Welcome to the University of South Carolina. We’re thrilled to have you as a member of our team! This booklet provides a summary of the insurance and retirement benefits, privileges and services for which you may be eligible as a qualifying employee of the University of South Carolina.

The University of South Carolina is a participating employer in South Carolina state government benefit programs, administered by the SC Public Employee Benefit Authority (PEBA). Whether you have recently joined the University as a new employee or are a candidate for employment, we hope you find this information helpful. If you would like additional information, please feel free to call the Benefits Office at 803-777-6650 or visit the Human Resources website at sc.edu/hr. Please remember that we encourage new employees to be prepared to make their benefits decisions within 7 days of your hire date and most benefits options should be selected within 30 days of your start date.

This document does not create a contract of employment. All benefits and an individual’s right to them are subject to state regulations, University Policies and Procedures, the individual plan documents and the duly executed and recorded enrollment forms.
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Benefits Eligibility

One of the first steps in properly reviewing and selecting your benefits is to determine your eligibility.

Full Benefits Offerings

To qualify for full benefit offerings under state and University insurance plans, you must be employed in a state-defined FTE position working at least 20 hours a week. Research grant-funded and time-limited employees may be eligible for full benefits, if funded and specified in their grant agreement. Full benefits offerings include health, dental, vision, life, disability, flexible spending accounts, and retirement options. Additionally, supplemental offerings are also offered which include cancer, hospital confinement and auto and home insurance coverage.

Faculty and staff in FTE positions are required by state law to participate in a retirement program. Employees in other position types who previously opted into the South Carolina Retirement System (SCRS) program and continue to show established time within the SCRS program may be required to continue participation.

Upon receipt of your hiring paperwork from your department, a benefits counselor will send you a welcome email with a link to an online orientation resource. For your convenience, you may access this orientation prior to receiving your welcome email.

Limited Benefits Offerings through the Affordable Care Act (ACA)

Employees in other position types (temporary, temporary faculty positions, non-funded research grant or time-limited positions, eligible students, etc.) initially hired with a scheduled work week of 30 hours or more are eligible for health, dental, vision and retirement benefits, but not life or disability coverage, according to ACA, PEBA and University of South Carolina guidelines.

Please note that if you are eligible for insurance (whether you decide to enroll or refuse) you will be required to come off of your spouse’s coverage if they are enrolled under another PEBA participating entity.

Medicare eligible PEBA retirees and their Medicare eligible dependents (whether you decide to enroll or refuse active group coverage) will be required to refuse PEBA coverage. Medicare eligible employees and dependent(s) should contact Medicare directly at 1-800-MEDICAR (1-800-633-4227) to inquire about the impacts and options of electing active group coverage in coordination with Medicare.

According to ACA guidelines, employees initially hired with a scheduled work week of less than 30 hours per week will be placed in a measurement period of one year, which begins the first of the month following your hire date. If it is determined at the conclusion of that year that you
qualify for benefits based on averaging at least 130 hours per month, you will be extended insurance based on ACA guidelines. In this instance, insurance rights will continue for one year (if employed) regardless of the scheduled number of work hours during that year.

Upon determination of eligibility by the Benefits Office, a benefits counselor will send you an email with a link to an online orientation resource. For your convenience, you may access [this orientation](#) prior to receiving your email. Please note that any reference to life and disability insurance included in this orientation does not apply to ACA eligible employees.

### Optional Pension Program Participation

New employees in temporary, temporary faculty positions, funded research grant or time-limited positions are extended an opportunity to participate in or opt out of pension program benefits. If non-election of membership does not take place within 30 days of your hire date, you are automatically enrolled in the South Carolina Retirement System (SCRS) program. There are certain guidelines that may require participation and will be reviewed accordingly based on PEBA guidelines. Please note that non-funded research grant or time-limited employees are required to opt out of pension program benefits.

Upon determination of eligibility by the Benefits Office, a benefits counselor will send you an email with a link to an online orientation resource. For your convenience, you may access [this orientation](#) prior to receiving your email.

### Eligible Dependents

You may cover either your lawful spouse, or a former spouse (if required by a divorce decree or court order), but not both. However, if your spouse, or former spouse is an employee of a South Carolina state-covered entity or a retiree, each of you must carry your own insurance coverage (based on the insurance for which you qualify), and you may not duplicate coverage for the same dependent children.

You may cover any of your children under the health, dental, or vision plans as long as s/he is under age 26 (with the exception of incapacitated children). Incapacitated children may continue to be covered past age 26, if s/he is an incapacitated unmarried child incapable of self-sustaining employment because of a disability and is principally dependent on you for support (incapacity must be established within 90 days prior to age 26, or prior to age 19 for Dependent Life Child coverage). The PEBA incapacitation review and determination process may take up to 30 days. For additional information regarding what is needed, please speak with your assigned benefits counselor.

For your dependent spouse and children, you must provide proof of relationship, date of birth and social security number. This information is subject to review, prior to a determination of coverage enrollment. Please see page 24 for a list of acceptable documents to show proof of relationship. These documents will need to be included with your insurance.
enrollment paperwork. Your insurance cannot be activated without this information.

**Effective Dates of Coverage**

As a new hire, the effective date of coverage for the various insurance plans for which you enroll is the first day of the month following your date of hire. However, if you begin work on the first workday of the month, you may choose an effective date of the first of that month or the first of the following month*.

If you are an employee whose eligibility has to be assessed over a year for ACA purposes, your insurance coverage will be effective the first of the month following your qualification for coverage.

As applicable, the effective date for retirement program membership is your initial date of hire.

Depending on when your hiring paperwork is completed and received by the Benefits Office, you may not have completed your enrollment forms by the effective dates described above. However, as long as your insurance forms are completed and submitted within 31 days of your start date (pension forms must be completed within 30 days of your date of hire), your coverage is retroactive to the appropriate effective date. Please make a note that each month insurance premium deductions are scheduled to be taken one month in advance and are retroactive to the effective date of coverage.

*Note: Please notify the Benefits Office immediately if you begin your employment in a leave without pay status. For insurance purposes, the effective date will be deferred until you actually start work, whereas pension membership will still be effective as of the date of hire.

**Insurance Costs and Payroll Deductions**

Employees are paid on the 15th and the last workday of each month. If these dates fall on the weekend or a holiday, you will be paid the business day preceding the weekend or holiday. Generally, time worked up to that date will be included (with the exception of temporary employees who are paid on a 2 week lag). Employees are required to have your paychecks direct deposited to the checking and/or savings account of your choice.

