Exiting Employment – COBRA Information

PEBA COBRA Information:
https://www.peba.sc.gov/cobra

MUSC University COBRA/Leaving Employment:
https://web.musc.edu/human-resources/university-hr/benefits/cobra-and-leaving-employment

Attached you will find the **COBRA NOE form**, **Tobacco Certification** and **2024 COBRA rates**.

Your active insurance coverage will terminate the first of the month after last day employed.

If you do not wish to enroll in COBRA, please contact PEBA at 888-260-9430 to request a Credible Coverage Letter. This letter may be needed in the future to prove the loss of coverage.

If you do wish to enroll in COBRA coverage, you would simply complete the COBRA NOE form and Tobacco Certification. Mail both forms to PEBA Insurance Benefits (PO Box 11661, Columbia, SC 29211) with a check to cover the initial premium. Once you leave employment and enroll in COBRA, PEBA will become your Benefits Administrator, not MUSC.

You have 60 days from the date of loss of coverage or the date the notification of COBRA rights is sent (whichever is later) to elect to continue coverage under COBRA. You can carry COBRA for up to 18 months. You have 45 days from the date of election to make your initial payment to PEBA for premiums. The initial payment must include the COBRA premiums back to the date of the loss of coverage. Example: if your active coverage terminates on 01/01/2024 and you elect COBRA coverage mid-February, you would need to send premiums for January and February. Coverage would retro to 01/01/2024.

COBRA coverage will not be activated and claims will not be paid until the initial premium payment is received. Following the initial premium payment, subsequent payments are due on the 10th of the month for that month. COBRA subscribers have a 31-day grace period to pay.

In the example above, premiums for March would be due March 10. The subscriber has until April 10 to pay premiums. If the subscriber does not make a payment within the 31-day grace period, his coverage will terminate and he loses all continuation rights under the plan. Upon termination of COBRA coverage, please contact PEBA directly at 888-260-9430 to request a Credible Coverage Letter. The Credible Coverage Letter may be needed in the future to prove loss of outside coverage.

COBRA NOTICE OF ELECTION (NOE) FOR MUSC AND MUHA

SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY

MC

See Instructions - if completing by hand use black ink

You must also complete a *Certification Regarding Tobacco Use* form within 31 days of enrolling in health coverage and whenever the status of tobacco use changes for you or a dependent covered under your health insurance.

ELIGIBILITY

Select One

☐ Left Employment (RIF'd, resigned, transferred, retired, fired)
☐ Had reduction in hours of employment ☐ Called to active duty
☐ Divorced ☐ Separated ☐ Dependent Child Eligibility Ended

Employee/Retiree Social Security number (SSN)

Date of Qualifying Event (MM/DD/YYYY)

Benefits Administrator Signature N/A

Employer ID:

ACTION

Select One

☐ New Subscriber ☐ Termination Due to Non-Payment of Premiums *(otherwise, use Notice to Terminate COBRA Continuation Coverage)*

☐ Change *(Specify)*

Date of Change Event _____ SSN Change - Incorrect # *(Attach copy of Social Security card)*

Name Change - Prior Name

PEBA Use Only

Employer ID:

Effective Date: _____

Group ID:

ENROLLEE INFO

1. Social Security number or BIN	2. Last Name	3. Suffix	4. First Name	5. M.I.	6. Date of Birth (MM/DD/YYYY)

7. Sex	8. Marital Status	9. Home Phone #	10. Email Address
☐ M ☐ F	☐ Single ☐ Divorced ☐ Widowed ☐ Married ☐ Separated		

11. Mailing Address	12. Apt.	13. City	14. State	15. Zip Code	16. County Code

COVERAGE

17. HEALTH PLAN *(Refuse or select one plan and one level of coverage)*

PLAN	COVERAGE LEVEL
☐ Refuse	☐ Subscriber
☐ MUSC Health Plan	☐ Subscriber/Spouse
☐ TRICARE Supplement	☐ Subscriber/Child(ren)
	☐ Family
	☐ Child(ren) only

18. DENTAL *(Refuse or select one plan and one level of coverage)*

PLAN	COVERAGE LEVEL
☐ Refuse	☐ Subscriber
☐ Dental Plus	☐ Subscriber/Spouse
☐ Basic Dental	☐ Subscriber/Child(ren)
	☐ Family
	☐ Child(ren) only

