

Exiting- COBRA Information

<https://www.peba.sc.gov/cobra>

<https://web.musc.edu/human-resources/university-hr/benefits/cobra-and-leaving-employment>

Attached find the COBRA NOE form, Tobacco Certification and 2022 Cobra Rates.

Your active insurance coverage will terminate the 1st of the month after last day employed. If you wish to enroll for Cobra coverage, you would simply complete the COBRA NOE form and Tobacco Certification- and send to PEBA Insurance, (address on bottom of page 2), with a check to cover the initial premium. Once you leave employment 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 07/01/2022 and you elect COBRA coverage mid-August; you would need to send premiums for July & August. Coverage would retro to 07/01/2022.

COBRA coverage will not be activated and claims will not be paid until the initial 45-day 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 September would be due September 10. The subscriber has until October 10 to pay premiums. 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. In addition, PEBA will send you a Certificate of Creditable Coverage letter listing covered dependents, types of coverage lost & the termination date. This letter may be needed in the future to prove loss of outside coverage.

Please note if you were terminated from employment due to gross misconduct, you will not be eligible for coverage under COBRA.

COBRA NOTICE OF ELECTION (NOE) FOR MUSC AND MUHA
SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY



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 <input type="checkbox"/> Left Employment (RIF'd, resigned, transferred, retired, fired) <input type="checkbox"/> Had reduction in hours of employment <input type="checkbox"/> Called to active duty <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Dependent Child Eligibility Ended	Employee/Retiree Social Security number (SSN)	Date of Qualifying Event (MM/DD/YYYY)
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Benefits Administrator Signature <u>N/A</u>	Employer ID: _____
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Select One <input type="checkbox"/> New Subscriber <input type="checkbox"/> Termination Due to Non-Payment of Premiums (<i>otherwise, use Notice to Terminate COBRA Continuation Coverage</i>) <input type="checkbox"/> Change (<i>Specify</i>) Date of Change Event _____ SSN Change - Incorrect # _____ <i>(Attach copy of Social Security card)</i> Name Change - Prior Name _____	PEBA Use Only Employer ID: _____ Effective Date: _____ Group ID: _____
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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 <input type="checkbox"/> M <input type="checkbox"/> F	8. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Separated	9. Home Phone #	10. Email Address		
11. Mailing Address	12. Apt.	13. City	14. State	15. Zip Code	16. County Code

17. HEALTH PLAN (<i>Refuse or select one plan and one level of coverage</i>) PLAN <input type="checkbox"/> Refuse <input type="checkbox"/> MUSC Health Plan <input type="checkbox"/> TRICARE Supplement COVERAGE LEVEL <input type="checkbox"/> Subscriber <input type="checkbox"/> Subscriber/Spouse <input type="checkbox"/> Subscriber/Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> Child(ren) only	18. DENTAL (<i>Refuse or select one plan and one level of coverage</i>) PLAN <input type="checkbox"/> Refuse <input type="checkbox"/> Dental Plus <input type="checkbox"/> Basic Dental COVERAGE LEVEL <input type="checkbox"/> Subscriber <input type="checkbox"/> Subscriber/Spouse <input type="checkbox"/> Subscriber/Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> Child(ren) only	19. VISION CARE (<i>select one</i>) <input type="checkbox"/> Refuse <input type="checkbox"/> Subscriber <input type="checkbox"/> Subscriber/Spouse <input type="checkbox"/> Subscriber/Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> Child(ren) only
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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	
		<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> Renal Disease	Part A (MM/DD/YYYY)	Part B (MM/DD/YYYY)
		<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> Renal Disease		

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? <input type="checkbox"/> Yes <input type="checkbox"/> No
					Child		<input type="checkbox"/> Incapacitated
					Child		<input type="checkbox"/> Incapacitated
					Child		<input type="checkbox"/> Incapacitated

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.	Date _____
Enrollee/Guardian Signature _____	

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.

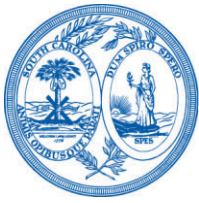
Block 18. DENTAL: If you refuse dental when first eligible, you can apply for coverage for yourself and your dependent(s) only during an open enrollment period during an odd-numbered year or within 31 days of a special eligibility situation. For dependents to be covered, they must be listed in **Block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



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: _____

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.

2022 Monthly insurance premiums for COBRA subscribers



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	\$510.40	\$1,078.58	\$784.72	\$1,351.78	\$274.32
Savings Plan¹	\$420.66	\$899.10	\$658.88	\$1,154.34	\$238.22
Medicare Supplemental^{1,2}	\$510.40	\$1,078.58	\$784.72	\$1,351.78	\$274.32
Dental Plus	\$40.90	\$76.40	\$91.02	\$117.74	\$50.14
Basic Dental	\$13.76	\$21.54	\$27.74	\$35.52	\$14.00
State Vision Plan	\$6.06	\$12.12	\$13.02	\$19.08	\$6.96
Tobacco-use premium¹	\$40.00	\$60.00	\$60.00	\$60.00	\$60.00

29 months

	Subscriber	Subscriber/ spouse	Subscriber/ children	Full family	Children only
Standard Plan¹	\$750.58	\$1,586.14	\$1,154.02	\$1,987.90	\$403.44
Savings Plan¹	\$618.60	\$1,322.20	\$968.94	\$1,697.56	\$350.34
Medicare Supplemental^{1,2}	\$750.58	\$1,586.14	\$1,154.02	\$1,987.90	\$403.44
Dental Plus	\$40.90	\$76.40	\$91.02	\$117.74	\$50.14
Basic Dental	\$13.76	\$21.54	\$27.74	\$35.52	\$14.00
State Vision Plan	\$6.06	\$12.12	\$13.02	\$19.08	\$6.96
Tobacco-use premium¹	\$40.00	\$60.00	\$60.00	\$60.00	\$60.00

¹State 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 he covers uses tobacco or e-cigarettes, or covered individuals who use tobacco or e-cigarettes have completed the Quit For Life[®] tobacco cessation program.

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