Each month insurance premiums are scheduled to be deducted one month in advance for the following month. Depending on when your coverage is effective and when the Payroll Office receives your enrollment forms, the first paycheck following enrollment may include payroll deductions for up to two months of premiums. You should always check your electronic pay stub after enrolling, or making any insurance changes, to make sure the appropriate premiums are being deducted. Please contact the Payroll Office at 803-777-4227 with questions about your payroll deductions.
Rates for the health insurance plans are provided on page 26. Rates for the dental and vision care plans are provided on pages 8-9. Optional and dependent life rates are provided on pages 27-29.

When your hiring documents and benefits enrollment forms have been processed, you will be able to access information about your paycheck, benefits, leave status and other personal information through the Visual Information Processing system (VIP) by using a personal identification number (PIN) that you select. For your first 30 days of employment, your PIN will be your birth month and date. You must change your PIN to keep it active.

You may also find more specific information about your insurance benefits at the PEBA Insurance Benefits division’s website and your retirement benefits at the PEBA Retirement Benefits website.

**Insurance Coverage**

**Health Insurance**

There are three health insurance plans from which to choose. The two State Health Plans include the **Standard Plan** or the **Savings Plan**. The third plan, **Tricare Supplement Plan**, is only extended to active and retired service members. The comparison chart on page 26 provides a more detailed description of plan summaries and cost.

**State Health Plans**

The State Health Plan offers a choice between two different insurance plans, **Standard Plan or Savings Plan**. These plans are self-insured and funded by premiums paid to the plan. Claims are processed by Blue Cross-Blue Shield of South Carolina. Most medical services must be medically necessary in order to be covered, with the exception of the following routine services: Pap smears, mammograms, Well-Child Care, colonoscopies and the preventative worksite screening benefit. The Savings Plan also covers a routine physical (later discussed in this section).

Payment of these services is subject to program plan guidelines. Both plans have an annual deductible that **must be met before co-insurance benefits are paid**. After the deductible is met, you will pay part of the expenses until you meet an annual out-of-pocket maximum. After the out-of-pocket maximum is met, you are covered for 100% of eligible charges for the remainder of the year (according to plan provisions and guidelines).

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Deductible Details</th>
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<tbody>
<tr>
<td>Standard Plan</td>
<td>$445 for individual coverage</td>
</tr>
<tr>
<td></td>
<td>$890 for family coverage</td>
</tr>
<tr>
<td>Savings Plan</td>
<td>$3,600 for individual coverage</td>
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</tbody>
</table>
$7,200 for family coverage

**Medi-Call (Medical preauthorization requirement of the State Health Plans):**
Preauthorization is required within 48 hours for all hospital admissions (inpatient/outpatient), all sclerotherapy, chemotherapy, radiation therapy, in vitro fertilization, GIFT, ZIFT, or any other fertility procedure for a covered member, within the first 3 months of pregnancy, when your baby is born, if your baby has complications at birth, before your baby is given the drug Synagis outside the hospital nursery; any non-emergency surgical procedure performed in a hospital, freestanding clinic, or ambulatory surgical center; hospitalization that exceeds the length of stay limitation previously authorized by Medi-Call; extended care services (hospice or alternative treatment plan, home health care, skilled nursing facility, long-term acute care facility, durable medical equipment); any medical service or procedure involving inpatient rehabilitative services and related outpatient physical, speech, or occupational therapy, second surgical opinion and extended care, and organ transplant, bone marrow transplant, or other stem cell rescue or tissue transplant for which benefits are provided.

Failure to obtain preauthorization in the above circumstances (or within 48 hours in an emergency) will result in a $200 penalty for each admission, and the costs incurred during the hospitalization or treatment will not contribute to the out-of-pocket maximums. It is your responsibility to ensure that the provider has pre-authorized the services. Medi-Call may be contacted at 803-699-3337 or 800-925-9724 (nationwide and Canada).

**National Imaging Associates (advanced radiology preauthorization requirement of the State Health Plans):** If you or a covered dependent are scheduled to receive CT, MRI, MRA, or PET scans from an out-of-network provider, you are responsible for ensuring that the provider receives preauthorization from National Imaging Associates (NIA). Otherwise, the provider will not be paid and you will be responsible for the entire bill. NIA may be reached by calling 866-500-7664.

**Provider Networks:** The State Health Plan has participating provider networks for hospitals, physicians, mental health and substance abuse, pharmacies, ambulatory surgical centers, transplant centers and mammography centers. Participants may also use out-of-network providers for most services, but are subject to any balance billed by those providers.

The networks include most providers in South Carolina and some providers in other states. Participating in-network providers have agreements with the State Health Plan that determine how much they can charge State Health Plan members for services. **You must use in-network providers for Well-Child Care, routine mammograms and prescriptions.** There is no reimbursement for out-of-network providers for these services.

You have access to doctors and hospitals for medical benefits almost everywhere- nationwide and internationally with the BlueCard Program, administered by Blue Cross and Blue Shield of South Carolina. You may call 800-810-BLUE (2583) for more information.

**Coordination of Benefits:** The State Health and Dental Plans use the birthday rule for
coordination of benefits. If a husband and wife have two different employer group insurance plans and both cover their children, the parent whose birthday comes first in the calendar year must file claims for the children under his or her insurance first, as the primary coverage.

**Standard Plan**

Under the Standard Plan, the family deductible is the same, regardless of the number of family members covered. The maximum that any one family member can contribute toward the $890 family deductible is $445. The family deductible may be met by any combination of two or more family members. In addition to the deductible, per-occurrence deductibles apply to certain services.

The per-occurrence deductibles are as follows and do not apply toward the plan deductible or the out-of-pocket maximum:

- $12 per-visit deductible for each visit to a professional provider's office
- $95 per occurrence for outpatient hospital services (see the Insurance Benefits Guide for exceptions)
- $159 for each emergency room visit (the emergency room deductible is waived if you are admitted to the hospital.

When the deductible is met, the plan pays 80% of allowed charges for in-network providers and 60% for out-of-network providers. For out-of-network providers, in addition to paying 40% of the allowable charges, you will also be liable for any balance billed by the provider.

Under the Standard Plan, for in-network services there is a $2,540 maximum coinsurance for individual coverage or $5,080 for family coverage. For out-of-network services there is a $5,080 maximum for individual coverage or $10,160 for family coverage. The Standard Plan will then pay 100% of the allowable charges.

Expenses paid for prescription drugs, deductibles and non-covered services are not credited toward your health coinsurance maximum. Also, penalties for not pre-certifying certain services (as outlined above) do not count toward the coinsurance maximum.

