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Introduction

BENEFITS ADMINISTRATORS AND OTHERS CHOSEN BY YOUR EMPLOYER WHO MAY ASSIST WITH INSURANCE ENROLLMENT, CHANGES, RETIREMENT OR TERMINATION AND RELATED ACTIVITIES ARE NOT AGENTS OF THE EMPLOYEE INSURANCE PROGRAM AND ARE NOT AUTHORIZED TO BIND THE EMPLOYEE INSURANCE PROGRAM.

THIS GUIDE CONTAINS AN ABBREVIATED DESCRIPTION OF INSURANCE BENEFITS PROVIDED BY OR THROUGH THE EMPLOYEE INSURANCE PROGRAM. THE PLAN OF BENEFITS DOCUMENTS AND BENEFITS CONTRACTS CONTAIN COMPLETE DESCRIPTIONS OF THE HEALTH AND DENTAL PLANS AND ALL OTHER INSURANCE BENEFITS. THEIR TERMS AND CONDITIONS GOVERN ALL BENEFITS OFFERED BY OR THROUGH THE EMPLOYEE INSURANCE PROGRAM. IF YOU WOULD LIKE TO REVIEW THESE DOCUMENTS, CONTACT YOUR BENEFITS ADMINISTRATOR OR THE EMPLOYEE INSURANCE PROGRAM.

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

We know that your benefits are important to you and to your family. We also know that you lead busy lives and often don't have a chance to read about your insurance until there is a need to use it. For that reason, we continually try to make the *Insurance Benefits Guide* (IBG) easier to understand and use.

"What's New?" on page 4 highlights major changes in insurance benefits offered through the Employee Insurance Program (EIP). There also are some changes in this book.

- We are now using "member," rather than "enrollee," to refer to someone covered under an insurance plan. It includes covered family members, as well as the subscriber, the person who makes participation in the plan possible, such as an employee or a retiree.
- "Allowed amount," rather than "allowable charge," is now used to refer to the most a plan will pay for a covered service or product, whether it is provided in-network or out-of-network.

As always, this guide includes explanations of benefits, premiums and contact information and gives an overview of the health plans and other benefits offered through EIP.

Every year the benefits EIP offers change. To avoid mistakes, please recycle your 2011 *Insurance Benefits Guide* and use this one.

Terms that may be unfamiliar to you are italicized and defined in the text. However, if you have questions, ask your benefits administrator; the third-party claims processor, such as BlueCross BlueShield of South Carolina; or EIP. Turn to the index for help in finding information about specific topics, including definitions of terms.

Remember, only information concerning those benefits for which you are eligible and in which you are enrolled applies to you.

We encourage you to review each chapter that applies to you and to discuss your benefits with your family. Charts are included to help you compare plans. Pay close attention to copayments, deductibles, preauthorization requirements and services that may be limited or not covered.

- **For a more detailed explanation of your benefits:** Check the appropriate chapter in the IBG. If you still have questions, call your benefits administrator or EIP.
- **For information about processing and payment of claims**: Contact the appropriate third-party claims processor listed on the inside cover of this book.

To make the best use of your insurance, please remember:

- **You are responsible for understanding your benefits. Ask questions if you do not understand them.**
- **Coverage and changes are not automatic.**
- **A special eligibility situation permits you to make changes in your coverage within 31 days of an event, such as birth, adoption, marriage or loss of other coverage. To do so, contact your benefits administrator.**
- **Whether you are enrolled in the State Health Plan or an HMO, some services are not covered or must be approved before you receive them. Check preauthorization requirements, such as those for maternity benefits, and exclusions now, so you will be familiar with them when you need services.**

Notices to Members

State Health Plan's Grandfathered Status Allows Premiums to Remain Stable

EIP believes the plans it offers are "grandfathered health plans" under the Affordable Care Act. As grandfathered plans, EIP will be able to minimize the increase in State Health Plan and HMO premiums while it assesses the future financial impact of the act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that the plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 803-734-0678 (Greater Columbia area) and 888-260-9430 (toll-free outside the Columbia area).

You may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.

Notice About the Early Retiree Reinsurance Program

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, copayments, deductibles, coinsurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you in your health plan coverage terms and conditions, for as long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for that purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who participate in this plan.

What's New?

Eligibility

- To enroll a family member during initial or open enrollment or as a result of a special eligibility situation, a subscriber is now required to provide copies of documents proving the eligibility of each family member he wishes to cover.

  For details, see pages 20-21.

- As part of the Dependent Eligibility Audits, which began in April 2011, each subscriber will be asked to provide documents proving the eligibility of each family member he covers.

  For details, see page 11.

All Health Plans

- Premiums for all health plans have increased.

  For details, see pages 227-230.

- The tobacco-use surcharge may be waived if a subscriber provides a letter from his physician saying that it is unreasonably difficult for him to stop using tobacco due to a medical condition or that it is medically inadvisable for him to attempt to stop using tobacco.

  For details, see page 40.

State Health Plan

- Companion Benefit Alternatives (CBA) is now the mental health/substance abuse manager for the Savings Plan, the Standard Plan and the Medicare Supplemental Plan. CBA is the mental health and substance abuse division of BlueCross BlueShield of South Carolina.

  For details about the provider network, see pages 47-48.

  For details about benefits, including preauthorization requirements, see pages 72-73.

Confidentiality Policies

The South Carolina Budget and Control Board Employee Insurance Program (EIP) is committed to protecting the privacy of your health information. EIP strives continually to ensure its compliance with the Health Insurance Portability and Accountability Act (HIPAA), which mandates security and privacy of health information by setting standards for access and distribution of that information.

EIP provides a Notice of Privacy Practices directly to all persons covered under the state insurance program. This brochure outlines the situations in which EIP uses and discloses health information. It also outlines your rights with regard to the information and disclosure. A copy of EIP's Notice of Privacy Practices begins on page 241 and is also on the EIP website, www.eip.sc.gov under "HIPAA." In addition, the website contains links to forms mentioned in the Notice of Privacy Practices.

If you would like for someone, such as your spouse or your parents, to have access to your protected health information – or if they would like for you to have access to theirs – you, as a subscriber or a covered dependent, must complete an Authorized Representative Form. The form is on EIP's website under "Forms." Go to "Other Forms" and select "HIPAA Information" and then "Authorized Representative Form."

If you have any questions about HIPAA, please contact:

Privacy Officer
South Carolina Budget and Control Board
1201 Main Street, Suite 300
Columbia, SC 29201
Phone: 803-734-0678
Fax: 803-737-0825
E-mail: privacyofficer@eip.sc.gov

Fraud Prevention Hotline

Inspector General's Fraud Hotline
(State agency fraud only)

1-855-723-7283
or
1-855-SCFRAUD

If you would like to report a fraud related to a specific program offered through the Employee Insurance Program, you may also call the program's customer service number.

General Information

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Your Insurance Benefits: Help When You Need It Most

Your insurance, offered through the Employee Insurance Program (EIP), provides a financial safety net when you are ill or injured. This chapter describes how to enroll in insurance coverage when you begin work for a state-covered employer. It also provides information that may be useful to anyone covered by any plan EIP offers.

Eligibility

An Eligible Active Employee

- Is employed by the state, a higher education institution, a public school district or a participating *local subdivision* and
- Works in a permanent, full-time position and
- Receives compensation from the state, a higher education institution, a public school district or a participating local subdivision.

Some benefits are based on your annual salary. If you do not know your salary, ask a staff member in your employer's personnel office.

Eligible employees also include clerical and administrative employees of the S.C. General Assembly and judges in the state courts; General Assembly members; elected members of the councils of participating counties or municipalities who also participate in the S.C. Retirement Systems (SCRS); and permanent, part-time teachers are considered employees for insurance purposes. Generally, members of other governing boards are not eligible for coverage. If you work for more than one *participating group***, contact your benefits administrator for further information.**

A *local subdivision* is any *participating group* other than a state agency, a higher education institution or public school district. Examples include: counties, municipalities, councils on aging, commissions on alcohol and other drug abuse, special purpose districts, community action agencies, disabilities and special needs boards, recreation districts, hospital districts and councils of government. The General Assembly passed legislation extending voluntary participation in the state insurance program to certain local subdivisions. For a local subdivision to be eligible to participate in the state insurance program, it must fall within one of the categories established by statute (Section 1-11-720 of the S.C. Code of Laws, as amended).

An orientation presentation for new employees is on EIP's website, www.eip.sc.gov.

An Eligible Retiree

A retiree may be eligible for coverage if he worked for an employer that participates in the state insurance program and retired:

- Due to years of service
- Due to age
- On approved disability
  - Through the S.C. Retirement Systems (SCRS)
  - Through approval by Standard Insurance Company for Basic Long Term Disability and/or Supplemental Long Term Disability, if he participates in the Optional Retirement Program (ORP) or works for an employer that does not participate in SCRS.

To learn where to find information about retiree insurance, see the Retiree Checklist on page 35.

An Eligible Spouse

- Is a lawful spouse or
- A former spouse who is required to be covered by a divorce decree.

You may cover your current spouse or your divorced spouse, but you cannot cover both spouses.

See page 20 for documentation requirements.

When you enroll a family member, you must document his relationship to you. See pages 20-21 to learn how to do it.

A spouse who is eligible for coverage as an employee of any participating group, including a local subdivision, or as a state-funded retiree may not be covered as a spouse under any plan. A spouse who is a permanent, part-time teacher may be covered as an employee or as a spouse, but not as both. A spouse who is a non-funded retiree may be covered as a retiree or as a spouse, but not as both.

An Eligible Child

- Must be younger than age 26
- Must not be eligible for a group health plan sponsored by an employer (either as an employee or as a spouse)
- Must be the subscriber's natural child, adopted child (including child placed for legal adoption), stepchild, *foster child*, a *child for whom the subscriber has legal custody* or a child the subscriber is required to cover due to a court order.

When you enroll a spouse or child of any age, you must give your benefits administrator his date of birth and Social Security Number.

A *foster child* is a child placed by an authorized placement agency with the subscriber, who is a licensed foster parent.

A *child for whom the subscriber has legal custody* is a child for whom the subscriber has guardianship responsibility, not merely financial responsibility, according to a court order or other legal document.

If you and your spouse are both eligible for coverage, only one of you can cover your children under any one plan. However, one parent can cover the children under health, and the other can cover the children under dental.

See page 20 for documentation requirements.

A Child Age 19 and Older

According to the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, a child age 19-25 does not need to be certified as a full-time student or an incapacitated child to be covered under his parent's health, dental or vision insurance.

Health, dental and vision coverage for a child ends the last day of the month in which he turns 26, unless he is covered as an incapacitated child.

However, according to state law, a dependent child, age 19-24, must be a full-time student to be covered under **Dependent Life-Child insurance**. A child of any age who has been certified by EIP as an incapacitated child may continue to be covered under Dependent Life-Child. For more information about eligibility for Dependent Life-Child coverage, see page 130.

To file a claim under Dependent Life-Child for a child age 19-24, a subscriber must obtain a statement on letterhead from the educational institution the child was attending that verifies he was a full-time student

and gives his dates of enrollment. The statement should be given to the subscriber's BA, who will send it to MetLife with the claim form.

To file a claim for an incapacitated child, the subscriber must give certification of incapacitation to his BA, who will send it to MetLife with the claim form.

Please note: If a child is found to be ineligible for Dependent Life-Child coverage, benefits will not be paid.

An Incapacitated Child

You can continue to cover your child who is age 26 or older if he is incapacitated and you are financially responsible for him. To cover your dependent child who is incapacitated, he must meet these requirements:

- The child must have been continuously covered by health insurance from the time of incapacitation
- The child must be unmarried and must remain unmarried to continue eligibility
- The child must be incapable of self-sustaining employment because of mental illness, retardation or physical disability and must remain principally dependent (more than 50 percent) on the covered employee, retiree, survivor or COBRA subscriber for support and maintenance.

Incapacitation must be established no earlier than 90 days before the child's 26th birthday (or before the child's 19th birthday for him to be covered under Dependent Life-Child) but no later than 31 days after the date he is no longer eligible for coverage as a child. An Incapacitated Child Certification Form must be completed by the subscriber and the child's physician and then sent to EIP for review. EIP will send the form to Standard Insurance Company for review of the medical information. Additional medical documentation from the child's physician may be required by The Standard. The Standard will forward its recommendation to EIP, which makes the final decision.

Please send a copy of your most recent federal tax return, which will demonstrate the child is principally dependent on you, the subscriber, for support and maintenance. Also attach a completed Authorized Representative Form signed by the incapacitated child, a copy of guardianship papers or a power of attorney that verifies your authority to act for your incapacitated child. Any of these documents give EIP permission to discuss or disclose the child's protected health information with the child's Authorized Representative.

A Survivor

Spouses and children covered under the State Health Plan, an HMO, a dental plan or the State Vision Plan are classified as "survivors" when a covered employee or retiree dies. **For more information about survivor coverage, see pages 32-33.**

Dependent Eligibility Audits

Your employer-sponsored health insurance is a valuable benefit, but it is also an expensive one. It becomes more costly to you and your employer when ineligible individuals are covered. In 2011, EIP began requiring documentation of eligibility when family members enroll in coverage. The Dependent Eligibility Audit checks the eligibility of family members who were covered through EIP before that rule went into effect. This ongoing process is designed to ensure that only eligible individuals are covered under state benefits.

If you enrolled before EIP began requiring proof of eligibility, you will eventually receive a letter asking you to provide specific documents showing that family members you cover are eligible. If you do not do so within 60 days of the date of the letter from EIP, they will be dropped from coverage.

If you wish to prepare for the audit, go to EIP's website, www.eip.sc.gov, and check MyBenefits to make sure EIP has your correct address on file. You may also want to go ahead and obtain the documents you will need for the audit. To get a link to the list and to learn more about the audit, go to www.eip.sc.gov/audit.

Coordination of Benefits

Some families in which one spouse works for a participating employer and the other works for an employer that is not covered through EIP are eligible to enroll in two health plans. While the additional coverage may mean that more of your medical expenses are paid by insurance, you will probably pay premiums for both plans. Weigh the advantages and disadvantages before purchasing extra coverage.

Most health plans have a system to determine how claims are handled when a person is covered under more than one insurance plan. This is called "coordination of benefits" (COB). When a subscriber has coverage under more than one plan, he can file a claim for reimbursement from each plan. Third-party claims processors, such as BlueCross BlueShield of South Carolina or an HMO, coordinate benefits so that you get the maximum reimbursement allowed. **That amount will never be more than 100 percent of your covered medical, dental or prescription drug benefits. Your plan will not pay more as a secondary plan than it would have paid if it were the primary plan.**

There are rules that determine the order in which the plans pay benefits. The plan that pays first is the *primary* plan. The *secondary* plan pays after the primary plan. Here are some examples of how that works:

- The plan that covers a person as an employee is primary to the plan that covers the person as a dependent.
- When both parents cover a child, the plan of the parent whose birthday comes earlier in the year is primary. Other rules may apply in special situations, such as when a child's parents are divorced.
- If you are eligible for Medicare and are covered as an active employee, your State Health Plan or HMO coverage is primary over Medicare. Exceptions may apply in the case of Medicare coverage due to kidney disease. Contact your local Social Security office for details.
- If a person is covered under one plan because the subscriber is an active employee and under another plan because the subscriber is retired, the active employee's plan typically pays first. There may be exceptions to this rule.

For more information about how coordination of benefits works, call your health plan's customer service number.

What to Do if You Previously Had Health Insurance

As required under HIPAA, when you enroll in a health plan, a certificate of *creditable coverage* from your former employer or insurance company may reduce or eliminate a period when your new plan does not cover *pre-existing conditions*, if there has been no *significant break in creditable coverage*. A *significant break in coverage* is a period of more than 62 days in which you had no health insurance.

Most health insurance is creditable coverage. To show you had it, give your benefits administrator a *creditable coverage* letter or a statement on letterhead from your former employer or insurance company that includes the dates coverage began and ended (or that it is still in effect), the names of those covered and the type of coverage.

A *pre-existing condition* is any illness or injury for which medical advice, diagnosis, care or treatment was recommended or received during a specified period.

- **For a new employee,** this period begins six months before the date he was hired. The period when the plan will not pay benefits for treatment of a pre-existing condition ends 12 months after his hire date.
- **In a special eligibility situation,** this period begins six months before the date the coverage became effective. The period when the plan will not pay benefits for treatment of a pre-existing condition ends 12 months after the date the coverage became effective. (See "Special Eligibility Situations" on pages 24-28.)

- **For a late entrant,** this period begins six months before the date the coverage became effective. The period when the plan will not pay benefits for treatment of a pre-existing condition ends 18 months after the date the coverage became effective. (Spouses and children added during open enrollment are also considered late entrants.)

Pregnancy is not considered a pre-existing condition. Rules excluding coverage of pre-existing conditions do not apply to a covered person age 18 and younger. CIGNA HMO, the State Dental Plan and Dental Plus and the State Vision Plan do not have pre-existing condition exclusion periods.

Late Entrants

If you do not enroll within 31 days of the date you begin employment, retire or experience a special eligibility situation, you cannot enroll yourself or your eligible spouse and/or children until the next open enrollment period. Open enrollment is held in October of odd-numbered years, and your coverage will take effect the following January 1. As late entrants, you and your spouse and/or children age 19 and older will be subject to an 18-month pre-existing condition exclusion period, which may be reduced by prior creditable coverage.

Enrolling as a Transferring Employee

As an active employee, EIP considers you a transfer if you change employment from one participating group to another with no break in insurance coverage or with a break of employment of no more than 15 calendar days.

To avoid a lapse in coverage or delays in processing claims, be sure to tell your benefits administrator if you transfer to another participating group. **Check with the benefits administrator at your new employer to be sure that your benefits have been transferred.**

A transfer is not a new hire for insurance purposes. He must remain enrolled in the same insurance benefits in which he was enrolled at his former employer.

As an **academic employee**, you are considered a transfer if you complete a school term and move to another participating academic employer at the beginning of the next school term. Your insurance coverage with the employer you are leaving will remain in effect until you begin work with your new employer, typically September 1. On that date, your new employer will pick up your coverage. If you do not transfer to another participating academic employer, your coverage ends the last day of the month in which you were engaged in active employment.

EIP Benefits Available to You

Choosing a Health Plan

Three health plans are available. The State Health Plan operates as a preferred provider organization (PPO). BlueChoice HealthPlan HMO and CIGNA HMO are health maintenance organizations.

