# 2022 Benefits Administrator Manual





# **Table of contents**

General information	12
How to use this manual	13
EBS	13
Contact PEBA	14
When you call PEBA on behalf of a subscriber	14
Requests for proof of insurance	14
Forms on the web	14
Training and resources	14
Using the online system	16
Terms	
Employee Benefits Services (EBS)	
Signing up	
EBS homepage	19
Manage Subscribers	19
Inquiry	19
Manage	20
Enrollment File Upload	24
Life Ins SOH	25
Manual transactions	25
Manage Groups	26
Enrollment reports	26
Accounting reports	26
Balance	26
Contacts	26
SLTD Salary Entry	26
Online Bill Pay	27
BA Console	28
Suspended tab	28
Acknowledgement tab	28
Approval tab	28
Current EBS tab	29
RFR (Request for Review) tab	29
Status	29

Tips	31
MyBenefits	31
Using MyBenefits	31
Making special eligibility changes	31
Making open enrollment changes	32
Active subscribers	33
Employee eligibility rules and procedures	36
Determining eligibility for benefits	36
Measurement periods	36
Administrative periods	37
Stability periods	38
Notes on employee eligibility	38
Procedures to elect 20-hour threshold	39
Assisting a benefits-eligible employee	39
Required information	39
Available benefits	39
Where to find more information	40
Refusal of coverage	40
Explain enrollment deadlines	41
Explain effective dates	41
Tobacco certification	41
MoneyPlus enrollment	42
Effect of MoneyPlus on other retirement plans	42
Review MoneyPlus features	43
Health Savings Account enrollment	45
GEA TRICARE Supplement Plan enrollment	46
Assisting a newly eligible variable-hour, part-time or seasonal employee	46
Assisting a permanent, part-time teacher	47
Process for medical emergencies	48
National Medical Support Notices	49
Rules and procedures for late entrants	50
Health plans	50
Dental	50
Vision care	50

Life insurance	50
Supplemental Long Term Disability	51
Changes in status and special eligibility situations	51
Gain of other group coverage	51
Gain of Medicare coverage	52
Gain of Medicaid coverage	52
Loss of other group coverage	53
Loss of TRICARE coverage	54
MoneyPlus change in status rules	54
Completing the enrollment for a change in status	55
Coverage changes for permanent, part-time teachers	55
Other coverage changes	56
Optional Life	56
Dependent Life	58
Supplemental Long Term Disability	59
MoneyPlus	59
Health Savings Accounts (HSAs)	59
Beneficiary changes	60
Open enrollment for active subscribers	60
Dental coverage	61
Open enrollment procedures and helpful hints	61
New employees or transfers hired October 2-December 31	61
Unpaid leave or reduction in hours	62
Employees with unpaid leave or reduction of hours	62
Premiums while on unpaid leave	63
SLTD and life insurance benefits while on unpaid leave	64
Continuing MoneyPlus while on unpaid leave	64
Continuing a Health Savings Account while on unpaid leave	65
Military leave	65
Family and Medical Leave Act (FMLA)	66
Workers' compensation	67
Affordable Care Act reporting requirements	68
Transfers and terminations	69
Assisting a transferring employee	71

Transferring out (losing employer)	71
Transferring in (gaining employer)	72
Transfers — new employer created or lateral transfer	75
Transfers — dual employment	75
Terminations	76
General rules for terminating active employees	76
Other termination information	77
Life insurance	77
Long term disability	77
MoneyPlus	77
Health Savings Account	78
Reinstating coverage after termination	78
Affordable Care Act reporting requirements	78
COBRA subscribers	79
What is COBRA?	81
Who is the COBRA administrator?	81
Required COBRA notices	81
Mailing requirements for all COBRA notices	81
Important note for National Medical Support Notices (NMSN)	82
Initial COBRA Notice	82
First required notice	82
60-day COBRA notification requirement for spouses and children	82
COBRA qualifying events and notices	82
Qualified beneficiaries	82
Second required notice	83
18-month COBRA qualifying events	84
Procedures for determining COBRA eligibility	85
COBRA election period	86
COBRA Termination Notice	86
Third required notice	86
Other coverage may end COBRA eligibility	86
Initial premium payment period	87
Administrative fee for optional employers	88
Benefit changes	88

COBRA procedures for the Medical Spending Account	88
Procedures at termination	88
Affordable Care Act reporting requirements	89
COBRA quick reference	89
Retiree subscribers	90
Requirements for retiree insurance	92
Assisting an eligible retiree	92
Retiree packet information	92
Administrative information	92
Important retirement information	93
Health insurance	93
Dental insurance	94
Vision insurance	94
Life insurance	94
Long term disability	95
MoneyPlus	95
Health Savings Account	96
Assisting a new retiree with enrollment	96
Completing the Retiree NOE	96
Changing coverage in retirement	96
Retiree returns to work	97
Life insurance	97
Medicare	97
Affordable Care Act reporting requirements	98
Survivors	
General rules about survivor coverage	101
If survivor was not covered at the time of subscriber's death	101
If survivor was covered at the time of subscriber's death	101
Assisting a survivor	101
If the deceased was an active employee subscriber	101
Procedures to continue coverage as a survivor	102
Premium waiver rules	102
Premiums	103
Which SSN/BIN to use for claims	

Optional Life benefits for survivors	104
When survivor coverage ends	104
Spouse	104
Gaining eligibility through participating employer	105
Children	105
Spouses and children	
Spouses: special eligibility requirements and changes in status	108
Both spouses employed by participating employers	108
Spouse is retiree subscriber	108
Marriage	108
Spouse of foreign national employee	109
Separated spouse	109
Former spouse/divorce	109
Death of covered spouse	110
Dependent Life-Spouse coverage	110
Eligibility requirements	110
Children: special eligibility requirements and changes in status	110
Child younger than age 26	111
Incapacitated child	115
Child in full-time military service	116
Child turns age 26	116
Dependent Life-Child coverage	116
Full-time students	116
Dependent Non-confinement Provision	117
Eligibility for MoneyPlus spending accounts	117
COBRA notification by subscriber required	117
Adoption Assistance Program	117
Adoption assistance is subject to taxes	118
Disability subscribers	119
Training	121
Workplace Possibilities	121
Eligibility	121
Applying for disability benefits	121
Assisting a disabled employee	122

Optional Life	
Basic Long Term Disability and Supplemental Long Term Disability	
MoneyPlus	
Claims and appeals	126
State Health Plan claims	
Tips for filing claims	
State Health Plan claims for services outside the U.S.	
Coordination of benefits	
Accident questionnaires	
Other health/dental questionnaire	129
Mental health and substance use claims	
Dental Plus and Basic Dental claims	130
Tips for filing claims	130
State Vision Plan claims	130
In-network claims	130
Out-of-network claims	130
Denials and appeals	130
Life insurance claims	130
Submitting the claim	
Retirees	
Claims payments	132
Accidental death benefit	132
Suicide	132
Other benefits	132
Dependent Life	133
Denials and appeals (Optional Life and Dependent Life)	
Long term disability claims	133
Basic Long Term Disability	133
Supplemental Long Term Disability	133
MoneyPlus claims and reimbursement	135
Medical Spending Account and Dependent Care Spending Account reimbursements	135
Health Savings Account reimbursements	
Administrative or eligibility appeals	
Appeals related to claims or authorization of benefits	139

Third-party claims administrators	139
Accounting and billing	141
General accounting rules	143
Collecting premiums for mid-month changes	143
Unpaid leave rules	143
Issuing credits	143
Retroactivity	143
Billing statements	143
Advance deposit billing statement	144
Active billing file	144
Submitting premium payments to PEBA	144
MoneyPlus and HSA payrolls and accounting	145
For optional employers	145
Administrative fee	145
Experience rating health premiums	145
For optional employers and charter schools	146
Retiree, COBRA and Survivor premiums	146
Retiree, COBRA and Survivor Roster	146
Submitting premiums for employees on unpaid leave	147
For school districts, public higher education institutions and charter schools	147
Retiree, COBRA and Survivor premiums	147
Submitting premiums for employees on unpaid leave	147
For Comptroller General (CG) agencies only	147
Retiree, COBRA and Survivor premiums	147
Submitting premiums for employees on unpaid leave	147
Payroll reconciliation report	148
SCEIS payroll process	148
Annual SLTD salary updates	148
Affordable Care Act	148
Nondiscrimination testing	149
Imputed income (taxable portion of Optional Life premiums)	149
Important reminders in calculating imputed income	150
Reclassification of outstanding MoneyPlus MSA debit card transactions	151
Reclassification report	151

Reclassification	
MoneyPlus and HSA payroll deductions	
Enrollment	154
Payroll deductions	
When to report payroll deductions	
How to report payroll deductions	
Transmit via common file format	
Manually enter payroll deduction data	
How to submit funding	
Processing the payroll deduction file	
Types of discrepancies	
Financial discrepancies	
Enrollment and eligibility discrepancies	
Discrepancy reports	
If you transmitted data via common file format	
If you manually entered payroll deduction data	
Responding to discrepancy reports	
How to respond	
Refunds and adjustments	159
Escalation path	
Year-end adjustments	
Transfer employees	
Special handling for participant accounts with carryover funds only	
Available reports	
Complete Balance Sheet Discrepancy Report (YTDEXP)	
ASI MoneyPlus Year-to-Date Contribution Report (HIS763NP)	
MoneyPlus Enrollment Data (HIS761NP)	
MoneyPlus Pretax Feature (HIS912NP)	
ASIFlex account manager team	
Payroll process	
Sample discrepancy report	
EBS reports	
Accounting reports	
Enrollment reports	

Comptroller General (CG) agencies only	184
Optional employers only	188
Reference	193
Acronyms used in this manual	196
County codes	197
Quick reference charts	198
Active NOE quick reference	198
Active NOE quick reference (cont.)	199
Active NOE quick reference (cont.)	200
Special eligibility situations quick reference	201
Special eligibility situations quick reference (cont.)	202
Special eligibility situations quick reference (cont.)	203
Special eligibility situations quick reference (cont.)	204
Special eligibility situations quick reference (cont.)	205
Special eligibility situations quick reference (cont.)	206
Special eligibility situations quick reference (cont.)	207
Special eligibility situations quick reference (cont.)	208
Special eligibility situations quick reference (cont.)	209
Special eligibility situations quick reference (cont.)	210
Special eligibility situations quick reference (cont.)	211
Special eligibility situations quick reference (cont.)	212
Special eligibility situations quick reference (cont.)	213
Special eligibility situations quick reference (cont.)	214
Special eligibility situations quick reference (cont.)	215
Special eligibility situations quick reference (cont.)	216
Effective date quick reference	217
Effective date quick reference (cont.)	218
Effective date quick reference (cont.)	219
Documentation quick reference	219
Documentation quick reference (cont.)	220
Active Termination Form quick reference	221
Affordable Care Act glossary	222
Quick reference calendar for determining eligibility	223
Quick reference for unpaid leave or reduction in hours	224

Premium checks quick reference	.225
Employer checklists	.225
Coverage termination processes	.226
Termination of employment due to resignation, RIF, dismissal	.226
Termination of employment with transfer to another PEBA-participating employer	.226
Termination of employment due to retirement (service or disability)	.227
Termination due to death of subscriber	.227
Termination due to nonpayment of premiums	.228
Termination during military leave	.228
Termination of covered spouse and/or child	.228
Retiree orientation checklist	.229
Disability checklist	.231
Claims checklist	.231
Accounting system checklist	232
Index	233

# **General information**

This manual outlines the rules, regulations, policies and procedures of the S.C. Public Employee Benefit Authority (PEBA) and contains an abbreviated description of insurance benefits offered by or through PEBA.

When determining benefits, the <u>Plan of Benefits</u> supersedes all other publications and contains a complete description of the State Health Plan. Its terms and conditions govern all health benefits under the Plan. The <u>Plan of Benefits</u> is available online at <u>peba.sc.gov/publications</u>. There are also <u>plan documents available</u> for the dental plans and MoneyPlus. For other benefits, the respective contract with PEBA supersedes all other publications.

The <u>Optional Employer Handbook</u> and <u>Charter</u> <u>School Handbook</u> detail the <u>Requirements for</u> <u>Participation</u> for employers that elect to join the state insurance benefits program.

The *Insurance Benefits Guide* provides details about the various insurance programs offered by PEBA and is available on PEBA's website. The *Insurance Summary* provides a high-level overview of insurance benefits offered by PEBA.

All participating employers must offer their insurance-eligible subscribers all the insurance programs that PEBA offers:

- Health insurance benefits (State Health Plan and the GEA TRICARE Supplement Plan);
- Health and wellness programs;
- Dental insurance (Dental Plus and Basic Dental);
- State Vision Plan;
- Life insurance (Basic, Optional Life and Dependent Life);
- Long term disability (Basic and Supplemental);
- MoneyPlus (all plans, as eligible); and
- Health Savings Accounts.

Employers may not offer competing products and/or programs that PEBA already offers. Employers may offer products not offered by PEBA; however, premiums for those products may not be paid pretax through MoneyPlus.

Benefits administrators and others chosen by the employer who may assist with insurance enrollment, changes, retirement or termination and related activities are not agents of the S.C. Public Employee Benefit Authority and are not authorized to bind the S.C. Public Employee Benefit Authority.

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

# How to use this manual

The manual is divided into sections that address Employee Benefits Services (EBS), types of subscribers you assist and insurance billing. A table of contents is included to make it easier to locate the information you need, and each section of the manual also includes a contents page.

# EBS

EBS, <u>ebs.eip.sc.gov</u>, is a secure website that gives you instant, online access to insurance benefits information, reporting data and billing reports. Through EBS, you can perform several functions:

- View subscriber account and benefits information;
- Enroll new employees and make coverage changes; and
- Access billing statements and make online payments.

EBS access is required for participating employers. See the **Using the online system** chapter for information on how to sign up and use the features of EBS.

# **Contact PEBA**

Throughout the manual, you will be referred to PEBA for assistance.

### **Customer Service**

Contact the dedicated staff of the Employer Support Center in PEBA's Customer Service at 803.737.6800 or 888.260.9430, Option 6, then Option 2.

### Address

202 Arbor Lake Drive Columbia, SC 29223

### Website

<u>peba.sc.gov</u>

### Email

Select Contact at the top of <u>peba.sc.gov</u> and select Question about insurance benefits.

# When you call PEBA on behalf of a subscriber

Be sure the subscriber has already attempted to resolve the issue by contacting the third-party claims processor, plan administrator or PEBA. There are excellent online resources available to subscribers, and you should encourage subscribers to use them. If you do need to call PEBA:

- Have the Social Security number (SSN) or Benefits ID Number (BIN) of the individual and your agency group number ready.
- Have your question ready and please be specific.
- Remember HIPAA guidelines. PEBA cannot release personal health information to you, except enrollment and premium information, unless the subscriber has signed an <u>Authorized Representative Form</u> and filed it with PEBA, thereby giving you access to his personal health information.

# Requests for proof of insurance

Individuals often need proof of health insurance when they travel overseas, particularly if they are students or will be employed in another country. PEBA can provide these letters; however, it may take up to 10 business days to process these requests. Please encourage subscribers to request proof of insurance as soon as they know they need it.

# Forms on the web

The forms mentioned in this manual are available at <u>peba.sc.gov/forms</u>. You can view insurance forms either by name or category.

# Training and resources

Employer Services is committed to supporting employers. Staff is available to assist employers with training. An insurance benefits support menu is online at <u>peba.sc.gov/employers</u>. Contact the Employer Services department by email at <u>EmployerServices@peba.sc.gov</u>.

Training presentations explain the benefit plans and procedures, and they are designed to help benefits administrators better inform and counsel employees about their insurance coverage and benefits. Benefits administrators and personnel/payroll staff are encouraged to view the presentations and recorded trainings at peba.sc.gov/insurance-training.

- Insurance Benefits Training, which is an overview of all benefits;
- COBRA;
- MoneyPlus and Health Savings Accounts; and
- Retirement, Disability and Death.

Additional resources are also available. Benefits administrators can also register for online events at peba.sc.gov/events.

Part of the role of the benefits administrator is to inform employees of their benefits. Please take advantage of the publications PEBA produces, which are all on the PEBA website at peba.sc.gov/publications.

Benefits administrators also have access to the PEBA Health Hub at <u>www.PEBAHealthHub.com</u>. Turnkey marketing toolkits for a variety of topics are available for download.

# Using the online enrollment system

# Contents

<u>Terms</u>
Employee Benefits Services (EBS)
Signing up18
EBS homepage
Manage Subscribers
<u>Inquiry</u> 19
Manage
Enrollment File Upload
Life Ins SOH
Manual transactions
Manage Groups
Enrollment reports
Accounting reports
Balance
Contacts
SLTD Salary Entry
Online Bill Pay
BA Console
Suspended tab
Acknowledgement tab
Approval tab
Current EBS tab
RFR (Request for Review) tab
<u>Status</u>
 MyBenefits31
Using MyBenefits
Making special eligibility changes
Making open enrollment changes

# Terms

# **MyBenefits**

<u>MyBenefits</u> is a secure website that allows active subscribers, retirees, survivors, COBRA subscribers and former spouses to access their own enrollment information in PEBA insurance benefits' enrollment database. Through MyBenefits, subscribers can view their enrollment information and make some enrollment changes to their coverage, as well as approve changes you make in EBS and submit to them. Most transactions are paperless, and employees can upload supporting documentation. See Page 31 for more details about MyBenefits.

### Summary of Enrollment (SOE)

This document is generated when a new enrollment is completed online.

## Summary of Change (SOC)

This document is generated when an enrollment change is completed online.

## Summary of Intent (SOI)

This document is generated when an open enrollment change is completed online through MyBenefits. The SOI is a summary of the subscriber's intended changes but does not necessarily display his final choices, because he can make multiple changes online throughout October. At midnight on November 1, PEBA accepts the last change the subscriber submitted.

### **Summary of Termination**

This document is generated when a termination is completed online.

# Notice of Election (NOE)

Some transactions cannot be completed online and require a *Notice of Election* (NOE) form. Find the NOEs at <u>peba.sc.gov/forms</u>.

## **Active Termination Form**

Some terminations cannot be completed online and require an *Active Termination Form*. Find the form at <u>peba.sc.gov/forms</u>.

## Comptroller General (CG) agencies

Some state agencies process payroll and remittances through the CG's office. For these agencies, some processes and EBS features are not applicable or differ from other employer types.

# **Employee Benefits Services** (EBS)

Access to <u>EBS</u> is required for authorized users to administer PEBA insurance benefits. EBS offers multiple features and access must be determined and approved by the employer's designated authorizing agent.

# Signing up

To access EBS, you need internet access with a compatible browser and Adobe Acrobat Reader software.

### A compatible browser

PEBA web applications support the current and previous major releases of Internet Explorer, Chrome, Firefox and Safari running on the Windows or Mac OS operating system. Each time a new version of a browser is released, PEBA begins supporting that version and stops supporting the third-most recent version.

### Adobe Acrobat Reader software

Many modern browsers include a built-in PDF viewer. PEBA supports the built-in PDF viewers in Chrome, Firefox and Safari, and it supports the latest version of Adobe Acrobat Reader.

### **EBS** access forms

You must request access to gain a valid user ID and password. The user ID is assigned by PEBA and is a vital part of protecting confidential information. It also is used to track who is using the system, how often and the exact functions used by the individual.

- <u>EBS Confidentiality Agreement</u> Required one per employer prior to users accessing EBS.
- <u>EBS Authorizing Agent Designation Form</u> Each employer must designate an authorized person (authorizing agent) to control EBS access for designated employees and any third-party enrollers. The authorizing agent is also responsible for updating the employer's contacts in EBS and maintaining the access of users on an annual basis.
- <u>EBS Designated Employee Confidentiality</u> <u>Agreement</u> – Required to issue a user ID and password for EBS access or to change the access of a current user. Review the provisions on this form carefully. Any violation may result in termination of EBS access. The authorizing agent must approve and sign this form. Select the appropriate systems to access.

If your employer uses a third-party enroller (TPE), complete these additional forms:

- <u>Memo of Understanding (for Third-Party</u> <u>Enrollers)</u>; and
- <u>TPE Designated Employee Confidentiality</u> <u>Agreement</u>.

The EBS access forms are available at <u>peba.sc.gov/forms</u> by category, under Employer. Return completed forms to PEBA at 202 Arbor Lake Drive, Columbia, SC 29223.

PEBA mails EBS credentials via USPS. A confidential user ID is mailed first. A confidential password will follow in a separate mailing.

If you fail to enter your password correctly, you may be locked out of EBS. Use the Forgot Password/Unlock Account link to reset your password or unlock your account.

## Annual recertification process

An annual recertification process requires the authorizing agent to complete an annual review and approval of EBS users and access. To assist the Authorizing Agent, the EBS950 accounting report is available. See the **EBS reports** chapter for information on this report.

# **Duo Security**

For additional security, PEBA uses Duo Security for two-factor authentication to access EBS. New users are required to enroll in Duo upon your initial login to EBS. <u>Learn more about Duo Security</u>.

# EBS homepage

The buttons on the left side of the homepage are accessible to you based on your *Confidentiality Agreement*. If your user ID does not allow access to a function, the button for that function will be grayed out.

# Manage Subscribers

View and manage subscriber coverage and more.

# Manage Groups

View enrollment reports and billing statements, manage contact information, remit online payments and more.

# **BA Console**

The tool in the middle section of the EBS homepage that allows you to manage your subscribers' coverage. See Page 28 for more information about the BA Console.

# Manage Subscribers

# Inquiry

View detailed information about a subscriber within your group(s). Search by SSN, BIN or last name. Subscriber Summary of Change (SOC) documents can also be searched by SSN.

Under Suspense Inquiry, view transactions that are in suspense. Select the transaction to learn more

about the status and if additional information is required by PEBA. Use this feature to stay aware of transactions that may need immediate attention, such as errors and incomplete transactions.

# Manage

Enroll new subscribers, make changes to current subscribers, terminate coverage for a subscriber, submit a Request for Review (RFR) or reinstate coverage for a subscriber.

## Enroll

Enroll a new employee or an employee who is transferring from another employer. Select how to complete the enrollment, either by the employee in MyBenefits or through EBS.

See the Enrollment File Upload section for information on initiating multiple online enrollments in one transaction.

**If you select MyBenefits Enrollment,** complete the required information on the Enrollee Data tab, including a valid email address, salary and date of hire. Select Apply.

EBS will create a transaction in *Pending Subscriber Enrollment* status on the Suspended tab. The transaction will also show under Suspense Inquiry in an N status.

Employees will receive an email with a link to complete their enrollment elections. Provide the <u>Insurance Enrollment Guide for New Hires</u> flyer. The Suspended tab transaction includes a *Resend Email Link* option, if needed.

Once the employee submits his enrollment, the transaction moves to the Approval tab in a Pending Employer Approval status. If the employee enrolled in a MoneyPlus flexible spending account or Health Savings Account, select the number of annual pay periods from the drop-down list. View and confirm any supporting documents. If necessary, upload any supporting documents for the employee. Retain a copy of the SOE and any supporting documents for the transaction.

The weekly *MyBenefits New Hires* report (HAC475) summarizes the MyBenefits enrollment new hire elections. The report includes an indicator if a new hire does not make his online elections within 31 days of hire. In this case, the employee defaults to no insurance coverage.

**If you select EBS Enrollment,** tabs will appear for you to enter the required information. System edits prompt the required data and return error messages, where applicable.

Because you are entering the information and elections for the employee, retain written confirmation from the employee of his elections.

On the Dependents tab, if the subscriber is married, the spouse must be listed, regardless of whether the spouse is covered. To choose coverages, select Activate from the drop-down list or leave the status blank if you are not adding the dependent to benefits. The Medicare coverage question defaults to No. If applicable, change to Yes and complete the required information. Upload a copy of the Medicare card prior to approving the enrollment.

On the Coverage tab, Tobacco-use defaults to Tobacco Coverage if you elect the Standard or Savings Plan. Change to Refused if the subscriber and dependents do not use tobacco or e-cigarettes.

To elect Optional Life, select the coverage level from the drop-down list. If the employee wants a higher level of coverage, the employee must complete and submit an online MetLife *Statement of Health* form and a paper *Notice of Election* form. Employers will submit a *Life Insurance Statement of Health Request* in EBS by selecting the Life Ins SOH button on the homepage. This will initiate the process and then MetLife will email employees a link to an online *Statement of Health* form within 10 days. Employees must register on MetLife's portal, which is also called MyBenefits, before submitting the form.

Dependent Life-Spouse will populate automatically, based on whether a spouse was entered on the Dependents tab. Select a coverage level of either \$10,000 or \$20,000. If the employee wants a higher level of coverage, he must complete and submit an online MetLife *Statement of Health* form and a paper *Notice of Election* form. This field will not appear if there is no eligible spouse. Employers will submit a *Life Insurance Statement of Health Request* in EBS by selecting the Life Ins SOH button on the homepage. This will initiate the process and then MetLife will email employees a link to an online *Statement of Health* form within 10 days. Employees must register on MetLife's portal, which is also called MyBenefits, before submitting the form.

If electing SLTD, select the coverage type from the drop-down list. The system will pull the salary from the Enrollee Data tab.

The Pretax Group Insurance Premium feature field will default to Refused. If electing the Pretax feature, select Active.

MoneyPlus accounts and Health Savings Accounts are listed based upon the health plan selected. If enrolling, enter the annual contribution amount for each account then select the Total Annual Pay Periods from the drop-down list.

On the Beneficiaries tab, if the desired beneficiary is a spouse or child listed on the Dependents tab, select Add, next to Add from existing dependent list. Select the dependent(s) from the list and select Add Selected Dependents to Beneficiaries. The information and relationship of the dependent(s) will populate. Additional beneficiaries can be added by selecting the number from the drop-down list and selecting Add. Complete the required beneficiary information and designate the beneficiary elections.

The Review tab is a complete list of all information entered on the previous tabs. You may return to any tab by selecting the tab at the top of the page if changes or corrections are needed. Retain a copy of the Summary of Enrollment (SOE) and note any required Supporting Documents. You may Suspend, Cancel or Apply the transaction by selecting the applicable button (top right of page).

- Suspend will allow you to keep what has already been processed, and you may retrieve it later. It will be on the Suspended tab of the BA Console and will be listed as Incomplete. You will receive a SUSPEND message box to add the reason for suspending the transaction.
- **Cancel** will remove the entire transaction. Once you confirm to cancel, it cannot be recovered.
- Apply will submit the transaction to either:
  - o MyBenefits; or
  - Current EBS.

**Select MyBenefits** for the employee to review, approve and upload any supporting documents. The transaction will appear on the BA Console under the Approval tab as Pending Subscriber Approval. The subscriber must log in to MyBenefits to review and complete the transaction.

If no documentation is required, the transaction will move from the Approval tab to the Acknowledgement tab on the BA Console. PEBA records will be updated. Once you acknowledge the transaction, a copy of the SOE is available. Do not mail any documents to PEBA.

If the subscriber uploaded the required documentation, review the transaction and documents on the Approval tab. If needed, upload additional documentation. Approve the transaction. Do not mail any documents to PEBA.

If the subscriber did not upload the required documentation, remind him to provide the required documentation promptly; otherwise, the transaction cannot be completed. The transaction will remain on the Approval tab with a Yes for Supp. Docs and a status of Pending Employer Approval. When you receive the documentation, you may then upload the documents. Approve the transaction. Do not mail any documents to PEBA. If the subscriber returns the transaction due to an error or change, the transaction will remain on the Approval tab, but the status changes to Subscriber Returned. You can then edit and resubmit the transaction to return it to the subscriber for approval, or you can delete it, thereby canceling the transaction.

**Select Current EBS** to complete the transaction for the employee. From the Current EBS tab on the BA Console, select the transaction. To print the barcode signature sheet, select Print Signature Sheet. The benefits administrator signature and date, as well as the subscriber's signature and date, are required on the signature page. If you need a copy of the SOE for your files or the subscriber, select Print SOE/SOC. Select Edit to make any necessary changes. Select Continue to review, upload documentation, including the signed barcode signature sheet, and approve the transaction.

The transaction will be listed as Pending PEBA Approval on the Current EBS tab. PEBA applies the transaction once the signed barcode signature sheet, along with any required documentation, is received. The transaction will no longer appear on the Current EBS tab.

If you choose to mail the signed barcode signature sheet and required supporting documentation to PEBA, please allow additional time for processing. Place the signed barcode-signature sheet on top and staple any required supporting documentation.

Do not delay in sending the signed barcode signature sheet. The subscriber's file is locked until the signed barcode signature sheet is received, processed, and the transaction is applied by PEBA.

#### Change

Changes for most family status changes can be completed in EBS. Some elections are not allowed, based on the selected reason(s) for change. Certain fields and tabs will automatically populate or may be hidden or grayed out depending on the change reason. Effective dates are calculated automatically based on the information entered on the *Define Your Change* screen. A summary of the changes can be viewed on the Review tab and on the Summary of Change (SOC). Required documentation is based on the change reason and/or the spouse or child(ren)'s eligibility status and can be uploaded through MyBenefits or EBS.

Select the Reason for Change from the drop-down list. You may be prompted to select a sub-reason from the drop-down list. If the change is due to a special eligibility situation, a new field, Date of Request, may appear. The Date of Request field is pre-filled with the current date. Adjust this date only if necessary. You will be prompted to make elections on each tab as allowed per the change reason.

Please note the following:

- Address changes processed using the Current EBS method require both the subscriber and the benefits administrator signatures.
- Changes to the subscriber's SSN or date of birth must be made on a paper NOE with the supporting documentation included.
- Changing eligibility to Ineligible terminates all coverage for the child(ren).
- Marking the Deceased box terminates all coverage for the deceased spouse or child(ren).
- For dependent gain of other coverage (state or non-state), terminate only those benefits gained elsewhere with the Coverage Status drop-down list.
- For dependent loss of other coverage (state or non-state), add only those benefits lost elsewhere with the Coverage Status dropdown list. Loss of state benefits for a spouse will allow adding Dependent Life-Spouse coverage.
- Previously covered child(ren) may be chosen from the Reactivate Dependent List and their benefits activated.

Based on the change reason, information will be pre-filled. Only fields with a white background may be edited.

Please note for the following change reasons:

- Marriage, newborn, adoption, custody
   Optional Life benefits may be selected or
   increased, and a new coverage level may be
   chosen from the drop-down list where the
   maximum amount available without
   medical evidence is displayed.
- Elections or increases of Optional Life coverage levels with medical evidence An online Statement of Health form must be completed. Employers will submit a Life Insurance Statement of Health Request in EBS by selecting the Life Ins SOH button on the homepage. This will initiate the process and then MetLife will email employees a link to an online Statement of Health form within 10 days. Employees must register on MetLife's portal, which is also called MyBenefits, before submitting the form.

For those who participate in the Pretax Group Insurance Premium feature, action must be requested within 31 days of a family status change. Approvals from MetLife should be forwarded directly to PEBA with an NOE and supporting documentation.

For those who do not participate in the Pretax Group Insurance Premium feature, requests may be processed through EBS and forwarded to PEBA with the SOC, approval letter from MetLife and supporting documentation. These requests may be made throughout the year.

Complete the required beneficiary information and any changes, if applicable.

The Review tab is a complete list of all information entered on the previous tabs. You may return to any tab by selecting the tab at the top of the page if changes or corrections are needed. Retain a copy of the Summary of Change (SOC) and note any required Supporting Documents.

You may Suspend, Cancel or Apply the transaction by selecting the applicable button (top right of page).

- Suspend will allow you to keep what has already been processed, and you may retrieve it later. It will be on the Suspended tab of the BA Console and will be listed as Incomplete. You will receive a SUSPEND message box to add the reason for suspending the transaction.
- Cancel will remove the entire transaction. Once you confirm to cancel, it cannot be recovered.
- Apply will submit the transaction to either:
   MyBenefits; or
  - Current EBS.

**Select MyBenefits** for the employee to review, approve and upload any supporting documents.

**Select Current EBS** to complete the transaction for the employee. The benefits administrator signature and date, as well as the subscriber's signature and date, are required.

### Terminate

Terminations are submitted directly to PEBA and PEBA's files are updated immediately for billing and transmission to the insurance carriers. Some types of terminations must be sent to PEBA on an *Active Termination Form*.

Select the Reason for Termination from the dropdown list. Enter the effective date and any additional information, if prompted to do so. Retain a copy of the Summary of Termination (SOT) for your files. The termination form is transmitted to PEBA. Do not mail any documents to PEBA.

### **Request for Review**

Complete a Request for Review (RFR) for new hires, newborns, marriage, divorce, adoption, gain or loss of health, dental and/or vision coverage not administered by PEBA, and gain or loss of PEBAadministered insurance benefits.

If there is a pending transaction for the subscriber, you will be alerted that the record has a pending suspense transaction. It will allow you to delete and rekey the transaction through the Request for Review process.

Select the change reason from the drop-down list. Enter the event date, requested effective date and the reason for review. Your phone number is not required; however, PEBA encourages you to enter your phone number in case more information is needed.

The Summary of Change allows you to explain the reason for the change. Then, enter a detailed explanation of the circumstances in the Please Explain box.

You will be prompted to complete the process as you would a normal transaction. Once applied, the RFR transaction is on the RFR tab in Pending Employer Approval status. Select the transaction to save or print the barcode signature sheet; retain a copy of the SOE/SOC for your files or the subscriber; save or print a copy of the Request for Review; and edit or delete the transaction. Select Continue to review, upload supporting documentation, including the signed Signature Sheet, and approve the transaction. Once approved, the status changes to Pending PEBA Approval.

If the RFR is approved, the transaction will apply with the requested effective date and the transaction will no longer appear on your RFR tab.

If the RFR is rejected, an explanation of what needs to be done to correct the error will be shown on the suspended transaction.

If the RFR is denied, the status changes to PEBA Denied. View the RFR Denial and denial reason and

save or print prior to your acknowledgement. You must provide the employee a copy of the denial request to notify the employee of his right to an appeal. Remember to retain a copy of the denial for the employee's file.

View a RFR tutorial at <u>peba.sc.gov/insurance-</u> training.

#### Reinstate

The reinstate feature allows you to reinstate an employee's coverage to the effective date of the termination entered into EBS. No changes can be made to the coverage once it is reinstated. EBS will allow you to reinstate coverage to 1-year prior. It is important to remember, any applicable premiums will be due.

Select the reinstatement reason. Once you have submitted the transaction, view the transaction in a Pending Employer Approval status on the Current EBS tab of the BA Console. Review and upload any supporting documentation. Retain a copy of the SOC/SOE. Approve the transaction to reinstate coverage.

# Enrollment File Upload

Upload multiple enrollment records for batch processing. This feature is only available for enrollment transactions, not changes or terminations.

View the *File Upload Help* for more information, including file layout requirements for the Excel File Format and Comma Separated Value Format options. For further assistance with creating a file, download the Enrollment File Template. Choose your file and upload.

Any formatting or coverage (i.e., currently active with another employer) errors will be returned. Review the error message(s), and correct or remove the employee data from the file before uploading the file again. Please note that if errors exist, none of the data is uploaded to PEBA.

Once you submit the file, PEBA will validate the file to ensure it meets all requirements and process the

file. An enrollment file may only be uploaded once per day. Files submitted after 5:30pm will be processed the next business day.

EBS will create a transaction in *Pending Subscriber Enrollment* status on the Suspended tab. The transaction will also show under Suspense Inquiry in an N status.

Employees will receive an email with a link to complete their enrollment elections. Provide the *Insurance Enrollment Guide for New Hires* flyer. The Suspended tab transaction includes a *Resend Email Link* option, if needed.

If the employee is unable to complete the enrollment online, you may convert the transaction to an *EBS Enrollment*. See Page 20 for more information about completing the EBS Enrollment for the employee. You can also edit or delete the transaction, if necessary.

Once the employee submits his enrollment, the transaction moves to the Approval tab in a Pending Employer Approval status. If the employee enrolled in a MoneyPlus account, select the number of annual pay periods from the drop-down list. View and confirm any supporting documents. If necessary, upload any supporting documents for the employee. Retain a copy of the SOE and any supporting documents for the employee the transaction.

The weekly *MyBenefits New Hires* report (HAC475) summarizes the MyBenefits enrollment new hire elections. The report includes an indicator if a new hire does not make his online elections within 31 days of hire. In this case, the employee defaults to no insurance coverage.

# Life Ins SOH

For new hires, complete the normal new hire enrollment process that allows a new hire to elect his benefits online. Once a new hire's information is available in PEBA's system and the new hire is assigned to the employer's group, complete a *Statement of Health Request* in EBS for coverage that requires medical evidence by selecting the Life Ins SOH button.

After submitting a request, download or print a copy of the request for your records. Each Friday, employers can download Report HIS314NP, Statement of Health Request Report, which will list all requests submitted the previous week. Employers will be able to access up to four previous weeks' reports in EBS.

Each week, PEBA will send a file to MetLife that includes all requests received that week. MetLife will then email employees a link to an online *Statement of Health* form within three days. Employees must register on MetLife's portal, which is also called MyBenefits, before submitting the form. MetLife will send reminder emails to employees who have not completed the form at Day 7 and Day 14. If an employee does not submit the online form by Day 30, MetLife will mail a paper Statement of Health form to the employee.

Employers will continue to receive approval reports via email from MetLife and must submit the NOE with the report to PEBA once they receive approval.

You may also complete a *Statement of Health Request* in EBS for open enrollment elections that require medical evidence by selecting the Life Ins SOH button.

# Manual transactions

Due to system limitations, there are some transactions that must be submitted on an NOE.

### **Enrollments/re-enrollments**

- Election changes if new hire changes his mind within 31 days, if the first enrollment has already been approved by the employer. Enrolling new hire if employee is currently covered as a dependent on another subscriber's coverage.
- Enrolling retirees, survivors, COBRA subscribers and former spouses.
- Enrolling working retiree in active coverage.
- Enrolling an active subscriber on stipend.

 Open enrollment changes that may require two transactions, such as family status changes with effective dates in October, November or December.

### Dependents

- Adding incapacitated children to coverage.
- Enrolling or keying a change for a subscriber with a National Medical Support Notice dependent.

### Changes

- Social Security numbers.
- Dates of birth.
- For a subscriber who has a covered child turning age 26 prior to the change effective date.
- For a subscriber who has a covered child on Dependent Life-Child coverage turning age 25 prior to the change effective date.
- For a stipend subscriber.
- For a subscriber covering a child with a relationship code of "Temporary Custody Pending Adoption," whose end date is prior to change effective date.
- For a subscriber who already has an effective date on file that is after the new change effective date (newborn to be added in November after open enrollment has processed).

### Terminations

- Due to nonpayment, military leave or those more than 31 days retroactive.
- Due to Supplemental Long Term Disability in a waiver of premium status.

# **Manage Groups**

# Enrollment reports

View reports with various enrollment information. The **EBS reports** chapter provides detailed information on formatting, frequency and samples.

# Accounting reports

View reports with various accounting information, including billing statements. The **EBS reports** chapter provides detailed information on formatting, frequency and samples.

# Balance

### For Comptroller General (CG) agencies only.

The Accumulated Balance Report feature displays subscriber payment and balance information. Data is displayed sorted from the begin (earliest) date to the end (current) date. The Begin Date defaults to a date approximately 12 months prior to the current date. Modify the begin date if necessary. Required parameters include the employer number and SSN or BIN.

See the **EBS reports** chapter for more information about the Accumulator reports.

# Contacts

The authorizing agent is required to review and update employer contact information periodically, including email addresses, in EBS. Ensuring correct email addresses are on file allows PEBA to send electronic correspondence without interruption. If needed, ask the authorizing agent for your employer to review and update the information on file for each contact.

A primary contact for the roles of benefits administrator, billing contact, executive contact and wellness contact must be assigned.

Additionally, use contacts to look up contact information for other employers. Use the Search feature to search by employer name and/or group ID.

# SLTD Salary Entry

Not applicable to Comptroller General (CG) agencies.

All salaries must be reviewed and updated annually during open enrollment. You may begin entering

the salaries in EBS on September 15, and the information is due to PEBA no later than October 31.

To update SLTD premiums correctly for the next plan year, PEBA needs updated salary information for your employees who are enrolled in SLTD. The salary on which SLTD premiums are based should include the employee's base rate of pay for the hours they are regularly scheduled to work, plus any of the following that apply to the employee:

- Longevity pay;
- Shift differential pay;
- Regular compensation earned by university teaching staff during regular summer sessions; and
- Contributions the employee makes to deferred compensation plans or fringe benefits (like payroll deductions for health insurance).

Do not include overtime pay, commissions, bonuses, employer contributions to benefits or any other extra compensation.

### If you do not update the salary information, premiums and any benefits paid will be based on the most recent salary information submitted to PEBA.

Update salaries for any employee who has had a salary change since the previous October 1.

*Example*: If an employee was hired March 2022 with a salary of \$25,000, and he has received a salary increase of \$3,000, and his salary as of October 1 includes this increase, you must submit the updated salary of \$28,000 to PEBA in October 2022.

The maximum annual salary for calculating SLTD benefits and premiums is \$147,684. If PEBA receives any salary updates that exceed this amount, the updated salary will default to the maximum.

Employers who implement furloughs should use employees' non-furlough salaries to calculate premiums. Use one of these methods to submit the updated salaries:

- Select SLTD Salary Browse to add employee salaries individually. Enter the data into each field and click on the button at the bottom of the screen to submit the information for each employee.
- Upload SLTD data text file.
- Download SLTD Coverage Data. This list includes all employees enrolled in SLTD at the time of your request. Follow the instructions to create a new text document, and then select Upload SLTD Data to upload your revised file to EBS.
- Select the Batch Entry Screen, which allows you to enter 10 employee salaries at a time.

Select Current SLTD Coverage List to receive a list of all employees currently enrolled in SLTD. Review and Confirm all SLTD salary entries when you've completed updates for your employer.

For more details, view the Updating salary information for SLTD resource at peba.sc.gov/insurance-training. If you have any questions about submitting SLTD salary information, contact PEBA.

# Online Bill Pay

Processing your payment online through EBS is easy and convenient. To use this feature, Online Bill Pay access in EBS is required. Complete a new *EBS Designated Employee Confidentiality Agreement* form, if necessary to update access.

Log in to your EBS account and verify your email address in the lower right corner on the EBS homepage before submitting a payment. Select the *Update My Email Address* link if changes are needed.

After you complete these steps, you will be able to schedule a payment; view the status of your account; view bill and payment history for the previous 12 months; and view billing statements for the previous 12 months. The minimum amount you may pay is your current balance.

# **BA Console**

All enrollment transactions, whether initiated by you or your subscribers in MyBenefits, will appear on this console. The console consists of five tabs: Suspended, Acknowledgement, Approval, Current EBS and RFR (Request for Review). Each transaction displays a status.

You can change the number of transactions displayed (10, 25, 50 or 100).

# Suspended tab

This tab includes transactions that are incomplete. You can suspend a transaction for any number of reasons, including missing supporting documentation. Incomplete transactions may be edited or deleted.

**Edit** allows you to make changes or corrections to the subscriber's data. Once you have made changes, review and apply to generate a revised SOC. The revised SOC must be submitted to PEBA, along with any required documentation. If you edit a transaction prior to approving, another barcode signature sheet must be submitted to PEBA. The latest edited transaction must be signed and dated by you and the subscriber before submitting.

**Delete** removes the transaction. Deleting a transaction before it is applied by PEBA will cancel the transaction, and it will disappear from the Suspended tab.

Transactions submitted to MyBenefits for an action by the employee are displayed on the Suspended tab as *Pending Subscriber Enrollment*.

The transaction status will change from Incomplete to Complete and move to the Approval tab or Current EBS tab for completion once you finish processing the transaction.

Transactions more than 31 days old are highlighted in yellow. At 60 days, suspended transactions are

canceled automatically and deleted. The transaction is not applied. If the transaction is still valid, you need to submit a Request for Review.

# Acknowledgement tab

This tab includes transactions that are initiated by subscribers using MyBenefits or initiated by you and sent to subscribers to approve online in MyBenefits. These transactions do not require supporting documentation.

Examples include:

- New hire enrollments that do not require documentation.
- Contact information (address, phone numbers, email address) changes; and
- Beneficiary changes.

When you acknowledge the transaction, a new window opens with the SOE/SOC for your review. Retain copies for your records. Do not mail any documents to PEBA.

Transactions more than 31 days old are highlighted in yellow. At 60 days, transactions are removed from the Acknowledgement tab automatically. However, these transactions were applied at the time the subscribers made them.

Acknowledging these transactions will remove them from the Acknowledgement tab. Notify any other applicable parties of address changes.

# Approval tab

This tab includes transactions that are initiated by subscribers using MyBenefits or initiated by you and sent to subscribers to approve online in MyBenefits. The Status column shows what needs to be approved by you, the subscriber or PEBA. The Support Documents column shows if supporting documents are required before approving the transaction.

You must review and approve (or reject) these transactions in time to allow your subscribers to make corrections or to change their minds (either through MyBenefits or by completing a paper *Notice of Election*) before the end of the enrollment period, either 31-days from hire or October 31 (open enrollment). **These transactions are not applied by PEBA or sent to the third-party claims processors until after you approve them.** Retain copies for your records.

Records that have been rejected by PEBA are highlighted in green and appear at the top of the list for your immediate attention.

Transactions more than 31 days old are highlighted in yellow. At 60 days, transactions are canceled automatically and deleted. The transaction is not applied.

# Current EBS tab

This tab includes transactions that are initiated by you and require signatures. To print the barcode signature sheet, select the transaction and the Print Signature Sheet option.

Select Edit to make any necessary changes. Select Continue to review, upload documentation, including the signed barcode signature sheet, and approve the transaction. Retain copies for your records.

PEBA applies the transaction once the signed barcode signature sheet, along with any required documentation, is received. The transaction will no longer appear on the Current EBS tab.

# RFR (Request for Review) tab

This tab includes Request for Review, or RFR, transactions that are submitted in EBS. Learn more about submitting an RFR on Page 20 in the EBS Manage Subscribers section.

Monitor the tab for rejected or denied RFR transactions.

# Status

Transaction statuses are explained below.

### **Pending Subscriber Enrollment**

Transactions on the Suspended tab that are created by a MyBenefits Enrollment. Once the employee submits his enrollment, the transaction moves to the Approval tab in a Pending Employer Approval status.

You may resend the email link to the subscriber, and edit or delete the transaction, if necessary.

If the employee is unable to complete the enrollment online, you may convert the transaction to an EBS Enrollment. You must complete the enrollment. Learn more about submitting an EBS Enrollment on Page 20 in the EBS Manage Subscribers section.

### **Pending Subscriber Approval**

These are transactions initiated by the employer and sent to the subscriber to approve in MyBenefits. You may review or delete the transaction but cannot make changes.

Notify the employee to log in to MyBenefits, review and approve the transaction and electronically sign.

#### No documentation required

Once approved by the subscriber, the transaction will move to the Acknowledgement Tab on the BA Console. PEBA's records are updated.

#### **Documentation required**

The subscriber can upload any required documentation in MyBenefits. Once approved by the subscriber, the transaction status changes to Pending Employer Approval.

### **Pending Employer Approval**

Select Continue to review and approve the transaction. Delete the transaction, if necessary. The enrollment/change is then canceled.

#### No documentation required

PEBA's records are updated once you approve the transaction.

#### **Documentation required**

Review any uploaded documentation by the subscriber or if the subscriber provides you with the documentation, upload the documents. The transaction status changes to Pending PEBA Approval.

If the required documentation is not uploaded, a barcode page is generated. Print and send only this barcode page with the documentation attached. Do not include a copy of the SOE/SOC. Retain copies for your records.

## Pending Employer Approval-Subscriber Changed

If a subscriber changes his mind about his initial open enrollment election(s), he may go into MyBenefits and edit and/or delete his changes until 11:59 p.m. on October 31.

If his employer has approved a previous transaction, this new status will appear on the Approval tab.

### **Pending PEBA Approval**

These are transactions approved by the employer and for which supporting documentation is uploaded. You may review and save or print a copy of the SOE/SOC or barcode page up until PEBA approves the transaction.

PEBA's records are updated once the supporting documentation is approved by PEBA. If the documentation submitted is incomplete or insufficient, PEBA will reject or remove the transaction.

### **Subscriber Returned**

**Documentation may or may not be required** These are transactions initiated by the employer and sent to the subscriber to approve in MyBenefits; however, the subscriber returned the transaction because of an error or change.

Select the transaction to view the subscriber's message for the correction(s) he is requesting.

Select Edit to send it back to the subscriber to review and approve in MyBenefits.

Select Review to view and print a copy of the SOE/SOC without making any changes to the document. After review, select Approve.

Your approval updates PEBA's records and sends a copy of the transaction to the appropriate third-party claims processors.

Delete the transaction, if necessary. The enrollment/change is then canceled.

### **PEBA Rejected**

These are transactions that PEBA has returned to the BA Console because the supporting documentation was incomplete or insufficient. They are highlighted in green at the top of the Approval tab.

View the rejection reason and then obtain and upload the additional or corrected documentation. You may also need to upload a copy of the original SOE/SOC as verification of the date the subscriber initially tried to make the change. Approve the transaction. The transaction status changes back to Pending PEBA Approval.

If the required documentation is not uploaded, a barcode page is generated. Print and send this barcode page with the documentation attached.

Delete the transaction, if necessary. The enrollment/change is canceled.

### **PEBA Denied**

These are RFR (Request for Review) transactions that are denied by PEBA. View the RFR Denial and denial reason, and retain a copy prior to your acknowledgement. You must provide the employee a copy of the denial request to notify the employee of his right to an appeal. Remember to place a copy of the denial in the employee's file.

### Incomplete

These are transactions on the Suspended tab that have been suspended by the employer. Incomplete transactions may be edited or deleted.

# Additional statuses on Suspense Inquiry transactions include the following:

- Advanced Keyed Transactions with future effective dates that are stored once keyed until PEBA runs the billing that coordinates with the date of the transaction.
- **Complete awaiting processing** Current EBS is pending employer approval.
- **Errored** Transactions are marked as an error if they are rejected.
- N A new enrollment has been initiated in EBS and is awaiting online elections from the employee.

# Tips

If you need to retain a copy of an SOE/SOC but do not see it on your screen after you apply the transaction, check the bottom toolbar or behind other windows on your screen. Sometimes the document will minimize.

Upload signed barcode signature sheets as soon as possible. If the employee is not available to sign, have him complete and sign a paper NOE and upload it with the SOE/SOC.

Do not write additional instructions on an SOE/SOC. PEBA cannot key handwritten changes. Rekey the transaction in EBS.

Notify your payroll department of any changes that affect premiums.

Retain copies of any rejected transactions.

If a NOE is required because of a rejection, include a copy of the original SOE/SOC with the NOE. This verifies the original request was made within 31 days.

# **MyBenefits**

MyBenefits allows subscribers to access their insurance information online and make some changes on their own. MyBenefits also allows subscribers to upload supporting documentation. You can view subscriber changes made through MyBenefits on the BA Console.

When contact or beneficiary information is changed, you will receive a notice on the Acknowledgement tab.

During open enrollment, subscribers can make coverage changes for the next year. Depending on the type of change, you will receive a notice on the Approval tab.

# Using MyBenefits

A step-by-step flyer on how to register for MyBenefits can be found at <u>peba.sc.gov/nyb</u>.

After logging in, the subscriber will see any transactions you submit for his approval, or he may choose to review his benefits, update his contact information, initiate changes as a result of a special eligibility situation, review and change his beneficiaries, and make changes during the open enrollment period.

When a subscriber initiates a change using MyBenefits, a Summary of Change (SOC) is generated, similar to what is generated in EBS. Changes and updates are in the New Value fields. To accept the change(s), he selects Approve. A certification, authorization and disclaimer statements appear, which require an electronic signature. The subscriber enters the last four digits of his SSN to authorize and process the change. A final SOC is generated that the subscriber can save or print for his records.

In EBS, you can access SOEs and SOCs initiated in MyBenefits. Under Manage Subscribers, select Subscriber SOCs.

# Making special eligibility changes

Subscribers can make changes using MyBenefits when a special eligibility situation occurs, such as adding a newborn, marriage, divorce or adoption. MyBenefits will display the documentation required for each change, which can be uploaded through MyBenefits.

# Making open enrollment changes

During open enrollment, subscribers can make changes in MyBenefits, as permitted during the open enrollment period.

### Your Current Coverage

This details the subscriber's coverage and coverage levels.

### **Make Coverage Changes**

The subscriber can enroll, change and cancel coverage for the programs allowed. Edits prevent the subscriber from enrolling in a program for which he, his spouse or his child(ren) is not eligible or from selecting a level of coverage above what is allowable.

#### Dependents

The subscriber can review his spouse and/or child(ren) and their coverage, add a spouse and/or child(ren), or add or cancel coverage for his spouse and/or each child by program, as allowed.

#### **Beneficiaries**

Details the subscriber's current beneficiaries. He can add or delete beneficiaries, designate them as

primary or contingent and change the percentages for Basic Life and Optional Life.

### **Completing open enrollment changes**

Once a subscriber has completed his change(s), he will be prompted to review the change(s) before electronically authorizing and submitting. A Summary of Intent (SOI) is generated that the subscriber can save or print for his records.

The enrollment change(s) will be sent to the Approval tab of the BA Console.

# If the subscriber changes his mind during open enrollment

If a subscriber changes his mind about his elections, he may go into MyBenefits and edit and/or delete his changes until 11:59 p.m. on October 31, regardless of whether the transaction has been approved by his employer.

If his employer has approved a previous transaction, a new status will appear on the Approval tab as Pending Employer Approval-Subscriber Changed.

The deadline for all open enrollment changes is October 31.

# **Active subscribers**

# Contents

Employee eligibility rules and procedures	36
Determining eligibility for benefits	36
Measurement periods	36
Administrative periods	37
Stability periods	
Notes on employee eligibility	
Procedures to elect 20-hour threshold	
Assisting a benefits-eligible employee	
Required information	
Available benefits	
Where to find more information	40
Refusal of coverage	40
Explain enrollment deadlines	41
Explain effective dates	41
Tobacco certification	41
MoneyPlus enrollment	42
Effect of MoneyPlus on other retirement plans	42
Review MoneyPlus features	43
Health Savings Account enrollment	45
GEA TRICARE Supplement Plan enrollment	46
Assisting a newly eligible variable-hour, part-time or seasonal employee	46
Assisting a permanent, part-time teacher	47
Process for medical emergencies	48
National Medical Support Notices	49
Rules and procedures for late entrants	50
Health plans	50
Dental	50
Vision care	50
Life insurance	50
Supplemental Long Term Disability	51
Changes in status and special eligibility situations	51
Gain of other group coverage	51
Gain of Medicare coverage	52

Gain of Medicaid coverage	52
Loss of other group coverage	53
Loss of TRICARE coverage	54
MoneyPlus change in status rules	54
Completing the enrollment for a change in status	55
Coverage changes for permanent, part-time teachers	55
Other coverage changes	56
Optional Life	56
Dependent Life	58
Supplemental Long Term Disability	59
MoneyPlus	59
Health Savings Accounts (HSAs)	59
Beneficiary changes	60
Open enrollment for active subscribers	60
Dental coverage	61
Open enrollment procedures and helpful hints	61
New employees or transfers hired October 2-December 31	61
Unpaid leave or reduction in hours	62
Employees with unpaid leave or reduction of hours	62
Premiums while on unpaid leave	63
SLTD and life insurance benefits while on unpaid leave	64
Continuing MoneyPlus while on unpaid leave	64
Continuing a Health Savings Account while on unpaid leave	65
Military leave	65
Family and Medical Leave Act (FMLA)	66
Workers' compensation	67
Affordable Care Act reporting requirements	68
# **Employee eligibility rules and procedures**

#### The Plan of Benefits defines an employee as:

A person employed by an Employer on a Full-Time basis, and who receives compensation from a department, agency, board, commission or institution of the State, including clerical and administrative Employees of the General Assembly, and judges in the State courts. Retirees who return to work with an Employer are considered Employees for purposes of eligibility under the Plan. For purposes of this Plan, the term shall include other Employees that the General Assembly has made eligible for coverage by law, including Employees of a public school district, county, municipality, or other Employer that has qualified for and is participating in, coverage under the Plan. The members of the South Carolina General Assembly and elected members of the councils of participating counties or municipalities, whose council members are eligible to participate in the South Carolina Retirement Systems, and Part-Time Teachers, are also Employees for purposes of the Plan.

#### The Plan of Benefits defines full-time as:

With regard to an Employee, shall mean an employee who is credited with an average of at least 30 hours of service per week. An employer may exercise a one-time, irrevocable option to elect the definition of Full-Time to mean an employee who is credited with an average of at least 20 hours per week, and to apply this definition, upon notification and acceptance by PEBA. Full-time status for purposes of eligibility to participate in the Plan is determined in accordance with the process set out in paragraphs 3.22, 3.23, and 3.24 of the Plan.

