

State Election Commission
1122 Lady Street suite 500
Columbia, SC 29201

September 18, 2025

Margaret Paige Salonich
Deputy Executive Director
Training and County Support Services

Subject: Notice of Suspension Pending Investigation

Dear Margaret Paige Salonich,

This letter is to inform you that, effective immediately, you are being placed on unpaid suspension pending the outcome of an internal investigation into Malicious use of profane/abusive language to others and Improper conduct or conduct unbecoming of a state employee.

COMMISSIONERS

HON. DENNIS W. SHEDD
Chairman

JOANNE DAY

CLIFFORD J. EDLER

LINDA MCCALL

SCOTT MOSELEY

This action is not a disciplinary measure, but rather a precautionary step to allow for a thorough and impartial investigation. During this period:

- You are not to report to work or perform any work-related duties unless otherwise instructed.
- You are not to contact any employees, clients, or stakeholders regarding this matter unless authorized.
- Your suspension will remain in effect until further notice. We will notify you promptly of any updates or decisions.

We understand that this may be a difficult time, and we assure you that the investigation will be conducted as quickly and fairly as possible. You will be given an opportunity to respond to any findings before a final decision is made.

Jenny Wooten
Interim Executive Director

If you have any questions or require clarification, please contact Sharese Johnson or Alfreida Weston at 803-734-9060

Sincerely,

1122 Lady Street
Suite 500
Columbia, SC 29201

Alfreida Weston

P.O. Box 5987

Columbia, SC 29250

Administrative Coordinator II

803-734-1192

803.734.9060

Fax: 803.734.9366

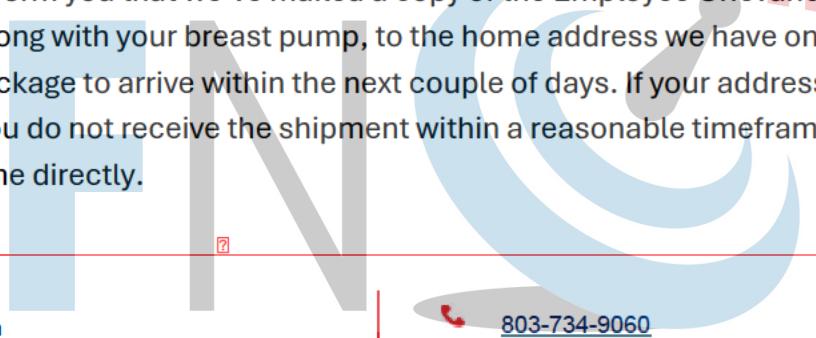
www.scvotes.gov

From: Weston, Alfreida
Sent: Thursday, September 18, 2025 3:48 PM
To: [REDACTED]
Subject: Grievance Policy & Personal Item Mailed
Importance: High

Dear Mrs. Salonich,

I wanted to inform you that we've mailed a copy of the Employee Grievance Policy and Procedure, along with your breast pump, to the home address we have on file. Please expect the package to arrive within the next couple of days. If your address has recently changed or you do not receive the shipment within a reasonable timeframe, feel free to reach out to me directly.

Alfreida Weston
Administrative Coordinator II
South Carolina State Election Commission
#PrepForThePolls | #NoExcuseSC



803-734-9060
alweston@elections.sc.gov
www.scvotes.gov
1122 Lady St., Columbia, SC 29201

From: Johnson, Sharese <sjohnson@elections.sc.gov>
Sent: Monday, September 22, 2025 5:40 PM
To: Paige Salonich <[\[REDACTED\]](mailto:[REDACTED])>; Weston, Alfreida <alweston@elections.sc.gov>
Subject: RE: [External] Resignation Letter

Good evening,

We have received your communication regarding your intent to resign from your position as Deputy Director with the South Carolina State Election Commission. Please be advised that the agency will not be accepting your resignation.

Official correspondence regarding this matter will be sent to your last known address via certified mail.

In addition, arrangements will be made for retrieval of your personal belongings. You will be contacted with details regarding this process.

Thank You

Sharese Johnson
Administrative Manager I

South Carolina Election Commission

1122 Lady St., 5th Floor, Columbia, SC 29201
P.O. Box 5987, Columbia, S.C. 29250
Tel: 803.734.9066
Fax: 803.734.9366
scvotes.gov

EVERY VOTE MATTERS.
EVERY VOTE COUNTS.

From: Paige Salonich <[REDACTED]>
Sent: Monday, September 22, 2025 1:39 PM
To: Johnson, Sharese <sjohnson@elections.sc.gov>; Weston, Alfreida <alweston@elections.sc.gov>
Subject: [External] Resignation Letter

Good afternoon,

Please see my resignation letter attached below. I would greatly appreciate the opportunity to come in and pack up my things personally. Please let me know when an appropriate time to do that would be.

Thank you,

Paige Salonich

Paige Salonich

[REDACTED]

September 22, 2025

SC State Election Commission
1122 Lady Street
Suite 500
Columbia, SC 29201

To Whom It May Concern:

Please accept this letter via email as my official notice of resignation effective immediately.

It has been the greatest honor to build and lead such an astounding team as the Training and County Support Services Division.

I wish the agency the best moving forward.