**Prescription Drug Program:** The Standard Plan includes a prescription drug program that is not subject to the health deductible. This program is administered by Catamaran and is easy and convenient to use. Participants simply show their Catamaran prescription card when purchasing prescriptions from a participating pharmacy and pay a co-payment for up to a 31-day supply of $9 for generic drugs, $38 for higher cost brand drugs, or $63 for highest cost brand drugs. If the price of your prescription is less than the co-payment amount, you pay the lesser amount.

You must use a participating pharmacy and show your Catamaran prescription card when purchasing medications. Benefits are not payable if you use a non-participating pharmacy.
However, if you incur prescription drug expenses while traveling outside the United States, you will be able to file a claim for reimbursement of your expenses that will be limited to the plan’s allowable charge less the co-payment.

There is an annual prescription drug out-of-pocket maximum of $2,500 per person. When a participant has spent $2,500 in prescription drug co-payments, the plan will cover that participant’s prescription drugs at no cost for the remainder of the year.

**State Health Savings Plan**

Under the State Health Savings Plan, the annual deductible for individual coverage is $3,600 and $7,200 for family coverage. The total amount of $7,200 has to be met before the insurance will begin paying the coinsurance percentage. There are no prescription drug co-pays within this plan. Until the deductible is met, the total allowable charge for drugs is paid by the participants and these amounts are included in the deductible. This plan has no per-occurrence or per-visit deductibles.

The State Health Savings Plan covers the following preventative services: Well-Child Care, routine mammograms, colonoscopies, health screenings, an annual physical (may include routine Pap smears), an annual flu shot, 24-hour access to a nurse care line and a self-care guide.

If you are covered under the Savings Plan, you pay the full allowable charge for all services received and it is applied to your deductible. After your annual deductible is met, the Savings Plan pays 80% of your covered medical, prescription drugs and mental health and substance abuse expenses, if you use network providers, and you pay 20%. If you use out-of-network providers, the Savings Plan pays 60% of your covered expenses, and you pay 40% and any other balance billed.

In addition to the deductible, each year the coinsurance maximum for in-network coverage is $2,400 ($4,800 out-of-network) for individual coverage or $4,800 ($9,600 out-of-network) for family coverage. The State Health Savings Plan will then pay 100% of allowable charges. Expenses paid for non-covered services, copayments and penalties resulting from not calling Medi-Call, National Imaging Associates (NIA) or Companion Benefit Alternatives (CBA) do not count toward the annual deductible or coinsurance maximum.

**Tricare Supplement Plan**

The Tricare Supplement Plan is underwritten by Monumental Life Insurance Company and is administered by Selman & Company/Association and Society Insurance Corporation (ASI). The premiums may be pre-taxed and are paid in full by the employee. Premiums are not subject to a tobacco surcharge. Basic life and basic long term disability coverage do not accompany this coverage.

Eligibility for coverage is extended to active and retired service members and their spouses who
are under the age of 65 years old, not eligible for Medicare and registered with the Defense Enrollment Eligibility Reporting System (DEERS). Additionally, dependent children are eligible based on Tricare eligibility guidelines. Upon termination of coverage, COBRA rights are not extended. Please see the 2015 Insurance Benefits Guide (pages 91-93) for more information regarding coverage details.

**Dental Insurance**

**State Dental Plan**

This plan provides minimal coverage and includes four classes of services:

- Class I (Preventive/Diagnostic) pays 100% of the established fee schedule.
- Class II (Basic Services), with Class III, has a combined annual deductible of $25 for each covered person, then pays 80% of the fee schedule.
- Class III (Prosthetics), with Class II, has a combined annual deductible of $25 for each covered person, then pays 50% of the fee schedule.
- Class IV (Orthodontics) only covers dependent children under age 19, and covers 50% of the fee schedule up to a lifetime maximum of $1,000.

The maximum benefit per year for classes I, II and III is $1,000 per covered person. Basic dental coverage for the employee’s coverage is paid by the employer and is at no cost to the employee. While this plan does provide some coverage, the coverage is minimal and in most instances, will not provide total coverage of claims.

**Dental Plus**

The Dental Plus Plan provides a higher level of coverage for most of the services covered under the State Dental Plan. It is **not** an offset program that pays what the State Dental Plan does not. Instead, it covers the same procedures and services (except orthodontia) at the same percentage levels as the State Dental Plan, but has a higher fee schedule.

Dental Plus premiums are paid entirely by the employee. Subscribers must carry the same level of coverage for Dental Plus as the State Dental Plan. The combined maximum per year for Dental Plus coverage is $2,000 per covered individual.

**Enrollment Periods:** Changes to and from the State Dental Plan and the Dental Plus plans are only allowed during **special enrollment periods** occurring in October of odd-numbered years. Changes made during this enrollment period will be effective January 1 of the following year. Please refer to the Insurance Benefits Guide for all exclusions.

**Dental and Dental Plus Premiums**

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<th>Employee Only</th>
<th>Employee/Spouse</th>
<th>Employee/Children</th>
<th>Full Family</th>
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<tbody>
<tr>
<td>12-month</td>
<td>9-month</td>
<td>12-month</td>
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<td>12-month</td>
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The Vision Care Plan is administered by EyeMed and provides savings on eye care and eyewear. The plan provides coverage for:

- An annual comprehensive eye exam once a year
- Standard plastic lenses or contact lenses once a year
- Frames once every two years

For more details, please refer to the 2015 Insurance Benefits Guide (pages 105-113).

Discounts on conventional contact lenses, additional eyeglasses and more are offered through the plan. Co-pays are required for some services and the plan provides coverage for out-of-network services. Please review the State Vision Plan Flyer for a list of providers, or visit the EyeMed website for more information.

**Vision Care Premiums:**

| Semi-Monthly Rates for 12-month and 9-month Pay Basis for EyeMed Vision Care Plan |
|---------------------------------|------------------|------------------|------------------|------------------|------------------|------------------|
| Employee Only                   | Employee/Spouse  | Employee/Children| Full Family       |
| 12-month                        | 9-month          | 2-month           | 9-month           | 2-month           | 9-month           |
| $3.50                           | $4.67            | $7.00             | $9.33             | $7.93             | $9.99             |
| $10.99                          | $14.65           |

**Life Insurance**

Note: Employees eligible as a result of ACA guidelines are not eligible for these benefits under group coverage.

**Basic Life Plan**

If you enroll in either of the State Health Plans, you will be covered for $3,000 in life insurance and $3,000 in accidental death and dismemberment, at no cost to you. Enrollment in the Tricare Supplemental Plan does not qualify for this benefit.

