Welcome to MUSC!

Founded in 1824 in Charleston, the Medical University of South Carolina is the oldest medical school in the South. Today, MUSC continues the tradition of excellence in education, research, and patient care. MUSC educates and trains more than 3,000 students and residents, and has nearly 13,000 employees, including approximately 1,500 faculty members. As the largest non-federal employer in Charleston, the university and its affiliates have collective annual budgets in excess of $1.7 billion. MUSC operates a 750-bed medical center, which includes a nationally recognized Children’s Hospital, the Ashley River Tower (cardiovascular, digestive disease, and surgical oncology), Hollings Cancer Center (one of fewer than 70 National Cancer Institute designated centers), Level I Trauma Center, and Institute of Psychiatry. For more information on academic information or clinical services, visit www.musc.edu. For more information on hospital patient services, visit www.muschealth.org.
Records

- Finish Employment Paperwork
- MyRecords
HR Records Staff

Tabatha W. Wilson  843-792-6734
HR Specialist II (A-G)

Tarsha Williams-Smalls  843-792-7190
HR Specialist II (H-O)

Kelley Harrison  843-792-5075
HR Specialist II (P-Z)

Spencer Irving  843-792-9677
HR Specialist II
MUSC NetID and Email

You should have received instructions today on how to activate your MUSC NetID and email.

If you have been employed at MUSC, MUHA, or MUSCP in the past, enrolled as a student, or worked as a volunteer you will need to have your NetID reactivated.

› 4th floor of the library – Library Systems office
› 1st floor of the North Tower
› 2nd floor of Harborview Office Tower (HOT)
My Records  www.musc.edu/hr/university
My Records

MyRecords Main Menu

Close All Browser Windows to Log Out!

- My PayStub
- My Benefits
- My Leave
- My Furlough
- My Immunization/Fit Testing
- My Personal Information
- SuccessFactors
- Flu Shot Decline Form
- W-4 Form
- Withholdings
- Contact Us

Human Resources Home Page

Close All Browser Windows to Log Out!
My Records

- Confirm Personal Data
- "Update Personal Info" to make any updates
## Section 1. Employee Information and Attestation

(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
<th>Middle Initial</th>
<th>Other Names Used (if any)</th>
</tr>
</thead>
<tbody>
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<thead>
<tr>
<th>Address (Street Number and Name)</th>
<th>Apt. Number</th>
<th>City or Town</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
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<thead>
<tr>
<th>Date of Birth (mm/dd/yyyy)</th>
<th>U.S. Social Security Number</th>
<th>E-mail Address</th>
<th>Telephone Number</th>
</tr>
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</tbody>
</table>

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- [ ] A citizen of the United States
- [ ] A noncitizen national of the United States (See instructions)
- [ ] A lawful permanent resident (Alien Registration Number/USCIS Number): ________________________
- [ ] An alien authorized to work until (expiration date, if applicable. mm/dd/yyyy) ____________________. Some aliens may write "N/A" in this field. (See instructions)

For aliens authorized to work, provide your Alien Registration Number/USCIS Number OR Form I-94 Admission Number:

1. Alien Registration Number/USCIS Number: ________________________

   OR

2. Form I-94 Admission Number: ________________________

   If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

   Foreign Passport Number: ________________________

   Country of Issuance: ________________________

   Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (See instructions)

Signature of Employee: ________________________ Date (mm/dd/yyyy): ________________________

---

**Preparer and/or Translator Certification (To be completed and signed if Section 1 is prepared by a person other than the employee.)**

I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator: ________________________ Date (mm/dd/yyyy): ________________________

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Address (Street Number and Name)</th>
<th>City or Town</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>
Assignment Information Sheet

Name: 
SSN: 

Proposed Start Date: 

In compliance with S.C. Code 41-10-30 of the South Carolina Code of Laws, 1976, as amended, you are hereby notified of the terms of employment. This document is not a contract of employment and should not be construed as such.

I understand I am employed in a(n) position at the Medical University of South Carolina.

I will be compensated hourly. My rate of pay will be $0.00 per hour on a base of 0.00 hours biweekly. Date of payment is according to the attached pay schedule. Deductions from pay may include: state and federal income taxes, FICA, plus other benefits/deductions selected. Per MUSC Division of Finance and Administration Policy 9.9, salary payment will be made through Direct Deposit.

As per Bill S618, retiree employees are employed in an at-will status (certain exceptions may apply).

Leave Benefits:
Annual Leave: I am not eligible for paid leave.

Holidays: I am not eligible for paid holidays.

Sick Leave: I am not eligible for paid leave.

Insurance Benefits: I am not eligible for insurance benefits through MUSC.

Retirement Benefits: I am eligible to participate in the State of South Carolina Retirement System. I can choose to enroll in 401(k) only for the first 30 days of employment.

Note: As a retirement and/or health insurance eligible employee, you have up to 30 days from your start date of employment to make your selections. Failure to submit valid selections for your benefits within the first 30 days of employment may result in defaulted retirement enrollment and/or denial of health insurance enrollment. If you currently have funds on deposit in the traditional SCRS plan with the State of South Carolina, your participation is required.

MUSC reserves the right to conduct a criminal record search at any time during employment, should circumstances arise.

Employee Signature ___________________________ Date ___________________________
Employer Signature ___________________________ Date ___________________________
Pay Cycle

Hourly paid employees (Non-exempt) are paid biweekly on every other Wednesday.

Monthly paid employees (Exempt) are paid on the last working day of each month.
Direct Deposit

1. Check the “Type of action”
2. Indicate type of account
   - E.g: savings or checking
3. Bank Name
4. Amount of deposit
   - First row is the net paycheck
   - If additional accounts note dollar amount for each account
5. Date and sign

Suzanne Bean – Payroll
(P) 843-792-9064
(F) 843-792-6157
Location: HOT 5th Floor
Employment Application

PLEASE TAKE A MOMENT TO SIGN YOUR APPLICATIONS
Congratulations from MUSC Human Resources!
Benefits

- Retirement
- Insurance
Dee Crawford, Benefits & Records Manager  792-4674, crawfodi@musc.edu
Patrice Gordon, Benefits Administrator (A-G)  792-9679, gordonp@musc.edu
Lisa Beattie, Benefits Administrator (H-O)  792-5922, beattie@musc.edu
LaDeidra Berry, Benefits Administrator (P-Z)  792-5924, berr@musc.edu
Benefits Fax and Email  792-9533, benefits@musc.edu
Topics to be Covered