Sincerely,

Paige Salonich



From: Johnson, Sharese <sjohnson@elections.sc.gov>
Sent: Tuesday, September 23, 2025 9:02 AM
To: Paige Salonich <[\[REDACTED\]](mailto:[REDACTED])>; Weston, Alfreida <alweston@elections.sc.gov>
Subject: Separation of Employment

Dear Ms. Salonich,

Please see the attached **Termination of Employment** letter regarding your position with the South Carolina State Election Commission. A hard-copy original of this letter is being sent to your **last known address via Certified Mail**.

Sharese Johnson
Administrative Manager I
South Carolina Election Commission
1122 Lady St., 5th Floor, Columbia, SC 29201
P.O. Box 5987, Columbia, S.C. 29250
Tel: 803.734.9066
Fax: 803.734.9366
scvotes.gov

SOUTH CAROLINA
ELECTION COMMISSION

September 22, 2025

CERTIFIED MAIL: 7008 1830 0002 6783 6405

Ms. Margaret Paige Salonich
[REDACTED]

RE: Separation of Employment

This letter is mailed to notify you that your employment with the South Carolina State Election Commission is terminated effective Thursday, September 18, 2025. This termination is in accordance with the Agency's Progressive Discipline Policy for your failure to maintain a satisfactory or harmonious working relationship with employees, including supervisors, malicious use of profane/abusive language to others, improper conduct or conduct unbecoming of a state employee, unauthorized use of state or agency property or equipment and misuse of state or agency property or equipment. Each of these policy violations allows for termination individually.

It was reported that on September 17, 2025, you failed to maintain a satisfactory or harmonious working relationship with agency employees, including supervisors, that you maliciously used profane and abusive language that was directed at others and demonstrated improper conduct and conduct unbecoming of a state employee. Subsequently, HR initiated an investigation into these claims. The investigation file contains a comprehensive list of investigative findings and supporting documentation. Specific findings include, but are not limited to, the examples listed in the paragraphs that follow.

Witnesses stated that on September 17, 2025, you raised your voice at leadership, used profanity, and made disruptive remarks such as declaring that you were being "held hostage at your own (Explicit language) job" and "that you would never be a hostage in this (Explicit language) place again". After leaving the conference room against instructions, you continued your outburst into public and employee workspaces, visibly upset, using inappropriate language, and drawing the attention of staff and visitors. Witnesses noted that your behavior left other employees visibly shaken, created an unprofessional environment, and undermined the Commission's ability to conduct business in an orderly and respectful manner.

In addition to these acts, on September 17, 2025, you were recorded on agency security cameras placing an unauthorized device in the SEC training room, a clear violation of state and agency policy. This act constitutes the unauthorized use and misuse of state property and raises serious concerns regarding trust, confidentiality, and workplace integrity.

Given the seriousness of these violations, and their impact on the agency's operations and employees, the decision has been made to terminate your employment as Deputy Director.

As a covered FTE employee, you are covered by the State Employee Grievance Procedure Act (Act), S.C. Code Ann. § 8-17-310 et seq., and Agency's Grievance Policy, and do have grievance rights. Attached to this notice you will find Agency's Grievance Policy, along with the Request for Grievance form.

scVOTES.gov

To be eligible to register, you must be:
A U.S. Citizen | S.C. Resident | 18 years or older

Please ensure the return of all state property in your possession no later than September 29, 2025. Items can be mailed to 1122 Lady Street Columbia, SC 29201. Please contact Sharese Johnson, Human Resources, via email at sjohnson@elections.sc.gov or at (803) 734 - 9066 with questions pertaining to this termination and questions regarding any state benefits to which you may be entitled.

Sincerely,



Sharese Johnson
Administrative Manager I/ Human Resources
State Election Commission

THIS DOCUMENT WILL BECOME PART OF YOUR PERSONNEL RECORD



From: Johnson, Shareese <sjohnson@elections.sc.gov>
Sent: Tuesday, September 23, 2025 10:43 AM
To: Nicholson, Thomas <tnicholson@elections.sc.gov>; Chavis, Madelyn <mcchavis@elections.sc.gov>
Cc: Williams, LaToria <lwilliams@elections.sc.gov>
Subject: P.S.

The Benefits items were sent separately from the termination on:
9/23/2025 via mail

The attached grievance policy and SEC grievance form was sent along
the termination letter via certificated mail 9/23/2025.

Shareese Johnson
Administrative Manager I
South Carolina Election Commission
1122 Lady St., 5th Floor, Columbia, SC 29201
P.O. Box 5987, Columbia, S.C. 29250
Tel: 803.734.9066
Fax: 803.734.9366
scvotes.gov



EVERY VOTE MATTERS.
EVERY VOTE COUNTS.

SEC EMPLOYEE GRIEVANCE FORM

Employee Information

Full Name:

Department: _____

Job Title: _____

Phone Number: _____

Email Address: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Grievance Details