Basic Life Insurance and Basic Long Term Disability Insurance are provided at no charge to active employees who enroll in a health plan. Those who do not enroll in a health plan do not receive this coverage.

The benefits each plan offers are similar but not identical. All cover prescription drugs and mental health and substance abuse services, as well as care from doctors and in hospitals. There are differences in provider networks, preventive services and a subscriber's freedom to decide when to see a specialist. The costs — including deductibles, copayments and premiums — also differ. Compare the plans to determine which one best suits your needs. Active employees may pay premiums before taxes through MoneyPlu$.

Comparison of Health Plan

Plan	SHP Savings Plan		SHP Standard Plan[2]	
Availability	Coverage worldwide		Coverage worldwide	
Active Employee Monthly Premiums *Employee Only* *Employee/Spouse* *Employee/Children* *Full Family*	**The tobacco-use surcharge is $40 a month for a subscriber with single coverage and**			
	$ 9.70 **$ 77.40** **$ 20.48** **$113.00**		**$ 97.68** **$253.36** **$143.86** **$306.56**	
	Please note that premiums for optional employer groups, such as local			
Annual Deductible *Single* *Family*	**(no per-occurrence deductibles)** **$3,000** **$6,000[3]**		**$350** **$700**	
Coinsurance	**In-network** Plan pays 80% You pay 20%	**Out-of-network** Plan pays 60% You pay 40%	**In-network** Plan pays 80% You pay 20%	**Out-of-network** Plan pays 60% You pay 40%
Coinsurance Maximum *Single* *Family*	**$2,000** **$4,000** **(excludes deductible)**	**$4,000** **$8,000** **(excludes deductible)**	**$2,000** **$4,000** **(excludes deductible)**	**$4,000** **$8,000** **(excludes deductible)**
Physicians Office Visits	Chiropractic payments limited to **$500** a year, per person		Chiropractic payments limited to **$2,000** a year, per person	
	No per-occurrence deductibles or copays		**$10** per-occurrence deductible, then:	
	In-network Plan pays 80% You pay 20%	**Out-of-network** Plan pays 60% You pay 40%	**In-network** Plan pays 80% You pay 20%	**Out-of-network** Plan pays 60% You pay 40%
Hospitalization/ Emergency Care	No per-occurrence deductibles or copays		Outpatient facility services: **$75** per-occurrence deductible Emergency care: **$125** per-occurrence deductible	
Prescription Drugs	Participating pharmacies and mail order only: You pay the State Health Plan's allowed amount until the annual deductible is met. Afterward, the plan will reimburse 80% of the allowed amount; you pay 20%. When coinsurance maximum is reached, the plan will reimburse 100% of the allowed amount.		Participating pharmacies only (up to 31-day supply): **$9** Tier 1 (generic–lowest cost alternative), **$30** Tier 2 (brand–higher cost alternative), **$50** Tier 3 (brand–highest cost alternative) Mail order (63-90-day supply): **$22** Tier 1, **$75** Tier 2, **$125** Tier 3 Copay maximum: **$2,500**	

[1]This table is for comparison purposes only.
[2]Refer to the Medicare chapter in this guide for information on how this plan coordinates with Medicare.
[3]If more than one family member is covered, no family member will receive benefits, other than preventive, until the $6,000 annual family deductible is met.

Benefits Offered for 2012[1]

	BlueChoice HealthPlan HMO[2]	CIGNA HMO[2]	Medicare Supplemental Plan[2]
	Available in all South Carolina counties Emergency and urgent coverage worldwide	**Not available** in *Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick or Saluda counties* Emergency and urgent coverage worldwide	Same as Medicare Available to retirees and covered spouse and/or children/survivors who are eligible for Medicare
$60 a month if a subscriber has dependent coverage and anyone he covers uses tobacco. See page 40 for details.			
	$201.82 **$558.76** **$384.74** **$769.48**	**$379.18** **$891.48** **$712.96** **$1,282.60**	Refer to the premium tables on pages 227-230 for rates
subdivisions, may vary. To verify your rates, contact your benefits office.			
	$250 **$500**	None	Pays Medicare Part A and Part B deductibles
	HMO pays 85% after deductible or hospital copays You pay 15%	HMO pays 80% after copays You pay 20%	Pays Part B coinsurance of 20%
	$2,000 **$4,000** **(excludes deductible)**	**$2,000** **$4,000** **(includes inpatient, outpatient, copays and coinsurance)**	None
	$15 PCP copay **$15** OB/GYN well-woman exam **$40** specialist copay	**$15** PCP copay **$15** OB/GYN exam **$30** specialist copay	Pays Part B coinsurance of 20%
	Inpatient: **$200** copay Outpatient: **$100** copay/first 3 visits Emergency care: **$125** copay, HMO pays 85% after copays; you pay 15% Urgent care: **$35** copay, then HMO pays 100%	Inpatient: **$500** copay per admission, then HMO pays 80% Outpatient facility: **$250** copay per admission, then HMO pays 80% Emergency room: **$100** copay, then HMO pays 100%	**For inpatient hospital stays**, the Plan pays: Medicare deductible; coinsurance for days 61-150; 100% beyond 150 days (Medi-Call approval required) **For skilled nursing facility care**, the Plan pays coinsurance for days 21-100; 100% beyond 100 days, up to 60 days per year.
	Participating pharmacies only (31-day supply): **$8/$15** generic, **$35** preferred brand, **$55** non-preferred brand, **$125/$80** specialty pharmaceuticals Mail order (Up to 90-day supply): **$20/$37.50** generic, **$87.50** preferred brand, **$137.50** non-preferred brand	Participating pharmacies only (up to 30-day supply): **$7** generic, **$25** preferred brand, **$50** non-preferred brand Mail order (up to 90-day supply): **$14** generic, **$50** preferred brand, **$100** non-preferred brand	Participating pharmacies only (up to 31-day supply): **$9** Tier 1 (generic-lowest cost alternative), **$30** Tier 2 (brand-higher cost alternative), **$50** Tier 3 (brand-highest cost alternative) Mail order (up to 90-day supply): **$22** Tier 1, **$75** Tier 2, **$125** Tier 3 Copay max: **$2,500**

No matter which health plan you choose or whether you are an active, retired, COBRA or survivor subscriber, if you have single coverage and use tobacco, you will pay a $40 monthly surcharge. If you have subscriber/spouse, subscriber/children or full-family coverage and anyone you cover uses tobacco, the monthly surcharge will be $60.

If your physician provides a letter stating that it is unreasonably difficult for you to stop using tobacco due to a medical reason or that it is medically inadvisable for you to attempt to stop using tobacco, you may be eligible for a waiver of the surcharge. See page 40 for more information.

Please note: No health plan offered through EIP has a lifetime maximum benefit.

For premiums, see pages 227-230.

The State Health Plan

As a *preferred provider organization*, the State Health Plan has networks of doctors, hospitals and other providers that will accept the plan's *allowed amount* as payment in full. An allowed amount is the most a health plan will pay for a covered procedure, service or supply. Network providers also file subscribers' claims.

A subscriber must use network pharmacies. He may use any doctor, hospital or mental health and substance abuse provider he chooses. However, a higher percentage of his healthcare costs will be paid if he receives care from a network provider. After he reaches his deductible, he pays coinsurance until he reaches the coinsurance maximum. After that, he is no longer required to pay coinsurance.

The SHP offers the Standard Plan, the Savings Plan and, for retirees who are eligible for Medicare, the Medicare Supplemental Plan.

The annual deductibles for the **Standard Plan** are lower than for the Savings Plan, but the premiums are higher. Subscribers also pay per-occurrence deductibles for office visits, outpatient facility services and emergency care. These deductibles continue even after a subscriber reaches his coinsurance maximum. Prescription drugs can be purchased for a copayment but do not contribute to the coinsurance maximum.

Savings Plan premiums are lower, but the deductible is higher. After a subscriber reaches his deductible, he pays coinsurance for services and prescription drugs until he reaches his coinsurance maximum. The Savings Plan offers more preventive benefits than the Standard Plan. An important advantage of the plan is that a subscriber can save for medical expenses with a tax-free Health Savings Account, which is discussed in the MoneyPlu$ chapter.

For more information about the State Health Plan, see pages 41-77.

Health Maintenance Organizations (HMOs)

HMO members must use network healthcare providers, including hospitals, except in emergencies. Each family member chooses his own primary care physician, who coordinates his care, including referrals to specialists.

BlueChoice HealthPlan HMO

BlueChoice HealthPlan HMO is offered statewide. Most services, such as office visits, well child care visits, routine physicals and immunizations, require only a copayment. BlueChoice has an annual deductible, which applies to some services. Prescription drugs are available from a network pharmacy for a copayment.

For more information about BlueChoice HealthPlan, see pages 78-89.

CIGNA HMO

CIGNA HMO is offered in all counties **except** Aiken, Abbeville, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda. CIGNA HMO has no pre-existing condition exclusion period and no annual deductible. Members share costs by making copayments for some services. Prescription drugs are available from a network pharmacy for a copayment.

For more information about CIGNA HMO, see pages 90-95.

Dental Insurance

This plan assists with dental expenses. Benefits are divided into four classes. The State Dental Plan covers Class IV, orthodontics, but Dental Plus does not. The maximum yearly amount paid for benefits for each covered person is $1,000 under the State Dental Plan and $2,000 for those covered under both plans. Active employees may pay premiums before taxes through MoneyPlu$.

State Dental Plan

The State Dental Plan is free to active employees and funded retirees. An eligible spouse and/or children may be added by paying a premium. They do not have to be enrolled in a health plan to enroll in the State Dental Plan.

Dental Plus

To enroll in Dental Plus, a subscriber must also be enrolled in the State Dental Plan, cover the same family members under both plans and pay an additional premium. Dental Plus covers the same services in Classes I – III. Because the *allowed amounts*, the maximum amounts the plan allows for covered services, are higher, you will pay less for dental care covered in Classes I- III.

Classes of Dental Coverage

Class	Services	Yearly Deductible	Percent Covered
I	Diagnostic and Preventive	None	100% of allowed amount
II	Basic	$25	80% of allowed amount
III	Prosthodontics	$25	50% of allowed amount
IV	Orthodontics	None	$1,000 lifetime maximum. Covered children age 18 and younger only. Dental Plus does not cover orthodontics.

For more information about dental insurance, see pages 99-106. For premiums, see pages 227-230.

Vision Care

State Vision Plan

This plan is open to active and retired employees, permanent, part-time teachers, survivors and COBRA subscribers, as well as to their eligible spouse and/or children. It offers benefits for a comprehensive vision exam every year, eyeglass lenses or contact lenses every year and frames every two years.

For more information about the State Vision Plan, see pages 109-114. For premiums, see pages 227-230.

Vision Care Discount Program

This program is offered at no cost to full-time and part-time employees, retirees, survivors and COBRA subscribers and their spouse and/or children. Participating providers offer a routine eye examination for $60.

Providers also give a 20 percent discount on all eyewear except disposable contact lenses. These discounts can vary yearly.

For more information about the Vision Care Discount Program, see page 114.

Life Insurance

Coverage offered through EIP is *term life insurance*. Term life insurance provides coverage for a specific period of time. It has no cash value.

Basic Life Insurance (for active employees only)

Term life and accidental death and dismemberment insurance is provided free to employees enrolled in a health plan. Employees younger than 70 receive $3,000 in life insurance. Those 70 and older receive $1,500.

Optional Life Insurance

Employees can enroll in this term life insurance within 31 days of the date they are hired. Enrollment in a health or dental plan is not required.

An employee can choose coverage, in $10,000 increments, up to three times his basic annual salary, rounded down to the nearest $10,000 ($500,000 maximum), without providing medical evidence of good health. An employee can purchase more insurance, in $10,000 increments, up to a maximum of $500,000, by providing medical evidence of good health. Coverage starts on the first day of the month in which he starts work, if he is actively at work as a full-time employee on that date. If he is not, it starts on the first day of the month after the date he began work. Coverage that requires medical evidence starts on the first day of the month after approval.

Dependent Life–Spouse

Within 31 days of the date he begins employment or marries, an employee can enroll his spouse for $10,000 or $20,000 in term life insurance without providing medical evidence of good health. The employee does not have to be enrolled in Optional Life.

Medical evidence is required for coverage of more than $20,000 and for late entrants. An employee enrolled in Optional Life may cover his spouse, in increments of $10,000, up to 50 percent of his Optional Life coverage, or $100,000, whichever is less.

Premiums for Dependent Life–Spouse coverage are based on the employee's age, and the employee is the beneficiary.

Dependent Life–Child

An eligible dependent child younger than age 19 and a child age 19-24 who is a full-time student may be covered for $15,000 in term life insurance. An incapacitated child of any age may be covered. (See page 11 for information on incapacitation.) Medical evidence is not required, even for late entrants. The premium is $1.24 a month, no matter how many children are covered. See page 130 for more information.

For more information about life insurance, see pages 117-134. For premiums, see pages 231-233.

Long Term Disability Insurance

Basic Long Term Disability (BLTD)

BLTD is provided free to active employees who are enrolled in a health plan offered through EIP. It pays a benefit of 62.5 percent of the employee's gross monthly salary, reduced by other sources of income, up to

a maximum of $800 a month. There is no minimum benefit. BLTD has a 90-day *benefit waiting period,* the time the employee must be disabled before benefits are payable.

Supplemental Long Term Disability (SLTD)

The SLTD premium is paid by the employee. The benefit is 65 percent of the employee's gross monthly salary, reduced by other sources of income, up to a maximum of $8,000 a month. There is a minimum benefit of $100 a month.

The employee may choose a 90-day or a 180-day benefit waiting period. Premiums are based on his age and salary. If the employee does not enroll within 31 days of the date he is hired, he can enroll year-round by providing medical evidence of good health. He may also reduce his benefit waiting period from 180 to 90 days by providing medical evidence.

For more information about long term disability insurance, see pages 137-147. For premiums, see page 144.

Long Term Care Insurance

Long term care is assistance needed because of a lengthy illness or disability. It typically involves a severe cognitive impairment or a need for help with everyday tasks, such as bathing, continence, dressing, eating, toileting and transferring. When a person qualifies for benefits, he must satisfy a one-time waiting period. Care may be provided at home, in an adult daycare center, an assisted living facility, a nursing home or a hospice.

An employee may enroll within 31 days of his hire date or with medical evidence of good health. Premiums are paid directly to The Prudential Insurance Company of America. Enrollment is through Prudential's website, www.prudential.com/gltcweb. EIP's group name is **eipltc,** and the access code is **carolina**.

For more information about long term care insurance, see pages 151-156 or call Prudential customer service at 877-214-6588. For premiums, see pages 234-235.

MoneyPlu$

This plan enables an active employee to save money on eligible medical and dependent care costs by paying these expenses with money deducted from his salary before taxes.

Pretax Premiums

The Pretax Group Insurance Premium Feature permits an employee to pay these premiums before taxes are taken from his paycheck: health (including the tobacco-use surcharge), vision, dental and Optional Life (for coverage up to $50,000).

Flexible Spending Accounts

The plan offers these Flexible Spending Accounts: a **Medical Spending Account**; a **limited-use Medical Spending Account**, which can accompany a Health Savings Account; and a **Dependent Care Spending Account**. A person with medical and dependent care expenses can open both accounts. An employee authorizes deposits to his account every pay period. As he has eligible expenses, he can request tax-free reimbursements from the account.

To open a Medical Spending Account, an employee must have worked for a state-covered employer for one year by January 1 after October enrollment.

Health Savings Account (HSA)

A Health Savings Account is available to employees enrolled in a high-deductible health plan, such as the Savings Plan. Funds in an HSA do not have to be spent the year they are deposited. Money in the account is

tax-free and can be used for eligible medical expenses even if an employee changes jobs. An eligible employee can enroll in an HSA by completing a MoneyPlu$ enrollment form and then going to the EIP website. Select "Links" and then "MoneyPlu$."

For more information about MoneyPlu$ programs, see pages 159-179 or the *Tax-Favored Accounts Guide*, which is available on the EIP website.

Initial Enrollment

If you are an eligible employee or retiree of a *participating group* in South Carolina, you can enroll in insurance coverage within 31 days of the date you are hired or the date you retire. You can also enroll your eligible spouse and/or children. A *participating group* is a state agency, higher education institution, public school district, county, municipality or other group that is authorized by statute and participating in the state insurance program.

To enroll, you must complete a *Notice of Election* (NOE) form or your BA may enroll you online. Coverage is not automatic.

Your coverage starts on the first calendar day of the month, if you are engaged in *active employment* that day.

- If you begin work on the first *working day* of the month (the first day that is not a Saturday, Sunday or observed holiday), and it is not the first calendar day, you may choose to have your coverage start on the first day of that month or the first day of the next month.
- If you start work on a day other than the first calendar day or first working day of the month, your coverage starts on the first day of the next month.
- Coverage of your enrolled spouse and/or children begins on the same day your coverage begins.

Active employment is defined as performing all the regular duties of an occupation on an employer's scheduled workday. You may be working at your usual workplace or elsewhere, if you are required to travel. You are also considered engaged in active employment while on jury duty, on a paid vacation day or on one of your employer's normal holidays if your were engaged in active employment on the previous regular workday. Coverage will not be delayed if you are absent from work due to a health-related reason when your coverage would otherwise start.

After you enroll, please check your payroll stub to make sure the correct premiums are deducted. Your coverage, except MoneyPlu$ accounts, will continue from one year to the next as long as you are a full-time, permanent employee or an eligible retiree and pay the premiums.

Documents You Need at Enrollment

You must bring photocopies of these documents to the orientation meeting at which you enroll in insurance coverage. You will also need this documentation when you add someone to your coverage during open enrollment or as a result of a special eligibility situation. Please do not submit original documents to EIP. They cannot be returned.

Action	Documentation Required
To cover a legal spouse	A copy of the marriage license or page 1 of federal tax return with financial information marked out.
To cover a common law spouse	The Common Law Marriage Affidavit, a notarized statement signed by both spouses.
To cover a former spouse	Copy of the divorce decree ordering the subscriber to cover the former spouse.
To cover a natural child	A copy of the long-form birth certificate showing the subscriber as the parent.