#### Determining eligibility for benefits

The Affordable Care Act (ACA) requires all Applicable Large Employers to offer health insurance that is affordable and provides minimum value to all full-time employees or pay a penalty to the IRS.

To accommodate this requirement, participating employers must offer coverage to any employee who meets the eligibility requirements established by the ACA.

All employees fall into one of three categories:

- New full-time employee (Permanent or Nonpermanent) A newly hired employee who was determined by the employer, as of the date of hire, to be full-time and eligible for benefits. The employee is eligible to enroll in coverage within 31 days of his hire date.
- New variable-hour, part-time or seasonal employee A newly hired employee who is not expected to be credited an average of 30 hours per week for the entire measurement period, as of the date of hire. Therefore, the employer cannot reasonably determine his eligibility for benefits as of the date of hire. The employer must measure the employee's hours to determine whether the employee will be eligible for benefits.
- **Ongoing employee** Any employee who has worked with an employer for an entire Standard Measurement Period (see below).

To assist employers with determining an employee's eligibility for benefits, the IRS has established three safe harbor regulations: Measurement Periods, Administrative Periods and Stability Periods.

#### Measurement periods

A measurement period is the 12-month period of time an employer uses to review the number of hours worked by an employee to determine eligibility for benefits.

There are two types of measurement periods: Initial Measurement Period and Standard Measurement Period.

An **Initial Measurement Period** applies to any newly hired variable-hour, part-time or seasonal employee. An Initial Measurement Period begins the first of the month after the date of hire and ends 12 months later. The employer would not offer benefits to a newly hired variable-hour, parttime or seasonal employee at the time of hire, instead the employer would review the employee's hours over the Initial Measurement Period to determine eligibility.

The **Standard Measurement Period** applies to all ongoing employees and begins on October 4 of each calendar year and ends on October 3 of the next calendar year. For Plan Year 2022, the Standard Measurement Period runs from October 4, 2021, and ends on October 3, 2022.

#### Administrative periods

The Administrative Period is the period of time (immediately after the measurement period) when the employer notifies an employee of his eligibility for benefits and the plan processes the employee's enrollment.

There are two types of administrative periods.

#### **Initial Administrative Period**

A new variable-hour, part-time or seasonal employee credited with an average of 30 hours per week during his Initial Measurement Period may enroll during an Initial Administrative Period, which begins the day after the end of his Initial Measurement Period and ends the last day of the same month. Coverage begins the first of the month after the end of the Initial Administrative Period.

For example, if a variable hour/part-time employee is hired June 3, his Initial Measurement Period is July 1 through June 30 of the following year. The Initial Administrative Period is during that following July. Throughout this Initial Administrative Period, review the hours worked during the Initial Measurement Period to determine if the employee averaged 30 hours per week.

#### **Standard Administrative Period**

The ACA requires employers to monitor the hours of all employees to ensure eligible employees are offered benefits. An ongoing employee credited with an average of 30 hours per week during the Standard Measurement Period may enroll annually during the October enrollment period with coverage effective January 1.

The Standard Administrative Period for plan year 2022 is October 3, 2022 to December 31, 2022. Employers, however, must determine eligibility and offer coverage to eligible employees during the plan's open enrollment period, which ends October 31, 2022. All enrollments must be submitted to PEBA according to the open enrollment submission deadline (refer to Page 32, Making open enrollment changes). PEBA will use the remainder of the Standard Administrative Period (November to December 31) to process enrollments to ensure employees have access to coverage at the beginning of the Stability Period (January 1, 2022).

The Standard Administrative Period is also the period of time an employer must notify an employee of his loss of eligibility for the next plan year. If an employee previously determined as eligible for coverage during the Initial Administrative Period is determined not to have met the average of 30 hours per week during the Standard Measurement Period, the employee will lose eligibility at the end of his stability period.

#### Ongoing employee

If the employee is an ongoing employee and he does not qualify for benefits in the next plan year, the employee will lose eligibility at the end of the current plan year.

- Notify the employee he will not be eligible for benefits in the next plan year;
- If the employee is enrolled in health, dental or vision, send the employee and his covered dependents an 18-month COBRA Notice. The COBRA Qualifying Event will be the employee's reduction of hours effective January 1; and

• Submit the termination in EBS. For the termination reason, choose Left Employment.

# New variable-hour, part-time or seasonal employee

If the employee is a new variable-hour, part-time or seasonal employee and he does not qualify for benefits based on the Standard Measurement Period, the employee will lose eligibility at the end of his Initial Stability Period. During the Standard Administrative Period, notify the employee he will not be eligible for benefits when his Initial Stability Period ends. At the end of the employee's Initial Stability Period:

- Notify the employee of his loss of eligibility;
- If the employee is enrolled in health, dental or vision, send the employee and his covered dependents an 18-month COBRA Notice. The COBRA Qualifying Event will be the employee's reduction of hours effective the end of his Initial Stability Period; and
- Submit the termination in EBS. For the termination reason, choose Left Employment.

#### Stability periods

The Stability Period is the period of time an employee remains eligible, regardless of the number of hours worked.

An Initial Stability Period for New Variable Hour, Part-Time and Seasonal Employees begins the first of the calendar month after the end of the Initial Administrative Period and ends the day before in the following calendar year. For example, an Initial Stability Period that begins on May 1 of one year would last until April 30 of the following calendar year.

A Standard Stability Period for Ongoing Employees begins January 1 of each year and ends on the following December 31.

#### Notes on employee eligibility

- An employee who returns to the same employer with no break in coverage or with no more than a 15-calendar-day break in employment is considered a transfer, not a new hire. For a break in service of greater than 15 calendar days, but less than 13 calendar weeks (26 weeks for academic employers), see the <u>ACA reporting</u> <u>requirements frequently asked questions</u>.
- An academic employee (public school districts, universities, colleges and technical colleges) who completes a school term and moves to another academic setting with another participating academic employer at the beginning of the next school term is a transfer, not a new hire.
- Eligibility for benefits is based on the number of hours the employee works for an employer. If an employee works for more than one participating entity that shares a common payroll center (i.e., CG agencies), the hours worked for both agencies should be combined to determine eligibility. In the case of a tie, both employers should offer coverage, and the employee can choose from which employer to accept coverage. See the <u>ACA reporting requirements</u> <u>frequently asked questions</u>.
- An employee who works for two participating employers is considered working for one employer or the other employer for insurance purposes. His insurance coverage and premiums *cannot* be split between the two employers, nor may he combine his two salaries for Optional Life/Dependent Life Insurance purposes. See Page 69, Transfers and terminations, for additional information.

Active nonpermanent full-time employees are eligible for the same insurance benefits as active permanent full-time employees. They are enrolled in benefits using an Active NOE, not a Part-time NOE. In the Eligible due to the Affordable Care Act box on the Active NOE, check Full-time nonpermanent.

While nonpermanent full-time employees are eligible for active employee insurance benefits, they may not be eligible for retiree coverage if they retire from a nonpermanent position. See Page 92 for retiree eligibility requirements, including that the last five years of active employment must be full-time, permanent and consecutive.

**Note:** PEBA does not verify the eligibility of employees for employers. Neither does it classify employees.

#### Procedures to elect 20-hour threshold

Any participating employer has the option of reducing the threshold for insurance eligibility for all full-time employees from 30 hours per week to at least 20 hours per week.

To elect the 20-hour threshold, the director/head of the participating employer must send a letter to PEBA requesting this option. The letter should acknowledge the guidelines below. The director/head must sign the letter, and the original should be sent to the Operations manager at PEBA (address on Page 14).

PEBA will send back a letter acknowledging receipt of the request. This letter will restate the guidelines below and will include the date the change to 20 hours will go into effect.

# Guidelines for extending benefits to 20-hour employees

- Benefits must be offered to **all** employees working 20 or more hours per week.
- The decision to extend benefits to employees working 20 or more hours per week is **irrevocable**.
- Employees working 20 or more hours per week are entitled to participate in the same state benefits available to other full-time employees.

 The minimum employer contribution for these employees is the same as for other full-time employees.

# Assisting a benefits-eligible employee

Use the *Enrolling a new hire* checklist at <u>peba.sc.gov/publications</u> under *Life event checklists*.

You may also prepare an information email/packet as outlined below.

#### **Required information**

When an employee becomes eligible for insurance benefits, provide the employee with the following items that are available online at <u>peba.sc.gov/new-employees</u>:

- Federally mandated notices;
- Insurance Summary;
- <u>Insurance Enrollment Guide for New Hires</u> flyer; and
- <u>Setting Up a New MyBenefits Account</u> flyer.

Also provide the <u>Marketplace Exchange Notice</u> and <u>Notice of Special Enrollment Rights</u>.

If system limitations prevent online enrollment and you are enrolling on paper, provide:

- <u>Active Notice of Election</u> (NOE); and
- <u>Certification Regarding Tobacco or E-</u> <u>cigarette Use</u>.

#### Available benefits

PEBA's publications provide helpful information on the following benefits. Encourage employees to carefully review the publications and the insurance flyers and videos at <u>peba.sc.gov/nyb</u>. Learning about the benefits and determining his insurance elections is the responsibility of the employee. The employee must choose or refuse each of the following, based on eligibility:

#### **Health insurance**

State Health Plan (includes prescription drugs and behavioral health coverage; includes an additional preventive benefit for Savings Plan).

Subscribers of the State Health Plan are also eligible for <u>PEBA Perks</u>, value-based benefits at no cost.

The premium for tobacco or e-cigarette users is automatic for State Health Plan subscribers, unless the subscriber certifies he nor anyone he covers uses tobacco or e-cigarettes, or covered individuals who use tobacco or e-cigarettes have completed a tobacco cessation program approved by PEBA. See Page 42 for more information.

GEA TRICARE Supplement Plan is available to members of the military community.

#### **Dental insurance**

- Dental Plus; or
- Basic Dental.

#### Vision care

• State Vision Plan.

#### Life insurance

- Automatic enrollment in Basic Life with AD&D, at no cost, if enrolled in health insurance.
- Optional Life with AD&D;
- Dependent Life-Spouse with AD&D; and
- Dependent Life-Child (a child ages 19-24 must be a full-time student or certified as incapacitated to be eligible for coverage; a child older than age 24 must be certified as incapacitated to be eligible for coverage).

#### Long term disability insurance

- Automatic enrollment in Basic Long Term Disability, at no cost, if enrolled in health insurance.
- Supplemental Long Term Disability (SLTD).

There is a 12-month preexisting condition exclusion period related to BLTD and SLTD benefits.

Any applicable late entrant procedures and the preexisting exclusion period is 12 months for late entrants to SLTD.

#### MoneyPlus

- Pretax Group Insurance Premium feature for health, Dental Plus, Basic Dental, State Vision Plan and up to \$50,000 in Optional Life coverage.
- Medical Spending Account (MSA).
- Limited-use Medical Spending Account.
- Dependent Care Spending Account (DCSA).

#### **Health Savings Accounts**

• Health Savings Account (HSA).

#### Where to find more information

Share the <u>how to access digital identification cards</u> <u>or replace cards</u> flyer for information on using the BlueCross, Express Scripts and EyeMed apps.

The *Insurance Benefits Guide* provides detailed descriptions of the State Health Plan and other benefits.

#### Refusal of coverage

An employee may refuse to enroll in any or all of the benefits plans offered by the state. If an employee refuses health coverage, he forfeits Basic Life and Basic Long Term Disability coverage.

To refuse coverage, an enrollment indicating **Refuse** must be submitted to PEBA.

If an employee is already enrolled as a dependent on his parent's coverage through PEBA, he may continue coverage as a dependent or enroll in coverage as an active employee. If the employee chooses to remain enrolled as a dependent, he may not enroll in any benefits as an employee, including SLTD and Optional Life.

The employee should complete and sign a paper NOE refusing all coverage. Under Type of Change on the NOE, next to Other, specify Enrolled as child of PEBA subscriber.

#### Explain enrollment deadlines

Enrollments must be completed and authorized within 31 days of date of hire or a special eligibility situation.

If not completed within 31 days, the employee must wait until the next open enrollment period or a special eligibility situation to enroll in health, dental and/or vision coverage. At that time, full-time employees may be required to provide medical evidence to enroll in Optional Life and Dependent Life-Spouse and medical evidence of good health to enroll in SLTD coverage.

The new employee can change his mind about an original selection within 31 calendar days of his date of hire (not the effective date of coverage). To make a new selection, a paper NOE must be signed within the 31-day window and submitted to PEBA for processing. Indicate on the NOE that it is a revision within 31 calendar days.

#### Explain effective dates

#### New full-time employees

If the employee's first scheduled workday is the *first* calendar day of the month, coverage begins that day (on the first of the month).

If the employee's first scheduled workday is the *first working day* of the month (first day of the month that is not a Saturday, Sunday or observed holiday), but not on the *first calendar day* of the month (for example, he begins on the 2<sup>nd</sup> or 3<sup>rd</sup> of the month), then the employee may choose when coverage begins:

- The first day of that month, or
- The first day of the following month.

If the employee's first scheduled workday is after the first calendar day and after the first working day of the month (after the first day that is not a Saturday, Sunday or observed holiday), coverage will begin the first day of the *following* month. Coverage of the spouse and/or children will become effective when the new employee's coverage becomes effective.

Life insurance coverage is subject to the Dependent Non-confinement Provision, as well as the Actively at Work requirement.

Explain any applicable late entrant procedures, open enrollment and special eligibility situations.

#### Tobacco certification

To avoid paying the tobacco-use premium, new employees must certify that neither they nor their covered spouse and/or child(ren) use tobacco products or electronic cigarettes.

When completing an online enrollment through MyBenefits or Current EBS, the tobacco and ecigarette use certification is submitted as part of the enrollment. The certification form is not required. The effective date for the waiver (or premium if certifying as tobacco or e-cigarette user) will be the effective date of coverage.

 Subscribers may also follow up and certify later by completing the Certification form and submitting it to you for signature and submission to PEBA. The effective date for the waiver (or premium if certifying as tobacco or e-cigarette user) will be the first of the month after PEBA receives the form.

If completing a paper *Notice of Election* (NOE), also complete and attach a <u>Certification Regarding</u> <u>Tobacco and E-cigarette Use</u> form before sending to PEBA for processing. The effective date for the waiver (or premium if certifying as tobacco or ecigarette user) will be the effective date of coverage.

• If the Certification form is not attached to the NOE and is sent later, the effective date for the waiver (or premium if certifying as tobacco or e-cigarette user) will be the first of the month after PEBA receives the form. If a change in status occurs that changes a subscriber's status for tobacco-use (i.e., a subscriber who does not use tobacco marries and enrolls his new spouse who does use tobacco), the subscriber must indicate the appropriate tobacco and ecigarette use on the online enrollment or complete a new certification form and submit to PEBA. The effective date for the premium will be the effective date of the coverage change.

Subscribers may apply to remove the premium once they and their covered spouse and/or child(ren) are tobacco- and e-cigarette-free for six months or if all covered individuals who use tobacco and/or ecigarettes complete the Quit For Life smoking cessation program. They may certify by completing the certification form and submitting it to you for signature and submission to PEBA. The premium will be removed the first of the month after PEBA receives the form.

Certification forms should not be held. Send them to PEBA immediately after being signed and dated.

### **MoneyPlus enrollment**

MoneyPlus is offered to all full-time employees who are also eligible for health, dental and vision coverage, regardless of whether they are enrolled in coverage. This program, administered by ASIFlex, was designed in compliance with sections 105, 125, 129 and 223 of the Internal Revenue Code (IRC).

MoneyPlus offers four features: the Pretax Group Insurance Premium feature, the Medical Spending Account (MSA), the Dependent Care Spending Account (DCSA) and the Limited-use MSA (LMSA). Participants in MSA, DCSA and LMSA accounts must re-enroll each year during open enrollment. Refer to the IBG for eligibility rules and information regarding these features.

If an employee has more than a 30-day break and is not considered a transfer or academic transfer, he will not be able to re-enroll in a MSA or DCSA until the next plan year. Note: In 2022, the Dependent Care Spending Account (DCSA) is capped at \$1,700 for highly compensated employees. However, the \$1,700 cap is subject to adjustment in mid-year if PEBA's DCSA does not meet the *Average Benefit Test*. The test is designed to make sure highly compensated employees don't receive a benefit that is out of proportion to the benefit received by other employees. For 2022, the Internal Revenue Code defines a highly compensated employee as someone who earned \$130,000 or more in calendar year 2021.

# Effect of MoneyPlus on other retirement plans

#### State retirement plan

Contributions to or benefits from the retirement systems administered by PEBA are based on an employee's gross salary. Participation in MoneyPlus has no effect on pension contributions or benefits.

#### **Deferred** Compensation

Contributions to a Deferred Compensation account are based on an employee's net salary. Pretax dollars set aside for MoneyPlus elections are not included in income when determining the maximum that can be contributed to a Deferred Compensation account.

#### **Social Security**

Pretax dollars set aside for MoneyPlus elections are not subject to Social Security taxes. Therefore, there may be a slight reduction in future Social Security benefits.

Employees do not typically contribute to a DCSA for more than a few years, but employees may contribute to an MSA for many years, and the amounts contributed may vary significantly year to year.

Employees should consult their tax preparer or adviser to discuss their options.

#### If both spouses are eligible

- Each may participate in MoneyPlus, but there may be limitations/certain restrictions.
- Either spouse may claim an expense, but not both.

#### Effective dates for enrollment and changes

The effective dates for enrollment and changes in the Medical Spending Account (MSA) and Dependent Care Spending Account (DCSA) are the same as for health, dental and vision coverage for new hires; change in status effective dates will vary. Eligible employees have 31 days to enroll or to make changes due to a change in status.

#### **Review MoneyPlus features**

#### **Pretax Group Insurance Premium**

This feature allows employees to pay insurance premiums for health, dental, vision and up to \$50,000 of Optional Life coverage before taxes. Once enrolled, the employee does not need to reenroll each year.

Be sure to forward the election to your payroll office.

An employee does not have to participate in the Pretax Premium feature to participate in the spending accounts.

#### Medical Spending Account and Dependent Care Spending Account

Employees can take advantage of tax-favored accounts to save money on eligible medical and dependent care costs.

Share the <u>MoneyPlus flyers</u> and refer the employee to <u>www.ASIFlex.com/SCMoneyPlus</u>. Note the monthly administrative fees.

- To participate in either account, the employee must enroll and elect an **annual** contribution amount.
- He must re-enroll each October to contribute the following year.

- The ASIFlex debit card is provided to MSA participants at no charge.
- Refer to the MoneyPlus COBRA section for employees who are retiring or otherwise terminating employment.

Limited-use Medical Spending Accounts are available to employees enrolled in the Savings Plan and a Health Savings Account. A Limited-use MSA will pay for expenses the Savings Plan does not cover, like dental and vision care.

#### **Comptroller General agencies only**

PEBA sends an enrollment file to SCEIS twice a month, and SCEIS uses it to determine the amount to be deducted on the next payroll. SCEIS sends the payroll file and contribution for each employee to ASIFlex along with the funds.

#### Medical Spending Account and Dependent Care Spending Account rules

Refer to the IBG for the eligibility information regarding these accounts.

- Participants may not be reimbursed twice for the same expense; an expense is not reimbursable if it is already covered under insurance or has been claimed through a spouse's flexible spending account.
- An employee has until December 31 to spend funds deposited in his MSA or Limited-use MSA during that year. An employee can carry over up to \$570 of unused funds into the next plan year.
- An employee has until March 15 to spend any remaining funds deposited in his DCSA from January through December of the previous year.
- An employee has a 90-day *run-out period* (until March 31) to file claims for services incurred during the previous plan year.
- An employee will forfeit any unused funds in his MSA or Limited-use MSA over the \$570 carryover amount not claimed by March 31.

- An employee will forfeit any unused funds in his DCSA not claimed by March 31. These funds cannot be returned to the employee or carried forward to a new plan year.
- ASIFlex provides easy access to account statements online or via the mobile app. In addition, account information is provided with each reimbursement.
- PEBA, at its discretion, may elect to send statements to participants who have an available balance. The statements are sent based on participant preference of email/text alert or USPS mail, and not more frequently than quarterly.
- ASIFlex includes a reminder of the 90-day run-out period in the statements.

#### **Medical Spending Accounts only**

Generally, the expense must be incurred prior to reimbursement. Incurred means that the service or supply has been provided that gives rise to the expense, regardless of when paid or billed.

If the employee has an ASIFlex debit card, ASI will auto-adjudicate debit card transactions it can match to claims received from other vendors. If ASIFlex cannot validate a claim, the employee will need to provide documentation for that transaction. The account must be reimbursed for any ineligible expenses that were paid with the card.

- Requests for documentation are emailed and posted online to the employee's ASIFlex account. The employee will have 52 days to respond, or the card will be deactivated. The employee will receive three notices before the card is deactivated.
- When documentation is submitted, the employee's card will be automatically reinstated.

If the employee does not have or use the ASIFlex debit card, he will need to submit a claim online or via the ASIFlex mobile app. The employee may also submit a paper claim form, along with any pertinent documentation. Any debit card transactions not cleared by March 31 after the plan year ends are in violation of IRS guidelines and may be taxable as income. In this situation, the transactions will be reclassified by the employer and may need to be included on next year's W-2 as income.

#### Orthodontia

There are special rules regarding orthodontia:

- The initial service (banding) must have occurred before reimbursements may begin.
- A contract payment agreement from your orthodontist can be provided with your claim, and you can be reimbursed as payments are made based on the agreement. You must also provide proof of payment, and reimbursement is made from the plan year in which the payment is made.

#### Whose expenses are eligible under an MSA?

- Employee;
- Employee's spouse;
- Employee's qualifying child; or
- Employee's qualifying relative.

An individual is a **qualifying child** if he is not someone else's qualifying child, and:

- Is a U.S. citizen, national or resident of the U.S., Mexico or Canada;
- Has a specified family-type relationship to the employee: son/daughter, stepson/stepdaughter, eligible foster child, legally adopted child, or child placed for legal adoption;
- Lives in the employee's household for more than half of the tax year;
- Does not reach age 27 during the taxable year; and
- Has not provided more than half of his own support during the tax year.

An individual is a **qualifying relative**, if he is a U.S. citizen, national or resident of the U.S., Mexico or Canada, and:

- Has a specified family-type relationship to the employee, is not someone else's qualifying child and receives more than half of his support from the employee during the tax year, or
- If no specified family-type relationship to the employee exists, is a member of, and lives in, the employee's household (without violating local law) for the entire tax year and receives more than half of his support from the employee during the tax year.
- "Qualifying relative" is a federal term and has no bearing on whether you can cover that person as a dependent under the state insurance benefits.

Note: There is no age requirement for a qualifying child if he is physically and/or mentally incapable of self-care. An eligible child of divorced parents is treated as a child of both, so either or both parents can have an MSA.

#### **Dependent Care Spending Accounts only**

Sufficient funds must be available for eligible expenses to be reimbursed.

• Funds are posted to participants' accounts upon processing of MoneyPlus payrolls.

Claims for which there are insufficient funds will be held and processed as the funds become available; the employee should not need to refile.

The expense (or period of service, such as a month's worth of daycare) must be incurred prior to reimbursement.

#### Whose expenses are eligible under a DCSA?

The employee may use his DCSA to receive reimbursement for eligible dependent care expenses for qualifying individuals. A qualifying individual includes a **qualifying child** if the child:

- Is younger than 13 or is physically or mentally incapable of self-care;
- Is not someone else's qualifying child;
- Is a U.S. citizen, national or resident of the U.S., Mexico or Canada;

A qualifying individual includes the employee's **spouse** if the spouse:

- Is physically and/or mentally incapable of self-care;
- Lives in the employee's household for more than half of the tax year; and
- Spends at least eight hours per day in the employee's home.

A qualifying individual includes the employee's **qualifying relative** if the relative:

- Is a U.S. citizen, national or resident of the U.S., Mexico or Canada;
- Is physically and/or mentally incapable of self-care;
- Is not someone else's qualifying child;
- Lives in the employee's household for more than half of the tax year;
- Spends at least eight hours per day in the employee's home; and
- Receives more than half of his support from the employee during the tax year.

Note: If the employee is the tax dependent of another person, he cannot claim DCSA expenses for other qualified individuals. The employee cannot claim a qualifying individual if that individual files a joint tax return with a spouse. If the parents of a child are divorced or legally separated, only the custodial parent can be reimbursed for child care through the DCSA.

### Health Savings Account enrollment

The Savings Plan goes hand in hand with a Health Savings Account, or HSA, which pays for future outof-pocket medical expenses. Eligible employees may enroll in an HSA at any time. They may change their HSA elections on a monthly basis. HSA changes become effective the first of the month following the change.

Share the *Health Savings Account* flyer.

To participate, the employee must enroll in the Savings Plan and elect to contribute to an HSA. HSA Central will automatically set up the bank account based on enrollment information from PEBA. The member will receive a welcome email from HSA Central once the account is set up and will receive a debit card within seven to 10 business days. To fully open the account, the member must log in to his online account at <u>schsa.centralbank.net</u>, accept the terms and conditions, and activate his debit card.

HSA Central charges all HSA participants a monthly fee of \$0.50 regardless of balance, which is automatically deducted from the account.

#### **Comptroller General agencies only**

If your payroll is processed through the CG's office, see Page 43 for instructions about how to change existing deductions or add new deductions.

#### **HSA rules**

If both spouses contribute to an HSA, and one of them has family coverage (employee/spouse, employee/children or full family coverage), their combined HSA contributions cannot exceed the IRSallowed limit for family coverage. If both spouses have employee-only coverage, each may contribute up to the IRS-allowed limit for single coverage.

Expenses are reimbursable only if there are sufficient funds in the account. Participants may use their HSA debit cards from HSA Central to pay for eligible expenses. Reimbursements are not requested through ASIFlex.

Participants may not be reimbursed twice for the same expense. An expense is not reimbursable if it is already covered at no cost under insurance. Participants are solely responsible for maintaining proper documentation of eligible expenses and providing it to the IRS, if requested.

HSA Central provides monthly online statements to participants. Paper statements are available for an additional \$3 monthly fee.

HSA funds belong to the participants, so balances carry over annually and remain with them even if they change jobs or retire.

An employee may defer reimbursements, until later tax years, if the eligible expenses were incurred after the HSA was established and the employee is keeping sufficient records to document the eligible expenses.

Participants will receive annual tax forms from HSA Central to use for tax filing purposes.

### **GEA TRICARE Supplement Plan enrollment**

When enrolling an employee in the GEA TRICARE Supplement Plan, submit a copy of the employee's TRICARE Card with the enrollment.

- PEBA will process the enrollment and send information to Selman & Company.
- Selman & Company will verify the employee's eligibility with the Defense Enrollment Eligibility Reporting System (DEERS).
- If the employee is eligible, Selman & Company will send him a GEA TRICARE Supplement Plan enrollment packet.

The monthly premium includes a minimal administrative fee for the processing of premium payment, which may appear as a discrepancy between Selman & Company's billing statement and subscriber's payroll deducted amount.

### Assisting a newly eligible variable-hour, part-time or seasonal employee

New variable-hour, part-time or seasonal employees are not offered benefits when they are first hired. Instead, the employer must measure the employee's hours over an initial 12-month measurement period to determine whether the employee will be eligible for benefits. A new variable-hour, part-time or seasonal employee credited with an average of 30 hours per week during his Initial Measurement Period may enroll during an Initial Administrative Period, which begins the day after the end of his Initial Measurement Period and ends the last day of the same calendar month. Once an employer deems an employee eligible for benefits, the employee remains eligible for 12 months during his Initial Stability Period regardless of the number of hours the employee works.

*Example*: An employee hired on February 5, 2022, would not have been employed for the entire Standard Measurement Period (October 4, 2022-October 3, 2023); therefore, the employee will have his own Initial Measurement Period, Administrative Period and Stability Period:

- Initial Measurement Period: January 1, 2023-December 31, 2023
- Initial Administrative Period: January 1, 2024-January 31, 2024
- Initial Stability Period: February 1, 2024-January 31, 2025

During the Administrative Period, the employer would review the hours worked by the employee during his Initial Measurement Period. If the employee is deemed eligible for benefits, the employer would offer coverage and complete the enrollment by January 31, 2024. If the employee was deemed eligible for benefits, he would remain eligible for the duration of his Stability Period, regardless of the number of hours he works.

In accordance with the ACA and as defined in paragraphs 3.23 of the *Plan of Benefits* document, variable-hour, part-time and seasonal employees who are eligible for benefits are eligible for all benefits.

Eligible employees must elect or refuse coverage within the employee's designated Administrative Period. Coverage is effective the first of the month after the end of the Administrative Period. Employees enrolling in a health plan must also certify their tobacco or e-cigarette use. The employee is allowed to change his mind about an original selection within the Administrative Period. To make a new selection, a paper *Notice of Election* must be signed within the 31-day window and submitted to PEBA for processing as a revision.

#### **Completing the enrollment**

The same procedures apply for completing the enrollment of an active subscriber (see Page 20) with the following exception:

**STATUS**: Select the category for the type of employee who is enrolling in coverage.

 While variable-hour, part-time and seasonal employees are eligible for active employee benefits, they are not automatically eligible for retiree coverage if they retire from a nonpermanent position. See the Retiree section beginning on Page 92 for retiree eligibility requirements, including that the last five years of active employment must be full-time, permanent and consecutive.

### Assisting a permanent, parttime teacher

As defined in S.C. Code Ann. §59-25-45 and in paragraph 2.53 of the Plan of Benefits document, permanent, part-time teachers of S.C. public schools, the S.C. Department of Corrections, the S.C. Department of Juvenile Justice and the S.C. School for the Deaf and Blind may be eligible for:

- Health (State Health Plan and GEA TRICARE Supplement Plan).
- Dental Plus and Basic Dental.
- State Vision Plan.
- MoneyPlus.
- Health Savings Account.

Permanent, part-time teachers are *not* eligible for:

- Basic Life insurance.
- Optional Life insurance.
- Dependent Life insurance for children or spouses.

- Basic Long Term Disability.
- Supplemental Long Term Disability.

The employee must be in a contract position and receive an EIA (Education Improvement Act of 1984) salary supplement. In addition to classroom teachers, this may also include other academic personnel, such as librarian/media specialists, guidance counselors, ROTC (Reserve Officer Training Corps) instructors, school nurses, social workers, psychologists, audiologists or other instructional staff. Contact the Department of Education at 803.734.8122 for additional information pertaining to the specific law or determining eligibility of a position.

The employee must work at least 15 hours per week, but fewer than 30 hours per week. There are three part-time categories based on the number of hours worked per week (Category I = 15-19 hours; Category II = 20-24 hours; Category III = 25-29 hours). Premiums are based on the applicable category.

An employee who is eligible as a permanent, parttime teacher and also eligible as a spouse under a covered spouse's file may elect coverage as a permanent, part-time teacher or as a spouse, but not both. A permanent, part-time teacher with health, dental and/or vision coverage as a subscriber cannot be covered on the spouse's plan under any benefit (health, dental, vision or Dependent Life).

If the employee wants to remain on his spouse's coverage, complete an <u>Active Part-time Teachers</u> <u>NOE</u> refusing all coverage and send it to PEBA.

While permanent, part-time teachers are eligible for active employee benefits under §59-25-45, they are not automatically eligible for retiree coverage if they retire from a part-time teacher position. See the Retiree section beginning on Page 92 for retiree eligibility requirements, including that the last five years of active employment must be full-time and continuous. Eligible employees must enroll within 31 days of date of hire by enrolling through EBS/MyBenefits or by completing an <u>Active Part-time Teachers NOE</u>.

Effective dates of coverage are the same as for other new hires. The 31-day window for elections and changing elections is also the same as for other new hires.

Employees enrolling in a health plan must also certify their tobacco use.

#### **Completing the enrollment**

When completing the permanent *Part-Time Notice of Election*, select one category based on the number of hours worked each week. Confirm the accuracy of the selection.

# Process for medical emergencies

If a subscriber has a medical emergency and an enrollment or change needs to be processed the same day, complete the transaction in EBS. A BIN will be generated immediately. See the **Using the online system** chapter for more information.

- If you are unable to get the employee's signature on the SOC or SOE, include a copy of the signed *Notice of Election* form. After the transaction is complete and you have uploaded the documentation required, if any, call PEBA's BA Contact Center.
- If the subscriber's file is in suspense because of a rejection, call PEBA's BA Contact Center. The call center representative will delete the suspended transaction so that you can complete the transaction in EBS. After the transaction has been approved, the call center representative will release it and update the third-party claims processors.

A subscriber can obtain medical services before he has an insurance card by giving his member ID to his provider.

- If the subscriber is enrolled, his member ID is ZCS followed by his BIN.
- If the subscriber is enrolled in the GEA TRICARE Supplement Plan, his member ID is PC followed by his BIN.

A subscriber can obtain prescription drugs before he has an insurance card.

State Health Plan subscribers can tell the pharmacist they are with Express Scripts. The pharmacist may need only the member's name and his eight-digit claim. If the pharmacist needs more information from the card:

- All active employees and their covered dependents should provide:
  - RxGroup: SCPEBAX;
  - o RxPCN: A4; and
  - o RxBIN: 003858.
- Retirees not enrolled in Medicare should provide:
  - RxGroup: SCPEBAX;
  - RxPCN: A4; and
  - o RxBIN: 003858.
- Retirees enrolled in Medicare should provide:
  - RxGroup: 7258MDRX;
  - RxPCN: MEDDPRIME; and
  - o RXBIN 610014.

### National Medical Support Notices

National Medical Support Notices (NMSNs) are forms sent to employers when an employee is under an existing court or administrative order to provide insurance for his child(ren). Timely completion helps ensure children have the required coverage.

If you receive an NMSN, email it to PEBA at <u>medicalsupportnotices@peba.sc.gov</u> as soon as possible. The format of the notice may vary, but it will always say National Medical Support Notice at the top of the first page, and it will have sections

labeled Employer Response and Plan Administrator Response.

- Complete only the Employer Response section and return it to the issuing child support agency before you send a copy to PEBA.
- You do not have to complete an NOE.
- Please note, the information on the custodial parent and child(ren) contained on the NMSN must not be shared with the employee. Additionally, the NMSN must not be placed in the employee's file unless identifying information for the child and custodial parent has been redacted. If the employee has questions concerning the coverage requirements and plan choice, please refer the employee to the issuing agency.
- PEBA will complete the Plan Administrator Response and send it to the issuing agency.
   PEBA will also complete any extra forms or questionnaires about health insurance that might be included. You will be notified if election changes are made.

**NOTE:** Special eligibility situation rules do not apply to NMSNs. Subscribers may not make changes to their benefits other than those specified in the NMSN, which PEBA will determine. Subscribers are not allowed to make coverage changes through MyBenefits.

Compliance with the NMSN is mandatory under federal law. PEBA **cannot** discontinue coverage until the issuing agency sends an updated NMSN or other order.

When an employee who is covering a child under an NMSN leaves employment, send a COBRA notice for the child to the custodial parent listed on the NMSN.

# **Rules and procedures for late entrants**

#### Health plans

- The employee must wait until the next October enrollment period to enroll as a late entrant or to add a spouse or child(ren) as a late entrant. Someone who enrolls due to a special eligibility situation is not considered a late entrant.
- No medical evidence of good health is required for subscribers, their spouses or children.
- There are no pre-existing condition exclusions under any of the health plans offered through PEBA.

#### Dental

- The employee must wait until the next open enrollment period of an odd-numbered year to enroll as a late entrant or to add a spouse or child(ren) as a late entrant.
- There is no dental underwriting for subscribers, their spouses or children.
- There are no pre-existing condition exclusions under Dental Plus or Basic Dental.

#### Vision care

#### (Group number 9925991)

- The employee must wait until the next October enrollment period or special eligibility situation to enroll in the State Vision Plan as a late entrant or to add a spouse or child(ren) as a late entrant.
- There is no medical evidence of good health for subscribers, their spouses or children.
- There are no pre-existing condition exclusions under the State Vision Plan.

#### Life insurance

#### **Optional Life**

#### (Policy number 200879)

- If they do not participate in the MoneyPlus pretax premium feature, eligible participants may enroll in Optional Life or increase coverage throughout the year.
- Late entrants must provide medical evidence and be approved.
- If they do participate in the MoneyPlus pretax premium feature, eligible participants may enroll in Optional Life or increase coverage only during announced enrollment periods or within 31 days of a special eligibility situation.
- Late entrants must provide medical evidence and be approved.

Refer to Page 56 for the procedures for adding and changing Optional Life insurance coverage outside of a new hire situation.

#### **Dependent Life-Spouse**

#### (Policy number 200879)

- Eligible spouses may be added throughout the year.
- Medical evidence is required for spouses enrolled as late entrants.

Refer to Page 58 for the procedures for adding and increasing Dependent Life insurance coverage with medical evidence.

#### **Dependent Life-Child**

#### (Policy number 200879)

- Eligible dependent children may be added throughout the year.
- No medical evidence is required for children enrolled as late entrants.

#### Supplemental Long Term Disability

#### (Policy number 621144A)

- Have the employee complete the <u>Medical</u> <u>History Statement for Late Entrants and</u> <u>Instructions</u>.
- Send the completed original to Standard Insurance Company.
- When an approval is received from The Standard, have the employee complete a paper Notice of Election to select the coverage for which he was approved. This may be done earlier and held for approval from The Standard.
- Send the approval from The Standard with the paper NOE to PEBA.
- Premiums start with the effective date of coverage (first of the month after approval).

# Changes in status and special eligibility situations

#### (Health, Dental Plus/Basic Dental, State Vision Plan, Dependent Life, MoneyPlus and Health Savings Accounts)

Enrollment changes must be requested within 31 days of the changes in status that follow, and any supporting documentation must be submitted. Changes not made within 31 days of the event cannot be made until the next open enrollment period or until another change in status or special eligibility situation occurs.

If the change in status or special eligibility situation changes the tobacco-use status, the subscriber must indicate the appropriate Tobacco Coverage on the paperless enrollment or complete a new Certification form and submit to PEBA with the NOE. The effective date for the premium will be the effective date of the coverage change on enrollment.

More information on changes related to a spouse or child(ren) can be found on Page 106.

#### Gain of other group coverage

**Effective date to drop PEBA coverage:** First of the month after gaining other coverage or the first of the month if coverage is gained on the first of the month. See exceptions for gaining Medicare and Medicaid effective dates below.

An exception to the 31-day rule exists when a spouse who gains coverage or becomes eligible for coverage *as a subscriber of a participating employer* must be dropped from the employee's coverage. If the employee fails to drop the ineligible spouse within 31 days, the spouse may be dropped retroactively to coincide with the date the spouse was added to coverage at the other participating employer.

An employee may terminate health, dental and/or vision coverage if he gains other group coverage. He can drop only the type of coverage he gained.

An employee may drop a spouse or child(ren) from coverage if his spouse or child(ren) gains other group coverage. Only the spouse or child(ren) who gained other coverage may be dropped. The spouse or child(ren) can be dropped only from the type of coverage he gained.

- However, if the spouse is gaining coverage as an employee of a *participating employer*, the subscriber must drop the spouse within 31 days; he cannot wait until the open enrollment period.
- If a spouse or child(ren) gains eligibility for coverage and attempts to enroll as an employee of a *participating employer*, PEBA will reject the enrollment, because the spouse or child(ren) must be terminated from the other coverage first.

A gain of other group coverage notice is required only if the group is **not** participating with PEBA insurance benefits. The notice must be submitted in EBS or attached to the NOE.

• The gain of coverage notice must include the effective date of coverage, the type(s)

of coverage (health, dental and/or vision) and list all individuals who gained coverage.

 The notice must state gained health coverage to change coverage level or drop health coverage; it must state gained dental coverage to drop dental coverage; it must state gained vision coverage to drop vision coverage. *Exception*: Medicaid includes health, dental and limited vision coverage (for children only) automatically.

If the group is participating with PEBA insurance benefits, write *Gained State Coverage* at the top of the NOE.

If the subscriber has not received the gain of coverage notice, and the deadline to enroll in PEBA coverage is nearing, complete the transaction in EBS or submit the NOE without the letter. Submit the letter as soon as it is available. Changes will not be processed until all documents have been received.

#### Gain of Medicare coverage

**Effective date to drop PEBA coverage:** First of the month after the gain of Medicare or the first of the month if Medicare is gained on the first of the month. If the effective dates of Part A and Part B are different, the subscriber can make a change in coverage through PEBA only within 31 days of the confirmation letter from the Social Security Administration. The letter is typically sent when the subscriber becomes eligible for Part A.

An employee may terminate health coverage if he gains Medicare.

An employee may drop a spouse or child(ren) from health coverage if his spouse or child(ren) gains Medicare. Only the spouse or child(ren) who gained Medicare may be dropped.

A copy of the Medicare card, verifying gain of Medicare coverage, must be attached to the NOE.

Note on Medicare Part B and Medicare Part D: Most active employees who become eligible for Medicare at age 65 should delay enrolling in Medicare Part B, because their coverage through PEBA remains primary while they are working. Likewise, most active employees should not sign up for a separate Medicare Part D plan, because their prescription drug expenses will continue to be covered through their plan with PEBA. If an active employee signs up for Part D, PEBA will *not* be able to drop his prescription drug coverage.

There are exceptions for employees who become eligible for Medicare due to disability or end-stage renal disease. Refer to the *Insurance Benefits Guide* or call PEBA's Customer Service for more information.

When an individual begins dialysis for end-stage renal disease, he becomes eligible for Medicare typically three months after beginning dialysis. At this point, he begins a coordination period of 30 months. During this time, his coverage through the State Health Plan remains primary. When the coordination period ends, Medicare becomes primary. The coordination period applies whether the subscriber is an active employee, a retiree, a survivor or a covered spouse or child, and regardless of whether the subscriber was already eligible for Medicare due to another reason, such as age. If the subscriber was covered by the Medicare Supplemental Plan, he will be changed to the Standard Plan during the 30-month coordination period.

#### Gain of Medicaid coverage

**Effective date to drop PEBA coverage:** Effective date of the Medicaid coverage.

*Exceptions to the 31-day rule:* If the subscriber and his covered family members become eligible for Medicaid or the Children's Health Insurance Program (CHIP), the subscriber has 60 days from the date of notification to drop coverage through PEBA. If the Medicaid effective date is retroactive more than 60 days before the date of notification, then the effective date will be the first of the month after the request. If the subscriber notifies PEBA more than 60 days after he was notified by Medicaid, no changes are allowed.

An employee may terminate health, dental and/or vision coverage if he gains Medicaid.

An employee may drop a spouse or child(ren) from coverage if his spouse or child(ren) gains Medicaid. Only the spouse or child(ren) who gained Medicaid may be dropped.

A copy of the Medicaid approval letter must be attached to the NOE or submitted in EBS.

Medicaid coverage includes health, dental and vision coverage. The vision coverage includes an annual eye exam and a pair of glasses following cataract surgery. Vision coverage for children younger than age 21 includes one eye exam and one pair of glasses once a year. For most adults ages 21 and older, this dental coverage includes emergency services only, such as extractions or treatment for acute infections. Dental coverage for children younger than age 21 includes basic coverage with preventive services. For more information on Medicaid coverage, contact DHHS (contact information will be on the Medicaid approval letter).

#### Loss of other group coverage

#### (Includes Medicare and Medicaid)

Effective date: The date of the loss of coverage.

*Exceptions to the 31-day rule:* If the subscriber and his covered family members lost coverage through Medicaid or the Children's Health Insurance Program (CHIP), the subscriber has 60 days to enroll in coverage through PEBA.

If the subscriber loses other health coverage, and he is not already enrolled in health through PEBA, he can enroll himself, his spouse and his child(ren) in health, Dental Plus or Basic Dental and vision. The subscriber must enroll in coverage he is adding for his spouse or child(ren). He cannot drop or change his current coverage.

If the subscriber is already enrolled in health through PEBA, he cannot make changes.

If the subscriber loses other dental coverage, he can enroll in Dental Plus or Basic Dental.

If the subscriber loses other vision coverage, he can enroll in vision.

If the subscriber's spouse or child(ren) loses other health coverage, he can enroll himself and the spouse or child(ren) who lost coverage in health, Dental Plus or Basic Dental and vision. The subscriber must enroll in coverage he is adding for his spouse or child(ren). If the subscriber is already enrolled in health, he may change plans if he adds the spouse or child(ren) who lost coverage. He cannot drop his current coverage.

If the subscriber's spouse or child(ren) loses other dental coverage, he can enroll himself and the spouse or child(ren) who lost coverage in Dental Plus or Basic Dental. The subscriber must enroll in coverage he is adding for his spouse or child(ren).

If the subscriber's spouse or child(ren) loses other vision coverage, he can enroll himself and the spouse or child(ren) who lost coverage in vision. The subscriber must enroll in coverage he is adding for his spouse or child(ren).

If the subscriber's spouse loses other life insurance coverage, it is not a special eligibility situation. However, the subscriber may add the spouse to Dependent Life with medical evidence throughout the year. If the subscriber's spouse loses life insurance coverage as an employee of a PEBA insurance benefits-participating employer, the spouse may be added to Dependent Life (\$10,000 or \$20,000 in coverage) without medical evidence.

Documentation of dependent eligibility must be submitted in EBS or attached to the NOE.

- A marriage license or Page 1 of the employee's latest federal tax return if filing jointly is required to add a spouse.
- A long-form birth certificate showing the subscriber as the parent is required to add a child.
- A long-form birth certificate and marriage license naming spouse as parent is required

to add a stepchild. Return the completed form to PEBA.

# Documentation of loss of coverage should be uploaded in EBS or attached to the NOE.

Acceptable documentation is a creditable coverage letter or a notice that includes the effective date of the loss of coverage, the type of coverage lost (health, dental and/or vision), and the names of all individuals who lost coverage.

- If the coverage that was lost was through a participating employer, write Lost State Coverage at the top of the NOE. This will alert PEBA staff to access the previous coverage data on the individual.
- If the subscriber loses other health coverage, and he is not already enrolled in health through PEBA, his spouse and child(ren) can be added to health, Dental Plus, Basic Dental and vision even if they are not listed on the loss of coverage letter. The letter does <u>not</u> need to state subscriber lost dental or vision for him to enroll in those coverages.
- If the subscriber's spouse or child(ren) loses other health coverage, the loss of coverage letter does <u>not</u> need to say spouse or child(ren) lost dental or vision for the spouse or child(ren) to enroll in Dental Plus or Basic Dental and vision.

If the subscriber has not received the loss of coverage letter, and the deadline to enroll in PEBA coverage is nearing, complete the transaction in EBS or submit the NOE without the letter. Submit the letter as soon as it is available. Changes will not be processed until all documents have been received. The effective date will remain the date of loss of other coverage.

#### Note about premiums

If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of loss of coverage. Premiums may be paid pretax beginning the first of the month following the date of the request.

#### Loss of TRICARE coverage

**Effective date to drop PEBA coverage:** First of the month after a subscriber or dependent is no longer eligible for TRICARE, if enrolled in the TRICARE Supplement.

Selman & Company provides employers with monthly eligibility reports. If a subscriber or dependent is no longer eligible for TRICARE, submit a paper NOE and a copy of the report from Selman & Company to PEBA to cancel coverage.

- Strike through any information that doesn't apply to that specific subscriber or dependent.
- If the report lists more than one subscriber or dependent who lost eligibility, attach a copy of the report to each NOE.

# MoneyPlus change in status rules

The rules and effective dates for changes in status are similar to those for health insurance. There are some additional changes that are allowed by the IRS. Refer to the *Flexible Benefits Plan* document for these allowed changes. For example, a child turning age 13, who is no longer eligible for dependent care, is an allowed change in status event for Dependent Care Spending Accounts.

Eligible employees have 31 days to enroll or to make a change when a qualifying change in status occurs. The payroll adjustment must coincide with the effective date of the change in status.

Changes/new elections must be consistent with a qualifying family status change. For example, decreasing your Medical Spending Account contributions when your adult child gets a job and coverage elsewhere is consistent with the gain of other coverage; increasing your contributions is not.

- Pretax Group Insurance Premium feature: If the employee is eligible to change health, dental, vision or Optional Life coverage due to a change in status, he may also enroll in or drop his Pretax Group Insurance Premium feature.
- Dependent Care Spending Account: If a DCSA is terminated, the employee can continue to submit claims, while employed, until the end of the year or until the account is exhausted.
- Medical Spending Account: If an MSA is terminated, the employee can submit expenses incurred before the first of the month following the last day worked.

Refer to the Transfers and terminations section and the COBRA section of this manual for more information on continuation of MSAs at termination.

# Completing the enrollment for a change in status

Use EBS when an employee wants to change his MoneyPlus account(s) due to a change in status.

Select MoneyPlus as the Reason for Change and select the Sub-Reason from the drop-down list. Enter the date of the event, not the effective date of the change. Complete the enrollment change(s) and apply to MyBenefits or Current EBS.

Note that certain changes are not allowed due to the defined change reason.

Deductions for any accounts which the employee has but does not wish to change as a result of the change in status will remain the same.

If completing the enrollment change(s) on a paper *Notice of Election* form, follow the NOE instructions and check and date all qualified change events for MSA and DCSA accounts, then return the completed form to PEBA.

If PEBA does not receive the enrollment change before the participant submits claims related to the change in status, those claims may be rejected. If ASIFlex does not receive adjusted payroll data that matches the payroll effective date or payroll amount on the form, related claims may be rejected.

### Coverage changes for permanent, part-time teachers

#### (Health, dental and vision)

The policies and procedures regarding health, dental and vision changes for active subscribers also apply to permanent, part-time teachers.

# Increase or decrease in the number of contract hours

If the increase or decrease in an employee's contracted work hours causes a change in status (i.e., from 15 to 25 hours per week, etc.):

- Submit a new NOE, reflecting the change in status.
- If this is a temporary change, you do not have to notify PEBA, and no changes should be made.
- If an increase in hours makes the employee eligible as a permanent, part-time teacher:
  - The date of hire will be the date of the contract change.
  - The effective date will be the first of the month after the date of the contract change (or the first working day of the month, if applicable).

If an employee's work hours are contractually reduced to fewer than 15 hours per week:

Submit the termination in EBS. For the termination reason, choose Left Employment. If submitting an <u>Active</u> <u>Termination Form</u>, check the T5 box, Not Eligible (Not in a Stability Period). Change is effective the first of the month after the work hours are reduced.

The employee may make new health and dental selections based on an increase or decrease in hours.

- If the decrease in hours places the employee in a lower category (e.g., he enrolled in Category III working 26 hours and the contract changes to 23 hours), he may decrease or increase his coverage.
- If the increase in hours places the employee in a higher category (e.g., he enrolled in Category I working 17 hours and the contract changes to 23 hours), he may select and/or increase his benefits.
- If the increase in hours reaches 30 hours per week, classifying him as a permanent, full-time employee, he is eligible to make all new selections. Treat him as a new hire and offer all benefits to him, effective the first of the month after he reaches permanent, full-time status.

### **Other coverage changes**

#### **Optional Life**

To determine the allowable timeline for changes to Optional Life coverage, review whether the employee participates in the MoneyPlus Pretax Group Insurance Premium feature.

#### Not participating in MoneyPlus Pretax Premium feature

The 31-day rule does not apply if a subscriber is **not** participating in the MoneyPlus Pretax Premium feature. Subscribers **not** participating in the Pretax Premium feature may:

- Add or increase coverage at any time during the year by providing medical evidence, with approval from MetLife:
  - Complete an online Statement of Health form. Employers will submit a Life Insurance Statement of Health Request in EBS by selecting the Life Ins SOH button on the homepage to initiate the process. If additional information or

medical data is needed, MetLife will send a letter to the subscriber.

- MetLife allows 60 days to respond to the request for additional information. A reminder letter is sent if no response is received within 31 days. If no response is received in another 31 days, the file is closed.
- MetLife subcontracts for a paramedical exam if an exam is necessary to make a determination. If required, this step also follows the same 31- and 60-day process.

Once MetLife receives all needed information, a decision usually will be made within 10 business days. MetLife mails a Notification Statement to the subscriber and emails the employer with a determination. Contact MetLife at <u>scpeba@metlife.com</u> if you are not receiving the determination spreadsheet.

Submit the change in EBS by selecting Optional Life Changes – Not a MoneyPlus participant as the Reason for Change and select the Sub-Reason from the drop-down list. Enter the approval date from MetLife. Complete the enrollment change(s) and apply to MyBenefits or Current EBS. A copy of the MetLife approval is required as supporting documentation.

If submitting on a *Notice of Election* form, forward a copy of the weekly *Statement of Health Report* from MetLife and the NOE that shows the increase in coverage to PEBA so the subscriber's file can be updated and the billing statement adjusted.

The effective date will be the first of the month after approval from MetLife.

2. Add or increase coverage, without medical evidence, due to a special eligibility situation:

- The change must be made within 31 days of the special eligibility situation (marriage, divorce, birth, adoption or placement for adoption).
- The effective date of the change will be the first of the month after the change is requested.
- If the subscriber refused Optional Life as a new hire, he may add coverage, up to \$50,000 (in increments of \$10,000).
   If the subscriber is already enrolled in Optional Life, he may increase coverage, up to an additional \$50,000 (in increments of \$10,000 and not to exceed the maximum amount allowed).
- 3. Decrease coverage: Effective the first of the month after the change is requested.
- 4. Cancel coverage: Effective the first of the month after the change is requested.

#### Participating in MoneyPlus Pretax Premium Feature

Changes must be made within 31 days of the special eligibility situation or the employee must wait until the next enrollment period. Subscribers participating in the Pretax Premium feature may:

- Add coverage. The Optional Life request must be consistent with the special eligibility situation. If the subscriber refused Optional Life as a new hire, he may:
  - Add coverage, up to \$50,000 (in increments of \$10,000), without medical evidence. The effective date of the change will be the first of the month after the change is requested.
  - Add coverage, more than \$50,000 (in increments of \$10,000 and not to exceed the maximum amount allowed), with medical evidence. Complete an online *Statement of Health* form. Employers will submit a *Life Insurance Statement of Health Request* in EBS by selecting the Life Ins SOH button on the homepage to initiate the process.

Complete the special eligibility enrollment in EBS, requesting the level for which the employee is eligible without medical evidence (\$50,000), effective the date of the event. Complete the NOE for the *total amount* of coverage (with medical evidence) and hold until approval is received from MetLife.

Once approved, send the NOE, with the weekly *Statement of Health* Report from MetLife, to PEBA. Each NOE should be accompanied by a *Statement of Health* – not one report for multiple NOEs.

The effective date will be the first of the month after approval from MetLife.

- Increase coverage, up to an additional \$50,000, without medical evidence. The effective date will be the first of the month after the change is requested.
- 3. Increase coverage, more than \$50,000, with medical evidence.

Complete the special eligibility enrollment in EBS, requesting the level for which the employee is eligible without medical evidence (\$50,000), effective the date of the event. Complete the NOE for the *total amount* of coverage (with medical evidence) and hold until approval is received from MetLife.

Once approved, send the NOE, with the weekly *Statement of Health Report* from MetLife, to PEBA.

- 4. Decrease coverage. The Optional Life request must be consistent with the special eligibility situation. The effective date will be the first of the month after the change is requested. *Exception*: The effective date for the death of a spouse will be the day after death, as with other benefits.
- 5. Cancel coverage. The Optional Life request must be consistent with the special eligibility situation. The effective date will be the first of the month after the change is requested. *Exception*: The effective date for

the death of a spouse will be the day after death, as with other benefits.

**Effective date note:** If the employee is not *actively at work* (the employee is absent from work due to a physical or mental condition, including absence due to maternity/birth) on the date his Optional Life selection becomes effective (add Optional Life coverage or increase in the level of Optional Life), the effective date will be the first of the month after the employee returns to work for one full day. The "Actively at Work" requirement is defined in the IBG's Life insurance chapter.

#### If request for additional coverage is denied

If MetLife denies additional coverage, based on medical evidence:

- The employee may request from MetLife, in writing, additional information regarding the denial.
- Do not forward the NOE or denials to PEBA.
- If denied, the employee may reapply by submitting a new online *Statement of Health* form.

#### Dependent Life

#### **Dependent Life-Spouse**

- Coverage of up to \$20,000 may be added within 31 days of date of marriage, birth, adoption or within 31 days of loss of other coverage with a participating employer, without providing medical evidence.
- Coverage may be added, increased, decreased or canceled throughout the year.
- Medical evidence is required for late entry and to increase Dependent Life-Spouse coverage beyond \$20,000, up to the maximum allowed.

#### Medical evidence procedures:

- Complete an NOE, listing the spouse to be added to coverage or to have coverage increased.
- Complete an online *Statement of Health* form. Keep a copy to hold in the pending

file. Employers will submit a *Life Insurance Statement of Health Request* in EBS by selecting the Life Ins SOH button on the homepage to initiate the process.

- Once approved, send the NOE along with the weekly Statement of Health Report from MetLife and the copy of the Statement of Health form to PEBA.
- MetLife will notify the subscriber of the approval/denial.
- The effective date will be the first of the month after approval from MetLife.