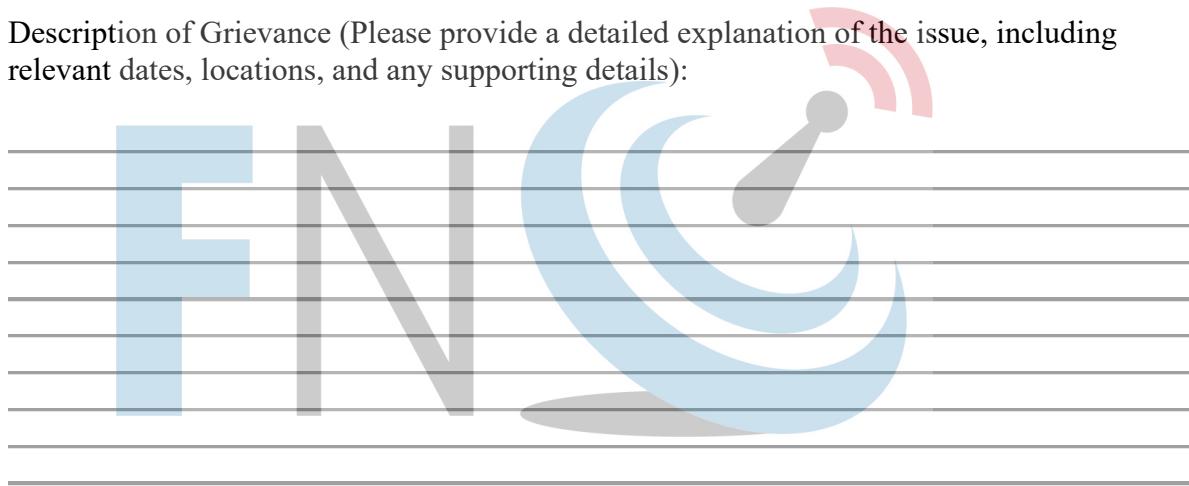
Type of Action Grieved (e.g., Termination, Suspension, Demotion, etc.):

Effective Date of Action:

HON. DENNIS W. SHEDD
Chairman

ISABELLE BAILL

HOWARD M. KNAPP
Executive Director



Relief Sought

(Please specify the action or remedy you are seeking to resolve this grievance):

1122 Lady Street
Suite 500
Columbia, SC 29201

P.O. Box 5987
Columbia, SC 29250

803.734.9060
Fax: 803.734.9366
www.scvotes.gov

Supporting Documents

(If applicable, please attach any relevant documents, emails, or other evidence related to the grievance.)

Employee Acknowledgment

I hereby certify that the above information is true and correct to the best of my knowledge. I understand that my grievance will be reviewed in accordance with agency Grievance Procedure Policy.

Employee Signature: _____

Date: _____

For Office Use Only

Date Received: _____

Received By: _____

Resolution/Outcome: _____



SOUTH CAROLINA
ELECTION COMMISSION

GRIEVANCE PROCEDURE POLICY
WITH OPTIONAL VOLUNTARY MEDIATION
(Revised and Effective 2/15/2017)

COMMISSIONERS

BILLY WAY, JR.
Chairperson

MARK A. BENSON

MARILYN BOWERS

E. ALLEN DAWSON

NICOLE SPAIN WHITE

MARCI ANDINO
Executive Director



1122 Lady Street
Suite 500
Columbia, SC 29201

P.O. Box 5987
Columbia, SC 29250

803.734.9060
Fax: 803.734.9366
www.scvotes.org

GRIEVANCE PROCEDURE MODEL POLICY

WITH

OPTIONAL VOLUNTARY MEDIATION

(Revised and Effective 2/15/2017)

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.

Introduction

The State Employee Grievance Procedure Act (Act) provides that the State Election Commission (SEC) shall establish an employee grievance procedure for covered employees which shall be reduced to writing and be approved by the State Human Resources Director. In addition, the approved grievance procedure must be made available to covered employees of the SEC. Covered employee is defined as a full-time or part-time employee occupying a part or all of an FTE position who has completed the probationary period and has a "meets" or higher overall rating on the employee's performance evaluation and who has grievance rights. If an employee does not receive an evaluation before the performance review date, the employee must be considered to have performed in a satisfactory manner and be a covered employee. This policy does not apply to non-covered employees (e.g., probationary employees, temporary employees, temporary grant employees, time-limited project employees, research grant employees and employees exempt from the State Employee Grievance Procedure Act).

Employees choosing to file a grievance or appeal must not be disciplined or otherwise prejudiced for exercising their rights or for testifying under the provisions of this policy.

Grievances and Appeals

As provided for in the Act, and defined in § 8-17-320 of the S.C. Code of Laws, a covered employee may file a grievance or an appeal concerning only the following employment actions:

- Terminations;
- Suspensions;

• Involuntary Reassignments in excess of thirty (30) miles from the prior

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DIVISION OF STATE HUMAN RESOURCES

February 2017

- work station;
- Demotions;
- Punitive Reclassifications but only when the SEC, in case of a grievance, or the State Human Resources Director, in the case of an appeal, determines that there is a material issue of fact that the action was solely done to penalize the covered employee. Reclassifications, reassignments, and transfers within the same state salary range are not considered to be grievable or appealable.
- Promotions in instances where the SEC, or in the case of appeals, the State Human Resources Director, determines that there is a material issue of fact as to whether or not the SEC has considered a qualified covered employee for a position for which the employee formally applied or would have applied if the employee had known of the promotional opportunity. When the SEC promotes an employee one organizational level above the promoted employee's former level, however, that action is not a grievance or appeal for any other qualified covered employee. Failure to be selected for a promotion is not considered an adverse employment action which can be considered grievable or appealable;
- Salary Decrease based on performance as the result of an Employee Performance Management System (EPMS) evaluation; and
- Reduction in Force is considered as a grievance only if the SEC, or as an appeal if the State Human Resources Director, determines that there is a material issue of fact that the SEC inconsistently or improperly applied its reduction in force policy or plan.