**Optional Life Plan**
New employees can elect initial coverage (within 31 days of the start date) in $10,000 increments up to three times their basic annual salary (up to a $500,000 maximum) without providing medical evidence of good health. This figure will be rounded down to the nearest $10,000 increment. During initial enrollment, additional coverage above three times your basic annual salary (up to $500,000) may be requested, provided that you show medical evidence of good health. When medical evidence of good health is required, you must complete Minnesota Life’s Evidence of Insurability form. You do not need to see a doctor to have this form completed. If coverage is approved, it will become effective the first of the month following approval. Premiums on the first $50,000 (or less) of Optional Life coverage will be tax-sheltered if enrolled in the MoneyPlus premium pretax feature.

Employees may enroll or make changes in the State Optional Life program in the event of a special eligibility situation within 31 days of a qualifying event. Examples of qualifying events include birth, marriage, adoption, or foster child placement.

The plan includes:

- accidental death and dismemberment benefits equal to the face amount of the policy
- a living benefit for terminally ill members under age 60
- a seat belt provision of an additional 25% of the accidental death benefit when applicable
- day care, education, felonious assault and repatriation benefits

Upon retiring, members under the age of 75 may maintain a certain amount of insurance at group rates. For coverage levels and costs, refer to the chart on pages 27-29 of this summary. Please note that faculty on nine-month appointments should multiply the monthly rates by 12, then divide the resulting annual rate by 18 pay periods to arrive at their specific pay period deduction. Those paid on a twelve month basis should multiply the monthly rates by 12, and then divide the annual rate by 24 pay periods to arrive at their correct per pay period deduction.

**Dependent Life Spouse Plan**

An employee may elect to cover their spouse with life coverage in increments of $10,000, up to 50% of the employee’s Optional Life coverage or $100,000, whichever is less. However, an employee either not enrolled or enrolled for up to $30,000 may still enroll in spouse coverage up to $20,000. Medical evidence of good health is required for initial coverage greater than $20,000. Premiums are the same as Optional Life rates for employees and are based on the employee’s age.

**Dependent Life Child Plan**

An employee may elect to cover his/her dependent children at a benefit of $15,000 up to age 25 (provided they are a full-time student from age 19-24; if not, enrolled children will be
provided coverage up to the last of the month following their 19th birthday). Children may be enrolled in the Dependent Life program at any time during the year. The premium for coverage for children is $1.10 per month, regardless of the number of children covered.

**Disability Insurance**

**Note:** Employees eligible as a result of ACA guidelines are not eligible for these benefits.

Employees have access to long term disability coverage which includes the **Basic Long Term Disability Plan** and the **Supplemental Long Term Disability Plan**. For both plans, a pre-existing condition limitation applies.

Generally, a pre-existing condition is a physical or mental condition for which you consulted a physician, received medical treatment or services, or took prescribed drugs during the six-month period before coverage became effective. No benefits will be paid for a disability caused or contributed to by a pre-existing condition unless:

1. on the date you become disabled you have been continuously covered under the plan for at least 12 months; or
2. you have not been consulted by a physician, received medical treatment or services, or taken prescribed medications during any 12 consecutive months between your date of disability and six months before the date your coverage became effective.

**Basic Long Term Disability Plan**

Members of either one of the State Health Plans automatically receive this benefit at no cost. Benefits under this Basic Long Term Disability Plan are not extended to Tricare Supplemental Plan subscribers.

For eligible employees, the plan pays up to 62.5% of the employee’s monthly base salary (up to a maximum of $800 a month) following a 90-day waiting period, less any deductible income received or income the employee is eligible to receive from other sources. Benefits are not paid for an injury or sickness caused by a pre-existing condition until you have been insured for at least 12 months or treatment free for 12 months immediately preceding the date of disability, whichever occurs sooner.

**Supplemental Long Term Disability Plan**

This optional disability income plan is intended to provide income protection, and supplements coverage for those who are automatically enrolled under the Basic Long Term Disability Plan. For those not enrolled under the Basic Long Term Disability Plan, this option may also be elected to supplement income.
After a 90 or 180-day waiting period, the benefit pays up to 65% of the member’s monthly salary to a maximum of $8,000 per month, less any disability benefits received from the basic disability plan and other sources; with a minimum payment of $100 a month. The cost is based on the employee’s salary and age. Benefits are not paid for an injury or sickness caused by a pre-existing condition until the participant has been insured for at least 12 months or is treatment free for 12 months immediately preceding the date of disability, whichever occurs sooner.

**Flexible Spending Accounts (MoneyPlus)**

MoneyPlus is a program administered by WageWorks that can help maximize your spendable income by allowing you to pay certain insurance costs on a pretax basis. This means no state, federal, or Social Security taxes are withheld from dollars included in the following MoneyPlus options.

**Pretax Premiums**

You may pay group insurance premiums on a pretax basis for your health, vision, dental, dental plus and up to the first $50,000 of State Optional Life Insurance coverage.

**Note:** While the pretax premium feature and the Health Savings Account (for Savings Plan participants as described below) is available to employees eligible as a result of ACA guidelines, they are not eligible for enrollment in the other flexible spending accounts.

**Flexible Spending Accounts**

**Medical Spending Account:** You may direct pretax dollars to be deposited into your account to pay for out-of-pocket medical expenses – the portion of expenses you are required to pay without any reimbursement by an insurance plan for you or anyone claimed on your income tax return. Enrollment occurs during October’s annual open enrollment, and you must re-enroll each year in October for the following year. To qualify, you must be employed for one year as of January 1 following an October enrollment period.

You can set aside up to $2,550 in a medical spending account each year. However, you must use the 2015 funds by the grace period of March 15, 2016 and file claims by March 31, 2016 or you will lose it. Paper claims are filed to facilitate reimbursement.

For an additional cost, employees may request a WageWorks Visa card to access Medical Spending Account funds to pay covered expenses.

**Dependent Care Spending Account:** Depending on your tax filing status, you may set aside, on a pretax basis, up to $5,000 each year to pay dependent care expenses for children under age
13 or for mentally or physically disabled dependents of any age. However, you must use the 2015 funds by the grace period of March 15, 2016 and file claims by March 31, 2016 or you will lose it. This benefit is only available to employees who must have dependent care to permit the employee and spouse (if married) to work or attend school. The day care provider is required to provide a statement of costs. Enrollment occurs upon initial hiring, within 31 days of a qualifying event, or during Open enrollment, and you must re-enroll each year in October for the following calendar year.

**Health Savings Account (HSA):** This account in conjunction with the State Health Plan Savings Plan was designed to provide an economical insurance plan to employees who are willing to take greater responsibility for their health care in an effort to reduce their insurance premiums and save money for qualified medical expenses. To be eligible, you must be enrolled in the Savings Plan, and cannot be covered by any other health plan, including Medicare. Enrollment occurs upon initial hiring, within 31 days of a qualifying event or during open enrollment, and you must re-enroll each year in October for the following calendar year.