Effective date note: Under the Dependent Nonconfinement Provision, if a spouse or child (other than a newborn) is confined to a hospital or elsewhere due to a physical or mental condition on the date his Dependent Life selection should become effective (because Dependent Life coverage is added or there is an increase in the level of Dependent Life), the effective date will be the date the spouse or child is discharged or no longer confined. To be confined elsewhere means the spouse or child is unable to perform the normal functions of daily living or is unable to leave home without assistance.

If MetLife denies coverage, refer to the Optional Life Insurance denial information on Page 58.

#### **Dependent Life-Child**

- If there is only one child on coverage, terminate the coverage in EBS.
- Other changes must be made on an NOE, dated and signed by the subscriber and the benefits administrator. *Exception:* Newborns are automatically covered for 31 days from live birth. To continue coverage, add the newborn via EBS within 31 days or submit a Request for Review in EBS if it's after the 31-day window.
- Coverage may be canceled upon request, effective the first of the month after the request is made (or up to 12 months retroactively if dropping the last eligible

child due to death or if the system terminates the last eligible child).

- Certification of student status or incapacitation is required for ages 19-24 to be covered. No death claims will be paid without this documentation.
- Coverage may be added throughout the year, effective the first of the month after the request. *Exception:* Legal custody/guardianship is not considered a special eligibility situation for enrolling a child in Dependent Life-Child coverage or for the subscriber to enroll himself or increase his Optional Life coverage. The child must be legally adopted or placed for adoption to make these changes.
- If the request is made within 31 days of birth or the date you acquired the child, coverage will become effective the date of the event.
- The Dependent Non-confinement Provision for spouses and children, explained in the IBG and below, will apply, *except for newborns*.

#### Supplemental Long Term Disability

Changes allowed throughout the year:

- Cancel coverage, effective the first of the month following the request.
- Increase the waiting period from 90 to 180 days, effective the first of the month following the request.
- Decrease the waiting period from 180 to 90 days, which requires medical evidence, effective the first of the month following approval.
- Add coverage if late entrant, which requires medical evidence, effective the first of the month following approval.

For late entrants, a <u>Medical History Statement</u> must also be completed and sent to Standard Insurance Company for review. If approved, a copy of the approval will be mailed to the employee and the employer. The approval letter from The Standard must be attached to the NOE and submitted to PEBA.

#### MoneyPlus

#### Flexible spending accounts

Medical Spending and Dependent Care Spending accounts can be changed during the year only if an approved change in status event occurs and the election change is consistent with the event.

Pretax contribution changes to HSAs must be made on a prospective basis. **Employees cannot make retroactive changes.** 

#### Health Savings Accounts (HSAs)

Contributions can be started at any time and stopped or changed on a monthly basis. Changes become effective the first of the month following the change.

To change an HSA contribution, active employees must complete a paper *Notice of Election* form. Mark *Contribution Amount Change* and the new plan year total amount in Box 27C. To stop HSA contributions, enter \$0.

- As the employer, when you sign and date the form, you are also certifying the employee's eligibility to continue contributing to an HSA.
- Each employer's payroll center may specify when the enrollment form must be received to allow enough time to change the payroll withholding.

Employees may also contribute directly to their HSAs, through HSA Central, on an after-tax basis, according to IRS guidelines.

#### To close an HSA account with HSA Central:

Step 1. The employee must stop contributing to his account. He must complete and submit a *Notice of Election* form, entering \$0 in Box 27C of the form to stop the payroll deductions. Both the employee and benefits administrator must sign this form. Completing the NOE does not close the account at HSA Central. *Step 2.* To close the account with HSA Central, the employee must contact HSA Central Consumer Services at 833.571.0503.

Encourage employees to close their HSAs if it has a \$0 balance. If there is money remaining in the HSA, the employee may continue to use the money for qualified medical expenses. If the employee does not close his account with HSA Central, the monthly \$0.50 fee will continue as long as he remains enrolled in the Savings Plan. If the employee switches to the Standard Plan, the fee will be \$2.50 per month.

### **Beneficiary changes**

#### **Basic Life/Optional Life**

Encourage subscribers to initiate a beneficiary designee change for Basic Life and/or Optional Life in MyBenefits. Share the <u>Designating Active</u> <u>Member Beneficiaries</u> flyer.

If the subscriber requests assistance, submit a change in EBS. See the **Using the online system** chapter for more information.

Select Beneficiary as the Reason for Change. Complete the change and apply to MyBenefits or Current EBS.

The effective date will be the subscriber's electronic (MyBenefits) or printed (Current EBS) signature date on the requested change.

# **Open enrollment for active subscribers**

During the October open enrollment period, eligible employees may change their coverage without having to have a special eligibility situation. Changes become effective the following January 1.

- Employees may enroll themselves, enroll or add their eligible spouse and/or their eligible child(ren) in health insurance.
- Employees may cancel health coverage or drop their spouse and/or child(ren) from health coverage.

- Employees may change from one health plan to another.
- Employees may enroll in or drop State Vision Plan coverage for themselves, their eligible spouse and/or their eligible child(ren).
- Employees may enroll or re-enroll in MoneyPlus features as follows:
  - Employees remain on the MoneyPlus Pretax Group Insurance Premium feature and do not need to re-enroll.
  - Permanent full-time employees must re-enroll in the MoneyPlus Medical Spending Account and/or Dependent Care Spending Account each year.
  - Medical Spending Account participants receive the debit card at no charge. Note that a new card is not sent to the participant each year; the card is valid for five years.
    - Employees participating in the MoneyPlus Pretax Premium feature may elect, make changes or cancel Optional Life. Medical evidence may be required. This does not affect the employee's eligibility to participate in an MSA or a DCSA.
- Employees do not need to re-enroll in the Health Savings Account each year if they wish to continue contributing the same amount. If they wish to change the amount they contribute during open enrollment, they can indicate a new amount in MyBenefits. If they wish to stop contributions or are no longer eligible to contribute, enter \$0.
  - Employees enrolling in an HSA and who currently have a full, not Limited-use Medical Spending Account can begin contributing to their HSA on January 1, if the MSA has a zero balance as of the last day of the previous plan year (December 31). ASIFlex will automatically convert any carryover

funds in an MSA to a Limited-use MSA for employees who enrolled in an HSA.

• Changes to other benefits may be made as announced.

#### Dental coverage

 Employees may enroll in, cancel or add or drop spouse and/or child(ren) from Dental Plus or Basic Dental only during open enrollment of odd-numbered years.

# Open enrollment procedures and helpful hints

You do not have to wait until October 1 to begin enrollment. You may begin early, if you wish.

- PEBA will make enrollment materials available as early as possible and will notify you through *PEBA Update* as they are printed and/or posted on the PEBA website. Be sure that NOEs and MyBenefits are ready before you tell your employees to start making their enrollment changes.
- Make the *Insurance Summary* available and distribute federally mandated notices to insurance-eligible employees prior to open enrollment.

#### Encourage employees to use MyBenefits to initiate any open enrollment changes and upload supporting documentation.

After October 31, the employee's open enrollment decision is final; he does not have 31 days to change his mind.

When making coverage changes on dependents, any spouse or child(ren) to be added or deleted must be listed. Social Security numbers and dates of birth are required.

If using a paper *Notice of Election*, **only** the requested changes need to be marked. If anything else is marked, be sure it is marked correctly to avoid unnecessary rejections or unintended

changes. Check the box Enrollment under TYPE OF CHANGE in the Administrative Information section.

- If more than one NOE is submitted, PEBA will process the NOE with the latest signature date as the final, enrollment NOE.
- NOEs must be signed by October 31.
- Upload any required documentation to EBS or staple it to the NOE.
- Do not hold enrollment NOEs. Send them to PEBA as they are completed.

All open enrollment transactions must be received by PEBA by November 15; no exceptions.

If there is also a change of address, complete a universal <u>Name/Address Change Form</u> and submit it to PEBA immediately.

### New employees or transfers hired October 2-December 31

#### Transfers

Employees who transfer from one participating employer to another with no break in coverage must make their open enrollment elections with the previous employer in October.

- The subscriber must advise the new employer of his open enrollment elections at the time of the transfer.
- The employee will need to complete a new hire NOE, change reason: Transfer, showing the current coverages with the new employer. The employee will also need to complete an NOE showing the open enrollment changes with the new employer. The employee and benefits administrator must sign, and the NOEs must be sent to PEBA.

# **Unpaid leave or reduction in hours**

#### **General leave policies**

PEBA does not dictate the employment status of an employee, only the coverage that is available to the employee through PEBA's programs. While on paid leave, an employee's eligibility for benefits continues, and the employer's share of any premiums during the paid leave must be paid.

This section describes how eligibility for insurance benefits is affected when an employee goes on an employer-approved leave of absence that is not associated with military leave or FMLA. See the Quick reference for unpaid leave or reduction in hours on Page 224 for more information.

# Employees with unpaid leave or reduction of hours

#### **Ongoing employees**

Any employee employed during the Standard Measurement Period (October 4-October 3) is an ongoing employee. Eligibility for benefits is based on the number of hours the employee worked during the Standard Measurement Period.

If the employee averaged 30 hours per week during the Standard Measurement Period, he is in a Stability Period and a reduction in hours (even to zero) does not make the employee ineligible for benefits. As long as the employee remains employed with the employer, his eligibility for benefits continues for the remainder of the stability period.

Provide the employee with the <u>Your Insurance</u> <u>Benefits When Your Hours are Reduced</u> form, which is under Insurance Benefits/Forms/Affordable Care Act (ACA). The employee's benefits will continue and the employee cannot cancel coverage unless one of the following occurs:

• The employee experiences a special eligibility situation such as a gain of other

coverage. In this case, submit an NOE or SOC with the supporting documentation.

The employee intends to enroll in coverage • through the Health Insurance Marketplace. In this case, submit the termination. All active terminations should be submitted using EBS, except for those who are on military leave. For the termination reason, choose Reduction of hours. Because the employee is voluntarily terminating coverage, neither the employee nor his covered dependents are eligible for COBRA. The employee is also not eligible to be covered as a dependent spouse since he is eligible for benefits as an active employee. Once the employee cancels his active coverage, the employee may not re-enroll in benefits until the next open enrollment period, if eligible, or within 31 days of a special eligibility situation.

If the employee did not average 30 hours per week during the Standard Measurement Period, he is not in a Stability Period, and a reduction in hours of less than 30 per week makes the employee ineligible for benefits.

#### Provide the employee with the <u>Your Insurance</u> <u>Benefits When Your Hours are Reduced</u> form.

Because the employee's hours have been reduced, the employee is no longer employed in a benefitseligible position. Eligibility for benefits ends the first of the month following the reduction in hours. Provide the employee with the 18-month COBRA Notice and, if enrolled in life insurance, the PEBA Coverage Verification Notice of Group Life Insurance.

All active terminations should be submitted using EBS, except for those who are on military leave. For the termination reason, choose Left Employment. If submitting an <u>Active Termination form</u>, check the T5 box, Not Eligible (Not in a Stability Period).

# New full-time Employees (Not Employed for the Standard Measurement Period)

These employees are not in a Stability Period. A reduction in hours of less than 30 per week makes the employee ineligible for benefits.

#### Provide the employee with the <u>Your Insurance</u> Benefits When Your Hours are Reduced form.

Because the employee's hours have been reduced, the employee is no longer employed in a benefitseligible position. Eligibility for benefits ends the first of the month following the reduction in hours. Provide the employee with the 18-month COBRA Notice and, if enrolled in life insurance, he will receive a conversion packet from MetLife.

All active terminations should be submitted using EBS, except for those who are on military leave. For the termination reason, choose Left Employment. If submitting an <u>Active Termination Form</u>, check the T5 box, Not Eligible (Not in a Stability Period).

#### Variable-Hour, Part-time, or Seasonal Employees (Within an Initial Stability Period)

If the employee averaged 30 hours per week during his Initial Measurement Period, he is in his Initial Stability Period and a reduction in hours (even to zero) does not make the employee ineligible for benefits. As long as the employee remains employed with his employer, the employee remains eligible for benefits through the end of his Initial Stability Period.

Provide the employee with the <u>Your Insurance</u> <u>Benefits When Your Hours are Reduced</u> form. The employee's benefits will continue, and the employee cannot cancel coverage unless one of the following occurs:

- The employee experiences a special eligibility situation, such as a gain of other coverage. In this case, submit an NOE or SOC with the supporting documentation.
- The employee intends to enroll in coverage through the Health Insurance Marketplace. In this case, submit the termination. All

active terminations should be submitted using EBS, except for those who are on military leave. For the termination reason, choose Reduction of hours. Because the employee is voluntarily terminating coverage, neither the employee nor his covered dependents are eligible for COBRA. The employee is also not eligible for COBRA. The employee is also not eligible to be covered as a dependent spouse since he is eligible for benefits as an active employee. Once the employee cancels his active coverage, the employee may not re-enroll in benefits until the next open enrollment period, if eligible, or within 31 days of a special eligibility situation.

Once the employee's Initial Stability Period ends, he becomes an ongoing employee and continued eligibility should be based on his hours worked during the Standard Measurement Period (October 4-October 3). Refer to the Ongoing employees section on Page 62.

#### Premiums while on unpaid leave

Only employees who are within a stability period or employees who are absent from work due to FMLA or military leave may continue their coverage with their employer when their hours are reduced below 30 per week. All other employees lose eligibility for benefits when their hours are reduced below 30 hours per week, and these employees should be offered COBRA continuation coverage.

All active terminations should be submitted using EBS, except for those who are on military leave. For the termination reason, choose Left Employment. If submitting an <u>Active Termination Form</u>, check the T5 box, Not Eligible (Not in a Stability Period).

Eligible employees are responsible for paying only the employee's share of the premium while on unpaid leave. All premiums should be paid to the employer by the first of the month. If an employee fails to pay his employer by the first of the month, the employer can cancel his coverage due to nonpayment by submitting an <u>Active Termination</u> Form. If an employer fails to submit an <u>Active Termination</u> <u>Form</u> to terminate coverage due to Nonpayment (TN) within the month payment is due, coverage will be terminated the first of the month after request.

There is a 31-day grace period for employees to make payment and have coverage reinstated. If the employee makes payment before the end of the grace period, submit a Request for Review to request the employee's coverage be reactivated, because the employee submitted payment within the payment grace period. Coverage will be reinstated retroactively to the termination date.

Cancellation due to nonpayment is not a COBRA qualifying event. No COBRA notice should be sent to the employee or his covered dependents. The employee may not re-enroll in benefits until the next open enrollment period, if eligible, or within 31 days of a special eligibility situation. **Please note: Returning to work is not a special eligibility situation that allows an employee to re-enroll in benefits.** 

# SLTD and life insurance benefits while on unpaid leave

- SLTD benefits will end 31 days after the last day worked. Submit the termination via the <u>Active Termination Form</u>.
- Life Insurance benefits end 12 months after the last day worked. Submit the termination via the *Active Termination Form*.

# Continuing MoneyPlus while on unpaid leave

If the employee remains eligible for benefits, and he decides to continue his MoneyPlus contributions to his spending accounts, he can continue only until the end of the calendar year in which he begins unpaid leave. There are three ways to manage an employee's spending account elections during unpaid leave:

- 1. **Prepay**. The employee is given the opportunity to prepay his contributions on a pretax basis.
- 2. **Pay-as-you-go**. The employee is given the opportunity to pay with after-tax and/or pretax dollars (to the extent the employee receives compensation during leave).
  - Collect the contributions from the employee and include the money with the deposit covering the active employee contributions for any given payroll period.
  - The employer must send payroll funding and participant remittances to ASIFlex via ACH or mail to P.O. Box 6044, Columbia, MO 65205-6044.
- 3. **Catch-up**. The employee and the employer agree that the employer pays the contribution on the employee's behalf during leave, and the employee repays the employer upon return. Provisions for catch-up are between the employer and the employee. This must be decided prior to leave. PEBA assumes no liability for this option.

If the employee remains eligible for benefits, and he decides not to continue his MoneyPlus contributions:

- Notify ASIFlex via the employer portal that the person is on unpaid leave and will not be continuing his contributions.
- Notify ASIFlex via the employer portal when the person returns from leave if his contributions will resume.

If the employee's unpaid leave makes him ineligible for benefits, refer to Page 77 regarding the procedures for terminating participation in MoneyPlus accounts.

# Continuing a Health Savings Account while on unpaid leave

If the employee remains eligible for benefits, and he decides to continue his HSA contributions, he can continue only until the end of the calendar year in which he begins unpaid leave. There are three ways to manage an employee's spending account elections during unpaid leave:

- 1. **Prepay.** The employee is given the opportunity to prepay his contributions on a pretax basis.
- Pay-as-you-go. The employee is given the opportunity to pay with after-tax and/or pretax dollars (to the extent the employee receives compensation during leave).
  - Collect the contributions from the employee and include the money with the deposit covering the active employee contributions for any given payroll period.
  - The employer must send payroll funding and participant remittances to ASIFlex via ACH or mail to P.O. Box 6044, Columbia, MO 65205-6044.
  - Employees may also contribute directly to their HSAs through HSA Central on an after-tax basis. If they choose to do this, there is nothing for the employer to report.

If the employee remains eligible for benefits, and he decides not to continue his HSA contributions:

- Notify ASIFlex via the employer portal that the person is on unpaid leave and will not be continuing his contributions.
- Notify ASIFlex via the employer portal when the person returns from leave if his contributions will resume.

### **Military leave**

The Uniformed Services Employment and Reemployment Rights Act (USERRA) requires employers to provide certain reemployment and benefits rights to employees who serve or have served in the uniformed services. The administration of military leave is based on the employer's policy and applicable laws. The general COBRA rules are modified to allow an employer to fulfill the requirements of USERRA when an employee takes military leave. Except as noted below, military leave should be administered as regular unpaid leave.

- If the employee chooses to continue coverage, the employer must continue to pay the employer share of the premiums for any period of paid military leave and then continue to pay the employer portion as long as the employee is in a stability period.
- If the employee chooses to terminate coverage, submit the <u>Active Termination</u>
  <u>Form</u> and a copy of the military orders to PEBA when the employee begins military leave. An employee on military leave is eligible for a total of 36 months of COBRA continuation coverage. Provide the employee with the 36-month COBRA Notice and, if he is enrolled in life insurance, he will receive a conversion packet from MetLife.
- When the employee returns from military leave, the employee may re-enroll in coverage within 31 days of returning to work.
- If the employee terminated coverage, and he returns to work within 15 calendar days or does not experience a break in coverage, the employee may reenroll in the same benefits he was enrolled in prior to military leave.
- If the employee terminated coverage, and he returns to work more than 15 calendar days later or he experiences a break in coverage, the employee may make elections as a new employee.
- An employee returning from military leave may reinstate his life insurance at the same level he had prior to going on military leave

without medical evidence, regardless of when he returns to employment, as long as he is honorably discharged.

• SLTD coverage may also be reinstated without medical evidence.

If a special eligibility situation occurred while the employee was on military leave, and he did not continue his coverage through PEBA, he may add the newly eligible spouse and/or child(ren) when he returns to work by providing documentation of the special eligibility situation.

### Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) requires qualifying employers to provide jobprotected leave, continuation of certain benefits and restoration of certain benefits upon return from leave for specific family and medical reasons. The administration of FMLA leave is based on the employer's policy and applicable laws. In most cases, the employee will not make changes to benefits and will return from FMLA leave, and no action will be required. However, if he does wish to make changes during FMLA, the following rules allow an employer to fulfill the requirements of FMLA when an employee takes FMLA leave.

Under FMLA, eligible employees of qualifying employers are entitled to 12 work weeks of leave in a 12-month period for:

- Birth of a child and to care for the newborn child;
- Placement of a child with the employee for adoption or foster care;
- Care for a family member (child, spouse or parent) with a serious health condition;
- Their own serious health condition; and
- Any qualifying exigency arising if the employee's spouse, son, daughter or parent is a covered military member on covered active duty.

Under FMLA, eligible employees of qualifying employers are entitled to 26 work weeks of leave in a 12-month period for an employee who is a spouse, son, daughter, parent or next of kin of a covered service member with a serious injury or illness to provide care for that service member.

The FMLA regulation 29 CFR section 825.209 Maintenance of Employee Benefits states: An employee may choose not to retain group health plan coverage during FMLA leave. However, when an employee returns from leave, the employee is entitled to be reinstated on the same terms as prior to taking the leave, including family or dependent coverages, without any qualifying period, physical examination, exclusion of pre-existing conditions, etc. See §825.212(c).

During FMLA leave, an employee remains eligible for benefits even if his hours reduce below 30 hours per week and even if the employee is not in a stability period. No action is required by the employer when an employee goes on FMLA leave unless the employee chooses to cancel his coverage.

If the employee chooses to keep coverage during FMLA leave, the employer must pay the employer share of the premiums for any period of FMLA leave, regardless of whether the leave is paid or unpaid.

- The employer must provide the employee advance, written notice of the terms and conditions under which the employee premium payment must be made if the premiums are not being payroll deducted.
- There is a 31-day grace period on premium payments. If the employee fails to make a timely payment within 31 days, the employer may:
- Pay the employee's share of premium payments for the remainder of the leave period and recover the amount from the employee when the employee returns to work. PEBA assumes no liability for this option.

- Cancel the employee's coverage. The employer must give the employee written notice at least 15 days before coverage would end. PEBA will refund a maximum of 31 days retroactive of premiums.
- To terminate the coverage, submit an <u>Active Termination Form</u> marked Nonpayment (TN). If the employee returns to work before FMLA leave is exhausted, the employee may reinstate coverage the first of the month following his return to work. Write on the top of the NOE, Employee returning from FMLA.

If the employee fails to return to work after exhausting FMLA leave, the employer may make the following benefits decisions.

- The employer may allow the employee to continue employment.
- If the employee is on paid leave, benefits continue and no action is required.
- If the employee is on unpaid leave, refer to the Unpaid leave section beginning on Page 61 to determine if the employee is eligible to continue benefits based on his status (ongoing employee, new full-time, new variable-hour, etc.).
- The employer may terminate employment.
- The employer offers the employee and his covered dependents 18 months of COBRA continuation coverage due to a reduction in hours. The date of the COBRA qualifying event should be listed as the last day of FMLA leave. Even if the employee canceled coverage during FMLA leave, COBRA continuation coverage should be offered at the end of FMLA leave if the employee does not return to work after exhausting FMLA leave.
- See Transfers and terminations (Page 69) and COBRA subscribers (Page 79) for additional procedures.

If the employee chooses to terminate coverage during FMLA leave:

- Submit an NOE to PEBA refusing all coverage. List change reason as Employee on FMLA.
- Upon return from FMLA leave, most employees are restored to their original or equivalent positions with equivalent pay, benefits and other employment terms.
- If the employee returns before FMLA leave is exhausted, the employee's coverage should be reinstated on the same terms and conditions without any qualifying period or medical evidence.
- The request to reinstate coverage must be made within 31 days of returning to work.
- Write on top of the NOE, Employee returning from FMLA.
- If the employee does not return to work at the end of FMLA leave, send the employee and his covered dependents the 18-month COBRA Notice. List the date of the COBRA qualifying event as the last day of FMLA leave.

### Workers' compensation

Workers' compensation is not administered as unpaid leave. An employee, on approved leave because of disability approved by the Office of Workers' Compensation Programs, is considered to be drawing a salary from the state.

- All coverage must continue as before during the benefit period unless a change in status/special eligibility situation occurs.
   Documentation may be required.
- The employee pays the employee's share of premiums to the employer's payroll office.
- The employer pays the employer portion of premiums.
- If the employee has stopped making payments for his share of the premiums, the employer may continue the coverage and request repayment of the employee's share once he returns to work.
- If the employer does not wish to continue the employee's coverage because he has

stopped paying his share of the premiums, consult with your legal counsel before terminating the employee's coverage.

 To terminate the coverage, submit an <u>Active Termination Form</u> marked Nonpayment (TN). The employee may reinstate coverage within 31 days of his return to work. Otherwise, he may enroll within 31 days of a special eligibility situation or during open enrollment.

### Affordable Care Act reporting requirements

Employers who participate in the State Health Plan have certain requirements under the Affordable Care Act. Employers must provide subscribers with proof of health coverage by issuing forms to subscribers. Each year, the IRS determines the date by which employers must send the forms to subscribers.

#### Employers with fewer than 50 employees

 Issue IRS Form 1095-B to any active employees enrolled in health coverage at any time during the previous calendar year.

#### Employers with 50 or more employees

 Issue IRS Form 1095-C to any employees who were eligible for health coverage at any time during the previous calendar year.

#### All employers except members of the State Applicable Large Employer (ALE) group

 Issue IRS Form 1095-B to any non-Medicare retirees or COBRA subscribers enrolled in health coverage at any time during the previous calendar year.

PEBA issues Form 1095-B to any non-Medicare retirees or COBRA subscribers for members of the State ALE group. PEBA also issues Form 1095-B for employers who are able to designate PEBA as its Designated Governmental Entity (DGE).

Only an employer required by statute to participate in the State Health Plan (Governmental Employer) may elect to designate the S.C. Public Employee Benefit Authority (PEBA) as its designated governmental unit. To do so, the employer must complete and submit the Designated Governmental Entity form. Optional employers are unable to designate PEBA as their Designated Governmental Entity (DGE).

Employers must also submit Forms 1094-B or 1094-C to the IRS. Each year, the IRS determines the date by which to submit these forms.

To assist employers with their reporting requirements, PEBA will post a file to EBS each year that contains information about employees and dependents who were enrolled in health coverage at any time during the previous calendar year. See the **EBS reports** chapter for more information about the 1095 reports.

For additional information, call PEBA's Customer Service or email Denise Hunter at <u>dhunter@peba.sc.gov</u>.

# Transfers and terminations

### Contents

Assisting a transferring employee
Transferring out (losing employer)71
Transferring in (gaining employer)72
<u>Transfers — new employer created or lateral transfer</u> 75
<u>Transfers — dual employment</u> <b>75</b>
Terminations
General rules for terminating active employees76
Other termination information
Life insurance
Long term disability
MoneyPlus
Health Savings Account
Reinstating coverage after termination
Affordable Care Act reporting requirements

# Assisting a transferring employee

For PEBA's insurance purposes, a **transfer** is defined as an active employee who moves from one participating employer (losing employer) to another participating employer (gaining employer) with no break in benefits or with no more than a 15calendar-day break in employment.

An **academic employee**, who completes a school term and moves to another academic setting at the beginning of the next school term, is also considered a transfer, not a new hire. Coverage remains in effect through the summer.

Generally, when he transfers, an employee will remain enrolled in the same insurance benefits. Contact PEBA for coverage information.

### Transferring out (losing employer)

Once the employee notifies you of his intention to transfer to another participating employer without a 15-day break in employment or with no break in insurance coverage, submit the transfer to PEBA.

Enter the transfer as a termination in EBS. Select *Transfer* from the *Reason for Termination* dropdown list. Enter the Transfer Group ID and effective date. EBS provides an *Employer Group ID Help* feature.

If the employee is on the payroll on the first day of the month, then the employee is covered by the transferring agency until the last day of the month. *Example:* Employee's termination date is May 1; employee's insurance will transfer effective June 1.

Once the transfer is applied, a *Summary of Termination* (SOT) can be saved or printed for your records. Do not mail the document to PEBA.

If the transfer cannot be completed in EBS or a correction needs to be made after the transaction in EBS, submit an <u>Active Termination Form</u> with Transfer (TT) as the termination reason. Include the gaining employer name and ID number. Please allow additional time for processing of paper forms.

PEBA will produce an active benefits transfer form for the new employer. The form lists an employee's benefits and his covered spouse and/or child(ren). The employee may change his address, telephone number, Basic Life and Optional Life beneficiaries on the form, if necessary.

The gaining employer does not have to wait until receipt of the transfer form to complete the enrollment in EBS.

#### **COBRA** applies to transfers

COBRA notification for continuation of health, dental and vision coverage must be sent to transferring employees, their covered spouses and covered dependent child(ren).

When an employee transfers, COBRA notification is not required for MoneyPlus accounts, but you may send notification. PEBA will notify the MoneyPlus administrator of any transferring employee who has a MoneyPlus account.

#### Academic transfers

Employees of public school districts, charter schools, and public higher education institutions are considered academic employees and are subject to the termination and transfer rules below.

*These rules apply, regardless of when you receive the resignation.* 

- Academic employees, who complete a school term and move to another participating academic employer, are considered academic transfers, even though they may not work during the summer.
- The losing academic employer must continue to cover academic transfer employees during the summer, pay the employer share of premiums, collect premiums from the employee and terminate coverage at the beginning of the fall term (September 1) to avoid a break in coverage.
- Exceptions may be made for academic positions that begin employment during the
summer, such as, but not limited to, coaches, principals and superintendents. If you use an NOE, be sure to write the employee's position at the top of the NOE so that the PEBA staff will know this is an exception.

- If *not* transferring or if working for the summer:
  - Academic employees, who are leaving employment and do not plan to transfer to another academic setting, should be terminated effective the first of the month following the last day worked. If an academic employee terminated employment at the start of summer, but returns to an academic setting in the fall, he is still considered a transfer. The employee must pay the back premiums for the summer months to his losing employer to avoid a break in coverage.
- If the academic employee was planning to return to an academic setting in the fall, but decided to retire retroactively, he should be terminated effective the first of the month following the last day worked. If the employee is eligible for retiree coverage but has missed the 31-day window to enroll, he should contact PEBA.
- Academic employees who work during the summer session, but who are not transferring to another academic setting in the fall, should be terminated from coverage effective the first of the month following the last day worked.
- The academic employer determines the eligibility status by contract with each employee and position. The summer session may or may not be considered permanent, full-time employment.
- The termination effective date from the losing academic employer should coincide with the effective date of the gaining academic employer, reflecting no break in coverage.

 Academic employees who are retiring effective July 1 should be terminated from active coverage July 1.

#### Permanent, part-time teacher transfers

A permanent, part-time teacher, who transfers from one academic employer to another with no more than a 15-calendar-day break in employment or with no break in coverage, should be considered a transfer and must keep the same coverage. The health and/or dental premium may change if the number of contract hours places the teacher in a different category. He may make changes based on the increase or decrease in hours as explained in the Active Subscribers section of this manual.

#### Change in status during the transfer

If a change in status or special eligibility situation occurs, and:

- The effective date of the change in status event falls before the effective date of the employee's transfer, the employee must contact the losing employer to complete an NOE for the change. Forward the completed NOE, along with any required documentation, to PEBA. PEBA will send a new transfer form to the gaining employer.
- If the effective date of the change in status falls on or after the effective date of the employee's transfer, the employee must contact his new employer to complete an NOE for the change. Coverage changes or add/drop a spouse and/or child(ren) cannot be completed as part of the transfer.

## Transferring in (gaining employer)

Confirm that the employee is a transfer from another participating employer:

- You may have received a transfer form from PEBA if the losing employer completed the termination in a timely manner; or
- The employee may give you a copy of his termination and/or creditable coverage

letter. PEBA can provide *Certificates of Creditable Coverage* upon request.

You do not have to wait until the transfer form is received to enter the transferring employee into EBS.

Contact PEBA if you have any questions about the status and eligibility of the transferring employee.

If you have questions about the transferring employee's MoneyPlus status, verification of contribution amounts can be found on the HIS763NP report in EBS. You can also contact ASIFlex.

Be sure that the transferring employee is offered the same orientation given to new employees with your group and review the COBRA regulations.

Documentation, such as proof of dependent eligibility, court orders and incapacitated child certification, is **not** needed if previously established.

The effective date of the gaining employer should coincide with the termination effective date from the losing employer, reflecting no break in coverage. If the employee is on the payroll on the first day of the month, then the employee is covered by the losing employer until the last day of the month.

If the effective date of loss under the losing employer is before the hire date for the gaining employer, but within 15 days, the employee's date of hire should be entered in EBS as the effective date of loss under the losing employer.

### Academic transfers

The termination effective date from the losing academic employer should coincide with the effective date of the gaining academic employer, **reflecting no break in coverage.** 

He must be enrolled in the same coverage he had previously. Contact PEBA for coverage information.

His previous employer must:

- Pay the employer share for his coverage, retroactively, for the summer to avoid a break in service, unless the employee works in a position that is an exception as explained on Page 71.
- Collect the employee share of coverage, retroactively, from the employee and include it with the employer payment.

## Enrolling the transferring employee through EBS

When you receive an active benefits transfer form from PEBA, complete the transfer in EBS by initiating an enrollment. You do not have to wait until the transfer form is received to enter the transferring employee into EBS.

Have the employee review the transfer form and make any necessary and/or allowed changes. The employee's information and coverage levels will be prepopulated in EBS. A spouse and/or child(ren) may not be added to, or deleted from, any benefit, unless a qualifying change in status has occurred.

Apply the transaction to MyBenefits for the employee to electronically approve and sign or Current EBS for a signature page to be signed by the employee. The transfer form can also be uploaded and submitted with the signed signature page. Refer to Page 22 for more information.

### Active benefits transfer form

The active benefits transfer form lists the employee's benefits and his covered spouse and/or child(ren). The employee may change his address, telephone number, Basic Life and Optional Life beneficiaries on the form, if necessary. Coverage and dependent changes are not allowed.

If the transfer is not completed in EBS with an enrollment transaction, complete the transfer form and return it to PEBA. Please allow additional time for processing of paper forms.

Please note the following about section A:

- Effective Date: Should reflect no break in coverage between employers. Verify there was no more than a 15-calendar-day break in employment or no break in insurance coverage to confirm the transfer status.
- Annual Salary: List the annual contract salary. Do not include any additional pay other than the contract salary. Groups affected by furloughs should use the nonfurlough salary. This salary will be used to calculate the SLTD premium if the transfer has SLTD coverage.
- Employment Date: First day physically at work.
- Pay Periods: Number of annual pay periods.
- **Pretax (MoneyPlus):** Y, N or Blank. You may need to confirm this with PEBA or the previous employer.

Mailing address, email address or telephone number changes are allowed. The employee should mark a single line through any information that needs to be updated and legibly print the new information.

Coverage through Medicare or another policy for a subscriber, spouse or child is included, if applicable.

Coverage and levels are included in the Coverage section. The employee may make limited changes to his life and SLTD coverage by completing an NOE. See Using an NOE instead of EBS on Page 75.

The spouse and/or child(ren) on file at the time of the transfer from the previous employer is included. The benefits under which each spouse or child is covered is indicated with an X beside the spouse or child's name.

The employee may correct any spelling of names, dates of birth, SSNs (copy of card required if not a keying error by PEBA) or add any missing information by submitting an NOE.

A spouse and/or child(ren) may not be added to, or deleted from, any benefit, unless a qualifying change in status has occurred. *Exception*:

Dependent Life coverage may be added or dropped throughout the year.

The beneficiaries are listed as reflected in PEBA's records. **Changes are allowed in this section.** If the employee wishes to make a beneficiary change:

- He should mark through the beneficiary including the asterisk (\*), initial the markthrough and write or type in the new beneficiary, including all necessary information, on the first available line.
- He must indicate the benefit (Basic Life, Optional Life) with an asterisk (\*) in the space under the benefit.
- If enough space is not available to list the new beneficiaries, he should write SEE ATTACHMENT and staple the attachment to the transfer form.
- If more than one beneficiary is designated, he must indicate the appropriate percentages and whether each beneficiary is primary or contingent.

If the employee has health coverage, a beneficiary for Basic Life must be indicated. If this field is blank, the employee must add a BL beneficiary.

The employee and benefits administrator must sign and date the form. Make a copy for your files and the subscriber. Return the original to PEBA for processing.

### Change in status during transfer

If a change in status or special eligibility situation occurs, and:

- The effective date of the change in status event falls before the effective date of the employee's transfer, the employee must contact the losing employer to complete an NOE for the change. That employer must send the completed NOE, along with any required documentation, to PEBA. PEBA will send a new transfer form to the gaining employer.
- If the effective date of the change in status event falls on or after the effective date of

the employee's transfer, the employee must contact his new employer to complete an NOE for the change. Coverage changes or add/drop a spouse and/or child(ren) cannot be completed as part of the transfer.

#### Using an NOE instead of EBS

Use a Notice of Election (NOE) only when:

- The losing employer has not terminated the transferring employee. If NOE is received before the employee is transferred, it will be rejected.
- A change in status or special eligibility situation has occurred. If you have an active benefits transfer form, attach the NOE and any required documentation and send to PEBA for processing. See Change in status during transfer on Page 74.

## If using an NOE, it must be completed in its entirety.

- Check Transfer at the top of the NOE.
- Contact PEBA to obtain levels of coverage.
- Remember to attach any required documentation listed beginning on Page 72.

## Transfers — new employer created or lateral transfer

*New employer created by interdepartmental transfers or lateral transfers from one employer to another (restructuring).* 

Employer ID numbers will change on all files (PEBA insurance benefits, PEBA retirement benefits and all plan administrators) for employees of new employer groups created by interdepartmental or agency reorganizations.

The same policies and procedures govern employees who are laterally transferred from one employer to another.

Each employee will be terminated from the old employer and added to the new employer, with no break in coverage and with the same coverage. Other coverage changes are permitted only if a special eligibility situation occurs. Documentation may be required.

#### **Old employer procedures (losing employer)**

Before the effective date of the transfer:

- Resolve all rejections for any employees being transferred.
- Process and send to PEBA any eligible changes in status for applicable benefits and coverage or Optional Life changes that occur before the effective date of transfer.
- The employees' names, SSNs, old employer ID number and new employer ID number with effective date of transfer must be sent to PEBA.
- Give all benefits documentation, including COBRA notification letters, to the new employer at the time of transfer.

#### New employer procedures (gaining employer)

Before the effective date of the transfer:

- Send letter of notification to PEBA with the following information:
  - Departing employer and ID number;
  - New employer and ID number;
  - Effective date of change; and
  - SSN and name of each employee being transferred.
- Send a copy of the notification letter to the losing employer.
- Place a copy of the notification letter in each employee's file.

The new employer must process any eligible family status changes that occur after the effective date of transfer.

## Transfers — dual employment

#### Employee working for two participating employers

If an employee is working for two participating employers, he is considered working for one employer or the other for insurance purposes. He cannot be considered working for both employers. The employee **cannot** have his insurance coverage and premiums split between the two employers, nor may he combine his two salaries for Optional Life/Dependent Life insurance purposes.

If an employee starts working for a second participating employer and wants his insurance coverage to be with the new employer, he is considered a transfer. He has 31 days to have his transfer processed. If the 31-day window is missed, his coverage remains with the first employer.

The standard procedures for transferring the employee apply, including the procedures for transferring out, transferring in and COBRA notification as explained earlier in this section.

## Terminations

# General rules for terminating active employees

Submit terminations in EBS immediately.

All changes in employment or special eligibility situations resulting in a termination of coverage must be processed within 31 days.

If submitting a termination outside of the 31 days, complete and send an <u>Active Termination Form</u>. Mark only one reason for termination.

### **Retroactive terminations**

Maximum 31 days retroactive (to be calculated from the date received by PEBA)

**Terminations may be no more than 31 days retroactive.** *Exception*: If PEBA receives an <u>Active</u> <u>Termination Form</u> that is more than 31 days retroactive, it will be accepted and processed only if it is accompanied by an NOE (such as a COBRA NOE or Retiree NOE) that shows the subscriber is continuing coverage, and with no break in his coverage.

If a termination is received **more than 31 days** from the date of loss of eligibility, PEBA will cancel coverage the first of the month after the date of receipt. During December, retroactive terminations should be submitted on an <u>Active Termination Form</u>, rather than through EBS, if the subscriber makes a change with an effective date of January 1.

#### Academic employees

If not transferring or if working during the summer:

- Academic employees, who are leaving employment and do not plan to transfer to another academic setting, should be terminated the first of the month following the last day worked.
- If an academic employee terminated employment at the start of summer, but returns to an academic setting in the fall, he is still considered a transfer. The employee must pay the back premiums for the summer months to his losing employer to avoid a break in coverage.
- Academic employees who work during the summer session, but who are not transferring to another academic setting in the fall, should be terminated from coverage the first of the month following the last day worked.
- The academic employer determines the eligibility status by contract with each employee and position. The summer session may or may not be considered permanent, full-time employment.
- Academic employees who are retiring effective July 1 should be terminated from active coverage July 1.
- You must refund overpaid premiums if the premiums are deducted on a prorated scale to cover the summer months. Advance deduction of premiums does not constitute continuous coverage.

### **COBRA** notification required

If an employee's coverage is terminated due to leaving employment, a reduction in hours, or service or disability retirement, notify the employee and dependents, if applicable, of continuation of coverage as a COBRA participant. Refer to the **COBRA** chapter for information on COBRA notification procedures.

## Termination due to unpaid leave or a reduction in hours

Refer to the Active subscribers chapter.

## Termination due to nonpayment of premiums

Termination is effective the first of the month following the last month in which premiums were due and paid in full.

If an employee fails to pay his premiums, submit an <u>Active Termination Form</u> to PEBA as soon as possible. Mark the reason for termination as Nonpayment (TN).

### If a termination is received more than 31 days from the date of loss of eligibility, PEBA will cancel coverage the first of the month after the date of receipt.

If coverage was terminated due to an administrative error, or because the employee subsequently paid the employer within the 31-day grace period, complete a Request for Review (RFR) in EBS. Otherwise, the employee and any eligible spouse and/or child(ren) must wait until the next open enrollment period or until a special eligibility situation occurs and enroll as late entrants.

Optional employers should complete the appropriate NOE to terminate coverage for retiree, COBRA and survivor subscribers.

If the subscriber is terminated due to nonpayment of premiums, do not send COBRA notification letters, since COBRA does not apply.

If the employee returns to work after coverage has been terminated, reinstatement of coverage must be requested within 31 days of returning to work. Otherwise, the employee and any eligible spouse and/or child(ren) must wait until the next open enrollment period or until a special eligibility situation occurs and enroll as late entrants.

# Other termination information

## Life insurance

If terminating employment, the employee may convert his Basic Life, Optional Life, Dependent Life-Spouse and/or Dependent Life-Child coverage to an individual whole life policy. To convert Basic Life, Optional Life, Dependent Life-Spouse and/or Dependent Life-Child coverage to an individual policy at termination of employment, the election must be made within 31 days of the date coverage would otherwise terminate.

MetLife will mail terminated employees a conversion packet via U.S. mail three to five business days after MetLife receives the eligibility file from PEBA; therefore, it is important to submit terminations in EBS in a timely manner. To convert coverage, an employee must follow the instructions in the packet from MetLife. Coverage must be converted within 31 days the date of coverage is lost. It is the employee's responsibility to contact MetLife regarding conversion.

## Long term disability

**Basic Long Term Disability** may not be continued or converted to an individual policy at termination.

**Supplemental Long Term Disability** (SLTD) may be converted within 31 days of termination if:

- The individual has had SLTD coverage for at least one year;
- The individual is not disabled; and
- The individual is not a retiree.

A <u>Request for Long Term Disability Conversion</u> <u>Materials</u> form is available on PEBA's website.

## MoneyPlus

**Medical Spending Account (MSA)** A terminated participant has through the plan year to submit expenses incurred before the first of the month following the last day worked unless he is

continuing participation on an after-tax basis through COBRA.

- If continuing an MSA through COBRA, the debit card will be canceled as of the date of termination submitted to PEBA.
- If the termination is due to the death of the employee, his eligible spouse and/or child(ren) may elect to continue the MSA through the end of the plan year. In this case, eligible spouse and/or child(ren) means IRS-qualified tax dependents as defined in IRS Publication 502. Otherwise, the spouse and/or child(ren) have through the run-out period to submit any eligible claims incurred through the employee's date of death.

**Dependent Care Spending Account** A terminated participant has until the end of the year or until the account is exhausted, whichever occurs first, to submit expenses.

## Health Savings Account

A terminated participant may continue to contribute to his HSA, so long as he is covered by a high deductible health plan, whether it is the State Health Plan Savings Plan or another high deductible plan offered by another insurer. He cannot be covered by any other type of health plan. Because he has terminated employment, he would contribute on an after-tax basis directly to HSA Central or other Health Savings Account custodian. He can then include these after-tax contributions on his tax returns according to the IRS guidelines.

• If he decides to close his HSA with HSA Central, it is a two-step process. In addition to the termination with PEBA, he must contact HSA Central Consumer Services at 833.571.0503.

• Encourage employees to close their account if it has a \$0 balance. They should contact HSA Central to close the account. See Page 59 for details.

## Reinstating coverage after termination

If an employee has terminated employment, coverage may be reinstated, if done quickly.

If coverage was terminated within the past 15 days submit the reinstatement via the reinstate function under Manage Subscribers in <u>EBS</u>.

If coverage was terminated more than 15 days ago, the employee is considered a new hire, and coverage cannot be reinstated. Submit an enrollment for the new hire.

*Exception*: Academic transfers. Send a letter to PEBA, explaining the employee is an academic transfer and include the employee's name, SSN and effective date of transfer. Be sure to follow the academic transfer procedures explained on Page 76.

## Affordable Care Act reporting requirements

Employers who participate in the State Health Plan have certain requirements under the Affordable Care Act. Employers must provide subscribers, including terminated employees, with proof of health coverage by issuing forms to subscribers. Each year, the IRS determines the date by which employers must send the forms to subscribers. Learn more on Page 68.

# **COBRA** subscribers

## Contents

What is COBRA?	81
Who is the COBRA administrator?	81
Required COBRA notices	81
Mailing requirements for all COBRA notices	81
Important note for National Medical Support Notices (NMSN)	82
Initial COBRA Notice	82
First required notice	
60-day COBRA notification requirement for spouses and children	82
COBRA qualifying events and notices	
Qualified beneficiaries	
Second required notice	
18-month COBRA qualifying events	
Procedures for determining COBRA eligibility	
COBRA election period	
COBRA Termination Notice	86
Third required notice	86
Other coverage may and CORPA eligibility	
Administrative for for ontional employers	
Administrative ree for optional employers	
Benefit changes	88
<u>COBRA procedures for the Medical Spending Account</u>	
Procedures at termination	
Affordable Care Act reporting requirements	89
COBRA quick reference	

## What is COBRA?

#### **Consolidated Omnibus Budget Reconciliation Act**

COBRA is a federal law that prevents covered employees and their covered dependents from losing group health, dental, vision and/or medical spending account coverage as a result of certain qualifying events.

COBRA regulations require that continuation of group insurance coverage be offered to eligible individuals who lose their group medical coverage due to a qualifying event. These qualifying events are listed in the Notices that address 18-, 29-(Extend) and 36-month COBRA continuation.

The following coverage may be continued under COBRA:

- State Health Plan;
- Dental Plus and Basic Dental;
- State Vision Plan; and
- MoneyPlus Medical Spending Account only through the end of the year.

COBRA notification procedures for continuing a Medical Spending Account are different than for health, dental or vision coverage. See Page 88 for information about COBRA procedures for Medical Spending Accounts.

Under COBRA, it is the responsibility of the covered employee, and/or the qualified beneficiary, to notify the benefits office within 60 days of a qualifying event.

View the COBRA employer insurance training materials at <u>peba.sc.gov/insurance-training</u>.

## Who is the COBRA administrator?

PEBA coined the term COBRA administrator to identify who collects COBRA premiums and receives notices from COBRA participants.

PEBA serves as the COBRA administrator for former employees of:

- State agencies;
- Public school districts;

- Charter schools that participate in both insurance and retirement; and
- Public higher education institutions.

Benefits administrators of optional employers and charter schools that participate in insurance only serve as the COBRA administrator for their former employees.

## **Required COBRA notices**

The required COBRA notices are available at <u>peba.sc.gov/forms</u> under the COBRA category.

Each COBRA notice includes an instruction sheet that summarizes the notification procedures for that notice. These instruction sheets are very helpful, so please be sure to read them before you proceed. Download the forms and enter the subscriber and COBRA information where prompted. Routinely check PEBA's website for updated forms.

#### Benefits administrators of participating employers, not PEBA, are responsible for completing and mailing these COBRA notices:

- <u>Initial COBRA Notice</u> and Your Rights and Responsibilities under COBRA;
- <u>18-month COBRA Notice</u> and Important Information about Your COBRA Continuation Coverage Rights; and
- <u>36-month COBRA Notice</u> and Important Information about Your COBRA Continuation Coverage Rights.

Retain a copy of the entire notice for the employee's file. See Important note for National Medical Support Notices (NMSN) below.

## Mailing requirements for all COBRA notices

Follow the detailed instructions, available within each notice, for issuing the notice(s).

Send the notice via first-class mail to each covered employee and spouse. The notice to covered spouse is notification to all covered dependents. One notice to the home satisfies the requirement if the spouse and child(ren) live at the same address as the employee. No proof of receipt is required.

Hand delivery to the employee is **not** considered notice to a covered spouse or child(ren). A separate notice must be mailed to the spouse and child(ren). The employee must sign for receipt of notice if using hand delivery.

## Important note for National Medical Support Notices (NMSN)

Do not retain copies of any NMSN dependent notices in the employee's file. This ensures the privacy of the NMSN dependent(s).

## **Initial COBRA Notice**

## First required notice

Send this notice of the right to purchase temporary extension of group health, dental or vision coverage when coverage is lost due to a qualifying event.

The initial notification provides a broad summary of the COBRA law and procedures, outlines the obligations of employers and explains the rights and responsibilities of employees and their dependents, including the 60-day notification requirement. Federal law states the *Initial COBRA Notice* must be mailed within 60 days of effective date of coverage.

Send the Initial COBRA Notice when:

- A new employee elects health, dental, vision or a Medical Spending Account for himself and/or his spouse and child(ren);
- An employee adds a spouse or child(ren) due to a special eligibility situation; or
- Anyone (employee and/or dependents) newly covered at open enrollment.

Follow the detailed instructions, available within each notice, for issuing the notice(s).

Notification is not required if the employee, his spouse and child(ren) do not enroll in health, dental, vision or a Medical Spending Account. If this notice has not been provided to your covered employees, spouse and child(ren), send a notice immediately.

You must review the employee file for coverage level information. If the employee is covered with dependent(s), carefully follow the notice instructions for how to complete and address the notice(s) and envelope(s).

# 60-day COBRA notification requirement for spouses and children

Spouses and children must meet this requirement to be eligible to continue coverage under COBRA.

Under COBRA, the employee, spouse or other covered family member must notify his benefits office within 60 days of the date when coverage would have been lost to be eligible to continue coverage under COBRA.

This rule applies to all spouses and children enrolled in health, dental and/or vision coverage.

If a qualifying event is not reported to the benefits office within 60 days of when coverage would have been lost, had it been reported in a timely manner, COBRA rights for that individual(s) are forfeited. In this situation, no COBRA coverage should be offered, and no second notification should be sent.

This 60-day requirement is included in the initial COBRA notice.

# **COBRA** qualifying events and notices

## Qualified beneficiaries

A qualified beneficiary is an individual eligible to continue coverage if coverage is lost due to a qualifying event. He must be covered (under Health, Dental Plus, Basic Dental, State Vision Plan and/or MoneyPlus Medical Spending Account) on the day before the qualifying event.  Includes a covered employee, the covered spouse of the covered employee or a covered child of the covered employee.

Each qualified beneficiary has independent rights to elect COBRA.

### Who is a qualified beneficiary?

- Active and retired employees.
- Spouses and dependent children of employees or retirees.
- Newborns or children placed for adoption with the covered former employee or retiree, if added to COBRA coverage within 31 days of birth or adoption, or during open enrollment.

Two situations may occur during the COBRA coverage period that would cause a child, who was not covered at the time of the qualifying event, to gain the status of a qualified beneficiary. These are:

- A child born to, adopted by or placed for adoption with a *covered employee* during a period of COBRA coverage.
- A child receiving benefits pursuant to a Qualified Medical Child Support Order or a National Medical Support Notice, if the support order or notice requires the covered employee to provide coverage.

Qualified beneficiaries under COBRA are eligible to elect individual health plans if desired, but they must complete separate NOEs.

## Who is not a qualified beneficiary?

- Individuals not meeting the definition of qualified beneficiaries who are added as dependents onto a qualified beneficiary's coverage during open enrollment or because of a special eligibility situation.
- Newborn or adopted children placed with individual on COBRA who is not the covered former employee or retiree.
- Non-resident aliens with no source of income in U.S.

Not every spouse or child who is added to coverage during the COBRA coverage period would be a qualified beneficiary, eligible to extend their COBRA coverage if a second qualifying event occurs, such as divorce. *Example*: If a subscriber on COBRA coverage gets married and adds his new wife to his coverage, she is *not* a qualified beneficiary and would not be eligible to extend her coverage to 36 months should the couple divorce one year later.

If a spouse or child is found not to be eligible for coverage due to an audit or other event, the individual is not eligible for COBRA coverage.

## Second required notice

Benefits administrator sends this notice to eligible qualified beneficiaries of their right to elect COBRA coverage when a qualifying event occurs.

The individual must be covered on the day before the qualifying event by health, dental and/or vision to continue coverage under COBRA. Each individual, including spouses and child(ren), covered under the plan is a qualified beneficiary and has independent election rights.

COBRA should **not** be offered to spouses or children who were dropped because of the Dependent Eligibility Audit.

After a qualifying event has occurred, eligible individuals should be notified of their rights to continue health, dental and/or vision coverage.

If the employee became eligible for Medicare within 18 months before the employee's termination of employment or reduction of hours, the maximum period of COBRA coverage for his covered spouse and/or child(ren) is 36 months from the date the employee became eligible for Medicare. This is known as the *Medicare Entitlement Rule*.

Depending on the tobacco and e-cigarette use status before and whether that status has changed for the new COBRA subscriber, a new <u>Certification</u> <u>Regarding Tobacco and E-cigarette Use</u> form may need to be completed and attached to the <u>COBRA</u> <u>NOE</u>.

## 18-month COBRA qualifying events

Provide the 18-month notice when an employee:

- Leaves employment;
- Transfers;
- Retires; or
- Has a reduction of hours and is not in a stability period (full-time to part-time, strikes, layoffs and leave of absence). Note: For information about administering COBRA for an employee who goes on a leave of absence, see Page 61.

### **Extending COBRA coverage to 29 months**

The Omnibus Budget Reconciliation Act of 1989 added a provision to COBRA that affects the 18month continuation period. The intent is to provide additional coverage protection for disabled qualified beneficiaries.

If a qualified beneficiary is approved for Social Security disability benefits according to Title II or XVI of the Social Security Act, he is entitled to extend the 18 months of COBRA coverage to 29 months from the date of the qualifying event, so long as these criteria are met:

- The qualifying event must be the covered employee's termination of employment or reduction of hours;
- The qualified beneficiary must be determined under the Social Security Act to have been disabled at any time before or during the first 60 days after loss of coverage. It is the qualified beneficiary's responsibility to obtain the disability determination from the Social Security Administration;
- The qualified beneficiary must notify the COBRA administrator of the Social Security disability determination within 60 days after the latest of:
  - The date of the Social Security disability determination;

- The date of the qualifying event (i.e., the employee's termination of employment or reduction of hours);
- The date that the qualified beneficiary loses (or would lose) coverage as a result of the qualifying event; or
- The date that the qualified beneficiary is informed, through the initial COBRA notice, of the responsibility to provide the notice of disability determination and the procedures for providing such notice to the COBRA administrator.

The qualified beneficiary must notify the COBRA administrator of the Social Security determination **before the end of the 18-month period following the qualifying event** (i.e., the employee's termination of employment or reduction of hours).

The extension of coverage to 29 months is not limited to just the disabled qualified beneficiary. *It applies to all individuals who are qualified beneficiaries as a result of the same first qualifying event. This is true even if the disabled qualified beneficiary does not elect to continue or extend coverage under COBRA.* 

If the disabled qualified beneficiary extends coverage, the COBRA administrator can increase the premium to 150 percent for all qualified beneficiaries during the extended 11-month COBRA period. If the disabled qualified beneficiary does not extend coverage, the COBRA premium remains 102 percent.

A qualified beneficiary, whose coverage is extended, must notify the plan administrator within 31 days if a final determination is made that he is no longer disabled. He should complete and submit to his COBRA administrator a <u>Notice to Terminate</u> <u>COBRA Continuation Coverage</u>.

### **Extending COBRA coverage to 36 months**

A second qualifying event may occur during the 18or 29-month period of coverage (i.e., divorce, child becomes ineligible). In such a case, the 18- or 29-month period of coverage may be extended to 36 months, but only for those individuals listed on Page 82.

Second qualifying events must be reported within 60 days of the event and within the original 18- or 29-month period. The subscriber should complete and submit to his COBRA administrator a <u>Notice to</u> <u>Extend COBRA Continuation Coverage</u>, along with the documentation requested on the form. He does not need to complete a COBRA NOE.

No qualifying event can extend the maximum coverage period beyond 36 months from the date of the first qualifying event, except for military leave.

