Health Insurance
**Table of Contents**

**Introduction**  ................................................................................................................. 48
- **What Are My Health Plan Choices?**  .................................................................................. 48
  - Notice to Subscribers: Tobacco-Use Surcharge ............................................................. 48
- **Benefits at a Glance: State Health Plan** ........................................................................... 49

**The State Health Plan**  ........................................................................................................ 50
- How the SHP Pays for Covered Benefits ........................................................................... 50

**How the Standard Plan Works**  .......................................................................................... 51
- Annual Deductible .............................................................................................................. 51
- Copayments .......................................................................................................................... 51
- Coinsurance .......................................................................................................................... 52

**How the Savings Plan Works**  ........................................................................................... 53
- Annual Deductible .............................................................................................................. 53
- Coinsurance .......................................................................................................................... 53

**Coordination of Benefits**  .................................................................................................. 54

**Using SHP Provider Networks**  .......................................................................................... 55
- How to Find a Medical or Mental Health/Substance Abuse Network Provider ............... 55
- BlueCard® and BlueCard Worldwide® ............................................................................... 55
- Mental Health/Substance Abuse Provider Network ............................................................ 57
- Prescription Drug Provider Network .................................................................................... 57

**Out-of-Network Benefits**  .................................................................................................. 58
- Balance Billing .................................................................................................................... 58
- Out-of-Network Differential .............................................................................................. 58

**Managing Your Medical Care**  ........................................................................................... 60
- Medi-Call ............................................................................................................................... 60
- Advanced Radiology Preauthorization: National Imaging Associates (NIA) .................. 61
- Maternity Management ...................................................................................................... 62
- Wellness Management ........................................................................................................ 63
- Health Management Program ............................................................................................ 63
- Medical Case Management .................................................................................................. 64

**Online Health Tools**  .......................................................................................................... 66
- My Health Toolkit ................................................................................................................ 66

**State Health Plan Benefits**  .................................................................................................. 67

**Preventive Benefits**  ........................................................................................................... 74
- Shingles Vaccine Benefit .................................................................................................... 74
- Benefits for Women ............................................................................................................ 74
- Well Child Care Benefits .................................................................................................... 75
- Additional Benefits for Savings Plan Participants ............................................................. 77
- Natural Blue™ and Member Discounts .............................................................................. 77

**Prescription Drug Benefits – 855-901-7322 (PEBA)**  .......................................................... 78
- Prescription Plans Available ............................................................................................... 78
- State Health Plan Prescription Drug Program ..................................................................... 79
- State Health Plan Medicare Prescription Drug Program .................................................. 79
- Features of the Prescription Drug Program ........................................................................... 80
Retail Pharmacies ............................................................................................................ 82
Mail-Order: A Way to Save Time and Money ................................................................. 83
Coordination of Benefits .............................................................................................. 83
Exclusions ....................................................................................................................... 84
Mental Health and Substance Abuse Benefits ............................................................... 84
Exclusions: Services Not Covered .................................................................................. 86
Additional Limits under the Standard Plan ................................................................. 88
Additional Limits and Exclusions under the Savings Plan ............................................. 88
Helpful Information May be Found on the Internet ....................................................... 88
Website: StateSC.SouthCarolinaBlues.com ................................................................. 88
Website: www.CompanionBenefitAlternatives.com ....................................................... 89
Appeals ......................................................................................................................... 89
Appeals to Third-party Claims Processors ....................................................................... 89
Appeals to PEBA – Preauthorizations and Services That Have Been Provided ................ 90
AMRA TRICARE Supplement Plan ............................................................................ 91
Eligibility ......................................................................................................................... 91
Loss of TRICARE Eligibility ........................................................................................ 93
Introduction

What Are My Health Plan Choices?

Your health plan choices are the Standard Plan, the Savings Plan and, if you are retired and enrolled in Medicare, the Medicare Supplemental Plan. Eligible members of the military community may enroll in the AMRA TRICARE Supplement Plan.

To learn about eligibility, enrollment and other features that are common to the programs offered through the Public Employee Benefit Authority (PEBA) Insurance Benefits, see the General Information chapter, which begins on page 9.

Please note: There is no lifetime maximum on benefits offered by the health plans available through PEBA Insurance Benefits.

Notice to Subscribers: Tobacco-Use Surcharge

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

To avoid this charge, a subscriber must certify no one covered under his health insurance uses tobacco, and no one has used it during the past six months. To do so, complete a Certification Regarding Tobacco Use form. If you have not certified or need to change your certification, go to PEBA’s Insurance Benefits website, www.eip.sc.gov, and click on “Tobacco Information.” Give the certification form to your benefits administrator, who will send it to PEBA Insurance Benefits. The certification will be effective the first of the month after PEBA Insurance Benefits receives the form.

A subscriber must pay all his premiums, including the tobacco-use surcharge, if it applies, when they are due. If he does not, coverage for all of his plans will be canceled effective the last day of the month in which the premiums were paid in full.

If You Are Unable to Stop Using Tobacco Due to a Medical Reason

If your physician provides a letter stating that it is unreasonably difficult due to a medical condition for you to stop using tobacco or that it is medically inadvisable for you to stop using tobacco, you may qualify for a waiver of the tobacco-use surcharge. Please give the letter to your benefits administrator, who will send it to PEBA Insurance Benefits.
# Benefits at a Glance: State Health Plan

This brief overview of your medical plan is for comparison only. The Plan of Benefits governs all health benefits offered by the state.

<table>
<thead>
<tr>
<th></th>
<th>Standard Plan</th>
<th>Savings Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$445 Individual $890 Family</td>
<td>$3,600 Individual $7,200 Family</td>
</tr>
<tr>
<td></td>
<td>(If more than one family member is covered, only the cost of preventive benefits will be paid until the $7,200 annual family deductible is met.)</td>
<td></td>
</tr>
<tr>
<td><strong>Copayments:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Care¹</td>
<td>$159</td>
<td>None</td>
</tr>
<tr>
<td>Outpatient Facility Services²</td>
<td>$95</td>
<td>None</td>
</tr>
<tr>
<td>Physician Office Visit³</td>
<td>$12</td>
<td>None</td>
</tr>
<tr>
<td><strong>Coinsurance (after deductible is met):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Network</td>
<td>20% You pay 80% Insurance pays</td>
<td>20% You pay 80% Insurance pays</td>
</tr>
<tr>
<td>Out-of-network⁴ ⁵</td>
<td>40% You pay 60% Insurance pays</td>
<td>40% You pay 60% Insurance pays</td>
</tr>
<tr>
<td><strong>Coinsurance Maximum:</strong></td>
<td>$2,540 Individual $5,080 Family</td>
<td>$2,400 Individual $4,800 Family</td>
</tr>
<tr>
<td>Network</td>
<td>$5,080 Individual $10,160 Family</td>
<td>$4,800 Individual $9,600 Family</td>
</tr>
<tr>
<td>Out-of-network⁴ ⁵</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>No annual deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Prescription Drug Deductible per Year⁴</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Retail Copayments for up to a 31-day supply (Participating pharmacies only)¹</strong></td>
<td>$9 Tier 1 (Generic – lowest cost)</td>
<td>$2,500 per person (applies to prescription drugs only)</td>
</tr>
<tr>
<td></td>
<td>$38 Tier 2 (Brand – higher cost)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$63 Tier 3 (Brand – highest cost)</td>
<td></td>
</tr>
<tr>
<td><strong>Mail Order and Retail Maintenance Network Copayments for up to a 90-day supply³</strong></td>
<td>$22 Tier 1 (Generic – lowest cost )</td>
<td>Medical Spending Account</td>
</tr>
<tr>
<td></td>
<td>$95 Tier 2 (Brand – higher cost)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$158 Tier 3 (Brand – highest cost)</td>
<td></td>
</tr>
<tr>
<td><strong>Prescription Drug Copayment Maximum⁴</strong></td>
<td>$2,500 per person (applies to prescription drugs only)</td>
<td>Health Savings Account</td>
</tr>
<tr>
<td><strong>Tax-favored Medical Accounts</strong></td>
<td>Medical Spending Account</td>
<td>Limited-use Medical Spending Account</td>
</tr>
</tbody>
</table>

¹Waived if admitted.
²Waived for dialysis, routine mammograms, routine Pap tests, routine physical therapy, clinic visits, oncology services, electro-convulsive therapy, psychiatric medication management and partial hospitalization and intensive outpatient behavioral health services.
³Waived for routine Pap tests, routine mammograms and well child care.
⁴Prescription drugs are not covered out of network.
⁵An out-of-network provider may bill you for more than the plan’s allowed amount for services.

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**Prescription Drugs**

You must use participating pharmacies. You pay the full allowed amount for prescription drugs, and the cost is applied to your annual deductible.

After you reach your deductible, you continue to pay the full allowed amount for prescription drugs. However, the plan will reimburse you for 80% of the allowed amount. You pay the remaining 20% as coinsurance.

Drug costs are applied to your plan’s network coinsurance maximum: $2,400 – individual; $4,800 – family.

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www.eip.sc.gov  S.C. Public Employee Benefit Authority 49
The State Health Plan

The State Health Plan (SHP) offers the **Standard Plan**, the **Savings Plan** and, for retirees enrolled in Medicare, the **Medicare Supplemental Plan**. It is important that you understand how your plan works.

The **Standard Plan** has higher premiums but lower annual deductibles than the Savings Plan. When one family member meets his deductible, the Standard Plan will begin to pay benefits for him, even if the family deductible has not been met. Under the Standard Plan, when you buy a prescription drug you make a copayment, rather than pay the *allowed amount*. (The *allowed amount* is the most a health plan allows for a covered service or product, whether it is provided in network or out of network. Network providers have agreed to accept the allowed amount as their total fee.) You do not have to meet your deductible to buy prescription drugs for the copayment.

As a **Savings Plan** subscriber, you take greater responsibility for your health care costs and accept a higher annual deductible. You pay the full allowed amount for covered medical benefits (including mental health/substance abuse benefits and prescription drugs) until you reach the deductible. As a result, you save money on premiums. Another advantage is that because the Savings Plan is a tax-qualified, high-deductible health plan, you may establish a **Health Savings Account** (HSA) if you have *no other health coverage*, including Medicare, unless it is another high-deductible health plan, and you cannot be claimed as a dependent on another person’s tax return. Funds in an HSA may be used to pay qualified medical expenses now and in the future.

For information about how the **Standard Plan** and the **Medicare Supplemental Plan** work with Medicare, see the Medicare chapter, which begins on page 199.

The **Plan of Benefits** contains a complete description of the plan. Its terms and conditions govern all health benefits offered by the state. To review it, contact your benefits administrator or PEBA Insurance Benefits.

**How the SHP Pays for Covered Benefits**

PEBA Insurance Benefits contracts with several companies to process your claims in a cost-efficient, timely manner:

- **BlueCross BlueShield of South Carolina** (BCBSSC) is the medical claims processor. **Medi-Call**, a division of BCBSSC, provides medical preauthorization and case management services. For more information about Medi-Call, see pages 60-62.
- **Companion Benefit Alternatives** (CBA), a wholly owned subsidiary of BCBSSC, is the behavioral health manager, handling mental health and substance abuse treatment preauthorization, case management and provider networks. For more information, see page 84-86.
- **Catamaran** processes prescription drug claims. For more information, see pages 78-84.

Subscribers share the cost of their benefits by paying deductibles, copayments and coinsurance for covered benefits.

**Allowed Amount**

The *allowed amount* is the most a plan allows for a covered service. Network providers have agreed to accept the allowed amount as their total fee, leaving you responsible only for copayments and 20 percent coinsurance after your annual deductible is met. (Savings Plan subscribers do not pay copayments.) For out-of-network services, you will pay more in coinsurance, and the provider may charge more than the allowed amount. See balance billing on page 58.
How the Standard Plan Works

Annual Deductible

The annual deductible is the amount you must pay each year for covered medical benefits (including mental health and substance abuse benefits) before the plan begins to pay a percentage of the cost of your covered medical benefits. The annual deductibles are:

- $445 for individual coverage
- $890 for family coverage.

Under the Standard Plan, the family deductible is the same, regardless of how many family members are covered. The family deductible may be met by any combination of two or more family members’ covered medical expenses, as long as they total $890. For example, if four people each have $222.50 in covered expenses, the family deductible has been met, even if no one person has met the $445 individual deductible. If only one person has met the $445 individual deductible, the plan will begin paying a percentage of the cost of his benefits but not a percentage of the cost of the rest of the family’s benefits until the family deductible has been met. No family member may pay more than $445 toward the family deductible.

If the subscriber and his spouse, who is also covered as an employee or retiree, select the same health plan, they share the family deductible. Both spouses must be listed on the same Notice of Election form.

Payments for non-covered services, copayments and penalties for not calling Medi-Call, National Imaging Associates or Companion Benefit Alternatives do not count toward the annual deductible.

Copayments

Standard Plan subscribers pay these copayments:

- Copayments for prescription drugs.
- Copayments for services in a professional provider’s office; for outpatient facility services, which may be provided in an outpatient department of a hospital or in a freestanding facility; and for care in an emergency room.

A prescription drug copayment is a fixed total amount a Standard Plan subscriber pays for each prescription. The copayment maximum for each family member covered is $2,500. Drug costs do not apply to the annual deductible or the coinsurance maximum. For more information, see page 79-81.

A copayment for services in a provider’s office, for outpatient facility services or in an emergency room is the amount a Standard Plan subscriber pays before the cost of care begins to apply to his deductible or to his coinsurance maximum.

You continue to pay these copayments even after you meet your annual deductible and reach your coinsurance maximum. These copayments do not apply to your annual deductible or your coinsurance maximum.

The copayment for each visit to a professional provider’s office is $12. This copayment is waived for routine Pap tests, routine mammograms and well child care visits. The following example uses a physician’s office visit that has a $56 allowed amount under the Standard Plan.
The copayment for outpatient facility services, which includes outpatient hospital services other than emergency room visits and outpatient surgery center services, is $95. This copayment is waived for dialysis, routine mammograms, routine Pap tests, routine physical therapy, clinic visits, oncology services, electro-convulsive therapy, psychiatric medication management and partial hospitalization and intensive outpatient behavioral health services. The copayment for each emergency room visit is $159. This copayment is waived if you are admitted to the hospital.

**Coinsurance**

After you meet your annual deductible, the Standard Plan pays 80 percent of the allowed amount for your covered medical and mental health/substance abuse benefits if you use network providers. You pay 20 percent as coinsurance, which applies to your coinsurance maximum.

If you use out-of-network providers, the plan pays 60 percent of the plan’s allowed amount for your covered medical and mental health/substance abuse benefits, and you pay 40 percent as coinsurance, which applies to your coinsurance maximum. Any charge above the plan’s allowed amount for a covered medical or mental health/substance abuse benefit is your responsibility. See pages 58-59 to learn more about balance billing and the out-of-network differential.

A different coinsurance rate applies for infertility treatments and prescription drugs associated with infertility. See page 70.

**Coinsurance Maximum**

The coinsurance maximum is the amount in coinsurance a subscriber must pay for covered benefits each year before he is no longer required to pay coinsurance. Under the **Standard Plan**, it is $2,540 for individual coverage and $5,080 for family coverage for network services and $5,080 for individual coverage and $10,160 for family coverage for out-of-network services.