Prior to Filing a Formal Grievance

Prior to filing a formal grievance, the covered employee may first attempt to resolve the matter informally with his immediate supervisor. This matter may be presented verbally or in writing. However, this is merely an informal attempt to resolve the matter and cannot be substituted for the requirements of Step One in the following procedure.

Procedure

Step One

A covered employee who wishes to file a grievance must initiate the grievance with the SEC's Human Resources Office. The grievance must be in writing and must be received (or, if mailed, postmarked) within 14 calendar days of the effective date of the action or 14 calendar days from when the employee is notified of the action, whichever is later. The employee should include a written summary of the facts of

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John M. Hargan 3 February 2017

the grievance and the relief sought.

The SEC's Division of Administration Director or other designated official shall initially review the grievance to determine whether the matter involves a grievance as defined by the Act. The SEC's Division of Administration Director or other designated official may conduct appropriate investigations and fact findings as he may consider necessary to make this determination. If it is determined that the matter is not grievable, the covered employee shall be so advised in writing by the SEC Executive Director or a designee, normally within five (5) calendar days of receipt of the grievance. Such determination shall be a final decision within the SEC which may be appealed to the State Human Resources Director.

If it is determined that the matter is grievable, the SEC's Division of Administration Director or other designated official will contact the covered employee and the appropriate SEC representative(s), normally within five (5) calendar days of receipt of the grievance, to inform them the issue can be heard under this grievance procedure and inquire whether or not they desire to participate in voluntary mediation. Both parties must make a written decision to the SEC's Division of Administration Director within two (2) calendar days of this notification. Failure by either party to respond timely to this notification is deemed a refusal to participate in the voluntary mediation.

Any initial determination by the SEC's Division of Administration Director or other designated official that the matter may be grievable shall only entitle the covered employee to have the matter considered in accordance with this grievance procedure and shall in no way be construed to be an adjudication of the merits of the grievance.

With Mediation:

When the covered employee and the SEC representative(s) both agree in writing to participate in voluntary mediation, the SEC's Division of Administration Director or other designated official will schedule a mediation conference to occur within five (5) calendar days and make the necessary arrangements for acquiring a mediator. The mediator will serve as an impartial third party who will encourage and facilitate a resolution to the dispute without advising what the result should be. The mediation conference(s) will be confidential and limited to the parties and their representatives. Other persons may attend with the permission of the mediator and the other party. The mediator may not be compelled by subpoena or otherwise to divulge any records or discussions or to testify in regard to the mediation conference in any adversary proceeding or judicial forum. If the parties agree to settle the matter, the mediator will assist in drafting a mediation agreement for the parties to review and sign. The mediator may share terms of the settlement agreement with the SEC's designated officials who need to finalize and assist in implementing the agreement. If the matter is not settled within eight (8) calendar days of the initial

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1000 8 February 2017

mediation conference, the mediator will inform the SEC's Division of Administration Director or other designated official that settlement has not occurred. The SEC's Division of Administration Director or other designated official will then schedule a conference to occur between the covered employee's next level supervisor and the covered employee within five (5) calendar days. At the conference with the covered employee's next level supervisor, the covered employee will have an opportunity to present his position regarding the grievance. The next level supervisor may conduct appropriate investigations and fact findings to determine whether to accept, reject, or modify the disciplinary action taken against the covered employee. The covered employee will be advised of his next level supervisor's decision in writing within five (5) calendar days of the conference.

Without Mediation:

If the matter is grievable and the covered employee or the SEC submits a written decision not to participate or fails to respond timely concerning voluntary mediation, the SEC's Division of Administration Director or other designated official will promptly schedule a conference to occur between the covered employee's next level supervisor and the covered employee, normally within five (5) calendar days. At the conference with the covered employee's next level supervisor, the covered employee will have an opportunity to present his position regarding the grievance. The next level supervisor may conduct appropriate investigations and fact findings to determine whether to accept, reject, or modify the disciplinary action taken against the covered employee. The covered employee will be advised of his next level supervisor's decision in writing within five (5) calendar days of the conference.

Step Two

To continue the grievance, the covered employee must notify the SEC Executive Director or a designee in writing. The request to continue the grievance must be received (or, if mailed, postmarked) within five (5) calendar days after receiving the Step One decision. The SEC Executive Director or a designee must promptly schedule and conduct a conference with the covered employee, normally within five (5) calendar days. The covered employee will be provided an opportunity at this time to present his position regarding the grievance. The SEC Executive Director or a designee may conduct appropriate investigations and fact findings to determine whether to accept, reject, or modify the disciplinary action taken against the covered employee. The SEC Executive Director or a designee must advise the covered employee of the decision in writing within five (5) calendar days of the conference. This decision will be final within the SEC.

Failure by the SEC to issue a final decision within 45 calendar days from date the grievance is initially filed with the SEC is considered an adverse decision.

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Tommy Mapp, February 2017

General Information

Failure by the covered employee to comply with the internal time periods in the SEC's grievance procedure constitutes a failure to exhaust administrative remedies and waives the covered employee's right to further continue the grievance. The internal time periods of the SEC's grievance procedure and the 45 calendar day period for action by the SEC may not be waived except by mutual written agreement of both parties.

The Act provides that a covered employee has the right during the grievance and appeal process to a representative, which may include legal counsel. If the covered employee chooses to exercise the right of legal counsel, it shall be at his expense.