#### Second qualifying events are:

- Death of former employee
  - The covered spouse and covered child(ren) are eligible for up to 36 months of continuation coverage.
- Divorce/legal separation
  - The covered spouse and covered child(ren) are eligible for up to 36 months of continuation coverage.
- Child(ren) becomes ineligible
  - The covered child(ren) who turns 26 during the original COBRA continuation period is eligible for up to 36 months of continuation coverage.
- Military leave.
  - The employee is eligible for up to 36 months of continuation coverage.
- The COBRA subscriber may complete a <u>Notice to Extend COBRA Continuation</u> <u>Coverage</u> if there has been a second qualifying event that may extend COBRA coverage. He should attach any documentation requested on the form.
- The completed form should be returned to his COBRA administrator.

## Procedures for determining COBRA eligibility

Determine if a COBRA-qualifying event has occurred. Document the date you are notified of the event. Confirm the date the initial notice was mailed and that it included the 60-day notification requirement.

Calculate the date of loss of coverage had the event been reported in a timely manner. Count 60 calendar days from the date determined to be the coverage loss date. If the qualifying event was reported within this 60-day period, offer COBRA and send <u>Notice of COBRA Qualifying Event</u>; if not or if ineligible, do not offer COBRA. Use the <u>COBRA</u> <u>Ineligibility Form for Dependents</u> form. Retain appropriate documentation.

#### Example

Date of qualifying event: September 15, 2021		
Date BA notified of event	January 20, 2022	
Date initial COBRA notice mailed	November 20, 1999	
60-day notification language included in notice?	Yes	
Date of coverage loss if reported in timely manner	October 1, 2021	
60 calendar days from date of coverage loss	November 29, 2021 (60 days from October 1, 2021)	
Qualifying event reported within this period?	No	
Action	Do not offer COBRA. Document file with COBRA Ineligibility Form for Dependents.	

### If the employee is not eligible to retire

Use the Leaving Employment before Retirement Eligibility checklist at <u>peba.sc.gov/publications</u> under Life event checklists.

Benefits administrators of participating employers, **not PEBA**, must offer the employee and his covered spouse and/or child(ren) COBRA enrollment information by letter, except if:

- The termination was due to nonpayment of premiums;
- The termination was due to gross misconduct. Consult your legal counsel before making this determination; or
- The employee, whose spouse is also a covered employee or retiree, may apply for health, dental or vision on his spouse's coverage within 31 days of termination.

#### If the employee is eligible to retire

You must offer the retiring employee and his covered spouse and/or child(ren) COBRA enrollment information by letter, even though he is eligible for retiree insurance benefits.

## **COBRA election period**

Once the qualifying event notification has been sent, each qualified beneficiary has a period of time to make the decision to elect COBRA continuation coverage.

The qualified beneficiary has 60 days after the date of loss of coverage or the date the notification of COBRA rights is sent (whichever date is later) to elect to continue coverage under COBRA.

• During this period, an employer cannot take any action to hurry an election or a waiver of COBRA coverage.

An election is deemed made on the date postmarked on the NOE that is sent to the COBRA administrator.

• If a qualified beneficiary signs a waiver of COBRA coverage, the waiver can still be

revoked at any time during the 60-day election period.

 Once a qualified beneficiary has elected COBRA coverage, he cannot waive afterward, even if time remains in the 60day election period.

Qualified beneficiaries who are enrolled under COBRA continue with the same health insurance plan. There is an exception:

• A qualified beneficiary may change *from* the Standard Plan *to* the Savings Plan. Keep in mind that any deductible amounts accrued under the previous plan will *not* carry over to the Savings Plan. A beneficiary who changes to the Savings Plan must meet the full deductible before benefits are payable.

## **COBRA Termination Notice**

## Third required notice

PEBA sends this notice directly to the qualified beneficiaries when COBRA continuation requirements have been met and COBRA coverage is ending (the end of the 18, 29 or 36 months of required continuation coverage). This notice is sent via first-class mail to the last known address.

Do **not** send this notice. PEBA can provide a *Certificate of Creditable Coverage* upon request.

## Other coverage may end COBRA eligibility

Eligibility for health, dental and/or vision coverage under COBRA may end sooner than the periods discussed earlier in this section. Eligibility will also end when:

- The subscriber or an eligible spouse or child(ren) enrolls in Medicare (Part A, Part B or both) *after* COBRA coverage is elected.
  - If the individual has Medicare and then elects COBRA, he can take COBRA for secondary coverage. Medicare will be primary.

- After the subscriber has elected COBRA, the subscriber or an eligible spouse or child becomes covered under other group coverage for which there is no exclusion or limitation for any preexisting condition that the individual may have.
  - If the individual *already* has the other coverage when he elects COBRA, he can have both. The plan that covers the subscriber as an employee will be primary to the plan that covers him as a spouse.

The loss of COBRA eligibility applies only to the person who enrolls in Medicare or other coverage. Covered persons who do not enroll in Medicare or other group coverage may continue their COBRA coverage as long as they are otherwise eligible.

To end COBRA coverage, the subscriber completes and submits to his COBRA administrator a <u>Notice to</u> <u>Terminate COBRA Continuation Coverage</u>, along with the documentation requested on the form.

# Initial premium payment period

The qualified beneficiary is allowed 45 days from the date of election to make his initial payment as explained below. If the 45<sup>th</sup> day falls on a weekend or holiday, the first payment is due the following business day.

The initial payment must include the COBRA premiums back to the date of the loss of coverage.

### Example

Qualifying event: Divorce	
Date of qualifying event	May 28
COBRA start date	June 1
COBRA election date	July 22
First payment due	September 5 If date falls on a weekend or holiday, the next business day.
First payment includes	COBRA premiums for June, July and August

COBRA coverage will not be activated, and claims will not be paid until the initial 45-day premium payment is received.

To activate COBRA coverage immediately so benefits can be paid, the initial 45-day premium payment, as described above, must accompany the COBRA NOE. Exception:

• Optional employers collect the premium payment before submitting the COBRA NOE to PEBA.

If the amount due is not paid within this period, COBRA coverage can be terminated retroactively, and the subscriber may be liable for any benefits paid during the period.

Following the initial premium payment, subsequent payments are due on the 10<sup>th</sup> of the month for that month. COBRA subscribers have a 31-day grace period to pay.

 In the example above, the premium for September would be due September 10, and the subscriber has until October 10 to pay it. If the subscriber does not make a payment within the 31-day grace period, his coverage is terminated, and he loses all continuation rights under the plan.

# Administrative fee for optional employers

PEBA charges optional employers a \$3-per-month administrative fee for COBRA subscribers. This administrative fee may not be passed along to the COBRA subscriber. See more information in the *Optional Employer Handbook*.

By law, the maximum premium the COBRA administrator can charge the subscriber is 102 percent of the total premium (employer and employee shares) charged to an active employee. There is one exception: when 18-month COBRA coverage is extended to 29 months, the COBRA administrator can charge 150 percent of the total premium for active employees (see Page 84).

## **Benefit changes**

Qualified beneficiaries are entitled to the same rights as active employees. These rights include participating in open enrollment periods, changing plans, special eligibility situations and adding a newly acquired spouse or child(ren).

## **COBRA procedures for the Medical Spending Account**

IRS Code Section 125 allows an employee to continue his Medical Spending Account under COBRA if certain conditions are met. The Medical Spending Account can be continued only for the rest of the plan year. Employees may not re-enroll for the next year.

The subscriber must be enrolled in the Medical Spending Account at termination.

The subscriber must, on a timely basis, elect to maintain continuous contributions, on an after-tax basis to the Medical Spending Account.

The monthly administrative fee will be added to the amount due.

• COBRA rules allow an additional administrative fee for continuing the

Medical Spending Account of two percent of the monthly amount in all cases, except disability. The fee is calculated and included with the payment.

## Procedures at termination

- PEBA will send ASIFlex a file to report COBRA qualifying events.
- ASIFlex will then notify the participant of his COBRA rights and include a COBRA Continuation Coverage Election Form.
- The monthly contribution amount already will be filled in on the form.
- The notification will include information regarding when and how payments should be made.
- When ASIFlex receives the election form from the participant, ASIFlex will process the application and send payment coupons to the participant for future monthly payments. Remember that participants may continue only their Medical Spending Accounts and coverage through the end of the year.
- The participant has 45 days from the date the election is signed to make the initial payment.
- The initial payment must include the cost of the continuation coverage from the time the coverage would have otherwise terminated, up to the time he makes his initial payment.
- The monthly contribution amount and the amount of the initial payment will be included in the payment coupons that will be sent to the participant.
- If no payment is received within 45 days, the individual will lose all continuation rights under the plan.
- Subsequent payments are due by the first day of the month coverage is provided. If payments are made on or before the due date, coverage will continue without any break.

 There is a 31-day grace period for payment. Payments must be postmarked by this date, and if ASIFlex does not receive payment by the end of the grace period, coverage will end as of the last paid-through date.

Benefits administrators with MoneyPlus COBRA questions may call ASIFlex at 833.SCM.PLUS. Employees should call ASIFlex at 833.SCM.PLUS.

# Affordable Care Act reporting requirements

Employers who participate in the State Health Plan have certain requirements under the Affordable Care Act. Employers must provide subscribers with proof of health coverage by issuing forms to subscribers. Each year, the IRS determines the date by which employers must send the forms to subscribers. Learn more on Page 68.

## **COBRA** quick reference

Action type	Required COBRA notice
New hire	Initial Notification
<ul> <li>Special eligibility situations (adding someone to coverage):</li> <li>Marriage</li> <li>Birth</li> <li>Adoption/placement for adoption</li> <li>Gaining custody</li> <li>Loss of other coverage</li> </ul>	Initial Notification
<ul> <li>Open enrollment (adding someone to coverage):</li> <li>Employee</li> <li>Spouse</li> <li>Child(ren)</li> </ul>	Initial Notification
<ul> <li>Open enrollment (dropping someone from coverage):</li> <li>Employee</li> <li>Spouse</li> <li>Child(ren)</li> </ul>	No notice required, unless due to a qualifying event (separation, divorce or child becomes ineligible).
Gain of other coverage	No letter required
Legal separation	36-Month Qualifying Event Notice
Divorce	36-Month Qualifying Event Notice
Child becomes ineligible	36-Month Qualifying Event Notice
Transfers	Losing employer sends the 18-month Qualifying Event Notice. Gaining employer sends the Initial Notification.
Leaves employment (for reasons other than gross misconduct or nonpayment of premiums)	18-month Qualifying Event Notice
Retires	18-Month Qualifying Event Notice
Working hours reduced (not in a stability period)	18-Month Qualifying Event Notice

## **Retiree subscribers**

## Contents

Requirements for retiree insurance	92
Assisting an eligible retiree.	92
Retiree packet information	92
Administrative information	92
Important retirement information	
Health insurance	93
Dental insurance	94
Vision insurance	94
Life insurance	94
Long term disability	95
MoneyPlus	95
Health Savings Account	96
Assisting a new retiree with enrollment	96
Completing the <i>Retiree NOE</i>	96
Changing coverage in retirement	
Retiree returns to work	97
Life insurance	
Medicare	
Affordable Care Act reporting requirements	

## **Requirements for retiree insurance**

Eligibility for retiree group insurance is not the same as eligibility for retirement. Determining retiree insurance eligibility is complicated, and only PEBA can make that determination.

PEBA recommends an employee review the requirements for retiree group insurance in the Retiree group insurance chapter of the *Insurance Benefits Guide* before he confirms his retirement date. Share the retiree insurance flyers, available at peba.sc.gov/nyb, with employees.

In addition to qualifying for retirement, an employee's last five years of employment must be served consecutively in a full-time, insuranceeligible permanent position with an employer that participates in the State Health Plan to qualify for retiree insurance.

PEBA insurance benefits **cannot** confirm eligibility over the telephone. If an employee's anticipated retirement date is **within 90 days**, direct him to submit an <u>Employment Verification Record</u> with a <u>Retiree NOE</u>.

If an employee's anticipated retirement date is **three to six months away**, direct him to submit an <u>Employment Verification Record</u> and PEBA will provide confirmation of his eligibility.

PEBA will not confirm eligibility for retiree insurance **more than six months** before an employee's anticipated retirement date.

## Assisting an eligible retiree

## Retiree packet information

The *Retiree Packet*, available at <u>peba.sc.gov/forms</u>, is a comprehensive packet that includes the retiree insurance flyers, *Employment Verification Record*, *Retiree NOE* and helpful information for retirees.

## Administrative information

PEBA acts as the benefits administrator for retirees, except retirees of optional employers. Benefits administrators serve as the main point of contact for retirees of optional employers.

Retirees do not have to receive a retirement benefit check from PEBA to be eligible for retiree insurance. However, they must be eligible for retirement and must meet the retiree insurance eligibility requirements explained in the Retiree group insurance chapter of the IBG.

Retirees continue to use the same health and dental ID cards (if they do not change plans) and the same *Insurance Benefits Guide*.

PEBA will send open enrollment information to retirees at their last known address in PEBA's records.

### For optional employers only

An optional employer does not have to participate in PEBA-administered retirement plan for its eligible retirees to participate in the State Health Plan. Eligibility is determined as if the retiree was a member of the South Carolina Retirement System.

Benefits administrators serve as the main point of contact for retirees of optional employers.

For PEBA to determine eligibility, the <u>Employment</u> <u>Verification Record</u> must be verified and signed by the employer.

Optional employers must offer all eligible retirees the entire package of state insurance benefits for which they are eligible and must allow retirees to refuse all or any part of the benefits package.

Optional employers are billed for all retirees and must collect all premiums for their retirees.

An optional employer can choose the amount, if any, it wishes to contribute toward health and dental coverage for its eligible retirees. If your optional employer wants to make contributions, you must develop your own premium tables by adjusting the non-funded retiree premiums in the IBG to reflect your optional employer's contribution.

#### Notes regarding academic retirees

If active employee insurance premiums are deducted on a prorated scale to cover the summer months, you must refund any overpaid premiums that result when a teacher or academic employee retires after the spring semester.

Advanced deduction of premiums does not constitute continuous coverage throughout summer months unless the employee is actively working on a full-time basis during that time.

# Important retirement information

## Health insurance

The same certification and documentation required of active subscribers, spouses and children applies to retirees and their spouses and children (i.e., eligibility documentation, spouse is a state group employee/retiree, spouse lost coverage, incapacitated child, etc.).

If both the retiree and spouse are covered retirees and both are enrolled in the same health plan, the family deductible will apply.

- Both retirees must enroll individually. Some exceptions may apply.
- Only one parent can enroll a child. However, one parent can cover the child under health and the other parent cover the child under dental, for example.

## When the retiree becomes eligible for Medicare

#### Applies also to covered spouses and children.

#### Due to age:

 PEBA will notify the retiree, in advance of his 65<sup>th</sup> birthday that his coverage will change automatically to the Medicare Supplemental Plan when he turns age 65.

- Advise your retirees to enroll in Medicare Parts A and B when they become eligible to have optimal coverage.
- Eligibility for the GEA TRICARE Supplement Plan will end.
- Retirees must submit a copy of their Medicare card to PEBA.

#### Due to disability/before age 65:

- The retiree or covered spouse or child must notify PEBA within 31 days of becoming eligible for Medicare due to disability or due to end-stage renal disease and submit a copy of his Medicare card to PEBA.
- When an individual begins dialysis for end-• stage renal disease, he becomes eligible for Medicare three months after beginning dialysis. At this point, he begins a "coordination period" of 30 months. During this time, his coverage through the State Health Plan remains primary. When the coordination period ends, Medicare becomes primary. The coordination period applies whether the subscriber is an active employee, retired, a survivor or a covered spouse or child, and regardless of whether the subscriber was already eligible for Medicare due to another reason, such as age.
- Eligibility for the GEA TRICARE Supplement Plan will end.

#### Medicare Part D

State Health Plan retirees, survivors, COBRA subscribers and their dependent spouses and children enrolled in Medicare are eligible for Express Scripts Medicare, a group-based, Medicare Part D Prescription Drug Plan (PDP). PEBA has determined that most subscribers covered by the Medicare Supplemental Plan or the Standard Plan will be better served if they remain enrolled in this Medicare Part D plan sponsored by PEBA.

 Each fall, before Medicare's annual enrollment period, PEBA is required to send a notice to subscribers who are eligible for Medicare notifying them of their options.

- If a Medicare-eligible subscriber or his eligible spouse or child enrolls in a Medicare Part D plan not sponsored by PEBA, he will lose his prescription drug coverage through his plan with PEBA, and his health insurance premiums will not decrease.
- Most individuals enrolled in Medicare who have coverage through PEBA should not enroll in a separate Medicare Part D plan because PEBA has determined its prescription drug coverage offered through the Medicare Supplemental Plan or Carveout Plan is considered to be creditable coverage.
- Under Part D, the federal government offers a program to help pay monthly premiums and a program to help pay copayments/coinsurance for people with limited resources. To apply for limited income assistance, individuals can complete an application online at www.socialsecurity.gov or call the Social Security Administration at 800.772.1213.

#### Medicare Supplemental Plan

For Medicare-eligible retirees enrolled in the Medicare Supplemental Plan:

- Claims will be paid according to the Standard Plan provisions for covered family members who are not eligible for Medicare.
- The private duty nursing deductible starts with the effective date of the Medicare Supplemental Plan, even if the yearly deductible under the previous plan (Standard Plan, etc.) has already been met.

## Dental insurance

The retiree group dental coverage is the same as the active group dental coverage. The retiree may elect dental coverage, even if he refuses health coverage.

## Vision insurance

The State Vision Plan coverage is the same as the active group vision coverage. The retiree may elect

the State Vision Plan, even if he refuses health coverage.

## Life insurance

At retirement, the employee may continue or convert his Optional Life coverage. He may convert his Basic Life, Dependent Life-Spouse and/or Dependent Life-Child coverage to an individual whole life policy.

MetLife will mail to the retiree a conversion/continuation packet via U.S. mail three to five business days after MetLife receives the eligibility file from PEBA. The eligibility file is created from terminations submitted to PEBA by the employer.

To continue or convert coverage, the retiree must follow the instructions in the packet from MetLife. Coverage must be continued/converted within 31 days of the date coverage is lost due to approved retirement or approved disability retirement.

- Premiums for continued or converted coverage are due by the payment due date.
- If the individual is billed monthly, his policy will be canceled 60 days from the billing date of the first unpaid or partially paid bill. Approximately 10 days after the first bill's due date, MetLife will bill again. The due date will be 21 days later. If neither of these bills are paid in full, the individual's coverage will cancel on the 60<sup>th</sup> day.
- If the individual is billed quarterly, semiannually or yearly, his policy will be canceled 60 days from the billing date of the first unpaid or partially paid bill. The individual will not receive another bill or a reminder notice.

## Death benefits within 31 days after retirement

If a retiree, his spouse or his child dies within the 31-day period in which he is entitled to have a conversion and/or continuation policy issued, the amount of group life insurance the retiree, his spouse or his child was eligible to continue or convert will be paid to the designated beneficiary. Complete and submit the claim to MetLife. More on filing life insurance claims is in the **Claims and appeals** chapter.

If death occurs after the 31-day period, benefits will not be paid, unless the retiree submitted an application and paid the premium for the conversion/continuation.

In the case of a living benefit, the remaining percentage can be continued through the continuation or conversion provision, if the employee is retiring due to service or disability. If the employee is not retiring due to service or has not been approved for disability by The Standard or PEBA, the remaining percentage can be converted. Refer to the IBG for information on the living benefit and continuation of life insurance in retirement.

#### **Basic Life**

Within 31 days of retirement, Basic Life coverage may be converted to an individual whole life policy through MetLife. The retiree should follow the instructions in the packet he receives from MetLife if he is interested in converting this coverage.

### **Optional Life**

Within 31 days of retirement, Optional Life coverage may be continued as a term policy with no cash value; or converted to an individual whole life policy through MetLife.

The minimum amount of coverage that can be continued as a term policy is \$10,000. The retiree should follow the instructions in the packet he receives from MetLife.

The subscriber may also choose to split his coverage and continue a portion as a term policy and convert a portion to an individual policy. If the retiree does not continue his coverage, he *cannot* re-enroll later (e.g., during open enrollment or if a special eligibility situation occurs). You may want to make a note in his file if he does not want to continue or convert this coverage. Accidental death and dismemberment coverage is available only to active employees; it cannot be continued into retirement.

Retirees with questions about their life insurance coverage may call MetLife at 888.507.3767.

### **Dependent Life**

Within 31 days of retirement, Dependent Life coverage may be converted to an individual whole life policy through MetLife.

If the retiree does not convert coverage, he *cannot* re-enroll his spouse or child(ren) later (e.g., during open enrollment). He also cannot add a new spouse or child to Dependent Life coverage later if a special eligibility situation occurs. You may want to make a note in his file if he does not want to convert this coverage.

- The spouse or child must be covered when the employee leaves employment.
- The 31-day rule applies to converting life insurance into retirement.

The retiree should follow the instructions in the packet he receives from MetLife.

## Long term disability

Basic Long Term Disability and Supplemental Long Term Disability may not be continued or converted to an individual policy at retirement.

## MoneyPlus

### Flexible spending accounts

Generally, a retiree cannot continue to participate in MoneyPlus in retirement, except:

 A Medical Spending Account participant may continue coverage on an after-tax basis, under COBRA, through the end of the plan year. As an alternative, a terminated retiree can waive COBRA coverage and elect to prepay all remaining contributions on a pretax basis in order to continue coverage through the end of the plan year. Otherwise, the retiree cannot use his Medical Spending Account after he leaves employment and cannot access any remaining funds.

 Refer to the IBG for specific eligibility information regarding the Pretax Group Insurance Premium feature and the Dependent Care and Medical Spending Accounts.

## Health Savings Account

If a retiree is not eligible for Medicare and is continuing coverage under the Savings Plan or other high deductible health plan, he may continue to contribute to his Health Savings Account (HSA) until age 65.

- A retiree cannot contribute to his HSA on a pretax basis through MoneyPlus.
- A retiree can contribute directly to HSA Central, custodian for HSAs, or to another HSA custodian.

# Assisting a new retiree with enrollment

Eligible retirees may enroll in and add or drop their spouse or child(ren) from health, dental and/or vision coverage within 31 days of the date of retirement.

Refer to the *Service retirement* checklist at <u>peba.sc.gov/publications</u> under *Life event checklists*.

## Completing the Retiree NOE

Refer to the instructions on the back of the *Retiree NOE* for details about completing the form. Use only this form when enrolling a retiree.

• An Active NOE with "Retiree" written across the top will be rejected by PEBA.

### **Important reminders**

### Eligibility

Indicate the type of retiree and provide the years, months and days of service. Attach an *Employment* 

*Verification Record* if the form has not previously been sent to PEBA, to determine eligibility.

If applicable, check whether there is a 5-14-year, 15-24-year, or age 55/25-year and corresponding end date.

Benefits administrators of optional employers must verify retirement eligibility for their employees and sign the *Retiree NOE*.

#### Coverage

The retiree must select coverage and if refusing coverage, must check *Refuse*.

#### Medicare

If the retiree or any family members are eligible for Part A or B of Medicare, this section must be completed. A copy of the Medicare card(s) must be provided to PEBA.

#### **Certification and authorization**

The retiree should read this section, then sign and date.

If the tobacco and e-cigarette use status has changed for the retiree and/or his dependents, complete a <u>Certification Regarding Tobacco or E-</u> <u>cigarette Use</u> form and attach it to the Retiree NOE.

# Changing coverage in retirement

Regular rules for coverage changes during open enrollment apply. If a retiree does not pay his complete bill, **all of his coverage** will be canceled effective the last day of the month in which he paid his premiums in full. This includes all premiums for health insurance including the tobacco and ecigarette use premium, Dental Plus, Basic Dental and the State Vision Plan. Benefits that require no retiree contribution (i.e., Basic Dental) are included in this cancellation policy. The retiree may re-enroll in coverage within 31 days of a special eligibility situation or during open enrollment.

## **Retiree returns to work**

If a retiree, who is covered under the state retiree group, returns to an insurance-eligible position, he must return to active coverage status or refuse all PEBA coverage. If the retiree, his eligible spouse or any of his children are eligible for Medicare, he must be offered active group coverage. See Medicare on Page 52 for additional information. There is one exception to this rule. Retirees who are not eligible for Medicare and who retired from an employer that does not participate in the state's Retiree Health Insurance Trust Fund can remain on retiree coverage if they return to work in an insurance-eligible position.

A part-time teacher who is not eligible for Medicare may choose to stay on retiree group insurance coverage.

## Life insurance

Retirees returning to work should review their current life insurance coverage and needs carefully before deciding how much coverage they need.

## **Optional Life**

If the retiree continued his Optional Life (OL) coverage at retirement, he must decide whether to keep his continued coverage or cancel it and enroll in OL as an active employee.

- If the retiree elects to enroll in OL coverage as an active employee, he must contact MetLife to cancel his continued retiree coverage due to his return to active status.
- A return-to-work retiree cannot keep his continued policy and elect OL coverage as an active employee.

If the retiree converted his OL coverage at retirement, he may keep the converted policy and enroll in OL as an active employee. In the event of a claim, both policies would pay, provided the premiums are paid.

## **Dependent Life**

Since Dependent Life (DL) coverage may be converted only at retirement, if the retiree returns to work and enrolls as an active employee, he is not required to drop any converted DL coverage to enroll his spouse and/or child(ren) in DL as an active employee.

## Medicare

If a return-to-work retiree, including a part-time teacher, his eligible spouse or any of his children are eligible for Medicare, he can:

- Change to one of the active group plans. Medicare will be the secondary payer to the active group coverage. He must notify Social Security that Part B will be the secondary payer to his active coverage; or
- Refuse PEBA health insurance coverage altogether, which includes prescription coverage (he must disenroll), and keep his Medicare coverage. However, you cannot offer an incentive for the employee to refuse active group coverage.
  - If the employee is not enrolled in Medicare drug coverage or other Medicare creditable prescription drug coverage for 63 days or more at any time after their initial enrollment period ends, he will be subject to a Medicare Part D late enrollment penalty as long as he has Medicare drug coverage. Visit medicare.gov for more information.

When the return-to-work retiree leaves active employment and his active group coverage is terminated, he will be eligible to return to retiree group coverage. He must submit a *Retiree NOE* to return to the state retiree group within 31 days of termination.

 In addition, he must notify Social Security that he is no longer covered under an active group, so Medicare can become his primary payer or so he can re-enroll in Medicare Part B during the special enrollment period, if Part B was canceled. The cost of Part B will not increase. Call the Social Security Administration at 800.772.1213 with questions.

# Affordable Care Act reporting requirements

Employers who participate in the State Health Plan have certain requirements under the Affordable Care Act. Employers must provide subscribers with proof of health coverage by issuing forms to subscribers. Each year, the IRS determines the date by which employers must send the forms to subscribers. Learn more on Page 68.

## **Survivors**

## Contents

General rules about survivor coverage	101
If survivor was not covered at the time of subscriber's death	101
If survivor was covered at the time of subscriber's death	101
Assisting a survivor	101
If the deceased was an active employee subscriber	101
Procedures to continue coverage as a survivor	102
Premium waiver rules	102
Premiums	103
Which SSN/BIN to use for claims	104
Optional Life benefits for survivors	104
When survivor coverage ends	104
Spouse	104
Gaining eligibility through participating employer	105
<u>Children</u>	105

# General rules about survivor coverage

A survivor is a spouse or child(ren) on the coverage of an active employee or retired subscriber who has died.

A survivor can continue health, dental and/or vision benefits as long as he is eligible.

If Dependent Life-Spouse and/or Dependent Life-Child coverage was in place when the subscriber died, that coverage can be converted within 31 days of the subscriber's date of death.

## If survivor was not covered at the time of subscriber's death

A surviving spouse or child(ren), who is not enrolled when the covered subscriber dies, is not eligible for coverage as a survivor.

The survivor will not be eligible to enroll later during open enrollment, nor will he be eligible to enroll due to a special eligibility situation.

## If survivor was covered at the time of subscriber's death

A surviving spouse or child(ren), who is enrolled in health, dental and/or vision coverage when the subscriber dies, is eligible to continue that coverage as a survivor.

The survivor can continue only the coverage he had at the time of the subscriber's death. He may change health plans within 31 days of gain of coverage as a survivor.

The survivor may add other coverage during open enrollment or within 31 days of a special eligibility situation such as loss of other coverage.

If the covered surviving spouse or covered child(ren) terminates health, dental **and** vision coverage, he loses his eligibility for coverage as a survivor. He will no longer be eligible to re-enroll during open enrollment, nor will he be eligible to enroll otherwise due to a special eligibility situation. If the covered surviving spouse or covered child(ren) terminates health, dental **or** vision coverage, but he still retains at least one of the other coverages, he keeps his eligibility for coverage as a survivor. He may re-enroll in the other coverage(s) during open enrollment or when a special eligibility situation occurs.

A surviving spouse may add eligible child(ren) to coverage during open enrollment or when a special eligibility situation occurs.

Survivors of deceased active employees are classified as survivor subscribers under the retiree group.

## Assisting a survivor

Refer to the *Death of a covered employee* checklist at <u>peba.sc.gov/publications</u> under *Life event checklists*.

If applicable, notify PEBA retirement benefits regarding the death and any refund or monthly benefit that may be due.

Submit the termination in EBS. For the termination reason, choose Death. If submitting an <u>Active</u> <u>Termination Form</u>, check the T1 box, Deceased. Terminate the coverage as soon as the death is confirmed. Include a copy of the death certificate/documentation.

If the deceased was killed in the line of duty, attach the appropriate verification documents.

# If the deceased was an active employee subscriber

If the subscriber was enrolled in Optional Life and/or enrolled in a health plan, thus has Basic Life coverage, file for life insurance with MetLife. See Page 94 for more information.

If the subscriber was enrolled in Long Term Disability and receiving benefits at the time of death, call The Standard to report the death for any potential benefits payable to eligible survivors.

- Any BLTD benefits remaining unpaid will be paid to the employee's estate.
- Any SLTD benefits remaining unpaid will be paid to the person(s) eligible to receive the survivor benefit that is defined in the SLTD policy. In case there are no eligible survivors as defined in the SLTD policy, survivor benefits would not be paid, and any SLTD benefits remaining unpaid would then be paid to the employee's estate.

MoneyPlus Medical Spending Accounts (MSA) and Dependent Care Spending Accounts (DCSA) are not refundable to the survivor. These accounts are terminated effective the date of death of the subscriber, unless the IRS-qualified spouse, child(ren) or beneficiaries elect to continue the MSA under COBRA through the end of the plan year.

If the subscriber had an HSA, advise the survivor/beneficiary to contact HSA Central to settle the account. HSA Central will require proof of death for the deceased and identification for the beneficiary.

## Procedures to continue coverage as a survivor

You must notify survivors about enrollment, cost of premiums, premium collection, coverage changes and terminations.

When PEBA receives the termination, PEBA will notify any covered survivor(s) that health coverage may be continued at no cost for one year (if eligible for the premium waiver) or by paying survivor premiums.

A <u>Survivor NOE</u> must be completed within 31 days of the subscriber's date of death. If, as a result of the death, the tobacco and e-cigarette use status for the survivor has changed, complete and attach a <u>Certification Regarding Tobacco or E-cigarette Use</u> form.

The survivor will receive new ID cards with a new benefits ID number (BIN). See also Which SSN/BIN to use for claims on Page 104.

PEBA will bill for continuation of dental and vision coverage if the survivor was covered and while the survivor is on a health premium waiver.

Optional employers are responsible for premium collection.

The survivor may pay premiums:

- Through deduction from a monthly PEBA retirement benefit check;
- By automatic bank draft; or
- By direct billing.

For any child(ren) covered by the deceased subscriber, if both parents were covered as active employees or retirees:

- **Health**: Add child(ren) to the surviving parent's health plan within 31 days of the ending date of the premium waiver.
- **Dental**: Add child(ren) to the surviving parent's dental plan within 31 days of the loss of coverage under the deceased's plan.
- Vision: Add child(ren) to the surviving parent's State Vision Plan within 31 days of the loss of coverage under the deceased's plan.

## Premium waiver rules

A spouse and/or child(ren) must be enrolled in the State Health Plan, under the deceased employee's or employer-funded retiree's coverage, at the time of death to be eligible for coverage and the oneyear waiver of premium for health insurance. Spouses and children who are eligible for coverage under the Plan as an active employee or retiree are not eligible for survivor coverage, including any premium waiver.

The waiver of health premium is effective the day after the date of death.

The premium waiver applies only if there was an employer premium contribution. This includes survivors of employees who work at least 20 hours a week if the employer has elected the 20-hour threshold. Survivors of deceased permanent, part-time teachers are not eligible for the premium waiver.

Optional employers may elect, but are not required, to waive the health premiums for survivors of retirees.

Survivors not eligible for the waiver may continue coverage by paying the full survivor premiums. Refer to the IBG for additional information on survivor coverage.

A surviving spouse is not entitled to a premium waiver if he feloniously or intentionally kills his active or retired spouse.

After the one-year waiver, survivors must pay the full cost to continue health coverage.

- *Exception:* If the deceased was "Killed in the Line of Duty" while working for an employer that participates in the South Carolina Retiree Health Insurance Trust Fund, the surviving spouse or child(ren) may continue coverage, if he is eligible, at the employer-funded rate after the waiver ends. Optional employers may elect, but are not required, to fund this survivor coverage. Survivors not eligible for employer-funded premiums may continue coverage by paying the full survivor premiums.
- "Killed in the Line of Duty" means that the death of an active employee was a natural and proximate result of an injury by external accident or violence while the employee was performing acts connected with, or resulting from, duties assigned, required, or authorized by his or her employer. An employee is not considered to have been Killed in the Line of Duty if: (i) the death of the employee was caused by the employee's intentional misconduct or intention to bring about his or her own death; (ii) the employee was voluntarily intoxicated at the time of death; or (iii) the

employee was performing his or her duties in a grossly negligent manner at the time of death.

There is no premium waiver for Dental Plus, Basic Dental or the State Vision Plan.

• *Exception:* If the deceased was killed in the line of duty while working for a participating employer, the dental premium of a surviving spouse or child(ren) will be waived for the first year after the employee's death.

All policies and procedures apply to survivors during the premium waiver period (i.e., changes due to family status changes, open enrollment, gaining coverage as an employee of a participating employer, etc.).

PEBA notifies survivors when the waiver period ends and when plan policies and procedures change. Optional employers receive a copy of this notification sent to survivors.

Survivors may drop health coverage within 31 days of the waiver end date. Otherwise, they must wait until open enrollment or a special eligibility situation.

## Premiums

View monthly premiums at <u>peba.sc.gov/monthly-premiums</u>.

- Survivors of active employees, funded and partially funded<sup>1</sup> retirees:
  - State Health Plan premiums waived for one year.
  - After the waiver, survivor pays the full cost of the premiums.
- Survivors of non-funded retirees pay full cost of premiums from date of retiree's death.
- Survivors pay full cost of dental and vision premiums from date of retiree's death.

<sup>&</sup>lt;sup>1</sup> Survivors of partially funded retirees pay half the employer share during the waiver year.

• Survivors of optional employer retirees must contact employer for premiums.

## Which SSN/BIN to use for claims

Continue to file claims for services provided to the deceased subscriber under his SSN or benefits ID number (BIN).

Effective the day after the date of death, the BIN for the surviving spouse and child(ren) is the surviving spouse's SSN or BIN, if the surviving spouse is covered. Otherwise, a BIN will be generated for the surviving spouse.

If survivor coverage is for child(ren) only, the BIN is the SSN or BIN of the youngest child, unless Medicare covers one of the children. Then, the BIN is the SSN or BIN of the child with Medicare. A BIN will be generated for the youngest child or the child with Medicare coverage, whichever is applicable.

New ID cards with the new BIN will be issued to the survivor(s).

For any child(ren) covered by the deceased subscriber, if both parents were covered as active employees or retirees:

- Health: During the waiver period, if applicable, claims should be filed using the SSN or BIN of the child. If there is more than one child, this would be the BIN of the youngest child.
- **Dental**: Dental claims should be filed using the surviving parent's SSN or BIN.
- Vision: State Vision Plan claims should be filed using the surviving parent's SSN or BIN.

## **Optional Life benefits for survivors**

Once MetLife receives the completed life insurance claim and required documentation, MetLife will determine eligibility and pay the life insurance proceeds and any accidental death and dismemberment benefits, if applicable, such as:

- Accidental Death Benefit (based on the death certificate);
- Seat Belt and Air Bag benefit (based on the police report and/or accident report);
- Dismemberment benefits (based on the accident report);
- Felonious Assault Benefit (based on the police report/death certificate);
- Day Care Benefit (paid to beneficiaries, younger than age 7, who are enrolled in day care); and
- Dependent Child Education Benefit (paid to qualified beneficiaries).

MetLife also offers legacy planning resources and beneficiary financial counseling. Share the *MetLife Advantages* flyer available at <u>peba.sc.gov/nyb</u> and view the MetLife folder on the <u>Health Hub</u>.

The subscriber may assign benefits to a third party, such as a funeral home. However, MetLife will not be bound by an assignment of the certificate or of any interest in it unless it is made as a written statement, and the subscriber files the original instrument or a certified copy with MetLife's home office, and MetLife sends the subscriber an acknowledged copy. For more information, contact MetLife or see the IBG.

More information on life insurance claims is in the claims and appeals section, beginning on Page 126.

## When survivor coverage ends

## Spouse

The surviving spouse's eligibility to continue health, dental and/or vision coverage as a survivor ends upon remarriage. Survivor coverage ends the first of the following month.

Continuation of coverage under COBRA must be offered. The 36-month COBRA continuation period starts when eligibility for survivor coverage ends, regardless of when the survivor notifies his COBRA administrator. *Example*: Surviving spouse remarries but fails to notify his COBRA administrator for 12 months. He is thus eligible for COBRA coverage only for the remaining 24 months.

# Gaining eligibility through participating employer

Eligibility for survivor coverage ends if a surviving spouse or child(ren) becomes eligible for coverage as an active employee with a participating employer. He cannot remain on survivor coverage and must enroll as an active employee.

If the survivor is on waiver status, he must pay the employee share of the premium, unless he is the survivor of an employee who was killed in the line of duty. He may return to survivor coverage when he leaves employment or continue coverage as a retiree, if eligible. He must enroll in survivor or retiree coverage within 31 days of when his active coverage ends. The remainder of the waiver period would not apply.

Any covered child who is not employed with a participating employer may remain on the waiver until it ends.

## Children

A child may continue coverage until no longer eligible. Coverage ends the first of the following month after he becomes ineligible.

Continuation of coverage under COBRA must be offered. The 36-month COBRA continuation period starts when eligibility for survivor coverage ends, regardless of when the survivor notifies his COBRA administrator. *Example*: Surviving child becomes eligible for employer-sponsored group health coverage but fails to notify his COBRA administrator for 12 months. He is thus eligible for COBRA coverage only for the remaining 24 months.

# **Spouses and children**

## Contents

Spouses: special eligibility requirements and changes in status	
Both spouses employed by participating employers	
Spouse is retiree subscriber	
Marriage	
Spouse of foreign national employee	
Separated spouse	
Former spouse/divorce	
Death of covered spouse	
Dependent Life-Spouse coverage	
Eligibility requirements	
Children: special eligibility requirements and changes in status	
Child younger than age 26	
Incapacitated child	
Child in full-time military service	
Child turns age 26	
Dependent Life-Child coverage	
Full-time students	
Dependent Non-confinement Provision	
Eligibility for MoneyPlus spending accounts	
COBRA notification by subscriber required	
Adoption Assistance Program	
Adoption assistance is subject to taxes	
# Spouses: special eligibility requirements and changes in status

The subscriber is required to submit documentation to enroll a spouse as a dependent. See the <u>Enrollment documentation worksheet</u>. If he fails to submit the required documentation, the dependent will be removed from coverage. Any documentation that is in a language other than English must be completely translated into English and should be certified with a letter of accuracy from the translator.

The eligibility of a spouse is subject to review by PEBA. In general, an eligible spouse may be added to coverage within 31 days of the special eligibility situation. Otherwise, a spouse may be added to coverage during open enrollment. Ineligible spouses must be dropped from coverage within 31 days of the event that makes them ineligible for coverage.

Details and exceptions are outlined in each of the situations that follow.

# Both spouses employed by participating employers

If legal spouses are employed by participating employers and eligible for coverage as employees, neither may be covered as a dependent spouse. When a spouse gains eligibility with a participating employer, even if the spouse refuses coverage, he may not continue to be covered as a dependent.

A spouse is not required to carry the same health coverage. However, family deductibles will not apply unless the spouses elect the same health plan. Spouses cannot cover the same child(ren) under the same benefit (health, dental, vision, Dependent Life).

# Spouse gains eligibility as an employee of a PEBA-participating employer

When a spouse gains eligibility as an employee, his coverage as a dependent must be dropped.

The effective date to drop a spouse as a dependent is the date the spouse's employee coverage begins.

• *Exception*: If a spouse goes to work as a part-time teacher with a participating employer, he may be covered as an employee or a spouse, but not both.

## Spouse is retiree subscriber

A legal spouse who is also an employer-funded retiree is not eligible for coverage as a dependent.

#### Spouse gains eligibility as a retiree subscriber

When a spouse gains eligibility as a retiree, his coverage as a dependent must be dropped. The effective date to drop a spouse as a dependent is the date the spouse's retiree coverage begins.

### Marriage

Refer to the Adding a dependent due to Marriage checklist at <u>peba.sc.gov/publications</u> under Life event checklists.

The eligible employee may enroll himself, existing eligible dependents, his new spouse and new stepchild(ren) in health, dental and/or vision coverage within 31 days of the date of marriage.

 If the employee is already enrolled in health, he may change plans if he is adding his spouse or stepchild to health.

The effective date of coverage is the date of marriage for health, dental and vision coverage.

The eligible employee may add Dependent Life-Child, Dependent Life-Spouse (\$10,000 or \$20,000 without medical evidence) and Optional Life (up to \$50,000 without medical evidence) within 31 days of date of marriage.

Dependent Life-Child coverage begins the first of the month after the date of the request.

Optional Life and Dependent Life-Spouse coverage begin the first of the month following the date of the request if the employee is actively at work. If not actively at work, the effective date is the first of the month following the return to work.

The eligible employee may be able to make changes to his Medical Spending Account or Dependent Care Spending Account. The eligible employee must be on the plans or added with the spouse and/or child(ren).

#### Documentation

A marriage license or Page 1 of the employee's latest federal tax return if filing jointly is required to add a spouse.

A long-form birth certificate showing the name of the natural parent plus proof natural parent and subscriber are married is required to add a stepchild.

#### Note about premiums

If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of marriage. Premiums may be paid pretax beginning the first of the month following the date of the request.

# Spouse of foreign national employee

#### Add to coverage

A legal spouse of an eligible foreign national employee may be added to health, dental, vision and Dependent Life coverage within 31 days of arrival in the U.S. A copy of the visa/visa stamp, showing the arrival date, and a copy of the marriage license are required to add the spouse as a dependent. The effective date of coverage is the date the spouse entered the U.S.

#### **Drop from coverage**

A spouse of an eligible foreign national employee may be dropped from coverage within 31 days of departure from the U.S. A copy of the visa/visa stamp, showing the departure date, is required to drop the spouse. The effective date is the date the spouse left the U.S.

### Separated spouse

Separation is not recognized as a legal status in South Carolina, and therefore is not a special eligibly situation in which a subscriber can make changes to his coverage. If the subscriber has a court order from a jurisdiction that recognizes legal separation as a legal status, PEBA will honor that order and allow the subscriber to drop coverage as a result of a special eligibly situation. It's important to note, however, that in these cases, reconciliation is not a special eligibly situation.

## Former spouse/divorce

Refer to the *Dropping a dependent due to Divorce* checklist at <u>peba.sc.gov/publications</u> under *Life event checklists*.

When a divorce is final, the subscriber must drop the former spouse from all benefits within 31 days of the divorce. A copy of the first page of the divorce decree and the page with the judge's signature must be submitted to confirm the drop in coverage.

The effective date is the first of the month after the divorce becomes final.

• Exception: If the subscriber fails to drop the former spouse within 31 days of the divorce, the effective date will be the first of the month after the request is made.

The subscriber may enroll in or increase Optional Life coverage up to \$50,000 without medical evidence. The subscriber may be able to make changes to his Medical Spending Account or Dependent Care Spending Account.

# **Required to cover former spouse by divorce decree or court order**

If a divorce decree or court order requires a subscriber to continue to cover a former spouse under the State Health Plan, the former spouse is required to have his own policy at the full cost of the premium. The subscriber is thus permitted to cover a current spouse as a dependent under his policy. The active employee subscriber is eligible to participate in the MoneyPlus Pretax Group Insurance Premium feature.

A former spouse must enroll using the *Former Spouse NOE* within 31 days of the date the court order or divorce decree is signed. A copy of the first page of the divorce decree or court order, the page with the judge's signature and pages related to insurance coverage, must be included. The divorce decree or court order must state that the subscriber is directed to provide insurance for the former spouse.

The effective date of former spouse coverage is the first of the month after the divorce becomes final.

# Death of covered spouse

Refer to the *Death of a covered dependent* checklist at <u>peba.sc.gov/publications</u> under *Life event checklists*.

Upon the death of a covered spouse, the spouse must be dropped from coverage within 31 days of the date of death. The effective date is the day after the spouse's date of death.

 Exception: If the subscriber fails to drop the spouse within 31 days of the death, the request to change the level of health, dental, vision and Dependent Life, if applicable, may be changed retroactively, up to 12 months.

The subscriber may decrease or drop his Optional Life coverage within 31 days of his spouse's death.

# Dependent Life-Spouse coverage

# Eligibility requirements

The employee is the beneficiary for proceeds from Dependent Life-Spouse insurance. Spouses enrolled in Dependent Life are covered for Accidental Death and Dismemberment benefits. They are eligible for the Seat Belt and Air Bag benefit, Child Care benefit and Dependent Child Education benefit. The employee may enroll his spouse in Dependent Life-Spouse coverage within 31 days of initial eligibility or within 31 days of loss of other coverage through a participating employer without medical evidence.

Medical evidence is required if the requested coverage is greater than \$20,000 or the spouse is not added within 31 days of initial eligibility, which is the:

- Date of hire, if spouse is not an eligible employee;
- Date of marriage; or
- Date spouse is no longer eligible as an active employee.

Note: A spouse, who is a retiree subscriber, may be covered on Dependent Life-Spouse as a spouse within 31 days of the date he retires or during a specified enrollment period.

Follow the same procedures as outlined under Optional Life beginning on Page 56 for submitting medical evidence. The Actively at Work requirement and the Dependent Non-confinement Provision, as explained in the IBG, apply.

# Children: special eligibility requirements and changes in status

The subscriber is required to submit documentation to enroll a child as a dependent. If he fails to submit the required documentation, the dependent will be removed from coverage. Any documentation that is in a language other than English must be completely translated into English and should be certified with a letter of accuracy from the translator.

The eligibility of a child is subject to review by PEBA. Eligible children may be added to coverage within 31 days of the special eligibility situation. Otherwise, a child may be added to coverage during open enrollment.

Special eligibility situations allowing a subscriber to enroll himself and his eligible child(ren) in health,

dental and/or vision coverage include marriage, birth, adoption/placement for adoption, placement of a foster child, gaining of legal custody, other court order or loss of other coverage.

Two employees cannot cover the same child(ren) under the same benefit (health, dental, vision, Dependent Life).

# Child younger than age 26

A child who is younger than age 26 is eligible if either:

- The child is the employee's natural or adopted child, stepchild, foster child or child for whom the employee has legal custody; or
- The employee is required to provide health insurance because of a court order.

The subscriber must submit proof of the child's relationship to the subscriber within 31 days of enrollment and at other reasonable times.

#### Birth

Refer to the *Adding a dependent due to birth* checklist at <u>peba.sc.gov/publications</u> under *Life event checklists*.

A newborn may be added to coverage within 31 days of the date of birth. The eligible employee may enroll himself, an eligible spouse, existing eligible dependents and the newborn in health, dental and/or vision coverage within 31 days of the date of birth.

• If the employee is already enrolled in health, he may change plans if he is adding his spouse or newborn to health.

The effective date of coverage is the date of birth of the newborn for health, dental and vision coverage.

Newborns are covered under Dependent Life-Child automatically for 31 days from live birth. A request must be submitted to continue Dependent Life-Child coverage beyond 31 days. The eligible employee may add Dependent Life-Child, Dependent Life-Spouse (\$10,000 or \$20,000 without medical evidence) and Optional Life (up to \$50,000 without medical evidence) within 31 days of the date of birth. The subscriber must complete an online *Statement of Health* for any requested coverage amounts more than \$20,000 for Dependent Life-Spouse.

Dependent Life-Child coverage continues the first of the month after the date of the request. Optional Life and Dependent Life-Spouse coverage begin on the first of the month following the date of the request if the employee is actively at work. If not actively at work, the effective date is the first of the month following the return to work.

The employee may be able to make changes to his Medical Spending Account or Dependent Care Spending Account.

The eligible employee must be on the plans or added with the spouse and/or newborn.

If the 31-day window to add the newborn is missed, the subscriber has 90 days (from the date on the rejection letter if the NOE is submitted after 31 days, or 90 days after the initial 31-day window) to send a written explanation and request for reconsideration to PEBA.

If the subscriber misses the 31-day window and 90day appeal period explained above, coverage may be provided only from the date of birth through the end of the month after the first 31 days. To process claims for these 31 days of coverage, PEBA will need an NOE to add the infant for claims payment for the first 31 days and another NOE to drop coverage, effective the first of the month after the 31-day period. The request/NOEs to add and then drop may be submitted retroactively, up to 12 months.

#### Documentation

A long-form birth certificate showing the subscriber as the parent is the preferred document to add the newborn. However, if the child needs immediate service before the birth certificate can be obtained and the provider will not render services without proof of insurance, PEBA will accept an official document from the hospital signed by the attending physician or other hospital staff. The document must include the child's name, date of birth and parents' names.

A marriage license or Page 1 of the employee's latest federal tax return if filing jointly is required to add a spouse.

#### Note about premiums

If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums may be paid pretax beginning the first of the month following the date of the request.

# Adoption/placement for adoption (child younger than age 18)

Refer to the Adding a dependent due to adoption checklist at <u>peba.sc.gov/publications</u> under Life event checklists.

A child younger than 18 may be added to coverage within 31 days of the date of the adoption/date of placement for adoption. The eligible employee may enroll himself, an eligible spouse, existing eligible dependents and the newly adopted child in health, dental and/or vision coverage within 31 days of the date of the adoption/date of placement for adoption.

 If the employee is already enrolled in health, he may change plans if he is adding his spouse or newly adopted child to health.

The effective date of coverage is the date of birth for health, dental and vision coverage if the baby is adopted or placed for adoption within 31 days of birth. If adopted or placed for adoption after 31 days of birth, the effective date is the date of adoption or placement for adoption.

The eligible employee may add Dependent Life-Child, Dependent Life-Spouse (\$10,000 or \$20,000 without medical evidence) and Optional Life (up to \$50,000 without medical evidence). The subscriber must complete an online *Statement of Health* for any requested coverage amounts more than \$20,000 for Dependent Life-Spouse. Dependent Life-Child coverage is effective the date of birth if the baby is adopted or placed for adoption within 31 days of birth. If adopted or placed for adoption after 31 days of birth, the effective date is the date of adoption or placement for adoption.

Optional Life and Dependent Life-Spouse coverage begins on the first of the month following the date of the request if the employee is actively at work. If not actively at work, the effective date is the first of the month following the return to work.

The eligible employee may be able to make changes to his Medical Spending Account or Dependent Care Spending Account.

*Exception: International adoptions.* The effective date of coverage must be either:

- The date of adoption on the adoption paperwork (required documentation); or
- The date the child entered the U.S. A copy of the visa/visa stamp is required if using this date as the effective date of coverage.

If the adopted child is a newborn, please see Birth section on Page 111 for additional requirements if the 31-day window to add the child is missed.

The eligible employee must be on the plan or added with the spouse and/or newly adopted child.

#### Documentation

Acceptable documentation to add the newly adopted child includes a long-form birth certificate showing the subscriber as the parent; a copy of legal adoption documentation from a court, verifying the completed adoption; or a letter of placement from an adoption agency, an attorney or the Department of Social Services (DSS), verifying the adoption is in progress.

A marriage license or Page 1 of the employee's latest federal tax return if filing jointly is required to add a spouse.

#### Note about premiums

If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, may be paid pretax beginning the first of the month following the date of the request.

#### Custody or guardianship

A subscriber who gains custody or guardianship over a child may add the child within 31 days.

The eligible employee may enroll himself only or any eligible spouse and/or child with new legal custody in health, dental and/or vision coverage.

 If the employee is already enrolled in health, he may change plans if he is adding his spouse or child with new legal custody to health.

The eligible employee may add Dependent Life-Child for eligible children (a foster child is not eligible for Dependent Life coverage). The effective date of coverage is the date of custody or guardianship for health, dental, vision and Dependent Life-Child coverage.

The eligible employee may be able to make changes to his Medical Spending Account or Dependent Care Spending Account. The eligible employee must be on the plan or added with the spouse and/or newborn.

#### Documentation

Acceptable documentation to cover a child with new legal custody includes a court order or other legal documentation from a placement agency or the S.C. Department of Social Services, granting custody or guardianship of a child/foster child to the subscriber. The documentation must verify the subscriber has guardianship responsibility for the child and not merely financial responsibility.

A marriage license or Page 1 of the employee's latest federal tax return if filing jointly is required to add a spouse.

#### Note about premiums

If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of gaining custody or guardianship. Premiums may be paid pretax beginning the first of the month following the date of the request.

#### Divorce decree or court order

A child may be added to coverage. The child should be added to coverage within 31 days of the decree/court order. The effective date of coverage is the first of the month after the court orders' date stamp from the clerk of court.

If the subscriber fails to drop the separated spouse within 31 days of the date on the order, the subscriber must wait until open enrollment or until another special eligibility situation occurs to add the child(ren).

Former stepchildren are not eligible and may not be covered, even if it is specified in the court order.

Special eligibility rules do not apply to National Medical Support Notices (NMSNs). See Page 49 for more information about NMSNs.

#### Documentation

A copy of the entire divorce decree or court order is required.

- The document should list what insurance the subscriber is directed to provide (i.e., health, dental, vision).
- The document must list the name(s) of those to be covered.

Only the insurance listed may be provided for the child(ren) listed in the document.

#### Note about premiums

If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of gaining custody or guardianship. Premiums may be paid pretax beginning the first of the month following the date of the request.

#### Child of foreign national employee

#### Add to coverage

A child of an eligible foreign national employee may be added to health, dental, vision and Dependent Life coverage within 31 days of arrival in the U.S. A copy of the visa/visa stamp, showing the arrival date, and a copy of the long-form birth certificate showing the subscriber as the parent are required to add the child as a dependent.

A copy of the visa/visa stamp, showing the arrival date, a copy of the long-form birth certificate showing the name of the natural parent and proof that the natural parent and subscriber are married are required to add a stepchild as a dependent.

The effective date of coverage is the first of the month after arrival in the U.S.

#### Drop from coverage

A child of an eligible foreign national employee may be dropped from coverage within 31 days of departure from the U.S.

A copy of the visa/visa stamp, showing the departure date, is required to drop the child.

The effective date of coverage is the first of the month after departure from the U.S.

#### Child gains employment with coverage

A child who becomes eligible for other employersponsored group health coverage as an employee or as a spouse may continue his dependent coverage through the subscriber.

- If the child chooses to be covered under his parent's insurance as a dependent child, he is eligible only for benefits offered to children. The child is not eligible for Basic Life, Optional Life, Dependent Life-Child or Long Term Disability insurance.
- The child cannot be covered as a child on one insurance program, such as health, and then enroll for coverage as an employee on another, such as vision.
- The child should complete an Active NOE with his employer, refusing coverage. Under Type of Change on the NOE, next to Other, specify Enrolled as child of PEBA subscriber.
- If the child loses his coverage through his employer, and the child is otherwise eligible for coverage through the subscriber, the

child may be re-enrolled within 31 days of the loss of coverage event or during open enrollment.

• If the child later decides to enroll in coverage as an employee, rather than as a dependent, he must complete an *Active NOE*.

The subscriber may drop the child within 31 days of when the child becomes eligible for other employer-sponsored group health coverage. The effective date is the first of the month after gaining coverage.

#### Note about premiums

If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of gaining custody or guardianship. Premiums may be paid pretax beginning the first of the month following the date of the request.

#### Death of covered child

Refer to the *Death of a covered dependent* checklist at <u>peba.sc.gov/publications</u> under *Life event checklists*.

Upon the death of a covered child, the child must be dropped from coverage within 31 days of the date of death. The effective date is the day after the child's date of death.