**Please note:** The coinsurance for network services does not apply to the out-of-network coinsurance maximum. The coinsurance for out-of-network services does not apply to the network coinsurance maximum. For example: If you have individual coverage, the network coinsurance maximum is $2,540 and you have paid $2,000 in network coinsurance and $600 in out-of-network coinsurance, you have not met your in-network coinsurance maximum.

**Standard Plan subscribers** continue to pay copayments even after they meet their annual deductible and coinsurance maximum. Copayments for services in a provider’s office, for outpatient facility services and in an emergency room do not apply to the annual deductible or to the coinsurance maximum. Prescription
drug copayments apply to the $2,500 prescription drug copayment maximum but do not apply to the annual deductible or the coinsurance maximum.

Payments for non-covered services, deductibles and penalties for not calling Medi-Call, National Imaging Associates or Companion Benefit Alternatives (CBA) do not count toward the coinsurance maximum.

**How the Savings Plan Works**

**Annual Deductible**

The annual deductible is the amount you must pay each year for covered medical and mental health/substance abuse benefits and prescription drugs before the Savings Plan begins to pay a percentage of the cost of your covered benefits. The annual deductibles are:

- $3,600 for individual coverage
- $7,200 for family coverage.

There is no individual deductible if more than one family member is covered. If the subscriber and spouse, who is also covered as an employee or retiree, select the same health plan, they will share the family deductible. The deductible is not met for any covered individual until the total allowed amount paid for covered benefits exceeds $7,200. For example, even if one family member has paid $3,601 for covered medical benefits, the plan will not begin paying a percentage of the cost of his covered benefits until his family has paid $7,200 for covered benefits. However, if the subscriber has paid $2,199 for covered benefits, the spouse has paid $3,001 for covered benefits and a child has paid $2,000 for covered benefits, the plan will begin paying a percentage of the cost of the covered benefits for all family members.

If you are covered under the Savings Plan, you pay the full allowed amount for covered prescription drugs, and the amount is applied to your deductible. After you meet your deductible you still have to pay the full allowed amount, but you are reimbursed for 80 percent of the allowed amount. After you meet your coinsurance maximum, you are reimbursed for 100 percent of the allowed amount.

There are no copayments under the Savings Plan. You pay the full allowed amount for services, and it is applied to your annual deductible.

**Coinsurance**

After you meet your annual deductible, the Savings Plan pays 80 percent of the allowed amount for your covered medical, prescription drug and mental health/substance abuse benefits if you use network providers. You pay 20 percent as coinsurance.

If you use out-of-network providers, the plan pays 60 percent of the plan’s allowed amount for your covered medical and mental health/substance abuse benefits, and you pay 40 percent as coinsurance. Any charge above the plan’s allowed amount for a covered medical or mental health/substance abuse benefit is your responsibility. See pages 58-59 to learn more about balance billing and the out-of-network differential. Prescription drug benefits are paid only if you use a network provider.

A different coinsurance rate applies for infertility treatments and prescription drugs associated with infertility. See page 70.

**Coinsurance Maximum**

The coinsurance maximum is the amount in coinsurance a subscriber must pay for covered benefits each year before he is no longer required to pay coinsurance. Under the Savings Plan it is $2,400 for individual coverage or $4,800 for family coverage for network services and $4,800 for individual coverage or $9,600 for family coverage for out-of-network services.

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Please note: The coinsurance for network services does not apply to the out-of-network coinsurance maximum. The coinsurance for out-of-network services does not apply to the network coinsurance maximum. For example: If you have individual coverage and have paid $2,000 in network coinsurance and $400 in out-of-network coinsurance, you have not met your network coinsurance maximum.

Payments for non-covered services, deductibles and penalties for not calling Medi-Call, National Imaging Associates or Companion Benefit Alternatives (CBA) do not count toward the coinsurance maximum.

**Coordination of Benefits**

All State Health Plan benefits are subject to coordination of benefits (COB). COB is a system to make sure a person covered under more than one insurance plan is not reimbursed more than once for the same expenses. For more information about COB, see page 20.

Under this system, the plan that pays first is the **primary plan**. The **secondary plan** pays after the primary plan. Here are some examples of how that works:

- The plan that covers a person as an employee typically **pays before** the plan that covers the person as a dependent.
- When both parents cover a child, the plan of the parent whose birthday comes earlier in the year **pays first**. **Other rules may apply in special situations, such as when a child’s parents are divorced.**
- If you are eligible for Medicare and are covered as an active employee, your State Health Plan coverage **pays before** Medicare. Exceptions may apply in the case of Medicare coverage due to kidney disease. Contact your local Social Security office for details.
- If a person is covered under one plan because the subscriber is an active employee and under another plan because the subscriber is retired, the plan that covers him as active employee typically **pays first**. There may be exceptions to this rule.

As part of coordination of benefits, under the Standard Plan and the Savings Plan:

On your Notice of Election (NOE) form, you are asked if you are covered by more than one group insurance plan. Your response is recorded and placed in your file. However, BlueCross BlueShield of South Carolina (BCBSSC), may ask you this question every year, by sending you a questionnaire. **Complete this form and return it to BCBSSC promptly, since claims will not be processed or paid until your information is received.** You can also update this information by calling BCBSSC or by visiting [www.StateSC.SouthCarolinaBlues.com](http://www.StateSC.SouthCarolinaBlues.com). Under “Member Resources,” select “Forms and Documents” and then “Other health/dental Insurance form.”

This is how the SHP works when it is secondary insurance:

- For a **medical** or a **mental health/substance abuse** claim, you or your provider must file the Explanation of Benefits from your primary plan with BCBSSC.
- For **prescription drug** benefits, you must present your card for your primary coverage first. Otherwise, the claim will be rejected because the pharmacist’s electronic system will show that the SHP is secondary coverage. After the pharmacy processes the claim with your primary coverage, you must file a paper claim through Catamaran for payment of any secondary benefits. Prescription drug claim forms are on the PEBA Insurance Benefits website, [www.eip.sc.gov](http://www.eip.sc.gov). You may also ask your benefits administrator for the form.
- The SHP will pay the lesser of: 1) what it would pay if it were the primary payer; or 2) the balance after the primary plan’s network discounts and/or payments are deducted from the total charge.
- The SHP’s limit on balance billing does not apply. Therefore, it is important that you use a provider in your primary plan’s network.
• You will also be responsible for the SHP copayments and deductible and the SHP coinsurance, if the coinsurance maximum has not been met.

**Please note:** If your coverage with any other health insurance program is canceled, you must request a letter of termination. The letter of termination must be submitted to BCBSSC promptly, because claims will not be processed or paid until your information is received.

**Using SHP Provider Networks**

When you are ill or injured, you decide where to go for your care. The SHP operates as a *preferred provider organization* (PPO). As such, it has networks of physicians and hospitals, outpatient surgery centers and mammography testing centers. There are also networks available to subscribers for ambulatory surgery centers, durable medical equipment, labs, radiology and X-ray, physical therapy, occupational therapy, speech therapy, skilled nursing facilities, long term acute care facilities, hospices and dialysis centers. They have agreed, as part of the network, to accept the plan’s allowed amount for covered benefits as payment in full. **Network providers will charge you for your deductible, copayments and coinsurance when the services are provided. They will also file your claims.**

If you use an out-of-network medical or mental health/substance abuse provider or your physician sends your laboratory tests to an out-of-network provider, your costs will increase.

**Please note:** Even if you are at a network hospital or at a network provider’s office, the provider may employ out-of-network contract providers or technicians. **If an out-of-network provider renders services, even in a network facility, he can still balance bill you, and you will still pay the out-of-network differential.** For more information, see pages 58-59.

In the U.S., prescription drug benefits are paid only if you use a network provider.

**How to Find a Medical or Mental Health/Substance Abuse Network Provider**

To view the online provider directory, go to PEBA Insurance Benefits website, [www.eip.sc.gov](http://www.eip.sc.gov), and select “Online Directories” and then “State Health Plan Doctor/Hospital Finder (for medical and mental health/substance abuse)”

• Now you can search for a provider by name, location and specialty.
• You can also search for “ER Alternatives,” places to go for care other than an emergency room, such as urgent care and walk-in clinics near you.
• When you find a provider, you can view “Networks” to make sure he participates in the State Health Plan.

If you do not have access to the Internet, call BCBSSC at 803-736-1576 (Greater Columbia area) or 800-868-2520 (toll-free outside the Columbia area) to ask that a list of SHP providers in your area be mailed to you.

**BlueCard® and BlueCard Worldwide®**

State Health Plan members have access to doctors and hospitals throughout the United States and around the world through the BlueCard Program and Blue Cross and Blue Shield provider networks. If you are covered by the State Health Plan and need mental health or substance abuse care outside South Carolina, call 800-810-2583.
Inside the U.S.

With the BlueCard program you can choose network doctors and hospitals that suit you best. Follow these steps for health coverage when you are away from home but within the United States:

1. **Always carry your health plan and your prescription drug ID cards.**
2. To find the names and addresses of nearby doctors and hospitals, choose “Links” on the PEBA Insurance Benefits website. Follow the steps above and enter the location where you need a provider. You may also call BlueCard Access at 800-810-2583.
3. **State Health Plan subscribers must call Medi-Call within 48 hours of receiving emergency care.** The toll-free number is on your SHP ID card.
4. When you arrive at the participating doctor’s office or hospital, show your identification card. The provider will recognize the Blue Cross Blue Shield logo, which will ensure that you get the highest level of benefits with no balance billing.
5. The provider should file claims with the Blue Cross and Blue Shield affiliate in the state where the services were provided.

You should not have to complete any claim forms, nor should you have to pay up front for medical services other than the usual out-of-pocket expenses (deductibles, copayments, coinsurance and non-covered services). BCBSSC will mail an Explanation of Benefits to you.

For information about out-of-network benefits, see pages 58-59.

Outside the U.S.

Through the BlueCard Worldwide® program, your health plan card gives you access to doctors and hospitals in more than 200 countries and territories worldwide and to a broad range of medical services.

**Please note:** Medicare does not offer benefits outside the U.S. Because the Medicare Supplemental Plan does not allow benefits for services not covered by Medicare, Medicare Supplemental Plan subscribers do not have coverage outside the U.S. See page 206 for more information.

To take advantage of the BlueCard Worldwide program, follow these steps:

1. **Always carry your health plan ID card.**
2. Before your trip:
   - If you have questions, call the phone number on the back of your ID card to check your benefits and for preauthorization, if necessary. *(Your health care benefits may be different outside the U.S.)*
   - The BlueCard Worldwide Service Center can help you find providers in the area where you are traveling. It can also provide other helpful information about health care overseas. To reach the center, go to the PEBA Insurance Benefits website, www.eip.sc.gov, and, under “Links,” select “Medical/My Health Toolkit (BlueCross BlueShield of South Carolina).” Under “Find a Doctor or Hospital,” select “Worldwide Directory.” You may also call toll-free at 800-810-2583 or collect at 804-673-1177.
3. During your trip:
   - **If you need to find a doctor or hospital or need medical assistance, go to the state BCBSSC website through “Links” on the PEBA Insurance Benefits website.** www.eip.sc.gov. Under “Find a Doctor or Hospital,” select “Worldwide Directory.” You must accept the terms and conditions and login with the first three letters of your identification number. Then you may “Select a Provider Type.”

If you need proof of insurance for overseas travel, please request it from PEBA Insurance Benefits in writing through the “Contact Us” link on the PEBA Insurance Benefits website or in a letter. The request must be made least 10 working days in advance.

Please note: Some toll-free numbers do not work overseas. You can always reach BlueCard Worldwide by calling collect at 804-673-1177. We recommend you take this number with you when you leave the United States.
You also can choose a specialty, city, nation and distance from the city.

- You may also call the BlueCard Worldwide Service Center toll-free at 800-810-2583 or collect at 804-673-1177 (24 hours a day, seven days a week).
- If you are admitted to the hospital, call the BlueCard Worldwide Service Center toll-free at 800-810-2583 or collect at 804-673-1177.
- The BlueCard Worldwide Service Center will work with your plan to arrange direct billing with the hospital for your inpatient stay.
- When direct billing is arranged, you are responsible for the out-of-pocket expenses (non-covered services, deductibles, copayments and coinsurance) you normally pay. The hospital will submit your claim on your behalf.
- Please note: If direct billing is not arranged between the hospital and your plan, you must pay the bill up front and file a claim. For outpatient care and doctor visits, pay the provider when you receive care and file a claim.

4. To file a claim for services you paid for when you received care or paid to providers that are not part of the BlueCard Worldwide network, complete a BlueCard Worldwide International Claim Form and send it to the BlueCard Worldwide Service Center with this information: the charge for each service; the date of that service and the name and address of each provider; a complete, detailed bill, including line-item descriptions; and descriptions and dates for all procedures and surgeries. This information does not have to be in English. Be sure to get all of this information before you leave the provider’s office.

5. The claim form is available on the PEBA Insurance Benefits website. Select “Forms” and then, under “State Health Plan (SHP),” select “BlueCard Worldwide International Claim Form.” You may also call the service center toll-free at 800-810-2583 or collect at 804-673-1177. The address of the service center is on the claim form. BlueCard Worldwide will arrange billing to BCBSSC.

### Mental Health/Substance Abuse Provider Network

The State Health Plan offers coverage for mental health and substance abuse services, on the same terms as medical coverage. Preauthorization is required by Companion Benefit Alternatives (CBA), the mental health and substance abuse benefits manager, for most hospital services and some outpatient services (see Mental Health and Substance Abuse Benefits on pages 84-86). A greater percentage of the cost of your covered benefits will be paid if you use a network provider.

The most up-to-date list of network providers is available under “Find a Doctor or Hospital” on the state BCBSSC website. There is a link to StateSC.SouthCarolinaBlues.com under “Online Directories” on the PEBA Insurance Benefits website. When you get to the site, enter your “Location” and the “Specialty.” Be sure to “view” the provider’s networks A printable version of the directory is on the CBA website, CompanionBenefitAlternatives.com. Under “Looking for a Mental Health Provider?” select “Get Started” and follow the prompts. The directory can be searched using the “binoculars” search feature. For help selecting a provider, call CBA at 800-868-1032. To find a provider outside the U.S., select “Worldwide Directory” under the “Find a Doctor or Hospital” on the state BCBSSC website or call collect 804-673-1177.

If you do not have access to the Internet, printed lists of providers from the directory are available from your benefits office or, if you are a retiree, survivor or COBRA participant, from BCBSSC.

For more information on your mental health and substance abuse benefits, see pages 84-86.

### Prescription Drug Provider Network

Because the State Health Plan offers no out-of-network coverage for prescription drugs in the U.S., it is important that you find a network provider for this service. A list of network providers is on the website sponsored by Catamaran, the prescription drug manager. The site is accessible through the PEBA Insurance Benefits website, www.eip.sc.gov, under “Links” or you can go directly to Catamaran’s website, www.myCatamaranRx.com. At the Catamaran site, sign in and click on “Pharmacy Locator.”

www.eip.sc.gov

S.C. Public Employee Benefit Authority
Insurance Benefits Guide

If you do not have Internet access, ask your benefits administrator to print a list of network pharmacies near you. If you are a retiree, COBRA or survivor subscriber, call Catamaran for network pharmacies near you.

Please note: Not all network pharmacies belong to the Retail Maintenance Network, which offers 90-days supplies of drugs at mail-order prices. A list of the Retail Maintenance Network pharmacies is on the PEBA Insurance Benefits website, www.eip.sc.gov, under “Online Directories” or from your benefits administrator. For more information, see pages 82-83.

For more information about your prescription drug benefits, see pages 78-84.