• State Retirement Plans
• Supplemental Retirement Plans
• Flexible Spending Plans (Section 125)
• Health, Dental and Vision Insurance
• Life Insurance
• Long Term Disability Insurance
401(a) State Retirement Participation

Mandatory Participation
• Classified, Unclassified Non-Faculty, and Faculty Employees
• Employees with current SCRS accounts (active or inactive)
• Retirees of PEBA Retirement

Optional Participation
• Research Grant and Temporary employees
• Residents and Postdoctoral Scholars
• Employees with annual salaries less than $1,200.00
# Retirement Plan Contributions

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCRS/ORP July 1, 2015</td>
<td>8.16%</td>
</tr>
<tr>
<td>PORS July 1, 2015</td>
<td>8.41%</td>
</tr>
<tr>
<td>SCRS/ORP July 1, 2016</td>
<td>8.16%</td>
</tr>
<tr>
<td>PORS July 1, 2016</td>
<td>8.74%</td>
</tr>
</tbody>
</table>

Pre-tax contribution amount that is determined and set by the SC Public Employee Benefit Authority.
Retirement Plans Overview

Retirement Video

https://www.youtube.com/watch?v=vgUs9y-Kx4M
State Retirement – ORP Vendors

If you elect State ORP you must complete the additional enrollment form with your Vendor.

Valic
- Enoch Booth 843-343-7400 enoch.booth@valic.com
- Mark Taylor 843-442-3715 marksc.taylor@valic.com

MetLife
- Frank Pugliese 843-321-3880 fpugliese@metlife.com

Mass Mutual
- Charlyne Cottrell 843-615-4634 ccottrell@massmutual.com
- Dave Bennett 803-404-0019 davidbennett@massmutual.com

TIAA CREF
- Terry Pait 704-988-4882 tpait@tiaa-cref.org
Police Officers Retirement System (PORS)

Class Two Members (Membership Effective prior to July 1, 2012)
• Retire after 25 years of service or at age 55 or older.
• You must have at least five years of earned service to receive a retirement benefit.

Class Three Members (Membership Effective on or after July 1, 2012)
• Retire after 27 years of service or at age 55 or older.
• You must have at least eight years of earned service to receive a retirement benefit.
Retirement Plan Participation

- PEBA will send an email for you to elect your retirement plan. If you do not respond within 30 days, you will be defaulted to the SCRS plan.
- You have 30 days to elect a retirement plan or Non-Membership, (if eligible).
- Retirement contributions will be withheld from your paycheck and listed as “Undecided” on your pay stub until you make an election.
- If you select Non-Membership as a new hire, you cannot join a retirement plan at a later time unless you are assigned to a position that requires participation.
- Per SC Code of Laws, election of membership is permanent until you separate employment.
Retirement Open Enrollment

• January 1st - March 1st each year
• May switch ORP vendors each year
• If currently enrolled in ORP, may irrevocably elect to switch to SCRS; if by March 1st it is at least 12 months from your initial enrollment date in ORP, but no more than 60 months
RETISSION INFORMATION SHEET

Mandatory Participation
I have been made aware that participation in the State Retirement Plan (SCRS, ORP or PORS) is mandatory for Classified employees and Faculty. I have been informed that employees have thirty days from the effective date of employment to select a retirement plan. If my participation is required and I do not make a decision within the required time period, I will automatically default to the SCRS traditional plan.

Optional Participation
I have been made aware that participation is optional for Temporary employees, Research Grant employees, Residents and Postdoctoral Fellows, unless the employee has a current account (active or inactive) with money on deposit in the SCRS traditional plan. I have been informed that employees have thirty days from the effective date of employment to select a retirement plan. If my participation is optional and I do not make a decision within the required time period, I will automatically default to the State Retirement Plan (SCRS).

If I select Non-Membership, I may not enroll at a later time unless I am assigned to a position that requires my participation.

Enrollment
I will receive an email from PEBA Retirement to the address provided in which I must respond with my retirement election. If I do not respond within 30 calendar days of my first day of employment I will be defaulted to SCRS and this election is irrevocable. After 30 calendar days the election I make cannot be changed. Beneficiary elections are made separately. Should I choose the South Carolina Optional Retirement Program (ORP), I am required to select an approved investment provider and complete an enrollment form for the selected provider. I understand that I must forward the enrollment form to the HR Benefits Office of my provider choice so that my contributions may be deposited correctly. Failure to do so may result in the default of my contributions and the loss of interest earnings.

Changing Plans
I understand that if I wish to change plans I must do so within 30 calendar days of my hire date. I understand that membership in the SCRS traditional plan is irrevocable until I separate employment. I understand that should I elect to participate in the South Carolina ORP I may irrevocably change to the SCRS traditional plan during the designated open enrollment period of January 1 – March 1 during the years for which I have between one and five years of State ORP service. This change may not be made at any other time.

Resources
I have received a verbal and written overview of the South Carolina Retirement Systems plans (traditional and ORP) or SC Police Officers Retirement plan. I have received a “Select Your Retirement Plan” booklet or have been notified that electronic access to this booklet may be obtained at http://www.retirement.sc.gov/publications/select.pdf. Additional information regarding retirement may be accessed online at http://www.retirement.sc.gov or by calling the HR Benefits Office at (843) 792-2507 or the South Carolina Retirement System at (800) 868-9002.

EMPLOYEE INFORMATION
NOTE: If you currently have funds on deposit in the Retirement System, you may not elect non-membership.

1. Last Name & Suffix 2. First/Middle Name 3. Social Security Number
13. Telephone Number 14. Email Address
15. Have you ever been a member of PEBA’s retirement system? 16A. If “Yes” indicate the name(s) of your former employer:
   [ ] No  [ ] Yes
16B. Did you withdraw your contributions?
   [ ] No  [ ] Yes
17. Do you currently have a pending refund request? 18. Are you now receiving or have you applied to receive a monthly benefit from any of PEBA’s retirement systems?
   [ ] No  [ ] Yes  [ ] Application in Process

By signing below I acknowledge that all information provided is correct to the best of my knowledge, and I understand and agree to the terms of this page's content.

Employee Signature Date

Employer Signature Date
# ACTIVE MEMBER BENEFICIARY FORM

**Beneficiary Designation. Contingent beneficiary for active members only. Retirees use Form 7201.**

SC Public Employee Benefit Authority
South Carolina Retirement Systems
P.O. Box 11960, Columbia, SC 29311-1969

Use for designation of active member beneficiaries and contingent beneficiaries. You may wish to consult with an attorney/estate planner before completing this form.