Appeals to the State Human Resources Director

The Act also provides for an appeal of a grievance beyond the SEC to the State Human Resources Director after all administrative remedies to secure relief within the SEC have been exhausted. A covered employee has not exhausted administrative remedies to secure relief within the SEC until the SEC's internal grievance process is completed or the 45 calendar days provided for the SEC to issue a decision has elapsed, whichever occurs sooner.

Any covered employee may appeal the decision of the SEC Executive Director or a designee. Such appeal must be in writing and submitted to the State Human Resources Director within ten (10) calendar days of receipt of the SEC's final decision or 55 calendar days from the initial date the grievance was filed within the SEC, whichever occurs later. As to the 55 calendar days, the Act provides that a covered employee may appeal directly to the State Human Resources Director in the event the SEC does not complete its entire internal grievance procedure within 45 calendar days from the time the grievance is initially filed within the SEC. Failure by the SEC to issue a final decision within this 45 calendar day period is considered an adverse decision and allows the covered employee to proceed with an appeal to the State Human Resources Director after 45 calendar days, but no later than 55 calendar days from the initial date the grievance was filed within the SEC.

Failure by the covered employee to file an appeal within the time periods referenced in this section shall constitute a waiver of the right to appeal.

The time periods related to filing an appeal with the State Human Resources Director may not be waived.

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John M. Daigle February 2017

COBRA Coverage Election Notice

(18-month qualifying event)

September 22, 2025

Address: [REDACTED]

Dear Margaret Paige Salonich, [REDACTED]:

This notice contains important information about your right to continue your coverage in your group health, dental and/or vision insurance offered by the South Carolina Public Employee Benefit Authority (PEBA), as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace (visit www.healthcare.gov or call 800.318.2596). You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. Please read this notice and enclosures very carefully.

In this notice, "you" refers to each individual addressed above. COBRA ADMINISTRATOR identifies the entity to which you must deliver all notices and payments regarding COBRA continuation coverage (COBRA coverage).

The contact information for your COBRA ADMINISTRATOR is:

S.C. Public Employee Benefit Authority
Insurance Benefits
P.O. Box 11661
Columbia, SC 29211-1661
Telephone: 803.737.6800 or 888.260.9430

Each person (qualified beneficiary) in the category(ies) checked below is entitled to elect COBRA coverage, which may continue group health coverage under PEBA for up to 18 months for the following individuals covered under PEBA on the day before the event that caused the loss of coverage:

- Employee or former employee:* Paige Salonich
- Spouse or former spouse:* [REDACTED]
- Child(ren):* [REDACTED]

Each qualified beneficiary has 60 days from the date of this notice, or the date coverage ends due to the qualifying event, whichever is later, to elect COBRA coverage. If elected, COBRA coverage will begin October 1, 2025, and can last until March 18, 2027. You may elect to continue any of the following coverage options in which you are already enrolled: Standard Health, Dental, Dental Plus, Vision.

Generally, each qualified beneficiary is required to pay the entire cost of COBRA coverage. The premium includes both the employee's *and* employer's share of the total premium. Please refer to the enclosed monthly insurance premiums for COBRA document for more information. To elect COBRA coverage, please do the following:

- Step 1: Complete the enclosed *COBRA Notice of Election* form.
- Step 2: Make a copy of the signed *COBRA Notice of Election* form for your records.
- Step 3: Mail or hand-deliver the *COBRA Notice of Election* form to your COBRA ADMINISTRATOR at the address above. If mailed, it is recommended you obtain proof from the post office that you mailed the *COBRA Notice of Election* form. Your election is considered made on the date the *COBRA Notice of Election* form is postmarked, if mailed, or the date your *COBRA Notice of Election* form is received by the individual at the address specified for delivery, if hand delivered. No late elections will be accepted.
- Step 4: Call your COBRA ADMINISTRATOR within 10 days to ensure the *COBRA Notice of Election* form has been received.

If you do not elect COBRA coverage, your coverage under PEBA ends on October 1, 2025 due to the following qualifying event:

End of employment.
 Reduction in hours of employment.

If you were enrolled in a MoneyPlus Medical Spending Account, ASIFlex, the third-party administrator, will contact you regarding continuation of coverage.

You do not have to send any payment with the *COBRA Notice of Election* form. However, coverage will not start and claims will not be paid until payment is received. Important additional information about paying for COBRA coverage is in the enclosure *Important Information about Your COBRA Continuation Coverage Rights*.

If you have any questions about this notice or your rights to COBRA coverage, you should contact us at PEBA at 803.737.6800 or 888.260.9430.

Enclosures: Monthly insurance premiums for COBRA

COBRA Notice of Election form

Important Information about Your COBRA Continuation Coverage Rights

Important Information about Your COBRA Continuation Coverage Rights

What is COBRA continuation coverage?

Federal law requires that most group health plans (including those offered by PEBA) give employees and their families the opportunity to continue their health care coverage when there is a qualifying event that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, qualified beneficiaries can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse (or former spouse, if court ordered), and the children of the covered employee.

COBRA continuation coverage (COBRA coverage) is the same coverage that PEBA gives other participants or beneficiaries who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA coverage will have the same rights as other participants or beneficiaries covered under PEBA, including open enrollment and special enrollment rights.

COBRA (and the description of COBRA coverage in this notice) applies only to the group health benefits offered by PEBA (the health, dental, vision, and MoneyPlus Medical Spending Account) and not to any other benefits offered by PEBA.