Out-of-Network Benefits

You can use providers for medical and mental health/substance abuse care who are not part of the network and still receive some coverage. Before the State Health Plan will pay 100 percent of the plan’s allowed amount:

• For out-of-network benefits, Standard Plan subscribers pay a $5,080 individual coinsurance maximum or a $10,160 family coinsurance maximum after they meet their annual deductible. Savings Plan subscribers pay a $4,800 individual coinsurance maximum or a $9,600 family coinsurance maximum after they meet their annual deductible. Subscribers to both plans may also have to fill out claim forms.

Please note: No benefits will be paid for advanced radiology services (CT, MRI, MRA or PET scans) that are not preauthorized by National Imaging Associates.

There is no out-of-network coverage for prescription drugs filled at a pharmacy in the U.S. Limited drug coverage is offered to members enrolled in the SHP Prescription Drug Program who become ill while traveling overseas. For more information, see page 228.

Balance Billing

If you use a provider who is not part of the network, you may be subject to balance billing. When the State Health Plan is your primary coverage, network providers are prohibited from billing you for covered benefits, except for copayments, coinsurance and the deductible. However, an out-of-network provider may bill you for more than the plan’s allowed amount for the covered benefit, which will increase your out-of-pocket cost. The difference between what the out-of-network provider charges and the allowed amount is called the “balance bill.” The balance bill does not contribute toward meeting your annual deductible or coinsurance maximum.

Out-of-Network Differential

In addition to balance billing, if you receive services from a provider that does not participate in the State Health Plan, Companion Benefit Alternatives or BlueCard networks, you will pay 40 percent of the allowed amount, instead of 20 percent, in coinsurance. These examples show how it will cost you more to use an out-of-network provider:

In both examples below, you have subscriber-only coverage under the SHP, and you have not met your deductible. The allowed amount is $4,000. The provider charged $5,000 for the service.
## Standard Plan

<table>
<thead>
<tr>
<th>Network provider</th>
<th>Out-of-network provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5,000 Billed charge</td>
<td>$5,000 Billed charge</td>
</tr>
<tr>
<td>$4,000 Allowed amount¹</td>
<td>-4,000 Allowed amount</td>
</tr>
<tr>
<td>- 445 Annual deductible</td>
<td>$1,000 Balance bill¹</td>
</tr>
<tr>
<td>$3,555 Allowed amount after annual deductible</td>
<td>$4,000 Allowed amount</td>
</tr>
<tr>
<td>- 445 Annual deductible</td>
<td>$3,555 Allowed amount after annual deductible</td>
</tr>
<tr>
<td>$3,555 Allowed amount after annual deductible</td>
<td>$3,555 Allowed amount after annual deductible</td>
</tr>
<tr>
<td>x 20%²</td>
<td>x 40%²</td>
</tr>
<tr>
<td>$ 711 Coinsurance, which goes toward your coinsurance maximum</td>
<td>$1,422 Coinsurance, which goes toward your coinsurance maximum</td>
</tr>
<tr>
<td>$ 711 Coinsurance</td>
<td>$1,422 Coinsurance</td>
</tr>
<tr>
<td>+ 445 Annual deductible</td>
<td>+ 445 Annual deductible</td>
</tr>
<tr>
<td>$1,156 Your total payment</td>
<td>+1,000 Balance bill</td>
</tr>
<tr>
<td>$1,156 Your total payment</td>
<td>$2,867 Your total payment</td>
</tr>
</tbody>
</table>

¹ Network providers are not allowed to charge more than the allowed amount.
² In this example, the Standard Plan paid 80 percent of the $3,555 allowed amount after the deductible, totaling $2,844.

## Savings Plan

<table>
<thead>
<tr>
<th>Network provider</th>
<th>Out-of-network provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5,000 Billed charge</td>
<td>$5,000 Billed charge</td>
</tr>
<tr>
<td>$4,000 Allowed amount¹</td>
<td>-4,000 Allowed amount</td>
</tr>
<tr>
<td>- 3,600 Annual deductible</td>
<td>$1,000 Balance bill¹</td>
</tr>
<tr>
<td>$ 400 Allowed amount after annual deductible</td>
<td>$4,000 Allowed amount</td>
</tr>
<tr>
<td>- 3,600 Annual deductible</td>
<td>$400 Allowed amount after annual deductible</td>
</tr>
<tr>
<td>$ 400 Allowed amount after annual deductible</td>
<td>$400 Allowed amount after annual deductible</td>
</tr>
<tr>
<td>x 20%²</td>
<td>x 40%²</td>
</tr>
<tr>
<td>$ 80 Coinsurance, which goes toward your coinsurance maximum</td>
<td>$ 160 Coinsurance, which goes toward your coinsurance maximum</td>
</tr>
<tr>
<td>$ 80 Coinsurance</td>
<td>$ 160 Coinsurance</td>
</tr>
<tr>
<td>+3,600 Annual deductible</td>
<td>+3,600 Annual deductible</td>
</tr>
<tr>
<td>$3,680 Your total payment</td>
<td>+1,000 Balance bill</td>
</tr>
<tr>
<td>$3,680 Your total payment</td>
<td>$4,760 Your total payment</td>
</tr>
</tbody>
</table>

¹ Network providers are not allowed to charge more than the allowed amount.
² In this example, the Savings Plan paid 80 percent of the $400 allowed amount after the deductible, totaling $320.

¹ Out-of-network providers can charge any amount they choose above the allowed amount and bill you the balance above the allowed amount.
² In this example, the Standard Plan paid 60 percent of the $3,555 allowed amount after the deductible, totaling $2,133.

Out-of-network providers can charge any amount they choose above the allowed amount and bill you the balance above the allowed amount.
² In this example, the Savings Plan paid 60 percent of the $400 allowed amount after the deductible, totaling $240.
Managing Your Medical Care

Medi-Call

Under the State Health Plan, some covered services require preauthorization before you receive them. A phone call gets things started. Your health care provider may make the call for you, but it is your responsibility to see that the call is made.

Medi-Call numbers are:

- 800-925-9724 (South Carolina, nationwide, Canada)
- 803-699-3337 (Greater Columbia area)
- 803-264-0183 (fax)

Please note: Some mental health/substance abuse and prescription drug benefits require preauthorization. See pages 84-85 for mental health and page 82 for prescription drugs.

What Are the Penalties for not Calling?

If you do not preauthorize treatment when required, you will pay a $200 penalty for each hospital, rehabilitation or skilled nursing facility or mental health/substance abuse admission. In addition, the coinsurance maximum will not apply. You will continue to pay your coinsurance, no matter how much you pay out-of-pocket.

How to Preauthorize Your Treatment

You can reach Medi-Call by phone from 8:30 a.m. to 5 p.m., Monday through Friday, except holidays. You may fax information to Medi-Call 24 hours a day. However, Medi-Call will not respond until the next business day. If you send a fax to Medi-Call, provide, at a minimum, this information so the review can begin:

- Subscriber’s name
- Patient’s name
- Subscriber’s Benefits ID number or Social Security number
- Information about the service requested
- A telephone number where you can be reached during business hours.

Medi-Call promotes high-quality, cost-effective care for you and your covered family members through reviews that assess, plan, implement, coordinate, monitor and evaluate health care options and services required to meet an individual’s needs. You must contact Medi-Call at least 48 hours or two working days, whichever is longer, before receiving any of these medical services at any hospital in the U.S. or Canada:

- You need any type of inpatient care in a hospital, including admission to a hospital to have a baby¹
- Your preauthorized outpatient services result in a hospital admission (You must call again for the hospital admission.)
- You need outpatient surgery for a septroplasty (surgery on the septum of the nose)
- You need outpatient or inpatient surgery for a hysterectomy
- You need sclerotherapy (vein surgery) performed in an inpatient, outpatient or office setting
- You will receive a new course of chemotherapy or radiation therapy (one-time notification per course)
- You are admitted to a hospital in an emergency (Your admission must be reported within 48 hours or the next working day after a weekend or holiday admission.)¹
- You are pregnant (You are encouraged to notify Medi-Call within the first three months of your pregnancy. See page 62 for more information.)
- You have an emergency admission during pregnancy²
- Your baby is born (if you plan to file a claim for any birth-related expenses)²
- Your baby has complications at birth
- Before your baby is given Synagis (a drug to protect high-risk babies from respiratory syncytial virus disease) outside the hospital nursery

¹requiring notification within 48 hours;²requiring notification within 14 days.

S.C. Public Employee Benefit Authority  www.eip.sc.gov
• You are to be, or have been, admitted to a long-term acute care facility, skilled nursing facility, or need home health care, hospice care or would like an alternative treatment plan
• You need durable medical equipment
• You or your covered spouse decides to undergo in vitro fertilization, GIFT, ZIFT or any other infertility procedure
• You or your covered family member needs to be evaluated for a transplant
• You need inpatient rehabilitative services and related outpatient physical, speech or occupational therapy.

1For mental health or substance abuse services, you must call Companion Benefit Alternatives (CBA) at 800-868-1032 for preauthorization before a non-emergency admission or, in the case of an emergency admission, within 48 hours or the next working day, whichever is longer.
2Contacting Medi-Call for the delivery of your baby does not add the baby to your health insurance. You must add your child by filing an NOE and submitting the required documentation, a long-form birth certificate, within 31 days of birth for benefits to be payable.

A preauthorization request for any procedure that may be considered cosmetic must be received in writing by Medi-Call seven days before surgery. (Procedures in this category include: blepharoplasty, reduction mammoplasty, augmentation mammoplasty, mastopexy, TMJ or other jaw surgery, panniculectomy, abdominoplasty, rhinoplasty or other nose surgery, etc.) Your physician should include photographs if appropriate.

A determination by Medi-Call that a proposed treatment is within generally recognized medical standards and procedures does not guarantee claim payment. Other conditions, including eligibility requirements, other limitations or exclusions, payment of deductibles and other provisions of the plan must be satisfied before BlueCross BlueShield of South Carolina makes payment. Remember, if you use an out-of-network provider, you will pay more.

**Advanced Radiology Preauthorization: National Imaging Associates (NIA)**

The State Health Plan has a system for preauthorizing CT, MRI, MRA and PET scans.

**Network South Carolina physicians, radiology (imaging) centers and outpatient hospital radiology centers** are responsible for requesting advanced radiology preauthorization from National Imaging Associates (NIA).

Doctors can get more information on the BCBSSC website, StateSC.SouthCarolinaBlues.com, or by calling 800-444-4311. To request preauthorization over the Internet, providers can go to NIA’s website, www.RadMD.com. They may also call NIA at 866-500-7664, Monday through Friday, from 8 a.m. to 8 p.m., ET.

If a subscriber or a covered family member is scheduled to receive a CT, MRI, MRA or PET scan from an out-of-network provider in South Carolina or any provider outside South Carolina, it is the subscriber’s responsibility to make sure his provider calls for preauthorization. A subscriber may begin the process by calling NIA at 866-500-7664. He should be able to give NIA the name and phone number of the ordering physician and the name and phone number of the imaging center or the physician who will provide the radiology service.

NIA will make a decision about non-emergency preauthorization requests within two business days of receiving the request from the provider. If the situation is urgent, a decision will be made within one business day of receiving the request from the provider. However, the process may take longer if additional clinical information is needed to make a decision.

A subscriber can check the status of a preauthorization request online through “My Health Toolkit” at StateSC.SouthCarolinaBlues.com.

**What are the Penalties for not Calling?**

If a network South Carolina physician or radiology center does not request preauthorization, the provider will not be paid for the service, and he cannot bill the subscriber for the service.
If a subscriber or a covered family member receives advanced radiology services from an out-of-network provider in South Carolina or from any provider outside South Carolina without preauthorization, the provider will not be paid by BCBSSC, and the subscriber will be responsible for the entire bill.

**Maternity Management**

Regular prenatal care and following your doctor’s recommendations can help keep you and your baby healthy. If you are a mother-to-be, you are encouraged to participate in the Maternity Management Program.

Medi-Call administers PEBA Insurance Benefits’ comprehensive maternity management program, “Coming Attractions.” The program monitors expectant mothers throughout pregnancy and manages Neonatal Intensive Care Unit (NICU) infants or other babies with special needs until they are 1 year old.

To enroll in the program, notify Medi-Call during the first trimester (three months) of your pregnancy. Medi-Call’s numbers are 803-699-3337 (Greater Columbia area) and 800-925-9724 (toll-free outside the Columbia area). You do not have to wait until you have seen your physician to call and enroll in “Coming Attractions.”

You can also notify Medi-Call of your pregnancy and enroll in “Coming Attractions” online through the Personal Health Record’s maternity screening program. Go to the PEBA Insurance Benefits website, [www.eip.sc.gov](http://www.eip.sc.gov). Under “Links,” select “Medical/My Health Toolkit (BlueCross BlueShield of South Carolina).” At the site, log in to “My Health Toolkit.” At the site, under “Quick Links,” select “Personal Health Record.” Now select the member. From there, you will be taken to the home screen of the “Personal Health Record,” which includes “My Activity Center.” Under “My Other Assessments” box, select “Coming Attractions.”

**Please note:** If you fail to preauthorize a hospital admission related to your pregnancy or to have your baby, you will pay a $200 penalty for each admission, as you would for any admission, whether the admission was maternity related or not. Also, the coinsurance you pay will not count toward your coinsurance maximum. For more information, see page 60 or call your maternity care nurse.

As a participant in “Coming Attractions,” you will receive a welcome packet that includes a pregnancy guide book to assist you in having a healthy pregnancy and other educational information throughout your pregnancy.

A Medi-Call maternity nurse will complete a Maternity Health Assessment form when you enroll. It is used to identify potential high-risk factors during your first trimester. If high-risk factors are identified, you will be scheduled for follow-up calls. If no risks are identified, you should call with any changes in your condition. Otherwise, your Medi-Call nurse will call you during your second and third trimester. Your Medi-Call nurse will also call you after your baby is born.

If you enroll in the program through the Personal Health Record, you can use the online system to correspond with your nurse and receive articles of interest from recognized medical sources.

Also, you can call Medi-Call anytime you have questions. A maternity case management nurse will be there to help you with both routine and special needs throughout your pregnancy and the postpartum period.

For more information about maternity benefits, see Pregnancy and Pediatric Care on pages 71-72.

You can also get to “My Health Toolkit” through StateSC.SouthCarolinaBlues.com.

Participating in the Maternity Management Program or contacting Medi-Call about the birth of your baby does not add your baby to your health insurance. Even if you have Full Family or Employee/Children coverage, you must add the baby to your policy by completing an NOE and submitting a long-form birth certificate within 31 days of his birth.
Wellness Management

Wellness Incentive Program

The Wellness Incentive Program enables eligible State Health Plan members with cardiovascular disease, congestive heart failure or diabetes to qualify for a drug copayment waiver, 12 months of free generic drugs that treat these conditions. Diabetes testing supplies (glucometer, test strips, control solution, lancet, syringes, pen needles, etc.) purchased at a network pharmacy are also covered at no charge. The waiver can be renewed yearly. This program is designed to encourage participants to take more responsibility for their health and save themselves and the plan money.

Employees, retirees, COBRA subscribers and survivors and their covered family members are eligible to qualify if the State Health Plan is their primary insurance. If a subscriber is enrolled in the Medicare Supplemental Plan but covers family members who are not eligible for Medicare, these dependents are eligible for the incentive program. If Medicare or other coverage becomes primary while receiving the waiver, the waiver will continue for the 12-month period, but it will not be extended. Children age 5 and older are eligible if they have been diagnosed with a condition covered by the program.