To cover a stepchild	A copy of the long-form birth certificate showing the name of the natural parent **plus** proof that the natural parent and the subscriber are married (see legal spouse and common law spouse requirements above).
To cover an adopted child or a child placed for adoption	A copy of the long-form birth certificate showing the subscriber as the parent **or** a copy of legal adoption document from the court, stating the adoption is complete **or** a letter of placement from an attorney, an adoption agency or the S.C. Dept. of Social Services, stating the adoption is in progress.
To cover a foster child	A court order or another legal document placing the child with the subscriber, who is a licensed foster parent.
To cover other children	For all other children for whom a subscriber has legal custody, a court order or other legal document granting custody of the child to the subscriber. The document must verify the subscriber has guardianship responsibility for the child, not just financial responsibility.
To cover an incapacitated child	Incapacitated Child Certification Form. (See the "Incapacitated Child" section on page 11 for complete information on the process.) **Plus,** proof of the relationship. See the appropriate section above for the type of documentation required.
To reduce or eliminate a period when your plan does not cover pre-existing conditions	Copy of creditable coverage letter or a copy of a letter on company letterhead that includes: Beginning and ending dates of previous insurance coverage (or that coverage is still in effect), individuals covered and type of coverage.

Tips for Completing a Paper Enrollment Form, the Notice of Election

- As a new employee, fill out the form completely.
- Please write clearly.
- Under each benefit, mark a plan or "Refuse." If applicable, select a coverage level.
- If you have questions, ask your benefits administrator.
- Check the form for accuracy.
- Make sure you sign the form and give your benefits administrator copies of the appropriate documents.

Please don't use a highlighter on any document or form sent to EIP or to a third-party claims processor.

Note: Your BA may enroll you online, which is the best way to ensure no errors are made. If he submits your benefit selections electronically, you must register in MyBenefits and then go online to approve your selections by electronically signing a Summary of Enrollment (SOE). Your BA also has the option of printing a paper SOE, which he will ask you to sign. Give any documentation to your BA, who will send it to EIP.

After Your Initial Enrollment

Insurance Cards

If you enroll in the Standard Plan, Savings Plan or Medicare Supplemental Plan, BlueCross BlueShield of South Carolina (BCBSSC) will send insurance cards for you and your covered family members. BlueChoice HealthPlan HMO and CIGNA Healthcare HMO will mail insurance cards to their members. Benefits administrators will provide State Dental Plan subscribers with a card upon which they can write their name and Benefits ID Number. Dental Plus subscribers will receive an insurance card from BCBSSC. State Vision Plan subscribers will receive two cards from EyeMed Vision Care.

Insurance cards for all family members are issued in the subscriber's name.

Benefits Identification Number

The Employee Insurance Program gives each subscriber an eight-digit Benefits Identification Number (BIN). This unique number is used instead of a Social Security Number (SSN) in emails and written

Sample Notice of Election Form

You must also complete a Tobacco Certification form within 31 days of your hire date and whenever the status of tobacco use changes for you or a dependent covered under your health insurance.

ACTIVE EMPLOYEE NOTICE OF ELECTION (NOE)
SOUTH CAROLINA BUDGET AND CONTROL BOARD
EMPLOYEE INSURANCE PROGRAM (EIP)

A
See Instructions - If Completing By Hand Use Black Ink

ACTION

Select One:	Type of Change	BA Use Only	MoneyPlu$ Pretax Premiums
☐ New Hire ☐ Transfer ☐ Change	☐ Enrollment Other *(specify)* _____ Date of Change Event: _____	Effective Date: _____ ☐ Permanent P/T EE *(20 hrs.)* Group ID #: _____ Group Name: _____	☐ Refuse ☐ Yes

ENROLLEE INFO

1. Social Security Number (SSN)	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. Work Phone #	11. E-mail Address
☐ M ☐ F	☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated	( )	( )	

12. Mailing Address	13. Apt.	14. City	15. State	16. Zip Code	17. County Code	18. Annual Salary	19. Date of Hire MM/DD/YYYY

MEDICARE & OTHER COVERAGE

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

Name	Medicare #	Eligible Due To	Effective Date Part A MM/DD/YYYY	Effective Date Part B MM/DD/YYYY
		☐ Age ☐ Disability ☐ Renal Disease		
		☐ Age ☐ Disability ☐ Renal Disease		

21. Do you or any of your dependent(s) have other health coverage? ☐ YES ☐ NO Does this coverage include prescription drug benefits? ☐ YES ☐ NO

Dependent Name	Insurance Company	Policy Holder Date of Birth	Effective Date of Policy	Termination Date *(if Applicable)*

COVERAGE

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

PLAN
☐ Refuse ☐ HMO_____ *Name of HMO*
☐ Standard ☐ Savings
Basic Life and Basic Long Term Disability included automatically with health plan

COVERAGE LEVEL
☐ Employee ☐ Employee/Child(ren)
☐ Employee/Spouse ☐ Family

23. STATE DENTAL PLAN *(Select One)*
☐ Refuse ☐ Employee/Spouse
☐ Employee ☐ Employee/Child(ren)
☐ Family

24. DENTAL PLUS *(Select One)*
☐ Refuse
☐ Yes

25. DEPENDENT LIFE - Child(ren) *(Select One)*
☐ Refuse
☐ $15,000

26. DEPENDENT LIFE - Spouse *(Select One)*
☐ Refuse ☐ Coverage Level
$_____
(Must be in increments of $10,000)

27. OPTIONAL LIFE *(Select One)*
☐ Refuse ☐ Coverage Level
$_____
(Must be in increments of $10,000)

28. SUPPLEMENTAL LTD *(Select One)*
☐ Refuse
☐ Plan One - *90-day benefit waiting period*
☐ Plan Two - *180-day benefit waiting period*

29. VISION CARE *(Select One)*
☐ Refuse ☐ Employee/Spouse
☐ Employee ☐ Employee/Child(ren)
☐ Family

BENEFICIARIES

In blocks 30 and 31, if there are additional beneficiaries or dependents, list on separate sheet, signed and dated by employee.

30. Basic Life/Optional Life *(Select one or both)*	SSN#	Last Name	First Name	Relationship	Date of Birth MM/DD/YYYY	Primary or Contingent?
☐ Basic Life ☐ Optional Life						☐ Primary ☐ Contingent
☐ Basic Life ☐ Optional Life						☐ Primary ☐ Contingent

If beneficiary is an estate or trust, complete the following:
Estate/Trust_____Address_____If Trust, Date Signed_____

DEPENDENTS

31. 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 reverse of this NOE.

Add (A) or Delete (D)	Dependent SSN#	Last Name	First Name	Sex M/F	Relationship	Date of Birth MM/DD/YYYY	Indicate Special Status
	Spouse						Is spouse employed with, or retired from, an EIP-covered employer? ☐ Yes ☐ No
	Child						☐ Full-time Student ☐ Incapacitated
	Child						☐ Full-time Student ☐ Incapacitated
	Child						☐ Full-time Student ☐ Incapacitated

CERTIFICATION & AUTHORIZATION

32. 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 certify that any child enrolled in Dependent Life/Child insurance is eligible according to the requirements on the reverse of this NOE. I also understand that proof of eligibility (at the time of enrollment and at the time of the claim) will be required before any Dependent Life/Child insurance claim is paid. I understand that unless otherwise provided in the Plan, I may cancel coverage for me or my dependent(s) only during an open enrollment period (every two years). Should I refuse any coverage or fail to enroll all eligible dependents when first eligible, I and/or all eligible dependents may only enroll during an open enrollment period (every two years) unless otherwise provided by the Plan. I understand and agree that all selected plans will not be effective unless and until the NOE is approved. I 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 hereby authorize my employer to deduct from my salary premiums necessary to pay for all plans selected and verify my salary for enrollment. 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.

Employee Signature _____ Date _____

33. I hereby attest the employee meets eligibility requirements, proper premiums are being collected, this form is complete and accurate and all required documentation is attached to process NOE form.

Benefits Administrator Signature _____ Date _____

EIP REV. 8/11 ORIGINAL TO EIP COPY TO EMPLOYEE

communication between you and your spouse and/or children and EIP. It is designed to make your personal information more secure.

The State Health Plan and BlueChoice HealthPlan HMO put your BIN on your identification card. The BIN is also used on Dental Plus cards. CIGNA HMO gives its members another secure number. If you are not enrolled in a plan that uses the BIN, EIP will send you your number. Keep your BIN in a safe place.

Subscribers need their BIN to use MyBenefits, EIP's online enrollment system. If you forget your BIN, you can get it through MyBenefits. Just click on "Get my BIN."

Annual and Open Enrollment

Every October, you may make changes in your **health coverage** without regard to special eligibility situations.

- During *annual enrollment,* eligible employees, retirees, survivors and COBRA subscribers may change health plans. This includes changing to the Medicare Supplemental Plan, if you are retired.
- During *open enrollment*, which occurs in odd-numbered years, eligible subscribers may enroll in or drop their own health coverage and add or drop their eligible spouse and/or children.

Changing Plans or Coverage During Enrollment Periods

You can change to or from the Savings Plan, the Standard Plan or an HMO only during October enrollment periods. Retirees and survivors and their eligible spouse and/or children who are enrolled in a health plan may change to the Medicare Supplemental Plan within 31 days of Medicare eligibility or during annual or open enrollment. There may be exceptions to this rule.

Contact your benefits administrator for details if you are an active employee or if you are a retiree, a survivor or COBRA subscriber of a local subdivision. Retirees, survivors and COBRA subscribers of other employers should contact EIP, which is their benefits administrator.

You may add or drop State Vision Plan coverage for yourself and for your eligible spouse and/or children during annual or open enrollment.

You can add or drop State Dental Plan and Dental Plus coverage only during open enrollment, which is in October of odd-numbered years, or within 31 days of a special eligibility situation.

Other changes you may make in your coverage are explained in *The Insurance Advantage,* which you receive each September. Open or annual enrollment changes become effective the following January 1.

MyBenefits — EIP's Online Enrollment System

The easiest way to make your coverage changes during annual and open enrollment is through MyBenefits. Look for it in the column on the left on EIP's website, www.eip.sc.gov. During October, links to written instructions accompany each section in which you are eligible to make changes.

The system is useful year-round. With it, all subscribers can:

- Update contact information
- Print a list of the insurance plans under which they are covered
- Get their Benefits Identification Number (BIN).

COBRA subscribers must pay their initial COBRA premiums before they can register to use MyBenefits.

Employees also can:

- Update beneficiaries
- Approve changes made as a result of a special eligibility situation.

To protect the confidentiality of your insurance information, you must register the first time you use MyBenefits. After you register, you will see a screen listing your password and your answers to the security questions. You are now ready to use MyBenefits. Information about how to do so is offered as you work through the program.

Please note: If you have a question about a claim, contact the third-party claims processor listed on the inside cover of this book or under "Links" on the EIP website. For a description of benefits in which you are enrolled, contact the third-party claims processor or read the appropriate chapter of this book.

Special Eligibility Situations

If you have a new family member as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible spouse and/or children in health, Dental/Dental Plus and/or State Vision Plan coverage. However, you must complete a Notice of Election (NOE) form within **31 days** of the date of the marriage, birth, adoption or placement for adoption and submit copies of the appropriate documents showing the new member's relationship to you. A salary increase does not create a special eligibility situation.

Changes permitted by a special eligibility situation must be made within 31 days of the event.

If you decline enrollment for yourself or your eligible spouse and/or children, because of other health, dental or vision coverage, you may be able to enroll yourself and your spouse and/or children in coverage at a later date if you or your spouse and/or children lose eligibility for that other coverage (or if the employer stops contributing toward your or your spouse and children's other coverage). However, you must complete an NOE within **31 days** of the date your or your spouse and/or children's other coverage ends (or after the employer stops contributing toward the other coverage).

If you are an active employee and eligible to change your health, Dental/Dental Plus, State Vision Plan or Optional Life Insurance coverage due to a special eligibility situation, you also may enroll in or drop the Pretax Group Insurance Premium Feature.

Please note: Rather than using a paper NOE, your BA may make your changes electronically and send them to you through MyBenefits. You will need to approve and electronically sign the Summary of Change (SOC). Your BA may also print a paper SOC for you to sign. Give copies of any required documents to your BA, who will send them to EIP.

Marriage

If you, as a covered subscriber, wish to add a spouse because you marry, you can do so by completing an NOE and submitting a copy of your marriage license within 31 days of the date of your marriage. If you are not enrolled, you may add health, Dental/Dental Plus and/or State Vision Plan coverage for yourself and for your eligible spouse and/or newly acquired stepchildren within 31 days of the date of your marriage. If you add your new spouse or your newly acquired stepchildren to your health coverage, you may also change health plans. You may add your spouse and/or newly acquired stepchildren to Dental/Dental Plus and State Vision Plan coverage. Coverage becomes effective with the date of marriage.

Marriage also allows a covered subscriber to enroll in or increase Optional Life coverage by $50,000 and enroll a spouse for up to $20,000 of Dependent Life-Spouse coverage without medical evidence of good health.

You cannot cover your spouse or stepchildren if they are eligible, or become eligible, for coverage as an employee or as a funded retiree of a participating group. If you do not add your spouse and/or your newly acquired stepchildren within 31 days of the date of marriage, you cannot add them until the next open enrollment period or within 31 days of a special eligibility situation.

To add a common law spouse to your coverage, you must complete the Common Law Marriage Affidavit, a notarized statement signed by both spouses. Within 31 days of the notary's signature, submit the affidavit and an NOE to your benefits administrator. Submit the forms to EIP if you are a COBRA or a survivor subscriber or a retiree of a state agency, a higher education institution or a public school district. The forms are available on the EIP website. Select "Forms." The affidavit is under "Other Forms." You may also contact EIP or your BA for a copy of the affidavit.

Legal Separation

If you and your covered spouse separate, your spouse may remain on your health, Dental/Dental Plus, State Vision Plan and Dependent Life-Spouse coverage until the divorce is final.

If you do not participate in the MoneyPlu$ pre-tax premium feature, you can remove your spouse from your coverage when you separate. To do so, give your benefits administrator a copy of a complaint filed in Family Court showing that a divorce is in progress or a court order signed by a Family Court judge showing a divorce is in progress. **A letter from an attorney is not sufficient documentation.** The complaint or court order must be attached to an NOE. Your spouse's coverage will end the last day of the month after the date of separation, if you drop your spouse within 31 days of separation. Otherwise, coverage will end the first of the month after the date you request it.

If you reconcile with your spouse after you drop his health insurance, it cannot be reinstated until the next open enrollment period or a special eligibility situation. He will then be considered a late entrant. As a late entrant, he will not be eligible for coverage of pre-existing conditions until 18 months after enrollment. If he enrolls due to a special eligibility situation, he will not be eligible for coverage of pre-existing conditions until 12 months after enrollment (which may be reduced by prior creditable coverage). For more information, see page 12.

You may re-enroll your spouse in Dependent Life-Spouse insurance year-round if you submit medical evidence of good health and it is approved by MetLife. Dental/Dental Plus coverage can be reinstated during the next open enrollment period or within 31 days of a special eligibility situation. Vision coverage can be reinstated during the next annual enrollment period or within 31 days of a special eligibility situation.

These rules also apply to common law marriages.

You cannot drop your spouse from your MoneyPlu$ coverage because you are in the process of a divorce. When a divorce is final, it is a change-in-status event that permits you to change your MoneyPlu$ account.

Divorce

If you, as a subscriber, divorce, you must remove your spouse and former stepchildren from your coverage by completing an NOE and submitting **a complete copy** of the divorce decree within 31 days of the date stamped on the divorce decree. Coverage for your divorced spouse and former stepchildren will end the last day of the month after the divorce decree is stamped.

You may continue to provide health, vision and dental coverage for your former spouse and/or stepchildren only if the Family Court requires that you do so. You must provide a copy of the divorce decree ordering you to cover your former spouse, as well as an NOE, to your benefits administrator, who will send both to EIP. The document must list the plans under which your former spouse must be covered. Retirees of state agencies, higher education institutions and school districts, survivors and COBRA subscribers should notify EIP. Retirees of local subdivisions should notify their benefits administrator. You cannot continue to cover your former spouse under Dependent Life-Spouse under any circumstances.

When your divorce is final, you can enroll in or increase your Optional Life coverage by $50,000 without medical evidence of good health. You may also cancel or decrease your Optional Life coverage.

If you remarry, you can cover your divorced spouse or your current spouse, but you cannot cover both under any EIP plan. Spouses who lose coverage due to a qualifying event may be eligible to continue coverage under COBRA. For more information, you must contact your benefits administrator or EIP as soon as possible, but **within 60 days** after the event or from when coverage would have been lost due to the event, whichever, is later.

These rules also apply to common law marriages.

Adding Children

Eligible children may be added by completing an NOE **within 31 days of:**

- Date of birth (effective on the date of birth)
- Gaining legal custody or guardianship (effective on the date of custody or guardianship)
- Adoption or placement for adoption (effective on the date of adoption or placement for adoption).

The newly eligible child must be offered health, Dental/Dental Plus and State Vision Plan coverage. The subscriber and all other previously enrolled family members may change health plans. A child who is eligible, but not newly eligible, **cannot** be added at this time. However, a spouse may be added.

If you add to your coverage a newborn or a child you adopt or who is placed with you for adoption, you can enroll in Optional Life or increase your coverage by $50,000 without medical evidence of good health.

Children must be listed on your NOE to be covered, even if you already have full family or subscriber/children coverage. You must also submit a copy of the child's long-form birth certificate. Notification to Medi-Call of the delivery of your baby does not add the baby to your health insurance.

To add a stepchild to your policy, you must submit a copy of his long-form birth certificate, showing the name of the child's natural parent plus proof that the natural parent and the subscriber are married. For a legal spouse, this would be a marriage license. For a common law spouse, this would be the Common Law Marriage Affidavit.

To add children who are adopted or placed for adoption to your policy, you must submit an NOE with one of the following: 1) a copy of the legal adoption documentation from the court verifying the completed adoption or a copy of the long-form birth certificate showing the subscriber as the parent; 2) a letter of placement from an attorney verifying the adoption is in progress; or 3) a letter of placement from an adoption agency or the S.C. Department of Social Services verifying the adoption is in progress. The effective date of coverage of a child who is adopted or placed for adoption will be upon the subscriber's assumption of legal obligation for the child as reflected in the submitted documentation, as long as the deadlines for the special eligibility situation have been met.

To add a foster child to your policy, you must submit a copy of a court order or another legal document placing the child with you, the subscriber, and showing that you are a licensed foster parent.

