full	Up to $200
Laser vision correction		
LASIK or PRK from U.S. laser network	15% off the retail price or 5% off the promotional price	
Frequency		
Examination	Once every year	
Lenses or contact lenses	Once every year	
Frame	Once every year	

Benefits are not provided for services or materials arising from: orthopic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses, medical and/or surgical treatment of the eye, eyes or supporting structures; any vision examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear; services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; Plano (non-prescription) lenses; non-prescription sunglasses; two pairs of glasses in lieu of bifocals; services or materials provided by any other group benefit plan providing vision care; services rendered after the date an insured person ceases to be covered under the Policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured person are within 31 days from the date of such order. Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next benefit frequency when vision materials would next become available. Benefits may not be combined with any discount, promotional offering or other group benefit plans. Standard/Premium Progressive lens not covered — fund as a bifocal lens. Standard Progressive lens covered – fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use within the same benefits year. Fees charged for a non-insured benefit must be paid in full to the provider. Such fees or materials are not covered. This is a snapshot of your benefits.

State Vision Diabetic Plan

Diabetic care services Type 1 and Type 2 diabetics frequency: up to two services per benefit year	In-network member cost	Out-of-network reimbursement
Office service visit (medical follow-up exam)	Covered 100%, $0 copay	Up to $77 per service
Retinal imaging	Covered 100%, $0 copay[2]	Up to $50 per service
Extended ophthalmoscopy	Covered 100%, $0 copay[3]	Up to $15 per service
Gonioscopy	Covered 100%, $0 copay	Up to $15 per service
Scanning laser	Covered 100%, $0 copay	Up to $33 per service

[2]Not covered if extended opthalmoscopy is provided within six months.
[3]Not covered if fundus photography is provided within six months.
Exclusions and limitations:
The diabetic benefit covers diabetic eye care evaluation services only. The following services and benefits are excluded:

1. Costs associated with securing frames, lenses or any other materials
2. Orthoptics or vision training and any associated supplemental testing
3. Surgical procedures, including laser or any other form of refractive surgery, and any pre- or post-operative services
4. Pathological treatment of any type for any condition
5. Any eye examination required by an employer as a condition of employment
6. Insulin or any medications or supplies of any type
7. Services and/or materials not included in this rider

Learn more about vision care benefits at ***www.peba.sc.gov/vision.html****.*

Protect your family with life insurance

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 insurance. Your coverage will reduce to 50 percent at age 70. You may elect more coverage for yourself, spouse and/or children.

Additional coverage options

	Coverage option	Coverage level	Coverage details
✓	**Optional Life and Accidental Death and Dismemberment (AD&D)**	• Elect in **$10,000** increments • Maximum of **$500,000**	• The lesser of three times annual earnings or $500,000 is guaranteed within 30 days of initial eligibility • 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 and Accidental Death and Dismemberment (AD&D)**	• Elect in **$10,000** increments • Maximum of **$100,000** or 50% of your Optional Life amount	• If you are not enrolled in Optional Life, spouse coverages of $10,000 or $20,000 are still available • $20,000 guaranteed within 30 days of initial eligibility • Matching amount of AD&D insurance
✓	**Dependent Life – Child**	**$15,000**	• Coverage is guaranteed • Children are eligible from live birth to age 19 or 25 if a full-time student • A child can only be covered by one parent

Learn more about life insurance benefits at ***www.peba.sc.gov/life.html****.*

Prepare for the unexpected with disability coverage

Unexpected events can always occur, and many people think they will never become disabled. PEBA offers disability coverage, administered by Standard Insurance Company (The Standard). Consider these statistics:

- Just over 1 in 4 of today's 20 year olds will become disabled before reaching age 67.[1]
- Forty-eight percent of U.S. families do not save any of their annual income.[2]

Basic long term disability

Eligible employees enrolled in the State Health Plan have basic long term disability protection at no cost. The Basic Long Term Disability (BLTD) Plan helps protect a part of your income if you become disabled.

BLTD Plan benefits summary

- Benefit waiting period: 90 days
- Monthly BLTD benefit[3] percentage: 62.5 percent of your predisability earnings, reduced by deductible income
- Maximum benefit: $800 a month

Supplemental long term disability

This optional disability insurance plan provides more protection for you and your family. The Supplemental Long Term Disability (SLTD) Plan is a voluntary benefit for which you pay.

SLTD Plan benefits summary

- Benefit waiting period: 90 or 180 days
- Monthly SLTD benefit[3] percentage: 65 percent of your predisability earnings, reduced by deductible income
- Maximum benefit: $8,000 a month
- Minimum monthly benefit: $100 a month

Maximum benefit period

The maximum benefit period is determined by your age when your disability begins.

Age	Maximum benefit period
61 or younger	To age 65, or 3 years, 6 months, whichever is longer
62	3 years, 6 months
63	3 years
64	2 years, 6 months
65	2 years
66	1 year, 9 months
67	1 year, 6 months
68	1 year, 3 months
69 or older	1 year

Learn more about disability coverage, including limitations and restrictions, at ***www.peba.sc.gov/longtermdisability.html****.*

[1]U.S. Social Security Administration, 2017 Fact Sheet.
[2]Federal Reserve Board, Survey of Consumer Finances, 2010.
[3]BLTD and SLTD benefits are subject to federal and state income taxes. Check with your accountant or tax adviser about your tax liability.

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 2018 *Summaries of Benefits and Coverag*e 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 2018 *Insurance Benefits Guide* is available online at **www.peba.sc.gov/assets/insurancebenefitsguide.pdf**. 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. 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.

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 નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1.803.734.0119.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.803.734.0119 .

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, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ

1.803.734.0119 ។

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