## Section I: Personal Information

<table>
<thead>
<tr>
<th>1. Last Name &amp; Suffix</th>
<th>2. First/Middle Name</th>
<th>3. Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>4. Date of Birth</th>
<th>5. Address</th>
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</table>

## ALL SECTIONS MUST BE COMPLETED

### Section II-A: Beneficiary(ies) for refund of contributions/survivor benefits

- I designate the following primary beneficiary(ies) to receive my Retirement Systems refund of contributions or survivor benefits if eligible:

<table>
<thead>
<tr>
<th>1. Name of Beneficiary (ONE PERSON)</th>
<th>Social Security #</th>
<th>Sex</th>
<th>Date of Birth</th>
<th>Relationship</th>
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<thead>
<tr>
<th>2. Name of Beneficiary (ONE PERSON)</th>
<th>Social Security #</th>
<th>Sex</th>
<th>Date of Birth</th>
<th>Relationship</th>
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<table>
<thead>
<tr>
<th>3. Name of Beneficiary (ONE PERSON)</th>
<th>Social Security #</th>
<th>Sex</th>
<th>Date of Birth</th>
<th>Relationship</th>
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</table>

### Section II-B: Contingent Beneficiary(ies) have no rights unless all primary beneficiaries have died. I designate the following contingent beneficiary(ies) to receive my Retirement Systems refund of contributions or applicable survivor benefits. If the contingent beneficiary designation below is blank, all previous contingent beneficiaries will be revoked and your estate will become your contingent beneficiary:

<table>
<thead>
<tr>
<th>1. Name of Beneficiary (ONE PERSON)</th>
<th>Social Security #</th>
<th>Sex</th>
<th>Date of Birth</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
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</table>

<table>
<thead>
<tr>
<th>2. Name of Beneficiary (ONE PERSON)</th>
<th>Social Security #</th>
<th>Sex</th>
<th>Date of Birth</th>
<th>Relationship</th>
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<thead>
<tr>
<th>3. Name of Beneficiary (ONE PERSON)</th>
<th>Social Security #</th>
<th>Sex</th>
<th>Date of Birth</th>
<th>Relationship</th>
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</table>

### Section III: Beneficiary(ies) for incidental death benefit

- You may not designate contingent beneficiaries for the incidental death benefit. I designate the following beneficiary(ies) to receive my Retirement Systems Incidental Death Benefit:

<table>
<thead>
<tr>
<th>1. Name of Beneficiary (ONE PERSON)</th>
<th>Social Security #</th>
<th>Sex</th>
<th>Date of Birth</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Name of Beneficiary (ONE PERSON)</th>
<th>Social Security #</th>
<th>Sex</th>
<th>Date of Birth</th>
<th>Relationship</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>3. Name of Beneficiary (ONE PERSON)</th>
<th>Social Security #</th>
<th>Sex</th>
<th>Date of Birth</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

### Section IV: Certification and Conditions

**IMPORTANT:** Please read the Certification and Conditions sections of the instructions on the reverse (Page 2) before signing this form. I hereby certify I have read and understand the information on the reverse (Page 2), including the certification and conditions, and I agree to the provisions stated.

**MEMBER’S SIGNATURE**

**WITNESS**

**STATE OF**

**COUNTY OF**

Admired before me this date __________________________

**NOTARY NAME**

My Commission Expires __________________________

**NOTARY SIGNATURE**

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS AND DOES NOT CREATE A CONTRACT BETWEEN THE MEMBER AND THE SOUTH CAROLINA RETIREMENT SYSTEMS. THE SOUTH CAROLINA RETIREMENT SYSTEMS RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT.
**STATE ORP ACTIVE INCIDENTAL DEATH BENEFIT**
**BENEFICIARY DESIGNATION**
South Carolina Retirement Systems
SC Public Employee Benefit Authority
Attention: Enrollment
P.O. Box 11960, Columbia SC 29211-1960

CHECK ONE:
☐ State ORP New Enrollee
☐ State ORP Active Incidental Death Benefit Beneficiary Change

---

### Section I  PERSONAL INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Last Name &amp; Suffix</td>
</tr>
<tr>
<td>2.</td>
<td>First/Middle Name</td>
</tr>
<tr>
<td>3.</td>
<td>Social Security Number</td>
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<tr>
<td>4.</td>
<td>Date of Birth</td>
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<tr>
<td>5.</td>
<td>Address</td>
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<tr>
<td>6.</td>
<td>City</td>
</tr>
<tr>
<td>7.</td>
<td>State</td>
</tr>
<tr>
<td>8.</td>
<td>ZIP+4</td>
</tr>
</tbody>
</table>

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### Section II  BENEFICIARY(IES) FOR ACTIVE INCIDENTAL DEATH BENEFIT

I designate the following beneficiary(ies) to receive the State ORP Group Life Insurance:

1. **Name of Beneficiary (ONE PERSON)**
   - Social Security #
   - Sex: ☐ M ☐ F
   - Date of Birth
   - Relationship

2. **Name of Beneficiary (ONE PERSON)**
   - Social Security #
   - Sex: ☐ M ☐ F
   - Date of Birth
   - Relationship

3. **Name of Beneficiary (ONE PERSON)**
   - Social Security #
   - Sex: ☐ M ☐ F
   - Date of Birth
   - Relationship

4. **Name of Trustee(s)**
   - Trust ID, if applicable
   - Address of Trustee(s)

5. **Name of Trust Beneficiary (ONE PERSON)**
   - Social Security #
   - Sex: ☐ M ☐ F
   - Date of Birth
   - Relationship

6. **Name of Trust Beneficiary (ONE PERSON)**
   - Social Security #
   - Sex: ☐ M ☐ F
   - Date of Birth
   - Relationship

---

### Section III  CERTIFICATION AND CONDITIONS

**IMPORTANT:**
Please read the Certification and Conditions section of the instructions on Page 2 before signing this form. I hereby certify I have read and understand the information on Page 2, including the certification and conditions, and I agree to the provisions stated.

**MEMBER’S SIGNATURE**

(Do not print)

**WITNESS**

(Required only when signed by mark)

**STATE OF**

COUNTRY OF

**ACKNOWLEDGED BEFORE ME THIS DATE**

**NOTARY NAME**

**MY COMMISSION EXPIRES**

**NOTARY SIGNATURE**

(Out of state, requires Seal)
Supplemental Retirement Plans

Funded by voluntary employee contributions.
Plans can be started year round.