Members are identified through claims or preauthorizations for one of the qualifying conditions. Members who are eligible will receive a letter or a phone call from BCBSSC explaining the details of the Wellness Incentive Program, including how to qualify for the waiver.

When a member meets the requirements to qualify for the waiver, he is sent a letter telling him when he will begin to receive free drugs. About three months before the waiver ends, he will receive a letter telling him what he needs to do to requalify. If a member loses eligibility, he also receives a letter.

For detailed information about the Wellness Incentive Program, call BCBSSC Customer Service at 800-868-2520 or go to StateSC.SouthCarolinaBlues.com. If you think you qualify for the program but have not been notified of your eligibility, call 855-838-5897. For more information about prescriptions, call Catamaran, the pharmacy benefit manager, at 855-901-PEBA (7322).

Weight Management Program

The BlueCross Weight Management program is designed to help you achieve weight-loss goals through small changes you can make while still getting on with your life. You will receive information about weight management, and a confidential survey will help a registered nurse tailor the program to meet your needs. Program candidates are identified through claims analysis, preauthorizations, doctor referral or self-referral.

If you think you qualify but have not received a letter or would like more information, call 855-838-5897.

Healthy Weight for Kids and Teens

This confidential program is for overweight and obese children between the ages of 2 and 17. It is designed to teach children and their parents healthy habits, support their efforts and help them work with their doctor on weight management. Members are enrolled based on medical claims, or they may be referred by a doctor. Also, a parent can enroll his covered child by calling 855-838-5897.

Health Management Program

Managing a chronic condition can be difficult. However, studies show you can help control your symptoms by making lifestyle changes and by following your doctor’s advice. You can also delay, or even prevent, many of the complications of the disease.
Insurance Benefits Guide 2015

The Health Management Program is designed for Standard Plan and Savings Plan subscribers and their covered family members who have diabetes, heart disease or chronic respiratory conditions. BCBSSC selects participants by reviewing medical, pharmacy and laboratory claims. If you are identified as someone who could benefit from it, you are automatically enrolled. You may, however, opt out of the program.

As a participant, you will receive a welcome letter that includes the name of and contact information for your BlueCross health coach. Your coach will be a registered nurse who will help you learn more about your condition and how to manage it. He or she will also help you work with your physician to develop a plan to take charge of your illness, contacting you by phone or through the online Personal Health Record. You can contact your health coach as often as you like with questions or to ask for advice. For more information, call 855-838-5897.

If you have diabetes, congestive heart failure or cardiovascular disease, BCBSSC may send you a letter saying you are eligible for the Wellness Incentive Program.

About Your Privacy
In compliance with federal law, your health information will always be kept confidential. Your employer does not receive the results of any surveys you complete. Enrolling will not affect your health benefits now or in the future.

Health Management for Migraine Program
The program encourages a member to work with his doctor to create a plan to ease the pain of migraine headaches. A health coach helps the member learn to identify migraine triggers, develop healthy habits to prevent migraines and comply with his treatment plan. Members, who must be at least age 18, are invited to participate based on medical and pharmacy claims. They can also enroll by calling 855-838-5897.

Medical Case Management
Facing a serious illness or injury can be confusing and frustrating. You may not know where to find support or information to help you cope with your illness, and you may not know what treatment options are available. Case management can help.

The case management programs available to State Health Plan members are explained below. Each program includes teams of specially trained nurses and doctors. Their goal is to assist participants in coordinating, assessing and planning health care. They do so by giving a patient control over his care and respecting his right to knowledge, choice, a direct relationship with his physician, privacy and dignity. None of the programs provide medical treatment. All recognize that, ultimately, decisions about your care are between you and your physician. Each program may involve a home or facility visit to a participant but only with permission.

By working closely with your doctor, using your benefits effectively and using the resources in your community, the case management programs may help you through a difficult time. For more information on any of these programs, call 800-925-9724 and ask to be transferred to the case management supervisor.

BlueCross Medi-Call Case Management Program
This program is designed for State Health Plan members who have specific catastrophic or chronic disorders, acute illnesses or serious injuries. The program facilitates continuity of care and support of these patients while managing health plan benefits in a way that promotes high-quality, cost-effective outcomes.

Case managers talk with patients, family members and providers to coordinate services among providers and support the patient through a crisis or chronic disease. Case management intervention may be short- or long-term. Case managers combine standard preauthorization services with innovative approaches for
patients who require high levels of medical care and benefits. Case managers can often arrange services or identify community resources available to meet the patient's needs.

The case manager works with the patient and the providers to assess, plan, implement, coordinate, monitor and evaluate ways of meeting a patient’s needs, reducing readmissions and enhancing quality of life. Your Medi-Call nurse case manager may visit you at home, with your permission, or in a treatment facility or your physician’s office when the treatment team determines it is appropriate.

A Medi-Call nurse stays in touch with the patient, caregivers and providers to assess and re-evaluate the treatment plan and the patient’s progress. All communication between BlueCross BlueShield of South Carolina and the patient, family members or providers complies with HIPAA privacy requirements. If a patient refuses medical case management, Medi-Call will continue to preauthorize appropriate treatment.

**Alere Complex Care Management Program**

Some members are referred to Alere for complex care management. The program is designed to assist the most seriously ill patients. They include those with complex medical conditions, who may have more than one illness or injury, who have critical barriers to their care and who are frequently hospitalized.

The complex care management program provides you with information and support through a local care coordinator, who is a registered nurse. This nurse coordinator can help you identify treatment options; locate supplies and equipment recommended by your doctor; coordinate care with your doctor and the SHP; and research the availability of transportation and lodging for out-of-town treatment. The nurse stays in touch weekly with patients and caregivers to assess and re-evaluate the treatment plan and the patient’s progress. This program helps you make informed decisions about your health when you are seriously ill or injured. Participation is voluntary. You can leave the program at any time, for any reason. Your benefits will not be affected by your participation.

Here is how the program works: BlueCross BlueShield of South Carolina will refer you to Alere if the program may benefit you. You will receive a letter explaining the program, and an Alere representative will contact you. A care coordinator in your area will visit you to discuss ways he can help you and will ask permission to contact your doctor to offer assistance.

An Alere team of specially trained nurses and doctors will review your medical information and treatment plan. (Your medical history and information will always be kept confidential among your caregivers and the Alere team.) Your local care coordinator nurse will be your main contact. You and your doctor, however, will always make the final decision about your treatment. Complex care management does not replace your doctor’s care. Always check with your doctor before following any medical advice.

A BlueCross nurse will act as a liaison with the Alere nurse. This BlueCross nurse provides information about benefits and networks and helps complete authorization for medically necessary services that are covered by the plan.

**VillageHealth Disease Management Renal Case Management Program**

VillageHealth Disease Management provides renal disease management care for select State Health Plan members receiving renal dialysis. These nurses visit patients in dialysis centers and in their homes to provide education and outreach that may help prevent acute illnesses and hospitalizations.

Here is how the program works. Subscribers receiving renal dialysis are referred to VillageHealth by BCBSSC. A South Carolina-based VillageHealth nurse then contacts the individual to confirm that he is a good candidate for renal case management. The nurse, who has many years of renal dialysis experience, coordinates care across all disciplines and facilitates Medi-Call referrals for patients accepted into the program.
As the link between the patient, providers and dialysis team, the nurse identifies the patient’s needs through medical record review and consultations with the patient, family and health care team. Needs may be medical, social, behavioral, emotional and financial. The nurse coordinates services based on the long-term needs of the patient and incorporates these needs into a plan agreed upon by the patient, physician(s), dialysis team and other providers. Your VillageHealth nurse may visit you at home, with your permission, or in the dialysis center when the treatment team determines it is appropriate. Your nurse will call you frequently and receive updates from your providers.

A Medi-Call case manager will be the liaison with the VillageHealth nurse. This Medi-Call nurse provides information about the use of benefits and networks and completes authorization for medically necessary services covered by the plan.

**Online Health Tools**

**My Health Toolkit**

**Personal Health Record**

Your Personal Health Record, which is available on the state BCBSSC website, is safe and secure. Through it, you have access to your health information, including a list of your claims and the prescription drugs you are taking, 24 hours a day, seven days a week.

You can enter medical information, such as allergies, vaccinations, test results and personal or family medical history. This information can be shared with family members or new doctors as you feel is appropriate. Through the “My Care Plan” section, you can get information about your health conditions and other medical topics that are of interest to you. If you participate in the Health Management Program, your health coach can use it to send you messages, assign tasks and provide you with additional information about your condition.

To review your record, go to the PEBA Insurance Benefits website, [www.eip.sc.gov](http://www.eip.sc.gov). Under “Links,” select “Medical/My Health Toolkit (BlueCross BlueShield of South Carolina).” Log in to “My Health Toolkit” and select “Personal Health Record.” From there, you will be asked to select the member. Then you will be taken to the home screen of the “Personal Health Record.”

**Personal Health Assessment**

An Personal Health Assessment (PHA) is available to State Health Plan subscribers who are 18 years and older. Go to the PEBA Insurance Benefits website, [www.eip.sc.gov](http://www.eip.sc.gov). Under “Links,” select “Medical/My Health Toolkit (BlueCross BlueShield of South Carolina).” At the site, log in to “My Health Toolkit.” Then, under Wellness, select “Personal Health Assessment” You will be taken to the survey.

The survey asks questions and then provides a wellness score based on your responses. To get the most useful results, you need measurements of your cholesterol, triglycerides, glucose and blood pressure, as well as of the circumference of your neck and waist. Most of this information is available through the Preventive Workplace Screening. See page 30 for more information.

The PHA gives you access to programs designed to address your risk factors. These interactive tools will help you reach your goals at your own pace. You can print your PHA results and recommendations, and you will continue to have access to them online. The program is on a secure web link. All assessments remain confidential. You can retake the survey each year to measure your progress toward your health goals.
Wellness

The Wellness section of My Health Toolkit offers ways to take a more active role in improving your health. Go to the PEBA Insurance Benefits website, www.eip.sc.gov. Under “Links,” select “Medical/My Health Toolkit (BlueCross BlueShield of South Carolina)” and then log in to “My Health Toolkit.” Then click on “Wellness” and choose “Healthy Living Programs.”

Healthy Living Programs range from Stress Relief to Cancer Fighting to Healthy Aging. You can even design a program based on your own goals and interests. Healthwise Conversations® on a variety of topics tell how to get healthier by making simple changes. Interactive activities include tools to help you make healthy salads and sandwiches, shop better at the grocery store and track your meals and physical activity.

State Health Plan Benefits

The Standard Plan and the Savings Plan pay benefits for treatment of illnesses and injuries meeting the definition of medically necessary under the plan. This section is a general description of the plan. The Plan of Benefits contains a complete description of the benefits. Its terms and conditions govern all health benefits offered by the state. Contact your benefits administrator or PEBA Insurance Benefits for more information. Some services and treatment require preauthorization by Medi-Call, National Imaging Associates, Catamaran or Companion Benefit Alternatives (CBA). Be sure to read the Medi-Call section beginning on page 60, the National Imaging Associates section on page 61 and the mental health and substance abuse section on page 84 for details.

Under the terms of the plan, a medically necessary service or supply is:

- Required to identify or treat an existing condition, illness or injury and
- Prescribed or ordered by a physician and
- Consistent with the covered person’s illness, injury or condition and in accordance with proper medical and surgical practices in the medical specialty or field of medicine at the time provided and
- Required for reasons other than the convenience of the patient and
- Results in measurable, identifiable progress in treating the covered person’s condition, illness or injury.

The fact that a procedure, service or supply is prescribed by a physician does not automatically mean it is medically necessary under the terms of the plan.

Advanced Practice Registered Nurse

Expenses for services received from a licensed, independent Advanced Practice Registered Nurse (APRN) are covered, even if these services are not performed under the immediate direction of a doctor. An APRN is a nurse practitioner, certified nurse midwife, certified registered nurse anesthetist or a clinical nurse specialist. All services received must be within the scope of the nurse’s license and needed because of a service allowed by the plan.

The State Health Plan only recognizes certified nurse midwives as providers of midwife covered services. A certified nurse midwife (CNM) is an APRN who is licensed by the State Board of Nursing as a midwife. The services of lay midwives and midwives licensed by the S.C. Dept. of Health and Environmental Control (DHEC) are not reimbursed.

Alternative Treatment Plans (ATP)

An alternative treatment plan is an individual program to permit treatment in a more cost-effective and less intensive manner. An ATP requires the approval of the treating physician, Medi-Call and the patient. Services and supplies that are authorized by Medi-Call as medically necessary because of the approved alternative treatment plan will be covered.

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Ambulance Service

Ambulance service, including air ambulance service, is covered to the nearest outpatient hospital department to obtain medically necessary emergency care. Ambulance service is also covered to transport a member to the nearest hospital that can provide medically necessary inpatient services when those services are not available at the current facility. No benefits are payable for ambulance service used for routine, non-emergency transportation, including, but not limited to, travel to a facility for scheduled medical or surgical treatments, such as dialysis or cancer treatment. All claims for ambulance service are subject to medical review. Ambulance services are reimbursed at 80 percent of the allowed amount. However, non-participating providers can balance bill you up to the total of their charge for the service. For information on balance billing, see page 58.

Autism Spectrum Disorder Benefits

Applied Behavior Analysis (ABA) for treatment of Autism Spectrum Disorder is covered, subject to Companion Benefit Alternatives (CBA) guidelines and preauthorization requirements. All services must be approved by CBA and performed by a certified ABA provider.

Bone, Stem Cell and Solid Organ Transplants

State Health Plan transplant contracting arrangements include the BlueCross BlueShield Association (BCBSA) national transplant network, Blue Distinction Centers for Transplants (BDCT). All BDCT facilities meet specific criteria that consider provider qualifications, programs and patient outcomes.

All transplant services must be approved by Medi-Call (see page 60). You must call Medi-Call, even before you or a covered family member is evaluated for a transplant.

Through the BDCT network, SHP members have access to the leading organ transplant facilities in the nation. Contracts are also in effect with local providers for transplant services so that individuals insured by the plan may receive transplants at those facilities. You will save a significant amount of money if you receive your transplant services either at a BDCT network facility or through a local South Carolina network transplant facility. If you receive transplant services at one of these network facilities, you will not be balance billed. You will be responsible only for your deductible, coinsurance and any charges not covered by the plan. In addition, these network facilities will file all claims for you.

Transplant services at nonparticipating facilities will be covered by the plan. However, the SHP will pay only the SHP allowed amount for transplants performed at out-of-network facilities. If you do not receive your transplant services at a network facility, you may pay substantially more. In addition to the deductible and coinsurance, subscribers using out-of-network facilities are responsible for any amount over the allowed amount and will pay 40 percent coinsurance because they used out-of-network providers. Costs for transplant care can vary by hundreds of thousands of dollars. If you receive services outside the network, you cannot be assured that your costs will not exceed those allowed by the plan. For information on balance billing, see page 58. You may also call Medi-Call for more information.