To add other children for whom you have legal custody, you must submit a copy of a court order or other legal document granting you custody. The documents must verify that you, the subscriber, have guardianship responsibility for the child and not just financial responsibility.

If a court order is issued requiring you to cover your child, you must notify your employer and EIP and elect coverage within 31 days of the date the court order was filed. Please note: if the court order was for health and/or dental coverage, you must enroll yourself if you are not already enrolled.

If you and your spouse are both eligible for coverage, only one of you can cover your children under any one plan. For example, one parent can cover the children under health, and the other can cover the children under dental. Only one parent can carry Dependent Life coverage for eligible dependent children.

Dropping a Spouse and/or Children

If a covered spouse or child becomes ineligible, you must drop him from your health, dental, vision and Dependent Life coverage. This may occur because of divorce or separation, a child becomes eligible for a group health plan sponsored by an employer (either as an employee or as a spouse of an employee) or a child turns 26. If you drop a spouse or child from your coverage, you must complete an NOE within 31 days of the date he becomes ineligible and provide documentation to your BA.

If your child becomes eligible for group health insurance sponsored by an employer, either as an employee or as a spouse, he is no longer eligible for insurance through EIP. This includes EIP's Dental/Dental Plus and State Vision Plan insurance and applies even if he does not enroll in the coverage. Within 31 days of eligibility or as soon as possible, you should provide your BA with a letter from the employer showing the date the child became eligible for coverage. Your child will be dropped from coverage the first of the month after the notice.

When your child becomes ineligible for coverage because of age, he will be dropped automatically. If he is your last covered child, your level of coverage will be changed.

Gaining Other Coverage

When your spouse or child gains coverage as an employee of an **EIP-participating group**, you must drop him within 31 days by completing a Notice of Election (NOE) form. No other documentation is needed.

If you or your spouse and/or children gain coverage through a group that doesn't participate in EIP, you have 31 days to cancel the type of coverage gained by completing an NOE and returning it to your benefits office with proof of the other coverage. To document that you have gained coverage, you must present a letter on company letterhead that includes the effective date of coverage, names of all individuals covered and the types of coverage gained. Only those who gained coverage may be dropped.

If you fail to cancel coverage within 31 days, you must wait until the next open enrollment period. For more information, contact your benefits administrator or EIP.

Loss of Other Coverage

If you refuse enrollment for yourself or your eligible family members because of other coverage, you may be able to enroll yourself and/or your eligible family members in coverage at a later date if you and your spouse and/or children lose eligibility for that other coverage (or if the employer stops contributing to the coverage).

- If you are the employee or retiree and you lose other group health coverage, you may enroll yourself and any eligible spouse and/or children in health, Dental/Dental Plus, and/or State Vision Plan coverage.

This only applies if you are not already enrolled in health coverage through EIP.

- If you are the employee or retiree and have a spouse or child who loses other group health coverage, you may enroll the eligible spouse and/or children in health, Dental/Dental Plus, and/or State Vision Plan coverage. If you are not already enrolled, you may enroll yourself with the individual who lost coverage. You may enroll only the spouse and/or children who lost health insurance coverage. If you are already enrolled as an employee or retiree, you may change health plans (for example, Savings Plan to Standard Plan) when you add the spouse and/or children who lost health insurance coverage, and contributions toward your deductible will start over.
- If you, your spouse, and/or children lose dental and/or vision coverage only (not health), then you, your spouse, and/or children who lost the dental and/or vision coverage may enroll in the type of coverage that was lost. If you are not already enrolled, you may enroll yourself with the individual who lost dental and/or vision coverage.

You must complete an NOE within 31 days of the date the other coverage ends. To enroll because of a loss of coverage, you must submit to your benefits office a creditable coverage letter or a letter on company letterhead that states the names of those covered and dates of coverage, a completed NOE, and documents proving any added spouse and/or child's relationship to you.

Coverage under Medicaid or the Children's Health Insurance Program (CHIP)

Eligibility for Premium Assistance

If you or your spouse and/or children become eligible for premium assistance under Medicaid or through CHIP, you may be able to enroll yourself and your spouse and/or children in EIP-sponsored health insurance. However, you must request enrollment within **60 days** of being determined to be eligible for premium assistance.

Loss of Other Coverage

If you refused enrollment in EIP-sponsored health, dental and vision insurance for yourself or for your eligible spouse and/or child because of coverage under Medicaid or CHIP and then lost eligibility for that coverage, you may be able to enroll in an EIP plan. However, you must request enrollment within **60 days** of the date the other coverage ends.

To request enrollment or to learn more, please contact your benefits administrator.

Leave Without Pay

If you are an active employee, you may be eligible to continue your coverage for a limited time if you are on leave without pay, as long as you pay the required premiums. Please contact your benefits administrator about your insurance coverage if you are taking: educational leave, military leave, leave provided under the Family and Medical Leave Act (FMLA), or any other medical or disability-related leave. Leave must be approved by your employer.

Workers' Compensation

If you are on approved leave and receiving Workers' Compensation benefits under state law, you may continue your coverage as long as you pay the required premium. Insurance offered through EIP is not meant to replace Workers' Compensation and does not affect any requirement for coverage for Workers' Compensation insurance. It is not intended to provide or duplicate benefits for work-related injuries that are within the Workers' Compensation Act. If you need more information, please contact your benefits office.

Prevention Partners

Prevention Partners, a unit of EIP, is designed to help subscribers and their families lead healthier lives. Its activities, programs and services promote good health through disease prevention, early detection of disease and chronic disease education.

Look for apples as you read this guide. They highlight programs that help prevent and control diseases.

A major initiative of Prevention Partners is the Preventive Workplace Screening. For only $15, this comprehensive, biometric screening includes clinical fasting blood work, a personal health risk appraisal, height and weight, blood pressure and lipid panels. It usually takes about three weeks to receive results. These reports highlight measurements outside the normal range, which may indicate the individual is at risk for developing diseases such as hypertension, diabetes and anemia. A subscriber may wish to give the screening results to his doctor.

This benefit is available every year to employees and retirees and their covered spouses whose primary insurance coverage is the Standard Plan, the Savings Plan, BlueChoice HealthPlan HMO or CIGNA HMO. Subscribers whose primary coverage is Medicare are not eligible. The $15 cost of the Preventive Workplace Screening does not contribute toward a subscriber's annual deductible or out-of-pocket maximum. Individuals are screened at their current or former workplace. To find out when a screening is scheduled, employees should contact their benefits administrator. Retirees should contact the staff at their former workplace.

Chronic disease and lifestyle change workshops give subscribers and their family members information they need to help them take better care of themselves. Workshops include: Caregivers, Diabetes, Heart Disease, Asthma, Kidney Evaluation, Women's Reproductive Health, Weight Management, Medications, Men's Health, Cholesterol/Lipids and Gastrointestinal Ailments.

These programs can be very helpful. For example, in Club Sugar, a diabetes program, participants controlling their blood pressure increased from 51 percent to 85 percent, and participants with desirable blood sugar levels increased from 33 percent to 60 percent. Other Prevention Partners programs include:

- Wellness Walk
- Lifestyle change workshops on weight loss, exercise and lowering risk factors
- Workplace program consultation
- Volunteer Workplace Prevention Partners coordinator network and conferences
- Prevention Partners training workshops.

For more information on Prevention Partners, contact your benefits office, your Prevention Partners coordinator or call 888-260-9430. You also can go to the EIP website, www.eip.sc.gov, and click on "Prevention Partners," which is on the left of the home page.

EIP's Website Provides Helpful Information

EIP offers helpful information through the Internet. Two places to find it are *EIP Direct* and the EIP website, www.eip.sc.gov.

EIP Direct is a bimonthly newsletter sent to your benefits administrator, who may send you the articles or the newsletter itself. It gives you information about benefit changes, answers questions about benefits and tells you about programs that may interest you.

The website offers other tools to help you make the best use of your insurance. For example, it includes links to the websites of third-party claims processors, such as BlueCross BlueShield of South Carolina.

These sites give you access to your account information, including claim status, verification of authorization for inpatient and outpatient visits and Explanations of Benefits.

Other useful features on the EIP site include:

- FAQs, which cover EIP plans in general, as well as the Savings Plan, HSAs, Vision, Tobacco-use Certification, Wellness Incentive Program, Healthcare Reform and the Dependent Eligibility Audit
- Online directories, lists of providers that are part of plans' networks
- Publications, such as this benefits guide and FB-WW's *Tax-Favored Accounts Guide*
- Information about eligibility and copies of forms.

Through MyBenefits, EIP's online enrollment system, you can make coverage changes during October enrollment periods. Year-round, all subscribers can change contact information and print a list of the programs under which they are covered. Active employees can change beneficiaries, and approve changes made as a result of a special eligibility situation. For more information, see page 23.

The Prevention Partners section of the site provides information on ways to improve your health. Under "Training Calendar," for example, you can sign up for educational programs, such as Club Sugar. You can also read a newsletter, *Health Bulletin*.

If you need help or additional information or would like to make a suggestion, click on "Contact Us."

When Coverage Ends

Your coverage will end:

- The last day of the month in which you were engaged in active employment, unless you are transferring to another participating group
- The last day of the month in which you become ineligible for coverage (for example, your working hours are reduced from full-time to part-time)
- The day after your death
- The date the coverage ends for all subscribers or
- The last day of the month in which your premiums were paid in full. (You must pay the entire premium, including the tobacco-use surcharge, if it applies.)

Coverage for your spouse and/or children will end:

- The date your coverage ends
- The date coverage for spouses and children is no longer offered or
- The last day of the month in which your spouse or child's eligibility for coverage ends.

If your coverage or your spouse or child's coverage ends, you may be eligible for continuation of coverage as a retiree, as a survivor or under COBRA. **If you are dropping a spouse or child from your coverage, you must complete a Notice of Election (NOE) form within 31 days of the date the spouse or child is no longer eligible for coverage**.

COBRA

COBRA is short for Consolidated Omnibus Budget Reconciliation Act. It requires that continuation of **group health, vision, dental and/or Medical Spending Account coverage** be offered to you and/or your covered spouse and/or children if you are no longer eligible for coverage due to a qualifying event. Qualifying events include:

- The covered employee's working hours are reduced from full-time to part-time
- The covered employee voluntarily quits work, retires, is laid off or is fired (unless the firing is due to

gross misconduct)
- A covered spouse loses eligibility due to a legal separation or divorce
- A child no longer qualifies for coverage.

Please note: An individual who loses coverage as a result of a Dependent Eligibility Audit is not eligible for COBRA.

A copy of the Initial COBRA Notice begins on page 246. For more information about COBRA, including the length of your coverage, check your COBRA notice or contact your benefits administrator.

For a covered spouse and/or children to continue coverage under COBRA, the subscriber or covered family member must notify his benefits office **within 60 days after the qualifying event or the date coverage would have been lost due to the qualifying event,** whichever is later. Otherwise, the individual will lose his rights to COBRA coverage.

To begin coverage under COBRA, a COBRA NOE and premiums must be submitted. The premiums must be paid within 45 days of the date coverage was elected. Your first premium payment must include premiums for the month following the date you lost coverage, the month you elected coverage and the first full month of COBRA coverage.

For example: You lost coverage on June 30, elected coverage on August 15 and paid the initial premium on September 17. You would be required to pay three premiums: one for the month following the date you lost coverage (July); one for the month in which you elected coverage (August); and one for the month in which you made your first payment (September).

COBRA coverage becomes effective when the first premium is paid and remains in effect only as long as the premiums are up-to-date. A premium is considered paid on the date of the postmark or the date it is hand-delivered, not by the date on the check.

EIP is the benefits administrator for COBRA subscribers of state agencies, higher education institutions and public school districts. COBRA subscribers from local subdivisions keep the same benefits administrator.

How COBRA Coverage May End

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

1. A subscriber fails to pay the full COBRA premium on time
2. A qualified beneficiary gains coverage under another group health plan that does not impose a pre-existing condition exclusion
3. A qualified beneficiary becomes entitled to Medicare
4. EIP no longer provides group health coverage
5. During a disability extension, the Social Security Administration determines the qualified beneficiary is no longer disabled
6. An event occurs that would cause EIP 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 EIP when he is no longer eligible for COBRA. COBRA coverage will be canceled automatically by EIP in situations numbered 1, 3 and 6. The qualified beneficiary is responsible for submitting a Notice to Terminate COBRA Continuation Coverage, along with supporting documents, in situations numbered 2 and 5.

How Medicare Affects COBRA Coverage

If you or your eligible spouse or child is covered by COBRA and becomes eligible for Medicare Part A, Part B or both, please notify the Employee Insurance Program.

A subscriber or eligible spouse or child who is covered by Medicare and then becomes eligible for COBRA can enroll in COBRA for secondary coverage. Medicare will be his primary coverage.

If you need more information about COBRA, contact your benefits office or EIP.

When COBRA Benefits Run Out

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) guarantees that persons who have exhausted COBRA benefits and are not eligible for coverage under another group health plan have access to health insurance coverage without being subject to a pre-existing condition exclusion period. However, certain conditions must be met. In South Carolina, the South Carolina Health Insurance Pool provides this guarantee of health insurance coverage. For information, call 803-788-0500, ext. 46401 (Greater Columbia area) or 800-868-2500, ext. 46401 (toll-free outside the Columbia area).

Death of a Subscriber or Covered Spouse or Child

If an active employee or a retiree of a local subdivision dies, a family member should contact the deceased's employer to report the death, to discontinue the employee's coverage and start survivor coverage for any covered spouse and/or children. If a retiree of a state agency, higher education or public school district dies, a family member should contact EIP.

For a list of steps to take when a covered person dies, see page 36.

If your covered spouse or child dies, please contact your benefits administrator. EIP is the benefits administrator for retirees of state agencies, higher education institutions and public school districts. Retiree subscribers of local subdivisions keep the same benefits administrator.

Survivors

Spouses and children who are covered under the State Health Plan or an HMO are eligible as survivors for a one-year waiver of health insurance premiums, including the tobacco-use surcharge, if it applies, when a covered employee dies.

Premiums are also waived for qualified survivors of funded retirees of state agencies, higher education institutions and public school districts. Participating local subdivisions may elect to, but are not required to, waive the premiums of survivors of retirees. A survivor of a retiree of a participating local subdivision should check with the retiree's benefits administrator to see whether the waiver applies.

After the premium has been waived for a year, a survivor must pay the subscriber and employer share of the premium to continue coverage. If the deceased and his spouse are both covered employees or retirees at the time of death, the surviving spouse is not eligible for the premium waiver.

Dental and vision premiums are not waived. However, survivors may continue dental and vision coverage by paying the full premium.

The health and dental premiums of a covered spouse or child of a covered employee who was **killed in the line of duty** while working for a participating group will be waived for the first year after the employee's death. The survivor must submit verification of death in the line of duty. After the one-year waiver, a covered surviving spouse of a state agency, higher education institution or a public school district employee may continue coverage, *at the employer-funded rate*, until he remarries or otherwise becomes ineligible. A covered surviving child may continue coverage at the *employer-funded rate* until he is no longer eligible. Participating local subdivisions may elect to, but are not required to, contribute to a survivor's insurance

premium, but the survivor may continue coverage, at the full rate, for as long as he is eligible.

A surviving spouse may continue coverage until he remarries. A child can continue coverage until he is no longer eligible. Please notify EIP within 31 days of loss of eligibility for coverage. A person who is no longer eligible for coverage as a survivor may be eligible to continue coverage under COBRA. Contact EIP for details.

As long as a survivor remains covered by health, vision or dental insurance, he can add the others during open enrollment or within 31 days of a special eligibility situation. If he drops health, vision and dental insurance, he is no longer eligible as a survivor and cannot re-enroll in coverage, even at open enrollment.

If a surviving spouse becomes an active employee of a participating employer, he can switch to active coverage. When he leaves active employment, he can go back to survivor coverage within 31 days, if he has not remarried.

Appeals

What If I Disagree With A Decision About Eligibility?

This chapter includes a summary of the eligibility rules for benefits offered through EIP. Eligibility determinations are subject to the provisions of the Plan of Benefits and state law.

If you are dissatisfied after an eligibility determination has been made, you may ask EIP to review the decision. If you are an employee, this Request for Review should be submitted through your benefits office. Your BA may write a letter or use the Request for Review form, which is available online on EIP's website, www.eip.sc.gov. If you are a retiree, survivor, or COBRA subscriber, you may submit your request directly to EIP, which is your BA.

If the request for review is denied, you may appeal by writing to EIP within 90 days of notice of the decision. If the decision is upheld by the EIP Appeals Committee, you have 30 days to seek judicial review as provided by Sections 1-11-710 and 1-23-380 of the S.C. Code of Laws, as amended.

Checklists: Quick Guides to Your Benefits

New Employee Checklist

Welcome! You now have a job that makes you eligible for benefits offered through the Employee Insurance Program (EIP). This list will help you as your benefits administrator (BA) guides you through enrollment.

Eligibility

- You can cover yourself and, under some plans, your spouse and children. See pages 9-11.

Previous Health Insurance

- If you had no more than a 62-day break in health insurance coverage, you may not be subject to a pre-existing condition exclusion. See page 12. Covered persons age 18 and younger are not subject to the pre-existing condition exclusion.

Health Plans Offered Through EIP

- The **State Health Plan**, which includes the **Standard Plan** and the **Savings Plan**, and two health maintenance organizations, **BlueChoice HealthPlan HMO** and **CIGNA HMO**, are available to you. Please read the Health Insurance chapter of this guide for detailed information. For brief descriptions of the plans, see pages 13-17.

- No matter which plan you choose, you will pay a $40 monthly **tobacco-use surcharge** if you have subscriber-only coverage and you use tobacco. You will pay a $60 monthly surcharge if you cover your spouse or children and anyone you cover uses tobacco. See page 40.

- **Basic Life Insurance** and **Basic Long Term Disability Insurance** are provided free to active employees who enroll in a health plan offered through EIP. See pages 18-19.

Other Insurance Benefits Offered Through EIP

- You may also be eligible for **dental, vision, life, long term disability** and **long term care insurance.** We recommend you read the chapters about these plans, as well as the summaries in the General Information chapter. See pages 17-19.