- SC Deferred Compensation Program
  Empower Retirement Services
- Tax Sheltered Annuity Plans

- Traditional 457 (Pre-tax)
- Roth 457 (Post-tax)
- Traditional 401(k) (Pre-tax)
- Roth 401(k) (Post-tax)
- 403(b) (Pre-tax)

$18,000 limit*
$18,000 limit*

*Add'l $6,000 if over age 50

- Diversification of investment choices
- Both 401(k) plans and 403(b) have a penalty for early withdrawals (age 59 1/2)
- The 457 plan has a three year catch-up provision
- The 457 will not accept the TERI account or any other plan rollover

MUSC accepts no responsibility for nor recommends any product presented.
MUSC has no financial interest in any presenting company and/or product and assumes no responsibility for services provided by the presenting company.
BREAK

Up Next: Insurance Benefits
Insurance Guidelines

Effective Date

- First day of the following month after you begin active employment; unless you begin employment on the first working day of the month

Initial New Hire Period

- May make a change to any insurance selected within 31 days of your hire date

*THE INFORMATION CONTAINED IN THIS PRESENTATION IS MEANT TO BE AN OVERVIEW. EMPLOYEES ARE RESPONSIBLE FOR READING BENEFIT DETAILS FOUND IN THE IBG.
Insurance Guidelines

Family Covered by State Insurance

• The Public Employee Benefit Authority (PEBA) does not allow an employee to cover their spouse or children on health, dental, vision or life insurance if they are covered by another parent who has State insurance.
• This guideline results in lower premiums for the entire family!

Transfer from another State Insurance Entity

• If you have less than a 15 day break in service, you must continue the same coverage you had with your previous employer.
Affordable Care Act Guidelines

- There are no pre-existing condition limitations for health insurance.
- Dependent children can stay on health, dental and vision until age 26 even if they are eligible for another employer’s insurance. (age 19-25 for life insurance if they are a FT student)
- Free preventive exams are available (eg. well child visit, well woman visit, etc.).
Documentation Required for Dependents

In an effort to control costs, PEBA will audit subscribers who cover dependents to ensure that only eligible dependents are insured.

According to experts, 4 to 8% of the dependents covered under an employer-sponsored plan are ineligible for coverage. Based on these estimates, if only 4% of dependents are ineligible, it will save our self-insured plan more than $19 million a year!
### Enrollment Documentation Worksheet

This is a list of acceptable documentation to prove the relationship of family members you are adding to coverage. **Please be sure to submit photocopies only, originals will not be returned to you.** If you do not have the required documentation, you may have to pay a fee to receive one from the governmental agency that has the original. We encourage you to request your documentation as soon as possible since this process may take several weeks and many agencies increase fees for expedited delivery.

- Marriage license/birth certificate: [http://www.cdc.gov/nchs/w2w.htm](http://www.cdc.gov/nchs/w2w.htm)

#### Legal Spouse:
- Marriage license

#### Former Spouse:
- Photocopy of divorce decree ordering the subscriber to cover the former spouse

#### Common Law Spouse:
- Common Law Marriage Affidavit

#### Natural Child:
- A copy of a birth certificate (long form) showing the subscriber as the parent

#### Step Child:
- A copy of the birth certificate showing the name of the natural parent (long form), plus proof that the natural parent and the subscriber are married (see Legal Spouse/Common Law Spouse requirement from above)

#### Adopted Child:
- Court documentation verifying completed adoption or
- A letter of placement from an adoption agency, an attorney or the S.C. Department of Social Services, verifying the adoption is in progress

#### Foster Child:
- A court order or other legal document placing the child with the subscriber, who is a licensed foster parent

#### Other Children:
- For all other children for whom a subscriber has legal custody, a court order or other legal document granting custody of the child to the subscriber. Documentation must verify the subscriber has guardianship responsibility for child, not merely financial responsibility

#### Incapacitated Child:
- [Incapacitated Child Certification Form](http://www.cdc.gov/nchs/w2w.htm) plus proof of relationship. See the appropriate child type (natural, step, adopted, foster or other) in the above list for acceptable proof of relationship

By signing below, I understand that failure to provide the required documents will delay my benefits being activated. Payroll will begin deducting premiums in an effort to avoid having to collect multiple premiums from one check, but coverage will not be active until all documentation is received. I also understand that if I do not provide the required documentation within 60 days, my benefits will be canceled and all premiums will be refunded to me. I will need to wait to enroll in insurance due to a special event or an open enrollment period (October odd years).

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Sign name</th>
<th>Date</th>
</tr>
</thead>
</table>
MONEYPUL$ Enables you to deduct expenses before taxes are calculated - lowering your taxable income!

**Pre-tax Insurance Premiums** *(Eligible Immediately)*
- Pay health, dental, vision and optional life* premiums before taxes
- ($.28 monthly administration fee)
  - *Pre-tax premiums up to $50,000 in optional life coverage*

**Dependent Care Spending Account** *(Eligible Immediately)*
- Allocate pre-tax funds to reimburse for dependent care expenses for children age 12 and younger ($5,000 maximum)
- $3.14 monthly administration fee
- All funds at calendar year-end are forfeited

**Medical Spending Account** *(Eligible Immediately)*
- Allocate pre-tax funds to pay for you/family’s eligible medical, dental, vision & prescription expenses ($2,550 maximum)
- $3.14 monthly administration fee
- All remaining funds not used by March 15th of the following year are forfeited
MONEYPLUS ENROLLMENT FORM
Plan Year 2016

You must complete this form if you wish to start a tax-free Medical Spending and/or Dependent Care Spending Account or to enroll in or change a Health Savings Account.

Please be sure to read the IMPORTANT information on the back of this form. Submit your completed form to your Sanefit Administrator. Please press hard with a black ballpoint pen.

<table>
<thead>
<tr>
<th>Name (Please Print)</th>
<th>Last</th>
<th>First</th>
<th>MI</th>
<th>Social security #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mailing Address</td>
<td>Street (if applicable) continue to P.O. Box:</td>
<td>City</td>
<td>Zip</td>
<td>State (if applicable)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Address</td>
<td>Street (if applicable) continue to P.O. Box:</td>
<td>City</td>
<td>Zip</td>
<td>State (if applicable)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Complete Section A to enroll in or to change a Health Savings Account. Additional forms will be required to establish your HSA. Refer to your Tap-Flex Accounts Guide for more information. If you would also like to enroll in a limited-use Medical Spending Account (LUSA) for dental and vision expenses, complete Section B. To enroll in a Medical Spending Account, complete Section C. In Box #6, include the dollar amount you expect to contribute for the upcoming plan year. In Box #9, indicate the number of regular payroll checks you will receive during the upcoming plan year. In Box #12, indicate the reduction amount per paycheck. (Note: If Box #9 times Box #3 does not equal Box #1, the amount in Box #12 may be changed subjectively by WageWorks due to rounding.)