Chiropractic Care

You are covered for specific office-based services from a chiropractor, including detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the body to remove nerve interference and the effects of such nerve interference, where such interference is the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column. Diagnostic X-rays are covered if medically necessary. For Standard Plan subscribers, chiropractic benefits are limited to $2,000 per person each year. Under the Savings Plan, they are limited to $500 per person each year. Both plans are limited to one Manual Therapy per visit, which is subject to the plan maximum. Services of a massage therapist are not covered.
### Colonoscopies

Routine colonoscopies are covered once every ten years, starting at age 50, even when no symptoms are apparent. The plan will not cover the consultation before the routine colonoscopy. The amount billed for the consultation will be the patient’s responsibility. The plan also covers diagnostic colonoscopies. However, the plan does not pay 100 percent of the cost of a colonoscopy. All routine and diagnostic colonoscopies are subject to the plan’s copayments, deductible and coinsurance. Your copayments and the amount you pay in coinsurance may vary based on where you receive the service.

### Contraceptives

For subscribers and covered spouses, routine contraceptive prescriptions, including birth control pills and injectables (including, but not limited to, Depo-Provera and Lunelle), filled at a participating pharmacy or through the plan’s mail-order pharmacy, are covered as prescription drugs. Birth control implants and injectables, given in a doctor’s office, are covered as a medical benefit. Contraceptives are covered for covered children only to treat a medical condition and must be preauthorized by Catamaran.

### Cranial Remodeling Band or Helmet

The plan covers a cranial remodeling band when preauthorization review determines it to be medically necessary for the correction of a child’s moderate to severe positional head deformities associated with premature birth, restrictive intrauterine positioning, cervical abnormalities, birth trauma, torticollis or sleeping positions. Remodeling must begin between 4 and 12 months of age, following a failed two-month trial of conservative treatment (e.g., repositioning, neck exercises, etc.).

### Diabetic Supplies

Insulin is allowed under the prescription drug program or under the medical plan but not under both. Insulin requires a $39 copayment for each supply of up to 31 days. Diabetic supplies, including syringes, lancets and test strips, are covered at participating pharmacies through your drug benefit for a $9 copayment, per item, for each supply of up to 31 days. **Generic drugs to treat diabetes and diabetes testing supplies are covered at no charge for Standard Plan and Savings Plan members enrolled in the Wellness Incentive Program.** Because insulin is not a generic drug, it is not eligible for coverage under the Wellness Incentive Program. For more information about the program, see page 63. Claims for diabetic durable medical equipment should be filed under your medical coverage.

### Doctor Visits

Treatments or consultations for an injury or illness are covered when they are medically necessary under the terms of the plan and not associated with a service excluded by the plan. Some mental health and substance abuse outpatient visits still require preauthorization. For details on mental health and substance abuse benefits, see pages 84-85.

### Durable Medical Equipment (DME)

Generally, DME must be preauthorized by Medi-Call. Some examples include:

- Any purchase or rental of durable medical equipment
- Any purchase or rental of durable medical equipment that has a nontherapeutic use or a potentially non-therapeutic use
- C-Pap or Bi-Pap machines
- Oxygen and equipment for oxygen use outside a hospital setting, whether purchased or rented
- Any prosthetic appliance or orthopedic brace, crutch or lift, attached to the brace, crutch or lift, whether initial or replacement.

[www.eip.sc.gov](http://www.eip.sc.gov)  
S.C. Public Employee Benefit Authority
DME provider networks are available to State Health Plan members. They offer you discounts while providing you with high-quality products and care.

**Home Health Care**

Home health care includes part-time nursing care, health aide service or physical, occupational or speech therapy provided by an approved home health care agency and given in the patient’s home. You cannot receive home health care and hospital or skilled nursing facility benefits at the same time. These services do not include custodial care or care given by a person who ordinarily lives in the home or is a member of the patient’s family or the patient’s spouse’s family. **Benefits are limited to 100 visits per year.** These services must be preauthorized by Medi-Call, and the member must be home bound.

**Hospice Care**

The plan will pay up to $6,000 for hospice care for a patient certified by his physician as having a terminal illness and a life expectancy of six months or less. The benefit also includes a maximum of $200 for bereavement counseling. These services must be preauthorized by Medi-Call.

**Infertility**

If either the subscriber or the spouse has had a tubal ligation or a vasectomy, the plan will not pay for the diagnosis and treatment of infertility for either member.

To be eligible for benefits to treat infertility, the subscriber or spouse must have a diagnosis of infertility. **Coverage is limited to a lifetime maximum payment of $15,000. Please note:** The limit applies to any covered medical benefits and covered prescription drug benefits incurred by the subscriber or the covered spouse, whether covered as a spouse or as an employee.

Included in the $15,000 maximum are diagnostic tests, prescription drugs and up to six cycles of Intrauterine Insemination (IUI), and a maximum of three completed cycles of zygote or gamete intrafallopian transfer (ZIFT or GIFT) or in vitro fertilization (IVF) per lifetime. A cycle reflects the cyclic changes of fertility with the cycle beginning with each new insemination or assisted reproductive technology (ART) transfer or implantation attempt. ART procedures not specifically mentioned are not covered, including but not limited to: tubal embryo transfer (TET), pronuclear stage tubal embryo transfer (PROUST) oocyte donation and intracytoplasmic sperm injection (ICSI).

Benefits are payable at 70 percent of the allowed amount. Your share of the expenses does not count toward your coinsurance maximum. All procedures related to infertility must be preauthorized by Medi-Call. Call Medi-Call at 803-699-3337 in the Greater Columbia area and at 800-925-9724 in South Carolina, nationwide and in Canada for more information.

**Prescription drugs for treatment of infertility are subject to a 30 percent coinsurance payment under both the Savings Plan and the Standard Plan.** This expense does not apply to the $2,500 per person prescription drug copayment maximum under the Standard Plan. It does apply to the Savings Plan deductible. The 70 percent plan payment for prescription drugs for infertility treatments applies to the $15,000 maximum lifetime payment for infertility treatments. Call Catamaran’s Member Services at 855-901-PEBA (7322) for more information about prescription drugs.

**Please note:** When you become pregnant, you are encouraged to enroll in the “Coming Attractions” Maternity Management Program. See page 62 for more information.
Inpatient Hospital Services

Inpatient hospital care, including a semi-private room and board, is covered. In addition to normal visits by your physician while you are in the hospital, you are covered for one consultation per consulting physician for each inpatient hospital stay. **Inpatient care must be approved by Medi-Call or Companion Benefit Alternatives (CBA). For more information, see page 60.**

Outpatient Facility Services

Outpatient facility services may be provided in the outpatient department of a hospital or in a freestanding facility.

Outpatient services and supplies include:

- Laboratory services
- X-ray and other radiological services
- Emergency room services
- Radiation therapy
- Pathology services
- Outpatient surgery
- Infusion suite services and
- Diagnostic tests.

If you are covered under the Standard Plan, you will be charged a $95 outpatient facility services copayment. You will be charged a $159 copayment for emergency room services. These copayments do not apply to your annual deductible or your coinsurance maximum. The copayment for emergency room services is waived if you are admitted to the hospital.

The outpatient facility services copayment **does not** apply to dialysis, routine mammograms, routine Pap tests, routine physical therapy, clinic visits, oncology services, electro-convulsive therapy, psychiatric medication management and partial hospitalization and intensive outpatient behavioral health services.

**Please note:** When lab tests are ordered, you may wish to talk with your provider about the possibility of having the service performed at an independent lab. This would enable you to avoid the $95 copayment for outpatient facility services or the $12 copayment for a physician office visit.

Pregnancy and Pediatric Care

Maternity benefits are provided to covered female employees or retirees and to covered wives of male employees or retirees. **Covered children do not have maternity benefits.** Maternity benefits include necessary prenatal and postpartum care, including childbirth, miscarriage and complications related to pregnancy. **You are encouraged to enroll in the “Coming Attractions” Maternity Management Program.** See page 62 for information.

Under federal law, group health plans generally cannot restrict benefits for the length of any hospital stay in connection with childbirth for the mother or the newborn to fewer than 48 hours after a vaginal delivery or fewer than 96 hours after a caesarean section. However, the plan may pay for a shorter stay if the attending physician, after consultation with the mother, discharges the mother or newborn earlier.

Also under federal law, group health plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan may not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce out-of-pocket costs, a member may be required to obtain precertification.

www.eip.sc.gov

S.C. Public Employee Benefit Authority
The State Health Plan only recognizes certified nurse midwives as providers of midwife covered services. A certified nurse midwife (CNM) is an Advance Practice Registered Nurse (APRN) who is licensed by the State Board of Nursing as a midwife. Services from an APRN are covered, even if these services are not performed under the immediate direction of a doctor. The services of lay midwives and midwives licensed by the S.C. Dept. of Health and Environmental Control (DHEC) are not reimbursed.

Please note: Breast pumps are not covered.

**Prescription Drugs**

Prescription drugs, including insulin, are covered at a participating pharmacy, subject to plan exclusions and limitations. Drugs in FDA Phase I, II or III testing are not covered. Prescription drugs associated with infertility treatments have a different coinsurance rate. See page 70 for more information.

Nonsedating antihistamines and drugs for treating erectile dysfunction are not covered under the Savings Plan.

**Reconstructive Surgery After a Medically Necessary Mastectomy**

The plan will cover, as required by the Women’s Health and Cancer Rights Act of 1998, mastectomy-related services, including:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications in all stages of mastectomy, including lymphedema.

These services apply only in post mastectomy cases. All services must be approved by Medi-Call.

**Rehabilitation Care**

The plan provides benefits for physical rehabilitation designed to restore a bodily function that has been lost because of trauma or disease.

Rehabilitation care is subject to all terms and conditions of the plan including:

- Preauthorization is required for any inpatient rehabilitation care, regardless of the reason for the admission
- The rehabilitation therapy must be performed in the most cost-effective setting appropriate to the condition.
- The provider must submit a treatment plan to Medi-Call
- There must be reasonable expectation that sufficient function can be restored for the patient to live at home
- Significant improvement must continue to be made
- An inpatient admission must be to an accredited (JCAHO or CARF) rehabilitation facility.

Rehabilitation benefits are not payable for:

- Vocational rehabilitation intended to teach a patient how to be gainfully employed
- Pulmonary rehabilitation (except in conjunction with a covered and approved lung transplant)
- Cognitive (mental) retraining
- Community re-entry programs
- Long-term rehabilitation after the acute phase
- Work-hardening programs
- Services by a massage therapist.
Rehabilitation – Acute

Acute-phase rehabilitation often is done in an outpatient setting. In complex cases, the rehabilitation may be done in an acute-care facility and then a sub-acute rehabilitation facility or an outpatient facility. Acute rehabilitation begins soon after the start of the illness or injury and may continue for days, weeks or several months. Cardiac and pulmonary rehabilitation require preauthorization.

Rehabilitation – Long-term

Long-term rehabilitation refers to the point at which further improvement is possible, in theory, but progress is slow and its relationship to formal treatment is unclear. Long-term rehabilitation after the acute phase is generally not covered.

Second Opinions

If Medi-Call advises you to seek a second opinion before a medical procedure, the plan will pay 100 percent of the cost of that opinion. These procedures include surgery, as well as treatment (including hospitalization).

Skilled Nursing Facility

The plan will pay limited benefits for medically necessary inpatient services at a skilled nursing facility for up to 60 days. Physician visits are limited to one a day. These services require approval by Medi-Call.

Speech Therapy

The plan covers short-term speech therapy to restore speech or swallowing function that has been lost as a result of disease, trauma, injury or congenital defect (e.g., cleft lip or cleft palate). Speech therapy must be prescribed by a physician and provided by a licensed speech therapist. Speech therapy, whether it is offered in an inpatient setting or in the member’s home, requires preauthorization by Medi-Call. For more information about this benefit, contact BlueCross BlueShield of South Carolina (BCBSSC) customer service at 803-736-1576 (Greater Columbia area) or 800-868-2520 (toll-free outside the Columbia area).

Maintenance therapy begins when the therapeutic goals of a treatment plan have been achieved or when no further functional progress is documented or expected to occur. Maintenance therapy is not covered.

Speech therapy is not covered when associated with any of the following:

- Verbal apraxia or stuttering
- Language delay
- Communication delay
- Developmental delay
- Attention disorders
- Behavioral disorders
- Cognitive (mental) retraining
- Community re-entry programs or
- Long-term rehabilitation after the acute phase of treatment for the injury or illness.

After a claim is paid, BCBSSC can still review speech therapy services to determine if the services are a benefit covered by the plan.
Surgery

Physician charges for medically necessary inpatient surgery, outpatient surgery and use of surgical facilities are covered, if the care is associated with a service allowed by the plan.

Other Covered Benefits

These benefits are covered if they are determined to be medically necessary and associated with a service allowed by the plan:

- Blood and blood plasma, excluding storage fees
- Nursing services (part-time/intermittent)
- Dental treatments or surgery to repair damage from an accident, for up to one year from the date of the accident
- Dental surgery for bony, impacted teeth when supported by X-rays.

Extended care is covered as an alternative to hospital care only if it is approved by Medi-Call.

Preventive Benefits

The Standard Plan and the Savings Plan have benefits that can help make it easier for you and your family to stay healthy. You also are eligible for Prevention Partners programs. By helping prevent potentially expensive health problems and hospital admissions, these benefits help control medical claims costs, saving you and the plan money.

Please note: Preventive and routine services, other than those listed below, generally are not covered by the plan.

Shingles Vaccine Benefit

Zostavax, the shingles vaccine, is covered as a pharmacy benefit for State Health Plan members age 60 and older. The vaccination requires a prescription. (To save the cost of an extra office visit, the member may want to get the prescription on a regular visit to his doctor.) Remember: Zostavax, like all prescription drugs, is covered only if it is purchased at a network pharmacy.

- For a Standard Plan member, the vaccine is covered as a Tier 2 drug, which has $38 copayment.
- For a Savings Plan member, the allowed amount for the drug is applied to his annual deductible, if it has not been met.

Some network pharmacies administer the vaccine. If the vaccination is not given on site, Zostavax needs to be kept frozen and taken immediately to a doctor’s office for administration.

Please note: The plan covers the cost of the vaccine only. It does not cover any charges related to providing the vaccination, including the cost of any office visits or the fee for giving the vaccination, whether it is given at a pharmacy or at a doctor’s office.

Benefits for Women

Mammography Program

Routine mammograms are covered at 100 percent as long as you use a provider in the mammography network and you meet eligibility requirements.
Mammography benefits include:
- One base-line mammogram (four views) for women age 35 through 39
- One routine mammogram (four views) every year for women age 40 through 74. (It is recommended that you schedule your mammogram after your birthday.)

**Please note:** To find a mammography network provider, go to “Find a Doctor or Hospital” on StateSC. SouthCarolinaBlues.com. If you do not have Internet access, contact your provider or call BCBSSC at 803-736-1576 (Greater Columbia area) or 800-868-2520 (toll-free outside the Columbia area) for assistance.

Charges for routine mammograms performed at nonparticipating facilities are not covered, with the exception of procedures performed outside South Carolina. Out-of-network providers are free to charge you any price for their services, so you may pay more.

A doctor’s order is not required for a routine mammogram. However, most centers ask for one, so it is recommended that you get one.

Preventive mammogram benefits are in addition to benefits for diagnostic mammograms. Any charges for additional mammograms are subject to copayments, the deductible and coinsurance.

Women, age 40 and older, covered as retirees and enrolled in Medicare, should contact Medicare or see Medicare and You 2015 for information about coverage. The State Health Plan is primary for a woman covered as active employee or as the spouse of an active employee, regardless of Medicare eligibility.