PEBA provides no greater COBRA rights than what COBRA requires—nothing in this notice is intended to expand your rights beyond COBRA's requirements.

How can you elect COBRA continuation coverage?

To elect COBRA coverage, you must complete and submit the *COBRA Notice of Election* form according to the directions on the form. Each qualified beneficiary has a separate right to elect COBRA coverage. For example, the employee's spouse may elect COBRA coverage even if the employee does not. COBRA coverage may be elected for one, several or all children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of a child who is losing coverage as a result of the qualifying event. The employee or the employee's spouse can elect COBRA coverage on behalf of all the qualified beneficiaries.

COBRA coverage is available to qualified beneficiaries subject to their continued eligibility. PEBA reserves the right to verify COBRA eligibility and terminate COBRA coverage retroactively if a qualified beneficiary is determined to be ineligible or if there has been a material misrepresentation of the facts.

You may elect COBRA coverage under any or all of the group health components offered by PEBA (health, dental vision, and MoneyPlus Medical Spending Account) under which you were covered on the day before the qualifying event. For example, if a qualified beneficiary was covered under health and dental on the day before a qualifying event, he or she may elect COBRA coverage under dental only, health only, or under both health and dental. Such a qualified beneficiary could not elect COBRA coverage under Dental Plus, because he or she was not covered under Dental Plus on the day before the qualifying event.

Additional information about PEBA's health, dental, vision, and MoneyPlus Medical Spending Account coverage is found in the *Insurance Benefits Guide*, available at peba.sc.gov/publications.

Qualified beneficiaries who are eligible to elect COBRA coverage may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA coverage is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will end if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan

coverage. COBRA coverage will end after the qualified beneficiary satisfies any preexisting condition exclusion period or limitation under the new coverage. See the section entitled *How long will COBRA continuation coverage last?* for more information.

Special considerations in deciding whether to elect COBRA continuation coverage

In considering whether to elect COBRA coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, if you do not continue coverage and, as a result, have a break in coverage of more than 62 days, another group health and/or dental plan can impose a preexisting condition exclusion period on enrollees age 19 and older. Continuation under COBRA can prevent such a break in coverage. Second, you will lose the guaranteed right to purchase individual health coverage that does not impose a preexisting condition exclusion period, if you do not elect COBRA coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

Electing COBRA continuation coverage under the MoneyPlus Medical Spending Account (MSA)

COBRA coverage under the MoneyPlus Medical Spending Account (MSA) can last only until the end of the plan year in which the qualifying event occurred, subject to Plan rules on carryovers. The period of COBRA coverage under the MoneyPlus MSA cannot be extended under any circumstances. COBRA coverage under the MoneyPlus MSA will be offered only to qualified beneficiaries losing coverage. COBRA coverage will consist of the MoneyPlus medical flexible spending account coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by reimbursable claims submitted up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, and COBRA coverage will end at the end of the Plan Year in which the Qualifying Event occurred, subject to Plan rules on carryovers. ASIFlex, the third-party administrator, will contact you regarding continuation of coverage.

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a special enrollment period. Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

How long will COBRA continuation coverage last?

If the loss of coverage is due to end of employment or reduction in hours of employment, coverage generally may be continued up to 18 months. When the qualifying event is the end of employment or reduction of the

employee's hours of employment, *and the employee became entitled to Medicare benefits within the 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) can last up to 36 months after the date of Medicare entitlement. This COBRA coverage period for a spouse or children who are qualified beneficiaries is available only if the covered employee becomes entitled to Medicare within 18 months before the termination or reduction of hours.*

COBRA coverage under the MoneyPlus MSA can last only until the end of the plan year in which the qualifying event occurred, subject to Plan rules on carryovers. See the section entitled *Electing COBRA continuation coverage under the MoneyPlus Account (MSA)*.

COBRA coverage will end before the maximum benefit period is over if:

1. Any required premium is not paid in full on time;
2. A qualified beneficiary, after electing COBRA coverage, gains coverage under another group health plan that does not impose a pre-existing condition exclusion;
3. A qualified beneficiary first becomes entitled to Medicare benefits after electing COBRA coverage;
4. PEBA no longer provides group health coverage to any of its subscribers;
5. During a disability extension period the Social Security Administration determines the qualified beneficiary is no longer disabled (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate); or
6. An event occurs that would cause PEBA to end the coverage of any subscriber, such as the subscriber commits fraud.

The qualified beneficiary, his personal representative or his guardian is responsible for notifying PEBA when he is no longer eligible for COBRA. COBRA coverage will be canceled automatically by PEBA in situation numbers 1, 3, 4 and 6. The qualified beneficiary is responsible for submitting a *Notice to Terminate COBRA Continuation Coverage*, along with supporting documents, in situation numbers 2 and 5.

How can you extend the length of COBRA continuation coverage?

If you elect COBRA coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify your COBRA ADMINISTRATOR of a disability or a second qualifying event to extend the period of COBRA coverage. Failure to provide a timely notice of a disability or a second qualifying event may affect the right to extend the period of COBRA coverage.

Disability

If any of the qualified beneficiaries is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from a covered employee's termination of employment or reduction of hours (generally 18 months) may be extended to a total of up to 29 months. Each qualified beneficiary who has elected COBRA coverage will be entitled to the 11-month disability extension if one of them qualifies. This extension applies separately to each qualified beneficiary. If the disabled qualified beneficiary chooses not to continue coverage, the other qualified beneficiaries are still eligible for the extension.