A Health Savings Account (Additional forms are required)

<table>
<thead>
<tr>
<th>NEW ACCOUNT</th>
<th>CONTRIBUTION AMOUNT CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B Limited-Use Medical Spending Account

<table>
<thead>
<tr>
<th>NEW INVESTMENT</th>
<th>RE-INVESTMENT Accounting interest only</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C Medical Spending Account

<table>
<thead>
<tr>
<th>NEW INVESTMENT</th>
<th>RE-INVESTMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

D Dependent Care Spending Account (for child/dependant day care)

<table>
<thead>
<tr>
<th>NEW ENROLLMENT</th>
<th>RE-ENROLLMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If YOU ENROLL IN A HEALTH SAVINGS ACCOUNT (SECTION A), YOU CANNOT ENROLL IN A MEDICAL SPENDING ACCOUNT (SECTION C), BUT MAY ENROLL IN A LIMITED-USE MEDICAL SPENDING ACCOUNT (SECTION B).

Please read reverse side before signing this form below.

EMPLOYEE SIGNATURE:

DATE:

If YOU ARE ELIGIBLE to participate, notify the Employer if the employees is eligible for the Account(s) in which the expenses are allowable. If the Employee has not enrolled in an HSA, certify that the employee is also enrolled in the State’s Health Plan Savings Plan Plan, and, if applicable, has correctly accounted for the Employer Contribution.

EMPLOYER/BENEFITS ADMINISTRATOR SIGNATURE:

DATE:

Note: Tap-Flex: Individuals in Group Health Plans that are Tap-Flex plans (e.g., HMO or PPO) may participate in Tap-Flex accounts as described above.

MUSC Changing What’s Possible | MUSC.edu
# ACTIVE EMPLOYEE NOTICE OF ELECTION (NOE)

**SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY
INSURANCE BENEFITS**

## ACTION
- [ ] New Hire
- [ ] Transfer
- [ ] Change

**Type of Change**
- [ ] Enrollment Other (specify)
- [ ] BA Use Only
- [ ] Permanent PTEE (20 hrs.)
- [ ] Refuse
- [ ] Yes

**Date of Change Event**

**Group ID**
- [ ] Group Name

**Eligible due to the Affordable Care Act:**
- [ ] Full time permanent
- [ ] Variable Hour

1. **Soc. Sec. # (SSN)**
2. **Last Name**
3. **BIA #**
4. **First Name**
5. **M.I.**
6. **Date of Birth**

7. **City**
8. **State**
9. **Zip Code**
10. **County Code**
11. **Annual Salary**
12. **Date of Hire**

## ELIGIBLE INFO

### MEDICARE

**Name**

**Medicare #**

- [ ] Age
- [ ] Disability
- [ ] Renal Disease

- [ ] Age
- [ ] Disability
- [ ] Renal Disease

### HEALTH PLAN

- [ ] Refuse or select one plan and one level of coverage
- [ ] MUSC
- [ ] ITRCARE
- [ ] Employee
- [ ] Employee/Spouse
- [ ] Family

### STATE DENTAL PLAN

- [ ] Refuse
- [ ] Employee
- [ ] Employee/Spouse
- [ ] Family

### DENTAL PLUS

- [ ] Refuse
- [ ] Employee
- [ ] Employee/Spouse
- [ ] Family

### DEPENDENT LIFE - CHILDREN

- [ ] Refuse
- [ ] Employee
- [ ] Employee/Spouse
- [ ] Family

### VISION CARE

- [ ] Refuse
- [ ] Employee
- [ ] Employee/Spouse
- [ ] Family

### Optional Life

- [ ] Refuse
- [ ] Employee
- [ ] Employee/Spouse
- [ ] Family

### 2014 DEPENDENT LIFE - CHILDREN

- [ ] Refuse
- [ ] Employee
- [ ] Employee/Spouse
- [ ] Family

### Additional Beneficiaries

- [ ] Other

**Date of Birth**

**Social Security Number**

**Last Name**

**First Name**

**Relationship**

**Date of Birth**

**Citizenship**

**Date of Birth**

## EMPLOYEE PER allerdings

### ADD (A) OF DEPENDENT(S)

- [ ] Spouse
- [ ] Child

**Dependent SSN#**

**Last Name**

**First Name**

**Sex**

**Relationship**

**Date of Birth**

**Indicate Special Status**

- [ ] Does PERSA Insurance Benefits already cover your spouse?
- [ ] Yes
- [ ] No

**Date of Birth**

**Sex**

**Relationship**

**Date of Birth**

**Indicate Special Status**

- [ ] Full-time Student
- [ ] Full-time Student

**Date of Birth**

**Sex**

**Relationship**

**Date of Birth**

**Indicate Special Status**

- [ ] Full-time Student
- [ ] Full-time Student

## CERTIFICATION & AUTHORIZATION

1. I hereby certify that I am covered by this notice.

2. The beneficiary is an estate or trust, complete the following:

   - [ ] Estate/Trust

   **Address**

   **Date**

3. Always list spouse. List eligible children to be covered. If not listed, they will not be covered. For a child age 19-24 to be eligible for Dependent Life coverage, your child must be eligible according to the requirements on the reverse of this NOE.

4. **Employee Signature**

5. **Beneficiary Administrator Signature**

**PERSA INSURANCE BENEFITS GUIDELINES**

**COPY TO EMPLOYERS**

**MUSC**

**Changing What’s Possible | MUSC.edu**
# 2016 Comparison of Health Plan Benefits for MUSC Employees

<table>
<thead>
<tr>
<th></th>
<th>MUSC Health Plan: Basic</th>
<th>MUSC Health Plan: Basic + Plus</th>
<th>MUSC Health Plan: Total Plus</th>
<th>Premiums</th>
<th>Max Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monthly Premiums</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Employee</strong></td>
<td>$74.65</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Employee/Spouse</strong></td>
<td>$153.36</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Employee/Children</strong></td>
<td>$124.98</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Full Family</strong></td>
<td>$223.54</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tobacco users</strong></td>
<td></td>
<td></td>
<td></td>
<td>50.00</td>
<td>52.95</td>
</tr>
<tr>
<td><strong>Tobacco users</strong></td>
<td></td>
<td></td>
<td></td>
<td>52.46</td>
<td>56.10</td>
</tr>
<tr>
<td><strong>Tobacco users</strong></td>
<td></td>
<td></td>
<td></td>
<td>13.73</td>
<td>16.50</td>
</tr>
<tr>
<td><strong>Tobacco users</strong></td>
<td></td>
<td></td>
<td></td>
<td>223.54</td>
<td>278.80</td>
</tr>
</tbody>
</table>