**Pap Test Benefit**

**Standard Plan members**
The plan covers only the cost of the lab work associated with a Pap test each calendar year, without any requirement for a deductible or coinsurance, for covered women ages 18 through 65. Before you receive this service, please consider the following:
- The cost of the portion of the office visit associated with the Pap test is covered.
- Costs for the portion of the office visit not associated with the Pap test, charges associated with a pelvic exam, breast exam, or a complete or mini-physical exam and any other laboratory tests, procedures or services associated with receiving the Pap test benefit are not covered and are the member’s responsibility.
- If the test is performed by an out-of-network provider, the member may be billed for the amount of the charge above the State Health Plan allowed amount for the test.

It is strongly advised that the member contact the provider before scheduling an office visit to determine the cost of the exam and related services. The amount the member pays for additional services does not count toward her annual deductible.

**Savings Plan members**
Savings Plan participants have the same Pap test benefit as Standard Plan members. However, Savings Plan members older than 18 are entitled to a routine annual exam. They may receive a routine annual exam or an exam performed in conjunction with the Pap test, but not both. If both are performed in the same year, the first one filed will be allowed.

**Well Child Care Benefits**
Well Child Care benefits are designed to promote good health and aid in the early detection and prevention of illness in children enrolled in the State Health Plan.

**Who is Eligible?**
Covered children are eligible for Well Child Care check-ups until they turn age 19.
How Does it Work?

This benefit covers Well Child Care exams and timely immunizations, which must be performed by a network professional. When these services are received from an SHP or BlueCard network doctor, benefits will be paid at 100 percent of the allowed amount. The State Health Plan will not pay for services from out-of-network providers. Some services may not be considered part of Well Child Care. For example, if during a well child visit a fever and sore throat were discovered, the lab work to verify the diagnosis would not be part of the routine visit. These charges, if covered, would be subject to the copayment, deductible and coinsurance, as would any other medical expense.

Well Child Care Checkups

The plan pays 100 percent of the allowed amount for approved routine exams, Centers for Disease Control-recommended immunizations and American Academy of Pediatrics-recommended lab tests when a network doctor provides these checkups:

- Younger than 1 year old — five visits
- 1 year old — three visits
- 2 years old until they turn 19 years old — one visit a year. (The Well Child Care exam must occur after the child’s birthday.)

Immunizations

Benefits are provided for all immunizations at the appropriate ages recommended by the Centers for Disease Control for children until they turn age 19. To be sure the immunization will be covered, the child must have reached the age at which the schedule says the immunization should be given.

If your covered child has delayed or missed receiving immunizations at the recommended times, the plan will pay for catch-up immunizations until he turns age 19, subject to the limitations outlined above. The schedule below provides general information but is subject to change. Please contact your State Health Plan pediatrician or call Medi-Call for the most up-to-date information about how to immunize your child properly.

<table>
<thead>
<tr>
<th>Disease</th>
<th>Recommended Immunization Schedule</th>
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</thead>
<tbody>
<tr>
<td>Hepatitis B (HepB)</td>
<td>Birth 1-2 months 6-18 months</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>2 months 4 months 6 months</td>
</tr>
<tr>
<td>Inactivated Polio vaccine (IVP)</td>
<td>2 months 4 months 6-18 months 4-6 years</td>
</tr>
<tr>
<td>Diphtheria-Tetanus-Pertussis</td>
<td>2 months 4 months 6 months 15-18 months 4-6 years 11-12 years</td>
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<tr>
<td>(Whooping cough)</td>
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<tr>
<td>Haemophilus (HIB)</td>
<td>2 months 4 months 6 months (optional) 12-15 months</td>
</tr>
</tbody>
</table>
Additional Benefits for Savings Plan Participants

Under the Savings Plan, each covered family member is eligible for the allowed amount for a yearly flu immunization. (If the member does not go to a network physician, he may be billed for the difference between the charge and the allowed amount.)

Savings Plan participants age 19 and older may receive an annual physical exam from a network provider in his office that includes:

- A preventive, comprehensive examination
- A complete urinalysis, if coded as a preventive screening
- A preventive EKG
- A fecal occult blood test, if coded as a preventive screening
- A general health laboratory panel blood work, if coded as a preventive screening. (This benefit does not include a more comprehensive executive blood panel test.)
- A preventive lipid panel once every five years (for testing cholesterol and triglycerides).

Note: If your network physician sends tests to a out-of-network physician or lab, the tests will not be covered.

When you check out, you may wish to remind your physician’s staff that you are covered under the Savings Plan and your exam should be coded as a routine physical. If a service that would have otherwise been covered is coded as a diagnostic procedure, it will apply to the member’s deductible or be paid as a diagnostic procedure at the contract rate.

Natural Blue™ and Member Discounts

Natural Blue™ is a discount program available to State Health Plan subscribers and offered by BCBSSC. The program has a network of licensed acupuncturists, massage therapists and fitness clubs that may be used at lower fees, often as much as a 25 percent discount. Natural Blue also offers discounts on health products, such as vitamins, herbal supplements, books and tapes.

Like Natural Blue, Member Discounts offers savings on other products and services that BCBSSC makes available but that are not State Health Plan benefits. Companion Global Healthcare, for example, assists with providing lower-cost medical care in countries ranging from Costa Rica to Ireland to Thailand. All care

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Health Insurance is offered at facilities accredited by the Joint Commission International. Members also may be able to save money on major dental work through Companion Global Dental. For more information, call 800-906-7065 or go to www.companionglobalhealthcare.com.

Member Discounts include:

- Discount network
- TruHearing Digital Hearing Aids
- Walking Works®
- Vision One EyeCare Program
- Allergy relief
- Doctors Wellness Center
- Fitness centers
- My Gym Children’s Fitness Center
- Vitamins and supplements
- Bosley Hair Restoration
- Cosmetic and restorative dentistry
- Cosmetic surgery
- Jenny Craig
- Blue 365
- Healthy products

Members may use their Medical Spending Account (MSA) funds tax free for contacts, eyeglasses, hearing aids and many other services. For more information, see IRS Publication 969, “Health Savings Accounts and Other Tax-Favored Health Plans.” It is available on the IRS website, www.irs.gov.

For more information on Natural Blue or Member Discounts, go to the PEBA Insurance Benefits website, www.eip.sc.gov. Click on “Links” in the top menu bar and, under State Health Plan, select “Member Discounts.” You also may call BCBSSC Customer Service at 800-868-2520.

### Prescription Drug Benefits – 855-901-7322 (PEBA)

#### Prescription Plans Available

<table>
<thead>
<tr>
<th>Active employees, Retirees not eligible for Medicare</th>
<th>Medicare subscribers</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Health Plan Prescription Drug Program</td>
<td>State Health Plan</td>
</tr>
<tr>
<td>State Health Plan Prescription Drug Program</td>
<td>Medicare Prescription</td>
</tr>
<tr>
<td>Standard Plan: pay copayments up to $2,500 maximum</td>
<td>Drug Program</td>
</tr>
<tr>
<td>Savings Plan: allowed amount for drugs applies to annual deductible</td>
<td>Advantages:</td>
</tr>
<tr>
<td></td>
<td>● May use discount cards, coupons</td>
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<td>● TRICARE members may join</td>
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<td>● No IRMAA adjustment for high-income subscribers</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered family members who are not eligible for Medicare are covered under the Standard Plan.</td>
<td></td>
</tr>
</tbody>
</table>
**State Health Plan Prescription Drug Program**

Prescription drugs are a major benefit to you and a major part of the cost of our self-insured health plan. Using generic drugs saves you and the plan money. You also can save money, and receive the same FDA-approved drugs, when you refill prescriptions through the plan’s mail-order prescription service. **Remember: Benefits are paid only for prescriptions filled at network pharmacies or through the mail-order pharmacy in the U.S.** Limited coverage is offered outside the U.S. For more information, see page 228.

Prescription drugs, including insulin or other self-injectable drugs (drugs administered at home), are covered subject to plan exclusions and limitations, provided you use a participating pharmacy. Drugs in FDA Phase I, II or III testing are not covered. Prescription drugs associated with infertility treatments have a different coinsurance rate. See page 70 for more information.

**Please note:** You will receive two pharmacy benefits cards from Catamaran, the State Health Plan pharmacy benefits manager. Please present your card when you fill a prescription, particularly the first time you use your card, and any time you fill a prescription at a different pharmacy.

**Standard Plan**

Under the Standard Plan, you show your pharmacy benefits card the first time you purchase a prescription from a participating retail pharmacy and pay a copayment. Copayments are $9 for Tier 1 (generic – lowest cost), $38 for Tier 2 (brand – higher cost) or $63 for Tier 3 (brand – highest cost) for up to a 31-day supply.

The *prescription drug copayment* is a fixed total amount a subscriber must pay for a covered drug. The insurance plan pays the cost beyond the copayment, up to the allowed amount.

**Prescription drug benefits are payable without an annual deductible.** There are no claims to file.

The prescription drug benefit has a separate annual copayment maximum of $2,500 per person. This means that after you spend $2,500 in prescription drug copayments, the plan will pay 100 percent of the allowed amount for your covered prescription drugs for the rest of the year. Drug expenses do not count toward your medical annual deductible or coinsurance maximum.

**Savings Plan**

Under the Savings Plan, you show your pharmacy benefits card the first time you purchase a prescription from a participating retail pharmacy. There are no copayments under the Savings Plan. You pay the full allowed amount for your prescription drugs, and a record of your payment is transmitted electronically to BCBSSC.

- If you have not met your annual deductible, the full allowed amount for the drug will be credited to it.
- If you have met your annual deductible, you will still pay the full allowed amount for the drug. However, BCBSSC will reimburse you for 80 percent of the drug’s allowed amount. The remaining 20 percent of the allowed amount will be credited to your coinsurance maximum.

Nonsedating antihistamines and drugs for erectile dysfunction are not covered under the Savings Plan.

**State Health Plan Medicare Prescription Drug Program**

If you are enrolled in the State Health Plan as an **active employee**, there are no changes in your prescription drug coverage when you or your covered dependents become eligible for Medicare. PEBA

www.eip.sc.gov  
S.C. Public Employee Benefit Authority  
79
automatically enrolls Medicare-eligible retirees and their Medicare-eligible dependents in the SHP Medicare Prescription Drug Program. However, they have the option to switch back to the SHP Prescription Drug Program, which covers members who are not eligible for Medicare. For information about the SHP Medicare Prescription Drug Program, see pages 200-201.

**Features of the Prescription Drug Program**

**Find Pharmacy Information Online**

Catamaran offers several tools that may help you and your doctor make more economical decisions about your long-term prescriptions. After you log in at myCatamaranRx.com you can search for the medications you take, learn what you will pay for them and find out how much you could save by using lower-cost alternatives available under your plan. Your options could include generic drugs, less expensive brand-name drugs or the use of Catamaran Home Delivery for long-term prescriptions. Remember, no prescription will ever be changed without your doctor’s approval.

**For Members on the Go**

The Catamaran Mobile App provides easy access to your prescription drug information. With the mobile app, you can:

- Show your doctor which drugs you are taking
- Pull up your medication history
- Shop around for the best price on your prescription
- Compare copayments at retail pharmacies and mail order before you fill your prescription
- Find the pharmacy you want quickly and easily
- Get directions to network pharmacies and find a nearby 24-hour retail pharmacy.

**Step Therapy Program**

This program is designed to encourage use of generics and over-the-counter drugs that are alternatives to some high-volume, high-priced brand-name drugs. For example, omeprazole is a less expensive alternative to Aciphex.

If you or your doctor thinks you should not use the lower-cost drug, your prescription may require preauthorization or it may be covered at the Tier 3 (highest cost) rate. You or your doctor may request a coverage review by calling Catamaran. As part of the process, you may be required to have tried and failed to successfully use the lower-cost drug. If as a result of the review, the drug is approved, it will be covered at the appropriate tier. If approval is denied, your health plan will not cover the drug.

For more information, call Catamaran at 855-901-PEBA (7322).

**Tiers Determine Prescription Drug Cost**

Members covered under the Standard Plan and the SHP Medicare Prescription Drug Program pay copayments for drugs.

**Tier 1 (Generic — $9 copayment)**

Generic drugs may differ in color, size or shape, but the FDA requires that the active ingredients be the chemical equivalent of the brand-name alternative and have the same strength, purity and quality. Because generic drugs have a lower copayment, you typically get the same health benefits for less.

You may wish to ask your doctor to mark “substitution permitted” on your prescription. If he does not, your pharmacist will have no choice but to give you the brand-name drug, if that is the drug your doctor wrote on the prescription.
Tier 2 (Brand — $38 copayment)
These are drugs Catamaran’s Pharmacy and Therapeutics Committee has determined to be safe, effective and available at a lower cost than Tier 3 drugs. The list may be updated during the year. It is available online at www.myCatamaranRx.com. You may reach the Catamaran website through the PEBA Insurance Benefits website by clicking on “Links” and then “Prescription Drugs (Catamaran).”

Tier 3 (Brand — $63 copayment)
These medications carry a higher copayment or higher price. Tier 3 contains drugs that may be considered preferred or nonpreferred on the formulary, the list of prescription drugs approved by your plan.

Pay-the-Difference Policy
Under the State Health Plan, there is a “pay-the-difference” policy. If you purchase a brand-name drug when an FDA-approved generic equivalent is available, the payment will be limited to what the plan would have paid for the generic equivalent. This policy will apply even if the doctor prescribes the drug as “Dispense as Written” or “Do Not Substitute.”

Under the Standard Plan and the Medicare Supplemental Plan* if you purchase a Tier 2 or Tier 3 (brand) drug over a Tier 1 (generic) drug, you will be charged the generic copayment, PLUS the difference between the allowed amounts for the brand drug and the generic drug. If the total amount is less than the Tier 2 or Tier 3 (brand) copayment, you will pay the brand copayment.

*The pay-the-difference policy does not apply to members covered by the State Health Plan Medicare Prescription Drug Program.

Please note: Only the copayment for the Tier 1 (generic) drug will apply toward a member’s annual prescription drug copayment maximum.

The examples below show how pay-the-difference works under the Standard Plan and, if you are covered under the SHP Prescription Drug Program, the Medicare Supplemental Plan:

This is what you pay for a Tier 2 (brand) drug when a Tier 1 (generic) drug is not available.

<table>
<thead>
<tr>
<th></th>
<th>Tier 1 (generic)</th>
<th>Tier 2 (brand)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allowed amount for the drug</td>
<td>N/A</td>
<td>$125</td>
</tr>
<tr>
<td>Generic copayment</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Amount you pay</td>
<td>N/A</td>
<td>$38</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(the brand copayment only)</td>
</tr>
</tbody>
</table>

This is what you pay when a Tier 1 (generic) drug is available and you choose the Tier 2 (brand) drug.

<table>
<thead>
<tr>
<th></th>
<th>Tier 1 (generic)</th>
<th>Tier 2 (brand)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allowed amount for the drug</td>
<td>$65</td>
<td>$125</td>
</tr>
<tr>
<td>Generic copayment</td>
<td>$9</td>
<td>N/A</td>
</tr>
<tr>
<td>Amount you would have paid had you chosen the generic drug</td>
<td>$9</td>
<td>$69</td>
</tr>
<tr>
<td></td>
<td>(the generic copayment only)</td>
<td>(The generic copayment [$9] plus the difference between the allowed amount for the generic drug and the brand drug [$60])</td>
</tr>
<tr>
<td>Amount you pay because you chose the brand drug</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Insurance Benefits Guide

Under the Savings Plan, if you purchase a Tier 2 or Tier 3 (brand) drug over a Tier 1 (generic) drug, only the allowed amount for the generic drug will apply toward your deductible. After you have met your deductible, only the patient’s 20 percent share of the allowed amount for the generic drug will apply toward your coinsurance maximum.