• Exception: If the subscriber fails to drop the child within 31 days of the death and this is the last eligible child, the request to change the level of health, dental, vision and Dependent Life, if applicable, may be changed retroactively, up to 12 months.

#### Note about premiums

If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of gaining custody or guardianship. Premiums may be paid pretax beginning the first of the month following the date of the request.

## Incapacitated child

An incapacitated, unmarried child who is incapable of self-sustaining employment because of mental illness or intellectual or physical disability and who is principally dependent (more than 50 percent) on the covered employee, retiree, survivor or COBRA subscriber for maintenance and support is eligible if:

- The child is covered at the time of incapacitation and has been continuously covered by a health insurance plan from the time of incapacitation;
- The child remains unmarried; and
- The incapacitation is established no earlier than 90 days before the child's 26<sup>th</sup> birthday but no later than 31 days after his 26<sup>th</sup> birthday.
- For the child to be covered under Dependent Life-Child, the incapacitation is established no earlier than 90 days before the child's 19<sup>th</sup> birthday but no later than 31 days after his 19<sup>th</sup> birthday or within 31 days of loss of student status.

PEBA determines whether the child is eligible to be considered for incapacitated child status.

Coverage for an incapacitated child may continue beyond age 26, when coverage would otherwise end, as long as the child remains eligible (this does not apply to children covered under COBRA). PEBA reserves the right to require the subscriber to submit satisfactory proof of such incapacity and dependency at any time. This proof is typically required within 31 days of initial enrollment, upon attaining age 26, and at other reasonable times, but not more frequently than annually.

A child who becomes incapacitated after age 26 is not eligible.

#### Incapacitated child certification procedures

If a covered child will turn age 26 within 90 days or the child is ages 19-25 and covered under Dependent Life-Child and incapable of attending school full-time, *and* if the child is incapacitated due to a mental or physical disability, the subscriber should complete an *Incapacitated Child Certification* form and send it to PEBA for a determination of eligibility.

If establishing incapacitation at age 26, this form should be sent to PEBA no earlier than 90 days before the child's 26<sup>th</sup> birthday and no later than 31 days afterward.

If establishing incapacitation within 31 days of loss of student status for Dependent Life-Child coverage, the subscriber must submit a completed <u>Incapacitated Child Certification</u> form and attach:

- A copy of the letter of withdrawal from the educational institution, verifying full-time student status up to the date of incapacitation; and
- A copy of the latest tax return, verifying the child is principally dependent on the subscriber. Tax schedules do not need to be included, and the tax return may be redacted as necessary.

#### Completing the *Incapacitated Child Certification* form

The subscriber must complete and sign Section A and the shaded areas of Section B.

If the child is ages 19-25, attach a copy of the letter of withdrawal from the educational institution, verifying full-time student status up to the date of incapacitation.

The dependent's physician must complete the remainder of Section B and sign Page 4.

The subscriber should also complete and attach an <u>Authorized Representative Form</u>, signed by the incapacitated child, to confirm permission for PEBA to discuss or disclose the child's protected health information to the particular person who acts as the child's Authorized Representative.

 If the child is incapable of signing the Authorized Representative Form, PEBA may accept, instead, documentation verifying the representative's authority to act on behalf of the child in these matters (i.e., guardianship papers or a power of attorney).

The subscriber returns the completed forms to PEBA for review, approval/denial and processing.

PEBA will forward the completed forms to The Standard for a review of the medical information provided, as well as the terms of the plan of benefits, and a recommendation. The Standard may request additional information from the subscriber and/or the child's health care providers. The Standard will forward its recommendation to PEBA, which makes the final determination based on the recommendation and documentation provided.

PEBA will notify the employer and the subscriber of its decision. Under HIPAA, no personal health information is disclosed to the employer.

If eligibility as an incapacitated child is denied, the subscriber has 31 days to submit additional medical records and documentation to The Standard for review and reconsideration.

If the child's eligibility as incapacitated is denied, the subscriber can appeal the decision by writing to PEBA within 90 days of receipt of the denial letter. If the denial is upheld by PEBA, the subscriber has 30 days from receipt of the denial letter from PEBA to seek judicial review as provided by S.C. Code Ann. 1-11-710 and 1-23-380. For more information regarding the appeals process, please see Page 139.

The subscriber may be required periodically to recertify the child's incapacitation.

## Child in full-time military service

A child in full-time military service is not eligible for Dependent Life-Child coverage.

## Child turns age 26

Unless the child is approved to continue coverage as an incapacitated child, the child must be dropped from the subscriber's coverage when he turns 26. The effective date is the first of the month after the child's  $26^{th}$  birthday.

Important note: The child will be dropped from coverage automatically, and any ineligible claims will not be paid.

# Dependent Life-Child coverage

Eligible children may be added or dropped throughout the year, effective the first of the month after the request or effective the date of the event, if added within 31 days of birth, adoption, etc. No medical evidence is required.

If both parents are eligible for PEBA insurance benefits, only one can carry Dependent Life coverage for eligible children.

The Dependent Non-confinement Provision applies.

The subscriber pays one Dependent Life-Child premium to insure all covered children, and the subscriber is the beneficiary. There are no accidental death or dismemberment benefits for Dependent Life-Child.

Newborns are covered under Dependent Life-Child automatically for 31 days from live birth. A request must be submitted to continue Dependent Life-Child coverage beyond 31 days.

To be eligible for coverage, the child must be:

- Unmarried;
- Supported by the subscriber (however, a foster child is not eligible for Dependent Life coverage); and
- Younger than 19 years old; or at least 19 years old but younger than 25 and a fulltime student, not employed on a full-time basis; or any age while certified as incapacitated.

## Full-time students

A child who is at least 19 years old but younger than 25 and enrolled in and attending school in a full-

time student status may be eligible for Dependent Life coverage as a full-time student.

- School includes high school, college or university (including graduate school), accredited technical, vocational or trade school or academic military academy.
- Full-time student status is defined by the institution.
- The student must be working toward a diploma or degree. Internet classes do qualify, provided they are offered through a school as defined earlier.

The child may be added to Dependent Life-Child coverage within 31 days of when he becomes a fulltime student. The effective date is the first of the month after attaining full-time student status.

For students already covered, 90 days before a covered child's 19<sup>th</sup> birthday PEBA provides a letter in EBS for you to provide to the subscriber. The child's coverage will continue unless the subscriber notifies you that the child is no longer a full-time student or incapacitated child.

No Dependent Life claims will be paid for children who are at least 19 years old but younger than 25 who were not eligible as full-time students.

## Dependent Non-confinement Provision

If a dependent is hospitalized or confined because of illness or disease on the date his insurance would otherwise become effective, his effective date shall be delayed until he is released from such hospitalization or confinement. This does not apply to a newborn child. However, in no event will insurance on a dependent be effective before the subscriber's insurance is effective.

# **Eligibility for MoneyPlus spending accounts**

A list of who qualifies for reimbursement from a Medical Spending Account or Dependent Care Spending Account is in the *Insurance Benefits Guide*. For more information, consult with a tax adviser.

# COBRA notification by subscriber required

COBRA notification by the employee, spouse or other family member is required within 60 days for spouses and children when eligibility for health, dental and/or vision coverage ends.

Upon notification, issue the appropriate second notice to the employee, spouse or other family member. See the COBRA section for additional details.

# **Adoption Assistance Program**

When funds are available and authorized in the state's budget, it is the policy of the State of South Carolina to provide financial assistance to eligible employees who are adoptive parents of a child, including a special needs child. This program is administered through PEBA.

Qualified applicants will receive:

 When there are not enough funds available or authorized to meet every qualified applicant's expenses, funds will be divided evenly among the applicants. Those who adopted a special needs child will receive twice the amount as those who adopted a non-special needs child.

To be eligible, the adopting employee must be covered by PEBA insurance and must be employed when the adoption is finalized, when the application is submitted and when the payment is made.

As it relates to the Adoption Assistance Program, a **child** means any person younger than age 18. A stepchild is not eligible for adoption assistance benefits.

As it relates to the Adoption Assistance Program, a **special needs child**, means a child, as defined above, who meets other specific requirements

established in PEBA's Adoption Assistance Policy. For information on these requirements, contact PEBA's Insurance Finance department at 803.734.16296 or insuranceaccounting@peba.sc.gov.

Adoption assistance is not available for the adoption of a stepchild or for any other adoption involving a state employee who resides in the same home as the adopted child and the adopted child's parent.

Applications must be submitted between July 1 and September 30 for adoptions finalized the previous fiscal year (July 1-June 30). Following the September 30 deadline, payments will be sent to employees by the end of the following November. Payments cannot be sent to service providers.

Payments will be made to employees for costs related directly to the adoption, such as:

- Medical costs of the biological mother not covered by other insurance, Medicaid or other available resources;
- Medical costs of the child not otherwise covered;
- Licensed adoption agency fees, legal fees and guardian ad litem fees; and
- Allowable travel fees associated with the adoption process.

#### Adoption assistance is subject to taxes

Financial assistance through the Adoption Assistance Program is subject to federal income and FICA payroll taxes but is not subject to state income taxes. PEBA will withhold Social Security and Medicare payroll taxes (7.65 percent) from the benefit payment. *These withholdings will be forwarded to the employer.* 

- The employer is responsible for the employer payroll tax match. This amount must be reported at the end of the year on the individual's W-2 in Box 3 (Social Security wages), Box 5 (Medicare wages) and Box 12 (using Code T — Miscellaneous Income).
- The employee is responsible for determination and payment of any federal income tax liability.

According to IRS Publication 15-B, *Employers Tax Guide to Fringe Benefits*, an employer must report all qualifying adoption expenses reimbursed to an employee under an adoption assistance program for each employee. IRS Publication 15-B is available online at <u>www.irs.gov</u>.

#### **Comptroller General (CG) Agencies**

If your employer is a CG agency, you are not responsible for reporting FICA taxes for adoption benefits. SCEIS will transfer the employer's FICA match from the STARS account. SCEIS will then forward the employee and employer FICA taxes to the IRS and report the adoption benefit and withholdings on the employee's W-2. A check for the net reimbursement from the Adoption Assistance Program will be issued to the employee, along with a letter explaining the deduction.

For more information or for an application, employees may contact PEBA.

# **Disability subscribers**

# Contents

Training	121
Workplace Possibilities	121
Eligibility	121
Applying for disability benefits	121
Assisting a disabled employee	122
Optional Life	123
Basic Long Term Disability and Supplemental Long Term Disability	123
MoneyPlus	125

# Training

View the Retirement, Disability and Death (RDD) employer insurance training materials at peba.sc.gov/insurance-training.

# **Workplace Possibilities**

The odds of an employee returning to work after a disability diminish with time. The best chance for an employee to return to work is to do so as soon as possible. The Standard's Workplace Possibilities program may be able to help your disabled employee remain productive. The Workplace Possibilities program is an additional benefit that provides a disability consultant based in South Carolina who can help covered employees overcome barriers to job performance caused by their medical condition. The services are included in PEBA's disability policy.

Benefits administrators may refer an employee for Stay at Work services while the employee is still working. The goal is to help the employee perform their job tasks. Return to Work services are provided soon after an employee goes out of work. The goal is to quickly return the employee to work.

Learn more about the program <u>online</u> and sign up for The Standard's blog at <u>www.workplacepossibilities.com/blog</u>.

# How can I request services from the Workplace Possibilities team?

The first step is for the employee's manager to discuss the issue with the employee. Then, you should submit a <u>Stay at Work Request for Services</u> form and give the employee a one-page <u>Stay at</u> <u>Work Medical Information Request</u> form for their doctor to fill out and send to The Standard. The employee will also need to complete an <u>Authorization to Obtain and Release Health</u> <u>Information</u>. Once The Standard receives this information, a Workplace Possibilities consultant will contact your employee.

# Eligibility

An employee may be eligible for retiree group insurance if he is approved for disability retirement benefits through one of the defined benefit plans administered by PEBA.

Disability retirement eligibility for South Carolina Retirement System (SCRS) members is based on entitlement to Social Security benefits. Police Officers Retirement System (PORS) disability retirement claims are evaluated by a disability determination provider and a medical board.

State Optional Retirement Program (State ORP) does not provide disability protection. However, a State ORP participant may meet the retirement eligibility requirement for retiree group insurance through approval through The Standard for Basic Long Term Disability and/or Supplemental Long Term Disability. The State ORP participant must also be approved for disability by the Social Security Administration to be eligible for insurance as a disability retiree.

State ORP participants and employees of optional employers who do not participate in a PEBA administered retirement plan may meet the disability retirement eligibility requirements for retiree group insurance through disability approval by the Social Security Administration.

For more information about disability retirement, see Chapter 7 of the PEBA retirement benefits <u>Covered Employer Procedures Manual</u>. For more information about retiree disability insurance, see the Disability Retirement section in the Retirement and Disability chapter of the <u>Insurance Benefits</u> <u>Guide</u>.

# Applying for disability benefits

An employee should apply for disability benefits as soon as he becomes disabled and **before leaving covered employment**. He may be eligible for optional life insurance benefits through MetLife and long term disability through The Standard.

- 1. Complete and submit an *Application for Disability Retirement* to PEBA, if applicable.
- 2. Complete and submit optional life insurance information to MetLife, if applicable.
- 3. Complete and submit long term disability information to The Standard, if applicable.

If the employee is unable to file, you may file on his behalf. The process may always be canceled if the employee recovers.

# Assisting a disabled employee

Refer to the *Disability retirement* checklist at <u>peba.sc.gov/publications</u> under *Life event checklists*.

If an employee is leaving employment due to disability:

- Follow the procedures in the **Transfers and terminations** chapter.
- COBRA notification rules apply.
- If eligible for disability retirement, refer the employee to PEBA for assistance with filing for disability retirement.

If the employee applied for disability retirement with PEBA before he left covered employment, and he is terminated from employment before he receives approval, he may continue coverage through COBRA.

- He has 31 days from the date he leaves employment to apply for conversion of his life insurance with MetLife.
- If he is later approved for disability retirement, he may apply for retiree insurance within 31 days of the date of notification from PEBA. If he does not apply within 31 days of the date of notification, he must wait for a special eligibility situation or open enrollment to enroll as a retiree.

If the employee is covered as an active employee until he receives disability approval, he may apply

for retiree insurance within 31 days of the date of notification from PEBA.

- If eligible, retiree coverage will be effective the first of the month following his termination from active coverage, provided he is terminated from active coverage on or after the date of retirement.
- If he does not apply within 31 days of the date of notification, he must wait for a special eligibility situation or open enrollment to enroll as a retiree.
- He has 31 days from the date of notification from PEBA to apply for continuation/conversion of his life insurance with MetLife.

Employees who are approved for BLTD/SLTD benefits cannot use that approval to apply for retiree insurance.

The effective date for insurance will be the first of the month following the date on the approval letter from PEBA (disability retirement), or from The Standard (BLTD/SLTD) as explained in the above bullet. The retiree must apply for coverage within 31 days of the date of the approval letter.

Review the deductible income/offset rules and overpayment potential for BLTD and SLTD benefits as explained in the Long Term disability chapter of the IBG.

If the employee becomes eligible for Medicare as a disability retiree through Social Security, advise the disabled employee he will need to enroll in Medicare Parts A and B. He must also notify PEBA within 31 days of eligibility and provide a copy of his Medicare card. He will no longer be able to contribute to an HSA if he enrolls in Medicare.

If the individual has end-stage renal disease, please read Page 90 in the **Retiree subscribers** chapter for additional information about Medicare's coordination period.

If the employee does not qualify for retiree insurance, but enrolls in COBRA, he must notify PEBA when he is approved for Social Security disability benefits so PEBA can determine his eligibility for the 11-month extension of COBRA coverage. Refer to the **COBRA** chapter for further instructions.

## **Optional Life**

If the employee takes a leave of absence due to a total disability (as determined by the employer), his Optional Life (OL) coverage continues for up to 12 months by paying the premiums, beginning the first of the month after the last day worked.

 If he retires while on a leave of absence, he can choose to continue or convert his coverage within 31 days of leaving active employment, as explained below.

If the employee does not return to work at the end of 12 months, terminate his coverage. He may be able to continue or convert his coverage within 31 days of his termination. Read Continuation/conversion below for more information and instructions.

• The employee can be considered eligible for Dependent Life coverage on his spouse's coverage, if applicable, when his eligibility for OL as an employee ends or if he converts coverage. He is not eligible if he chooses to continue his coverage.

#### Continuation/conversion

If the employee is approved for PEBA disability retirement and/or BLTD/SLTD, but does *not* qualify for retiree insurance benefits, he may continue or convert his OL coverage.

• He may also choose to split this coverage and continue a portion as a term policy and convert a portion to an individual policy.

If the employee is not approved for PEBA disability retirement or BLTD/SLTD, he can only convert his OL coverage.

The procedures for continuing and converting Optional Life coverage are explained beginning on Page 95.

#### Accelerated benefits

The accelerated benefits option may be available to active employees on a leave of absence who are terminally ill with a life expectancy of no more than 12 months. Claiming this benefit, which is 80 percent of his OL coverage, will reduce the amount of any optional life coverage and will reduce any optional life coverage eligible for continuation or conversion.

Complete a MetLife Accelerated Benefit Option claim. Refer to the **Claims and appeals** chapter for further instructions.

# Basic Long Term Disability and Supplemental Long Term Disability

#### Eligibility for benefits

Eligibility for BLTD and SLTD benefits is based on criteria using terminology from The Standard:

- Own occupation is a person who is unable to perform his <u>own</u> occupation as it is performed in the national economy during the benefit waiting period and the first 24 months for which LTD benefits are paid.
- Any occupation is a person who is unable to perform <u>any</u> occupation from the end of the own occupation period to the end of the maximum benefit period.
- Partial disability.

See the BLTD and SLTD plan certificates at <u>peba.sc.gov/publications</u> for details.

#### Note regarding partial disability

An employee may work in another occupation while he meets his own occupation's definition of disability. If the employee is disabled from his own occupation, there is no limit on his earnings in another occupation. However, the employee's earnings may be deductible income — BLTD/SLTD benefits may be reduced by this income.

#### **BLTD/SLTD claim information**

Refer to the **Claims and appeals** chapter for the procedures for filing claims and appeals. Below is

some general information regarding claim documentation.

Satisfactory written proof that the employee is disabled and entitled to BLTD and/or SLTD benefits must be provided. Claims may be submitted online, via telephone or on paper.

**Time limits for filing and substantiating claims** An employee should submit a completed claim to The Standard as soon as possible, but within 90 days after the end of the benefit waiting period.

In situations in which the employee is unable to obtain the information to submit a completed claim to The Standard within the timeframe above, The Standard will accept completed claims up to one year after the 90-day period following the waiting period (see above).

If a completed claim is not filed within one year after the 90-day period following the waiting period, the employee's claim will be denied.

These time limits do not apply while the employee lacks legal capacity. In this situation, contact The Standard for additional information and instructions.

#### Documentation

If The Standard asks the employee to provide documentation to complete a claim, the employee must provide that documentation within 45 days of The Standard's request. Otherwise, the claim will be denied. The cost for providing the requested documentation is the employee's responsibility.

If The Standard asks a provider to provide documentation to complete a claim, the provider must provide that documentation within 45 days of The Standard's request. Otherwise, the claim may be denied.

#### **BLTD/SLTD** payments

The Standard may pay BLTD and/or SLTD benefits within 60 days after The Standard receives satisfactory proof of loss. BLTD and/or SLTD benefits will be paid to an employee at the end of each month he qualifies for benefits. The payment should be received by the first of the month for the previous month.

Any BLTD benefits remaining unpaid will be paid to the employee's estate.

Any SLTD benefits remaining unpaid will be paid to the person(s) eligible to receive the survivor benefit that is defined in the SLTD policy. In case there are no eligible survivors as defined in the SLTD policy, survivor benefits are not paid, and any remaining SLTD benefits unpaid would be paid to the employee's estate.

#### No assignment

The rights and benefits of the SLTD and BLTD plans cannot be assigned (paid to a third party).

Advise of adjustments and potential overpayments Remind any employee who is applying for BLTD and SLTD benefits that these benefits are reduced by other forms of deductible income, or offsets, as outlined in the IBG.

 These offsets are applied against BLTD and SLTD benefits, according to an individual's eligibility to receive them, regardless of whether he actually does receive them.

Eligibility for any benefits (Social Security, PEBA retirement benefits disability, workers' compensation, sick leave, return-to-work earnings, etc.) should be reported to The Standard immediately as they may be considered offsets.

#### Waiver of premiums

The SLTD premium waiver begins the first of the month after the end of the benefit waiting period, and premiums should continue until then.

The waiver ends when the employee returns to work. At that time, notify The Standard and complete the <u>SLTD Premium Waiver Form</u>.

#### The Standard prepays FICA and Medicare

BLTD and SLTD benefits are subject to taxes, including FICA and Medicare.

- The employee share of these taxes is deducted before the benefit payments are issued.
- The Standard prepays the employer share and bills the employer quarterly for reimbursement of these amounts. You will receive a letter itemizing the charges.
   Follow the instructions outlined in the letter. If you receive such a letter and have any questions, please call Cindy Bofinger at The Standard at 971.321.4653.

#### When you should call The Standard

Notify The Standard when you become aware of any of the following events concerning an employee receiving SLTD and/or BLTD benefits:

• Employee receives deductible income/offsets (PEBA retirement benefits

disability or retirement benefits, Social Security disability or retirement benefits, workers' compensation benefits, sick leave or shared leave, etc.);

- Employee returns to work in any capacity;
- Employee needs help or assistance in returning to work;
- Employee dies; or
- Employee is terminated.

### MoneyPlus

If on leave due to disability, the employee can continue his MoneyPlus accounts as explained on Page 61 under Unpaid leave or reduction in hours.

If the employee is eligible for disability retirement through PEBA, his options are explained in the **Retiree subscribers** chapter of this manual.

# **Claims and appeals**

# Contents

State Health Plan claims	128
Tips for filing claims	
State Health Plan claims for services outside the U.S.	
Coordination of benefits	
Accident questionnaires	129
Other health/dental questionnaire	129
Mental health and substance use claims	129
Dental Plus and Basic Dental claims	130
Tips for filing claims	
State Vision Plan claims	
In-network claims	
Out-of-network claims	
Denials and appeals	
Life insurance claims	
Submitting the claim	
Retirees	
<u>Claims payments</u>	
Accidental death benefit	
Suicide	
Other benefits	
Dependent Life	
Denials and appeals (Optional Life and Dependent Life)	
Long term disability claims	
Basic Long Term Disability	
Supplemental Long Term Disability	
MoneyPlus claims and reimbursement	
Medical Spending Account and Dependent Care Spending Account reimbursements	
Health Savings Account reimbursements	
Administrative or eligibility appeals	
Appeals related to claims or authorization of benefits	
Third-party claims administrators	

Many of the claims and appeals procedures are outlined in the <u>IBG</u>. Refer to the appropriate benefit sections of the IBG for general claims and appeals information and procedures.

This section highlights specifics related to filing claims and appeals that are not included in the IBG and that you might need to know as a benefits administrator.

# **State Health Plan claims**

Network providers file claims for subscribers. However, to receive benefits when a hospital or doctor does not file, subscribers can file a claim manually, as outlined in the IBG.

# Tips for filing claims

The insured's name on the <u>State Health Plan</u> <u>Benefits Claim Form</u> should match the subscriber's name on file with PEBA.

Subscribers should allow about three weeks to receive an *Explanation of Benefits* (EOB) before calling BlueCross or PEBA for assistance.

Claims should be filed as soon as possible, but MUST be filed no later than the end of the calendar year following the year in which expenses are incurred. Claims filed after that time will be denied.

The claim form cannot be used to make an address change. Subscribers can update their addresses online using MyBenefits.

# State Health Plan claims for services outside the U.S.

Claims outside the U.S. are filed for subscribers through the BlueCross BlueShield Global® Core provider network. However, to receive benefits when a hospital or doctor does not file, subscribers can file the <u>BCBS Global Core International Claim</u> <u>Form</u> manually.

# Coordination of benefits

State Health Plan benefits for health and prescription drug coverage are coordinated with

other coverage that a subscriber, his covered spouse or his covered child(ren) may have. Refer to the IBG for the general rules about how to determine which plan is considered primary or secondary.

#### Prescription drug benefit

If the State Health Plan is the secondary payer for prescription drug benefits when coordination of benefits applies, the covered person should present the primary insurance card first.

The covered person would then file a manual claim using the <u>Prescription Drug Claim Form</u> for any benefits due as the secondary payer.

A person with a MoneyPlus debit card is advised not to use the card at the pharmacy when the State Health Plan is the secondary payer, because the manual claim must be filed to determine the amount of unreimbursed expense before filing a Medical Spending Account claim.

# Claims for an active subscriber with Medicare

Medicare is the secondary payer under the active employer, unless the employee, spouse or child is enrolled in Medicare solely due to end-stage renal disease.

When an active employee, his spouse or his child(ren) is enrolled in Medicare, claims are filed with BlueCross first. Once the employee receives the *Explanation of Benefits* (EOB), he should send an itemized bill and a copy of the EOB to Medicare to be processed for secondary benefits.

If an employee is enrolled in Medicare solely due to end-stage renal disease, contact Medicare for additional information. After 30 months, Medicare becomes the primary payer for a subscriber with end-stage renal disease.

#### Claims for a retiree subscriber with Medicare

Medicare is the primary payer for a retiree who is eligible for Medicare. The State Health Plan

(including the Medicare Supplemental Plan) coordinates claims payment as though the subscriber is enrolled in Medicare Part A and B, regardless of whether the subscriber is actually enrolled. Prior to Medicare eligibility, the Plan is the primary payer.

A retiree, who is not eligible for Medicare by his own employment record, but who may become eligible on a spouse's employment record, must enroll for Medicare when the spouse enrolls. If either refuses Medicare coverage, the Plan still coordinates claims payment as if they have both Part A and Part B benefits. If the Medicare-eligible subscriber is not covered by Part A and Part B, he will be required to pay the portion of his health care costs that Part A and Part B would have covered.

#### Accident questionnaires

For accident-related claims, BlueCross may need information about the event. BlueCross gathers this information through an accident questionnaire. Gathering this information is typically related to subrogation, when more than one party is involved in the accident. Subrogation is explained under *Helpful terms* in the <u>IBG</u>.

Questionnaires are sent to subscribers when there is a claim filed for treatment of an injury or diagnosis that has been established by BlueCross' staff of physicians as likely to be an accident or work-related.

Questionnaires are generated once per week. Subscribers can receive multiple questionnaires related to the same event, due to any of the following:

- BlueCross may not have received a response to the first questionnaire before a second one is sent. Additional questionnaires will be sent to the subscriber each week until BlueCross receives a completed one.
- Subscribers may also receive more than one questionnaire if more than one covered person in the family receives treatment

related to the same accident. A separate questionnaire is sent for each covered individual being treated for injuries related to the accident. The name of the patient is included at the top of the questionnaire.

 Once BlueCross receives a questionnaire response, it is valid for six months. If claims meeting the established accident-related criteria are reported more than six months after the original accident date, the subscriber will receive another questionnaire. This six-month cycle helps BlueCross identify any subsequent accidents that may have occurred.

If claims reported more than six months after the original accident are related to that event, the subscriber should simply check the update space and return the questionnaire to BlueCross. This will update the subscriber's file for another six months.

### Other health/dental questionnaire

BlueCross sends this questionnaire to subscribers who cover dependents under the health and/or dental coverage to determine if the dependent has other primary coverage. Dependent claims can be suspended until the questionnaire is returned to BCBS. Upon receipt of the questionnaire, it is valid for one year.

# Mental health and substance use claims

Office visit services for psychological or neuropsychological testing and applied behavior analysis and all hospital inpatient, partial and intensive outpatient program admissions must be preauthorized by Companion Benefit Alternatives (CBA).

#### **In-network claims**

The provider files claims when the subscriber, his covered spouse or his covered child(ren) uses a provider that participates in the mental health and substance use provider network.

#### **Out-of-network claims**

The subscriber must complete and submit a claim form for out-of-network services. The claim form is the same for State Health Plan medical claims and mental health and substance use claims. The subscriber can file a claim manually as outlined in the IBG.

# Dental Plus and Basic Dental claims

Most dental offices can file claims directly with BlueCross. However, to receive benefits when a dentist does not file directly, subscribers can file a <u>Dental Claim Form</u> manually as outlined in the IBG.

## Tips for filing claims

The subscriber's name on the dental claim form should match the subscriber's name on file with PEBA.

A <u>Pretreatment Estimate</u> from BlueCross must be returned with the claim after the services are rendered. These estimates are valid for one year. Subscribers should allow about three weeks to receive an *Explanation of Benefits* (EOB) before calling BlueCross or PEBA for assistance.

Claims should be filed as soon as possible, but MUST be filed no later than 24 months following the date charges were incurred. Claims filed after that time will be denied.

The claim form cannot be used to make an address change. Subscribers can update their addresses online using MyBenefits.

# **State Vision Plan claims**

#### In-network claims

There are no claims to file when the subscriber uses a provider that participates in EyeMed's provider network.

EyeMed no longer requires prior authorization for medically necessary contact lenses. The provider is responsible for determining adherence to the criteria and submits a medically necessary contact lens claim form to EyeMed directly.

# Out-of-network claims

The subscriber must complete and submit an <u>Out-of-Network Vision Services Claim Form</u> to be reimbursed for eligible expenses.

EyeMed will accept only itemized, paid receipts that list the services and the amount charged for each service. Handwritten receipts must be on the provider's letterhead.

Itemized receipts should be attached to the completed claim form and mailed to EyeMed's Outof-Network Claims department at the address on the claim form's instructions page or follow instructions to submit claims online.

Claims must be submitted within 15 months of the date of service.

## Denials and appeals

Because the Vision Plan is fully insured, subscribers cannot appeal EyeMed determinations to PEBA.

If a claims question cannot be resolved by EyeMed's Customer Care Center, the subscriber may write to:

EyeMed Vision Care Attn: Quality Assurance Department 4000 Luxottica Place Mason, OH 45040

Information may also be faxed to 513.492.3259. EyeMed will work with the subscriber to resolve the issue within 30 days. If the subscriber is dissatisfied with EyeMed's decision, the subscriber may appeal to an EyeMed appeals subcommittee. All appeals are resolved by EyeMed within 30 days of the date the subcommittee receives it.

# Life insurance claims

#### Policy Number 200879

Submit the termination in EBS to cancel life insurance coverage and submit the life insurance claim with MetLife.

## Submitting the claim

Log in to <u>MetLink</u> to submit a claim. Using the Submit a Claim function, select a Claim Type and indicate who the Claim is for from the drop-down lists. Complete the required information, including the employee, coverage and informant/beneficiary information. Review the information for accuracy, edit if necessary, and submit the claim.

Once submitted, you may upload supporting documentation for the claim. Required forms for a standard life claim include:

- Completed Claimant Statement;
- Original death certificate;
- Last two years of enrollment documentation;
- Most recent beneficiary designation documents; and
- Additional documentation such as accident and toxicology and/or autopsy reports, if applicable.

Share the life insurance claim kit, available in the *Life insurance claim* form, with the claimant(s). The kit includes the Claimant Statement.

#### Using a paper claim form

You may also complete and return a paper employer statement of the <u>Life insurance claim</u> form to MetLife. Please allow additional time for processing of paper forms.

- If a subscriber dies, complete sections 1, 2 and 4 of the employer statement.
  - Employer name is South Carolina PEBA and group number is 200879 in Section 1.
  - In Section 4, indicate the type of benefit coverage, effective date(s) and list the benefit amount coverage.
  - Attach a copy of the subscriber's SOE, SOC or NOE showing his coverage amount.

- Attach beneficiary designation and any additional beneficiary contact information.
- If a dependent dies, complete sections 1, 2, 3 and 4 of the employer statement. See above for more information.

Send the completed claim form, along with coverage beneficiary information, to MetLife.

- Fax to 570.558.8645; or
- Mail to: MetLife Group Life Claims
   P.O. Box 6100
   Scranton, PA 18505-6100

#### Notification

After MetLife receives the completed claimant statement and certified death certificate, the claim will either be approved, and payment will be made to the beneficiary, or the claim will be denied, and MetLife will send a notification of denial to the beneficiary.

Claims that are completed and submitted properly are typically processed within 10 business days, unless there are extenuating circumstances surrounding the death.

Allow at least 10 business days before checking the claim status if it is an uncomplicated claim. More complicated claims — accidents and homicides may require an in-depth investigation. MetLife may also need to request additional medical information. Payment will be determined after the investigation is complete. If a beneficiary has a question about the status of a life insurance claim, he may call MetLife at 800.638.6420, then press 2.

#### Retirees

If the claim is for a deceased retiree, the beneficiary should call MetLife at 888.507.3767. The necessary claim form will be sent to the correct party for completion. MetLife will need to verify that the retiree has continued the coverage into retirement.

### Claims payments

MetLife will pay life insurance benefits to the beneficiary or beneficiaries as indicated on file with PEBA. *Exceptions* include:

- Estate of the insured: Benefits will be paid to the administrator or executor of the deceased's estate.
- A minor: Benefits will be paid to the courtappointed guardian for the minor and minor's estate.
- An incompetent beneficiary: Benefits will be paid to the guardian or other appointed representative for the beneficiary.

If applicable, a court certificate showing the appointment must be submitted. Do not delay submitting proof of death. Send it in, noting the court certificate of appointment is pending.

When the claim is approved, MetLife will send a payment notice to the beneficiary.

Claims for employees and dependents, regardless of how they were originally submitted, can be searched in MetLink.

#### Assignment

MetLife is not responsible for the validity or tax consequences of any payment to a third party (called *assignment*). An assignment is the irrevocable, legal transfer of some or all of the *interest* (amount payable in the future) under a policy to a third party. The individual with the interest (e.g., the insured) makes the irrevocable assignment. The insured can assign certain rights, such as, but not limited to:

- The right to convert group coverage to individual coverage;
- The right to designate or change a beneficiary;
- The right to accelerate death benefits, if applicable; and
- The right to increase coverage, as applicable.

No assignment will be binding on MetLife until MetLife receives a completed <u>Absolute Assignment</u> <u>to Trust</u> form, records and acknowledges it. Assignments for collateral are not permitted (such as for a loan).

PEBA will maintain a copy of records of death claim payments.

### Accidental death benefit

Completing and filing an <u>Accidental Death &</u> <u>Dismemberment Claim</u> form in cases of accidental death can be done using <u>MetLink</u>. Complete and submit the claim information, as instructed in MetLink.

See the Life Insurance chapter of the IBG for descriptions of additional accidental death benefits.

#### Suicide

Suicide is a covered life claim; however, doubleindemnity benefits are not payable. No Optional Life or Dependent Life-Spouse benefits are payable if death results from suicide, whether sane or insane, within two years of the effective date.

If death occurs within two years of the effective date of an increase, the death benefit payable is limited to the amount of coverage prior to the increase.

#### Other benefits

#### **Dismemberment benefits**

If a claim is for dismemberment or loss of vision, the employer, employee and his physician must complete the <u>Accidental Death & Dismemberment</u> <u>Claim</u> form and submit it to MetLife. Dismemberment benefits are not available to retirees or dependent children.

# Accelerated benefits option (Living benefit option)

When a physician diagnoses an employee or his covered dependent spouse as terminally ill with a life expectancy of no more than 12 months, the employee may request that MetLife pay up to 80 percent of his Optional Life or Dependent Life-Spouse benefit prior to death, up to \$400,000. The employer, employee and his physician must complete the <u>Accelerated Benefit Option</u> form and submit it to MetLife. When the ABO is used, a death certificate must be submitted to MetLife to obtain the remaining benefit. There is no need to complete an additional claim form.

If terminating employment, refer to the **Transfers** and terminations chapter for additional information and procedures.

#### Dependent Life

#### Policy Number 200879

Follow the claims procedures explained on Page 130.

File a claim using <u>MetLink</u>. If the spouse or child was the last eligible covered family member, and the level of coverage is affected by the spouse's or child's death, the employee has 31 days to complete the coverage change.

If coverage is not affected, to delete the spouse's or child's name the employee must still complete, sign and date an NOE.

Dependent Life pays double the amount for accidental death of a covered spouse, but not a covered child.

# Dependent Life Accidental Death and Dismemberment

The procedures for filing accidental death and dismemberment claims for covered spouses are the same as for employees.

# Denials and appeals (Optional Life and Dependent Life)

If a claim is denied, MetLife will notify the claimant in writing. The notice of denial states:

- The specific reason(s) for the denial;
- A reference to the plan provisions on which the denial is based; and

• An explanation of the review procedure.

The claimant may request an appeal in writing.

- Eligibility appeals should be sent to PEBA. For more information regarding the PEBA appeals process, please see Page 133.
- All other appeals should be sent to MetLife.

# Long term disability claims

# Basic Long Term Disability (BLTD Policy #627284-B)

# Supplemental Long Term Disability

#### (Policy #621144-B)

Provide employees with the <u>Frequently asked</u> <u>questions about LTD coverage provided through</u> <u>The Standard</u> and the latest LTD Certificate(s) of Coverage(s). Both certificates of coverage, for BLTD and SLTD, are available publications on the PEBA website.

The FAQ document provides details on how to initiate a claim and what to expect once the claim has been submitted. Employees can initiate their disability claim(s) telephonically, online or by completing and submitting their portion of the <u>LTD</u> <u>Benefits Claim Form packet</u>. Only one submission per disability is required and will be used for both BLTD and SLTD claims. Claims should be initiated

as soon as the employee is absent from work for more than 31 days or when modified duties have exceeded 31 days. Employees may work part-time or have modified duties and still be eligible for benefits.

Once the employee initiates his disability claim(s) with The Standard, regardless of which submission method he uses, The Standard will fax the *Attending Physician's Statement* to his treating physician. The primary benefits administrator for his agency (according to PEBA's records) will also receive an email from

<u>DoNotReplyCl@standard.com</u>. That email is the benefits administrator's notification that one of his

employees has initiated a disability claim and that an employer form is required. The email will include a link to the secure site where the employer form can be completed and submitted online. Please follow the instructions in the email. If The Standard does not receive a response to its initial employer outreach email, it will make two more outreach attempts.

If the employee is not able to apply for benefits, you may initiate a claim on behalf of the employee by contacting The Standard.

Satisfactory written proof that the employee is disabled and entitled to BLTD and/or SLTD benefits must be provided. If using the paper claim form packet for submission, the claim form packet must be completed by the appropriate parties in its entirety. Detailed instructions are included on the first two pages of the packet.

Please note the following if using the paper claim form packet:

- The employee completes the *Employee's Statement* in its entirety.
- The employee signs and dates the Authorization to Obtain and Release Information.
- The employee also signs and dates the *Authorization to Obtain Psychotherapy Notes,* if applicable.
- The employee should forward the *Employee's Statement* and both *Authorizations* to The Standard at the address on the form.
- The employee completes only Part A of the Attending Physician's Statement and forwards it to his physician, who should complete Part B. The physician should forward the completed Attending Physician's Statement directly to The Standard at the address on the form.
- The employee should complete Section 1 of the *Employer's Statement* and forward it to his benefits administrator. You should then complete the *Statement* and forward

directly to The Standard at the address on the form.

# Time limits for filing and substantiating claims

An employee should submit a completed packet to The Standard as soon as possible, but within 90 days after the end of the benefit waiting period (90 or 180 days, based on the chosen benefit waiting period). The Standard will review the *completed claim* upon receipt.

In situations where the employee is unable to obtain the information to submit a completed claim to The Standard within the timeframe above, The Standard will accept completed claims up to one year after the 90-day period following the respective benefit waiting period.

If a completed claim is not filed within one year after the 90-day period following the waiting period, the employee's claim will be denied.

These time limits do not apply while the employee lacks legal capacity. In this situation, contact The Standard for additional information and instructions.

#### Documentation

If The Standard asks the employee to provide documentation to complete a claim packet, the employee must provide that documentation within 45 days of The Standard's request. Otherwise, the claim will be denied. The cost for providing the requested documentation is the employee's responsibility.

If The Standard asks a provider to provide documentation to complete a claim packet, the provider must provide that documentation within 45 days of The Standard's request. Otherwise, the claim may be denied.

#### Investigation of claim

Once The Standard receives a completed claim packet, The Standard will review the claim and

gather any additional information necessary to make a determination on the claim.

The Standard continues to manage the employee's claim and may investigate the claim at any time for the duration of the claim.

At The Standard's expense, The Standard may have the employee examined at any time by specialists of The Standard's choice. The Standard may deny or suspend benefits if an employee fails to attend an examination or cooperate with the specialist.

If The Standard approves the employee for SLTD benefits, The Standard will notify PEBA, the employee and the employer of the approval.

- The employee's premiums are waived while SLTD benefits are payable.
- PEBA will process the waiver of premiums and generate a letter to the employer, requesting PEBA be notified immediately if the employee returns to work.

#### **Denials and appeals**

If the claim is denied, the decision is made within a reasonable period (in most cases, no more than 105 days) and communicated afterward. The notice of denial states:

- The specific reason(s) for the denial;
- A reference to the plan provisions on which the denial is based; and
- A description of additional information or material that may reverse the denial decision and why it is necessary.

# How to request an appeal of a long term disability claim

The claimant can write to Standard Insurance Company, P.O. Box 2800, Portland, OR 97208, to request a review. The request must be made to The Standard within six months of receipt of the denial letter. The claimant should include any additional documentation to be considered.

The claimant will receive notification of The Standard's final decision within 90 days of the

request, or within 120 days if special circumstances require an extension.

If The Standard reviews the claim and upholds the denial, the claimant will receive correspondence from the Administrative Review Unit at The Standard, including instructions for appealing the decision.

# BLTD only: If The Standard upholds its decision on a claim

An appeal may be filed with PEBA within 90 days of the notice of denial.

If the denial is upheld by PEBA, the subscriber has 30 days from receipt of the denial letter from PEBA to seek judicial review as provided by S.C. Code Ann. §1-11-710 and 1-23-380.

**Please note**: Because Supplemental Long Term Disability is fully insured by The Standard, SLTD decisions may not be appealed to PEBA.

Refer to the Disability subscribers section of this manual for additional information.

# MoneyPlus claims and reimbursement

## Medical Spending Account and Dependent Care Spending Account reimbursements

The subscriber files claims for reimbursement directly with ASIFlex.

ASIFlex offers several easy ways to submit claims for reimbursement. Employees can use any of these options throughout the year:

- ASIFlex website;
- ASIFlex mobile app; or
- MoneyPlus claim form.

If approved, reimbursement will be made within three business days of receipt. Reimbursement may be direct deposited into bank accounts within one day of processing a claim. Employees can log in to their ASIFlex account to sign up for direct deposit, as well as email and text alerts. Employees can also opt to receive a mailed check.

There is no reimbursement minimum for direct deposit. The minimum check reimbursement is \$25, except for the last reimbursement, which brings an account balance to zero.

# Special notes on Medical Spending Account reimbursements

Only eligible expenses may be claimed. Any medical expenses that are already covered by health, dental or vision insurance are not reimbursable.

Medical Spending Account (MSA) reimbursements are issued for the full amount of the claim, regardless of the employee's account balance, up to the unused portion of the elected annual deduction.

If not continuing an MSA after termination through COBRA, the employee has through the run-out period to submit claims incurred during his period of coverage while he was an employee.

#### **ASIFlex debit card reimbursements**

The ASIFlex debit card may be used at:

- Medical service providers, such as physician and dental offices, hospitals, medical labs;
- Prescription drug mail-order websites, such as Express Scripts Pharmacy, the State Health Plan's mail-order prescription drug service; and
- Pharmacies and any other stores that use Inventory Information Approval Systems (IIAS).
  - Prescriptions and eligible over-thecounter items are coded and identified electronically by the debit card and other MSA card programs. Only the items that are IIAS coded may be purchased with the card.
     *Example*: If you go to Walgreens, an IIAS user, and buy a prescription, contact lens solution and a magazine, the

charge for the magazine will not process. It must be paid for separately.

Persons with an ASIFlex debit card should not use the card at a pharmacy if they have other coverage, because claims for both primary and secondary plans must be filed to determine the amount of *unreimbursed* expense before filing a MSA reimbursement.

#### Documentation

ASIFlex will receive claims information from other third-party vendors to auto-adjudicate as many card transactions as possible. Use of the card, however, is not paperless. Employees may be required to submit documentation to substantiate claims.

Requests for documentation are emailed and posted to an online secure message center. A participant has 52 days to respond.

- An initial notice is sent approximately five days after ASIFlex receives notice of transaction.
- A reminder notice is sent 21 days after initial notice.
- A deactivation notice is sent 21 days after reminder notice.
- Future claim submissions are offset by any outstanding amount.

Card transactions that remain unsubstantiated by March 31 after the end of the plan year are taxable as income, and ASIFlex will send a report to employers listing all unsubstantiated card transactions. Refer to the Accounting, Billing and Reports section of this manual for additional information.

#### Special notes on Dependent Care Spending Account reimbursements

The dependent care provider may sign the <u>MoneyPlus claim form</u> where indicated in lieu of an itemized receipt.

There must be sufficient funds in the account balance to reimburse expenses. Payroll deductions from the employer are submitted to ASIFlex. If no payroll discrepancy, ASIFlex will post contributions to accounts within one business day of receipt or on the actual payroll date, whichever is later.

If an employee submits a reimbursement request before ASIFlex receives and posts the payroll deduction, the request is suspended and then paid within three business days after the payroll deduction posts.

A suspended request also results when an employee incurs expenses for more than the account balance. Payment for the balance is issued. Additional reimbursements are issued as the payroll deduction posts and the funds become available.

# Health Savings Account reimbursements

There must be sufficient funds in a Health Savings Account (HSA) to pay for eligible expenses. Payroll deductions from the employer are submitted to ASIFlex. If no payroll discrepancy, ASIFlex will send contributions to HSA Central to post to participants' accounts within one business day of receipt or on the actual payroll date, whichever is later.

After receiving the welcome email from HSA Central, employees who elected to contribute to an HSA must log in to their online account at <u>schsa.centralbank.net</u>, accept the terms and conditions, and activate their debit card to use the card.

The participant is responsible for reimbursing himself from his HSA by using his HSA debit card at the time of service or transferring funds from his HSA to his checking account online.

The participant is responsible for ensuring that he reimburses himself *only for eligible expenses*. The participant is responsible for retaining documentation and providing it to the IRS, if requested.

Refer to the **MoneyPlus and HSA payroll deductions** chapter for more information about payroll deductions.

# Administrative or eligibility appeals

If an employee, retiree, survivor, spouse, former spouse or child(ren) is unable to enroll, disenroll or change their coverage, the subscriber has the right to a review.

Examples include, but are not limited to:

- Eligibility for incapacitated child coverage;
- Enrollment in MoneyPlus;
- A coverage change request outside of an open enrollment period;
- A coverage change request more than 31 days after a special eligibility situation occurs;
- Eligibility for nonfunded, partially-funded or funded retiree coverage;
- Extension of COBRA coverage; and
- Removal of the tobacco and e-cigarette use premium.

Retirees, survivors and COBRA subscribers of state agencies, public school districts or public higher education institutions can submit requests directly to PEBA, which serves as their benefits administrator.

Retirees, survivors or COBRA subscribers of optional employers can submit requests through the benefits office of their former employer, which serves as their benefits administrator.

Employees may request a review through their benefits administrator.

#### **Request for Review process**

Submit a Request for Review (RFR) through EBS under Manage Subscribers. An RFR describes the active subscriber's issue, explains the surrounding circumstances and includes any supporting documentation. Upon the employee's request, you must submit the RFR regardless of whether you support the subscriber's request. If a mistake was made by the benefits office, such as misplacing or failing to submit documentation in a timely manner, select the reason as *Late* -*Employer* or *Correction* – *Employer* from the dropdown list of reasons. Include a summary of the change requested, explain the circumstances of the request and upload any supporting documentation. Subscriber negligence is not considered an employer delay or correction.

If no mistake was made by the benefits office, select the reason as *Late - Employee* or *Correction – Employee* from the drop-down list of reasons. Include a summary of the change requested, explain the circumstances of the request and upload any supporting documentation.

If the RFR is approved, the transaction will apply with the requested effective date and the transaction will no longer appear on your RFR tab. Any premiums due must be paid; therefore, it is imperative that the subscriber understand the possibility of retro premiums.

If the RFR is rejected, an explanation of what needs to be done to correct the error will be shown on the suspended transaction.

If it is denied, the status changes to *PEBA Denied* and the employee will receive an email. View the RFR Denial and denial reason and save or print prior to your acknowledgement. Remember to place a copy of the denial in the employee's file.

# View a RFR training resource at peba.sc.gov/insurance-training.

If completing a request on the paper <u>Request for</u> <u>Review</u> form, complete the form in its entirety and mark the change reason as either a *BA clerical error* or delay or a Subscriber request. Explain the circumstances of the request and attach any supporting documentation.

 If making a change to coverage, you need to include an original NOE, completed and signed by you and the subscriber. The NOE must correct the error addressed on the form.

- Attach an NOE whenever an effective date correction is more than 90 days retroactive.
- If denied, PEBA will send you a denial that must be sent to the subscriber, notifying him that he has 90 days to appeal to PEBA.

A Request for Review is not required for retroactive termination of a subscriber's file. If the retroactive termination exceeds 31 days, the employer is responsible for paying any premiums beyond the 31-day period, back to the date of termination.

If the request is approved due to an employer delay or error, the approval is effective retroactively, up to one year back to the actual effective date. Any premiums due must be paid. Changes cannot be made prospectively or for the date the request is made.

**Example:** A new employee was hired on March 1, 2021, but due to an employer delay, the enrollment is not submitted to PEBA until July 1, 2022. PEBA receives a Request for Review and enrollment to add the employee effective July 1, 2022.

• The employee will be added effective July 1, 2021, one year retroactive from PEBA's receipt of the request, as the request was received more than one year after the hire date of March 1, 2021. Premiums are due from July 1, 2021, forward.

#### Appeal process

If the subscriber disagrees with PEBA's decision, the subscriber may appeal in writing to PEBA within 90 days of the denied request. The subscriber should explain why he is appealing, attach any additional information and supporting documents and include a copy of the denial.

If the Request for Review was denied because of lack of documentation, the subscriber should include the previously missing documentation.

A benefits administrator, employer or healthcare provider may not appeal to PEBA on the subscriber's behalf. Only the subscriber, his authorized representative or a licensed attorney admitted to practice in South Carolina may initiate an appeal through PEBA. A benefits administrator, employer or healthcare provider may not be an authorized representative.

In most cases, the appeal should be sent to IAD@peba.sc.gov or:

S.C. PEBA Attn: Insurance Appeals Division 202 Arbor Lake Drive Columbia, SC 29223

If the appeal is urgent and relates to a pregnancy, newborn child or the prior authorization of a lifesaving treatment or drug, the subscriber may send the appeal to <u>urgentappeals@peba.sc.gov</u>.

PEBA will review the request and make every effort to process the subscriber's appeal within 180 days of the date all of the appeal information is received. However, this time may be extended if additional material is requested or if the subscriber asks for an extension. PEBA will send the subscriber periodic updates on the status of the review. Once PEBA's review of the appeal is complete, the subscriber will receive a written determination in the mail.

If the appeal is approved, PEBA will process the enrollment and notify the subscriber and his benefits administrator of any other needed documentation.

If the appeal is denied, PEBA will send the subscriber a detailed decision letter explaining the reason(s) for denial. The subscriber will then have 30 days to seek judicial review at the Administrative Law Court, as provided by Section 1-11-710 and 1-23-380 of the S.C. Code of Laws, as amended.

# Appeals related to claims or authorization of benefits

If an employee, retiree, survivor, spouse, former spouse or child is seeking authorization of benefits or reimbursement for a claim, the subscriber has the right to a review. Vision, Life Insurance and Supplemental Long Term Disability benefits are fully insured products and are not to be appealed to PEBA. Page 139 describes the appeals process for these fully insured products.

All other coverage issues related to claims or the authorization of benefits are appealed first to the applicable third-party claims administrator and then to PEBA. Examples include, but are not limited to:

- Prior authorization of medical, behavioral health, or dental services, and treatments or devices;
- Prior authorization of prescription medication;
- Reimbursement of MoneyPlus claims;
- Reimbursement of claims for medical, behavioral health or dental services, and treatments, or devices; and
- Payment for Basic Long Term Disability claims.

If a subscriber request for authorization of benefits or reimbursement for a claim from the appropriate third-party claims administrator is denied, then the subscriber can appeal to the third-party claims administrator within:

- Three days for radiology prior authorization appeals;
- 31 days for MoneyPlus appeals; and
- Six months for other appeals.

If the third-party claims administrator denies the appeal, the subscriber can appeal to PEBA within 90 days.

Exception: The pharmacy benefits manager, Express Scripts, may conduct one to three reviews, depending on the circumstances of the appeal. Once the appeals process is completed, Express Scripts will send a decision letter to the subscriber. If denied, the denial letter will describe the subscriber's appeal rights to PEBA. The subscriber will still have 90 days to appeal to PEBA.

## Third-party claims administrators

- BlueCross BlueShield of South Carolina (health insurance claims) <u>StateSC.SouthCarolinaBlues.com</u> 803.736.1576 or 800.868.2520
- Medi-Call (medical prior authorization) 803.699.3337 or 800.925.9724
- Companion Benefit Alternatives

   (behavioral health benefits prior authorization)
   www.CompanionBenefitAlternatives.com
   803.736.1576 or 800.868.2520
- National Imaging Associates (radiology prior authorization) <u>www.RadMD.com</u> 866.500.7664
- Express Scripts (prescription medication) Attn: Benefit Coverage Review Department P.O. Box 66587 St. Louis, MO 63166-6587
- BlueCross BlueShield of South Carolina (dental claims)
   Attn: State Dental Appeals
   AX-B15
   P.O. Box 100300
   Columbia, SC 29202-3300
- Standard Insurance Company (Basic Long Term Disability)
   P.O. Box 2800
   Portland, OR 97208
- ASIFlex (MoneyPlus claims) ASIFlex Appeals Attn: S.C. MoneyPlus P.O. Box 6044 Columbia, MO 65205-6044

Once the subscriber has received the denial letter from the third-party claims administrator with the 90-day appeal language, the subscriber can appeal to PEBA. A benefits administrator, employer or healthcare provider may not appeal to PEBA on the subscriber's behalf. Only the subscriber, his authorized representative or a licensed attorney admitted to practice in South Carolina may initiate an appeal through PEBA. A benefits administrator, employer or healthcare provider may not be an authorized representative.

In most cases, the appeal should be sent to IAD@peba.sc.gov or:

S.C. PEBA Attn: Insurance Appeals Division 202 Arbor Lake Drive Columbia, SC 29223

If the appeal is urgent and relates to a pregnancy, newborn child or the prior authorization of a lifesaving treatment or drug, the subscriber may send the appeal to <u>urgentappeals@peba.sc.gov</u>.

PEBA will review the request and make every effort to process the subscriber's appeal within 180 days of the date all the appeal information is received. However, this time may be extended if additional material is requested or if the subscriber asks for an extension. PEBA will send the subscriber periodic updates on the status of the review. Once PEBA's review of the appeal is complete, the subscriber will receive a written determination in the mail.

If the appeal is denied, PEBA will send the subscriber a detailed decision letter explaining the reason(s) for denial. The subscriber will then have 30 days to seek judicial review at the Administrative Law Court, as provided by Section 1-11-710 and 1-23-380 of the S.C. Code of Laws, as amended.

# **Accounting and billing**

# Contents

General accounting rules	143
Collecting premiums for mid-month changes	143
Unpaid leave rules	
Issuing credits	143
Retroactivity	143
Billing statements	143
Advance deposit billing statement	
Active billing file	144
Submitting premium payments to PEBA	
MoneyPlus and HSA payrolls and accounting	145
For optional employers	145
Administrative fee	145
Experience rating health premiums	145
For optional employers and charter schools	146
Retiree, COBRA and Survivor premiums	146
Retiree, COBRA and Survivor Roster	146
Submitting premiums for employees on unpaid leave	147
For school districts, public higher education institutions and charter schools	147
Retiree, COBRA and Survivor premiums	147
Submitting premiums for employees on unpaid leave	147
For Comptroller General (CG) agencies only	147
Retiree, COBRA and Survivor premiums	147
Submitting premiums for employees on unpaid leave	147
Payroll reconciliation report	
SCEIS payroll process	148
Annual SLTD salary updates	148
Affordable Care Act	148
Nondiscrimination testing	149
Imputed income (taxable portion of Optional Life premiums)	
Important reminders in calculating imputed income	150
Reclassification of outstanding MoneyPlus MSA debit card transactions	151
Reclassification report	151
Reclassification	

This section includes information about the monthly billing statement and other accounting procedures. This is only a guide; it will not cover every situation. If you have questions, call your PEBA Insurance Finance account representative (indicated on your Billing Statement) at 803.734.1696 or at 888.260.9430.

View information about accounting and enrollment reports in the **EBS reports** chapter.