19. VISION CARE *(select one)*

☐ Refuse
☐ Subscriber
☐ Subscriber/Spouse
☐ Subscriber/Child(ren)
☐ Family
☐ Child(ren) only

MEDICARE

20. List yourself and any other persons to be covered who are eligible for Medicare Part A and/or Part B.

Name	Medicare #	Eligible due to	Effective Date	
			Part A (MM/DD/YYYY)	Part B (MM/DD/YYYY)
		☐ Age ☐ Disability ☐ Renal Disease		
		☐ Age ☐ Disability ☐ Renal Disease		

DEPENDENTS

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

Add (A) or Delete (D)	Dependent SSN	Last Name	First Name	Sex	Relationship	Date of Birth (MM/DD/YYYY)	Indicate Special Status
	Spouse						Does PEBA Insurance Benefits already cover your spouse? ☐ Yes ☐ No
	Child						☐ Incapacitated
	Child						☐ Incapacitated
	Child						☐ Incapacitated

CERTIFICATION & AUTHORIZATION

22. CERTIFICATION: I have read this NOE and made authorizations herein and selected the coverage noted. I have provided Social Security numbers and documentation establishing my dependent(s)' eligibility for the plan(s) selected. I understand and agree that all selected plans will not become effective unless and until this NOE is submitted and the first payment is made. I understand my COBRA continuation coverage rights and responsibilities, as explained in the election notice and attachments provided to me. I also understand that the State reserves the right to alter benefits or premiums at any time to preserve the financial stability of the Plan. I further acknowledge that the eligibility status of any covered individual is subject to audit at any time.

AUTHORIZATION: I authorize any healthcare provider, prescription drug dispenser and claims administrator to release any information necessary to evaluate, administer and process claims for any benefits.

DISCLAIMER: THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS. THE AGENCY 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.

Enrollee/Guardian Signature _____ Date _____

INSTRUCTIONS FOR COMPLETING THE COBRA NOTICE OF ELECTION (NOE) FOR MUSC AND MUHA

You must also complete a *Certification Regarding Tobacco Use* form within 31 days of enrolling in health coverage and whenever the status of tobacco use changes for you or a dependent covered under your health insurance.

ELIGIBILITY: Indicate the reason you are enrolling under COBRA for the first time. New COBRA enrollees should also indicate date of the qualifying event (i.e., date left employment, disability approved by Social Security, divorce, child ineligible, etc.). If you are already enrolled in COBRA and are making a change, skip to the Action section.

ACTION: If you are enrolling in COBRA for the first time, select New Subscriber. If you are already enrolled and are making a change, select Change and enter the type of change and date of the change event.

ENROLLEE INFORMATION: Blocks 1-16 must be completed for all transactions, including termination of coverage. If coverage is for dependent children only, enrollee information should be for the youngest child or, if applicable, for a child covered under Medicare; additional children should be included as dependents in block 21. In block 16, enter the county code of your mailing address.

COUNTY CODES:

01 Abbeville	07 Beaufort	13 Chesterfield	19 Edgefield	25 Hampton	31 Lee	37 Oconee	43 Sumter
02 Aiken	08 Berkeley	14 Clarendon	20 Fairfield	26 Horry	32 Lexington	38 Orangeburg	44 Union
03 Allendale	09 Calhoun	15 Colleton	21 Florence	27 Jasper	33 McCormick	39 Pickens	45 Williamsburg
04 Anderson	10 Charleston	16 Darlington	22 Georgetown	28 Kershaw	34 Marion	40 Richland	46 York
05 Bamberg	11 Cherokee	17 Dillon	23 Greenville	29 Lancaster	35 Marlboro	41 Saluda	99 Out of S.C
06 Barnwell	12 Chester	18 Dorchester	24 Greenwood	30 Laurens	36 Newberry	42 Spartanburg	

COVERAGE. ALTERATIONS IN THIS SECTION ARE NOT ALLOWED:

Block 17. HEALTH: Select one health plan and one level of coverage or select Refuse. Changes from one health plan to another are allowed only during designated enrollment periods (exception: changing plans due to eligibility for Medicare). The Savings Plan is available only to non-Medicare-eligible enrollees and dependents. If you refuse health coverage or fail to enroll yourself and all eligible dependents within 30 days of eligibility, you can enroll yourself and/or your eligible dependents during an open enrollment period or within 30 days of a special eligibility situation.