If you are taking a Tier 2 or Tier 3 drug, you may wish to ask your doctor about using a generic drug, if one is available. If appropriate, the doctor may note on the prescription that substitution is permitted.

Compound Prescriptions

A compound prescription is a medication that requires a pharmacist to mix two or more drugs, based on a doctor’s prescription, when such a medication is not available from a manufacturer. It must be purchased from a participating pharmacy. Prior authorization is required of any compound prescription costing $500 or more.

If a network pharmacy does not file your claim, you must pay the entire cost of the prescription and then submit a claim to Catamaran. Information on how to file a claim to Catamaran is on page 228. Claims must be accompanied by an itemized list of the ingredients. Ask your pharmacist to provide you with this list when you fill your prescription. Please be sure it includes:

- The name of each ingredient
- The valid National Drug Code (NDC) for each ingredient
- The quantity of each ingredient.

This information allows Catamaran to process your claim based on the actual ingredients in the medication.

When you file your own claim, your reimbursement may be less than what you paid for the drug because it will be limited to the plan’s allowed amount minus the copayment for the actual ingredients in the compound prescription. Prescriptions filled at out-of-network pharmacies will not be reimbursed.

Some compound drugs may be available through the mail-order pharmacy. Please contact Catamaran to see if they are available before ordering.

Prior Authorization

Some medications will be covered by the plan only if they are prescribed for certain uses. These drugs must be authorized in advance, or they will not be covered under the plan. If the prescribed medication requires prior authorization, you, your doctor or your pharmacist may begin the review process by contacting Catamaran at 855-901-PEBA (7322).

Retail Pharmacies

You must use a participating pharmacy, and you must show your health plan identification card when purchasing medications. The State Health Plan uses Catamaran’s national pharmacy network. Most major pharmacy chains and independent pharmacies participate in this network. If you are enrolled in the State Health Plan, you may get a list of network pharmacies through the PEBA Insurance Benefits website, www.eip.sc.gov, by selecting “Online Directories” and then “State Health Plan Pharmacy Locator.” You will need to register and sign in. You may also get a list of network pharmacies from your benefits administrator.

Retail Maintenance Network

If you are enrolled in the SHP Prescription Drug Program or the SHP Medicare Prescription Drug Program, you may buy up to 90-day supplies of prescription drugs at mail-order prices at local pharmacies belonging to the Retail Maintenance Network. You pay the same copayment as you would pay through mail order. The discount applies only to prescriptions filled for a 63-90 day supply. Copayments
for prescriptions filled for a 0-62 day supply at these retail pharmacies remain the same. The copayments also remain the same at all other network pharmacies. A list of the pharmacies is on the PEBA Insurance Benefits website, www.eip.sc.gov, under “Online Directories.” If you do not have Internet access, ask your benefits administrator to print the list for you. For more information, call Catamaran at 855-901-PEBA (7322).

Mail-Order: A Way to Save Time and Money

The SHP Prescription Drug Program and the Medicare Prescription Drug Program offer home delivery for 90-day supplies of prescriptions. By using this service, you receive a discount on the same FDA-approved prescription drugs that you would buy at a retail pharmacy. Mail order is an ideal option for anyone with a recurring prescription, such as birth control medicine, or a chronic condition, such as asthma, high cholesterol or high blood pressure. Some controlled substances may not be available by mail. Please call Catamaran before submitting your prescription.

Please be sure your physician writes your prescription for a 90-day supply. If you have any questions before you order a 90-day supply of a drug, call Catamaran at 855-901-PEBA (7322).

Standard Plan and the Medicare Supplemental Plan

The copayments for up to a 90-day supply are:
- Tier 1 (generic) – $22
- Tier 2 (brand) – $95
- Tier 3 (brand) – $158

Savings Plan

You pay the full allowed amount when you order prescription drugs through the mail. However, that cost for a 90-day supply will typically be less than you would pay at a retail pharmacy.

How to Order Drugs by Mail

This is how Catamaran’s home delivery service works:
- Ask your physician to write two prescriptions: one for a single 31-day supply and one for a 90-day supply with refills.
- Fill your prescription for the 31-day supply at a network retail pharmacy.
- Complete a home delivery prescription form and mail it to Catamaran Home Delivery. Order forms are available through the PEBA Insurance Benefits website, www.eip.sc.gov, under "Forms." On Catamaran’s website, www.myCatamaranRx.com, select “More Info” and then "Forms/Documents." An order form also will be included in your welcome packet.
- Your mail order prescription(s) will be sent to your home, typically within 10-14 business days. Meanwhile, use your prescription from the network retail pharmacy.

Once the initial prescription has been entered and filled, you may order refills online or by phone using Catamaran’s toll-free number: 855-901-PEBA (7322).

If you want to save money by ordering a 90-day supply by mail, be sure to ask your doctor to write a prescription for a **90-day supply with refills**. Under the **Savings Plan**, you can buy less than a 90-day supply.

Coordination of Benefits

The State Health Plan coordinates prescription drug benefits, as well as medical benefits. This ensures that if you are covered by more than one health plan, both plans pay their share of the cost of your care. See pages 20 and 54 for more information.
Exclusions

Some prescription drugs are not covered under the plan. See page 72 for more information.

Mental Health and Substance Abuse Benefits

For Customer Service and Claims – 800-868-2520

For customer service and information about claims for mental health and/or substance abuse care, call BlueCross BlueShield of South Carolina (BCBSSC).

How Are Mental Health/Substance Abuse Claims Filed?

Claims for mental health and substance abuse are subject to the same copayments, deductibles, coinsurance and coinsurance maximums as medical claims. There is no limit on the number of provider visits allowed as long as the care is medically necessary under the terms of the plan. There is not a separate annual and lifetime maximum for mental health and substance abuse benefits.

If you use a network provider, the provider is responsible for submitting claims for services. If you receive care from a provider who is not a member of the network, see page 228 for information about how to file a claim. Your mental health and substance abuse provider will be required to conduct periodic medical necessity reviews (similar to Medi-Call for medical benefits).

The Mental Health/Substance Abuse Provider Network

Medically necessary mental health and substance abuse services are covered when rendered by network and out-of-network providers. Just like benefits for medical services, a higher percentage of the cost of your care is covered if you use network services.

The most up-to-date list of providers is on the state BCBSSC website. Under “Online Directories” on the PEBA Insurance Benefits website, select “State Health Plan Doctor/Hospital Finder.” To see a printable directory of network providers in South Carolina and surrounding counties in Georgia and North Carolina, select “Mental health/substance abuse (Companion Benefit Alternatives)” under “Links.” This will take you to CompanionBenefitAlternatives.com where you can select “Members.” Under “Find a Provider,” select “Network Directory.” To learn more about how to use these directories, see page 55-57.

Paper copies of lists of providers from the directory are available from your benefits office or, if you are a retiree, survivor or COBRA subscriber, from BCBSSC. If you have questions about these or other network providers, call BCBSSC. Remember, if you use an out-of-network provider, you will pay more.

For Preauthorization and Case Management – 800-868-1032

Preauthorization and case management of mental health and substance abuse benefits are handled by Companion Benefit Alternatives (CBA). CBA is the mental health/substance abuse benefit manager and a wholly owned subsidiary of BCBSSC.

Office visits to a mental health or substance abuse provider, such as a psychologist, a clinical social worker or a professional counselor, do not require preauthorization except for the services listed below.

These services must be preauthorized by CBA:

- Inpatient Hospital Care
- Intensive Outpatient Hospital Care
- Partial Hospitalization Care
• Outpatient Electroconvulsive Therapy (ECT) – Hospital and Physician Services  
• Repetitive Transcranial Magnetic Therapy (rTMS)  
• Applied Behavior Analysis Therapy (ABA)  
• Psychological/Neuropsychological Testing.

To preauthorize services, your provider must call CBA at 800-868-1032 before you are admitted or, in an emergency situation, within 48 hours or the next working day. For professional services listed above, your provider must call before services are rendered. To assess medical necessity, CBA will require clinical information from the mental health or substance abuse provider currently treating you. Although your provider may make the call for you, it is your responsibility to see that the call is made and the preauthorization has been granted. A determination by CBA does not guarantee payment. Other conditions, including eligibility requirements, other limitations and exclusions, payment of deductibles and other provisions of the plan must be satisfied before BCBSSC makes payment.

What are the Penalties for not Calling CBA for Preauthorization?

Mental Health Professional Services
If mental health and substance abuse outpatient services that require preauthorization, (Applied Behavior Analysis Therapy and Psychological/Neuropsychological Testing) are not preauthorized, they will not be covered.

Facility Services
If your provider does not call CBA when required, you will pay a $200 penalty for each hospital admission. In addition, the coinsurance maximum will not apply. You will continue to pay your coinsurance, no matter how much you pay out-of-pocket.

Case Management
Case management is designed to support members with catastrophic or chronic illness. Participants are assigned a case manager, who will help educate them on the options and services available to meet their mental health and substance abuse needs and assist in coordinating needed services.

Case managers are licensed nurses and social workers. They assist members by answering questions and helping them get the most out of their mental health, medical and pharmacy benefits. This may include care planning, patient/family education, benefits review and coordinating other services and community resources. Covered members enrolled in this program receive access to a personal case manager, educational resources and web tools that help them learn more about their health and how they can better manage their condition. Participation is voluntary and confidential.

Quit For Life® Program

The research-based Quit For Life® Program is brought to you by the American Cancer Society® and Alere Wellbeing. It is available at no charge to State Health Plan subscribers, their covered spouses and covered dependents age 13 or older.

One of the most successful programs of its kind, the Quit For Life Program helps participants stop using cigarettes, cigars, pipes and smokeless tobacco. A professionally trained Quit Coach® works with each participant to create a personalized quit plan. As part of the 12-month program, participants receive a complete Quit Guide and five telephone calls from a Quit Coach. Participants may call the toll-free support line as often as they wish. For members age 18 and older, the program also provides free nicotine replacement therapy, such as patches, gum or lozenges, if appropriate. Your Quit Coach may also recommend that your doctor prescribe a smoking cessation drug, such as bupropion or Chantix, which is available through your prescription drug coverage.

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Registration is available 24 hours a day, seven days a week, and coaches are available from 8 a.m. to 3 a.m., ET, seven days a week. If the participant still needs help after the 12-month program ends, he may re-enroll.

Call 866-QUIT-4-LIFE (866-784-8454) or visit www.quitnow.net/ScStatehealthPlan to enroll in the Quit For Life Program. After your eligibility is verified, you will be transferred to a Quit Coach for your first call. You may also go to the PEBA Insurance Benefits website and select “Tobacco Information” then “Tobacco Cessation” and then “State Health Plan Quit for Life Program.”

Exclusions: Services Not Covered

There are some medical expenses the State Health Plan does not cover. The Plan of Benefits (available in your benefits office or through PEBA Insurance Benefits) contains a complete list of the exclusions.

1. Services or supplies that are not medically necessary under the terms of the plan
2. Routine procedures not related to the treatment of injury or illness, except for those specifically listed under the Preventive Benefits section
3. Routine physical exams, checkups (except Well Child Care and Preventive Benefits according to guidelines), services, surgery (including cosmetic surgery) or supplies that are not medically necessary. (The Savings Plan covers an annual physical by a network physician for each participant age 19 and older.)
4. Routine prostate exams, screenings or related services are not covered under the plan. (A diagnostic prostate exam may be covered when medically necessary but not as part of the Savings Plan annual physical exam. The diagnostic exam will be subject to the State Health Plan’s usual deductibles and coinsurance.)
5. Routine PSA (Prostate-Specific Antigen) tests
6. Diabetic education and training are not covered
7. Eyeglasses
8. Contact lenses, unless medically necessary after cataract surgery and for the treatment of keratoconus, a corneal disease affecting vision
9. Routine eye examinations
10. Refractive surgery, such as radial keratotomy, laser-assisted in situ keratomileusis (LASIK) vision correction, and other procedures to alter the refractive properties of the cornea
11. Hearing aids and examinations for fitting them
12. Dental services, except for removing impacted teeth or treatment within one year of a condition resulting from an accident
13. TMJ splints, braces, guards, etc. (Medically necessary surgery for TMJ is covered if preauthorized by Medi-Call.) TMJ, temporomandibular joint syndrome, is often characterized by headache, facial pain and jaw tenderness caused by irregularities in the way joints, ligaments and muscles in the jaws work together.
14. Custodial care, including sitters and companions or homemakers/caretakers
15. Admissions or portions thereof for custodial care or long-term care, including:
   • Respite care
   • Long-term acute or chronic psychiatric care
   • Care to assist a member in the performance of activities of daily living, i.e. custodial care (including, but not limited to: walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation and taking medication)
   • Psychiatric or substance abuse long-term care, including: therapeutic schools, wilderness/boot camps, therapeutic boarding homes, half-way houses and therapeutic group homes
16. Any item that may be purchased over the counter, including but not limited to, medicines and contraceptive devices
17. Services related to a vasectomy or tubal ligation performed within one year of enrollment
Health Insurance

2015 Insurance Benefits Guide

18. Surgery to reverse a vasectomy or tubal ligation
19. Diagnosis or treatment of infertility for a subscriber or a spouse if either member has had a tubal ligation or vasectomy
20. Assisted reproductive technologies (fertility treatment) except as noted on pages 63-64 of this chapter
21. Diet treatments and all weight loss surgery, including, but not limited to: gastric bypass, gastric banding or stapling; intestinal bypass and any related procedures; the reversal of such procedures; and conditions and complications as a result of such procedures or treatment
22. Equipment that has a nontherapeutic use (such as humidifiers, air conditioners, whirlpools, wigs, artificial hair replacement, vacuum cleaners, home and vehicle modifications, fitness supplies, speech augmentation or communication devices, including computers, etc.), regardless of whether the equipment is related to a medical condition or prescribed by a physician
23. Air quality or mold tests
24. Supplies used for participation in athletics (that are not necessary for activities of daily living), including but not limited to, splints or braces
25. Physician charges for medicine, drugs, appliances, supplies, blood and blood derivatives, unless approved by Medi-Call
26. Medical care by a doctor on the same day or during the same hospital stay in which you have surgery, unless a medical specialist is needed for a condition the surgeon could not treat
27. Physician’s charges for clinical pathology, defined as services for reading any machine-generated reports or mechanical laboratory tests. Interpretation of these tests is included in the allowance for the lab service.
28. Fees for medical records and claims filing
29. Food supplements, including but not limited to, formula, enteral nutrition, Boost/Ensure or related supplements
30. Services performed by members of the insured’s immediate family
31. Acupuncture
32. Chronic pain management programs
33. Transcutaneous (through the skin) electrical nerve stimulation (TENS), whose primary purpose is the treatment of pain
34. Biofeedback when related to psychological services
35. Complications arising from the receipt of noncovered services
36. Psychological tests to determine job, occupational or school placement or for educational purposes; milieu therapy; or to determine learning disability
37. Any service or supply for which a covered person is entitled to payment or benefits pursuant to federal or state law (except Medicaid), such as benefits payable under workers’ compensation laws
38. Charges for treatment of illness or injury or complications caused by acts of war or military service, injuries received by participating in a riot, insurrection, felony or any illegal occupation (job)
39. Intentionally self-inflicted injury that does not result from a medical condition or domestic violence
40. Cosmetic goods, procedures or surgery or complications resulting from such procedures or services
41. Smoking cessation or deterrence products or services, with the exception of provisions established under the Prescription Drug Program or as authorized by the behavioral health manager for eligible participants in its tobacco cessation program.
42. Sclerotherapy (treatment of varicose veins), including injections of sclerosing solutions for varicose veins of the leg, unless a prior-approved ligation (tying off of a blood vessel) or stripping procedure has been performed within three years and documentation submitted to Medi-Call with a preauthorization request establishes that some varicosities (twisted veins) remained after the procedure
43. Services performed by service or therapy animals or their handlers
44. Abortions, except for an abortion performed in accordance with federal Medicaid guidelines
45. Pregnancy of a covered child
46. Storage of blood or blood plasma
47. Experimental or investigational surgery or medical procedures, supplies, devices or drugs. Any surgical or medical procedures determined by the medical staff of the third-party claims processor, with appropriate consultation, to be experimental or investigational or not accepted medical practice.

www.eip.sc.gov  S.C. Public Employee Benefit Authority  87
Experimental or investigational procedures are those medical or surgical procedures, supplies, devices or drugs, which at the time provided, or sought to be provided:

- Are not recognized as conforming to accepted medical practice in the relevant medical specialty or field of medicine; or
- The procedures, drugs or devices have not received final approval to market from appropriate government bodies; or
- Are those about which the peer-reviewed medical literature does not permit conclusions concerning their effect on health outcomes; or
- Are not demonstrated to be as beneficial as established alternatives; or
- Have not been demonstrated, to a statistically significant level, to improve the net health outcomes; or
- Are those in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting.