The Social Security Administration must determine that the qualified beneficiary's disability started before the 61st day after the covered employee's employment ended or reduction of hours began, *and the disability must last until the end of the 18-month period of COBRA coverage.*

The disability extension is available only if you notify your COBRA ADMINISTRATOR in writing at the address above of the Social Security Administration's determination of disability within 60 days after the latest of:

- The date of the Social Security Administration's disability determination;
- The date of the covered employee's termination of employment or reduction of hours; and
- The date on which the qualified beneficiary loses (or would lose) coverage under PEBA as a result of the covered employee's termination or reduction of hours.

You also must provide this notice within 18 months after the covered employee's termination of employment or reduction of hours to be entitled to a disability extension. In providing this notice, you must use PEBA's form, *Notice to Extend COBRA Continuation Coverage*. You may obtain a copy of this form from PEBA at no charge, or you can print the form at peba.sc.gov/forms. You must follow the procedures specified in the section entitled *Notification procedures to extend COBRA continuation coverage*. **If these procedures are not followed or if the notice is not provided during the 60-day notice period and within 18 months after the covered employee's end of employment or reduction of hours, THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.**

If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify your COBRA ADMINISTRATOR of that fact within 30 days after the Social Security Administration's determination. You must use PEBA's form, *Notice to Terminate COBRA Continuation Coverage*. You may obtain a copy of this form from PEBA at no charge, or you can print the form at peba.sc.gov/forms.

Second Qualifying Event

An extension of coverage will be available to spouses and children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered employee's end of employment or reduction of hours.

The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months from the date of the original qualifying event. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, or a child ceasing to be eligible for coverage under PEBA. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under PEBA if the first qualifying event had not occurred.

It is the qualified beneficiary's responsibility to notify PEBA according to the notification procedures listed below within 60 days of the second event and within the 18 months (or, in the case of a disability extension, the 29 months) following the covered employee's end of employment or reduction of hours.

This extension due to a second qualifying event is available only if you notify your COBRA ADMINISTRATOR, in writing at the above address, of the second qualifying event within 60 days after the date of the second qualifying event or when coverage would have been lost, whichever is later. In providing this notice, you must use PEBA's form, *Notice to Extend COBRA Continuation Coverage*. You may obtain a copy of this form from PEBA at no charge, or you can print the form at peba.sc.gov/forms. You must follow the procedures specified in the section entitled *Notification procedures to extend COBRA continuation coverage*.

Notification procedures to extend COBRA continuation coverage

To extend your COBRA coverage due to a disability or a second qualifying event, please do the following:

- Step 1: Complete the *Notice to Extend COBRA Continuation Coverage*.
- Step 2: Complete a *COBRA Notice of Election* form available online at peba.sc.gov/forms or by calling PEBA at 803.737.6800 or 888.260.9430.
- Step 3: Make a copy of the forms for your records.
- Step 4: Attach the required documentation depending upon the qualifying event (refer to the *Notice to Extend COBRA Continuation Coverage*).
- Step 5: Mail the forms to your COBRA ADMINISTRATOR and document your mailing.
- Step 6: Call your COBRA ADMINISTRATOR within 10 days to ensure the forms have been received.

If these procedures are not followed or if the notice is not provided during the 60-day notice period, THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT. The notice to extend COBRA coverage can be made by any of the qualified beneficiaries.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary is required to pay 100 percent of the applicable premium for the coverage that is continued, plus a 2 percent administration charge. The premium includes both the employee's and employer's share of the total premium. If continuation coverage is extended due to a disability and the disabled qualified beneficiary elects the extension, the rate is 150 percent of the applicable premium. If only non-disabled qualified beneficiaries extend coverage, the rate will remain at 102 percent. The monthly premium for each component of the plan for which you can elect COBRA coverage is described in this notice.

There may be other coverage options for you and your family. For example, if you purchase health coverage in the Health Insurance Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a 30-day special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees.

When and how must payment for COBRA continuation coverage be made?

First payment for COBRA continuation coverage

If you elect COBRA coverage, you do not have to send any payment with the *COBRA Notice of Election* form. However, you must make your first payment for COBRA coverage no later than 45 days after the date of your election. This is the date the *COBRA Notice of Election* form is postmarked, if mailed, or the date your *COBRA Notice of Election* form is received by the individual at the address specified for delivery, if hand-delivered. **If you do not make your first payment for COBRA coverage in full no later than 45 days after the date of your election, you will lose all COBRA coverage rights under PEBA.**

Your first payment must cover the cost of COBRA coverage from the time your coverage under PEBA would have otherwise ended up through the end of the month before the month in which you make your first payment. For example, if you lost health insurance on January 31, 2019, and elected COBRA coverage on March 1, 2019, you would have until April 15, 2019, to pay your first payment. You are responsible for making sure the amount of

your first payment is correct. You may contact your COBRA ADMINISTRATOR to confirm the correct amount of your first payment.

Monthly payments for COBRA continuation coverage

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due each month for each qualified beneficiary is shown in this notice. Each premium payment for COBRA coverage is due on the 10th of the month for that month (for example, the payment for coverage for April is due on April 10). If you make a monthly payment on or before the 10th day of the month to which it applies, your coverage under PEBA will continue for that month without a break. Once you are enrolled for COBRA coverage, PEBA may send monthly reminders, although this is not required by federal law.