# **General accounting rules**

Employers are responsible for collecting all premiums and submitting them to PEBA. In relation to this responsibility, an employee authorizes his employer to collect his portion of the premiums for the coverage selected. The employer will be billed and is required to pay all outstanding premiums.

# Collecting premiums for mid-month changes

#### **Changes in status**

For changes in status effective on or before the 15<sup>th</sup> of the month, collect premiums for that entire month.

For changes in status effective *after the* 15<sup>th</sup> of the *month*, start collecting premiums the first of the following month.

#### Death of employee/subscriber

If terminating coverage due to death of an employee or other subscriber *on or before the 15<sup>th</sup> of the month,* do not collect premiums for that month.

 Exception: If the employee or other subscriber dies on the 15<sup>th</sup> of the month, coverage will be terminated on the 16<sup>th</sup> of the month. Collect premiums for the entire month.

If terminating coverage due to death of an employee or other subscriber *after the* 15<sup>th</sup> of the *month*, collect premiums for that entire month.

## Unpaid leave rules

For more information and policies regarding unpaid leave, refer to the **Active subscribers** chapter under unpaid leave or reduction in hours.

In an unpaid leave situation, be consistent and fair with notification and time allowances on premium payments owed by the employee.

If the employee does not pay the premiums, the employer can terminate the coverage for nonpayment of premiums, but only up to 31 days retroactive.

See Submitting premiums for employees on unpaid leave for your employer type.

#### Issuing credits

#### Not applicable to Comptroller General (CG) agencies

PEBA does not issue individual refunds. Instead, a credit is applied to the billing statement and the employer then refunds the subscriber.

 When a refund of tax-deferred premiums is issued to an employee, the employee's taxable salary should be adjusted for his W-2 records. It is not PEBA's responsibility to confirm this adjustment is made.

## Retroactivity

When a coverage election is processed with an effective date prior to the current billing statement month, a charge or credit of premiums is considered retroactive.

# **Billing statements**

On or before the first of each month, PEBA produces a billing statement in EBS (HAC610) for active subscribers. This PDF billing statement enables you to maintain the accounting records of each employee. If you verify the information on the billing statement and communicate with PEBA whenever there are questions about the information, the financial process for employees' benefits should work smoothly.
The billing statement includes employer contributions and employee premiums due for all insurance programs.

See the **EBS reports** chapter for more information about the billing statements in EBS.

### Advance deposit billing statement

### Not applicable to Comptroller General (CG) agencies

An advance deposit of at least one month's premium for employer contributions is due to PEBA each year. Payment is due to PEBA by July 15.

The advance deposit bill lists insurance programs for which the employer contributes to the monthly premium (State Health Plan, Basic Dental, Basic Life, Basic LTD) and the subscriber count enrolled in each of these programs at the end of June. The subscriber count is multiplied by the current employer rate to arrive at the deposit amount.

See the **EBS reports** chapter for more information.

### Active billing file

All employers are responsible for reconciling their employer and employee records on a monthly basis. PEBA provides Active Billing Files (HAC450 or HAC460) in EBS.

See the **EBS reports** chapter for more information.

## Submitting premium payments to PEBA

### Not applicable to Comptroller General (CG) agencies

All balances are due to PEBA on the 10<sup>th</sup> of the month and must be paid as billed. If there is a keying error on the Coverage Processing pages of the bill, please contact PEBA immediately. If payment is not remitted by the 10<sup>th</sup>, employers will risk suspension of claims payments for their employees.

• Do not adjust the billing statement.

- Do not delay the regular remittance of monthly premiums due to inability to collect payments from subscribers.
- Employers must pay no less than the current employer share of the premiums for their active employees.
- Do not submit individual checks from your employees. See Submitting premiums for employees on unpaid leave for your employer type.

Remit payments to PEBA through one of the three following options:

### **Online Bill Pay**

Processing your payment online through EBS is easy and convenient.

To use this feature:

- Complete a new *EBS Designated Employee Confidentiality Agreement* form and mark Online Bill Pay.
- Log in to your EBS account and verify your email address in the lower right corner on the EBS homepage before submitting a payment. Select the *Update My Email Address* link if changes are needed.

After you complete these steps, you will be able to complete the following with Online Bill Pay:

- Schedule a payment;
- View the status of your account;
- View bill and payment history for previous 12 months; and
- View billing statements for previous 12 months.

Please note, the minimum amount you may pay is your current balance.

### **Electronic Funds Transfer (EFT)**

Electronic Funds Transfer, or automatic draft, gives PEBA authorization to automatically deduct the total amount due, per the monthly billing statement (HAC610), from the designated bank account. The amount will be drafted from the designated bank account on the 10<sup>th</sup> of the following month. If the 10<sup>th</sup> falls on a weekend or holiday, the draft will occur on the next business day.

To enroll in EFT payments, complete an *Authorization Agreement for Electronic Funds Transfer*. Submit this form with a voided check from the designated bank account. After PEBA receives the authorization, it will take about 31 days for the automatic draft to begin.

### Check

Please allow additional time for processing of paper checks. All checks should be made payable to PEBA. See more information about check payments for your employer type in the next section.

You must return a completed Remittance Advice form with every payment. See the **EBS reports** chapter for information about the Remittance Advice.

If you are submitting more than one check, list the amount of each check on the right side of the Remittance Advice. Verify the total check amounts equal the total amount due. Sign, date and provide a telephone number in the appropriate spaces.

Do not return any other section of the billing statement with your payment.

Mail your payment to the following mailing address:

S.C. PEBA Attn: Insurance Finance Department P.O. Box 11661 Columbia, SC 29211

See also the premium checks quick reference on Page 225.

## MoneyPlus and HSA payrolls and accounting

Each employer is responsible for reporting the actual amount of each payroll deduction every payroll cycle to ASIFlex. Refer to the **MoneyPlus and HSA payroll deductions** chapter for details about the ASIFlex employer portal, processing payroll deduction files, reviewing and responding to discrepancy reports, and more.

To post contributions to participant accounts, ASIFlex must receive the funding from each employer in a timely manner. Send actual funds via ACH to ASIFlex three business days prior to the actual pay date. View the *Quick Guide* for details.

## For optional employers

Review the *Requirements for Participation* and more information in the <u>Optional Employer</u> <u>Handbook</u>.

### Administrative fee

Optional employers must pay a \$3 administrative fee for each active employee, retiree, survivor and COBRA participant per month. Employers cannot pass this fee to active employees and COBRA participants. An employer may require retirees and survivors to pay this fee.

### Experience rating health premiums

Optional employers are subject to experience rating of health insurance premiums. The experience rating load factor or a percentage amount is added to the optional employer's health premiums based on claims history. This factor is adjusted each year.

PEBA calculates the experience rating load factor of all optional employers annually. Employers will receive written notification of their load factor each March, and the factor will be applied in January of the following year to both the employer and employee premiums.

The employer may choose to absorb some or all of any increase in the employee share. However, an employer may **not** pass along any of the employer share of the increase to the employee. The employer is responsible for notifying its subscribers of any rate changes. Employer contributions and employee premiums may be different than those published in PEBA publications. Use the <u>fillable</u> <u>optional employer premium worksheet</u>. Rate changes due to experience rating are separate and are in addition to any annual, across-the-board rate increases that are announced each fall for the upcoming plan year.

When optional employers initially join the State insurance benefits program, they are categorized by their number of covered lives (number of individuals insured under the program).

- Small: Fewer than 100 covered lives. Rated according to average claims experience of all the small employers.
- Medium: 100-500 covered lives. Once 24 months of claims are incurred for an employer, rated using a formula that gives 50 percent weight to the average claims experience of all medium employers combined and 50 percent weight to the claims experience of the individual employer.
- Large: More than 500 covered lives. Once 12 months of claims are incurred for an employer, rated solely on the claims experience of that employer.

See the <u>Optional Employer Handbook</u> for complete details about experience rating load factors. A <u>history of load factors</u> is also available.

View information about two reports that detail updated health insurance premiums in the **EBS reports** chapter.

- Active Rate with Load Factor (HTB527)
- Individual Rate with Load Factor (HTB528)

## For optional employers and charter schools

PEBA designates charter schools as Track 1 if the school participates in the state insurance benefits program only and does not participate in the state retirement systems. Learn more in the <u>Charter</u> <u>School Handbook</u>.

## Retiree, COBRA and Survivor premiums

The employer continues to serve as the benefits administrator for these subscribers; therefore, the employer will receive the monthly Retiree, COBRA and Survivor bill (HRA610) in EBS.

The PDF billing statement is the same as that for active subscribers. Note that some programs are not listed, because they are not available to these subscribers. The \$3 administrative fee for each retiree, survivor and COBRA participant per month is included on the Account Summary pages.

Collect the premiums for covered retirees, COBRA and survivor subscribers and deposit their checks into your account. Their checks should be made payable to the employer, **not** PEBA. **Do not submit personal subscriber checks to PEBA.** 

Subscriber questions regarding the premium amounts or billing will be directed to the employer.

Remit a single check for the total amount due shown on the Remittance Advice page of the individual and active group bills.

### Retiree, COBRA and Survivor Roster

This monthly PDF or CSV-formatted roster (HRA500) provides information on each retiree, COBRA and survivor subscriber's coverage, and the monthly employee premium for each program:

- State Health Plan;
- Basic Dental;
- Dental Plus;
- Vision; and
- Tobacco and e-cigarette use premium.

The roster is divided into sections based on subscriber type (18-month COBRA, 29-month COBRA, 36-month COBRA, Retiree-Regular, Retiree-25 Year, Survivor, etc.).

In each of the sections, names are printed in alphabetical order by last name, first name and middle initial, with the BIN listed in the next column. This roster will not include Social Security numbers.

## Submitting premiums for employees on unpaid leave

Premiums for employees on unpaid leave are included on the monthly billing statement (HAC610).

Collect the total monthly premium due for employees on unpaid leave. Personal checks must be made payable to the employer, **not** PEBA. Deposit the collected unpaid leave premiums into your employer account and include the premiums in your monthly payment. **Do not submit personal subscriber checks to PEBA.** 

## For school districts, public higher education institutions and charter schools

PEBA designates charter schools as Track 2 if the school participates in the both the state retirement systems and the state insurance benefits program. Learn more in the <u>Charter School Handbook</u>.

## Retiree, COBRA and Survivor premiums

PEBA becomes the benefits administrator for these subscribers. The subscriber, not the employer, will receive a bill from PEBA.

Personal checks, payable to PEBA, must be submitted to PEBA with the bill. Retirees, who have their premiums deducted from their retirement checks or auto-drafted from a bank account, do not receive a bill.

## Submitting premiums for employees on unpaid leave

Premiums for employees on unpaid leave are included on the monthly billing statement (HAC610).

Collect the total monthly premium due for employees on unpaid leave. Personal checks must be made payable to the employer, **not** PEBA. Deposit the collected unpaid leave premiums into your group account and include the premiums in your monthly payment. **Do not submit personal subscriber checks to PEBA.** 

## For Comptroller General (CG) agencies only

## Retiree, COBRA and Survivor premiums

PEBA becomes the benefits administrator for these subscribers. The subscriber, not the CG agency, will receive a bill from PEBA.

Personal checks, payable to PEBA, must be submitted to PEBA with the bill. Retirees, who have their premiums deducted from their retirement checks or auto-drafted from a bank account, do not receive a bill.

## Submitting premiums for employees on unpaid leave

Premiums for employees on unpaid leave are included on the monthly billing statement (HAC610).

Collect the total monthly premium due for employees on unpaid leave. Make sure the personal check(s) includes the employee's BIN. Submit the personal checks from the employees on unpaid leave, along with a <u>personal checks</u> form of the plans/coverage for each.

If you do not collect the monthly premium from a subscriber while he is in unpaid leave status, SCEIS will collect the total amount due from the first payroll check the subscriber receives once he is no longer in unpaid leave status. If you remit the monthly premiums, notify SCEIS that the payments have been sent to PEBA so they will not deduct the incorrect amount. SCEIS will continue to remit the monthly employer premiums for the subscriber while he is in unpaid leave status.

See Page 143 for more information on unpaid leave rules.

### Payroll reconciliation report

PEBA sends an enrollment file to SCEIS daily. SCEIS uses the information on the file (benefit, effective date, type of entry, coverage level and premium) to determine the premiums to be deducted on the next payroll. The reconciliation reports are a comparison of the enrollment files at PEBA and the SCEIS payroll deductions.

PEBA provides a monthly reconciliation (Employee-HAC402; Employer-HAC403) of monthly premiums to all CG agencies. The reconciliations identify when a billed amount is different than the deducted premium (employee) or SCEIS employer contribution. Research each difference and take proper action to correct any problem(s).

See the **EBS reports** chapter for more information.

### SCEIS payroll process

SCEIS collects and remits to PEBA the employer and employee premiums based on the daily enrollment file. You may view your monthly billing statement (HAC610); however, do <u>not</u> remit payment for the monthly premiums. See *Billing Statement* and the **EBS reports** chapter for details.

Contact the SCEIS Help Desk with questions concerning which account the employer premiums are taken from or the funding source for the employer premiums.

If you discover an enrollment error on the billing statement, contact PEBA to resolve the error, which should correct the deduction. If the coverage is correct but the payroll deductions are not, contact the SCEIS Help Desk.

For a new hire or coverage change that results in a large balance due, premiums may be collected over several pay periods. Contact the SCEIS Help Desk to

change the amount of the deduction and the number of pay periods.

Refunds are a reimbursement of overpaid insurance premiums to the employee, or to the employer in certain situations.

SCEIS will not process a refund check for amounts less than \$1; therefore, an adjustment must be requested to zero out an employee's balance.

### **Unclaimed refund checks**

If the U.S. Postal Service returns a refund check to your employer as undeliverable, the check, along with the envelope returned from the U.S. Postal Service stating it was unable to deliver the refund check, should be forwarded to PEBA. The overpayment of premiums will become a part of the Unclaimed Property maintained by the Office of the State Treasurer. Former employees can search by their name to locate any unclaimed funds due to them at treasurer.sc.gov.

### **Annual SLTD salary updates**

Not applicable to Comptroller General (CG) agencies

All salaries must be reviewed and updated annually during open enrollment. You may begin entering the salaries in EBS on September 15, and the information is due to PEBA no later than October 31.

See the **Using the online system** chapter for more information.

## **Affordable Care Act**

The Patient Protection and Affordable Care Act, also known as the Affordable Care Act (ACA), is the health reform legislation signed into law in March 2010. Key provisions of the legislation include extending coverage to millions of uninsured Americans, implementing measures that will lower health care costs and eliminating industry practices that include denial of coverage due to preexisting conditions. The ACA does not require businesses to provide health benefits to their workers, but applicable large employers may face penalties if they don't make affordable coverage available. The Employer Shared Responsibility Provision of the ACA penalizes employers who either do not offer coverage or do not offer coverage that meets minimum value and affordability standards.

As a participating employer in PEBA insurance benefits, you must offer coverage to all employees eligible to participate in the insurance benefits. The <u>Plan of Benefits</u> document has been amended to allow coverage for permanent full-time employees, as well as non-permanent full-time employees and variable-hour, part-time and seasonal employees.

PEBA offers "grandfathered health plans" under the ACA. As a grandfathered plan, PEBA will be able to minimize the increase in State Health Plan premiums while it assesses the future financial impact of the act. As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted.

Being a grandfathered health plan means that the plan may not include certain consumer protections of the ACA that apply to other plans, such as the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the ACA, such as the elimination of lifetime limits on benefits.

For ACA resources, including frequently asked questions and reporting requirements, go to peba.sc.gov/aca.

## Nondiscrimination testing

To remain tax free under Internal Revenue Code sections 105, 125 and 129, the MoneyPlus plan must pass several nondiscrimination tests.

One of these tests, the 55 percent Average Benefits Test, requires that all eligible employees' gross compensation be collected. This test is vital in determining the MoneyPlus plan's compliance with Internal Revenue Service (IRS) nondiscrimination rules.

PEBA performs this test twice each plan year.

This is for your information only. PEBA will contact you directly if they need any information for the purpose of nondiscrimination testing.

## Imputed income (taxable portion of Optional Life premiums)

Optional Life insurance coverage in excess of \$50,000 is considered imputed income (taxable) by the IRS when the premium for this coverage is paid through the MoneyPlus Pretax Group Insurance Premium feature. The imputed income is based on an employee's age and amount of Optional Life coverage in excess of \$50,000. It is added to the employee's salary and is subject to federal income tax and FICA. The taxable portion of the Optional Life coverage will always be the amount over \$50,000 of the total coverage, regardless of any employer contributions.

### Imputed income rate table

### (2022 tax year)

Age category	Rate per \$1,000 in coverage beyond \$50,000
Younger than 25	0.05
25-29	0.06
30-34	0.08
35-39	0.09
40-44	0.10
45-49	0.15
50-54	0.23
55-59	0.43
60-64	0.66
65-69	1.27
70 and older	2.06

Imputed income is calculated based on the IRS rate table above. The IRS may change these rates periodically. Each \$1,000 of Optional Life coverage beyond \$50,000 is multiplied by the monthly rate for the applicable age group.

**Example:** An employee, who elected \$180,000 in Optional Life coverage, turns age 40 in October 2021. His monthly Optional Life premium on \$180,000 in coverage is \$14.04, based on his age category the previous December 31.

His imputed income would be calculated like this:

- 1. \$180,000-\$50,000 = \$130,000
- 2. \$130,000 ÷ 1,000 = \$130 (the per-thousand amount)
- 3. 130 × 0.10 (the rate for the age 40-44 category from the IRS rate table) = \$13.00

per month. This is the taxable monthly amount of imputed income.

This monthly amount may be multiplied by 12 to get an annual amount. The employer is responsible for reporting the imputed income amounts on employees' W-2 forms.

On a monthly basis, PEBA provides the Optional Life Taxable/Non-taxable Change File (HAC998) and prior to the new plan year, after open enrollment changes have been updated, PEBA will provide the OL Taxable/Non-taxable Premiums File (HAC999). Files include employees enrolled with Optional Life coverage over \$50,000. See the **EBS reports** chapter for more information.

At the end of the year, PEBA will provide the YTD Imputed Income Report (HAC996) so you can adjust the employees' W-2 forms accordingly. See the **EBS reports** chapter for more information .

Your employer may choose to deduct the taxable and non-taxable premium amounts separately each pay period. If your employer accounts for the taxable portion of the OL premiums for employees throughout the year on all payrolls, you will need to use only the YTD Imputed Income Report (HAC996) for comparison purposes.

## Important reminders in calculating imputed income

Imputed income for employees who were enrolled only part of the year should be prorated.

Unlike calculating PEBA OL premiums, which are based on the employee's age category as of the *previous* December 31, imputed income is calculated by the IRS, based on the employee's age category as of December 31 of the *current* year.

**Example:** For the 2021 tax year, if an employee turns age 50 in September, his IRS-imputed income for 2021 is based on the rate for the 50-54 age category in the IRS rate table, even though his 2021 OL premium is based on the age 45-49 category.

Instead of one age category for OL premiums for those younger than 35, there are three age categories in the IRS rate table for those younger than 35:

- Younger than 25;
- 25-29; and
- 30-34.

The last category in the IRS rate table is for those ages 70 and older, whereas the last age category for OL premiums is 80 and older.

## **Reclassification of outstanding MoneyPlus MSA debit card transactions**

### **Reclassification report**

By November 1 each fall, ASIFlex will send benefits administrators a payback report that lists any employees with outstanding debit card transactions from the previous plan year. This report shows each individual transaction (by SSN and name) and the total amount due. Employers will receive the report only if they have employees with outstanding transactions.

Employees who are on this report have received multiple notifications about the outstanding transaction(s), including a final notice sent by September 1 to provide documentation.

### Reclassification

The unsubstantiated amounts must be reclassified as taxable income, and that employee's W-2 must be amended to reflect that amount.

Example: For the 2021 plan year, an employee has an outstanding card transaction of \$50. That employee has until March 31, 2022, to clear up the expense by:

- Submitting the necessary documentation to substantiate the claim;
- Filing a paper claim or claims that will offset the outstanding card transaction amount; or
- Writing a check made payable to the State of South Carolina and mailing it to ASIFlex, S.C. MoneyPlus, P.O. Box 6044, Columbia, MO 65205-6044. This check will repay his account for the amount of the outstanding card transaction amount.

If the outstanding transaction amount is not cleared up by one of these methods, the amount is taxable as income. Since this amount cannot be confirmed until after the end of the tax-reporting period (April 15, 2022), the amount will be reported for the 2022 tax year. In November 2022, ASIFlex will post a report on its employer portal that will include the employee's name and the amount to be added to his taxable income on his 2022 W-2, which will be issued to him in early 2023.

For CG agencies, ASIFlex will send a file to the Comptroller General's Office to include the unsubstantiated amounts on the employee's W-2. Your accountant/auditor can discuss the proper W-2 application.

# MoneyPlus and HSA payroll deductions

## Contents

Enrollment	154
Payroll deductions	154
When to report payroll deductions	155
How to report payroll deductions	155
Transmit via common file format	155
Manually enter payroll deduction data	155
How to submit funding	156
Processing the payroll deduction file	156
Types of discrepancies	156
Financial discrepancies	157
Enrollment and eligibility discrepancies	157
Discrepancy reports	157
If you transmitted data via common file format	157
If you manually entered payroll deduction data	157
Responding to discrepancy reports	157
How to respond	158
Refunds and adjustments	159
Escalation path	160
Year-end adjustments	160
Transfer employees	160
Special handling for participant accounts with carryover funds only	161
Available reports	161
Complete Balance Sheet Discrepancy Report (YTDEXP)	161
ASI MoneyPlus Year-to-Date Contribution Report (HIS763NP)	161
MoneyPlus Enrollment Data (HIS761NP)	161
MoneyPlus Pretax Feature (HIS912NP)	161
ASIFlex account manager team	162
Payroll process	163
Sample discrepancy report	164

ASIFlex administers the MoneyPlus flexible spending accounts, as well as Health Savings Accounts (HSAs). HSA Central serves as the custodial bank for HSAs. Health Savings Accounts are no longer a part of MoneyPlus; however, employers will continue to submit payroll deductions for HSAs to ASIFlex. There are no changes to the payroll submission process with the new HSA contract.

Each employer is responsible for sending funds for flexible spending accounts and HSAs to ASIFlex and for timely reporting of payroll deductions to these accounts to ensure uninterrupted claim processing for employees. This chapter provides an overview of the process; describes your ongoing duties regarding when and how to report deductions; discusses how ASIFlex identifies and reports account discrepancies to you; and tells you how to respond to and resolve discrepancies.

### Enrollment

Each year during open enrollment, employees elect to participate in, or re-enroll in, the MoneyPlus programs for the following year. Employees can elect to contribute to an HSA throughout the year. Mid-year new hires can enroll within 31 days of employment. PEBA reports enrollment to ASIFlex daily, and accounts are established for each participant with the plan year election amount. During the plan year, employers will take pretax payroll deductions from each participant to fund the accounts.

As the claims administrator, ASIFlex establishes an expected payroll deduction amount for each participant, which is based on the participant's election and payroll cycle provided to PEBA. These expected amounts can be modified during the year within 31 days of a qualifying change in status event for flexible spending accounts.

HSA elections roll over from year to year unless a participant changes his election during open

enrollment. HSA contribution elections can be changed at any time for any reason, but no more frequently than monthly. Changes must be made through PEBA's enrollment process, and PEBA will provide the updated election amount and payroll cycle to ASIFlex.

## **Payroll deductions**

Each employer is responsible for reporting the actual amount of each payroll deduction every payroll cycle to ASIFlex.<sup>2</sup> There are two ways an employer may report deductions to ASIFlex:

- 1. Use a common file format to transmit data; or,
- 2. Enter payroll deduction data through a secure ASIFlex employer portal.

Each employer will send the actual funds to ASIFlex via an ACH transaction. Although checks can be accepted for account funding, it is recommended that funds be sent to ASIFlex via ACH transaction, which is secure and fast. Sending a check may delay the process and ultimately impact timely claim reimbursements for participants. Contributions cannot be posted to participant accounts until funding is received.

The expected payroll deduction amounts will be compared to the payroll deduction file sent by the employer each payroll cycle by one of the two methods above. ASIFlex will determine if there are any discrepancies in the deduction information. If there are no discrepancies between the expected amounts and payroll deduction file, and the payroll deduction file matches the actual funding, the contributions are posted to participant accounts on the payroll date and no discrepancy report is produced.

If the total funding does not match the payroll deduction file, the entire process is stopped and ASIFlex will contact the employer by email (from scdata@asiflex.com) to request that the payroll

<sup>&</sup>lt;sup>2</sup> Does not apply to employers whose payroll is submitted through the Comptroller General's Office.

deduction file and funding be reconciled timely so that correct contributions can be posted to participant accounts by the payroll date.

If there are any individual account contributions that do not match the expected amounts, ASIFlex will produce a discrepancy report to identify the individual account discrepancies. The employer is then responsible for reviewing the discrepancy report and informing ASIFlex if the amounts have changed, if there is a new enrollee or if an account has terminated. The employer must also make eligibility and enrollment updates in EBS with PEBA, if needed.

ASIFlex will post the contributions to participant accounts provided funding is received and matches the payroll deduction file, even if there are individual account discrepancies. If the employer reports a \$100 contribution but sends funding of only \$25, this is reported to the employer as a discrepancy. If the employer reports a \$25 contribution but sends funding of \$100, the error is still reported to the employer as a discrepancy.

A flowchart of the process is on Page 163.

## When to report payroll deductions

The reporting date is determined by each employer's pay cycle. The contributions must be posted to the participant accounts no later than the actual payroll date. Therefore, report deductions to ASIFlex at least three business days prior to the actual payroll date. Late payroll deduction files or funding may directly impact claim reimbursements and cause delays in reimbursements to participants.

## How to report payroll deductions

Employers report payroll deduction data through ASIFlex's secure employer portal. ASIFlex provides secure login credentials to each employer. There are two ways to report payroll deductions to ASIFlex.

- Transmit via common file format Use a common file format to upload the data file to the secure employer portal prior to each pay date.
- 2. Enter payroll deduction data Enter the payroll deduction data online through the secure employer portal. The online reporting includes a pre-populated template created by ASIFlex each pay cycle based on the elections in force at that time. Employers will not have to re-enter the deduction data for each pay date.

### Transmit via common file format

- To access the portal, go to <u>www.asiflex.com/SCMoneyPlus</u>, select the Account Login tab, then select Employer Login.
- 2. Enter your user ID and password to sign in.
- Select Upload File. Select Browse to locate and select your file to upload. Then, click Submit.

### Manually enter payroll deduction data

- To access the portal, go to <u>www.asiflex.com/SCMoneyPlus</u>, select the Account Login tab, then select Employer Login.
- 2. Enter your user ID and password to sign in.
- 3. Select Payroll Data Entry from the top menu.
- 4. Select the issue date and a location.
- 5. Review the current employee information details and contributions. If the deduction amount shown is correct and there are no changes, click Submit. To edit deductions for this payroll cycle, click Edit and modify the appropriate amount for each employee. If the change is beyond more than \$0.01 (either up or down), you must also add a comment to explain the reason for the change. Add this information in the last column, which is labeled Comment. Once you've made all changes, click Submit.

6. View the employee's current deduction amount.

After the payroll cycle has been processed, you cannot make edits.

## How to submit funding

To post contributions to participant accounts, ASIFlex must receive the funding from each employer in a timely manner. Send actual funds via ACH to ASIFlex three business days prior to the actual pay date.

Funds should be sent to ASIFlex via ACH transaction to the designated bank accounts. Participant contributions and administrative fees must be sent in two separate transactions. **Please include your employer group number on the memo/invoice line.** Below is the bank name and account number for each transaction.

### **Participant contributions**

Bank name: Central Bank of Boone County Routing number: 081500859 Account number: 128608478

### Administrative fees

Bank name: Central Bank of Boone County Routing number: 081500859 Account number: 128613463

If your employer requires you to complete a vendor form to send payment, use the information below.

Central Bank of Boone County Attn: Government Affairs Division P.O. Box 779 Columbia, MO 65102

If you must mail a check, make the check payable to ASIFlex, include your employer group number on the memo line of the check and use the mailing address below. Note that sending a check may cause a delay in contributions being posted to participants' accounts.

ASIFlex Attn: Accounting Department P.O. Box 6044 Columbia, MO 65205-6044

Physical address for delivery other than via USPS:

ASIFlex Attn: Accounting Department 201 West Broadway, Suite 4C Columbia, MO 65205

## Processing the payroll deduction file

Once each employer submits its payroll deduction file and funds, ASIFlex will compare the payroll deduction file and funds. If funds do not match the file, the process stops and ASIFlex will contact the employer. If funds match the file, contributions will be posted to individual participant accounts. ASIFlex will then compare the expected deduction amounts to the actual contributions reported on the file and funding that is received. Contributions that do not match for individual participants will be identified as a discrepancy and reported to the employer for review and resolution.

ASIFlex will post contributions to each participant's account within one business day of receipt or on the actual payroll date, whichever is later. ASIFlex will send Health Savings Account (HSA) contributions to HSA Central to post to participants' accounts within three business days.

At any point in time, ASIFlex's record of each employee's year-to-date contributions should agree with the employer's year-to-date record of participant contributions. See Page 161 to learn about the ASI MoneyPlus Year-to-Date Contribution Report that is available in EBS.

## **Types of discrepancies**

There are three types of discrepancies that can occur:

1. The contribution sent for a participant is different than the expected amount.

- 2. A record is missing on the payroll deduction file for a participant for whom ASIFlex expects to receive a contribution.
- A record is received on the payroll deduction file for an employee for whom ASIFlex does not have enrollment information on file.

### Financial discrepancies

Some discrepancies may only be financial in nature. This could be because of a keying error or because a participant is on unpaid leave. In these instances, the employer will respond directly to ASIFlex to resolve the discrepancy.

## Enrollment and eligibility discrepancies

Some discrepancies may be due to an enrollment or eligibility change, which includes new hires, terminations and qualifying changes in status. In these instances, the employer will respond to ASIFlex to notify them of the reason for the discrepancy. The employer must also update enrollment information in EBS with PEBA. If the employer does not update information in EBS, the discrepancy will continue to appear in subsequent payroll cycles.

### **Discrepancy reports**

## If you transmitted data via common file format

A discrepancy report will be posted to the secure employer portal after the payroll deduction file is processed. The employer will receive an email (from <u>scdata@asiflex.com</u>) to indicate the discrepancy report has been posted to the portal and is ready for review. Each employer will need to download and review the discrepancy report and provide resolution to ASIFlex timely so that accounts can be updated by the actual payroll date. This discrepancy report can also be used as a communication tool to identify coverage changes and terminations, which need to be updated with PEBA.

## If you manually entered payroll deduction data

The online reporting includes a pre-populated template for each pay cycle based on the elections ASIFlex receives from PEBA. This pre-populated information allows an employer to see if a discrepancy exists before the employer submits the information. As such, a separate discrepancy report will not be posted to the secure employer portal. If an edit is needed to the deductions, and the change is beyond more than \$0.01 (either up or down), you must also add a comment to explain the reason for the change. Add this information in the last column, which is labeled Comment. This comment provides a resolution to the discrepancy. Once you've made all changes, click Submit. This pre-populated information can also be used as a communication tool to identify coverage changes and terminations, which need to be updated with PEBA. The employer will be contacted separately if the funding ASIFlex receives does not match the deductions reported.

## **Responding to discrepancy reports**

It is critical that each employer carefully review the discrepancies and respond to ASIFlex within two business days or before the payroll date. If the employer transmitted data via a common file, the preferred method of responding to a discrepancy report is to open the report from the employer portal and, if necessary, add a comment in the field next to the discrepancy. Then, save the file as the original file name, adding the payroll date to the end. Upload it to the employer portal. Employers may also send a secure email to ASIFlex at <u>scdata@asiflex.com</u>. The employer must also make eligibility and enrollment updates in EBS with PEBA, if needed.

Unlike Medical Spending Accounts, Dependent Care Spending Accounts and Health Savings Accounts are not prefunded at the beginning of the year. Instead, they rely on reported and received funds for ASIFlex to make timely reimbursements to participants. If the payroll deduction file or funding is late, or if discrepancies are not resolved timely, reimbursements to participants may be delayed.

### How to respond

There are four discrepancy messages that may display on your discrepancy report:

- 1. Amount you sent not as expected.
- 2. No data expected.
- 3. No data sent for this employee.
- 4. EID/SSN not found.

For more information about types of discrepancies, refer to Page 8. Below are examples of the discrepancy messages and how to respond. Discrepancies will continue to appear in subsequent payroll cycles if the error still exists. Your previous comments will show on subsequent reports.

To resolve discrepancies and understand the status of participant accounts, you may also reference the Complete Balance Sheet Discrepancy Report (YTDEXP10), which is available on the employer portal, to compare year-to-date expected contributions with year-to-date actual contributions.

You can view a sample discrepancy report on Page 164. This sample report also includes comments in Column M that help explain what the discrepancy means.

### **Discrepancy message 1**

### Amount you sent not as expected

If ASIFlex receives a payroll deduction for a participant that is different from what was expected (i.e., a lesser or greater amount), there are two options:

 If the payroll deduction amount sent is correct, provide a reason for the change in the amount in Column M on the discrepancy report. If the participant had a qualifying status change and his election amount was changed, you must also update his election amount in EBS with PEBA.  If the payroll deduction amount sent is incorrect, indicate this in Column M on the discrepancy report and correct the contribution on the next payroll deduction file. If the expected contribution amount is also incorrect, confirm the enrollment information on file with PEBA in EBS (i.e., annual election amount, number of payroll cycles) and submit any necessary updates in EBS to PEBA because ASIFlex calculates the expected contribution amount from enrollment information it receives from PEBA.

### **Discrepancy message 2**

### No data expected

If ASIFlex receives a payroll deduction for a participant, but does not expect it, there are two options:

- ASIFlex does not have the enrollment • information on file for that participant for the specific account type (i.e., MSA, DCSA or HSA). However, ASIFlex has a record for this participant because he currently contributes to another account type or has contributed to an account in the past. Respond to the discrepancy in Column M by indicating the effective date of enrollment for this account type. You must also confirm the enrollment information on file with PEBA in EBS and submit any necessary updates. To expedite the process of resolving the discrepancy, email a screenshot of the enrollment in EBS to ASIFlex at sc@asiflex.com. Contact PEBA with questions about enrollment.
- If the payroll deduction was made in error, refund the amount on the next payroll deduction file by entering a negative amount that offsets the deduction. To refund the amount on your next file, reduce the total amount of money you send to ASI Flex by the amount you are refunding, and enter a negative amount on your payroll deduction file. Confirm the funds you send

match the data on the payroll deduction file.

### **Discrepancy message 3**

### No data sent for this employee

If ASIFlex was expecting to receive a contribution for a participant, but the participant is missing on the payroll deduction file, there are two options:

- If the payroll deduction should have been made, provide a reason for the missing contribution in Column M on the discrepancy report and include the missing deduction(s) on the next payroll file. A participant's account will be put on hold by ASIFlex after missing two consecutive payroll deductions. If an employee misses a contribution, contact ASIFlex to spread out the missed contribution over several pay periods, if necessary. You may also double the contribution amount on the next payroll cycle. If a participant's account is on hold, email ASIFlex at sc@asiflex.com to request the hold to be removed and MSA debit card reactivated after you send the missed payroll deductions to ASIFlex.
- If the participant had a change in eligibility or enrollment, provide a reason for the missing contribution in Column M on the discrepancy report and update his information in EBS with PEBA.

### **Discrepancy message 4**

### **EID/SSN not found**

If ASIFlex receives a payroll deduction for a participant, but does not expect it, there are two options:

 ASIFlex has never received any enrollment information on file for that participant, current or previous. Respond to the discrepancy in Column M by indicating the effective date of enrollment. You must also confirm the enrollment information on file with PEBA in EBS and submit any necessary updates. To expedite the process of resolving the discrepancy, email a screenshot of the enrollment in EBS to ASIFlex at <u>sc@asiflex.com</u>. Contact PEBA with questions about enrollment.

 If the payroll deduction was made in error, refund the amount on the next payroll deduction file by entering a negative amount that offsets the deduction. To refund the amount on your next file, reduce the total amount of money you send to ASIFlex by the amount you are refunding, and enter a negative amount on your payroll deduction file. Confirm the funds you send match the data on the payroll deduction file.

### **Discrepancy message 5**

## No data sent - Account is suspended due to insufficient contributions

If ASIFlex was expecting to receive a contribution for a participant, but ASIFlex does not receive a payroll deduction for two consecutive payroll cycles, the participant's MSA will be placed in suspense. Investigate and respond appropriately. Once the discrepancy is resolved, ASIFlex will remove the hold on the participant's account. If a participant's account is in suspense, he does not have access to his funds and cannot use his ASIFlex Card.

You can also ignore a recurring discrepancy to which you have already responded if you know that it will be resolved in future payroll cycles. Remember that your previous comments will show on subsequent reports if the same discrepancy exists.

### **Refunds and adjustments**

Occasionally, refunds of payroll deductions must be issued because of an administrative error, enrollment error or other instances that are allowed by the IRS.

For flexible spending accounts (MSAs, DCSAs and Limited-use MSAs), process the refund through your employer/payroll center. Also, submit the refund to

ASIFlex as a negative amount on your next payroll deduction file so that ASIFlex may reconcile the participant's account. If the participant had a change in eligibility or enrollment, update his information in EBS with PEBA.

If a payroll deduction was sent to ASIFlex in error, HSA refunds are processed the same as flexible spending account refunds as long as ASIFlex has not sent the funds to HSA Central. Once funds are deposited into the account, ASIFlex cannot issue refunds, because the funds belong to the employee once deposited. If the participant had a change in eligibility or enrollment, update his information in EBS with PEBA.

If the employee changes his mind about participating in an HSA, he may stop contributing to his account and withdraw the funds from his HSA bank account with HSA Central according to IRS guidelines. The employee can change his HSA contributions only once a month (stop, increase or decrease contributions), and the change in contributions is made on a prospective basis. Retroactive changes are not allowed.

If you are unable to process a refund by including a negative amount on your payroll file, please contact ASIFlex at <u>sc@asiflex.com</u> to initiate a manual refund.

### **Escalation path**

If a discrepancy remains unresolved after you provided a response, please email the Data Team at <u>scdata@asiflex.com</u>. If the Data Team does not reply, email Sarah Luebrecht at <u>sc@asiflex.com</u>.

## Year-end adjustments

Refer to the *Complete Balance Sheet Discrepancy Report* (YTDEXP), which is available on the employer portal, to determine if you need to adjust MSA and DCSA participant accounts that are on track to overcontribute. Be sure to do this in a timely manner. It is recommended that you make changes by late November each year so the correction can be made through payroll prior to the end of the year.

### **Transfer employees**

When an employee transfers to your employer group from another employer group that participates in PEBA-administered insurance benefits, follow the process below:

- Confirm the participant's year-to-date contributions from the previous employer on the ASI MoneyPlus Year-to-Date Contribution Report (HIS763NP) in EBS.
- 2. To determine the participant's new expected contribution amount:
  - Confirm the participant's annual election amount in EBS.
  - Subtract the year-to-date contributions from the annual election.
  - Divide by the number of payrolls remaining in the plan year based on your employer group's payroll cycle.
- Send ASIFlex's Data Team an email to scdata@asiflex.com with the subject line "Transfer participant's new expected amount." Do not use the message feature in the portal. Include the following details in the email:
  - Participant name;
  - Last four digits of the participant's Social Security number;
  - Your employer's group number;
  - Name of prior employer;
  - o New expected amount; and
  - Your payroll cycle.

The first time you send a payroll deduction for the transfer employee, a "no data expected" discrepancy may appear on your discrepancy report due to the timing of the deduction and receiving enrollment information from PEBA. If this occurs, indicate the reason in Column M on the discrepancy report (Transfer, new expected amount \$xxxx.xx).

If you are the losing employer, remember to remove the employee who transferred from your subsequent payroll deduction files.

## Special handling for participant accounts with carryover funds only

MoneyPlus MSAs include a provision that allows participants to carry over up to \$570 of unused funds into the next plan year. If a participant doesn't re-enroll in an MSA for the following year, he can still use any carryover funds in the new year until the funds are exhausted as long as he remains eligible to participate in MoneyPlus. The monthly administrative fee will be deducted from the participant's account during the next plan year.

## **Available reports**

There are several reports that employers have access to either via the ASIFlex employer portal or EBS. The reports are described below.

### Complete Balance Sheet Discrepancy Report (YTDEXP)

### Report available on employer portal

ASIFlex produces this report monthly only if there are discrepancies for individual participants. This report shows the difference between the actual contribution ASIFlex has received year-to-date as of the last payroll cycle and the expected amount based on the annual election amount for each participant. The per pay columns (Columns G, K and O) show the amount ASIFlex expects for that participant per payroll cycle.

The year-to-date received and year-to-date expected amounts for HSAs are shown in Columns C and E, respectively. The difference in these two amounts is shown in Column F. The year-to-date received and year-to-date expected amounts for MSAs are shown in Columns H and I, respectively. The difference in these two amounts is shown in Column J. The year-to-date received and year-todate expected amounts for DCSAs are shown in Columns L and M, respectively. The difference in these two amounts is shown in Column N.

If the amounts in Columns F, J and N are negative, the participant will be short in meeting his annual election. If these amounts are positive, the participant is on track to exceed his annual election amount.

If the amounts in Columns F, J and N are off by more than the amount ASIFlex expects to receive in one payroll cycle, contact the Data Team at <u>scdata@asiflex.com</u>. If the amounts are off by one payroll cycle or less, adjust the participant's contribution on the next payroll deduction file.

### ASI MoneyPlus Year-to-Date Contribution Report (HIS763NP)

### **Report available on EBS**

PEBA produces this report daily. This report shows the annual election amounts and year-to-date contributions for MSA and DCSA participants. Use this report to verify the contribution amounts ASIFlex has received for its participants. Employees who transfer employers will also appear on this report once PEBA processes their enrollment.

## MoneyPlus Enrollment Data (HIS761NP)

### **Report available on EBS**

PEBA produces this report monthly. This report shows employees' annual MoneyPlus elections for MSAs, DCSAs and HSAs. Use this report to verify the enrollment information PEBA has on file. Employees who are enrolled in multiple MoneyPlus accounts will appear multiple times.

## MoneyPlus Pretax Feature (HIS912NP)

### **Report available on EBS**

PEBA produces this report monthly. This report shows employees who participate in the Pretax

Group Insurance Premium feature, as well as employees who have opted out of the pretax feature. Use this report to determine which employees have elected to have their premiums deducted before or after taxes. Premiums for health, dental, vision and up to \$50,000 of Optional Life coverage, as well as the tobacco-use premium, should be deducted pretax for employees who have elected to participate in the pretax feature.

## ASIFlex account manager team

Role	Contact				
	Sarah Luebrecht				
Day-to-day Assistant	573.777.5635				
Account Manager	888.602.4132, ext. 5633				
	SC@asiflex.com				
	Gordon Sherard				
Account Manager	573.239-9692				
	gsherard@asiflex.com				
Backup account	000 602 4122				
manager team	888.602.4132				
Data Team Lead	Jacon House				
(payroll deduction file	Jason nouse				
processing)	<u>SCuala@asillex.com</u>				

### **Payroll process**



### **Discrepancy report examples**

**IMPORTANT!** To respond to your discrepancy report, add comments in Column M, such as the enrollment date, LWOP with date or new expected amount. Save the file as the original file name, adding the payroll date to the end. Upload it to the employer portal. If you have a question regarding a discrepancy or the posting of funds, email the Data Team at scdata@asiflex.com. Do not use the message feature in the portal.

Soc-Sec-Num	Employee Name	Pay Cyc	<-Employee ID->	Loc	Dept	Agency	OrgID	Sent	Expected			What could this discrepancy mean?
9999999999	LAST, FIRST	26		10	SC	x	0	\$20.88	\$41.66	MSA	Amount you sent not as expected	If the payroll deduction amount sent is correct, provide a reason for the change in the amount in Column M on the discrepancy report. If the participant had a qualifying status change and his election amount was changed, you must also update his election amount in EBS with PEBA.
888888888	LAST, FIRST	24		10	SC	x	0	\$150.00	\$75.00	HSA	Amount you sent not as expected	If the payroll deduction amount sent is incorrect, indicate this in Column M on the discrepancy report and correct the contribution on the next payroll deduction file. If the expected contribution amount is also incorrect, you should confirm the enrollment information on file with PEBA in EBS (i.e., annual election amount, number of payroll cycles) and submit any necessary updates in EBS to PEBA, because ASIFlex calculates the expected contribution amount from enrollment information it receives from PEBA
777777777	LAST, FIRST	24		10	SC	x	0	\$110.42	\$0.00	DCSA	No data expected	ASIFIex does not have the enrollment information on file for that participant for the specific account type (i.e., MSA, DCSA or HSA). However, ASIFIex has a record for this participant because he currently contributes to another account type or has contributed to an account in the past. Respond to the discrepancy in Column M by indicating the effective date of enrollment for this account type. You must also confirm the enrollment information on file with PEBA in EBS and submit any necessary updates. To expedite the process of resolving the discrepancy, email a screenshot of the enrollment in EBS to Mo Willoh at sc@asiflex.com. You should contact PEBA with questions about enrollment
666666666	LAST, FIRST	26		10	SC	х	0	\$41.67	\$0.00	MSA	No data expected	If the payroll deduction was made in error, refund the amount on the next payroll deduction file by entering a negative amount that offsets the deduction. To refund the amount on your next file, reduce the total amount of money you send to ASIFlex by the amount you are refunding, and you should enter a negative amount on your payroll deduction file. You should confirm the funds you send match the data on the payroll deduction file

#### 1/06/20 FSA PR issue 1/05/20 442-3035 (800) 659-3035 ASI

Soc-Sec-Num	Employee Name	Pay Cyc	<-Employee ID->	Loc	Dept	Agency	OrgID	Sent	Expected			What could this discrepancy mean?
555555555	LAST, FIRST	24		10	SC	x	0	\$0.00	\$300.00	HSA	No data sent for this employee	If the payroll deduction should have been made, provide a reason for the missing contribution in Column M on the discrepancy report and include the missing deduction(s) on the next payroll file. A participant's account will be put on hold by ASIFlex after missing two consecutive payroll deductions. If an employee misses a contribution, contact ASIFlex to spread out the missed contribution over several pay periods, if necessary. You may also double the contribution amount on the next payroll cycle. If a participant's account is on hold, email ASIFlex at sc@asiflex.com to request the hold to be removed and MSA debit card reactivated after you send the missed payroll deductions to ASIFlex.
444444444	LAST, FIRST	26		10	SC	x	0	\$0.00	\$126.83	DCSA	No data sent for this employee	If the participant had a change in eligibility or enrollment, provide a reason for the missing contribution in Column M on the discrepancy report and update his information in EBS with PEBA.
333333333	LAST, FIRST	26		10	SC	x	0	\$200.00	\$0.00	MSA	EID/SSN not found	ASIFlex has never received any enrollment information on file for that participant, current or previous. Respond to the discrepancy in Column M by indicating the effective date of enrollment. You must also confirm the enrollment information on file with PEBA in EBS and submit any necessary updates. To expedite the process of resolving the discrepancy, email a screenshot of the enrollment in EBS to Mo Willoh at sc@asiflex.com. You should contact PEBA with questions about enrollment.
222222222	LAST, FIRST	24		10	SC	x	0	\$152.07	\$0.00	HSA	EID/SSN not found	If the payroll deduction was made in error, refund the amount on the next payroll deduction file by entering a negative amount that offsets the deduction. To refund the amount on your next file, reduce the total amount of money you send to ASI Flex by the amount you are refunding, and you should enter a negative amount on your payroll deduction file. You should confirm the funds you send match the data on the payroll deduction file.
111111111	LAST, FIRST	24		10	SC	х	0	\$0.00	\$62.50	MSA	No data sent - Account is suspended due to insufficient contributions	ASIFlex has not received contributions for two consecutive payroll cycles, Consequently, the participant's account has been placed in suspense, and the participant no longer has access to his funds. Investigate the reason for missed contributions and respond in Column M on the discrepancy report what action you will take on the next payroll cycle. For example, you will make up the missed contributions, you will recalculate the expected amount or the employee is on leave without pay. Once the discrepancy is resolved, excluding LWOP, ASIFlex will remove the hold on the participant's account.

## **EBS reports**

## Contents

Accounting reports	168
Enrollment reports	176
Comptroller General (CG) agencies only	
Optional employers only	

PEBA provides several reports in EBS. Below are details about the format, availability and information for reports. Screenshots of reports are only examples and may not reflect the report in its entirety.

### **Accounting reports**

### **EBS User Recertification (EBS950)**

### Frequency: Annual Format: PDF

Authorizing agents must review and certify EBS users and users' access each year. This report lists users who have not been certified.

	EMPLOYEES NEEDING EBS ACCESS RECERTIFICATION	
GROUP ID:		AUTHORIZING AGENT:
****** SUBSCRIBER ****** NAME	***** EBS ***** ACCESS	

### Supplemental Long Term Disability Roster (HAC436)

### Frequency: Annual Format: PDF and .csv

Active subscriber roster for SLTD benefits. Roster indicates if an age group change is applicable.

GROUP ID:	ACTIVE SUBSCRIBER	ROSTER FOR AS OF	SUPPLEMENTAL	LONG TERM	DISABILITY			
GROUP NAME:			'*' indicates	s age group	change.			
NAME	BIN	EFFECTIVE DATE	PLAN	AGE RANGE	RATE	PREMIUM	SEMI-MONTH PREMIUM	

Last Name First Name MI Bin SSN SLTD Eff Date Plan Age Range SLTD Rate Premium Semi-Month Premium

### Active Billing File (HAC450/460)

### **Frequency: Monthly**

#### Format: .txt

Provided to assist employers with reconciling their employer and employee records on a monthly basis. Files include demographic and coverage information for subscribers, their dependents and beneficiaries.

The 460 version is four files, while the 450 version is two larger files that contain the same information but are formatted to use with CSI payroll software. HAC450 is available for all employers unless the HAC460 is requested. Contact your accounting representative if you wish to change to HAC460.

- Subscriber Data (HAC450/460).
- Dependent Data (HAC450/460).
- Beneficiary Data (HAC460).
- Other Insurance Data (HAC460).

### Subscriber Premium Data (HAC470)

### Frequency: Daily

### Format: .csv and .txt

A daily snapshot of all benefits and premiums for subscribers.

### **CSV** format

- SSN, last name, first name, middle initial.
- For each benefit:
- Active (A) or terminated (T) status.
- Category or coverage level of enrollee only (1); enrollee/spouse (2); enrollee/children (3); or full family (4).
- $\circ \quad \text{Monthly employee premium.}$
- Effective date of coverage.
  - Health plan:
- Standard Plan (BB).
- Savings Plan (BD).
- TRICARE (TC).
  - Basic Dental.
  - Dental Plus.
  - Dependent Life-Child.
  - Basic Life (employer contribution).
  - Basic LTD (employer contribution).
  - Optional Life (coverage amount).
  - Dependent Life-Spouse (coverage amount.
  - Vision.
  - Tobacco premium.
  - SLTD (plan level).

				Hith	Hith	Hith	Hith	Dntl I	Dntl	Dntl	Dntl	Dntp	Dntp	Dntp	Dntp	DL	D	L	DL	DL	SL	SL	SL
SSN	Last Name	First Na	me N	1I Status	Plan/Cat	Premium	Eff Date	Status I	Plan/Cat	Premium	Eff Date	Status	Plan/Cat	Premiu	m Eff Da	ate Sta	atus Pl	lan/Cat	Premiur	n Eff Da	te Statu	s Plan/Cat	Eff Date
			1				-	-									-						
LTD	LTD	LTD	OL	OL	OL	OL	OLS	OLS	OLS	OLS	Visn	Visn	Visn	ı V	/isn	Tob	Tob	Т	ob	SLTD	SLTD	SLTD	SLTD
Statu	s Plan/Cat	Eff Date	Status	Plan/Lv	I Premiur	n Eff Date	Status	Plan/L	vl Premiu	um Eff D	ate Stat	us Plan	/Lvl Prei	mium E	ff Date	Status	Prem	nium E	ff Date	Status	Plan/Lvl	Premium	Eff Date

### Active Subscriber Roster (HAC500)

### Frequency: Monthly

#### Format: PDF and .csv

Provides coverage information for each subscriber, as well as the monthly employer contribution and employee premium for insurance programs. Use this roster to update and/or verify records. Contact PEBA if there is a discrepancy.

### **CSV** format

- SSN, last name, first name, employee status.
- For each program:
- Active (A) or terminated (T) status for each benefit.
- Category or coverage level of enrollee only (1); enrollee/spouse (2); enrollee/children (3); or full family (4).
- $\circ$   $\;$  Monthly employer contribution and employee premium.
  - Health plan:
- o Standard Plan (BB).

- Savings Plan (BD).
- TRICARE (TC).
  - Basic Dental.
  - Dental Plus.
  - Vision.
  - Tobacco-use premium.
  - Basic Life (employer contribution).
  - Basic LTD (employer contribution).
  - Optional Life (age bracket and coverage amount).
  - Dependent Life-Spouse (age bracket and coverage amount).
  - Dependent Life-Child.
  - SLTD (age group).

 ssn last\_name
 first\_name
 subscriber\_indicator
 health\_status
 health\_plan
 health\_category
 health\_ee\_rate
 dental\_status
 dental\_category
 dental\_er\_rate
 dental\_ee\_rate

 dental\_plus\_status
 dental\_plus\_ee\_rate
 vision\_status
 vision\_category
 vision\_category
 vision\_ee\_rate
 tobacco\_status
 blacto\_ee\_rate
 bl\_er\_rate
 ltd\_er\_rate

<u>lol\_status ol\_age\_group ol\_coverage\_level ol\_ee\_rate dis\_status dis\_age\_group dis\_coverage\_level dis\_ee\_rate dic\_status dic\_ee\_rate stid\_status stid\_age\_group stid\_ee\_rate</u> The PDF format lists the subscriber BIN, not the SSN, and is in alphabetical order by the subscriber's last name. It also does not include individual employee coverage for Basic Life and Basic Long Term Disability but totals the employer contribution on the final page.

		ACTIVE SUBS	SCRIBER ROSTE	R FOR				
GROUP ID:		GROUP NAME:						
FULL TI	ME EMPLOYEES							
PROGRAM	PLAN/CAT	ER	EE	PROGRAM I	PLAN/CAT		ER	EE
		ACTIVE SUBSCRIBE	R ROSTER TOTA	LS FOR				
GROUP ID:		GROUP NAME:						
TOTAL FO	R ALL EMPLOYEES							
INSURANCE	PLAN TOTA SUBSC	L TOTAL ER R PREMIUMS	TOTAL EE PREMIUMS	INSURANCE	PLAN	TOTAL SUBSCR	TOTAL I PREMIU	EE MS

### **Optional Life & Dependent Life-Spouse Age Group Changes (HAC502)**

### Frequency: Annually Format: PDF

Provided prior to the new plan year. Lists subscribers who are enrolled in Optional Life and/or Dependent Life-Spouse and who will have a premium adjustment effective in the new plan year, beginning January 1, due to a change in age group.

Displays the date of birth, coverage amount and new premium amount, effective January 1. Subscribers are listed in alphabetical order by last name.

		OPT	IONAL LIFE/DEP LIFE SPO	USE AGE GROU	JP CHANGES	
			** EFFECTIVE **************	**		
DISCLAIMER:	Effective January 1,2018 includes the spouses who	, premiums will have	s for Dependent Life Sp a change in their age	ouse Coverag bracket.	ge are based on spouse's ag	e. This report
		GROUP	ID:			
BIN NUMBER	SUBSCRIBER NAME	DOB	O P T I O N A L L COV AMT NEW PREM	I F E NEW SEMI	SP DOB COV AMT NE	OUSE W PREM NEW SEMI

### SLTD Age Group Changes (HAC515)

### Frequency: Annually

#### Format: PDF

Provided prior to the new plan year. Lists subscribers who are enrolled in SLTD and who will have a premium adjustment effective in the new plan year, beginning January 1, due to a change in age group.

Displays date of birth and SLTD benefit waiting period. Subscribers are listed in alphabetical order by last name. Employee premiums are not included.

	SUPPLEMENTAL LONG TERM DISABILITY AGE GROUP CHANGES
	*** EFFECTIVE
	GROUP ID:
BIN NUMBER SUBSCRIBER NAME	DATE OF BENEFIT WAITING BIRTH PERIOD

### **Optional and Dependent Life Roster (HAC516)**

#### Frequency: Annually Format: PDF and.csv

Provided prior to the new plan year. Includes Optional Life, Dependent Life-Spouse and/or Dependent Life-Child subscribers. Includes age bracket, coverage amount and premium for each program, effective in the new plan year, beginning January 1. An asterisk indicates if a change in age bracket is applicable for the new plan year.