## Availability

- **MUSC Network, approved pediatrics, National Allergy & Asthma, and Doctors Care**
- **Outside MUSC Network**
  - Standard State Health Plan approved providers
  - Not in MUSC Network and not a Standard State Health Plan approved provider

## Annual Deductibles

<table>
<thead>
<tr>
<th></th>
<th>Tier A</th>
<th>Tier B</th>
<th>Tier C</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Single</strong></td>
<td>$225</td>
<td>$440</td>
<td>$5,000</td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td>$770</td>
<td>$800</td>
<td>$10,160</td>
</tr>
</tbody>
</table>

Deductible is 20% of physician visits, certain outpatient services, and hospital facility charges associated with inpatient hospital stay, PT, OT, & Speech Therapy are subject to deductible and co-insurance.

### Co-insurance Maximum

- **Excludes deductible**
  - **Single Family**
    - $2,200
  - **Family**
    - $4,400

Additional copays may apply for each professional service provided. See MUSC Health Plan Summary of Benefits.

## Annual Deductible & co-insurance do not apply

- **Physicians Office Visits**
  - $25 - Rapid Access Clinic & Primary Care Physician copay
  - $45 - Specialist Physician copay
  - $50 - copay for ACA approved preventive visits & annual women's exam

## Outpatient

- 20% copay for hospital surgical outpatient, 57% for radiology & $20 for Pathology.

## Hospitalization

- Deductible and 20% coinsurance for physician fees, but no copay for inpatient hospital services.

## Urgent/Emergency Care

- Urgent: $75 copay at Doctor's Office, ER: $150
- copay, plus deductible & co-insurance

### MUSC Retail Pharmacy

- Tier 1 (Generic): $0
- Tier 2 (Brand): $2
- Tier 3 (Brand): $3
- Tier 4 (Mail order up to 30 day supply): $5

### Mail Order

- Tier 1 (Generic): $2
- Tier 2 (Brand): $3
- Tier 3 (Mail order up to 30 day supply): $5

### Co-pay Maximum

- $2,500

Please refer to the website [https://www.musc.edu/medcenter/muschealthplan/index.html](https://www.musc.edu/medcenter/muschealthplan/index.html) to ensure you are viewing the latest version of this chart. Refer to your 2016 Insurance Benefits Guide for information on how this plan coordinates with Medicare.

Subscribers who use tobacco or cover dependents who use tobacco will pay a tobacco surcharge - $250 per month for subscriber-only coverage, $600 monthly for other levels of coverage.

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

• The MUSC Health Plan requires notification within 24 hours of any specific diagnosis, injury or illness. It is the subscriber's responsibility to call Medi-Call to notify the insurance. There are monetary penalties for failure to obtain certification when required. You must also notify them within the 1st trimester of pregnancy.

• Employees on a J1 VISA are required to enroll in the MUSC Health Plan which meets the requirement of the VISA.

• The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers to offer all employees and/or their eligible dependents continuing group health, dental and vision insurance for up to 18 months if they meet specific qualifications.
  • COBRA coverage requires payment of full premiums
  • Letter of COBRA coverage sent to all new employees and exiting employees
TRICARE Supplement

• Employees eligible for TRICARE may choose to enroll in the TRICARE Supplement sponsored by the American Military Retirees Association (AMRA).

• The TRICARE Supplement Plan is secondary coverage to TRICARE. It pays the subscriber’s share of covered medical expenses under the TRICARE Prime (in-network), Extra and Standard options. Eligible participants have almost 100 percent coverage.

• Eligible individuals must be registered with the Defense Enrollment Eligibility Reporting System (DEERS) and must not be eligible for Medicare.
Tobacco Surcharge

Effective January 1, 2010, the SC Budget and Control Board approved a monthly surcharge be added to the health insurance premiums of tobacco users. The MUSC Health Plan is self-insured. All premiums are placed in a fund and used to pay claims. Illnesses caused and contributed to by tobacco use increase costs to the plan.

The subscriber is charged based on the level of health insurance.

- Enrollee Only: $40/month
- Enrollee/Child(ren): $60/month
- Enrollee/Spouse: $60/month
- Family: $60/month

Employees are required to certify whether they, or anyone covered on their insurance, are tobacco users. Tobacco use is smoking tobacco in such forms as a cigarette, pipe or cigar, or using smokeless tobacco, such as snuff or chewing tobacco (nicotine chewing gum is excluded). A non-tobacco user is someone who has not used tobacco within the past six months.
Tobacco Surcharge

If you fail to complete the certification you will automatically be charged the tobacco-user surcharge. Once the certification is completed, the surcharge will be removed the first of the month after the certification is received.

If a subscriber certifies that all dependents covered are non-tobacco users and it is determined that you or any of your covered dependents have used tobacco products within the past six months or started using tobacco products after the date of your certification as non-tobacco user(s), and you did not update your certification, you will be subject to penalties including, but not limited to:

› Payment of the additional surcharge, plus a 10-percent penalty, for each month since your last certification.
› Elimination of the out-of-pocket maximum for the current and the subsequent year.
Certification regarding tobacco use

Check the appropriate box, sign and return to S.C. PEBA, 202 Arbor Lake Drive, Columbia, SC 29223.

Subscriber name: ___________________________  Subscriber BIN/SSN: ___________________________

Non-tobacco user premium

☐ I certify that I am eligible for the Non-Tobacco-User Premium by checking this box and returning this form to PEBA. By checking this box, I certify truth and understanding of the following:
  • I certify that all persons covered on my health insurance coverage through PEBA (including myself and any dependents) are not currently using, and have not used, any tobacco products in any form (cigarettes, cigars, pipe, oral tobacco products, etc.) within the last six months.
  • I certify that if this information changes at any time in the future, while I have health insurance coverage through PEBA, I will notify PEBA of such change within 30 days through completion and resubmission of this form.
  • I certify that this information is true and correct to the best of my knowledge.
  • I understand that if it is determined that I (or any of my covered dependents) have used tobacco products within the last six months or if I (or any of my covered dependents) start using tobacco products subsequent to the date of this certification without notifying PEBA, I will be subject to penalties including, but not limited to, payment of premium difference since last certification plus a 10 percent penalty and elimination of tobacco user’s out-of-pocket maximum for current year and subsequent year.
  • I understand that this change in premiums will be prospective (apply only to premiums I pay in the future). I will not be refunded any part of the Tobacco-User Premium I have already paid.