**Additional Limits under the Standard Plan**

- Chiropractic benefits under the Standard Plan are limited to $2,000 per person per year.
- Chiropractic benefits for Manual Therapy are limited to one per visit per person.

**Additional Limits and Exclusions under the Savings Plan**

- Chiropractic benefits under the Savings Plan are limited to $500 per covered person per year.
- Chiropractic benefits for Manual Therapy are limited to one per visit per person.
- Nonsedating antihistamines and drugs for treating erectile dysfunction are not covered under the Savings Plan.

**Helpful Information May be Found on the Internet**

**Website: StateSC.SouthCarolinaBlues.com**

BlueCross BlueShield of South Carolina has a website designed to give State Health Plan subscribers quick access to information about their plan. You can go directly to the site or go to the PEBA Insurance Benefits website, www.eip.sc.gov, and click on “Links.” Under State Health Plan,” choose “Medical (BlueCross BlueShield of South Carolina).”

**On the site, you will find direct links to:**

- The 2015 Insurance Benefits Guide
- Frequently used forms and publications
- A program for finding network doctors, dentists, hospitals and other providers
- Information about the Wellness Incentive Program, including how to enroll, which generic drugs are covered by the waiver and frequently asked questions.

**You will also find the login for MyHealth Toolkit.**

You must register and then log in to use MyHealth Toolkit. Once you do, you can do a variety of things, including:

- See how much of your deductible and coinsurance maximum you have satisfied
- Check the status of claims, preauthorizations and bills
- Review Information about your dental benefits, including a claims summary and how to get a pretreatment estimate
- Choose to view your Explanation of Benefits (EOB) online rather than receiving a paper copy in the
mail. You will be notified by email when an EOB is ready.

- Request an ID card
- Create a Personal Health Record
- Take a Personal Health Assessment
- Enroll in the “Coming Attractions” maternity program
- Ask Customer Service a question.

**Website: [www.CompanionBenefitAlternatives.com](http://www.CompanionBenefitAlternatives.com)**

The Companion Benefit Alternatives (CBA) website offers a variety of ways to learn more about mental health and health in general. Go to the PEBA Insurance Benefits website, [www.eip.sc.gov](http://www.eip.sc.gov), and click on “Links.” Under “State Health Plan,” you can choose “Mental health/substance abuse (Companion Benefit Alternatives).” At the CBA website select “Members.” You can sign up for an email newsletter. Other tools include:

- A description of CBA’s case management program
- A printable provider directory
- Links to other resources, including phone numbers for financial assistance hot lines.

CBA offers Beating the Blues™, an online therapy program, at no charge to members covered by the State Health Plan. The program is designed to teach skills that help relieve stress, depression and anxiety. For more information, go to [www.u2interactive.com](http://www.u2interactive.com) or the CBA website or call CBA at 800-868-1032.

**Appeals**

The Public Employee Benefit Authority (PEBA) Insurance Benefits contracts with third-party claims processors, BlueCross BlueShield of South Carolina (BCBSSC) and Catamaran, to handle claims for State Health Plan benefits, and Companion Benefit Alternatives (CBA), to manage mental health and substance abuse benefits. A subscriber has the right to appeal their decisions.

If all or part of a request for preauthorization or a claim for benefits is denied, the subscriber will be informed of the decision promptly and told why it was made. If he has questions about the decision, he should check the information in this book, or call the third-party claims processor that made the decision for an explanation.

**Appeals to Third-party Claims Processors**

**First-level Appeals: Preauthorizations and Claims**

A subscriber may appeal an initial denial of a preauthorization (to Medi-Call) or a claim (to BCBSSC) within 180 days of the decision. If a subscriber would like for someone else to appeal on his behalf, he may make this request in writing.

Please include in the appeal:

- The subscriber’s health identification number, ZCS followed by his eight-digit Benefits Identification Number (BIN)
- The subscriber’s name and date of birth
- A copy of the decision being appealed
- The claim number of the services being appealed, if applicable. (This is on the subscriber’s Explanation of Benefits.)
- A copy of medical records that support the appeal and
- Any other information or documents that support the appeal.
Appeal rights and instructions for an appeal are outlined in the denial letter.

**Please note:** Procedures to appeal preauthorization decisions by National Imaging Associates (NIA) are different from other appeal procedures.

If NIA denies a procedure on the grounds that it is not medically necessary, the subscriber has three days to file an appeal with NIA if the services have not been received. If three days have passed, the subscriber may request Medi-Call review the decision.

### Appeals to PEBA – Preauthorizations and Services That Have Been Provided

If a subscriber is still dissatisfied after the decision is re-examined, he may request a second-level appeal by writing to PEBA Insurance Benefits within 90 days of notice of the denial. Please include a copy of the denial with the appeal. Appeals are processed in the order in which they are received. If the denial is upheld by the PEBA Insurance Benefits Health Appeals Committee, the subscriber has 30 days to seek judicial review as provided by Sections 1-11-710 and 1-23-380 of the S.C. Code of Laws, as amended.

**Please note:** A provider may not appeal to PEBA Insurance Benefits, even if it appealed the decision to the third-party claims processor. Only a subscriber or his authorized representative may initiate an appeal through PEBA Insurance Benefits. A provider may not be an authorized representative.

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Please note: Effective Jan. 1, 2015, BlueChoice HealthPlan, a health maintenance organization, is no longer offered to members covered by PEBA Insurance Benefits. If you were formerly covered by BlueChoice and have any questions related to it, call Member Services at 803-786-8476 (Columbia area) or 800-868-2528 (toll-free outside the Columbia area).
AMRA TRICARE Supplement Plan

TRICARE is the Department of Defense health benefit program for the military community. It consists of TRICARE Prime, an HMO; TRICARE Extra, a preferred-provider option; and TRICARE Standard, a fee-for-service plan.

The TRICARE Supplement Plan is secondary coverage to TRICARE. It pays the subscriber’s share of covered medical expenses under the TRICARE Prime (in-network), Extra and Standard options. Eligible participants have almost 100 percent coverage. Underwritten by Monumental Life Insurance Company, the plan is administered by Selman & Company/ASI. Federal law requires that the plan be sponsored by an association, not an employer. The plan sponsor is the American Military Retirees Association (AMRA).

The TRICARE Supplement Plan is designed for TRICARE-eligible active employees and retired employees until they become eligible for TRICARE for Life, a Medicare supplement. It is an alternative to the State Health Plan (SHP).

Eligibility

PEBA Insurance Benefits does not confirm eligibility for the TRICARE Supplement Plan. Eligible individuals must be registered with the Defense Enrollment Eligibility Reporting System (DEERS) and must not be eligible for Medicare. A subscriber must drop his State Health Plan coverage to enroll in the TRICARE Supplement Plan.

An individual who is unsure if he is eligible for TRICARE should confirm eligibility with DEERS before enrolling in the TRICARE Supplement. If a dependent's Military ID card has expired or if information has changed (i.e., address corrections), call DEERS at 800-538-9552.

The TRICARE Supplement Plan is available to:

Eligible employees, retirees and survivor subscribers and spouses who are under age 65 and not eligible for Medicare:
• Military retirees receiving retired, retainer or equivalent pay
• Spouse/surviving spouse of a military retiree
• Retired reservists between the ages of 60 and 65 and spouses/surviving spouses of retired reservists
• Retired reservists younger than 60 and enrolled in TRICARE Retired Reserve (TRR) (“Gray Area” retirees) and spouses/surviving spouses of retired reservists enrolled in TRR.

Please note: There are limited exceptions to the Age 65 Eligibility Rule. Contact Selman & Company/ASI for more information.

A subscriber may cover his eligible dependent children. However, dependent eligibility for the TRICARE Supplement Plan is based on TRICARE eligibility rules and is different from PEBA Insurance Benefits’ dependent eligibility rules.

Eligible dependent children
• Unmarried dependent children up to age 21, or, if the child is a full-time student, up to age 23. Documentation that a child, age 21-22, is a full-time student must be provided to TRICARE.
• Incapacitated dependents are covered after age 21, 23 or 26, if the child is dependent on the member for primary support and maintenance and is still eligible for TRICARE. Proof of continued incapacity and dependency is required. Documentation must be provided to TRICARE.
• Adult dependent children who are younger than 26 and who are enrolled in TRICARE Young Adult (TYA). The child must send a copy of his TYA Enrollment ID card to Selman & Company/ASI.
For more information about eligibility, contact TRICARE or Selman & Company/ASI.

How to Enroll

Individuals who are eligible for TRICARE and eligible for coverage under the South Carolina state health insurance program can enroll themselves and their eligible dependents within 31 days of the date they are hired or become eligible for TRICARE. They also can enroll during open enrollment, which is offered yearly in October. If they enroll during open enrollment, coverage becomes effective on Jan. 1.

To enroll:
1. Membership in AMRA is required for enrollment in the TRICARE Supplement Plan. Information about AMRA is provided in the TRICARE Supplement Plan welcome packet. Dues are included in the plan’s monthly premium. For more information, contact AMRA at 800-424-2969 or info@amra1973.org.
2. Complete a Notice of Election (NOE) form, and check TRICARE Supplement Plan under the health plan section. Return the NOE to your benefits administrator along with a copy of your military ID or TRICARE ID card. Also, a BA can enroll an active employee using EBS. A subscriber can enroll through MyBenefits during open enrollment. See page 21 for more information. A retired employee of a state agency, public school district or a higher education institution should submit an RNOE to PEBA Insurance Benefits. A local subdivision retiree should submit an RNOE to the benefits office at his former employer. See page 182 for more information. Coverage is not automatic.
3. Eligible subscribers should complete the Other Health Insurance (OHI) form if they were previously enrolled under the State Health Plan. The OHI form for each region is on the TRICARE website, www.tricare.mil. Fax the completed forms to TRICARE at the number on the form. Remember, the TRICARE Supplement Plan is not considered other health insurance.

Upon enrollment, a subscriber will receive a packet with his certificate of insurance, identification card, claim forms and instructions on how to file claims.

In addition to enrolling in the TRICARE Supplement Plan, during open enrollment eligible subscribers may drop TRICARE Supplement Plan coverage for themselves or their dependents. They also may add dependents. See page 21 for more information.

Plan Features

The TRICARE Supplement Plan provides subscribers with additional coverage, which, when combined with the other TRICARE coverage, usually pays 100 percent of the subscriber’s out-of-pocket expenses. Some of the plan’s features include:

• No deductibles, coinsurance or out-of-pocket expenses for covered services
• Subscribers may choose any TRICARE-authorized provider, including network, non-network, participating and nonparticipating providers. For more information, see the TRICARE Supplement Plan Member Handbook.
• Reimbursement of prescription drug copayments.

Premiums

The monthly premiums for the TRICARE Supplement Plan for active employees, retirees and survivors are:

<table>
<thead>
<tr>
<th>Membership Category</th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$62.50</td>
</tr>
<tr>
<td>Employee/spouse</td>
<td>$121.50</td>
</tr>
<tr>
<td>Employee/children</td>
<td>$121.50</td>
</tr>
<tr>
<td>Full family</td>
<td>$162.50</td>
</tr>
</tbody>
</table>

The premiums are paid entirely by the subscriber with no employer contribution. However, they may be
paid before taxes are deducted from the employee’s paycheck through the MoneyPlus Pretax Group Insurance Premium Feature.

Filing Claims

Most providers submit TRICARE Supplement Plan claims. If a provider does not, a subscriber may submit the claims to Selman & Company/ASI. Detailed information about filing doctor/hospital and pharmacy claims is in the TRICARE Supplement Plan Member Handbook and on the ASI website, www.asicorporation.com/SC. The claim form is in the welcome packet and on the website under “ASI Member Resources.”

Portability

The TRICARE Supplement Plan is portable. If a subscriber leaves his job, he can continue coverage by paying the premiums directly to Selman & Company/ASI.

Medicare Eligibility and the TRICARE Supplement Plan

When an active employee, survivor or retiree becomes eligible for Medicare Part A, he must purchase Medicare Part B to remain eligible for TRICARE. His TRICARE health benefit changes to TRICARE for Life, a Medicare supplement. TRICARE Supplement Plan coverage ends for him. He may continue the supplement plan coverage for his eligible dependents by making premium payments directly to Selman & Company/ASI. Contact Selman & Company/ASI for details.

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

Loss of TRICARE Eligibility

The TRICARE Supplement Plan pays after TRICARE pays. Therefore, if an employee, spouse or dependent child loses TRICARE eligibility, TRICARE Supplement Plan coverage ends. Dependents who lose TRICARE eligibility are not eligible for continued TRICARE Supplement Plan coverage under COBRA or on portability. Loss of TRICARE eligibility is a special eligibility situation that permits an eligible employee or retiree and his dependents, if the dependents are otherwise eligible for PEBA Insurance Benefits coverage, to enroll in health, dental and vision coverage. Basic Life Insurance and Basic Long Term Disability Insurance are provided free to active employees who enroll in the State Health Plan.

Loss of a spouse’s TRICARE eligibility

- A spouse may lose TRICARE eligibility due to a divorce. When this occurs, he also loses eligibility to continue coverage under the TRICARE Supplement Plan.

Loss of a dependent child’s TRICARE eligibility

- A dependent child loses TRICARE eligibility at age 21 if he is not enrolled in school on a full-time basis. A dependent also loses eligibility at midnight on his 23rd birthday, regardless of whether or not he is a full-time student, or on the date he graduates from college, whichever comes first.

- An adult dependent child enrolled in TRICARE Young Adult loses eligibility at midnight on the night of his 26th birthday or the date he fails to make full premiums payments to his TRICARE regional contractor.

For More Information

For more information about the AMRA TRICARE Supplement Plan, contact the Selman & Company/ASI Call Center at 866-637-9911 or by email at memberservices@selmanco.com or log on to www.asicorporation.com/SC. For more information about TRICARE for Life, call 866-773-0404 or go to www.tricare4u.com.