						OL	OL	OL		DL/Spouse	DL/Spouse	DL/Spouse	DL/Child	DL/Child
Bin	SSN	Last Name	First Name	МІ	Age Bracket	Coverage	Premium	Semi-Monthly	Dep Age	Coverage	Premium	Semi-Monthly	Coverage	Premium

GROUP ID:		OPTIONA	AL AND DEPENDENT LIFE ROSTER FOR BILLING			
GROUP NAME:						
BIN NUMBER	NAME	AGE BRACKET	OPTIONAL LIFE COVERAGE PREMIUM SEMI-MTHLY	DEP AGE	DEPENDENT LIFE / SPOUSE COVERAGE PREM SEMI-MTHLY	DL/CHIL PREMIUM

### Subscribers in SLTD Waiver Status (HAC555)

Frequency: Monthly, if applicable Format: PDF

Includes employees in a premium waiver status for SLTD. See Page 133.

	SUBSCRIBERS IN WAIVER STATUS AS OF
GROUP ID: GRO	UP NAME:
BIN NAME	EFF DATE AGE OPTIONAL LIFE SUPPLEMENTAL LTD OF WAIVER COV PREM PLAN PREM

### Bills – Advance Deposit (HAC576)

Not applicable to Comptroller General (CG) agencies

#### Frequency: Annually Format: PDF

An advance deposit of at least one month's premium for employer contributions is due to PEBA each year. At the beginning of the fiscal year in July, PEBA bills employers for the advance deposit. Payment is due to PEBA by July 15. You can also view the advance deposit bill in EBS through Online Bill Pay.

The advance deposit bill lists insurance programs for which the employer contributes to the monthly premium (State Health Plan, Basic Dental, Basic Life, BLTD) and the subscriber count enrolled in each of these programs at the end of June. The subscriber count is multiplied by the current employer rate to calculate the deposit amount.

Conveniently pay online in EBS, or if sending payment by check, on the last page of the bill, fill in the amount for one-month deposit or more than one-month deposit in the appropriate space. Sign, date and include a telephone number in the space provided.

- A one-month deposit will be credited to the June billing statement, which may result in a balance due or overpayment.
- A more than one-month deposit is credited to your account immediately.

		**EMPLOYER	SHARE ADVANCE DEPOSIT FISCAL YEAR	BILLING STATEME	NT**	
GROUP ID :	GROUP 1	NAME:				
FULL TIME						
BENEFIT	CATEGORY		SUBSCRIE	ER COUNT	EMPLOYER RATE	DEPOSIT AMOUNT
	,	**EMPLOYER	SHARE ADVANCE DEPOSIT FISCAL YEAR	BILLING STATEM	ENT**	
GROUP NAME:						
GROUP ID :						
ACCT REP :						
						CHECK AMOUNT
TOTAL ONE-MONTH DE	POSIT					
MORE THAN ONE-MONT	H DEPOSIT					
Payment is due by Remittance is paya Remittance Advice : If payment is by I Billing Statement.	July 15th. ble to PEBA INSURANCE must be completed and DT, return two copies More than one-month	FINANCE. submitted w of remittar deposit wil	with payment. nee advice. One-month 1 be credited to your	deposit will b group account	e credited to the June immediately.	
Signature:						
Date:						
Telephone#:						
			•			

### **Bills – Active Subscribers (HAC610)**

### **Frequency: Monthly**

### Format: PDF

On or before the first of each month, PEBA produces a billing statement for active subscribers. This PDF billing statement enables you to maintain the accounting records of each employee. If you verify the information on the billing statement and communicate with PEBA whenever there are questions about the information, the financial process for employees' benefits works smoothly.

The billing statement includes employer contributions and employee premiums due for all insurance programs.

#### **Group Address page**

This page contains the group number, employer name and address, and the billing contact person PEBA will contact if there are any questions. The billing contact person should be the individual responsible for remitting payment for insurance premiums. If there is a change, your authorizing agent should update the primary Billing Contact in EBS under Contacts.

The middle of the page lists your account representative, phone number and PEBA Insurance Finance's return address.

At the bottom of the page, there is a key to assist with the Coverage Processing section of the billing statement.

PLAN		DESCRIPTION	CATEGORY
BB	-	STANDARD	01 - SUBSCRIBER ONLY
BD	-	SAVINGS	02 - SUBSCRIBER/SPOUSE
TC	-	TRICARE	03 - SUBSCRIBER/CHILDREN
DD	-	DENTAL	04 - FULL FAMILY
DP	-	DENTAL PLUS	05 - CHILD ONLY
LTD	-	LONG TERM DISABILITY	
BL	-	BASIC LIFE	
OL	-	OPTIONAL LIFE	PART TIME
DLS	-	DEPENDENT LIFE SPOUSE	
DLC	-	DEPENDENT LIFE CHILD	PT1 - 15-19 HRS
SLTD	-	SUPPLEMENTAL LONG TERM DISABILITY	PT2 - 20-24 HRS
VC	-	VISION CARE	PT3 - 25-29 HRS
TS	-	TOBACCO SURCHARGE	

#### **Account Summary pages**

These pages summarize the prior month's activity, ending with the net premium outstanding from the prior month and the billing for the current month, including any retroactivity.

The Employer Share for health, dental, Basic Life and BLTD is rolled into one total. Separate totals are provided for the Employee Share for health, Basic Dental, Dental Plus, Optional Life, Dependent Life-Spouse, Dependent Life-Child, SLTD, State Vision Plan, and the tobacco use premium. A grand total is provided (total employer plus employee shares).

	GI	ROUP BILLING STATEM	ENT							
GROUP NAME:										
GROUP ID :	IP ID : BILLING MONTH:									
		ACCOUNT SUMMARY								
	EMPLOYER SHARE		E	IPLOYEE SHARE						
		HEALTH	DENTAL	DENTAL PLU	S OPTIONAL LIFE	DLS				
ROUP NAME:	GR	OUP BILLING STATEM	IENT							
ROUP NAME:	GR	OUP BILLING STATEM	HENT BILLING MONTH:							
ROUP NAME:	GR	OUP BILLING STATEN	MENT BILLING MONTH:							
GROUP NAME: GROUP ID :	GR	OUP BILLING STATEM ACCOUNT SUMMARY EMPLO	MENT BILLING MONTH: YEE SHARE							
SROUP NAME: SROUP ID :	GR 	OUP BILLING STATEM ACCOUNT SUMMARY EMPLO S	HENT BILLING MONTH: YEE SHARE LTD VI:	SION CARE 1	TOBACCO SURCHARGE	T(				

Beginning Balance lists the Total Net Balance due from the prior month's billing statement.

Payment Transactions lists all payments received since the completion of the prior month's billing statement, including SCEIS payroll deductions (CG agencies only) and returned payments.

Accounting Transactions lists all refunds, canceled refunds and accounting adjustments processed since the prior month's billing statement. There are two types of accounting adjustments: subscriber and employer account.

- A subscriber adjustment is processed to correct the effective date of a coverage change. A group account adjustment is processed to correct a payment posted incorrectly.
- If an adjustment is processed for a subscriber, the BIN will be listed on the Account Summary page and an Adjustment form will be sent to the employer. This form will show the amount and explain why the subscriber's account was adjusted.

The Net Premium Outstanding is the total of the Beginning Balance less the Total Payments, plus or minus the Total Adjustments.

The Current Month Billing details are on the Billing Summary pages.

The Retro Summary details are on the Billing Summary and Coverage Processing pages.

The \$3/subscriber Administrative Fee is included for optional employers only.

Total Net Balance is the total of the Net Premium Outstanding, Current Month Billing and Retro Summary.

BEGINNING BALANCE	
PAYMENT TRANSACTIONS	
DATE BIN NAME	TYPE
MOMAL DAVMENING	Payment
TOTAL PAIMENTS	
ACCOUNTING TRANSACTIONS	
DATE BIN NAME	TYPE
TOTAL ADJUSTMENTS	
NET PREMIUM OUTSTANDING	
CURRENT MONTH BILLING	
DEMDO CINBUNDY	
RETRO SUMMARY	
TOTAL NET BALANCE	

### Billing Summary pages

These pages show a breakdown of the current month's bill for each program by employee type (full-time; part-time; non-permanent full-time; variable hour).

The summary itemizes the current month premiums, retroactive premiums and total due, for the employer share and the employee share, of each program. The current month's total number of subscribers enrolled in each of the programs is also included.

		BI	ILLING SUMMARY				
	SUBSCRIBER	EMPL	OYER SHARE		EMPL	OYEE SHARE	
INSURANCE PROGRAM	COUNT	CURRENT MONTH	RETRO	TOTAL	CURRENT MONTH	RETRO	TOTAL

#### **Coverage Processing pages**

These pages provide a detailed list of enrollments, changes and terminations processed since the completion of the last month's bill. These changes are listed in alphabetical order by the subscriber's last name, with the information displayed only for the program(s) affected by the transaction. If no transactions are processed, this section of the billing statement is not included.

Review each subscriber listed against any transaction processed to confirm it was processed correctly. If there is a discrepancy, contact PEBA.

The first column lists the subscriber's name with the BIN and the date of birth displayed across the page on the same row.

The second column shows which program is affected by the coverage processing entry. View the key on the Group Address page for program help.

The third column lists which plan and coverage level the subscriber elected. The alpha and numeric characters for the various plans are in the key on the Group Address page.

The fourth column shows the effective date.

The next two columns display the employer and employee retroactive premiums and the current rate. The purpose of the current rate is to assist you in reconciling the bill.

The last column (Action) indicates the reason for the transaction.

The grand total for all retroactivity can be found after the last employee listed in the Coverage Processing pages. Retroactivity amounts are also listed on the Account Summary and Billing Summary pages.



#### **Remittance Advice page**

This final page of the billing statement includes the total amount due for the current month. This amount is also at the bottom of the Account Summary page.

Conveniently pay online in EBS, or if sending payment by check, return the completed Remittance Advice page with payment to PEBA. See Submitting premium payments to PEBA for detailed instructions.

GROU	UP BILLING STATEMENT	
GROUP NAME:		
GROUP ID :	BILLING MONTH:	
ACCT REP :		
	REMITTANCE ADVICE	CHECK AMOUNTS
Employer Share		
Health		
Dental	If you are submitting more than one check,	
Dental Plus	please list each amount in the spaces provided. The total of the checks should equal to the Total Amount Due.	
Optional Life		
Dependant Life Spouse		
Dependant Life Child		
Supplemental Long Term Disability		
Vision Care		
Tobacco Surcharge		
Total Amount Due		
Payment is due by the 10th of the month. Remittance is payable to PEBA INSURANCE FINANCE. Remittance Advice must be completed and submitted with paymen	t.	
Signature:		
Date:		
Telephone#:		

### **YTD Imputed Income (HAC996)**

### **Frequency: Annually**

#### Format: .csv

Includes employees with Optional Life coverage in excess of \$50,000, which is considered imputed income and taxable by the IRS when the premium is paid through the MoneyPlus Pretax Group Insurance Premium feature. Use this information to adjust employees' W-2 forms. See Imputed Income on Pages 149 and 150.

### SSN Last Name First Name YTD Imputed Income

### OL Taxable/Non-taxable Change File (HAC998)

### **Frequency: Monthly**

#### Format: .csv

Includes new hires and changes to Optional Life coverage due to special eligibility events when Optional Life coverage is in excess of \$50,000. See Imputed Income on Pages 149 and 150.

										Monthly Taxable		
						PEBA OL Monthly			IRS Rate	Amount (Imputed	Monthly Non-	Pre-Tax
SSN	Last Name	DOB	OL Total Coverage	Coverage > 50K	Status	Premium	<b>IRS Age Bracket</b>	<b>IRS Rate Factor</b>	Calculated	Income)	Taxable Amount	Indicator

### OL Taxable/Non-taxable Premiums File (HAC999)

### **Frequency: Annually**

#### Format: .csv

Provided prior to the new plan year. Includes employees with Optional Life coverage in excess of \$50,000. See Imputed Income on Pages 149 and 150.

ſ											Monthly Taxable		
							PEBA OL Monthly			IRS Rate	Amount (Imputed	Monthly Non-	Pre-Tax
	SSN	Last Name	DOB	OL Total Coverage	Coverage > 50K	Status	Premium	IRS Age Bracket	<b>IRS Rate Factor</b>	Calculated	Income)	Taxable Amount	Indicator

### **Enrollment reports**

View under Enroll. Reports in EBS.

### **MyBenefits New Hires (HAC475)**

#### **Frequency: Weekly**

#### Format: .csv

Summarizes MyBenefits enrollment new hire elections. The report includes an indicator if a new hire does not make his online elections within 31 days of hire, and thus defaults to no insurance coverage.

#### **CSV** format

- SSN, BIN, last name, first name, middle initial.
- For each program:
  - Active (A) or refused (T4) status.
  - Category of enrollee only (1); enrollee/spouse (2); enrollee/children (3); or full family (4).
  - Effective date of coverage.
- Health plan:
  - o Standard Plan (BB).
  - $\circ$  Savings Plan (BD).
  - TRICARE (TC).

- Basic Dental.
- Dental Plus.
- Dependent Life-Child.
- Basic Life.
- Basic LTD.
- Optional Life (coverage amount).
- Dependent Life-Spouse (coverage amount).
- Vision.
- Tobacco-use premium.
- SLTD (plan level).
- MSA (annual election amount).
- HSA (annual election amount).
- DCSA (annual election amount).
- Pay periods.
- Pretax premium feature (Y or N).
- MSA-Limited indicator (if Y, see MSA annual election amount).
- Default refusal indicator (Y, if defaulted to no election within 31 days of hire).
- Transaction Type (Enroll).
- Trans Created Method (NOELECT, if defaulted to no election within 31 days of hire).

					Hlth	Hlth	Hlth	Dntl	Dntl	Dntl	Dntp	Dntp	Dntp
SSN	BIN	Last Name	First Name	М	Status	Plan/Cat	Eff Date	Status	Plan/Cat	Eff Date	Status	Plan/Cat	Eff Date

 DL
 DL
 SL
 SL
 LTD
 LTD
 OL
 OL
 OL
 OLS
 OLS
 OLS

 Status
 Plan/Cat
 Eff Date
 Status
 Eff Date
 Status
 Eff Date
 Status
 Plan/Lvl
 Eff Date
 Sta

Visn	Visn	Visn	Tob	Tob	SLTD	SLTD	SLTD	MSA	MSA	MSA	MSA
Status	Plan/Cat	Eff Date	Status	Eff Date	Status	Plan/Lvl	Eff Date	STATUS	Eff Date	End Date	AMT

 HSA
 HSA
 HSA
 DCA
 DCA
 DCA
 Pay
 Flex
 FLEX
 MSA
 Default
 Transaction
 Trans Created

 STATUS
 Eff Date
 End Date
 AMT
 STATUS
 Eff Date
 End Date
 AMT
 Period
 IND
 Eff Date
 Limited
 Refusal
 Type
 Method

### Weekly EBS Report of Member BINs (HIS17546)

### Frequency: Weekly

### Format:.txt

Includes employee name, SSN and BIN in alphabetical order by last name.

### Statement of Health – Extract Report (HIS314NP)

### Frequency: Weekly, if applicable Format: PDF

PDF report lists all life insurance *Statement of Health* requests submitted the previous week. Employers can access up to four previous weeks' reports in EBS.



### Dependent Turning 19/25/26 Within 90 Days (HIS501)

## Frequency: Monthly, if applicable Format: PDF

PDF report and letter (HIS600) provides advance notice to an employee within 90 days of when a child turns age 19 or 25 (for Dependent Life-Child) and age 26 (for all other coverage).

Report includes subscriber name, dependent name and date of birth, dependent coverage and letter type. Report also indicates subscribers with coverage level changes due to dependent terminations.

• Provide the letter (HIS600) to the employee and necessary COBRA information.

If the child is incapacitated, the subscriber and dependent's physician must complete the Incapacitated Child Certification Form and forward to PEBA for review and a determination. See Page 115 for more details.

See also Dependent Turning 19/25/26 Within 90 Days Letters (HIS600).



### Temporary Coverage on Adoptions Ending Within 90 Days (with letters) (HIS507)

#### Frequency: Monthly, if applicable Format: PDF

PDF report and letter give advance notice to an employee who has added a child to his coverage and is waiting for completion of the one-year final adoption.

Also serves as notification to employers of employees who failed to furnish the needed final placement agreement at the end of the one-year temporary placement.

- Provide the letter to the employee and keep a copy for your files.
- Send an NOE for corrections if the child is no longer eligible. Attach a copy of the final adoption/placement agreement to the employee's letter and return them to PEBA for processing.

If the child is no longer eligible, provide a copy of the denial for placement letter from the agency and the NOE to delete the child. Notify payroll of any necessary adjustments.

### **Terminated Subscriber Listing (HIS512)**

#### Frequency: Monthly, if applicable Format: PDF

PDF report lists subscribers who are terminated from the current month's billing. Includes terminated coverage(s) and effective date(s).

- Make sure the proper notification is sent to each listed employee.
- If the termination is in error, submit a corrected Active NOE or a letter to PEBA immediately to reinstate the employee's benefits or to correct an incorrectly keyed late entrant date.
- Refer to the key (reminder) at the bottom of the report for proper notification.

	**** ]	FERMINATE	ED :	SUBSCR	IBER	LIS	TING	***	*				
REPORT MONTH:													
SUBSCRIBER TYPE: ACTIVE - REGULAR (AR)													
EMPLOYER	GROUP:		COV	ERAGE							EFF DATE	COVERAGE	EFF DATE
SOCTAL SECURITY													
NUMBER	EMPLOYEE NAME	Н	D	DP	DL	DLS	SL	LTD	LTC	STLD		OL	
#### Subscribers with Incorrect Coverage Level (HIS518)

#### Frequency: Monthly, if applicable Format: PDF

Letters to subscribers who, according to PEBA records, are enrolled in an incorrect coverage level.

```
Dear Subscriber:

According to our records, you have this level of coverage, but no eligible dependents:

PLAN COVERAGE LEVEL EFFECTIVE DATE

Dependent Life/Child(ren) Child(ren) only

Since there are no eligible dependents, you may be paying higher premiums for a level of

coverage that you do not need. To reduce your level of coverage, you must complete a

Notice of Election form, removing all ineligible dependents from your coverage, within

31 days of the date of their ineligibility.

For additional information and assistance, please contact your benefits office or call

us at 803-734-0678 (Greater Columbia area) or at 888-260-9430 (toll-free outside the

Columbia area).
```

#### Dependent Age 1 and Older with No SSN (HIS534)

### Frequency: Monthly, if applicable

#### Format: PDF

PDF report of subscribers with eligible spouses or children on file without Social Security numbers. Report includes subscriber name, dependent name, relationship type, date of birth and age. The spouse or child(ren) will be listed on this report each month until an SSN is provided.

			REPORT (	OF DEPENDENTS	AGE	6 MONTHS	OR MORE	WITH NO	O SSN			
		EMP	LOYER GROUP ID:									
TYPE	SUBSCRIBER SSN	NAME			D	EPENDENT NAME				REL ELIG	DOB	YRS/MON

#### Subscriber/Dependent Roster (HIS539)

#### **Frequency: Monthly**

#### Format: PDF and.csv

Provides coverage information for each subscriber and any dependents.

#### **CSV** format

- Last name, first name, middle initial, last four of SSN, BIN.
- For each program:
  - Category of enrollee only (1); enrollee/spouse (2); enrollee/children (3); or full family (4).
- Health plan:
  - Standard Plan (STD).
  - Savings Plan (SAV).
- Basic Dental.
- Dental Plus.
- Vision.
- Dependent Life-Child.
- Optional Life (coverage amount).

- Dependent Life-Spouse (coverage amount).
- SLTD (waiting period).
- Tobacco-use premium.
- Dependent information, coverage, date of birth, relationship to subscriber (for up to 15 dependents).

Subscriber					Hlth	Dn	tl Dni	p Visi	۱				Tob
Last Name	First Name	МІ	SSN	Bin	Plan/Ca	at Ca	t Cat	Cat	DL/C	но	L DL/S	P SLTD	Use
Dependent	1			ŀ	llth	Dntl	Dntp	Visn					
Last Name	First Nam	e N	AL SS	SN F	Plan/Cat	Cat	Cat	Cat	DL/CH	OL	DL/SP	Dep 1 l	DOB

Dependent information repeated up to 15 dependents on this report.

The final page of the PDF report includes total number of subscribers and dependents for each program.

GROUP:	*** A	сті	ΙE	s u	JBS	CR	IBE	R	LI	ιsτ	I	N G	***		
NAME	SSN	HLT PLAN/	H D CAT C	NTL AT	DNTP CAT	VISN CAT	DL/	СН (	DL_	DL/S	P	SLTD	TOBC USER	DEP DOB	DEPENDENT RELATION
	SUBSCRIBER LISTIN	2						1							
	TOTALS														
INSURANCE PLAN	TOTAL SUBSC	RIBERS		TOTA	AL DE	PENDE	NTS								
HEALTH STANDARD DLAN															
HEALTH SAVINGS PLAN															
BLUECHOICE															
CIGNA															
STATE DENTAL PLAN															
DENTAL PLUS															
DEPENDENT LIFE															
OPTIONAL LIFE															
OPTIONAL LIFE SPOUSE															
VISION															
SUPPLEMENTAL LONG TERM DIS	SABILITY														
TOBACCO USER															

#### Dependent Turning 19/25/26 Within 90 Days Letters (HIS600)

#### Frequency: Monthly, if applicable Format: PDF

#### Letters to accompany dependent turning 19/25/26 within 90 days (HIS501).



## Automated Subscriber Coverage Changes Report (HIS615), MoneyPlus Enrollment Data (HIS761)

#### **Frequency: Monthly**

#### Format: .csv

Employees' annual MoneyPlus elections for MSAs, DCSAs and HSAs. Employees who are enrolled in multiple MoneyPlus accounts will appear multiple times.

Ssn Bin First Name Last Name Addr1 Addr2 City St Zip Code Group Id Money Plus Coverage Annual Amt Pay Period Pretax

#### **MoneyPlus YTD Contribution Report (HIS763)**

#### **Frequency: Weekly**

#### Format: PDF

PDF report of year-to-date contributions for MSA and DCSA accounts as reported by ASIFlex. Includes previous employer group number, if applicable, for a subscriber transferring between employers.

	ASI YTD CONTRIBUTIONS FOR MSA/DCA											
	GROUP ID:											
BIN	SUBSCRIBER NAME	MSA ANN AMOUNT	MSA YTD CONTRIB	DCA ANN AMOUNT	DCA YTD CONTRIB	PREVIOUS GROUP ID						

#### **MoneyPlus Pretax Feature (HIS912)**

#### Frequency: Weekly

**Format: PDF and .csv** Active subscribers with Pretax indicator of Y or N.

#### Last Name First Name MI Bin SSN PreTax

GROUP	ID:		MON	NEY PLUS PRETA AS OF	AX FEATURE
GROUP	NAME:				
		NAME	BIN	SSN	PRETAX

#### **Dependents Terminated from Dependent Life-Child (HIS991)**

### Frequency: Monthly, if applicable Format: PDF

This report shows dependents who have terminated from Dependent Life-Child coverage.

#### 1095-C NMSN File (HT1095CN)

#### Frequency: Annually, if applicable

#### Format: .txt

This report is for groups that have employees for whom they received a National Medical Support Notice. Do not list the child's Social Security number on the Form 1095-C that they issue.

#### 1095-B File (HTB1095B)

**Frequency: Annually Format: .txt** View the <u>ACA reporting requirements FAQs</u> for more information.

An employer subject only to Code Section 6055 will report the necessary information for an employee on Form 1095-B. In Part IV of the 1095-B, non-ALEs must report about their employees (and their dependents) who are covered by the Plan for the purposes of satisfying their reporting obligations under Code Section 6055. To facilitate the employer's reporting requirement, PEBA provides this report in late-December, refreshing each Friday prior to the deadline for mailing the forms, which contains this information. View the <u>file layout</u> for more information.

#### 1095-C File (HTB1095C)

#### **Frequency: Annually**

#### Format: .txt

View the <u>ACA reporting requirements FAQs</u> for more information.

An employer subject to Code Section 6055 and Code Section 6056 will report the necessary information for an employee on Form 1095-C. In Part III of the 1095-C, ALEs must report about their employees and their dependents who are covered by the Plan for the purposes of satisfying their reporting obligations under Code Section 6055. To facilitate the employer's reporting requirement, PEBA provides this report in late-December, refreshing each Friday prior to the deadline for mailing the forms, which contains this information. View the <u>file</u> layout for more information.

#### Health Subscriber and/or Spouse's TEFRA/DEFRA Letter

Tax Equity and Fiscal Responsibility Act/Deficit Reduction Act

#### Frequency: Monthly, if applicable

PEBA mails this letter to employees and spouses 90 days prior to their 65<sup>th</sup> birthday. The letter details their insurance options once they become eligible for Medicare at age 65.

Letters are mailed the first of each month to the subscriber and/or his spouse. Retain a copy for your files.

## Comptroller General (CG) agencies only

#### **Payroll Reconciliation Report**

#### **Frequency: Monthly**

#### Format: PDF (Accounting Reports)

PEBA sends an enrollment file to SCEIS daily. SCEIS uses the information on the file (benefit, effective date, type of entry, coverage level and premium) to determine the premiums to be deducted on the next payroll. The reconciliation reports are a comparison of the enrollment files at PEBA and the SCEIS payroll deductions.

PEBA provides a monthly reconciliation (Employee-HAC402; Employer-HAC403) of monthly premiums to all CG agencies. The reconciliation for the previous month is forwarded to the agency with the current month's billing statement.

The employee reconciliation report (HAC402) lists the subscriber(s) who is being billed a different amount than the deducted premium, in the following page order.

- State Health Plan and the TRICARE Supplement Plan;
- Basic Dental;
- Dental Plus;
- Optional Life;
- Dependent Life-Child;
- Dependent Life-Spouse;
- SLTD;
- State Vision Plan; and
- Tobacco-use premium.

ſ	EMPLOYEE RECONCILIATION INSURANCE MASTER VS SCEIS PAYROLL DEDUCTIONS FOR:											
	GROUP ID/NAME: TYPE OF INSURANCE:											
	BIN	INSURANCE MASTER NAME PREMIUM BIN SCEIS DEDUCTION NAME PREMIUM DIFFER										
				SUMMARY								
INSURANCE MASTER TOTALS PREMIUM AMOUNT				ASTERS TOTALS ED		DIFFERENCE TOTALS AMOUNT						

The Employer Reconciliation Report (HAC403) lists the subscriber(s) for which the employer is billed a different amount than the SCEIS employer contribution, in the following page order.

- State Health Plan and the TRICARE Supplement Plan (\$ per coverage level);
- Basic Dental;
- Basic LTD; and
- Basic Life.

EMPLOYER RECONCILIATION INSURANCE MASTER VS SCEIS PAYROLL DEDUCTIONS FOR:											
GROUP ID/NAME: TYPE OF INSURANCE:											
BIN INSURANCE MASTER NAME	PREMIUM	BIN	SCEIS DEDUCTION NAME		PREMIUM	DIFFEREN	ЪЕ				
		SUMMARY									
	0.0510.1110										

INSURANCE MASTER TOTALS PREMIUM AMOUNT	SCEIS MASTERS TOTALS AMOUNT DEDUCTED	DIFFERENCE TOTALS AMOUNT	

Insurance Master is the premium amount per PEBA's enrollment records. SCEIS Deduction is the premium amount that is payroll deducted. The final column is the difference between the two amounts. A summary for each program is included.

Research each difference and take proper action to correct any problem(s).

#### **Accumulator Reports**

#### Frequency: Monthly Format: PDF (Accounting Reports; six months of historical reports available)

#### Employee (HAC581)

This report identifies the payroll or enrollment discrepancies that need to be resolved before the next billing statement. Balance, retro billed, reconciliation amount, checks remitted, refunds/canceled refunds, canceled warrants, emergency payroll, adjustments, returned checks and employee balance summarized, as well as individual subscriber amounts for each program, are included on the report in the following order:

- State Health Plan and the TRICARE Supplement Plan;
- Basic Dental;
- Dental Plus;
- State Vision Plan;
- Optional Life;
- Dependent Life-Spouse;
- Dependent Life-Child;
- SLTD; and

#### • Tobacco-use premiums.

Benefit: Group:	loyee Accumulator For: June			
Subscriber	Beginning Balance from March	April	Мау	June
Balance Forward	· · · ·	· -		
Retro Billed				
Reconciliation Amount				
Checks Remitted				
Refunds / Cancelled Refunds				5. a.
Cancelled Warrants				
Emergency Payroll				
Adjustments		1		
Returned Checks	· · · · · · · · · · · · · · · · · · ·		1	
Employee Balance			· · · · ·	
Subscriber	Beginning Balance from March	April	Мау	June
		6		
			-	
Balance				

The report is created using the monthly amount billed and payroll deducted; refunds and billing adjustments processed; and personal checks remitted during the month. If the amount billed is the same as the amount payroll deducted, the subscriber will not appear on this report. A minus sign by the amount indicates a credit.

The top section of the report is a calculation using the total amount of premiums billed, payroll deductions, refunds, personal checks and billing adjustments to determine the employee balance. The net of the amounts shown for each subscriber equals the employee balance. The employee balance also matches the Net Premium Outstanding amount on the Account Summary pages of the billing statement.

The subscriber column lists the employee's benefits identification number (BIN) and name. The report is in alphabetical order based on the last name.

The amounts shown in the column for the most current month need your attention. A zero balance in the current month column means the discrepancy was resolved and no action is necessary. Zero balances will remain on the report through the end of the fiscal year and will be deleted once a new year begins. The report displays four consecutive months to help identify in which month the discrepancy occurred. Amounts that are not resolved carry forward to the next month. If the amount carried forward remains the same, it was a one-time error. If the amount changes each month, the error is continuing and should take priority to resolve.

You may need to refer to the reconciliation report, billing statement, the balance screen and subscriber inquiry in EBS and the NOE in your research.

There are some situations in which the discrepancy cannot be avoided due the timing of the when the enrollment is processed and the SCEIS payroll schedule. For example, if a March 1 termination is processed on February 25, SCEIS cannot stop the deduction for the March 1 payroll, which results in a refund due.

In reviewing the report, you may see that balances appear in one month but do not carry forward to the next month. These are examples of a timing issue and the balances were resolved by a refund, payroll deduction or

enrollment transaction. A balance that appears one month and the same balance carries forward is an example of a one-time error. To resolve the discrepancy, determine if there was an enrollment processed (i.e., termination, new hire or coverage change). If the coverage is not correct in EBS, contact PEBA. If the enrollment is correct, review the payroll deductions to determine if the appropriate premiums were collected. If deductions are not correct, open a SCEIS ticket. SCEIS should automatically refund overpayments or collect amounts owed; however, that does not always occur. Therefore, review this report monthly.

It's important to note that after February 1 of each year, SCEIS will no longer collect or refund for enrollment transactions with an effective date in the previous year. The refund request for premiums deducted in the previous year should be submitted to PEBA, and balances should be paid by collecting and remitting a personal check from the subscriber to PEBA.

#### Employer (HAC582)

This report identifies the payroll or enrollment discrepancies for the employer premiums for health, dental, life insurance and long term disability insurance. The discrepancies on the employer accumulator will automatically be resolved in May of each year when the net amount of the employer under or over payments will be billed or refunded to the group. If there is a balance due, an IDT will be billed in SCEIS. If the group is due a refund, the group will enter an IDT document in SCEIS for PEBA to process.

Balance, retro billed, reconciliation amount, checks remitted, refunds/canceled refunds, canceled warrants, emergency payroll, adjustments, returned checks and employee balance summarized, as well as individual subscriber amounts for each program, are included on the report in the following order:

- State Health Plan;
- Basic Dental;
- Basic LTD; and
- Basic Life.

Benefit: Employe Group: For:	r Accumulator June			
Subscriber	Beginning Balance from March	April	May	June
Balance Forward	· · · · ·	· · · ·		
Retro Billed				
Reconciliation Amount				
Checks Remitted				2
Refunds / Cancelled Refunds		1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 -		5
Cancelled Warrants				· · · · ·
Emergency Payroll	· · · ·			
Adjustments		1		
Returned Checks				
Employer Balance				
Subscriber	Beginning Balance from March	April	May	June
Employer - BALANCE				
Balance				

#### Subscriber Balance Report (HAC583)

#### **Frequency: Monthly**

#### Format: Excel (Accounting Reports; six months of historical reports available)

This report shows the balances (under or overpayments) that are also listed on the Accumulator Report, but in a different format. This report displays the subscriber's name and the employee balance for each benefit, as well as the employer balance for health, dental, life insurance and long term disability insurance.

BIN Name Health Dental Dental+ Vision OL DLS DLC SLTD TS ER Health ER Dental ER LTD ER BL Total

#### 1095 Clean-up for SCEIS (HIS17981)

#### Frequency: Annually

#### Format: PDF (Enrollment Report)

To comply with Affordable Care Act (ACA) requirements, the S.C. Comptroller General's Office and SCEIS provided information that was included on your employees' 2021 Form 1095-C to the Internal Revenue Service (IRS). The IRS notified SCEIS that some of the information did not match their files. To determine a match, the IRS looks only at the first four letters of the last name and the SSN.

This report contains the mismatched information, if applicable, and includes the employee's information first, then the individual whose information did not match the IRS' files. Verify the information with your employee and use the guide below to make corrections. If the employee no longer works for you, use the information you have on file to verify the report.

Mismatched information	What to do
Correct dependent's name, SSN or DOB	Correct on report
Correct employee's SSN	Correct on report
Correct employee's name – misspelled	Correct on report
Correct employee's name – different name	Submit an NOE to PEBA and correct on report

	1095 CLEAN UP FOR SCEIS														
Е	MP SSN	·	EMP NA	ME	EMP S	TAT	SSN	TYPE	LAS	ST NAME	FIR	ST NAME	DOB	VER	IFIED
													~ 1 1 1		
Ret	urn t	o Publi	c Employee or EMAI	Benefit L: dhunt	Authority er @peba.	, Attn. .sc.gov	: Denise	Hunter,	202	Arbor	Lake	Drive,	Columbia,	SC	29223

## **Optional employers only**

#### **Retiree, COBRA and Survivor Roster (HRA500)**

#### **Frequency: Monthly**

#### Format: PDF and .csv (Accounting Report)

Provides coverage information for each retiree, COBRA and survivor subscriber and the monthly employee premium for the following PEBA insurance programs:

- State Health Plan;
- Basic Dental;
- Dental Plus;
- Vision; and

• Tobacco-use premium.

Subscriber type on the CSV format is identified as:

C18	18 month C	OBRA	RR	Retiree - Reg	gular	SR	R S	Survivo	or				
C29	29 month C	COBRA	R05	Retiree - 5/1	0 year								
C36	36 month C	COBRA	R25	Retiree - 25 y	year								
ssn	last_name	first_name	subscriber_ty	/pe health_status	health_plan	1	healt	th_category	rate_scheme	health_er_rate	health_ee_rate	]	
dental_st	atus dental_category	dental_er_rate	dental_ee_ra	ate dental_plus_status	dental_plus	_ee_rate	visior	n_status	vision_category	vision_ee_rate	tobacco_status	tobacco_ee	rate

The PDF format is divided into sections based on subscriber type (18-month COBRA, 29-month COBRA, 36month COBRA, Retiree-Regular, Retiree-25 Year, Survivor, etc.). In each of the sections, names are printed in alphabetical order by last name, first name and middle initial, with the BIN listed in the next column. This roster will not include the Social Security number.

#### Bills – Retiree, COBRA and Survivor (HRA610)

#### **Frequency: Monthly**

#### Format: PDF (Accounting Report)

The optional employer continues to serve as the benefits administrator for these subscribers; therefore, you will receive the monthly Retiree, COBRA and Survivor bill in addition to the Active Subscribers bill (HAC610).

The PDF billing statement is the same as that for active subscribers. Note that some programs are not listed, because they are not available to these subscribers. The \$3 administrative fee for each retiree, survivor and COBRA participant per month is included on the Account Summary pages.

Collect the premiums for covered retirees, COBRA and survivor subscribers, and deposit their checks into your account. Their checks should be made payable to the employer, not PEBA. **Do not submit personal subscriber checks to PEBA.** 

Remit a single check for the total amount due shown on the Remittance Advice page of the individual and active group bills.

C18	18 month COBRA	RR	Retiree - Regular	SRR	Survivor
C29	29 month COBRA	R05	Retiree - 5/10 year		
C36	36 month COBRA	R25	Retiree - 25 year		

#### Active Rate with Load Factor (HTB527)

## Frequency: Annually

Format: PDF

Provides monthly health employer contributions and employee premiums per plan (Standard Plan and Savings Plan) and coverage level, including the load factor. View more information about load factors in the <u>Optional</u> <u>Employer Handbook</u>.

	INSURANCE RATES FO	DR:			
SUBSCRIB HEALTH P	ER TYPE: LAN:		RATE SCHEME:		
EFF DATE LOAD FACTOR	CURRENT	PREVIOUS1	PREVIOUS2		
CATEGORY SUBSCRIBER SUBS/SPOUSE	EMPLOYEE EMPLOYER 	EMPLOYEE EMPLOYER     	EMPLOYEE EMPLOYER		
SUBS/CHILD FAMILY					

#### Individual Rate with Load Factor (HTB528)

#### Frequency: Annually

#### Format: PDF

Provides monthly health employer contributions and employee premiums per subscriber type and coverage level (detailed below), including the load factor. View more information about load factors in the <u>Optional</u> <u>Employer Handbook</u>.

Note: This report references the Standard Plan for Medicare-eligible members, not the Carve-out Plan.



#### Subscriber type: 18-month COBRA

• Standard, Medicare Supp, Savings

#### Subscriber type: 29-month COBRA

• Standard, Medicare Supp, Savings

#### Subscriber type: 36-month COBRA

• Standard, Medicare Supp, Savings

#### Subscriber type: Retiree 15/25

- Subscriber and Spouse have Medicare
   Standard, Medicare Supp
- Subscriber and Spouse not eligible for Medicare

- Standard, Savings, TRICARE
- Subscriber has Medicare; Spouse not eligible for Medicare
  - o Standard, Medicare Supp
- Subscriber not eligible for Medicare; Spouse has Medicare
  - Standard, Medicare Supp, Savings
- Child(ren) only eligible for Medicare
  - Standard, Medicare Supp, Savings

#### Subscriber type: Retiree – Buy-in/5-10 year/25 year

- Subscriber and Spouse have Medicare
  - Standard, Medicare Supp
- Subscriber and Spouse not eligible for Medicare
  - Standard, Savings, TRICARE
- Subscriber has Medicare; Spouse not eligible for Medicare
   Standard, Medicare Supp
- Subscriber not eligible for Medicare; Spouse has Medicare
  - Standard, Medicare Supp, Savings
- Child(ren) only eligible for Medicare
  - Standard, Medicare Supp, Savings

#### Subscriber type: Retiree – regular

- Subscriber and Spouse have Medicare
  - Standard, Medicare Supp
- Subscriber and Spouse not eligible for Medicare
  - Standard, Savings, TRICARE
- Subscriber has Medicare; Spouse not eligible for Medicare
  - Standard, Medicare Supp
- Subscriber not eligible for Medicare; Spouse has Medicare
   Standard, Medicare Supp, Savings
  - Child(ren) only eligible for Medicare
    - Standard, Medicare Supp, Savings

#### Subscriber type: Survivor – partially funded

- Spouse and child(ren) have Medicare
  - Standard, Medicare Supp
- Spouse and child(ren) not eligible for Medicare
  - Standard, Savings, TRICARE
- Spouse has Medicare; child(ren) not eligible for Medicare
  - Standard, Medicare Supp, Savings
- Spouse not eligible for Medicare; child(ren) has Medicare
  - o Standard, Medicare Supp, Savings

#### Subscriber type: Survivor - funded

- Spouse and child(ren) have Medicare
  - Standard, Medicare Supp
- Spouse and child(ren) not eligible for Medicare
  - o Standard, Savings, TRICARE

- Spouse has Medicare; child(ren) not eligible for Medicare
  - Standard, Medicare Supp, Savings
- Spouse not eligible for Medicare; child(ren) has Medicare
  - o Standard, Medicare Supp, Savings

#### Subscriber type: Survivor – regular

- Spouse and child(ren) have Medicare
  - $\circ$  Standard, Medicare Supp
- Spouse and child(ren) not eligible for Medicare
  - o Standard, Savings, TRICARE
- Spouse has Medicare; child(ren) not eligible for Medicare
   Standard, Medicare Supp, Savings
- Spouse not eligible for Medicare; child(ren) has Medicare
  - Standard, Medicare Supp, Savings

#### Subscriber type: Survivor – regular

Medicare

# Reference

## Contents

Acronyms used in this manual	
County codes	
Quick reference charts	
Active NOE quick reference	
Active NOE quick reference (cont.)	
Active NOE quick reference (cont.)	200
Special eligibility situations quick reference	201
Special eligibility situations quick reference (cont.)	202
Special eligibility situations quick reference (cont.)	203
Special eligibility situations quick reference (cont.)	204
Special eligibility situations quick reference (cont.)	205
Special eligibility situations quick reference (cont.)	
Special eligibility situations quick reference (cont.)	207
Special eligibility situations quick reference (cont.)	208
Special eligibility situations quick reference (cont.)	209
Special eligibility situations quick reference (cont.)	210
Special eligibility situations quick reference (cont.)	211
Special eligibility situations quick reference (cont.)	212
Special eligibility situations quick reference (cont.)	213
Special eligibility situations quick reference (cont.)	214
Special eligibility situations quick reference (cont.)	215
Special eligibility situations quick reference (cont.)	216
Effective date quick reference	217
Effective date quick reference (cont.)	218
Effective date quick reference (cont.)	219
Documentation quick reference	219
Documentation quick reference (cont.)	220
Active Termination Form quick reference	221
Affordable Care Act glossary	222
Quick reference calendar for determining eligibility	223
Quick reference for unpaid leave or reduction in hours	224
Premium checks quick reference	225
Employer checklists	

Coverage termination processes	.226
Termination of employment due to resignation, RIF, dismissal	226
Termination of employment with transfer to another PEBA-participating employer	226
Termination of employment due to retirement (service or disability)	227
Termination due to death of subscriber	227
Termination due to nonpayment of premiums	228
Termination during military leave	228
Termination of covered spouse and/or child	228
Retiree orientation checklist	229
Disability checklist	231
<u>Claims checklist</u>	231
Accounting system checklist	232

## Acronyms used in this manual

Acronym	Explanation			
AD&D	Accidental Death & Dismemberment			
BA	Benefits administrator			
BlueCross	BlueCross BlueShield of South Carolina			
BIN	Benefits ID number (subscriber identification number in lieu of SSN)			
BLTD	Basic Long Term Disability			
CBA	Companion Benefit Alternatives			
CG	Comptroller General			
COBRA	Consolidated Omnibus Budget Reconciliation Act			
DCSA	Dependent Care Spending Account (MoneyPlus)			
DHHS	Department of Health and Human Services (Medicaid)			
DSS	Department of Social Services			
EBS	Employee Benefits Services			
ERISA	Employee Retirement Income Security Act of 1974			
FSA	Flexible Spending Account (MoneyPlus)			
FMLA	Family and Medical Leave Act of 1993			
GEA	Government Employees Association, sponsor of the TRICARE Supplement Plan			
HIPAA	Health Insurance Portability and Accountability Act of 1996			
НМО	Health Maintenance Organization			
HSA	Health Savings Account			

Acronym	Explanation			
IBG	Insurance Benefits Guide			
LTC	Long term care			
LTD	Long term disability			
MSA	Medical Spending Account (MoneyPlus)			
NOE	Notice of Election			
PEBA	Public Employee Benefit Authority			
РСР	Primary care physician			
PPACA (ACA)	Patient Protection and Affordable Care Act of 2010			
RETRO	Retroactivity			
SCEIS	South Carolina Enterprise Information System			
SLTD	Supplemental long-term disability			
SOC	Summary of change			
SOE	Summary of enrollment			
SOI	Summary of intent			
SSN	Social Security number			
STARS	Statewide Accounting and Reporting System			
SVP	State Vision Plan			
URT	Unrequested refund transfer			
USERRA	Uniformed Services Employment and Reemployment Rights Act of 1994			

## **County codes**

Code	County	Code	County
1	Abbeville	25	Hampton
2	Aiken	26	Horry
3	Allendale	27	Jasper
4	Anderson	28	Kershaw
5	Bamberg	29	Lancaster
6	Barnwell	30	Laurens
7	Beaufort	31	Lee
8	Berkeley	32	Lexington
9	Calhoun	33	McCormick
10	Charleston	34	Marion
11	Cherokee	35	Marlboro
12	Chester	36	Newberry
13	Chesterfield	37	Oconee
14	Clarendon	38	Orangeburg
15	Colleton	39	Pickens
16	Darlington	40	Richland
17	Dillon	41	Saluda
18	Dorchester	42	Spartanburg
19	Edgefield	43	Sumter
20	Fairfield	44	Union
21	Florence	45	Williamsburg
22	Georgetown	46	York
23	Greenville	99	Out-of-state
24	Greenwood		

## **Quick reference charts**

## Active NOE quick reference

**Use EBS when permissible.** Instructions for the <u>Active Notice of Election</u> form are on Page 3 of the form. This chart includes specific details for additions and changes. Each column in the table represents a unique event.

NOE section	New hire	Open enrollment	Marriage	Divorce/separation
ACTION	Select: New Hire/Election.	Select: Change.	Select: Change.	Select: Change.
	Type of Change: Enrollment.	Type of Change: Enrollment.	Type of Change: Other (Specify Marriage and Date of Change Event). Must provide	Type of Change: Other (Specify Divorce and Date of Change Event). Must provide
			documentation.	documentation.
BA USE ONLY	Effective Date; Group ID#; Group Name; if 20-hour employee; Pay periods per year.	Effective Date; Group ID#; Group Name; Pay periods per year.	Effective Date; Group ID#; Group Name; Pay periods per year.	Effective Date; Group ID#; Group Name; Pay periods per year.
ENROLLEE INFO	#1-19	#1-5	#1-5; #8-17	#1-5; #8-17
COVERAGE	#20-26	#20-22, 23-24, 26, if applicable.	#20-24, 26 if changing coverage level.	#20-24, 26 if changing coverage level.
MONEYPLUS Pretax Premiums	Refuse or Yes.	Complete if changing election.	Complete if changing election.	Complete if changing election.
MONEYPLUS Elections	Complete if enrolling.	Complete if re- enrolling or enrolling.	Complete if changing election.	Complete if changing election.
EMPLOYEE INITIALS	Initial and date.	Initial and date.	Initial and date.	Initial and date.
MEDICARE	Complete all, if applicable.	Complete all, if applicable.	Complete all, if applicable.	Complete all, if applicable.

For beneficiaries and dependents:

Do not list "spouse" or "child." List relationship as wife, husband, daughter, son.

For beneficiaries
-------------------

An estate of trust has no relationship.						
BENEFICIARIES	Complete all.	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.		
DEPENDENTS	Complete all, if applicable.	Complete all, if applicable.	Add; complete all, listing dependents to add.	Delete; listing dependents to delete.		
CERTIFICATION & AUTHORIZATION	#31-32	#31-32	#31-32	#31-32		

An estate or trust has no relationship

## Active NOE quick reference (cont.)

NOE section	Ineligible child/coverage change	Last ineligible child/coverage change	Returning student	Dependent Life- Spouse coverage with medical approval
TYPE OF CHANGE	Select: Change.	Select: Change.	Select: Change.	Select: Change.
	Type of Change: Other (Specify ineligible child and give reason).	Type of Change: Other (Specify ineligible child and give reason).	Type of Change: Other (Specify returning student). Must provide documentation.	Type of Change: Other (Specify Dependent Life and increase with medical approval). Must provide approval from MetLife.
BA USE ONLY	Effective Date;	Effective Date;	Effective Date;	Effective Date;
	Name.	Name.	Name.	Name.
ENROLLEE INFO	#1-5	#1-5	#1-5	#1-5
COVERAGE	#20-22 and 26 if	#20-22 and 26 if	#20-22 and 26 if	#23
	decreasing	decreasing	decreasing	
	coverage level.	coverage level.	coverage level.	
MONEYPLUS Pretax	Complete if	Complete if	Complete if	N/A
Premiums	changing election.	changing election.	changing election.	
MEDICARE	Complete all, if	Complete all, if	Complete all, if	Complete all, if
	applicable.	applicable.	applicable.	applicable.

#### For beneficiaries and dependents:

Do not list "spouse" or "child." List relationship as wife, husband, daughter, son.

#### For beneficiaries:

An estate or trust has no relationship.

BENEFICIARIES	Employee option to	Employee option to	Employee option to	Employee option to
	change; complete	change; complete	change; complete	change; complete
	all, if applicable.	all, if applicable.	all, if applicable.	all, if applicable.
DEPENDENTS	Delete; list child to	Delete; list child to	Add; complete all,	Add; listing spouse.
	delete.	delete.	listing child to add.	
<b>CERTIFICATION &amp;</b>	#31-32	#31-32	#31-32	#31-32
AUTHORIZATION				

## Active NOE quick reference (cont.)

NOE section	Optional Life add/increase	Optional Life add/increase with medical approval	Optional Life decrease/ refuse	Dependent Life add/increase with medical approval	SLTD add/decrease waiting period with medical approval
TYPE OF CHANGE	Select: Change.	Select: Change.	Select: Change.	Select: Change.	Select: Change.
	Type of Change: Other (Specify OL add or increase and give reason).	Type of Change: Other (Specify OL add or increase with medical approval). Must provide approval from	Type of Change: Other (Specify OL decrease or refuse and give reason for change if on Pretax Feature).	Type of Change: Other (Specify DL add or increase with medical approval). Must provide approval from	Type of Change: Other (Specify: SLTD add or wait period). Must provide approval from The Standard.
	Effective Date:	MetLife.	Effective Date:	MetLife.	Group ID#
BA USE UNLT	Group ID#; Group Name.	Group ID#; Group Name.	Group ID#; Group Name.	Group Name.	Group Name.
ENROLLEE INFO	#1-5; 18	#1-5; 18	#1-5	#1-5; 18	#1-5, 18
COVERAGE	#24 (enter new amount).	#24 (enter new amount).	#24 (enter new amount or refuse).	#22 for child(ren), #23 (enter new amount).	#25
MONEYPLUS Pretax premiums	Complete if changing election.	Complete if changing election by choosing either yes or refuse.	Complete if changing election.	N/A	N/A
MEDICARE	Complete all, if applicable.	Complete all, if applicable.	Complete all, if applicable.	Complete all, if applicable.	Complete all, if applicable.
		For benef	iciaries:		· · ·
Do	not list "spouse" of A	r "child." List relatio An estate or trust h	onship as wife, hus as no relationship.	band, daughter, so	n.
BENEFICIARIES	Employee	Employee	Employee	Employee	Employee
	option to	option to	option to	option to	option to

BENEFICIARIES	Employee	Employee	Employee	Епрюуее	Employee
	option to				
	change;	change;	change;	change;	change;
	complete all, if				
	applicable.	applicable.	applicable.	applicable.	applicable.
DEPENDENTS	N/A	N/A	N/A	N/A? #30	N/A
<b>CERTIFICATION &amp;</b>	#31-32	#31-32	#31-32	#31-32	#31-32
AUTHORIZATION					

This information describes changes subscribers can make when a special eligibility situation occurs. Unless otherwise noted, all changes must be made within 31 days of the event. Additionally, refer to the Life event checklists at <u>peba.sc.gov/publications</u>.

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions ( <i>select as</i> <i>many as apply)</i>	Effective date	Documentation required
Birth of child	<ul> <li>Employee alone</li> <li>Employee and newborn child</li> <li>Employee and existing child(ren)</li> <li>Employee and spouse</li> <li>Employee, spouse, existing child(ren) and newborn child</li> </ul>	<ul> <li>Enroll in health (if employee already enrolled in health, may change plans if adding spouse or child to health)</li> <li>Enroll in dental</li> <li>Enroll in State Vision</li> <li>Enroll in Dependent Life- Child</li> <li>Enroll in or increase Dependent Life-Spouse (\$10,000 or \$20,000 without medical evidence; more than \$20,000 with medical evidence)</li> <li>Enroll in or increase Optional Life (up to \$50,000 without medical evidence; more than \$50,000 with medical evidence)</li> <li>Review changes available with MSA/DCSA</li> </ul>	Health, dental and vision: Date of birth Optional Life and Dependent Life- Spouse: For amounts available without medical evidence, first of month following date of request. For amounts requiring medical evidence, first of month following date of approval. Dependent Life- Child: Date of birth	Long-form birth certificate of child and if adding spouse, marriage license or Page 1 of latest tax return.
	Notes A. Note about premiur	ns: If the employee is enrolled i	n the MoneyPlus Preta	x Group Insurance

- A. Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums may be paid pretax beginning the first of the month following the date of the request.
- B. May not drop any coverage; may only change or add coverage.
- C. For Optional Life, if employee is not actively at work on the expected effective date, then the effective date will be first of the month following return to work. For Dependent Life, if dependent, other than a newborn, is confined to a hospital or elsewhere on the expected effective date, then the effective date will be deferred until the spouse or child is discharged from the hospital or no longer confined.

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required
Adoption of child (or placement for adoption)	<ul> <li>Employee alone</li> <li>Employee and newly adopted child</li> <li>Employee and existing child(ren)</li> <li>Employee and spouse</li> <li>Employee, spouse, existing child(ren) and newly adopted child</li> </ul>	<ul> <li>Enroll in health (if employee already enrolled in health, may change plans if adding spouse or child to health)</li> <li>Enroll in dental</li> <li>Enroll in State Vision</li> <li>Enroll in Dependent Life-Child</li> <li>Enroll in or increase Dependent Life-Spouse (\$10,000 or \$20,000 without medical evidence; more than \$20,000 with medical evidence)</li> <li>Enroll in or increase Optional Life (up to \$50,000 without medical evidence; more than \$50,000 with medical evidence)</li> <li>Review changes available with MSA/DCSA</li> </ul>	Health, dental and vision: Date of adoption or placement for adoption unless baby is adopted or placed for adoption within 31 days of birth — then date of birth. Optional Life and Dependent Life- Spouse: For amounts available without medical evidence, first of month following date of request. For amounts requiring medical evidence, first of month following date of approval. Dependent Life- Child: Date of birth for newborns. First of the month after date of request for other children.	Long-form birth certificate listing the subscriber as the parent; legal adoption documentation from court, verifying adoption completed; or letter of placement from adoption agency, attorney, or DSS verifying adoption in progress <b>and</b> if adding spouse, marriage license or Page 1 of latest tax return.

- A. Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums may be paid pretax beginning the first of the month following the date of the request.
- B. May not drop any coverage; may only change or add coverage.
- C. For Optional Life, if employee is not actively at work on the expected effective date, then the effective date will be first of the month following return to work. For Dependent Life, if dependent, other than a newborn, is confined to a hospital or elsewhere on the expected effective date, then the effective date will be deferred until the spouse or child is discharged from the hospital or no longer confined.