To contribute to an HSA through payroll deduction, you must enroll in the MoneyPlus HSA established with Wells Fargo. Contributions are reported and administered by WageWorks. The maximum contribution for a subscriber with single coverage is $3,350; $6,500 can be contributed for a subscriber with dependent coverage. Subscribers age 55 and older may make “catch-up” contributions to an HSA in the amount of $1,000 for 2015. Contributions may be paid in lump sum or in equal payments during the year. Once a month, you may change the amount of your MoneyPlus HSA payroll deduction.

Employees will be provided one Wells Fargo Visa debit card to pay for covered expenses from the HSA. You may order additional cards or request a supply of checks by calling 1-866-884-7374. You may only withdraw HSA funds that are actually in your account.

**Limited-Use Medical Spending Account:** This account may be used to pay expenses not covered by the Health Plan Savings Plan, including non-covered prescription drugs, dental and vision care. To be eligible, you must be enrolled in a Health Savings Account (HSA).

*Note: At termination of employment, claims may be submitted only for services incurred prior to termination, unless COBRA coverage is opted for the accounts.**

**Other Supplemental Offerings**

The following plans represent supplemental offerings outside of the State PEBA systems for which you may apply at any time, subject to approval of medical evidence of good health and pre-existing condition clauses.

**USC Cancer Plan**

According to plan guidelines administered by Colonial Life Insurance Company, this plan
provides a cash payment at the initial diagnosis of internal cancer and a daily benefit for hospital confinement, outpatient treatment and hospice care related to any type of cancer subject to the pre-existing conditions clause in the plan. Spouses and children also may be covered. Applicable benefits are paid in addition to other insurance coverage you may have.

**USC Hospital Confinement Plan**

This plan, administered by Colonial Life Insurance Company, offers a choice of a $50 or $80 daily benefit, to be paid directly to the member when the member or a covered spouse or child is confined in a hospital. Applicable benefits are paid in addition to other insurance plans you may have.

**Auto and Homeowners Insurance Plans**

Employees and members of their household may purchase automobile and homeowners insurance at low competitive rates through the Travelers Insurance Company. USC employees may pay premiums automatically through payroll deduction or regular monthly withdrawals from their checking or savings accounts. Free quotes may be obtained by calling Travelers at 1-800-842-5936 or by visiting the Travelers Insurance Company website.

**COBRA (Consolidated Omnibus Budget Reconciliation Act)**

After you enroll in the health, dental, vision, or medical spending account plans (as applicable), you will receive a notice advising you and/or your covered dependents of the right to keep this coverage in the event of certain qualifying circumstances.

A federal law known as Consolidated Omnibus Budget Reconciliation Act (COBRA) requires that this information be provided to you and your covered family members when you enroll in the health, dental, vision or medical spending account plans (as applicable), and thereafter, each time we are aware of a change in your family status that affects insurance eligibility. Please let your covered family members know so they may expect to receive this information in the event they experience a qualifying event.

Coverage may be continued for a limited time under COBRA if you or your dependents lose coverage for any of the following reasons:

- You are in a state-defined FTE position and your working hours are reduced to less than 20 hours a week
- You voluntarily quit work, are laid off, or fired (unless the firing is due to gross misconduct)
- You no longer qualify otherwise under insurance guidelines
- You have separated or divorced your spouse
- Your dependent child is no longer eligible for coverage
These events should be reported within 60 days of occurrence. COBRA coverage will be offered and, if desired, must be elected within 60 days of the insurance termination effective date. If elected, the COBRA coverage will be retroactive to the insurance termination date. If COBRA is not reported and elected within 60 days of occurrence COBRA coverage will not be extended.

Rules and regulations governing continuation of coverage under COBRA are described in your Insurance Benefits Guide, which is published annually by the SC PEBA Insurance Benefits division. This guide is mailed to your campus address by the 2nd week in January of each year. It is also available on the Human Resources website.

**Retirement Benefits**

University employees hired in permanent positions are required by state law to participate in either the South Carolina’s traditional pension program or the State Optional Retirement Program. Those in eligible law enforcement positions participate in the Police Officers Retirement Program. Additionally, the University also contributes to the federal Social Security program, for which participation is required of all employees. Employees hired in research grant-funded positions are eligible for benefits, including retirement, if allowed by the specifications of the grant.

**South Carolina Retirement Systems (SCRS) and Police Officers Retirement Systems (PORS)**

The SCRS and the PORS are known as defined benefit plans. These plans provide pension income to retired employees based on a formula that accounts for your average final compensation (AFC), age and years of credited service. Your AFC is the annual average of the 20 highest consecutive calendar quarters’ earnings (highest 12 quarters for those who became a member prior to July 1, 2012). Members may purchase credit for certain kinds of service such as active duty military, public service in other states, and civil service.

Contributions to these plans are made on a pretax basis at the rate of 8% and 8.41% (respectively) of earnings. Starting July 1, 2015, these rates will increase to 8.16 % and 8.74% (respectively). If you are an active member, your account will earn 4% interest compounded annually on your account balance as of the previous June 30 until your account becomes inactive.

After eight years of earned service (five years of earned service for those who became members prior to July 1, 2012) you are considered a vested member and may leave contributions on file with the Retirement System at separation from employment. Vested members may file for a reduced monthly annuity starting at age 60 (up to age 64) for the SCRS. Vested PORS members may file for a full monthly annuity at age 55. SCRS members may file for a full annuity upon reaching the age of 65.

**State Optional Retirement Program (State ORP)**
The State ORP is considered a defined contribution plan, and is an alternative to the SCRS and PORS plans. This plan is a 401(a) qualified governmental plan that provides an account into which both you and your employer contribute.

If you are eligible to participate in the State ORP, there are several vendors from which you may choose. Your contributions are made on a pretax basis at a rate of 8% of your earnings (starting July 1, 2015, this rate will increase to 8.16%). Your employer's contributions are made at a rate of 5% of your earnings.

**Retirement Program Death Benefits**

Members of the SCRS, State ORP and PORS are eligible for incidental death benefits.

Under the SCRS, PORS and the State ORP, this benefit pays your beneficiary an amount equal to your annual budgeted base salary (as long as you have at least 12 months of retirement service credit at the time of your death).

Under SCRS and PORS, your beneficiary is also entitled to a refund of your contributions, plus interest. If you have at least 15 years of retirement service credit, your beneficiary has the option to choose a lifetime annuity instead of a refund.