- **MoneyPlu$** enables you to save money by paying some expenses with funds deducted from your salary before taxes.
  - As a new employee, you are eligible for the **Pretax Group Insurance Premium Feature** and a **Dependent Care Spending Account**.
  - If you are enrolled in the Savings Plan, you are also eligible for a **Health Savings Account.**
  - When you have worked for a state-covered employer for one year, you will become eligible for a **Medical Spending Account** beginning January 1 after October enrollment.
  - For detailed information about MoneyPlu$ programs, see the MoneyPlu$ chapter in this guide. MoneyPlu$ programs are summarized on pages 19-20.

Enrolling with a Notice of Election (NOE) Form or Online

- As an eligible employee of a group participating in EIP, you can enroll yourself and your eligible spouse and/or children in insurance coverage **within 31 days of the date you are hired.** You can do so on paper by completing an NOE or online. Information about initial enrollment in EIP coverage is on page 20-21. A sample NOE is on page 22.

- You must give your BA copies of some documents when you enroll. See pages 20-21.

Retiree Checklist

Before you retire, check the coverage you have now. You can obtain a list of the plans under which you are covered from MyBenefits, the online enrollment system. Go to the EIP website, www.eip.sc.gov, and click on "MyBenefits" in the column on the left. After you log in, click on "Review Benefits."

Eligibility

- You must meet certain requirements to continue your insurance in retirement. See pages 183-184.

Funding

- Find out if your employer will pay part of your health insurance premium. See pages 184-186.

Enrollment

- You must complete a Retiree NOE form and an Employment Verification Record **within 31 days of your retirement date**. See pages 186-187.

Returning to Work

- If you plan to return to work for a participating employer after you retire, see page 194.

Benefit Choices

- **Health –**Your health plan choices as a retiree depend on whether you are eligible for Medicare. To learn what your choices are, see pages 188-189. For premiums, see pages 227-228.
- Notify your benefits administrator within 31 days of the date you or someone you cover becomes eligible for **Medicare. Enroll in Part A and Part B**. In most cases, you should **not** enroll in Part D. For details, see pages 205-208.
- **Dental –**You are eligible for the State Dental Plan and Dental Plus. For details, see page 189. For premiums, see pages 227-228.
- **Life Insurance –**You may convert your **Basic Life** insurance**.** You can convert or continue your **Optional Life** insurance. Your dependents may convert **Dependent Life** insurance. For details, see pages 190-191.
- **Vision –** You are eligible for vision care benefits. For details, see page 189.
- **Long Term Disability –** Eligibility for **Basic Long Term Disability** and **Supplemental Long Term Disability** insurance ends with retirement. For details, see page 192.
- **Long Term Care –**You can continue, or may be eligible to enroll in, Long Term Care coverage. For details, see page 192.
- **MoneyPlu$ –**Your eligibility ends at retirement. For details, see pages 191-192.

Your Benefits Administrator in Retirement

- If you worked for a state agency, a higher education institution or a public school district, EIP becomes your benefits administrator.
- If you worked for a local subdivision, your benefits administrator remains the same.

Survivor Checklist

We hope this list will help during a difficult time.

Contacts

If the deceased was an active employee, a retiree of a local subdivision or his covered spouse or child:
- Notify the subscriber's employer.

If the deceased was a retiree of a state agency, higher education institution or public school district, or his covered spouse or child:
- Notify EIP.

When Coverage Ends for the Deceased

- If the deceased was enrolled in health, dental, vision, Long Term Care and/or Long Term Disability coverage, this coverage ends the day after death. Optional Life coverage ends on the day of death.

Health and Dental Insurance, Vision Care Benefits

Please read the "Survivors" section, beginning on page 32.
- Spouses or children covered under the State Health Plan or an HMO can continue coverage as survivors. They **may also be eligible for a one-year waiver** of health insurance premiums, including the tobacco-use surcharge, if it applies.
- Survivors may continue dental insurance and vision benefits, but **the premiums are not waived**.

Life Insurance

A certified, raised-seal death certificate is needed to apply for benefits from MetLife.
- Basic Life insurance, $3,000, is provided to all full-time, active employees younger than age 70 enrolled in a health insurance plan. A $1,500 policy is provided to active employees age 70 and older who are enrolled in a health insurance plan. See page 118.
- If the deceased was covered by Optional Life insurance, see page 127.
- If the deceased was covered by Dependent Life insurance, see pages 132-133.
- If the deceased was retired and his last employer before retirement participates in the Retiree Group Life Insurance program, he may be eligible for a benefit based on his retirement-credited service in the S.C. Retirement Systems (SCRS). For more information, contact SCRS at 803-737-6800 (Columbia area) or 800-868-9002 (toll-free outside the Columbia area but within South Carolina).

Supplemental Long Term Disability Insurance

- If the deceased was receiving Supplemental Long Term Disability benefits provided by The Standard, survivor benefits may be payable to the eligible survivor in a lump sum. See page 147.

Long Term Care Insurance

- If the deceased was enrolled in Long Term Care (LTC), his beneficiary may receive a refund of a portion of the premiums paid based on the deceased's age and decreased by any benefits paid under the plan. For information, contact his LTC insurance provider.

MoneyPlu$

- If the deceased had a MoneyPlu$ Health Savings Account, contact NBSC about settling the account. See Article VII of the HSA Custodial Agreement, which is on the EIP website under "Publications."
- Medical Spending Account and Dependent Care Spending Account claims incurred through the day of death will be paid. See page 178.

Health Insurance

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Introduction

What Are My Health Plan Choices?

Your health plan choices include the State Health Plan (the Standard Plan, the Savings Plan and, if you are enrolled in Medicare, the Medicare Supplemental Plan) and two Health Maintenance Organizations (BlueChoice® HealthPlan HMO and CIGNA HMO).

All health plans offered through the Employee Insurance Program (EIP) are self-insured. EIP does not pay premiums to an insurance company. Subscribers' monthly premiums and employers' contributions are placed in a trust account maintained by the state to pay claims and administrative expenses. Administrative expenses comprise only about 4 percent of the total program spending.

To learn about eligibility, enrollment and other features that are common to all health plans offered through EIP, see the General Information chapter, which begins on page 9.

If you are an employee or retiree who is not eligible for Medicare and your primary coverage is the Standard Plan, the Savings Plan or an HMO, you and your covered spouse may participate yearly in a Preventive Workplace Screening. For $15, you receive a comprehensive, biometric health appraisal that includes a blood test and an evaluation of your risk factors. Ask your BA when a screening is scheduled.

Notice to Subscribers: Tobacco-Use Surcharge

If you are a subscriber with single coverage and you use tobacco, you will pay a $40 monthly surcharge. If you have subscriber/spouse, subscriber/children or full-family coverage and anyone you cover uses tobacco, the surcharge will be $60 monthly.

To avoid this charge, a subscriber must certify that no one covered under his health insurance uses tobacco, and no one has used it during the past six months by completing a Certification of Tobacco Use form. If you have not certified or need to change your certification, go to EIP's website, www.eip.sc.gov, and click on "Tobacco Information" on the left. Please give the certification form to your benefits administrator, who will send it to EIP. The certification will be effective the first of the month after EIP receives the form.

A subscriber must pay all his premiums, including the tobacco-use surcharge, if it applies, when they are due. If he does not, coverage for all of his plans will be canceled effective the last day of the month in which the premiums were paid in full.

If You Are Unable to Stop Using Tobacco Due to a Medical Reason

If your physician provides a letter that states that it is unreasonably difficult due to a medical condition for you to stop using tobacco or that it is medically inadvisable for you to stop using tobacco, you may qualify for a waiver of the tobacco-use surcharge. Please give the letter to your benefits administrator, who will send it to the Employee Insurance Program.

Subrogation: If Someone Else Caused Your Injury

To the extent provided by South Carolina law, health plans offered through EIP have the right to recover payment in full for benefits provided to a covered person under the terms of the plan when the injury or illness occurs through the act or omission of another person, firm, corporation or organization. If a covered person receives payment for such medical expenses from another who caused the injury or illness, the covered person agrees to reimburse the plan in full for any medical expenses paid by the plan.

Benefits at a Glance: State Health Plan

This brief overview of your medical plan is for comparison only. The *Plan of Benefits* governs all health benefits offered by the state.

	Standard Plan	Savings Plan
Annual Deductible	$350 Individual $700 Family	$3,000 Individual $6,000 Family (If more than one family member is covered, only the cost of preventive benefits will be paid until the $6,000 annual family deductible is met.)
Per-occurrence Deductibles: Emergency Care[1]	$125	None
Outpatient Facility Services[2]	$75	None
Physician Office Visit[3]	$10	None
Coinsurance (after deductible is met)**:** Network	20% You pay 80% Insurance pays	20% You pay 80% Insurance pays
Out-of-network[4]	40% You pay 60% Insurance pays	40% You pay 60% Insurance pays
Coinsurance Maximum: Network	$2,000 Individual $4,000 Family	$2,000 Individual $4,000 Family
Out-of-network[4]	$4,000 Individual $8,000 Family	$4,000 Individual $8,000 Family
Lifetime Maximum	None	None
Prescription Drug Deductible per Year[4]	No annual deductible	
Retail Copayments for up to a 31-day supply (Participating pharmacies only)[4]	$9 Tier 1 (Generic – lowest cost) $30 Tier 2 (Brand – higher cost) $50 Tier 3 (Brand – highest cost)	**Prescription Drugs** You must use participating pharmacies. You pay the full allowed amount for prescription drugs, and the cost is applied to your annual deductible.
Mail Order and Retail Maintenance Network Copayments for up to a 90-day supply[4]	$22 Tier 1 (Generic – lowest cost) $75 Tier 2 (Brand – higher cost) $125 Tier 3 (Brand – highest cost)	After you reach your deductible, you continue to pay the full allowed amount for prescription drugs. However, the plan will reimburse you for 80% of the allowed amount. You pay the remaining 20% as coinsurance.
Prescription Drug Copayment Maximum[4]	$2,500 per person (applies to prescription drugs only)	Drug costs are applied to your plan's in-network coinsurance maximum: $2,000 – individual; $4,000 – family.
Tax-favored Medical Accounts	Medical Spending Account	Health Savings Account Limited-use Medical Spending Account

[1] *Waived if admitted.*
[2] *Waived for dialysis, routine mammograms, routine Pap tests, clinic visits, emergency room, oncology, electro-convulsive therapy and psychiatric medication management.*
[3] *Waived for routine Pap tests, routine mammograms and well child care.*
[4] *Prescription drugs are not covered out of network.*

The State Health Plan

The State Health Plan (SHP) offers the **Standard Plan**, the **Savings Plan** and, for members enrolled in Medicare, the **Medicare Supplemental Plan**. It is important that you understand how your plan works.

The **Standard Plan** has higher premiums but lower deductibles than the Savings Plan. When one family member meets his deductible, the Standard Plan will begin to pay benefits for him, even if the family deductible has not been met. Under the Standard Plan, when you buy a prescription drug you make a copayment, rather than pay the *allowed amount*. (The *allowed amount* is the maximum amount a health plan will pay for a covered service or product, whether it is provided in-network or out-of-network. Network providers have agreed to accept the allowed amount.) You do not have to meet your deductible to buy prescription drugs for the copayment.

As a **Savings Plan** subscriber, you take greater responsibility for your healthcare costs and accept a higher annual deductible. You pay the full allowed amount for covered medical benefits (including mental health/substance abuse benefits and prescription drugs) until you reach the deductible. As a result, you save money on premiums. Another advantage is that because the Savings Plan is a tax-qualified, high-deductible health plan, you may establish a **Health Savings Account** (HSA) if you have *no other health coverage, including Medicare,* unless it is another high-deductible health plan, and you cannot be claimed as a dependent on another person's tax return. Funds in an HSA may be used to pay qualified medical expenses now and in the future.

The *Plan of Benefits* contains a complete description of the plan. Its terms and conditions govern all health benefits offered by the state. To review this document, contact your benefits administrator or EIP.

How the SHP Pays for Covered Benefits

EIP contracts with BlueCross BlueShield of South Carolina (BCBSSC), to process medical and mental health/substance abuse claims, and Medco Health Solutions, Inc., to process prescription drug claims. Subscribers share the cost of their benefits by paying deductibles, coinsurance and copayments for covered benefits.

Please note: Companion Benefit Alternatives (CBA) is now the mental health/substance abuse manager for the Savings Plan, the Standard Plan and the Medicare Supplemental Plan. CBA is the mental health/substance abuse division of BCBSSC. BCBSSC handles customer service, and claims are reported to you on your Explanation of Benefits from BCBSSC. CBA handles preauthorization, provider networks and case management.

How the Standard Plan Works

Annual Deductible

The *annual deductible* is the amount you must pay each year for covered medical benefits (including mental health and substance abuse benefits) before the plan begins to pay a percentage of the cost of your covered medical benefits. The annual deductibles are:

- $350 for individual coverage
- $700 for family coverage.

Under the Standard Plan, the family deductible is the same, regardless of how many family members are covered. The $700 family deductible may be met by any combination of two or more family members' covered medical expenses, as long as they total $700. For example, if five people each have $140 in covered expenses, the family deductible has been met, even if no one person has met the $350 individual deductible. If only one person has met the $350 individual deductible, the plan will begin paying a percentage of the cost

of his benefits but not a percentage of the cost of the rest of the family's benefits until the remaining family members have $350 in covered medical expenses. No family member may pay more than $350 toward the family deductible.

If the subscriber and his spouse, who is also covered as an employee or retiree, select the same health plan, they will share the family deductible.

Payments for non-covered services, per-occurrence deductibles and penalties for not calling Medi-Call, National Imaging Associates or Companion Benefit Alternatives (CBA) do not count toward the deductible.

If you are covered under the Standard Plan, you pay copayments for drugs, up to a maximum of $2,500 for each covered family member. Drug costs do not apply to your deductible or your coinsurance maximum.

Per-occurrence Deductibles

A *per-occurrence deductible* is the amount you pay before the Standard Plan begins to pay a percentage of the cost of services in a professional provider's office, in an emergency room or for outpatient facility services, which may be provided in an outpatient department of a hospital or in a freestanding facility. You continue to pay per-occurrence deductibles even after you meet your annual deductible and reach your coinsurance maximum. Per-occurrence deductibles do not apply to your annual deductible or to your coinsurance maximum.

The per-occurrence deductible for each visit to a professional provider's office is $10. This deductible is waived for routine Pap tests, routine mammograms and well child care visits. Here is an example of how it works. If the Standard Plan allowed $56 for a physician's visit, you would first pay the $10 per-occurrence deductible.

- If you *have not* met your annual deductible, the remaining $46 would apply toward your annual deductible (you owe $56).
- If you *have* met your annual deductible, the Standard Plan would pay 80 percent of the $46, or $36.80, and you would be responsible for the remaining $9.20, as well as for your $10 per-occurrence deductible (you owe $19.20).

The deductible for each emergency room visit is $125. This deductible is waived if you are admitted to the hospital. The deductible for outpatient facility services, which include outpatient hospital services and outpatient surgery center services, is $75. This deductible is waived for dialysis, routine mammograms, routine Pap tests, clinic visits, emergency room, oncology, electro-convulsive therapy and psychiatric medication management.

Coinsurance

After your annual deductible has been met, the Standard Plan pays 80 percent of the allowed amount for your covered medical and mental health/substance abuse benefits if you use network providers. You pay 20 percent as *coinsurance.*

If you use non-network providers, the plan pays 60 percent of the plan's allowed amount for your covered medical and mental health/substance abuse benefits, and you pay 40 percent as *coinsurance.* Any charge above the plan's allowed amount for a covered medical or mental health/substance abuse benefit is your responsibility. See page 49 to learn more about this out-of-network differential. **Prescription drug benefits are paid only if you use a network provider.**

A different coinsurance rate applies for infertility treatments and prescription drugs associated with infertility. See page 60.

How the Savings Plan Works

Annual Deductible

The *annual deductible* is the amount you must pay each year for covered medical and mental health/substance abuse benefits and prescription drugs before the Savings Plan begins to pay a percentage of the cost of your covered benefits. The annual deductibles are:

- $3,000 for individual coverage
- $6,000 for family coverage.

There is no individual deductible if more than one family member is covered. If the subscriber and spouse, who is also covered as an employee or retiree, select the same health plan, they will share the family deductible. The family deductible is not met for any covered individual until the total allowed amount paid for covered benefits exceeds $6,000. For example, even if one family member has paid $3,001 for covered medical benefits, the plan will not begin paying a percentage of the cost of his covered benefits until his family has paid $6,000 for covered benefits. However, if the subscriber has paid $1,000 for covered benefits, the spouse has paid $3,001 for covered benefits and a child has paid $2,000 for covered benefits, the plan will begin paying a percentage of the cost of the covered benefits of all family members.

If you are covered under the Savings Plan, you pay the full allowed amount for covered prescription drugs, and the amount is applied to your deductible. After you meet your deductible you still have to pay the full allowed amount, but you are reimbursed for 80 percent of the allowed amount. After you meet your coinsurance maximum, you are reimbursed for 100 percent of the allowed amount.

There are **no** per-occurrence deductibles under the Savings Plan. You pay the full allowed amount for services, and it is applied to your annual deductible.

Coinsurance

After your annual deductible has been met, the Savings Plan pays 80 percent of the allowed amount for your covered medical, prescription drug and mental health/substance abuse benefits if you use network providers. You pay 20 percent as *coinsurance.*

If you use non-network providers, the plan pays 60 percent of the plan's allowed amount for your covered medical and mental health/substance abuse benefits, and you pay 40 percent as *coinsurance.* Any charge above the plan's allowed amount for a covered medical or mental health/substance abuse benefit is your responsibility. See page 49 to learn more about this out-of-network differential. **Prescription drug benefits are paid only if you use a network provider.**

A different coinsurance rate applies for infertility treatments and prescription drugs associated with infertility. See page 60.

Coinsurance Maximum

The *coinsurance maximum* is the amount in coinsurance you must pay for covered benefits each year before you are no longer required to pay coinsurance. Under the **Standard Plan** and the **Savings Plan** it is $2,000 for individual coverage or $4,000 for family coverage for **network** services and $4,000 for individual coverage or $8,000 for family coverage for **non-network** services.

Please note: The allowed amount for network services does not apply to the non-network coinsurance maximum, and the allowed amount for non-network services does not apply to the network coinsurance maximum. For example: If you have individual coverage and have paid $1,500 in network coinsurance and $600 in non-network coinsurance, you have not met your network coinsurance maximum.

Payments for non-covered services, deductibles and penalties for not calling Medi-Call, National Imaging Associates or Companion Benefit Alternatives (CBA) do not count toward your coinsurance maximum.