Block 18. DENTAL: If you refuse dental when first eligible, you can apply for coverage for yourself and your dependent(s) only during an open enrollment period during an odd-numbered year or within 31 days of a special eligibility situation. For dependents to be covered, they must be listed in **Block 21**, and the appropriate level of coverage must be selected.

Block 19. VISION CARE: Select a level of vision care coverage to enroll or Refuse. If you refuse coverage or fail to enroll yourself and all eligible dependents within 30 days of eligibility, you can enroll yourself and/or your dependents during the next enrollment period (October) or within 30 days of a special eligibility situation.

Block 20: MEDICARE List yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare. Please contact PEBA if you or your dependents are eligible for Medicare before you elect COBRA coverage.

Block 21. DEPENDENTS: Legal documentation is required for all dependents. If you select a level of coverage that includes a spouse and/or dependent child(ren), they must be listed to be covered. A spouse can only be covered as a dependent if he is not an employee or retiree of an employer that participates in the state of South Carolina Insurance Benefits Program. If your spouse is an employee or retiree of an employer covered by PEBA insurance, check Yes. A child younger than 26 is eligible for health, dental and vision coverage. Misstatements on the NOE may result in termination of the dependent's coverage and recoupment of benefits paid on behalf of the ineligible dependent.

CERTIFICATION AND AUTHORIZATION: Read this block carefully, sign and date form. Send the original form and copies of any required documentation to PEBA Insurance Benefits, P.O. Box 11661, Columbia, SC 29211. Keep a copy for your records.

PEBA
SC Retirement Systems and State Health Plan

South Carolina Public Employee Benefit Authority
Serving those who serve South Carolina

Certification Regarding Tobacco or E-cigarette 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 or e-cigarette user

❑ I certify that I am eligible for the non-tobacco-use 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 or electronic cigarettes 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 31 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 or electronic cigarettes within the last six months or if I (or any of my covered dependents) start using tobacco products or electronic cigarettes 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 the 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-use premium I have already paid.

❑ I certify that I am eligible for the non-tobacco-use 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 covered individuals who use tobacco or electronic cigarettes 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-use premium I have already paid.

Tobacco or e-cigarette user

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

Subscriber signature: _____ Date: _____

Benefits administrator signature:_____ Date: _____

2024

Monthly insurance premiums for COBRA subscribers

PEBA℠ SC Retirement Systems and State Health Plan

Rates may vary for optional employers. Verify rates with your benefits office.

18 and 36 months

	Subscriber	Subscriber/ spouse	Subscriber/ children	Full family	Children only
MUSC Health Plan[1]	$586.18	$1,281.98	$957.32	$1,609.46	$371.14
Savings Plan[1]	$496.44	$1,102.50	$831.46	$1,412.02	$335.02
Medicare Supplemental[1,2]	$586.18	$1,281.98	$957.32	$1,609.46	$371.14
Dental Plus	$43.14	$80.94	$96.28	$124.56	$53.16
Basic Dental	$13.76	$21.54	$27.74	$35.52	$14.00
State Vision Plan	$6.44	$12.86	$13.82	$20.24	$7.38
Tobacco-use premium[1]	$40.00	$60.00	$60.00	$60.00	$60.00

29 months

	Subscriber	Subscriber/ spouse	Subscriber/ children	Full family	Children only
MUSC Health Plan[1]	$862.02	$1,885.26	$1,407.82	$2,366.86	$545.80
Savings Plan[1]	$730.06	$1,621.32	$1,222.74	$2,076.52	$492.68
Medicare Supplemental[1,2]	$862.02	$1,885.26	$1,407.82	$2,366.86	$545.80
Dental Plus	$43.14	$80.94	$96.28	$124.56	$53.16
Basic Dental	$13.76	$21.54	$27.74	$35.52	$14.00
State Vision Plan	$6.44	$12.86	$13.82	$20.24	$7.38
Tobacco-use premium[1]	$40.00	$60.00	$60.00	$60.00	$60.00

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

[2]If the Medicare Supplemental Plan is elected, claims for covered subscribers not eligible for Medicare will be based on the Standard Plan provisions.