Under the State ORP, your beneficiary is entitled to the cash value of your account at the time of your death. Your beneficiary has the option to receive the cash value of the account through annuities, lump-sum distributions, or periodic withdrawals.

**SCRS Disability Retirement program**

Members of the SCRS or PORS who are disabled and have obtained the required vesting years of earned retirement service credit may apply for disability retirement. If you became a member before July 1, 2012, and have at least five years of earned service credit, you may apply. If you became a member after July 1, 2012, you must have at least eight years of earned service credit. SCRS disability applications will require an approval of disability by the Social Security Administration. If disability is approved by PEBA Retirement Benefits, the employee will receive a monthly benefit for life.

**Other Tax-Sheltered Annuity Products**

For employees who would like to explore savings beyond the SCRS/ORP pension programs, the South Carolina Deferred Compensation web-based presentation outlines 401(k) and 457(b) savings plan offerings that are currently administered by Great West Retirement Services. You are also welcome to research providers of 403(b) plans offered by the University to determine if you would like to participate.
All enrollments and changes for these plans are coordinated directly with the vendor, who will then facilitate enrollment with the University's Payroll department. Please contact Payroll at 803-777-4227 with any questions about deductions.

Note: Funds from these plans can be rolled over to purchase retirement service credit with the SCRS.

Holidays and Leave

Note: Only eligible employees are entitled to USC Holidays and Leave. Employees eligible as a result of ACA guidelines are not entitled to these benefits.

Holidays

There are 13 paid holidays. The holiday schedule is set each year to coincide with the academic schedule. The holiday schedule for 2015 is provided below. The University's holiday schedule does not mirror all holidays observed by other state agencies. Dates with an asterisk (*) represent substituted days for these days.

<table>
<thead>
<tr>
<th>Holiday</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Year’s Day</td>
<td>Thursday, January 1, 2015</td>
</tr>
<tr>
<td>Martin Luther King, Jr. Day</td>
<td>Monday, January 19</td>
</tr>
<tr>
<td>Independence Day</td>
<td>Friday, July 3 (observance)</td>
</tr>
<tr>
<td>Labor Day</td>
<td>Monday, September 7</td>
</tr>
<tr>
<td>Thanksgiving Day</td>
<td>Thursday, November 26*</td>
</tr>
<tr>
<td>Day After Thanksgiving</td>
<td>Friday, November 27*</td>
</tr>
<tr>
<td>December Holiday</td>
<td>Wednesday, December 23*</td>
</tr>
<tr>
<td>Christmas Eve</td>
<td>Thursday, December 24</td>
</tr>
<tr>
<td>Christmas Day</td>
<td>Friday, December 25</td>
</tr>
<tr>
<td>Day After Christmas</td>
<td>Monday, December 28 (observance)</td>
</tr>
<tr>
<td>December Holiday</td>
<td>Tuesday, December 29*</td>
</tr>
<tr>
<td>December Holiday</td>
<td>Wednesday, December 30*</td>
</tr>
<tr>
<td>December Holiday</td>
<td>Thursday, December 31*</td>
</tr>
<tr>
<td>New Year’s Day (first 2016 holiday)</td>
<td>Friday, January 1, 2016</td>
</tr>
</tbody>
</table>

Sick Leave

If you work one-half the work week in a state defined full-time equivalent (FTE) position, you will earn sick leave. FTE employees earn at the rate of 1¼ days a month. Part-time FTE employees earn sick leave on a pro-rata basis.

Employees may accumulate up to a maximum of 195 days each year. However, no more than 180 days may be carried into a new calendar year. Up to 10 days of available sick leave may be used each year for the illness of an immediate family member. Sick leave is generally forfeited at
separation from employment. However, it may be transferable upon transferring without a break in service to another qualifying agency.

Employees in a grant-funded or time-limited position may earn sick leave, if allowed by the grant and USC guidelines. However, it may or may not be transferrable to other grant-funded or time-limited positions within the University. Sick leave for these position types can’t be transferred to another qualifying agency or an FTE position.

**Annual Leave**

If you work one-half the work week in a leave-eligible position on a 12-month pay basis, you will earn annual leave. Qualified FTE employees earn annual leave at the rate of 1¼ days a month for the first 10 years and an additional 1¼ days per year following the 10th year anniversary up through the 22nd year. Qualified part-time FTE employees earn annual leave on a pro-rata basis.

The maximum accumulation each year is 75 days. However, only 45 days may be carried over into a new calendar year. At separation from employment, you will be paid a lump sum amount for unused annual leave, up to 45 days*. Upon transfer to another FTE position in a qualifying agency without a break in service, annual leave may be transferred.

*Note: If allowed by the grant, employees in grant-funded and time-limited positions may be required under the grant to use accrued annual leave prior to the expiration of the grant or separation from employment. If it is not used, it may be lost. In addition, they may or may not be entitled to bonus annual leave accruals, but may or may not be able to transfer leave to another grant-funded or time-limited position within the University. Annual leave for these position types can’t be transferred to another qualifying agency or an FTE position.

**Family and Medical Leave Act**

The Family and Medical Leave Act (FMLA) allows qualified employees to take up to 12 weeks of unpaid leave per calendar year when they are unable to work because of their own serious health condition, the birth, placement, adoption of a newborn child (within one year of birth), or to care for a spouse or qualified family member with a serious health condition, or any qualifying exigency arising out of the fact that the employee’s qualified family member is a covered military member on “covered active duty.” FMLA may be allowed for a qualified caregiver for up to 26 weeks to care for a seriously injured or ill service member. Any available annual or sick leave used in conjunction with approved FMLA will run concurrently with FMLA leave, pursuant to University Policies and Procedures.

**Other Leave With Pay**

Up to three consecutive workdays of leave with pay are allowed at the death of an immediate family member, as outlined in HR Policy 1.09. Up to 15 workdays of leave with pay are allowed
for annual training in the National Guard or Armed Forces Reserves. Additional military leave may be granted during times of emergency. Leave with pay is also provided when an employee is subpoenaed to serve as a juror or witness for court, for reasons not in relation to personal litigation.

**Leave Pool**

Employees in state-defined FTE positions may voluntarily donate annual leave or sick leave to the University of South Carolina’s leave pool. In catastrophic situations, employees who have no available leave may request leave from the pool if the absence would result in at least 30 days in a leave without pay status. The leave request is subject to approval by both the department and the Division of Human Resources.

**Sabbatical Leave**

Tenured professors or associate professors may be granted sabbatical leave by the president, based on seniority, merit and six or more years of service as a full-time faculty member (see the Faculty Manual).