Coordination of Benefits

All State Health Plan benefits, including prescription drug and mental health benefits, are subject to *coordination of benefits* (COB). COB is a system to make sure a person covered under more than one insurance plan is not reimbursed more than once for the same expenses. For more information about COB, including how third-party claims processors determine which plan pays first, see page 12.

Here are some specific features of coordination of benefits under the Standard Plan and the Savings Plan:

On your Notice of Election (NOE) form, you are asked if you are covered by more than one group insurance plan. Your response is recorded and placed in your file. However, the third-party claims processor, BlueCross BlueShield of South Carolina (BCBSSC), may ask you this question every year, by sending you a questionnaire. **Complete this form and return it to BCBSSC promptly, since claims will not be processed or paid until your information is received.** You can also update this information by calling BCBSSC or by visiting www.SouthCarolinaBlues.com. Under "Members," select "My Health Toolkit."

This is how the SHP works when it is secondary insurance:

- For a **medical** or a **mental health/substance abuse** claim, you or your provider must file the Explanation of Benefits from your primary plan with BCBSSC.
- For **prescription drug** benefits, you must present your card for your primary coverage first. Otherwise, the claim will be rejected because the pharmacist's electronic system will show that the SHP is secondary coverage. After the pharmacy processes the claim with your primary coverage, you must file a paper claim through Medco for payment of any secondary benefits. Prescription drug claim forms are on the EIP website, www.eip.sc.gov. You may also ask your benefits administrator for the form.
- The SHP will pay the lesser of: 1) what it would pay if it were the primary payer; or 2) the balance after the primary plan's network discounts and/or payments are deducted from the total charge.
- The SHP's limit on balance billing does not apply. Therefore, it is important that you use a provider in your primary plan's network.
- You will also be responsible for the SHP deductible and SHP coinsurance, if the maximum has not been met.

Please remember: **The SHP is not responsible for filing or processing claims for a subscriber through another health insurance plan. That is your responsibility.**

Please note: If your coverage with any other health insurance program is canceled, you must request a letter of termination. The letter of termination must be submitted to BCBSSC promptly, because claims will not be processed or paid until your information is received.

Using SHP Provider Networks

When you are ill or injured, you decide where to go for your care. The SHP operates as a *preferred provider organization* (PPO). As such, it has networks of physicians and hospitals, outpatient surgery centers and mammography testing centers. There are also networks available to subscribers for ambulatory surgery centers, durable medical equipment, labs, radiology and X-ray, physical therapy, occupational therapy, speech therapy, skilled nursing facilities, long term acute care facilities, hospices and dialysis centers. They have agreed, as part of the network, to accept the plan's allowed amount for covered benefits as payment in full. **Network providers will charge you for your deductibles and coinsurance when the services are provided. They will also file your claims.**

If you use an out-of-network medical or mental health/substance abuse provider or your physician sends

your laboratory tests to an out-of-network provider, your costs will increase. Prescription drug benefits are paid only if you use a network provider.

How to Find a Medical or Mental Health/Substance Abuse Network Provider

To view the online provider directory, go to EIP's website, www.eip.sc.gov, and select "Online Directories:"

- Choose "State Health Plan Doctor/Hospital Finder."
- Under "Doctor & Hospital Finder" select "Visit Now."
- Under "Doctor and Hospital Finder," you can search in South Carolina and surrounding counties or nationally. You can also select the type of provider you would like to find.
  - If you would like to find a mental health/substance abuse provider, select, for example, "Behavioral Health Practitioners" from the drop-down list.
- After you choose the type of provider you need, select "State Health Plan" from the drop-down list. Provide your ZIP code and how close to your ZIP code you would like for the provider to be.
- Under "Optional" you can give more information about the type of provider you would prefer.

If you do not have access to the Internet, call BCBSSC at 803-736-1576 (Greater Columbia area) or 800-868-2520 (toll-free outside the Columbia area) to ask that a list of SHP providers in your area be mailed to you.

BlueCard® and BlueCard Worldwide®

State Health Plan and BlueChoice HealthPlan HMO members have access to doctors and hospitals throughout the United States and around the world through the BlueCard Program and Blue Cross and Blue Shield provider networks. If you are covered by the State Health Plan and need mental health or substance abuse care outside South Carolina, call 800-810-2583. If you are a BlueChoice member and need behavioral health services, call Companion Benefit Alternatives at 800-868-1032.

BlueCard Worldwide® is not available to Medicare Supplemental Plan subscribers.

Inside the U.S.

Please note: BlueChoice members have BlueCard® coverage for urgent and emergency care only.

With the BlueCard program you can choose the doctors and hospitals that suit you best. Follow these steps for health coverage when you are away from home but within the United States:

1. Always carry your health plan ID card.
2. In an emergency, go to the nearest hospital.
3. To find the names and addresses of nearby doctors and hospitals, go to the BCBSSC website through "Online Directories" on the EIP website. Then choose "State Health Plan Doctor/Hospital Finder." Under "Doctor & Hospital Finder" select "National Search." It is helpful to have the ZIP code of the area where you need a provider. You may also call BlueCard *Access* at 800-810-2583.
4. **Call Medi-Call within 48 hours of receiving emergency care if you are covered by the State Health Plan.** The toll-free number is on your SHP ID card. **If you have an emergency admission to a hospital, call BlueChoice HealthPlan Member Services within 24 hours or the next business day to notify the plan of the admission.**
5. When you arrive at the participating doctor's office or hospital, show your identification card. The provider will recognize the BlueCard logo, which will ensure that you get the highest level of benefits with no balance billing.
6. The provider should file claims with the Blue Cross and Blue Shield affiliate in the state where the services were provided.

You should not have to complete any claim forms, nor should you have to pay up front for medical services other than the usual out-of-pocket expenses (deductibles, copayments, coinsurance and non-covered services). BCBSSC will mail an Explanation of Benefits to you.

Outside the U.S.

Through the BlueCard Worldwide® program, your health plan card gives you access to doctors and hospitals in more than 200 countries and territories worldwide and to a broad range of medical services.

To take advantage of the BlueCard Worldwide program, follow these steps:

1. **Always carry your health plan ID card.**
2. **In an emergency, go to the nearest hospital.**
3. Before your trip:
   - If you have questions, call the phone number on the back of your ID card to check your benefits and for preauthorization, if necessary. (Your healthcare benefits may be different outside the U.S.)
   - The BlueCard Worldwide Service Center can help you find providers in the area where you are traveling. It can also provide other helpful information about healthcare overseas. To reach the center, go to the EIP website, www.eip.sc.gov, and, under "Links," select "Medical (BlueCross BlueShield of South Carolina)". Under "Understanding Your Coverage" select "BlueCard." You may also call toll-free at 800-810-2583 or collect at 804-673-1177.
4. During your trip:
   - **If you need to find a doctor or hospital or need medical assistance, go to the BCBSSC website through** "Online Directories" on the EIP website. Then choose "State Health Plan Doctor/Hospital Finder." On the "Doctor & Hospital Finder" screen select "Visit Now" under"Worldwide Directory." You must accept the terms and conditions and login with the first three letters of your identification number. **You may also call the BlueCard Worldwide Service Center toll-free at 800-810-2583 or collect at 804-673-1177 (24 hours a day, seven days a week).**
   - If you are admitted to the hospital, call the BlueCard Worldwide Service Center toll-free at 800-810-2583 or collect at 804-673-1177.
   - The BlueCard Worldwide Service Center will work with your plan to arrange direct billing with the hospital for your inpatient stay.
   - When direct billing is arranged, you are responsible for the out-of-pocket expenses (non-covered services, deductibles, copayments, and coinsurance) you normally pay. The hospital will submit your claim on your behalf.
   - **Note:** If direct billing is not arranged between the hospital and your plan, you must pay the bill up front and file a claim. For outpatient care and doctor visits, pay the provider when you receive care and file a claim.
5. To file a claim for services you paid for when you received care or paid to providers that are not part of the BlueCard Worldwide network, complete a BlueCard Worldwide International Claim Form and send it to the BlueCard Worldwide Service Center with this information: the charge for each service; the date of that service and the name and address of each provider; a complete, detailed bill, including line-item descriptions; and descriptions and dates for all procedures and surgeries. This information does not have to be in English. **Be sure to get all of this information before you leave the provider's office.**
6. The claim form is available on the EIP website. Select "Forms" and then, under "State Health Plan (SHP)," select "BlueCard Worldwide International Claim Form." You may also call the service center toll-free at 800-810-2583 or collect at 804-673-1177. The address of the service center is on the claim form. BlueCard Worldwide will arrange billing to BCBSSC.

Please note: Some toll-free numbers do not work overseas. You can always reach BlueCard Worldwide by calling collect at 804-673-1177. We recommend you take this number with you when you leave the United States.

Mental Health/Substance Abuse Provider Network

The State Health Plan offers in-network and out-of-network coverage for mental health and substance abuse services. Preauthorization is required by Companion Benefit Alternatives (CBA), the mental health and substance abuse manager, for most hospital services and some outpatient services (see Mental Health and Substance Abuse Benefits on page 72. A greater percentage of the cost of your covered benefits will be paid if you use a network provider.

The most up-to-date list of network providers is available on the "Doctor/Hospital Finder" on the BCBSSC website. To see a printable version of directory, go to CompanionBenefitAlternatives.com and select "Members." Then select "Find a Provider" and finally "Network Directory." The directory can be searched using the "binoculars" search feature on the left. For help selecting a provider, call CBA at 800-868-1032. To find a provider outside South Carolina, select "National Search" under the "Doctor & Hospital Finder" or call 800-810-2583.

If you do not have access to the Internet, printed lists of providers from the directory are available from your benefits office or, if you are a retiree, survivor or COBRA participant, from BCBSSC.

For information about how to file out-of network claims, see pages 239-240.

For more information on your mental health and substance abuse benefits, see pages 72-73.

Prescription Drug Provider Network

Because the State Health Plan offers no out-of-network coverage for prescription drugs, it is important that you find a network provider for this service. The list of network providers is on the website sponsored by Medco Health Solutions, Inc., the prescription drug manager. The site is accessible through EIP's website, www.eip.sc.gov. You can also go directly to www.medco.com, sign in and click on "Locate a pharmacy."

If you do not have Internet access, ask your benefits administrator to print a list of network pharmacies near you. If you are a retiree, COBRA or survivor subscriber, call Medco for network pharmacies near you.

For more information on your prescription drug benefits, see pages 67-72.

Out-of-Network Benefits

You can use providers for medical and mental health/substance abuse care who are not part of the network and still receive some coverage. Before the State Health Plan will pay 100 percent of the plan's allowed amount:

- **Standard Plan and Savings Plan** subscribers must pay a $4,000 individual coinsurance maximum for out-of-network benefits or an $8,000 family coinsurance maximum for out-of-network benefits. Subscribers to both plans may also have to fill out claim forms.

Please note: No benefits will be paid for advanced radiology services (**CT, MRI, MRA or PET scans**) that are not preauthorized by National Imaging Associates.

There is no out-of-network coverage for **prescription drugs**.

Balance Billing

If you use a provider who is not part of the network, you may be subject to *balance billing*. When the State Health Plan is your primary coverage, network providers are prohibited from billing you for covered benefits, except for copayments, coinsurance and deductibles. However, a non-network provider may bill you for more than the plan's allowed amount for the covered benefit. The difference between what the non-network provider charges and the allowed amount is called the "balance bill." The balance bill does not contribute toward meeting your annual deductible or coinsurance maximum.

Out-of-Network Differential

In addition to balance billing, if you receive services from a provider that does not participate in the State Health Plan, Companion Benefit Alternatives or BlueCard networks, you will pay 40 percent, instead of 20 percent, in coinsurance. These examples show how it will cost you more to use a non-network provider:

You have subscriber-only coverage under the SHP, and you have not met your deductible. The non-network provider charges $5,000 for the covered benefits you receive, but the SHP allowed amount is $4,000.

Standard Plan

Your out-of-pocket costs for services from a **network provider** would have been $1,080 ($350 deductible plus $730 coinsurance).

However, if you used a non-network provider for the same services:

You pay the $350 Standard Plan deductible. Then $3,650 remains of the Standard Plan responsibility. The plan pays 60 percent of that, $2,190. The remaining $1,460 coinsurance and the $1,000 balance bill from the non-network provider are your responsibility. Therefore, $1,460 is applied toward your $4,000 out-of-network coinsurance maximum.

$4,000	SHP allowed amount
- 350	Standard Plan deductible
$3,650	Standard Plan responsibility
x 60%	Standard Plan coinsurance
$2,190	Standard Plan pays

$3,650	Standard Plan responsibility
-2,190	Standard Plan pays
1,460	You pay as coinsurance
1,000	Your balance bill from provider
+ 350	Your Standard Plan deductible
$2,810	**Your out-of-pocket costs for the services of a non-network provider**

Standard Plan subscribers also pay per-occurrence deductibles (which do not apply toward your annual deductible) both in-network and out-of-network. They are not included in this example.

Savings Plan

Your out-of-pocket costs for the services of a **network provider** would have been $3,200 ($3,000 deductible plus $200 coinsurance).

However, if you used a non-network provider for the same services:
You pay the $3,000 Savings Plan deductible. Then $1,000 remains of the Savings Plan responsibility. The plan pays 60 percent of that, $600. The remaining $400 coinsurance, as well as the $1,000 balance bill from the non-network provider, is your responsibility. The $400 in coinsurance is applied to your $4,000 out-of-network coinsurance maximum.

$4,000	SHP allowed amount
- 3,000	Savings Plan deductible
$1,000	Savings Plan responsibility
x 60%	Savings Plan coinsurance
$ 600	Savings Plan pays

$1,000	Savings Plan responsibility
- 600	Savings Plan pays
400	You pay as coinsurance
1,000	Your balance bill from provider
+3,000	Your Savings Plan deductible
$4,400	**Your out-of-pocket costs for the services of a non-network provider**

Managing Your Medical Care

Medi-Call

Under the State Health Plan, some covered services require preauthorization before you receive them. A phone call gets things started. Your healthcare provider may make the call for you, but it is your responsibility to see that the call is made.

Please note: Some mental health/substance abuse and prescription drug benefits require preauthorization. See page 72 for mental health and page 70 for prescription drugs.

What are the Penalties for not Calling?

If you do not preauthorize treatment when required, you will pay a $200 penalty for **each** hospital, rehabilitation or skilled nursing facility or mental health/substance abuse **admission.** In addition, the coinsurance maximum will not apply. You will continue to pay your coinsurance, no matter how much you pay out-of-pocket.

How to Preauthorize Your Treatment

You can reach Medi-Call by phone from 8:30 a.m. to 5 p.m., Monday through Friday, except holidays. You may fax information to Medi-Call 24 hours a day. However, Medi-Call will not respond until the next business day. If you send a fax to Medi-Call, provide, at a minimum, this information so the review can begin:

- Subscriber's name
- Patient's name
- Subscriber's Benefits ID Number or Social Security Number
- Information about the service requested
- A telephone number where you can be reached during business hours.

Whether you are enrolled in the Standard Plan or the Savings Plan, you must use Medi-Call.

Medi-Call numbers are:
- 800-925-9724 (South Carolina, nationwide, Canada)
- 803-699-3337 (Greater Columbia area)
- 803-264-0183 (fax)

Medi-Call promotes high-quality, cost-effective care for you and your covered family members through reviews that assess, plan, implement, coordinate, monitor and evaluate healthcare options and services required to meet an individual's needs. You must contact Medi-Call at least **48 hours or two working days,** whichever is greater, before receiving any of these medical services at any hospital in the U.S. or Canada:

- You need **any type** of inpatient care in a hospital[1]
- Your preauthorized outpatient services result in a hospital admission (You must call again for the hospital admission.)
- You need outpatient surgery for a septoplasty (surgery on the septum of the nose)
- You need outpatient or inpatient surgery for a hysterectomy
- You need sclerotherapy (vein surgery) performed in an inpatient, outpatient or office setting
- You will receive a new course of chemotherapy or radiation therapy (one-time notification per course)
- You are admitted to a hospital in an emergency (Your admission must be reported within 48 hours or the next working day after a weekend or holiday admission.)[1]
- You are pregnant **(You must notify Medi-Call within the first three months of your pregnancy.)**
- You have an emergency admission during pregnancy[2]
- Your baby is born (if you plan to file a claim for any birth-related expenses)[2]
- Your baby has complications at birth
- Before your baby is given Synagis (a drug to protect high-risk babies from respiratory syncytial virus disease) outside the hospital nursery
- You are to be, or have been, admitted to a long-term acute care facility, skilled nursing facility, or need

home healthcare, hospice care or would like an alternative treatment plan
- You need durable medical equipment
- You or your covered spouse decides to undergo in vitro fertilization, GIFT, ZIFT or any other infertility procedure
- You or your covered family member needs to be evaluated for a transplant
- You need inpatient rehabilitative services and related outpatient physical, speech or occupational therapy.

[1]*For mental health or substance abuse services, you must call Companion Benefit Alternatives (CBA) at 800-868-1032 for preauthorization before a non-emergency admission or, in the case of an emergency admission, within 48 hours or the next working day, whichever is longer.*

[2]*Contacting Medi-Call for the delivery of your baby does not add the baby to your health insurance. You must add your child by filing an NOE and submitting the required documentation, a long-form birth certificate, within 31 days of birth for benefits to be payable.*

A preauthorization request for any procedure that may be considered cosmetic must be received in writing by Medi-Call seven days before surgery. (Procedures in this category include: blepharoplasty, reduction mammoplasty, augmentation mammoplasty, mastopexy, TMJ or other jaw surgery, panniculectomy, abdominoplasty, rhinoplasty or other nose surgery, etc.) Your physician should include photographs if appropriate. A determination by Medi-Call that a proposed treatment is within generally recognized medical standards and procedures does not guarantee claim payment. Other conditions, including eligibility requirements, other limitations or exclusions, payment of deductibles and other provisions of the plan must be satisfied before BlueCross BlueShield of South Carolina makes payment. Remember, if you use a non-network provider, you will pay more.

Advanced Radiology Preauthorization/National Imaging Associates (NIA)

The State Health Plan has a system for preauthorizing CT, MRI, MRA and PET scans.

Network South Carolina physicians, radiology (imaging) centers and outpatient hospital radiology centers will be responsible for requesting advanced radiology preauthorization from National Imaging Associates (NIA).