☐ I certify that I am eligible for the Non-Tobacco-User Premium by checking this box and returning this form to PEBA Insurance Benefits. By checking this box, I certify truth and understanding of the following:
  • I certify that all covered individuals who use tobacco have completed the Quit for Life® smoking cessation program.
  • I certify that this information is true and correct to the best of my knowledge.
  • I understand that this change in premiums will be prospective (apply only to premiums I pay in the future). I will not be refunded any part of the Tobacco-User Premium I have already paid.

Tobacco user premium

☐ I acknowledge that I will pay the Tobacco-User Premium by checking this box. I declare that one or more persons covered on my health insurance coverage through PEBA uses tobacco products in some form or that I choose not to disclose my status as it relates to tobacco use. I understand that by not making an election I am choosing to pay the Tobacco-User Premium. Please do not send me this certification again unless upon request.

Subscriber signature: ___________________________  Date: ___________________________
Mental Health & Substance Abuse

- Must use In-Network Providers
- Visits are billed through your medical insurance
- Pre-Authorization is necessary
Basic Dental

Class I - Preventive Services
• 100% of Allowable Charges

Class II - Basic Services
• 80% of Allowable Charges with $25 deductible

Class III - Prosthodontics
• 50% of Allowable Charges after $25 deductible

Class IV – Orthodontics
• 50% of Allowable Charges after $25 deductible
• $1000 Lifetime Benefit (dependents under age 19)

• The yearly maximum for each dependent is $1,000.
• Allowable Charge - The maximum amount paid for a covered service.
Dental Plus

• Same coverage as carried on Basic Dental Plan
• Raises the allowable charge
• Annual maximum benefit is $2,000 per dependent
• **NO** additional orthodontia benefits
• **Employee must pay the basic premium in addition to the plus premium**

![Image of children brushing teeth]
# Basic Dental Plan v. Dental Plus Plan

Examples provided by MUSC Dental Faculty Practice

<table>
<thead>
<tr>
<th>Service (Fee)</th>
<th>Basic Plan</th>
<th>Dental Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Insurance Pays</td>
<td>Patient Pays</td>
</tr>
<tr>
<td>Preventative &amp; Diagnostic Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaning ($77)</td>
<td>$30.10</td>
<td>$46.90</td>
</tr>
<tr>
<td>PANO X-ray ($96)</td>
<td>$42.10</td>
<td>$53.90</td>
</tr>
<tr>
<td>Bitewing X-ray ($55)</td>
<td>$19.30</td>
<td>$35.70</td>
</tr>
<tr>
<td>Comprehensive Exam ($72)</td>
<td>$19.30</td>
<td>$52.70</td>
</tr>
<tr>
<td><strong>Total ($300):</strong></td>
<td><strong>$110.80</strong></td>
<td><strong>$189.20</strong></td>
</tr>
<tr>
<td></td>
<td><strong>$300.00</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Basic Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surface Filling ($166)</td>
<td>$27.12</td>
<td>$138.88</td>
</tr>
<tr>
<td>Major Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Porcelain Crown ($1099)</td>
<td>$195.50</td>
<td>$903.50</td>
</tr>
<tr>
<td></td>
<td>$487.50</td>
<td>$611.50</td>
</tr>
</tbody>
</table>
Basic Life Insurance

- Free with enrollment in any health plan
- $3,000 coverage
Optional Term Life Insurance

• As a new hire, an employee may select up to 3 times their current salary, without providing medical evidence
• Employee may select up to $500,000 if medical evidence is approved within 31 days of hire date
• Premiums based on coverage and age
• Accidental Death and Dismemberment Benefits
  • Accidental Death equal to amount of life insurance
  • Dismemberment Benefits (see IBG for schedule of benefits)
  • Seat Belt (25%) and Air Bag (5%) Riders for automobile accidental death
  • Felonious Assault Benefit
  • Day Care Benefit- the lesser of 5% of the face value or $10,000 per year, 2-year max
  • Education Benefit- the lesser of 5% of the face value or $5000 per year, 4-year max
• Repatriation Benefit
Dependent Life Insurance

**Spouse**

**With Employee Coverage**
- $10,000 or $20,000 - with no medical evidence needed
- May increase up to 50% of employee’s coverage or $100,000 - if medical evidence is approved

**Without Employee Coverage**
- Only $10,000 or $20,000
- Premium is based on amount of coverage and employee’s age

**Dependent Child(ren)**
- $15,000 – no medical evidence needed
- Premium is $1.10 for any number of children
Basic Long Term Disability

Free with enrollment in any health insurance plan

• Monthly benefits
  • 62.5% of base salary
  • Maximum monthly benefit is $800 per month (may be insufficient for annual salaries over $15,000)
• 90 day waiting period
• Benefits are coordinated with other group benefits - Sick Leave, Annual Leave, Retirement, Social Security, Workers’ Compensation, etc.
• Pre-existing conditions will not be covered for 12 months from date of coverage.
Supplemental Long Term Disability

- Premium based on salary and age.
- Monthly benefits
  - 65% of base salary up to $147,692/year.
  - Maximum monthly benefit is $8,000 per month.
  - Minimum monthly benefit is $100 per month.
- 90 or 180 day waiting period
- Benefits are coordinated with other group benefits - Sick Leave, Long Term Disability, Retirement, Social Security, Workers’ Compensation, etc.
- Pre-existing conditions will not be covered for 12 months from date of coverage.