**Personal or Educational Leave Without Pay**

Leave without pay may be granted when deemed to be in the best interest of the University. Up to 10 days of personal leave without pay may be granted through your department. Requests for more than 10 days must be submitted through the department, with final approval made within the Division of Human Resources.

**Privileges and Discounts**

For many of our employees, family priorities or other limitations make it challenging to maintain a healthy balance between work and home life. Through the University’s campus resources and community relationships, we’ve developed a number of family-friendly privileges and unique discount opportunities for eligible employees.

While this Benefits Summary provides an overview of a few of the options available, a more comprehensive list can be found on the Privileges and Discounts section of our website. You may also learn more information about these benefits by attending a University Orientation. Please all the Organizational and Professional Development Office at 803-777-6578 for more information.

**Note:** Some of these benefits may not be available to all categories of employees. Please contact the administrator to determine if you are eligible.

**Dual Career Employment Services**
Finding suitable career opportunities for both the prospective University employee and their partner can often be a critical component of a candidate’s decision to accept a job offer at the University of South Carolina. Our Dual Career Employment Services Program helps to make that decision easier by providing employment assistance to the accompanying partners of newly hired faculty and staff. From building a resume to planning a proactive networking strategy – our experts will provide everything you need to conduct a successful job search. For details on this service, please call the Office of Recruitment and Employment at 803-777-3821.

**Tuition Assistance Program**

Our Tuition Assistance Program allows eligible faculty (after one semester) and staff (after six months) to take one three credit hour course (four hours in the case of a lab course) per academic term at no charge, on a space available basis. Eligible research grant-funded employees may apply for tuition assistance, but will only be reimbursed for a course if they receive a grade of “C” or better.

**Employee Assistance Program**

This program offers assistance to eligible faculty and staff and their family members who may be experiencing a range of life challenges such as child-rearing concerns, elder care issues, alcohol and drug-related problems, abuse issues, marital difficulties, depression, anxiety, stress, financial problems and legal issues. For assistance, contact Deer Oaks Employee Assistance Program at 1-866-327-2400.

**Additional Privileges and Discounts:**

- Reduced-Price Athletic Tickets
- Access to Fitness Centers
- Employee Wellness Programs
- USC Cultural Event Tickets
- USC Bookstore Discounts
- Software and Computer Purchase Discounts
- Free Notary Services
- The Children’s Center at USC
- Professional Development Programs
- Pre-Retirement Seminars

**Enroll and Make Changes**

**Initial Enrollment**

As a new employee, you may enroll in the insurance benefits described in this summary (according to eligibility) within 31 days following your date of hire. You must make a retirement plan election within 30 days following your date of hire. If you do not, you will automatically default into the SCRS program.*

If you are transferring from another South Carolina state-covered entity or transferring within the university, you are required to continue your same level and type of insurance coverage in existence until an open enrollment period or qualifying event takes place.
In order for the paperwork to be processed in a timely manner, the Benefits Office encourages all employees to have initial selections made and paperwork submitted within seven days of your hire date.

The Benefits Office will determine your eligibility and you will be assigned a benefits counselor who will send you an email with the appropriate benefits orientation information you require. Once you feel that you’ve properly reviewed your benefits options and are ready to make your selections, you will complete the forms designated in your specific orientation, and submit them to the Benefits Office. Please refer to pages 1-2 to review the proper orientation resource for your specific employee type and use the worksheet on page 25 as a guide to help in selecting the plans in which you want to enroll.

After this initial enrollment, your insurance benefits will be managed and renewed using the MyBenefits online enrollment system, and your retirement account may be accessed and reviewed using Member Access.

*Note: Please notify the Benefits Office immediately if you begin employment in a leave without pay status. Your insurance enrollment will be deferred until your actual start date (Insurance enrollment must take place within 31 days of your actual start date. However, pension program enrollment still needs to take place within 30 days of your date of hire).

Open Enrollment

The open enrollment period for the state insurance plans takes place in October each year. During this time, you may change from one health plan to another, enroll yourself and/or eligible dependents in a health plan, and/or drop health coverage for yourself and/or your dependents. Insurance changes made during open enrollment will be effective January 1 of the following year.

Changes to your dental and dental plus coverage can only be elected every other year, in odd-numbered years. Changes made during this time will be effective January 1 of the following year.

Information will be available to you in September about changes that are occurring in the state insurance plans for the next calendar year, and about the benefits changes that you may make during the enrollment period. It is important that you anticipate this information, review the content carefully and make changes appropriate to your needs during the enrollment period.

The open enrollment period for retirement programs takes place each year from January 1 to March 1. During this time, you may change your State Optional Retirement Program (State ORP) investment providers. You also have a one-time opportunity to switch to the South Carolina Retirement System (SCRS) as long as you have been enrolled in the State Optional Retirement Program (State ORP) for at least 12 months, but no more than 60 months, by
March 1 of the year you want to switch. Changes made during open enrollment will be effective April 1 of that year.

Outside of open enrollment, these changes can only be made due to a qualifying event.

**Qualifying Events**

You may make certain changes throughout the year within 31 days of a qualifying event. Qualifying events include marriage, divorce, legal separation, birth, death, adoption, legal guardianship of a dependent child, a child reaching age 26, or a spouse or child gaining or losing other insurance coverage. A spouse gaining or losing employment is also considered a qualifying event for Money Plus changes. The Benefits Office must be contacted within 31 days of the qualifying event, and any required documentation must be provided.

**Making Benefits Changes**

Once you have completed your initial enrollment, your insurance benefits can be reviewed using the MyBenefits online enrollment system. You may also use this system to make some name and beneficiary changes.

SCRS and PORS membership account information can be reviewed using Member Access. SCRS and PORS members may use this system to change your beneficiaries, request to purchase service credit, or update your personal information anytime throughout the year. State ORP participants should contact your vendor directly to find out more information about how you may view your account details.

Changes in Optional or Dependent Life coverage or enrollment in Supplemental Long Term Disability can be changed or added throughout the year. To apply as a late entrant, you must complete a medical questionnaire.

You should always check your electronic pay stub after enrolling or making changes to your benefits to make sure the appropriate premiums are being deducted. Please contact the Payroll Office at 803-777-4227 with any questions about your payroll deductions.

**Failure to Enroll or Update Coverage**

It is important that you know the consequences of missing an enrollment or change opportunity. When you fail to enroll or update coverage (as needed) within 31 days of hire, a qualifying event, or within open enrollment periods, your options are restricted as follows:

**Health, Vision and Dental Plans:** Open Enrollment for the health and vision plans is held during October of each year. Open Enrollment for dental plans is held every other year in the odd-numbered years. During Open Enrollment, you may enroll or cancel coverage for yourself or dependents. You may not make these changes at any other time, except when the change is
made within 31 days of a qualifying event.