If a subscriber or a covered family member is scheduled to receive a CT, MRI, MRA or PET scan from **an out-of-network provider in South Carolina or any provider outside South Carolina**, **it is the subscriber's responsibility to make sure his provider calls for preauthorization.** A subscriber may begin the process by calling NIA at 866-500-7664. He should be able to give NIA the name and phone number of the ordering physician and the name and phone number of the imaging center or the physician who will provide the radiology service.

Please note: Advanced radiology preauthorization is not required in an emergency room or if the person has been admitted to the hospital as an inpatient.

Please note: If NIA's telephone number is not on your State Health Plan ID card and you don't have this book handy, call Customer Service at 800-868-2520 and ask for the number for advanced radiology preauthorization.

NIA will make a decision about non-emergency preauthorization requests within two business days of receiving the request from the provider. If the situation is urgent, a decision will be made within one business day of receiving the request from the provider. However, the process may take longer if additional clinical information is needed to make a decision.

Doctors can get more information on the BCBSSC website, www.SouthCarolinaBlues.com, or by calling 800-444-4311. To request preauthorization over the Internet, providers can go to NIA's website, www.RadMD.com. They may also call NIA at 866-500-7664, Monday through Friday, from 8 a.m. to 8 p.m., ET.

A subscriber can check the status of a preauthorization request online through "My Health Toolkit" at www.SouthCarolinaBlues.com.

What are the Penalties for not Calling?

If a **network** South Carolina physician or radiology center does not request preauthorization, the provider will not be paid for the service, and he **cannot bill the subscriber for the service**.

If a subscriber or a covered family member receives advanced radiology services from an **out-of-network provider in South Carolina or from any provider outside South Carolina** without preauthorization, the provider will not be paid by BCBSSC, and the **subscriber will be responsible for the entire bill.**

Maternity Management

Regular prenatal care and following your doctor's recommendations can help keep you and your baby healthy. If you are a mother-to-be, **you must participate in the Maternity Management Program**. Medi-Call administers EIP's comprehensive maternity management program, "Coming Attractions." The program monitors expectant mothers throughout pregnancy and manages Neonatal Intensive Care Unit (NICU) infants or other babies with special needs until they are 1 year old. **To preauthorize your maternity benefits, you must notify Medi-Call during the first trimester (three months) of your pregnancy.** Medi-Call's numbers are 803-699-3337 (Greater Columbia area) and 800-925-9724 (toll-free outside the Columbia area). You do not have to wait until you have seen your physician to call and enroll in "Coming Attractions." If you do not enroll during your first trimester, you will incur a substantial financial penalty. See below.

You can also notify Medi-Call of your pregnancy and enroll in "Coming Attractions" online through the Personal Health Record's maternity screening program. Go to the EIP website, www.eip.sc.gov. Under "Links," select "Medical (BlueCross BlueShield of South Carolina)." At the site, select "My Health Toolkit" and then log in and select "Personal Health Record." From there, you will be asked to select the member. Then you will be taken to the home screen of the "Personal Health Record," which includes "My Activity Center." In the "My Assessments" box, select "Initial Maternity."

Participating in the Maternity Management Program or contacting Medi-Call about the birth of your baby does not add your baby to your health insurance. Even if you have Full Family or Employee/Children coverage, you must add the baby to your policy by completing an NOE and submitting a long-form birth certificate within 31 days of his birth.

If you do not notify Medi-Call of your pregnancy during the first trimester, or if you refuse to participate in the Maternity Management Program, you will pay a $200 penalty for failing to call. You will also incur a $200 penalty for each admission you fail to preauthorize, whether it is maternity related or not. There will also be a coinsurance penalty if you fail to enroll in the maternity management program during the first trimester, if you don't enroll in it at all or if you fail to preauthorize your hospital admission. The coinsurance you pay will not count toward your coinsurance maximum. For more information, see page 50 or call your maternity care nurse.

You are automatically enrolled in "Coming Attractions" when you preauthorize your pregnancy benefit through Medi-Call. As a participant in the program, you will receive a call from a Medi-Call nurse. Your nurse will mail you a welcome packet that includes a pregnancy guide book to assist you in having a healthy pregnancy and other educational information throughout your pregnancy.

A Medi-Call maternity nurse will complete a Maternity Health Assessment form when you enroll. It is used to identify potential high-risk factors during your first trimester. If high-risk factors are identified, you will be scheduled for follow-up calls. If no risks are identified, you should call with any changes in your condition. Otherwise, your Medi-Call nurse will call you during your second trimester and send you a reminder card with benefit information during your third trimester. Your Medi-Call nurse will also call you after your baby is born.

If you enroll in the program through the Personal Health Record, you can use the online system to correspond with your nurse and receive articles of interest from recognized medical sources.

Also, you can call Medi-Call anytime you have questions. A maternity case management nurse will be there to help you with both routine and special needs throughout your pregnancy and the post-partum period.

Wellness Management

Wellness Incentive Program

The Wellness Incentive Program enables eligible State Health Plan members with cardiovascular disease, congestive heart failure or diabetes to qualify for 12 months of free generic drugs that treat these conditions. Diabetes testing supplies (glucometer, test strips, control solution, lancet, syringes, pen needles, etc.) purchased at a network pharmacy are also covered at no charge. This program is designed to encourage participants to take more responsibility for their overall health and save themselves and the plan money.

Employees, retirees, COBRA subscribers and survivors and their covered family members are eligible to qualify if the State Health Plan is their primary insurance. If a subscriber is enrolled in the Medicare Supplemental Plan but covers family members who are not eligible for Medicare, these dependents are eligible for the incentive program. If Medicare or other coverage becomes primary while receiving the waiver, the waiver will continue for the 12-month period, but it will not be extended. Children age 5 and older are eligible if they have been diagnosed with diabetes. Participation for all other conditions can begin at age 18.

Potential participants are identified by the BCBSSC Health Management Program based on a member's claims, prescriptions or preauthorizations for one of the covered diseases and are automatically enrolled in the program. Individuals will receive an invitation from BSBSSC that outlines the requirements. If you think you qualify for the Wellness Incentive Program but have not been invited to participate, call 800-868-2500, select 1 and then extension 49043.

To qualify for the 12-month generic copayment waiver, a member must: 1) complete the condition-specific BCBSSC Health Management Program Survey (Instructions on how to complete it are on the EIP website under "Publications."); 2) see his health care practitioner about his condition at least once a year; 3) have the condition-specific lab tests performed (diabetes requires an A1C twice a year, and cardiovascular disease/congestive heart failure requires a yearly test that measures triglycerides, LDL, HDL and total cholesterol); 4) some participants will be required to complete four telephone calls with a BCBSSC health coach. As an alternative to the calls, participants with cardiovascular disease may complete a phase 2 cardiac rehabilitation prescribed by a physician. Participants with diabetes may enroll in Prevention Partners' Club Sugar or take a course approved by the American Diabetes Association or the American Association of Diabetes Educators.

After completing the requirements, a member will receive a letter from BCBSSC giving him the dates of the generic copayment waiver. Generic diabetes drugs and testing supplies, cholesterol-lowering drugs and antihypertensives (drugs to treat high blood pressure) purchased at a network pharmacy are covered. A list of generic drugs eligible for the waiver is updated yearly and is posted on the BCBSSC website. A link is on the EIP website as part of the Wellness Incentive Program FAQs. The drugs and diabetic supplies must be purchased at a network pharmacy or through the mail-order pharmacy.

For the waiver to extend beyond 12 months, a member must continue to participate in the Health Management Program, complete the requirements for the waiver again and take a follow-up survey, the Personal Health Assessment. The assessment is on the BCBSSC website. Select "Links" on the EIP website, www.eip.sc.gov, and then "My Health Tookit." The assessment is under "Quick Links."

For general information about the Wellness Incentive Program, call BCBSSC Customer Service at 800-868-2520. If you need to reach a health coach, call 800-868-2500, select 1 and then extension 49043. For more

information about prescriptions, call Medco, the pharmacy benefit manager, at 800-711-3450. Frequently Asked Questions about the program are on the EIP website.

Weight Management Program

The BlueCross Weight Management program is designed to help you achieve weight-loss goals through small changes you can make while still getting on with your life. You will receive information about weight management, and a confidential survey will help a registered nurse tailor the program to meet your needs. Program candidates are identified through claims analysis, preauthorizations, doctor referral or self-referral.

If you think you qualify but have not been invited to participate or would like more information, call 800-868-2500, select 1 and then extension 49043.

New for 2012: Healthy Weight for Kids and Teens

This confidential program is for overweight and obese children between the ages of 2 and 17. It is designed to teach children and their parents healthy habits, support their efforts and help them work with their doctor on weight management. Members are invited to participate based on medical claims, or they may be referred by a doctor. Also, a parent can enroll his covered child by calling 800-868-2500, select 1 and then extension 49043.

Health Management Program

Managing a chronic condition can be difficult. However, studies show you can help control your symptoms by making lifestyle changes and by following your doctor's advice. You can also delay, or even prevent, many of the complications of the disease.

The Health Management Program is designed for Standard Plan and Savings Plan subscribers and their covered family members who have diabetes, heart disease or chronic respiratory conditions. BCBSSC selects participants by reviewing medical, pharmacy and laboratory claims. If you are identified as someone who could benefit from it, you are automatically enrolled. You may, however, opt out of the program.

As a participant, you will receive a welcome letter that includes the name of and contact information for your BlueCross health coach. Your coach will be a registered nurse who will help you learn more about your condition and how to manage it. He or she will also help you work with your physician to develop a plan to take charge of your illness, contacting you by phone or through the online Personal Health Record. You can contact your health coach as often as you like with questions or to ask for advice. For more information, call 803-736-1576 (Greater Columbia area) or 800-868-2520 (toll-free outside the Columbia area).

If you have diabetes, congestive heart failure or cardiovascular disease, BSBSSC may invite you to participate in the Wellness Incentive Program.

About Your Privacy
In compliance with federal law, your health information will always be kept confidential. Your employer does not receive the results of any surveys you complete. Enrolling will not affect your health benefits now or in the future.

New for 2012: Health Management for Migraine Program

The program encourages a member to work with his doctor to create a plan to ease the pain of migraine headaches. A health coach helps the member learn to identify migraine triggers, develop healthy habits to prevent migraines and comply with his treatment plan. Members, who must be at least age 18, are invited to participate based on medical and pharmacy claims. They can also enroll by calling 800-868-2500, select 1 and then extension 49043.

Medical Case Management

Facing a serious illness or injury can be confusing and frustrating. You may not know where to find support or information to help you cope with your illness, and you may not know what treatment options are available. Case management can help.

The case management programs available to State Health Plan members are explained below. Each program includes teams of specially trained nurses and doctors. Their goal is to assist participants in coordinating, assessing and planning healthcare. They do so by giving a patient control over his care and respecting his right to knowledge, choice, a direct relationship with his physician, privacy and dignity. None of the programs provide medical treatment. All recognize that, ultimately, decisions about your care are between you and your physician. Each program may involve a home or facility visit to a participant but only with permission.

By working closely with your doctor, using your benefits effectively and using the resources in your community, the case management programs may help you through a difficult time. For more information on any of these programs, call 800-925-9724 and ask to be transferred to the case management supervisor.

BlueCross Medi-Call Case Management Program

This program is designed for State Health Plan members who have specific catastrophic or chronic disorders, acute illnesses or serious injuries. The program facilitates continuity of care and support of these patients while managing health plan benefits in a way that promotes high-quality, cost-effective outcomes.

Case managers talk with patients, family members and providers to coordinate services among providers and support the patient through a crisis or chronic disease. Case management intervention may be short- or long-term. Case managers combine standard preauthorization services with innovative approaches for patients who require high levels of medical care and benefits. Case managers can often arrange services or identify community resources available to meet the patient's needs.

The case manager works with the patient and the providers to assess, plan, implement, coordinate, monitor and evaluate ways of meeting a patient's needs, reducing readmissions and enhancing quality of life. Your Medi-Call nurse case manager may visit you at home, with your permission, or in a treatment facility or your physician's office when the treatment team determines it is appropriate.

A Medi-Call nurse stays in touch with the patient, caregivers and providers to assess and re-evaluate the treatment plan and the patient's progress. All communication between BlueCross BlueShield of South Carolina and the patient, family members or providers complies with HIPAA privacy requirements. If a patient refuses medical case management, Medi-Call will continue to preauthorize appropriate treatment.

Alere Complex Care Management Program

Some members are referred to Alere for complex care management. The program is designed to assist the most seriously ill patients. They include those with complex medical conditions, who may have more than one illness or injury, who have critical barriers to their care and who are frequently hospitalized.

The complex care management program provides you with information and support through a local care coordinator, who is a registered nurse. This nurse coordinator can help you identify treatment options; locate supplies and equipment recommended by your doctor; coordinate care with your doctor and the SHP; and research the availability of transportation and lodging for out-of-town treatment. The nurse stays in touch weekly with patients and caregivers to assess and re-evaluate the treatment plan and the patient's progress. This program helps you make informed decisions about your health when you are seriously ill or injured. Participation is voluntary. You can leave the program at any time, for any reason. Your benefits will not be affected by your participation.

Here is how the program works. BlueCross BlueShield of South Carolina will refer you to Alere if the program may benefit you. You will receive a letter explaining the program, and an Alere representative will contact you. A care coordinator in your area will visit you to discuss ways he can help you and will ask permission to contact your doctor to offer assistance.

An Alere team of specially trained nurses and doctors will review your medical information and treatment plan. (Your medical history and information will always be kept confidential among your caregivers and the Alere team.) Your local care coordinator nurse will be your main contact. You and your doctor, however, will always make the final decision about your treatment. Complex care management does not replace your doctor's care. Always check with your doctor before following any medical advice.

A BlueCross nurse will act as a liaison with the Alere nurse. This BlueCross nurse provides information about benefits and networks and completes authorization for medically necessary services that are covered by the plan.

VillageHealth Disease Management Renal Case Management Program

VillageHealth Disease Management provides renal disease management care for select State Health Plan members with end-stage renal disease (ESRD). These nurses visit patients in dialysis centers and in their homes to provide education and outreach that may help prevent acute illnesses and hospitalizations.

Here is how the program works. Subscribers with ESRD are referred to VillageHealth by BCBSSC. A South Carolina-based VillageHealth nurse then contacts the individual to confirm that he is a good candidate for renal case management. The nurse, who has many years of ESRD experience, coordinates care across all disciplines and facilitates Medi-Call referrals for patients accepted into the program.

As the link between the patient, providers and dialysis team, the nurse identifies the patient's needs through medical record review and consultations with the patient, family and health care team. Needs may be medical, social, behavioral, emotional and financial. The nurse coordinates services based on the long-term needs of the patient and incorporates these needs into a plan agreed upon by the patient, physician(s), dialysis team and other providers. Your VillageHealth nurse may visit you at home, with your permission, or in the dialysis center when the treatment team determines it is appropriate. Your nurse will call you frequently and receive updates from your providers.

A Medi-Call case manager will be the liaison with the VillageHealth nurse. This Medi-Call nurse provides information about the use of benefits and networks and completes authorization for medically necessary services covered by the plan.

Online Health Tools

Personal Health Record

Your Personal Health Record, which is available on the BCBSSC website, is safe and secure. Through it, you have access to your health information, including a list of your claims and the prescription drugs you are taking, 24 hours a day, seven days a week. You can enter medical information, such as allergies, vaccinations, test results and personal or family medical history. This information can be shared with family members or new doctors as you feel is appropriate. Through the "My Care Plan" section, you can get information about your health conditions and other medical topics that are of interest to you. If you participate in the Health Management Program, your health coach can use it to send you messages, assign tasks and provide you with additional information about your condition.

To review your record, go to the EIP website, www.eip.sc.gov. Under "Links," select "My Health Toolkit." At the site, select "My Health Toolkit." Log in and select "Personal Health Record." From there, you will be asked to select the member. Then you will be taken to the home screen of the "Personal Health Record."

Personal Health Assessment

An online Personal Health Assessment (PHA) is available to State Health Plan subscribers who are 18 years and older. Go to the EIP website, www.eip.sc.gov. Under "Links," select "My Health Toolkit." At the site, log in. Under "Quick Links," select "Personal Health Assessment" and select the member. Then you will be taken to the survey.

The survey asks questions and then provides a wellness score based on your responses. It gives you access to behavior-change programs that are designed to address your specific risk factors. These interactive tools will help you reach your goals at your own pace.

You can print your PHA results and recommendations, and you will continue to have access to them online. The program is on a secure Eeb link, and all assessments remain confidential. You can retake the survey each year to measure your progress toward your health goals.

Compare Hospital Quality

Under "Resources" on the "My Health Toolkit" page, you can select "Find a Doctor or Hospital." With this tool, you can compare hospitals in the same part of the state to determine the number of patients treated, complication rates, patient experience and other indicators of quality. This information can help you choose a hospital.

Estimate Treatment Costs

The cost estimator is under "Resources" on the "My Health Toolkit" page. At the EIP website, select "Links" and then "My Health Toolkit." When you reach the page, log in. The estimator can help you determine what you may pay for a medical service or procedure based on plan benefits and what you have paid toward your deductible and coinsurance maximum. This can be useful in budgeting and planning for the cost of certain health conditions. The estimator provides a cost range for an illness, breaks the cost down by type of care (e.g., medical, durable medical equipment, drugs, etc.) and compares costs by setting (e.g., inpatient versus outpatient). The cost estimator can help you plan contributions to a Medical Spending Account or a Health Savings Account.

State Health Plan Benefits

The Standard Plan and the Savings Plan pay benefits for *medically necessary* treatments of illnesses and injuries. This section is a general description of the plan. The Plan of Benefits contains a complete description of the benefits. Its terms and conditions govern all health benefits offered by the state. Contact your benefits administrator or EIP for more information. Some services and treatment require preauthorization by Medi-Call, National Imaging Associates or Companion Benefit Alternatives (CBA). Be sure to read the Medi-Call section beginning on page 50, the National Imaging Associates section on page 51 and the mental health and substance abuse section on page 72 for details.

A *medically necessary* service or supply is:

- Required to identify or treat an existing condition, illness or injury and
- Prescribed or ordered by a physician and
- Consistent with the covered person's illness, injury or condition and in accordance with proper medical and surgical practices in the medical specialty or field of medicine at the time provided and
- Required for reasons other than the convenience of the patient and
- Results in measurable, identifiable progress in treating the covered person's condition, illness or injury.