**Clinical Providers are not eligible for benefits as they are covered by MUSC Physicians disability insurance.**
Vision Care Discount Program

• Is free for all State Employees and their dependents.
• The program offers discounted vision care services. Participating providers have agreed to charge no more than $60 for a routine eye examination and offer a 20% discount on all eyewear (except disposable contact lenses).
• You must contact your vision provider to see if they are a participant of this program.
# State Vision Plan - 2015

<table>
<thead>
<tr>
<th>Vision Care Services</th>
<th>In-Network Member Cost</th>
<th>Out-of-Network Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exam With Dilation as Necessary</strong></td>
<td>$10 Copay</td>
<td>Up to $35</td>
</tr>
<tr>
<td><strong>Contact Lens Fit and Follow-Up</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard Contact Lens Fit &amp; Follow-Up</td>
<td>$0 Copay, paid in full fit and two follow up visits</td>
<td></td>
</tr>
<tr>
<td>Premium Contact Lens Fit &amp; Follow-Up</td>
<td>$0 Copay, 10% off retail price, then apply $55 Allowance</td>
<td>Up to $40</td>
</tr>
<tr>
<td><strong>Retinal Imaging</strong></td>
<td>Up to $599</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td>$0 Copay, $150 Allowance, 20% off balance over $150</td>
<td>Up to $70</td>
</tr>
<tr>
<td><strong>Standard Plastic Lenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>$10 Copay</td>
<td></td>
</tr>
<tr>
<td>Bifocal</td>
<td>$10 Copay</td>
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</tr>
<tr>
<td>Trifocal</td>
<td>$10 Copay</td>
<td></td>
</tr>
<tr>
<td>Lenticular</td>
<td>$10 Copay</td>
<td></td>
</tr>
<tr>
<td>Standard Progressive Lenses</td>
<td>$35 Copay</td>
<td></td>
</tr>
<tr>
<td>Premium Progressive Lenses</td>
<td>$55 Copay</td>
<td></td>
</tr>
<tr>
<td>Tier 1</td>
<td>$55 Copay-$80 Copay</td>
<td></td>
</tr>
<tr>
<td>Tier 2</td>
<td>$55 Copay</td>
<td></td>
</tr>
<tr>
<td>Tier 3</td>
<td>$65 Copay</td>
<td></td>
</tr>
<tr>
<td>Tier 4</td>
<td>$50 Copay</td>
<td></td>
</tr>
<tr>
<td>$35 Copay, 80% of charge less $120 Allowance</td>
<td>Up to $75</td>
<td></td>
</tr>
<tr>
<td><strong>Lens Options</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UV Treatment</td>
<td>$0</td>
<td>Up to $5</td>
</tr>
<tr>
<td>Tint (Solid and Gradient)</td>
<td>$0</td>
<td>Up to $5</td>
</tr>
<tr>
<td>Standard Plastic Scratch Coating</td>
<td>$0</td>
<td>Up to $5</td>
</tr>
<tr>
<td>Standard Polycarbonate—Adults</td>
<td>$30 Copay</td>
<td>Up to $5</td>
</tr>
<tr>
<td>Standard Polycarbonate—Kids under 19</td>
<td>$0</td>
<td>Up to $5</td>
</tr>
<tr>
<td>Standard Anti-Reflective Coating</td>
<td>$45</td>
<td>N/A</td>
</tr>
<tr>
<td>Premium Anti-Reflective Coating</td>
<td>$57-$58</td>
<td></td>
</tr>
<tr>
<td>Tier 1</td>
<td>$57</td>
<td>N/A</td>
</tr>
<tr>
<td>Tier 2</td>
<td>$68</td>
<td>N/A</td>
</tr>
<tr>
<td>Tier 3</td>
<td>$80% of charge</td>
<td></td>
</tr>
<tr>
<td>Transitions</td>
<td>$60</td>
<td>Up to $5</td>
</tr>
<tr>
<td>Photochromic Plastic</td>
<td>20% off retail price</td>
<td>N/A</td>
</tr>
<tr>
<td>Polarized</td>
<td>20% off retail price</td>
<td>N/A</td>
</tr>
<tr>
<td>Other Add-Ons and Services</td>
<td>20% off retail price</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Contact Lenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conventional</td>
<td>$0 Copay, $130 Allowance, 15% off balance over $130</td>
<td>Up to $104</td>
</tr>
<tr>
<td>Disposable</td>
<td>$0 Copay, $130 Allowance, plus balance over $130</td>
<td>Up to $104</td>
</tr>
<tr>
<td>Medically Necessary</td>
<td>$0 Copay, Paid in Full</td>
<td>Up to $200</td>
</tr>
<tr>
<td><strong>Laser Vision Correction</strong></td>
<td>15% off the retail price or 5% off the promotional price</td>
<td>N/A</td>
</tr>
<tr>
<td>LASIK or PRK from U.S. Laser Network</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Additional Pairs Discount</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Members also receive a 40% discount off complete pair eyeglass purchase and 15% off conventional contact lenses once the funded benefit has been used.</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

Frequency
- Examination: Once every year
- Lenses or Contact Lenses: Once every year
- Frame: Once every two years
Short Term Disability

- Short term disability not provided by the state Insurance Program
- AFLAC/ American Fidelity Assurance Company provides short term disability to new hires; no medical evidence needed
- Premiums are available for payroll deduction
Changes to Employee Benefits
(Must be made within 31 Days)

Initial Changes
(Within 31 days of your hire date)
• Add/Drop health, dental, or vision coverage for yourself or dependents
• Add/Drop Optional and Dependent Life and Supplemental Long Term Disability

Qualifying Event Changes
(31 Days from Date of Event)
• Marriage
• Separation/Divorce
• Birth/Adoption
• Death
• Employment/Insurance Change of Dependent
Year Round Allowable Changes

The following changes are allowed anytime during the year with medical evidence of good health:

- Add/Increase Dependent Spouse Life Insurance
- Add/Increase Supplemental Long Term Disability
- Increase Optional Life with medical evidence-if NOT enrolled in the Pre-tax Premium feature

The following changes are allowed anytime during the year:

- Add dependent life insurance for child(ren)-no medical evidence required
- Drop Dependent Life, Supplemental Long Term Disability
- Change beneficiaries
Insurance Enrollment Periods

**OCTOBER 1st – OCTOBER 31st**
Changes made during October will be effective January 1st of the following year

**OPEN ENROLLMENT-every year**
- Add/drop health and/or vision coverage for yourself or dependents
- Enroll/re-enroll in MoneyPlu$ Dependent Care, and/or Medical Spending Accounts for the following year
- Increase Optional Life with medical evidence (if enrolled in the Pre-tax Premium feature)
- Any special changes allowed for the year

**OPEN ENROLLMENT-odd numbered years**
- All of the above mentioned changes
- Add/drop dental for yourself or dependents
- Add/drop Dental Plus
CHECKOUT

Please organize the following items for the Benefits Counselors to review:

- Retirement Enrollment/Beneficiary Forms
- Retirement Information Sheet
- Insurance Enrollment (NOE) Form
- Wageworks MoneyPlu$ Enrollment Form
- Tobacco Certification Form
- Dependent Documentation Form
- Dependent Documentation (if applicable)