**MoneyPlus:** You may only enroll or cancel the insurance premium pretax feature during initial enrollment or open enrollment. You must enroll in or change your amounts under the medical or dependent care spending account features each year during open enrollment, or within 31 days of a qualifying event. Remember that if you do not re-enroll in the spending accounts each year during the October enrollment, the accounts will not continue the following year.

**Optional Life:** You may apply for Optional Life Coverage as a late entrant at any time during the year or within 31 days of a qualifying event. However, you must complete a Notice of Election form and [Evidence of Insurability](#) for review of medical evidence of good health and the insurance company must approve your application. If approved, coverage will be effective the first of the month following approval, as long as you are actively at work that day as a full-time employee. A deferred effective date provision applies if you are not actively at work on the effective date for all optional life coverage. You can also enroll during specified open enrollment periods without having medical evidence of good health. Coverage opted during an open enrollment period will be effective as of January 1 of the following year.

**Dependent Life:** If you did not enroll your eligible dependents during initial enrollment, or within 31 days of a qualifying event, you may apply as a late entrant any time during the year. However, you must complete an [Evidence of Insurability](#) for review of medical evidence of good health and the insurance company must approve your application. You may drop dependent life coverage at any time.

**Required Documentation**

The SC PEBA Insurance Benefits division requires documentation showing proof of relationship at the time of enrollment for dependents of new hires and for dependents added during open enrollment or within 31 days of a qualifying event. Please refer to the next page for a list of acceptable documents for showing proof of relationship. You and your dependent’s coverage cannot be activated without this information.

If married, you will need to provide the name, social security number, date of birth and relationship for your spouse. You will also need to provide this information for your beneficiaries and any dependents you wish to cover for health, vision, dental, or Dependent Life insurance.

If you are transferring from another South Carolina state-covered entity or transferring within the university, you are required to continue your same level and type of insurance (and pension, as applicable) coverage in existence until an open enrollment period or qualifying event takes place. Please complete the [Benefits Data Summary for Transfer Employees](#), attach a copy of your last pay stub and fax it to the Benefits Office at 803-777-1584.
Following is a list of acceptable documentation to prove your relationship to family members you are attempting to add to coverage. Please be sure to submit photocopies only as South Carolina PEBA divisions cannot return submitted documentation.

**Legal Spouse:** A copy of the marriage license or page 1 of your federal tax return.

**Former Spouse:** A copy of the divorce decree ordering the subscriber to cover the former spouse.

**Common Law Spouse:** A copy of the common law marriage affidavit.

**Natural Child:** A copy of the long-form birth certificate showing the subscriber as the parent.

**Step Child:** A copy of the long-form birth certificate showing the name of the natural parent, plus documentation that the natural parent and the subscriber are married (see requirement for Legal Spouse or Common Law Spouse in the list above).

**Adopted Child:** A copy of the court documentation verifying the adoption is complete, or a copy of a letter of placement from an adoption agency, an attorney, or the S.C. Department of Social Services verifying that the adoption is in progress.

**Foster Child:** A copy of the 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 copy of the court order or other legal document granting custody of the child/children to the subscriber. Documentation must verify the subscriber has guardianship responsibility for the child/children, not merely financial responsibility.

**Incapacitated Child:** A copy of the Incapacitated Child Certification Form, plus proof of relationship. See the appropriate child type (natural, step, adopted, foster or other) in the list above for acceptable documentation to prove the relationship.

If you do not have the required documentation to prove your relationship to a dependent, you may have to pay a fee to receive a copy 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. To obtain copies of marriage licenses or birth certificates, visit the Center for Disease Control website for marriage licenses and birth certificates or the SCDHEC website for birth certificates for children born in S.C.
# Benefits Selection Worksheet

## Health Insurance
- **State Savings Plan**
  - **Coverage Type:** Employee Only
  - **Cost:** ______
  - **Coverage Type:** Employee/Child(ren)
  - **Cost:** ______
- **State Standard Plan**
  - **Coverage Type:** Employee Only
  - **Cost:** ______
  - **Coverage Type:** Employee/Spouse
  - **Cost:** ______
- **Tricare Supplement Plan**
  - **Coverage Type:** Full Family
  - **Cost:** ______

## Dental Plan
- **Basic Dental:**
  - **Yes**
  - **No**
  - **Coverage Type:** Employee Only
  - **Cost:** ______
  - **Coverage Type:** Employee/Spouse
  - **Cost:** ______
- **Dental Plus:**
  - **Yes**
  - **No**
  - **Coverage Type:** Full Family
  - **Cost:** ______
  - **Coverage Type:** Employee/Spouse
  - **Cost:** ______

## Vision Plan
- **Yes**
- **No**
  - **Coverage Type:** Employee Only
  - **Cost:** ______
  - **Coverage Type:** Employee/Spouse
  - **Cost:** ______
  - **Coverage Type:** Full Family
  - **Cost:** ______

## MoneyPlus
- **MoneyPlus premium pretax feature**
  - **Yes**
  - **No**
  - **Dependent Care:**
    - **Amount:** ______
  - **Health Savings Account**:
    - **Amount:** ______

*Must be enrolled in Savings Plan in order to elect.*

## Life Insurance
- **State Group Life** (Automatic if enrolled in one of State health plans)
  - **Face Amount:** $3,000
  - **Cost:** -0-
- **Dependent Life/Spouse**
  - **Cost:** ______
- **Dependent Life/Child(ren)**
  - **Cost:** ______
- **State Optional Life**
  - **Cost:** ______

## Disability Insurance Plans
- **State LTD Plan** (Automatic if enrolled in one of the health plans)
  - **Waiver period:** 90 day
  - **Cost:** -0-
- **State Supplemental LTD**
  - **Waiver period:** 90 day
  - **Cost:** ______
  - **Waiver period:** 180 day
  - **Cost:** ______

## Other Insurance
- **Cancer Plan**
  - **Amount:** ______
- **Hospital Confinement Plan**
  - **Amount:** ______

## Retirement Deduction
- **S.C. Retirement System**
- **S.C. Police Officers Retirement System**
- **State Optional Retirement Program**
  - **MetLife**
  - **MassMutual**
  - **TIAA-CREF**
  - **VALIC**

## Direct Deposit:
Direct deposit is required and can be done online through [VIP](#). For assistance, talk with a Benefits counselor.

## Income Tax Withholding
- **Married**
- **Single**
- **Married, but withhold at single rate**
  - **Exemptions:** ______