Grace periods for monthly payments

Although premium payments are due on the 10th of the month for that month, you will be given a grace period of 60 days following the due date to make the premium payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. If payment is not made within the grace period, coverage will be canceled retroactively to the end of the previous month. **Once COBRA coverage is canceled, it cannot be reinstated.** Partial payments will not be accepted and will not prevent cancellation of coverage.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under PEBA.

All COBRA premiums must be paid by check or money order. Your first payment and all monthly payments for COBRA coverage should be sent to your COBRA ADMINISTRATOR.

If mailed, your payment is considered to have been made on the date it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified for delivery. You will not be considered to have made any payment by mailing or hand delivering a check if your check is returned due to insufficient funds or otherwise.

Warning about paying near the end of a grace period

If you wait until near the end of a grace period to mail your premium payment, you run the risk of not having sufficient time to correct errors, which may or may not be within your control, such as the U.S. Postal Service postmarked your payment AFTER the last date to pay or the envelope was lost. Take all precautions when paying, as no late premiums are accepted.

What is the Health Insurance Marketplace?

The Marketplace offers one-stop shopping to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from [Medicaid](#) or the [Children's Health Insurance Program \(CHIP\)](#). You can access the Marketplace for your state at [www.HealthCare.gov](#).

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.



When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a special enrollment event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an open enrollment period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a “special enrollment period.” But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you’ll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you’ve exhausted your COBRA continuation coverage and the coverage expires, you’ll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

More information about individuals who may be qualified beneficiaries

Children born to or placed for adoption with the covered employee during COBRA continuation coverage period

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child’s COBRA coverage begins when the child is enrolled in PEBA coverage, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in PEBA coverage, the child must satisfy the applicable eligibility requirements (for example, regarding age).

Alternate recipients under QMCSOs or NMSNs

A child of the covered employee who is receiving benefits under PEBA pursuant to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) received by PEBA during the covered employee’s period of employment is entitled to the same rights to elect COBRA coverage as an eligible child of the covered employee.

For more information

This notice does not fully describe COBRA coverage or other rights under PEBA. More information about COBRA coverage and your rights is available in the *Insurance Benefits Guide*, available online at peba.sc.gov/publications.

If you have any questions concerning the information in this notice or your rights to coverage, contact PEBA at 803.737.6800 or 888.260.9430, or visit PEBA's website at peba.sc.gov.

For more information about your rights under COBRA, contact the Centers for Medicare & Medicaid Services at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_qna.html.

Keep your COBRA ADMINISTRATOR informed of address changes

To protect your rights and your family's rights, you should keep your COBRA ADMINISTRATOR informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to your COBRA ADMINISTRATOR.





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
Standard Plan¹	\$637.28	\$1,389.44	\$1,070.80	\$1,791.00	\$433.52
Savings Plan¹	\$547.54	\$1,209.96	\$944.94	\$1,593.56	\$397.40
Medicare Supplemental^{1,2}	\$637.28	\$1,389.44	\$1,070.80	\$1,791.00	\$433.52
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 premium¹	\$40.00	\$60.00	\$60.00	\$60.00	\$60.00

29 months

	Subscriber	Subscriber/ spouse	Subscriber/ children	Full family	Children only
Standard Plan¹	\$937.16	\$2,043.30	\$1,574.70	\$2,633.82	\$637.54
Savings Plan¹	\$805.20	\$1,779.36	\$1,389.62	\$2,343.48	\$584.42
Medicare Supplemental^{1,2}	\$937.16	\$2,043.30	\$1,574.70	\$2,633.82	\$637.54
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 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 they cover uses tobacco or e-cigarettes, or covered individuals who use tobacco or e-cigarettes have completed the Plan's 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.

COBRA NOTICE OF ELECTION (NOE)

SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY

C

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)		
	Verification of eligibility (required of retirees from employers other than state agencies and school districts) <small>(Local Subdivisions: Make sure you have received payment before sending the NOE)</small>								
ACTION	Benefits Administrator Signature _____				Employer ID: _____				
					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 <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed □ F <input type="checkbox"/> Married <input type="checkbox"/> 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)			18. DENTAL (Refuse or select one plan and one level of coverage)			19. VISION CARE (select one)		
	PLAN	COVERAGE LEVEL		PLAN	COVERAGE LEVEL		PLAN	COVERAGE LEVEL	
<input type="checkbox"/> Refuse <input type="checkbox"/> Standard <input type="checkbox"/> Savings <input type="checkbox"/> Medicare Supplement	<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		<input type="checkbox"/> Refuse <input type="checkbox"/> Dental Plus <input type="checkbox"/> Basic Dental	<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		<input type="checkbox"/> Refuse <input type="checkbox"/> Standard <input type="checkbox"/> Savings <input type="checkbox"/> Medicare Supplement	<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		
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	
				<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					
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	
	<input type="checkbox"/>	Spouse			<input type="checkbox"/>			<input type="checkbox"/> Does PEBA Insurance Benefits <input type="checkbox"/> Yes <input type="checkbox"/> already cover your spouse? <input type="checkbox"/> No	
	<input type="checkbox"/>	Child			<input type="checkbox"/>			<input type="checkbox"/> Incapacitated	
	<input type="checkbox"/>	Child			<input type="checkbox"/>			<input type="checkbox"/> Incapacitated	
<input type="checkbox"/>	Child			<input type="checkbox"/>			<input type="checkbox"/> 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)

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.