Event	This p peopl	erson/these e ( <i>select one)</i>	Can do one or more of these actions <i>(select as many as</i> <i>apply)</i>	Effective date	Documentation required	
Placement of foster child (with court order) <i>If you</i> have gained legal custody of	Em     Em     Em     exi:     chi     Em     spc     chi     spc     chi     nev	ployee alone ployee and w foster child ployee and sting ld(ren) ployee and ouse ployee, puse, existing ld(ren) and w foster child	<ul> <li>Enroll in health (if employee already enrolled in health, may change plans if adding spouse or new foster child to health)</li> <li>Enroll in dental</li> <li>Enroll in State Vision</li> <li>Review changes available with MSA/DCSA</li> </ul>	Health, dental and vision Date of placement (usually date of court order).	Court order placing child in foster care with the employee and if adding spouse, marriage license or Page 1 of latest tax return.	
custouy oj	Notes					
your foster child, see Gains custody of child	A. No Pr of B. M	ote about prem emium feature gaining custod onth following ay not drop an	iums: If the employee is enrolled , premiums must be paid post-ta: y or guardianship. Premiums may the date of the request. y coverage; may only change or a	in the MoneyPlus Pre x for retroactive cover y be paid pretax begin dd coverage.	tax Group Insurance age back to the date ning the first of the	

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required	
Gains custody of child (with court order)	<ul> <li>Employee alone</li> <li>Employee and child for whom he gained legal custody</li> <li>Employee and existing child(ren)</li> <li>Employee and spouse</li> <li>Employee, spouse, existing child(ren) and child for whom he gained legal custody</li> </ul>	<ul> <li>Enroll in health (if employee already enrolled in health, may change plans if adding spouse or child to health)</li> <li>Enroll in dental</li> <li>Enroll in State Vision</li> <li>Review changes available with MSA/DCSA</li> </ul>	Health, dental and vision Date of court order	Court order granting custody of the child to employee and if adding spouse, marriage license or Page 1 of latest tax return.	
	<ul> <li>Notes</li> <li>A. Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of gaining custody or guardianship. Premiums may be paid pretax beginning the first of the month following the date of the request.</li> <li>B. May not drop any coverage; may only change or add coverage.</li> <li>C. For Dependent Life, if dependent, other than a newborn, is confined to a hospital or elsewhere on the expected effective date, then the effective date will be deferred until the spouse or child is discharged from the hospital or no longer confined.</li> </ul>				

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as</i> apply)	Effective date	Documentation required
Marriage	<ul> <li>Employee alone</li> <li>Employee and any new stepchild</li> <li>Employee and existing child(ren)</li> <li>Employee and spouse</li> <li>Employee, spouse, existing child(ren) and any new stepchild</li> </ul>	<ul> <li>Enroll in health (if employee already enrolled in health, may change plans if adding spouse or stepchild to health)</li> <li>Enroll in dental</li> <li>Enroll in State Vision</li> <li>Enroll in Dependent Life- Spouse (\$10,000 or \$20,000 without medical evidence; more than \$20,000 with medical evidence)</li> <li>Enroll in Dependent Life- Child</li> <li>Enroll in Or increase Optional Life (up to \$50,000 without medical evidence; more than \$50,000 with medical evidence; more than \$50,000 with medical evidence)</li> <li>Review changes available with MSA/DCSA</li> </ul>	<ul> <li>Health, dental and vision:</li> <li>Date of marriage</li> <li>Optional Life and</li> <li>Dependent Life-</li> <li>Spouse:</li> <li>For amounts available without medical evidence, first of month following date of request. For amounts requiring medical evidence, first of month following date of approval.</li> <li>Dependent Life-Child:</li> <li>First of the month after date of request.</li> </ul>	Marriage license and if adding stepchild(ren), also need long- form birth certificates for each child.
	<ul> <li>Notes</li> <li>A. Note about prem Premium feature of marriage. Pren date of the reque</li> <li>B. May not drop and</li> <li>C. For Optional Life, effective date with dependent, othe effective date, the from the hospital</li> </ul>	iums: If the employee is enrolled , premiums must be paid post-ta niums may be paid pretax beginn est. y coverage; may only change or a , if employee is not actively at wo Il be first of the month following r than a newborn, is confined to a en the effective date will be defe l or no longer confined.	d in the MoneyPlus Pretax ix for retroactive coverage ning the first of the month add coverage. ork on the expected effect return to work. For Deper a hospital or elsewhere or erred until the spouse or c	Group Insurance back to the date following the ive date, then the ident Life, if in the expected hild is discharged

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required
Divorce	Former spouse and any former stepchild(ren)	<ul> <li>The employee must drop former spouse and stepchild(ren) from health, dental and vision.</li> <li>Must drop Dependent Life for former spouse or stepchild(ren), even if court ordered to continue.</li> <li>If divorce decree requires the employee to continue coverage for former spouse, former spouse can enroll in own coverage using the <i>Former Spouse NOE</i>.</li> </ul>	Health, dental and vision: First of month following divorce Dependent Life: Date of divorce Exception to 31-day rule: If dropping ineligible spouse or stepchild(ren) and PEBA is notified more than 31 days after divorce, first of month following notification.	First page of divorce decree and judge's signature page
	Employee	<ul> <li>Enroll in or increase</li> <li>Optional Life up to</li> <li>\$50,000 without medical evidence</li> <li>Cancel or decrease</li> <li>Optional Life</li> <li>Review changes available with MSA</li> </ul>	<b>Optional Life:</b> If employee is actively at work, first of month following date of request. If not actively at work, first of month following return to work.	
	A. May not drop here eligible for cover B. For Optional Life,	alth, dental or vision coverage for age. , if employee is not actively at wo	r himself or any depender	its who remain ive date, then the

B. For Optional Life, if employee is not actively at work on the expected effective date, then the effective date will be first of the month following return to work.

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required	
Employee loses other health coverage (includes Medicare)	If employee is not already enrolled in PEBA's health coverage: Employee Employee and spouse Employee and children Employee, spouse and children	<ul> <li>Enroll in health</li> <li>Enroll in dental</li> <li>Enroll in State Vision</li> </ul>	Health, dental and vision: Date of loss of health coverage	Verifiable confirmation from prior employer (letter, email, etc.) stating employee lost health coverage and date of loss <b>and</b>	
	If employee is already enrolled in PEBA health coverage: Not eligible to change elections.	Not eligible to change elections.		long-form birth certificate if adding child; marriage license or Page 1 of latest tax return if adding spouse.	
	Notes		• •		
	A. Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of loss of coverage. Premiums may be paid pretax beginning the first of the month following				

the date of the request.

- B. Letter does NOT have to state employee lost dental or vision to add dental or vision.
- C. Letter does not have to state spouse or child(ren) lost coverage to add them.
- D. May not drop any coverage but may add coverage.

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as</i> <i>apply)</i>	Effective date	Documentation required	
Spouse or child loses other health coverage (includes Medicare)	□ Employee and spouse/child who lost health coverage	<ul> <li>Enroll in health (if employee already enrolled in health, may change plans if adding spouse or child to health)</li> <li>Enroll in dental</li> <li>Enroll in State Vision</li> </ul>	Health, dental and vision: Date of loss of health coverage	Verifiable confirmation from prior employer (letter, email, etc.) stating spouse/child(ren) lost health coverage and date of loss <b>and</b> long-form birth certificate if adding child(ren); marriage license or Page 1 of latest tax return if adding spouse.	
	Notes				
	A. Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of loss of coverage. Premiums may be paid pretax beginning the first of the month following				

- the date of the request.B. Letter does NOT have to say spouse/child(ren) lost dental or vision to add dental or vision.
  - C. Employee may not make changes to coverage unless he adds spouse/child(ren) who lost health coverage.
  - D. May not drop any coverage but may add coverage.
  - E. If the spouse/child(ren) lost coverage through PEBA and is then added to the employee's Dependent Life coverage, the effective date is the date of the loss or the first of the month following date of request, whichever is later.

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions (select as many as apply)	Effective date	Documentation required	
Employee loses other dental coverage only (not health)	☐ Employee	Enroll in dental	<b>Dental:</b> Date of loss of dental coverage	Verifiable confirmation from prior employer (letter, email, etc.) stating employee lost dental coverage and date of loss.	
Employee loses other vision coverage only (not health)	Employee	<ul> <li>Enroll in State</li> <li>Vision</li> </ul>	<b>Vision:</b> Date of loss of vision coverage	Verifiable confirmation from prior employer (letter, email, etc.) stating employee lost vision coverage and date of loss.	
Spouse or child loses other dental coverage only (not health)	Employee and spouse/child who lost dental coverage	Enroll in dental	<b>Dental:</b> Date of loss of dental coverage	Verifiable confirmation from prior employer (letter, email, etc.) stating spouse/child lost dental coverage and date of loss.	
	Notes				
	<ul> <li>A. Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of loss of coverage. Premiums may be paid pretax beginning the first of the month following the date of the request.</li> <li>B. If spouse/child(ren) not covered by employee for health, vision or life, dependent</li> </ul>				

documentation is required. See Enrollment documentation worksheet.

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions (select as many as apply)	Effective date	Documentation required
Spouse or child loses other vision coverage only (not health)	Employee and spouse/child who lost vision coverage	<ul> <li>Enroll in State</li> <li>Vision</li> </ul>	Vision: Date of loss of vision coverage If enrolled in MoneyPlus Pretax Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of loss. Premiums may be paid through the Pretax Premium feature beginning first of the month following date of request.	Verifiable confirmation from prior employer (letter, email, etc.) stating spouse/child(ren) lost vision coverage and date of loss.
	Notes			
	<ul> <li>A. Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage ba to the date of loss of coverage. Premiums may be paid pretax beginning the first of the month following the date of the request.</li> <li>B. If spouse/child(ren) not covered by employee for health, vision or life, dependent documentation is required. See <u>Enrollment documentation worksheet</u>.</li> </ul>			
Employee gains other health, dental or vision coverage	Employee	Drop coverage gained	Health, dental, vision: First of the month following gain of coverage or the first of the month if coverage is gained on the first of the month. Medical Spending Account: Change must be consistent with change reason	Verifiable confirmation from prior employer (letter, email, etc.) stating subscriber gained coverage and date of gain.
	Notes			
	A. Dependents enrolled in the same coverage must also be dropped.			
	B. If subscriber drops Dental Plus, cannot remain enrolled in Basic Dental.			

Event	This person/these people <i>(select</i> <i>one)</i>	Can do one or more of these actions (select as many as apply)	Effective date	Documentation required	
Spouse/child gains other health, dental or vision coverage	□ Spouse/child who gained other coverage	Drop coverage gained	Health, dental, vision: First of the month following gain of coverage or the first of the month if coverage is gained on the first of the month. Medical Spending Account: Change must be consistent with change reason	Verifiable confirmation from prior employer (letter, email, etc.) stating spouse/child(ren) gained coverage and date of gain.	
	Notes				
	<ul><li>A. If subscriber</li><li>B. Only the spo</li></ul>	drops Dental Plus, can puse/child(ren) listed or	not remain enrolled in Basic Dental. n gain of coverage letter may drop.		
Employee gains Medicaid or CHIP coverage	☐ Employee	<ul> <li>Drop health</li> <li>Drop dental</li> <li>Drop vision</li> <li>Decrease MSA (cannot be lower than amount contributed or reimbursed, whichever is greater)</li> </ul>	<ul> <li>Health, dental, vision:</li> <li>Exception to 31-day rule:</li> <li>Employee has 60 days from the date notified by Medicaid of gain of coverage to drop health, dental and/or vision.</li> <li>If notified by Medicaid within 60 days of gain of coverage, date of gain of Medicaid.</li> <li>If notified by Medicaid more than 60 days after gain of coverage, first of month following request. (See Note B below).</li> </ul>	Copy of Medicaid approval letter.	
	Notes				
	<ul> <li>A. Spouse or child(ren) enrolled in the same coverage will also be dropped.</li> <li>B. If the employee contacts PEBA later than 60 days after he was notified by Medicaid, no change can be made due to gain of Medicaid.</li> </ul>				

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required
Spouse/child gains Medicaid or CHIP coverage	□ Spouse/child who gained Medicaid or CHIP coverage	<ul> <li>Drop health</li> <li>Drop dental</li> <li>Drop vision</li> <li>Decrease MSA (cannot be lower than amount contributed or reimbursed, whichever is greater)</li> </ul>	Same as above	Copy of Medicaid approval letter.
	Notes			
	<ul><li>A. Only the spouse/child(ren) listed on gain of coverage letter may drop.</li><li>B. If the employee contacts PEBA later than 60 days after dependent was notified by</li></ul>			s notified by

Medicaid, no change can be made due to gain of Medicaid.

Event	This person/these people <i>(select</i> <i>one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required		
Employee loses Medicaid or CHIP coverage	If employee is not already enrolled in PEBA's health coverage: Employee and spouse Employee and children Employee, spouse and children If employee is already enrolled in PEBA health coverage: Not eligible to change elections	<ul> <li>Enroll in health</li> <li>Enroll in dental</li> <li>Enroll in State Vision</li> </ul>	<ul> <li>Health, dental and vision:</li> <li>Exception to 31-day rule: <ul> <li>Employee has 60 days from the date notified by Medicaid of loss of coverage to enroll. If notified by Medicaid within 60 days, date of loss of Medicaid.</li> <li>If notified by Medicaid more than 60 days after loss, first of month following request. (See Note D below).</li> </ul> </li> </ul>	Copy of Medicaid loss letter and Long-form birth certificate if adding child(ren); marriage license or Page 1 of latest tax return if adding spouse.		
	Notes A. Note about pr	emiums: If the employ	vee is enrolled in the MonevPlus Pr	retax Group Insurance		
	Premium feat of loss of cove the date of the B. Letter does no C. May not drop D. If the employe change is allo	mium feature, premiums must be paid post-tax for retroactive coverage back to the date oss of coverage. Premiums may be paid pretax beginning the first of the month following date of the request. ter does not have to state spouse or child(ren) lost coverage to add them. ay not drop any coverage but may add coverage. he employee contacts PEBA later than 60 days after he was notified by Medicaid, no ange is allowed				
Spouse/child loses Medicaid or CHIP coverage	□ Employee and spouse/child who lost health coverage	<ul> <li>Enroll in health employee alread enrolled in health may change plat adding spouse of to health)</li> <li>Enroll in dental</li> <li>Enroll in State V</li> </ul>	(if Same as above dy th, ns if or child ision	Copy of Medicaid loss letter <b>and</b> long- form birth certificate if adding child(ren); marriage license or Page 1 of latest tax return if adding spouse.		
	A. May add only the employee with the spouse/child(ren) who lost Medicaid.					
	B. May not drop any coverage but may add coverage.					

Event	This person/these people <i>(select</i> <i>one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required	
Employee gains premium assistance through Medicaid or CHIP	If employee is not already enrolled in PEBA's health coverage: □ Employee If employee is already enrolled in PEBA health coverage: Not eligible to change elections	<ul> <li>Enroll in health</li> <li>Enroll in dental</li> <li>Enroll in State Vision</li> <li>Not eligible to change elections</li> </ul>	<ul> <li>Health, dental and vision:</li> <li>Exception to 31-day rule:</li> <li>Employee has 60 days from the date notified of gain of</li> <li>Medicaid premium assistance to enroll.</li> <li>If notified by Medicaid within 60 days, date of gain of assistance.</li> <li>If notified by Medicaid more than 60 days after gain, first of month following request.</li> <li><i>If enrolled in MoneyPlus Pretax Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of loss. Premiums may be paid through the Pretax Premium feature beginning first of the month following date of request.</i></li> </ul>	Copy of Medicaid approval letter	
	<ul><li>A. May not drop any coverage but may add coverage.</li><li>B. If the employee contacts PEBA later than 60 days after he was notified by Medicaid, no change can be made due to gain of Medicaid premium assistance.</li></ul>				
Spouse/child gains premium assistance through Medicaid or CHIP	<ul> <li>Employee and spouse/child who gained Medicaid or CHIP premium assistance</li> </ul>	<ul> <li>Enroll in health (if employee already enrolled in health, may change plans adding spouse or child to health)</li> <li>Enroll in dental</li> <li>Enroll in State Visi</li> </ul>	, if on	Copy of Medicaid approval letter and Long-form birth certificate if adding child(ren); marriage license or Page 1 of latest tax return if adding spouse	
	A. May add only the employee with the spouse/child(ren) who receives Medicaid gain letter.				
	B. May not drop any coverage but may add coverage.				

Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as</i> <i>many as apply)</i>	Effective date	Documentation required
Employee loses premium assistance through Medicaid or CHIP	☐ Employee	<ul> <li>Drop health</li> <li>Drop dental</li> <li>Drop vision</li> </ul>	<ul> <li>Health, dental and vision:</li> <li>Exception to 31-day rule:</li> <li>Employee has 60 days from the date notified of loss of</li> <li>Medicaid premium assistance to enroll.</li> <li>If notified by Medicaid within 60 days, date of loss.</li> <li>If notified by Medicaid more than 60 days after gain, first of month following request.</li> </ul>	Copy of Medicaid loss letter
	Notes			
	A. If the employe	e drops coverage, spo	ouse or child(ren) enrolled in the sa	me coverage will also
	be dropped. B. If the employe change can be	e contacts PEBA later made due to loss of N	than 60 days after he was notified Aedicaid premium assistance.	by Medicaid, no
Spouse/child loses premium assistance through Medicaid or	□ Spouse/child who lost Medicaid or CHIP premium assistance	<ul> <li>Drop health</li> <li>Drop dental</li> <li>Drop vision</li> </ul>	Same as above	Copy of Medicaid loss letter
CHIP	Notes			
	<ul> <li>A. Only the spouse/child(ren) listed on loss of premium assistance letter may drop.</li> <li>B. If the employee contacts PEBA later than 60 days after he was notified by Medicaid, no change can be made due to loss of Medicaid premium assistance.</li> </ul>			
Event	This person/these people <i>(select one)</i>	Can do one or more of these actions <i>(select as many as apply)</i>	Effective date	Documentation required
---	--	--	---	---
Marital separation <i>Requires a</i>	Employee's separated spouse	Drop health, dental and vision	First of the month following date of notification	Decree of Separate Maintenance or other order filed with
signed, filed court order from a jurisdiction that	Employee	<ul> <li>Enroll in or increase Optional Life up to \$50,000</li> <li>Cancel or decrease Optional Life</li> </ul>	Optional Life: if employee is actively at work, first of month following date of request. If not actively at work, first of month after return to work.	court from a jurisdiction that recognizes legal separation as a distinct legal status
recognizes	Notes			
<ul> <li><i>legal</i></li> <li><i>A.</i> Must notify within 31 days of court order or no election change ca separation as a distinct</li> <li><i>a distinct</i></li> <li><i>legal status.</i></li> <li><i>As of the date of this publication,</i></li> <li><i>South</i></li> <li><i>Carolina does not.</i></li> <li>A. Must notify within 31 days of court order or no election change ca separation as 1 days of court order or no election change ca separation as 1 days of court order or no election change ca separation as 2 days of the separation as 1 days of court order or no election change ca separation as 2 days of the separation of this 1 days of court order or no election change ca separation as 2 days of the separation of the se</li></ul>				e made. ge for all the benefits effective date, then

## Special eligibility situations quick reference (cont.)

# Effective date quick reference

Type of action	Effective date
New hire	<ul> <li>If the employee begins active employment on the first day of the month, coverage begins on that day (on the 1<sup>st</sup> of the month).</li> <li>If the employee begins active employment on the first working day of the month (first day that is not a Saturday, Sunday or observed holiday), but not on the first day of the month (for example, he begins on the 2<sup>nd</sup> or 3<sup>rd</sup> of the month), then the employee may choose when coverage begins: <ul> <li>The first day of the following month.</li> </ul> </li> <li>If the employee begins active employment after the first working day of the month (after the first day that is not a Saturday, Sunday or observed holiday), coverage will begin the first day of the following month.</li> </ul>
Birth	Health, dental and vision, and Dependent Life-Child: Date of birth.
Adoption	Health, dental and vision: Date of adoption or placement for adoption, within 31 days of birth — then date of birth.
Foster care/guardianship	Health, dental and vision: Date of placement (usually date of court order).
Marriage	Health, dental and vision: Date of marriage.
Separation	Health, dental and vision:
Divorce	Health, dental and vision:
	First of month following divorce.
	Dependent Life:
	Date of divorce.
Employee loss of coverage	Health, dental and vision:
	Date of loss of coverage.
Spouse/child loss of coverage	Health, dental and vision:
	Date of loss of coverage.
Employee gain of coverage	Health, dental, vision:
	the month if coverage is gained on the first of the month
Spouse/child gain of coverage	Health. dental and vision:
	First of the month following gain of coverage or the first of the month if coverage is gained on the first of the month.

# Effective date quick reference (cont.)

Type of action	Effective date		
Employee gain of Medicaid or CHIP coverage or	Health, dental and vision:		
loss of premium assistance	Exception to 31-day rule:		
Spouse/child gain of Medicaid or CHIP coverage	<ul> <li>Employee has 60 days from the date notified by</li> </ul>		
or loss of premium assistance	Medicaid of loss of coverage to enroll.		
	• If notified by Medicaid within 60 days, date of loss of		
	Medicaid.		
	If notified by Medicaid more than 60 days after loss, first		
	of month following request.		
Employee loss of Medicald or CHIP coverage or	Health, dental and vision:		
gain of premium assistance	Exception to 31-day rule:		
or gain of promium assistance	Employee has boldays from the date notified of gain of Madigaid promium assistance to aproll		
of gain of premium assistance	Medicald premium assistance to enroll.		
	If notified by Medicaid within 60 days, date of gain of		
	assistance.		
	If notified by Medicaid more than 60 days after gain, first		
	of month following request.		
Spouse/child of Foreign National Employee	Date of arrival in the U.S. to add; first of the month		
	following departure from the U.S. to drop.		
Late entrant (health) (no medical evidence of	January 1 following open enrollment.		
good health)			
Ineligible spouse or child	First of the month after becoming ineligible.		
Returning student	First of the month after becoming eligible.		
Death (health, dental, SLTD)	One day after date of death.		
Death (Optional Life)	Date of death.		
Social Security number	N/A		
Name	N/A		
Address	N/A		
Beneficiary changes (all plans)	Date of the signature on the NOE.		
Optional Life increase throughout the year (not	First of the month after approval of medical evidence.		
on MoneyPlus)	Deferred effective date provision applies.		
Optional Life decrease or cancellation (not on	First of the month after request.		
MoneyPlus)			
Optional Life increase due to special eligibility	See the Special eligibility situations quick reference charts.		
situation			
Optional Life decrease or cancellation for	See the Special eligibility situations quick reference charts.		
Internet life increase due to exercise and life increases due to exercise and life inc			
Optional Life increase due to annual enrollment	Following low-row of four products and the low-the state of the state		
	Following January 1 for amount available without medical		
	Following January 1 for amount available without medical evidence, or first of month after approval of medical		
	Following January 1 for amount available without medical evidence, or first of month after approval of medical evidence if it is required for amount requested, whichever is later. Deferred effective date provision applies		
Ontional Life decrease or cancellation due to	Following January 1 for amount available without medical evidence, or first of month after approval of medical evidence if it is required for amount requested, whichever is later. Deferred effective date provision applies.		

## Effective date quick reference (cont.)

Type of action	Effective date
Dependent Life-Spouse enrollment or increase	First of the month after approval. Deferred effective date
required)	
Dependent Life-Spouse enrollment or increase	See the Special eligibility situations quick reference charts.
due to special eligibility situation	
Dependent Life-Child enrollment throughout the	Date of birth for newborns. First of the month after date
year	of request for other children. Deferred effective date
	provision applies to children other than newborns.
Retirement (service)	First of the month after retirement eligibility has been
	established.
Retirement (disability)	First of the month following the date on the approval
	letter from PEBA Retirement Benefits (disability
	retirement) or The Standard (BLTD/SLTD).

## Documentation quick reference

Type of action	Documentation required
Administrative error	Statement explaining error and circumstances on a Request for Review,
	with any supporting documentation attached.
Adoption/placement for	Copy of a birth certificate listing the subscriber as the parent; or a copy of
adoption	legal adoption documentation from the court, verifying the completed
	adoption; or a letter of placement from an attorney, adoption agency or
	DSS, verifying the adoption in progress.
Divorce Decree or Court Order	Copy of the entire divorce decree or court order. Document must stipulate
to Insure Ex-spouse or Child(ren)	the programs under which the spouse or child(ren) must be covered.
Custody or Guardianship of	Copy of court order or other legal documentation from a placement agency
Child(ren)	or DSS, granting custody or guardianship of a child/foster child to the
	subscriber. The documentation must verify the subscriber has guardianship
	responsibility for the child(ren) and not merely financial responsibility.
Death in the line of duty	Verification of death while on duty.
Dependent Life (adding or	Copy of approval from MetLife.
increasing when medical	
evidence is required)	
Divorce Decree (drop spouse)	Copy of the entire divorce decree (See also Divorce Decree or Court Order to Insure Ex-Spouse or Child(ren) above).
Divorce or annulment of	Copy of divorce decree or documentation of annulment, along with proof
married child (to add child) (For	of eligibility as a full-time student or incapacitated child, if child is age 19 or
Dependent Life only)	older.
Enrolling a child	Copy of the long-form birth certificate showing the subscriber as the parent.
Enrolling a spouse	Copy of marriage license or Page 1 of latest federal tax return if filling jointly.
Enrolling a stepchild	Copy of the long-form birth certificate showing name of natural parent plus proof natural parent and subscriber are married.

# Documentation quick reference (cont.)

Type of action	Documentation required
Gain Medicare coverage	Copy of Medicare card.
Gain/Loss Medicaid coverage	Letter from the Department of Health and Human Services, confirming Medicaid approval and effective date or confirming Medicaid coverage is ending and the effective date.
Gain/Loss other coverage	Copy of creditable coverage letter or verifiable confirmation from prior employer (letter, email, etc.) that includes: Date coverage gained/lost, individuals who gained/lost coverage, type(s) of coverage gained/lost and reason for gain/loss.
Incapacitation	Incapacitated Child Certification Form, completed by both the subscriber and the child's physician. For Dependent Life only, if child is ages 19-24, must also include letter from educational institution, confirming withdrawal from school as a full-time student.
Medicare correction	Copy of Medicare card.
Medicare due to disability	Copy of Medicare card.
Military activation	Copy of military orders.
Military — return from duty	Copy of military discharge papers.
Name change	Copy of driver's license, Social Security card, order of name change or vital records certificate.
Optional Life (adding or increasing when medical evidence is required)	Copy of approval from MetLife.
Retirement — Disability	Copy of approval letter from the S.C. Retirement Systems or Standard Insurance Company.
Retirement — Service	Copy of signed <i>Employment Verification Record</i> form.
Separation (to drop spouse)	Copy of a court order, signed by a judge. The court order must state that the divorce is in progress. Separation is not recognized as a legal status in South Carolina, and therefore is not a special eligibly situation in which a subscriber can make changes to his coverage. If the subscriber has a court order from a jurisdiction that recognizes legal separation as a legal status, PEBA will honor that order and allow the subscriber to drop coverage as a result of a special eligibly situation.
SSN Correction	Copy of Social Security card.
Student Certification	Statement on letterhead, from the educational institution, stating student is full time and dates of enrollment.
Supplemental Long Term Disability (adding/increasing when medical evidence is required)	Copy of the approval from The Standard.

## Active Termination Form quick reference

Submit terminations through EBS when permissible.

Action	Employee Information	Coverage/Dates	Certification
NOT ELIGIBLE: enter last day worked and check applicable reason	#1-7	Effective date and all plans in which enrolled.	COBRA and/or Conversion for OL (if applicable). Sign and date.
TRANSFER TO: new group ID # and group name	#1-7	Effective date and all plans in which enrolled.	COBRA and/or Conversion for OL (if applicable). Sign and date.
MILITARY LEAVE	#1-7	Effective date and all plans in which enrolled.	COBRA and/or Conversion for OL (if applicable). Sign and date.
NONPAYMENT	#1-7	Effective date and all plans in which enrolled.	Conversion for OL (if applicable). Sign and date.
SERVICE RETIREMENT: must meet criteria for PEBA Retirement Benefits and retiree insurance	#1-7	Effective date and all plans in which enrolled.	COBRA, Retiree and Conversion or Continuation for OL (if applicable). Sign and date.
DISABILITY: approved for BLTD/SLTD and/or PEBA Retirement Benefits disability	#1-7	Effective date and all plans affected by termination (OL can be continued). Do not terminate OL if in waiver; complete OL waiver form.	COBRA, Retiree and Conversion or Continuation for OL (if applicable). Sign and date.
DECEASED: enter date of death	#1-7	Effective date and all plans in which enrolled.	Sign and date only.

# Affordable Care Act glossary

New full-time employee (Permanent or Nonpermanent)	A newly hired employee who was determined by the employer, as of the date of hire, to be full-time and eligible for benefits.
New variable-hour, part-time or seasonal employee	A newly hired employee who is not expected to be credited an average of 30 hours per week for the entire measurement period, as of the date of hire. Therefore, the employer cannot reasonably determine his eligibility for benefits as of the date of hire.
Ongoing employee	Any employee who has worked with an employer for an entire Standard Measurement Period.
Plan year	January 1 to December 31.
Applies to new variable-hour, part-time	e and seasonal employees
Initial Measurement Period	Begins the first of the month after the date of hire and ends 12 months later. Review the employee's hours over the Initial Measurement Period to determine future eligibility for benefits.
Initial Administrative Period	Begins the day after the initial measurement period ends and ends the last day of the same month. The employer uses this time to review the employee's hours over the initial measurement period, and, if the employee is eligible, offers benefits to the employee the first of the following month.
Initial Stability Period	Begins the day after the Initial Administrative Period ends and lasts for 12 months. This is the period of time that an employee cannot lose eligibility for benefits regardless of the number of hours he works. If the employee is deemed eligible for coverage during the Initial Administrative Period, he remains eligible for 12 months as long as he remains employed by the employer.
Applies to all ongoing employees	
Standard Measurement Period	Begins on October 4 and ends 12 months later, on October 3. The employer will review the employee's hours over the Standard Measurement Period to determine eligibility for the upcoming plan year.
Administrative Period	Begins on October 3 and ends December 31. This is the period of time an employer and the plan have to identify and enroll eligible individuals in coverage. Employers must offer coverage to eligible employees during the plan's open enrollment period, which ends October 31. PEBA uses the remainder of the Administrative Period to process enrollments to ensure employees have access to coverage at the beginning of the Stability Period.
Stability Period	Begins on January 1 and ends 12 months later on December 31. This is the period of time that an ongoing employee cannot lose eligibility for benefits regardless of the number of hours he works. If the employee is deemed eligible for coverage during the Administrative Period, he remains eligible for the entire plan year as long as he remains employed with the employer.

For more information on the Affordable Care Act, including frequently asked questions, go to <u>peba.sc.gov/aca</u>.

# Quick reference calendar for determining eligibility

This chart helps determine eligibility for new variable-hour, part-time and seasonal employees. After an employee has been employed for a full Standard Measurement Period, he becomes an ongoing employee, and his hours should be reviewed during the open enrollment period (with all other ongoing employees) to determine his eligibility for benefits in the next plan year.

	Initial Measurement Period (12 months)	Administrative Period	Initial Stability Period (12 months)
	Begins the 1 <sup>st</sup> of the	Immediately follows the	Immediately follows the
	month after the date of	Initial Measurement	Administrative Period. If
	hire. During this period,	Period. Review the hours	the employee is deemed
	an employer would	worked during the Initial	eligible for benefits
	measure the employee's	Measurement Period. If	during the Administrative
	hours.	the employee averages	Period, this is the period
		30 hours or more per	of time the employee
		week, he is eligible for	remains eligible for
Month employee began		benefits.	benefits regardless of the
work			number of hours worked.
January	Feb. 1-Jan. 31	Feb. 1-28	March 1-Feb. 28
February	March 1-Feb. 28	March 1-31	April 1-March 31
March	April 1-March 31	April 1-30	May 1-April 30
April	May 1-April 30	May 1-31	June 1-May 31
Мау	June 1-May 31	June 1-30	July 1-June 30
June	July 1-June 30	July 1-31	Aug. 1-July 31
July	Aug. 1-July 31	Aug. 1-31	Sept. 1-Aug. 31
August	Sept. 1-Aug. 31	Sept. 1-30	Oct. 1-Sept. 30
September	Oct. 1-Sept. 30	Oct. 1-31	Nov. 1-Oct. 31
October	Nov. 1-Oct. 31	Nov. 1-30	Dec. 1-Nov. 30
November	Dec. 1-Nov. 30	Dec. 1-31	Jan. 1-Dec. 31
December	Jan. 1-Dec. 31	Jan. 1-31	Feb. 1-Jan. 31

# Quick reference for unpaid leave or reduction in hours

This information describes how eligibility for insurance benefits is affected when an employee goes on an employer-approved leave of absence that is not associated with military leave or FMLA.

Employee's	When unpaid leave (or	Premium	Employee's	When employee returns from unpaid leave (or
status	reduction of hours) begins	information	options	hours are increased)
Ongoing Employee (in a stability period) or variable- hour, part- time and seasonal employee (in an Initial Stability Period)	Eligibility for health, dental and vision continues through the end of the stability period. Send the employee the <u>Your</u> <u>Insurance Benefits When Your</u> <u>Hours are Reduced</u> form.	Employee pays employee's share; employer pays employer share. If employee fails to pay within the grace period, employer can submit termination to PEBA to terminate coverage. Employee is not eligible for CORPA	Employee may choose to voluntarily drop coverage to enroll in the Marketplace. If employee elects to drop coverage for this reason, submit termination in EBS, choose Reduction in Hours.	If employee continued coverage while on unpaid leave, no action required.* If employee voluntarily dropped coverage to enroll in Marketplace (or if coverage was terminated due to nonpayment), employee can enroll within 31 days of special eligibility situation or during open enrollment (if eligible). *If SLTD or life insurance were terminated, employee may enroll with medical ovidence
New variable- hour, part- time or seasonal employee (Not in a stability period)	Employee's eligibility has not yet been established.	N/A	N/A	If employee returns to work with same employer as a variable-hour, part-time or seasonal employee: Less than a 13-week break (26 weeks if academic employer), the initial measurement period continues. 13-week break or more (26- week break or more if academic employer), the initial measurement period begins the first of the month following return to work.
New full- time employee (Employee is not in a stability period nor on FMLA nor on FMLA nor on military leave)	Eligibility for active benefits ends first of the month following employee's last day of paid work or first of the month following his reduction of hours. Employer sends employee the <u>Your Insurance Benefits When</u> <u>Your Hours are Reduced</u> form. Employer submits termination to PEBA and sends the 18- month COBRA notice to employee.	Refer to COBRA rates	Employee and covered dependents may continue coverage through COBRA for up to 18 months (COBRA qualifying event is reduction of hours). Submit termination in EBS, choose Left Employment.	Eligibility for active benefits begins the first of the month following the employee's return to work or resumption of working 30 hours per week.

# Premium checks quick reference

Type of employer	Submitting insurance checks to PEBA Insurance Finance			
	Active employee	Unpaid leave	Retiree/COBRA/Survivor	
Optional employer	Single check from employer of all active premiums as billed by PEBA Insurance Finance.	Single check from employer; include with active group as billed. Do not send personal employee checks to PEBA Insurance Finance.	Include all premiums for these subscribers in the single check for active employees. Do not send personal employee checks to PEBA Insurance Finance.	
School districts and public higher education institutions	Single check from employer of all active premiums as billed by PEBA Insurance Finance.	Single check from employer; include with active group as billed. Do not send personal employee checks to PEBA Insurance Finance.	PEBA Insurance Finance bills subscribers. Subscribers submit personal checks to PEBA Insurance Finance or have premiums deducted from PEBA retirement benefits annuity payment or other account.	
CG agency	Employee and employer premiums are payroll- deducted by SCEIS and sent directly to PEBA Insurance Finance.	Submit personal employee checks, payable to PEBA Insurance Finance.	PEBA Insurance Finance bills subscribers. Subscribers submit personal checks to PEBA Insurance Finance or have premiums deducted from PEBA retirement benefits annuity payment or other account.	

# **Employer checklists**

Comprehensive PEBA employer checklists for life events are available at peba.sc.gov/publications.

- Enrolling a new hire.
- Adding a dependent due to marriage.
- Adding a dependent due to birth.
- Adding a dependent due to adoption.
- Dropping a dependent due to divorce.
- Leaving employment before retirement eligibility.
- <u>Service retirement</u>.
- Disability retirement.

- Death of a covered employee.
- <u>Death of a covered dependent</u>.

## **Coverage termination processes**

## Termination of employment due to resignation, RIF, dismissal

Effective date is the first of the month after the last day worked.

- □ Submit termination to PEBA immediately. Do not delay!
  - EBS termination: Left Employment.
  - <u>Active Termination Form</u>: Not eligible (T5).
- □ Offer the employee and his spouse and/or children COBRA enrollment information by letter.
- □ Refer to the *COBRA subscribers* section of this manual for additional information.

ASIFlex will send the Medical Spending Account COBRA qualifying event letter to the employee if he qualifies for COBRA continuation. The employee may continue a Medical Spending Account for the rest of the year on an **after-tax basis** through COBRA by electing coverage and paying monthly amounts in a timely manner.

If the terminating employee's spouse is a covered employee or retiree, the terminating employee may be added to the spouse's coverage and other eligible programs within 31 days. If enrolled within 31 days:

- The employee may convert Basic Life, Optional Life, Dependent Life-Spouse and/or Dependent Life-Child coverage.
- The employee may convert SLTD coverage if he meets the criteria.
- If eligible, the employee may continue to contribute to a Health Savings Account directly through HSA Central.

## Termination of employment with transfer to another PEBA-participating employer

- □ Submit termination to PEBA immediately. Do not delay!
  - EBS termination: Transfer.
  - <u>Active Termination Form</u>: Transfer (TT).

Include the group name and number to which the employee is transferring.

□ Offer the employee and his spouse and/or children COBRA enrollment information by letter.

□ Refer to the COBRA subscribers section of this manual for additional information.

Refer to the Transfers and terminations section of this manual for additional information.

## Termination of employment due to retirement (service or disability)

Effective date is the first of the month after retirement eligibility has been established. If it is a disability retirement, the effective date will be the first of the month following the date on the approval letter from PEBA Retirement Benefits or The Standard (BLTD/SLTD) in certain situations.

For more information on retirement eligibility refer to the *Insurance Benefits Guide*.

- □ Submit termination to PEBA immediately. Do not delay!
  - EBS termination: Retired or Disability retired.
  - o <u>Active Termination Form</u>: Service retirement (T7) or Disability retirement (T2).
- □ Provide the <u>Retiree Packet</u> to the employee. The required forms for establishing eligibility, enrolling in retiree insurance, and certifying tobacco or e-cigarette use are included in the packet.
  - Document in the employee's file the date you provided or mailed the *Packet*.
- □ Offer the employee and his spouse and/or children COBRA enrollment information by letter.
- □ Refer to the *COBRA subscribers* section of this manual for additional information.

ASIFlex will send the Medical Spending Account (MSA) COBRA qualifying event letter to the employee if he qualifies for COBRA continuation. The employee may continue the MSA for the rest of the year on an **after-tax basis** through COBRA by electing coverage and paying the monthly amounts in a timely manner.

The employee may continue the MSA for the rest of the year on a pretax basis if:

- The employee declined COBRA continuation coverage;
- The employee elected in advance, on his last enrollment form, to accelerate his pretax deductions up to the full, annual amount; or
- The remainder of his full, annual election was deducted from his final paycheck(s).

Refer to the Retiree subscribers section of this manual for additional information.

## Termination due to death of subscriber

Effective date is the day after date of death, except for Optional Life (date of death).

- □ Submit termination to PEBA immediately. Do not delay!
  - EBS termination: Death.
  - o <u>Active Termination Form</u>: Deceased (T1).

Forward a copy of the death certificate/documentation to PEBA immediately.

- □ Complete the *Life insurance claim form* and send along with coverage verification and beneficiary information to MetLife. If the death was accidental, attach the police/accident report, newspaper article, etc., and write Accidental at the top of the form.
- □ If the employee was receiving disability benefits, send a copy of the *claim form* to The Standard so that any potential benefits may be paid to eligible survivors.
- □ Explain survivor benefits to any covered spouse and/or children.

Refer to the Survivors section of this manual for additional information.

## Termination due to nonpayment of premiums

Effective the first of the month following the last month in which premiums were due and paid in full.

- □ Submit termination to PEBA immediately. Do not delay!
  - <u>Active Termination Form</u>: Nonpayment (TN).

Optional employers should complete the appropriate termination for Retiree, COBRA and Survivor subscribers.

Do not send COBRA notification letters because COBRA does not apply.

If the employee returns to work after coverage has been terminated, reinstatement of coverage must be requested within 31 days of returning to work. Otherwise, the employee and any eligible spouse and/or children must wait until the next open enrollment period or until a special eligibility situation occurs and enroll as late entrants. Returning to work is **not** a special eligibility situation that allows an employee to re-enroll in benefits.

## Termination during military leave

- Submit termination to PEBA immediately. Do not delay!
   <u>Active Termination Form</u>: Military leave (TM).
- □ If not continuing coverage during leave, refer to the information in Military Leave in the Active subscribers chapter.

A copy of the employee's military orders is required.

If the employee does not continue coverage during military leave, refer to the *Military Leave* information in the *Active subscribers* section of this manual. Coverage may be reinstated within 31 days of returning to work.

## Termination of covered spouse and/or child

Coverage changes must be made within 31 days of a special eligibility situation. *Exception*: **State Vision Plan.** Coverage changes may be made during the next October enrollment period.

- □ Submit in EBS or complete a paper <u>Active Notice of Election</u> to terminate coverage and change coverage level, if applicable.
  - Upload or attach any supporting documentation, if applicable. If submitting on paper and, if the subscriber's tobacco-use status has changed, attach a completed <u>Certification Regarding</u> Tobacco or E-cigarette Use form.
- □ Offer the employee and his spouse and/or child(ren) COBRA enrollment information by letter. Refer to the *COBRA subscribers* section of this manual for additional information.
- □ If the spouse or child(ren) is covered under Dependent Life insurance, that coverage can be converted.

#### Death of covered spouse or child

- Complete an Active NOE to terminate coverage of a deceased spouse or child and change coverage level, if applicable.
  - *Effective date:* Day after death.
  - Forward a copy of the form to PEBA.
- □ Complete the *Life Insurance Claim* form and send it, along with coverage verification and beneficiary information, to MetLife for Dependent Life benefits.

□ If applicable, complete *Notice of Election* form and send to PEBA if the employee is making a change to his Medical Spending or Dependent Care Spending account.

## **Retiree orientation checklist**

Determining retiree insurance eligibility is complicated, and only PEBA can make that determination. Provide the <u>Retiree Packet</u> to the employee.

Explain that enrollment in retiree insurance coverage is not automatic. To enroll in retiree insurance, he will first need to confirm his eligibility for retiree group insurance by completing and submitting an <u>Employment</u> <u>Verification Record</u> to PEBA. This may be done up to six months prior to his anticipated retirement date. It is very important to contact PEBA before making final arrangements for retirement.

If PEBA determines that he is eligible for retiree insurance coverage, he must complete and submit the <u>Retiree</u> <u>Notice of Election</u> and any other applicable forms within 31 days of his retirement date. These completed forms should be submitted to PEBA for state agency, public school district or higher education institution employees. These forms may be submitted to the employer's benefits office for optional employers.

At retirement, MetLife will mail a conversion/continuation packet. The packet will include instructions for available options. Call MetLife at 888.507.3767 if the retiree does not receive the packet.

Refer to the *Retiree group insurance* chapter of the <u>IBG</u> for a detailed description of benefits for retirees. Medicare-eligible retirees should refer to the <u>Insurance Coverage for the Medicare-eligible Member</u> handbook.

Explain optional employer funding, if applicable.

#### Health insurance

- □ Review options and benefits.
  - If the employee and his eligible spouse and/or children are not eligible for Medicare, he cannot choose the Medicare Supplemental Plan.
  - If eligible for, or enrolled in, Medicare:
    - Enroll in Part A and Part B for maximum coverage and to avoid the carve-out method of claims payment. The employee must notify his employer and PEBA as soon as he becomes eligible.
    - Subscribers covered by the Medicare Supplemental Plan or the Carve-out Plan will be automatically enrolled in the State Health Plan Medicare Prescription Drug Program, a group-based Medicare Part D Prescription Drug Plan (PDP). In most cases, a retiree will be better served if he remains enrolled in the Medicare Part D plan sponsored by PEBA. If the retiree enrolls in a separate Part D plan, he loses prescription drug coverage with his plan through PEBA; however, his premium through PEBA will not change.
    - If eligible for Medicare, the retiree is no longer eligible for the Savings Plan or an HSA.
- □ If the tobacco-use status for the retiree is changing, attach a <u>Certification Regarding Tobacco or E-</u> <u>cigarette Use</u> form to the <u>Retiree NOE</u>.
- □ Must wait until next open enrollment period or special eligibility situation if **not** enrolled within 31 days of retirement date.

#### **Dental Plus and Basic Dental**

□ Review options and benefits.

□ Must wait until next open enrollment period of an odd-numbered year or special eligibility situation if **not** enrolled within 31 days of retirement date.

#### **State Vision Plan**

- □ Review State Vision Plan benefits.
- □ Must wait until next open enrollment period or within 31 days of loss of other vision coverage if **not** enrolled within 31 days of retirement date.

#### Life insurance

- □ If the employee is eligible for retirement benefits through PEBA, he may choose to continue OR convert his Optional Life coverage with MetLife.
  - MetLife will mail a conversion/continuation packet via U.S. mail three to five business days after MetLife receives the eligibility file from PEBA.
  - To continue coverage, the retiree must complete the form that will be included in his packet from MetLife. Coverage must be elected within 31 days of the date coverage is lost due to approved retirement or approved disability retirement.
  - To convert coverage, the retiree must follow the instructions in the packet from MetLife. Coverage must be converted within 31 days of the date coverage is lost due to approved retirement or approved disability retirement. It is the retiree's responsibility to contact MetLife regarding conversion.

#### Long term disability

- □ Basic Long Term Disability coverage ends at retirement.
- □ Supplemental Long Term Disability coverage ends at retirement.

## MoneyPlus

- □ MoneyPlus is **not** available in retirement (HSA exception below). Generally, an employee's period of coverage for the flexible spending accounts will end at retirement, with this exception:
  - A Medical Spending Account participant may accelerate his pretax deductions, to extend his period of coverage through the end of the plan year. Otherwise, he may continue coverage on an after-tax basis through COBRA as explained in the IBG.

## **Health Savings Account**

□ A retiree may continue to contribute to an HSA as long as he is enrolled in the Savings Plan (or other high deductible health plan) as sole coverage until eligible for Medicare. Contributions in retirement are paid directly to HSA Central or other HSA custodian, not through payroll deduction or ASIFlex.

## Additional information to explain

- □ The retiree will receive from PEBA:
  - A letter confirming retiree coverage.
  - A *Certificate of Creditable Coverage* since active benefits are ending. PEBA will provide a *Certificate of Creditable Coverage* upon request.
  - A COBRA notification letter since active benefits are ending. (BA to send the Qualifying Event Notice according to procedures in **COBRA subscribers** chapter.)
- □ Premiums for health, dental and vision may be paid directly from his PEBA Retirement Benefits annuity payment, if the annuity payment is enough to cover the premiums.

- *Exception*: PEBA bills optional employers and those retirees who are not yet receiving annuity payments from PEBA Retirement Benefits.
- Retirement benefits are paid at the end of the month, for that month (in arrears). However, insurance premiums are deducted at the end of the month, for the next month (in advance).
- Based on the effective date of retirement, when the Retiree NOE is submitted and processing time, more than one month's premiums may be deducted from the first retirement check.
- If retiring due to disability, a copy of the disability approval letter from PEBA Retirement Benefits or Standard Insurance Company must be sent to PEBA as soon as it is received. The effective date for insurance purposes will be the first of the month following the date on the approval letter from PEBA Retirement Benefits or The Standard (if retiree is a State ORP participant or if employer is not a covered employer through PEBA Retirement Benefits).

## **Disability checklist**

- □ The employee should complete and submit an *Application for Disability Retirement* to PEBA Retirement Benefits, if applicable. The BA may apply on behalf of the employee if he is unable to do so.
- □ The employee should initiate their disability claim with The Standard either by phone, online or by completing and submitting a Long Term Disability Claim Form packet to The Standard. The BA may apply on behalf of the employee if he is unable to do so.
- The SLTD premium waiver begins the first of the month after the end of the benefit waiting period.
   Premiums should continue until then. The Standard will contact PEBA, the BA and the employee after approving the claim.
- □ The employee may continue MoneyPlus and HSA contributions while on disability leave. If the employee does not wish to continue MoneyPlus or his HSA, notify ASIFlex via the employer portal that the employee is on leave and will not be continuing his contributions.
- □ If the employee returns to work after a disability:
- Complete and send the <u>SLTD Premium Waiver Form</u> to PEBA.
- □ Contact The Standard.

For more information, see the **Disability subscribers** chapter.

# **Claims checklist**

- □ Make sure you are using the proper claim form for the program as instructed in the **Claims and appeals** chapter.
- □ Be certain that each required section has been completed and the information is legible and correct.
- □ Make sure the claimant's name is listed exactly as it is on the NOE or in EBS.
- Ensure that the SSN or BIN of the employee/retiree is used for himself and for his covered spouse and/or children. The providers use individual Medicare numbers when filing for health benefits through Medicare, with Medicare as the primary payer.
- □ Attach proper and complete documentation as requested, based on the type of claim.
- □ Send the completed claim form to the address listed on the form.
- □ For MoneyPlus flexible spending account claims, keep a copy of the MoneyPlus Claim Form, including any itemized receipts or explanation of benefits statements.
- □ HSA participants are responsible for maintaining their own documentation.

# Accounting system checklist

- □ All balances are due to PEBA on the 10<sup>th</sup> of the month and must be paid as billed. Do not adjust the billing statement.
- □ Payment is due as billed. The collection of premiums has no bearing on payment. Do not delay the regular remittance of monthly premiums due to failure to collect payments from subscribers.
- □ Employers must pay no less than the current employer share of the premiums for their active employees.
- All payments should be made payable to PEBA. If your office also pays for retiree, survivor and COBRA subscriber coverage, submit a separate check for these premiums. See Submitting premium payments to PEBA on Page 144.
- □ You must return a completed remittance advice form with every payment. Do not return any other section of the billing statement with your payment.
- □ Use the return envelope provided, or mail your payment to PEBA's Financial Services Department using the following mailing address:

S.C. PEBA

Attn: Insurance Finance Department

P.O. Box 11661

Columbia, SC 29211

- □ If there is a keying error on the coverage processing section of the bill, please call Customer Service at 803.737.6800 or 888.260.9430.
- □ If you have a question about the Account Summary or Billing Summary, call PEBA's Financial Services Department at 803.734.1696 or 888.260.9430.
- Payment of one month's advance billing is due by July 15 of each year for active employees. The advance billing is the total employer contribution for health, dental, life and LTD as determined by PEBA enrollment files for July.

# Index

## Index

academic retirees, 93 Academic transfers, 71, 73, 78 Accident questionnaires, 129 Accidental Death Benefit, 104 Accounting, 136, 196, 232 accounting rules, 143 Accounting system checklist, 232 Acronyms, 196 Active NOE, 38, 96, 114, 198, 199, 200, 228 Active NOE quick reference, 198, 199, 200 Active Termination Form quick reference, 221 Administrative error, 219 Administrative fee, 88, 145 Adoption Assistance Program, 117, 118 Adoption/placement for adoption, 89, 112, 219 Affordable Care Act, 36, 38, 62, 196, 222 appeals, 95, 104, 123, 127, 128, 130, 133, 135 Assisting a benefits-eligible employee, 39 Assisting an eligible retiree, 92 BA Console, 19, 21, 22, 23, 28, 29, 30, 31, 32 Basic Life, 32, 40, 47, 60, 71, 74, 77, 94, 95, 114, 226 Basic Long Term Disability, 40, 77, 95, 121, 123, 133 Beneficiary changes, 28, 60, 218 Benefit changes, 88 Birth, 26, 66, 89, 111, 112, 201, 217 Change in status, 72, 74 Changes, 22, 26, 31, 32, 51, 52, 54, 58, 59, 60, 74, 143 Child turns age 26, 116 Child younger than age 26, 111 Children, 52, 53, 110, 116 Claims checklist, 231 COBRA, 18, 37, 38, 43, 55, 62, 63, 64, 65, 67, 71, 73, 75, 76, 77, 78, 81, 82, 83, 84, 85, 86, 87, 88, 89, 95, 102, 104, 105, 115, 117, 122, 136, 146, 147, 196, 221, 224, 225, 226, 227, 228, 230, 232 COBRA notices, 81 Comptroller General (CG) agencies, 147 Continuation/conversion, 123 Coordination of benefits, 128 County codes, 197 Coverage changes, 55, 228 coverage in retirement, 96 Coverage termination checklists, 226 Custody or guardianship, 113

Death benefits, 94 Death of covered spouse, 110, 228 Dental, 13, 40, 50, 53, 54, 61, 82, 94, 96, 102, 103, 104, 146, 201, 202, 203, 204, 205, 207, 208, 209, 210, 211, 213, 214, 215 Dependent Care Spending Account, 40, 42, 43, 45, 54, 55, 60, 78, 109, 111, 112, 113, 136, 196 Dependent Life, 13, 20, 22, 38, 40, 41, 48, 50, 51, 53, 58, 59, 74, 76, 77, 94, 95, 97, 101, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 123, 132, 133, 199, 200, 201, 202, 204, 205, 206, 208, 219, 220, 226, 228 determining eligibility, 48 disability benefits, 84, 121, 122, 123, 227 Disability checklist, 231 Disability subscribers, 120 Documentation quick reference, 219, 220 Effective date quick reference, 217, 218, 219 eligibility rules, 36, 42, 113 Employee Benefits Services, 13, 18, 196 Enroll, 13, 46, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 213, 214, 216 enrollment changes, 18, 30, 32, 61 Experience rating, 145 Family and Medical Leave Act, 66, 196 Flexible spending accounts, 59, 95 Former spouse/divorce, 109 gain of other coverage, 22, 54, 62, 63 guardianship, 59, 113, 114, 116, 209, 210, 217, 219 Health insurance, 13, 40, 50, 93, 229 Health Savings Account, 40, 45, 46, 60, 96, 137, 196, 226 Imputed income, 149, 150 Incapacitated child, 115 Initial premium payment period, 87 Issuing credits, 143 late entrants, 40, 50, 59, 77 Life insurance, 13, 40, 41, 50, 58, 77, 94, 130, 230 Life insurance claims, 130 local subdivisions, 88, 92, 103, 145 Long term care, 196 Long term disability claims, 133 Manage subscribers, 20 Manual transactions, 25 Marriage, 23, 89, 108, 198, 205, 217

Medical Spending Account, 40, 42, 43, 54, 55, 60, 77, 81, 82, 88, 95, 109, 111, 112, 113, 128, 135, 136, 196, 226, 230 Mental health and substance use claims, 129 mid-month changes, 143 Military leave, 65, 85 MoneyPlus, 13, 40, 42, 43, 45, 47, 50, 54, 56, 57, 59, 60, 64, 71, 73, 74, 77, 81, 82, 89, 95, 96, 102, 109, 110, 112, 113, 114, 117, 125, 128, 135, 136, 145, 149, 196, 200, 209, 210, 214, 218, 230, 231 MoneyPlus enrollment, 42, 43 MoneyPlus payrolls and accounting, 145 MyBenefits, 18, 21, 22, 23, 28, 29, 30, 31, 32, 41, 47, 48, 61, 130 National Medical Support Notices, 49, 113 Nondiscrimination testing, 149 Online Bill Pay, 27, 144 Open enrollment, 60, 61, 89, 198 Optional Life, 13, 23, 32, 38, 40, 41, 48, 50, 55, 56, 57, 58, 59, 60, 71, 74, 75, 76, 77, 94, 95, 97, 101, 104, 108, 109, 110, 111, 112, 114, 123, 132, 133, 144, 149, 200, 201, 202, 205, 206, 216, 218, 220, 226, 227, 230 payroll center, 38, 59 Permanent, part-time teacher transfers, 72 premium payments, 66, 143 Premiums for retiree, survivor and COBRA subscribers, 147 Prescription drug benefit, 128 Process for medical emergencies, 48 proof of insurance, 14, 111 Quick reference calendar for determining eligibility, 223 Quick reference charts, 198 Quick reference for unpaid leave or reduction in hours, 224

Reclassification, 151 Reinstating coverage after termination, 78 Reports, 136 retiree insurance, 86, 92, 122, 123, 221 Retiree NOE, 76, 92, 96, 229, 231 Retiree orientation checklist, 229 Retiree packet information, 92 Retiree returns to work, 96 Retiree subscribers, 91 Separated spouse, 109 SLTD salary updates, 148 special eligibility situations, 41, 51, 76, 88, 103 Special eligibility situations quick reference, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216 Spouses and children, 82, 107 State Dental Plan and Dental Plus claims, 130 State Health Plan claims, 128 State Vision Plan claims, 104, 130 Submitting premium payments, 144 Supplemental long term disability, 51, 59, 196 Supplemental Long Term Disability, 26, 40, 77, 95, 121, 123, 133, 135, 220 survivor coverage, 101, 103, 104, 105 Termination, 18, 23, 55, 62, 63, 65, 66, 67, 76, 77, 86, 101, 221, 226, 227, 228 Terminations, 26, 38, 55, 76, 133, 226 Transferring in, 72 Transferring out, 71 Transfers, 38, 55, 61, 67, 75, 84, 89, 122, 133 Unpaid leave or reduction in hours, 61, 125 Unpaid leave rules, 143 Vision care, 40 Vision insurance, 50, 94 Workers' compensation, 67 Workplace Possibilities, 121



#### South Carolina Public Employee Benefit Authority

Serving those who serve South Carolina

202 Arbor Lake Drive Columbia, SC 29223

803.737.6800 | 888.260.9430 www.peba.sc.gov



This document does not constitute a comprehensive or binding representation regarding the employee benefits offered by PEBA. The terms and conditions of insurance plans offered by PEBA are set out in the applicable plan documents and are subject to change. The language on this flyer does not create any contractual rights or entitlements for any person. PEBA complies with applicable Federal civil rights and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.888.260.9430. 注意:如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1.888.260.9430

SCPEBA 122021 | Expires 12312022 Data classification: public information