The fact that a procedure, service or supply is prescribed by a physician does not automatically mean it is medically necessary.

Advanced Practice Registered Nurse

Expenses for services received from a licensed, independent Advanced Practice Registered Nurse (APRN) are covered, even if these services are not performed under the immediate direction of a doctor. An APRN is a nurse practitioner, certified nurse midwife, certified registered nurse anesthetist or a clinical nurse specialist. All services received must be within the scope of the nurse's license and needed because of a service allowed by the plan.

The State Health Plan only recognizes certified nurse midwives as providers of midwife covered services. A certified nurse midwife (CNM) is an APRN who is licensed by the State Board of Nursing as a midwife. The services of lay midwives and midwives licensed by the S.C. Dept. of Health and Environmental Control (DHEC) are not reimbursed.

Alternative Treatment Plans (ATP)

An alternative treatment plan is an individual program to permit treatment in a more cost-effective and less intensive manner. An ATP requires the approval of the treating physician, Medi-Call and the patient. Services and supplies that are authorized by Medi-Call as medically necessary because of the approved alternative treatment plan will be covered.

Ambulance Service

Ambulance service is covered to the nearest outpatient hospital department to obtain medically necessary emergency care. Ambulance service is also covered to transport a member to the nearest hospital that can provide medically necessary inpatient services when those services are not available at the current facility. No benefits are payable for ambulance service used for routine, nonemergency transportation, including, but not limited to, travel to a facility for scheduled medical or surgical treatments, such as dialysis or cancer treatment. All claims for ambulance service are subject to medical review. Ambulance services are reimbursed at 80 percent of the allowed amount. However, non-participating providers can bill you up to the total of their charge for the service.

Autism Spectrum Disorder Benefits

Applied Behavior Analysis (ABA) for children diagnosed with an Autism Spectrum Disorder at age 8 or younger is covered, subject to Companion Benefit Alternatives (CBA) guidelines and preauthorization requirements, for up to a maximum of $51,400 for 2012. A child must be younger than 16 years of age to receive benefits. All services must be approved by CBA and performed by a certified ABA provider.

Chiropractic Care

You are covered for specific office-based services from a chiropractor, including detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the body to remove nerve interference and the effects of such nerve interference, where such interference is the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column. Diagnostic X-rays are covered if medically necessary. For Standard Plan subscribers, chiropractic benefits are limited to $2,000 per person each year. Under the Savings Plan, they are limited to $500 per person each year. Both plans are limited to one Manual Therapy per visit, which is subject to the plan maximum.

Colonoscopies

Routine colonoscopies are covered once every ten years, starting at age 50, even when no symptoms are apparent. The plan will not cover the consultation before the routine colonoscopy. The amount billed for the consultation will be the patient's responsibility. The plan also covers diagnostic colonoscopies. All colonoscopies are subject to the plan's deductibles and coinsurance. Your per-occurrence deductibles and the amount you pay in coinsurance may vary based on where you receive the service.

Contraceptives

For subscribers and covered spouses, routine contraceptive prescriptions, including birth control pills and injectables (including, but not limited to, Depo-Provera and Lunelle), filled at a participating pharmacy or through the plan's mail-order pharmacy, are covered as prescription drugs. Birth control implants and injectables, given in a doctor's office, are covered as a medical benefit.

Cranial Remodeling Band or Helmet

The plan covers a cranial remodeling band when preauthorization review determines it to be medically necessary for the correction of a child's moderate to severe positional head deformities associated with premature birth, restrictive intrauterine positioning, cervical abnormalities, birth trauma, torticollis or sleeping positions. Remodeling must begin between 4 and 12 months of age, following a failed two-month trial of conservative treatment (e.g., repositioning, neck exercises, etc.).

Diabetic Supplies

Insulin is allowed under the prescription drug program or under the medical plan but not under both. (Insulin requires a $30 copayment for each supply of up to 31 days.) Diabetic supplies, including syringes, lancets and test strips, are covered at participating pharmacies through your drug benefit for a $9 copayment, per item, for each supply of up to 31 days. Claims for diabetic durable medical equipment should be filed under your medical coverage.

Doctor Visits

Treatments or consultations for an injury or illness are covered, when they are medically necessary and not associated with a service excluded by the plan. Some mental health and substance abuse outpatient visits still require preauthorization. For details on mental health and substance abuse benefits, see page 72.

Durable Medical Equipment (DME)

Generally, DME must be preauthorized by Medi-Call. Some examples include:

- Any purchase or rental of durable medical equipment
- Any purchase or rental of renal dialysis equipment
- Any purchase or rental of durable medical equipment that has a nontherapeutic use or a potentially nontherapeutic use
- C-Pap or Bi-Pap machines
- Oxygen and equipment for oxygen use outside a hospital setting, whether purchased or rented
- Any prosthetic appliance or orthopedic brace, crutch or lift, attached to the brace, crutch or lift, whether initial or replacement
- Orthopedic shoes.

DME provider networks are available to State Health Plan members. They offer you discounts while providing you with high-quality products and care.

Home Healthcare

Home healthcare includes part-time nursing care, health aide service or physical, occupational or speech therapy provided by an approved home healthcare agency and given in the patient's home. You cannot receive home healthcare and hospital or skilled nursing facility benefits at the same time. These services do not include custodial care or care given by a person who ordinarily lives in the home or is a member of the patient's family or the patient's spouse's family. **Benefits are limited to 100 visits per year.** These services must be preauthorized by Medi-Call.

Hospice Care

The plan will pay up to $6,000 for hospice care for a patient certified by his physician as having a terminal illness and a life expectancy of six months or less. The benefit also includes a maximum of $200 for bereavement counseling. These services must be preauthorized by Medi-Call.

Infertility

The plan will pay for the diagnosis and treatment of infertility for a subscriber and spouse who have not had a prior tubal ligation or a vasectomy.

Coverage is limited to a lifetime maximum payment of $15,000. The limit applies to any covered medical benefits and covered prescription drug benefits incurred by the subscriber or the covered spouse, whether covered as a spouse or as an employee. Included in the $15,000 maximum are diagnostic tests, prescription drugs and up to six cycles of Intrauterine Insemination (IUI), and a maximum of three completed cycles of zygote or gamete intrafallopian transfer (ZIFT or GIFT) or in vitro fertilization (IVF) per lifetime. A cycle reflects the cyclic changes of fertility with the cycle beginning with each new insemination or assisted reproductive technology (ART) transfer or implantation attempt. ART procedures not specifically mentioned are not covered, including but not limited to: tubal embryo transfer (TET), pronuclear stage tubal embryo transfer (PROUST) oocyte donation and intracytoplasmic sperm injection (ICSI).

Benefits are payable at 70 percent of the allowed amount. Your share of the expenses does not count toward your coinsurance maximum. All procedures related to infertility must be preauthorized by Medi-Call. Call Medi-Call at 803-699-3337 in the Greater Columbia area and at 800-925-9724 in South Carolina, nationwide and in Canada for more information.

The plan will pay a total lifetime maximum of $15,000 for fertility treatment. It applies to all benefits paid under any State Health Plan option. The limit may also be met by the number of cycles.

The plan will not provide infertility benefits for a subscriber or spouse who has had a tubal ligation or a vasectomy. **Prescription drugs for treatment of infertility are subject to a 30 percent coinsurance payment under both the Savings Plan and the Standard Plan.** This expense does not apply to the $2,500, per person, copayment maximum under the Standard Plan. It does apply to the Savings Plan deductible. The 70 percent plan payment for prescription drugs for infertility treatments applies to the $15,000 maximum lifetime payment for infertility treatments. Call Medco's Member Services at 800-711-3450 for more information about prescription drugs.

Inpatient Hospital Services

Inpatient hospital care, including a semi-private room and board, is covered. In addition to normal visits by your physician while you are in the hospital, you are covered for one consultation per consulting physician for each inpatient hospital stay. **Inpatient care must be approved by Medi-Call or Companion Benefit Alternatives (CBA). For more information, see page 50.**

Organ Transplants

State Health Plan transplant contracting arrangements include the BlueCross BlueShield Association (BCBSA) national transplant network, Blue Distinction Centers for Transplants (BDCT). All BDCT facilities meet specific criteria that consider provider qualifications, programs and patient outcomes.

All transplant services must be approved by Medi-Call (see page 50). You must call Medi-Call, even before you or a covered family member is evaluated for a transplant.

Through the BDCT network, SHP members have access to the leading organ transplant facilities in the nation. Contracts are also in effect with local providers for transplant services so that individuals insured by the plan may receive transplants at those facilities. You will save a significant amount of money if you receive your transplant services either at a BDCT network facility or through a local South Carolina network transplant facility. If you receive transplant services at one of these network facilities, you will not be balance billed. You will be responsible only for your deductible, coinsurance and any charges not covered by the plan. In addition, these network facilities will file all claims for you.

Transplant services at nonparticipating facilities will be covered by the plan. However, the SHP will pay only the SHP allowed amount for transplants performed at out-of-network facilities. If you do **not** receive your transplant services at a network facility, you may pay substantially more. In addition to the deductible and coinsurance, subscribers using out-of-network facilities are responsible for any amount over the allowed amount and will pay an additional 20 percent in coinsurance, totaling 40 percent, because they used out-of-network providers. Costs for transplant care can vary by hundreds of thousands of dollars. If you receive services outside the network, you cannot be assured that your costs will not exceed those allowed by the plan. Call Medi-Call for more information.

Outpatient Facility Services

Outpatient facility services may be provided in the outpatient department of a hospital or in a freestanding facility.

Outpatient services and supplies include:
- Laboratory services
- X-ray and other radiological services
- Emergency room services
- Radiation therapy
- Pathology services
- Outpatient surgery
- Infusion suite services and
- Diagnostic tests.

If you are covered under the Standard Plan, you will be charged a $75 outpatient per-occurrence deductible. You will be charged a $125 per-occurrence deductible for emergency room services. Per-occurrence deductibles do not apply to your annual deductible or your coinsurance maximum. The per-occurrence deductible for emergency room services is waived if you are admitted to the hospital.

Pregnancy and Pediatric Care

Pregnancy benefits are provided to covered female employees or retirees and to covered wives of male employees or retirees. **Covered children do not have maternity benefits**. Maternity benefits include necessary prenatal and postpartum care, including childbirth, miscarriage and complications related to pregnancy. **There are penalties if you do not call Medi-Call within the first three months of your pregnancy to enroll in the Maternity Management Program.** See page 52 for information.

Under federal law, group health plans generally cannot restrict benefits for the length of any hospital stay in connection with childbirth for the mother or the newborn to fewer than 48 hours after a vaginal delivery or fewer than 96 hours after a caesarean section. However, the plan may pay for a shorter stay if the attending physician, after consultation with the mother, discharges the mother or newborn earlier.

Also under federal law, group health plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan may not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However,

to use certain providers or facilities, or to reduce out-of-pocket costs, a member may be required to obtain precertification.

Pregnancy is not considered a pre-existing condition.

Prescription Drugs

Prescription drugs, including insulin, are covered at a participating pharmacy, subject to plan exclusions and limitations. Drugs in FDA Phase I, II or III testing are not covered. Prescription drugs associated with infertility treatments have a different coinsurance rate. Please refer to page 60 for more information.

Nonsedating antihistamines and drugs for treating erectile dysfunction are not covered under the Savings Plan.

Reconstructive Surgery After a Medically Necessary Mastectomy

The plan will cover, as required by the Women's Health and Cancer Rights Act of 1998, mastectomy-related services, including:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications in all stages of mastectomy, including lymphedema.

These services apply only in postmastectomy cases. All services must be approved by Medi-Call.

Rehabilitation Care

The plan provides benefits for physical rehabilitation designed to restore a bodily function that has been lost because of trauma or disease.

Rehabilitation care is subject to all terms and conditions of the plan including:

- Preauthorization is required for any inpatient rehabilitation care, regardless of the reason for the admission, and is required for any outpatient rehabilitation therapy that occurs after an inpatient admission for rehabilitation therapy.
- The rehabilitation therapy must be performed in the most cost-effective setting appropriate to the condition.
- The provider must submit a treatment plan to Medi-Call.
- There must be reasonable expectation that sufficient function can be restored for the patient to live at home.
- Significant improvement must continue to be made.
- An inpatient admission must be to an accredited (JCAHO or CARF) rehabilitation facility.

Rehabilitation benefits are not payable for:

- Vocational rehabilitation intended to teach a patient how to be gainfully employed
- Pulmonary rehabilitation (except in conjunction with a covered and approved lung transplant)
- Cognitive (mental) retraining
- Community re-entry programs
- Long-term rehabilitation after the acute phase
- Work-hardening programs.

Rehabilitation – Acute

Acute-phase rehabilitation often is done in an outpatient setting. In complex cases, the rehabilitation may be done in an acute-care facility and then a sub-acute rehabilitation facility or an outpatient facility. Acute

rehabilitation begins soon after the start of the illness or injury and may continue for days, weeks or several months.

Rehabilitation – Long-term

Long-term rehabilitation refers to the point at which further improvement is possible, in theory, but progress is slow and its relationship to formal treatment is unclear. Long-term rehabilitation after the acute phase is generally not covered.

Second Opinions

If Medi-Call advises you to seek a second opinion before a medical procedure, the plan will pay 100 percent of the cost of that opinion. These procedures include surgery, as well as treatment (including hospitalization).

Skilled Nursing Facility

The plan will pay limited benefits for medically necessary inpatient services at a skilled nursing facility for up to 60 days. Physician visits are limited to one a day. These services require approval by Medi-Call.

Speech Therapy

The plan covers short-term speech therapy to restore speech or swallowing function that has been lost as a result of disease, trauma, injury or congenital defect (e.g., cleft lip or cleft palate). Speech therapy must be prescribed by a physician and provided by a licensed speech therapist.

Speech therapy requires preauthorization when provided in an inpatient setting or in a home setting. However, claims for speech therapy that are not preauthorized may be verified for medical necessity after the claim is submitted. These expenses are covered only if they are determined to be medically necessary and associated with a service allowed by the plan.

Maintenance therapy begins when the therapeutic goals of a treatment plan have been achieved or when no further functional progress is documented or expected to occur. Maintenance therapy is not covered.

Speech therapy is not covered when associated with any of the following:

- Verbal apraxia or stuttering
- Language delay
- Communication delay
- Developmental delay
- Attention disorders
- Behavioral disorders
- Cognitive (mental) retraining
- Community re-entry programs or
- Long-term rehabilitation after the acute phase of treatment for the injury or illness.

After a claim is paid, BlueCross BlueShield of South Carolina can still review speech therapy services to determine if the services are a benefit covered by the plan.

Surgery

Physician charges for medically necessary inpatient surgery, outpatient surgery and use of surgical facilities are covered, if the care is associated with a service allowed by the plan.

Other Covered Benefits

These benefits are covered if they are determined to be medically necessary and associated with a service allowed by the plan:

- Blood and blood plasma, excluding storage fees
- Nursing services (part-time/intermittent)
- Dental treatments or surgery to repair damage from an accident, for up to one year from the date of the accident
- Dental surgery for bony, impacted teeth when supported by X-rays.

Extended care is covered as an alternative to hospital care **only** if it is approved by Medi-Call.

Preventive Benefits

The Standard Plan and the Savings Plan have benefits that can help make it easier for you and your family to stay healthy. You also are eligible for Prevention Partners programs. By helping prevent potentially expensive health problems and hospital admissions, these benefits help control medical claims costs, saving you and the plan money.

Benefits for Women

Mammography Program

Routine mammograms are covered at 100 percent as long as you use a participating facility and meet eligibility requirements.

- When you are between the ages 35 and 39, one baseline mammogram (four-view) will be covered.
- If you are age 40 through 74, one routine mammogram (four-view) will be covered each calendar year.

Charges for routine mammograms performed at nonparticipating facilities are not covered, with the exception of procedures performed outside South Carolina. Non-network providers are free to charge you any price for their services, so you may pay more.

A doctor's order is not required for a routine mammogram. However, most centers ask for one, so it is recommended that you get one.

Preventive mammogram benefits are in addition to benefits for diagnostic mammograms. Any charges for additional mammograms are subject to deductibles and coinsurance.

To learn how to find a provider, go to the EIP website and select "Publications." The mammography flyer is under "Health Insurance."

Women, age 40 and older, covered as retirees and enrolled in Medicare, should contact Medicare or see *Medicare and You 2012* for information about coverage. The State Health Plan is primary for a woman covered as active employee or as the spouse of an active employee, regardless of Medicare eligibility.

Pap Test Benefit

Standard Plan members
The plan only covers the cost of the lab work associated with a Pap test each calendar year, without any requirement for a deductible or coinsurance, for covered women ages 18 through 65. Before you receive this service, please consider the following:

- Costs for the office visit, charges associated with a pelvic exam, breast exam, or a complete or mini-

physical exam and any other laboratory tests, procedures or services associated with receiving the Pap test benefit **are not covered** and are the member's responsibility.
- If the test is performed by an out-of-network provider, the member may be billed for the amount of the charge above the SHP allowed amount for the test.

It is strongly advised that the member contact the provider before scheduling an office visit to determine the cost of the exam and related services. The amount the member pays for additional services does not count toward her annual deductible.

Savings Plan members
Savings Plan participants have the same Pap test benefit as Standard Plan members. However, Savings Plan members older than 18 are entitled to a routine annual exam. They may receive a routine annual exam or an exam performed in conjunction with the Pap test, but not both. If both are performed in the same year, the first one filed will be allowed.

Well Child Care Benefits

Well Child Care benefits are designed to promote good health and aid in the early detection and prevention of illness in children enrolled in the State Health Plan.

Who is Eligible?

Covered children through age 18 are eligible for Well Child Care check-ups.

How Does it Work?

This benefit covers Well Child Care exams and timely immunizations. When these services are received from a doctor in the State Health Plan Physician Network, benefits will be paid at 100 percent. **The State Health Plan will not pay for services from non-network providers.** Some services may not be considered part of Well Child Care. For example, if during a well child visit a fever and sore throat were discovered, the lab work to verify the diagnosis would not be part of the routine visit. These charges would be subject to deductibles and coinsurance, as would any other medical expense.

Well Child Care Checkups

The plan pays 100 percent of approved routine exams, Centers for Disease Control-recommended immunizations and American Academy of Pediatrics-recommended lab tests when a network doctor provides these checkups:

- Younger than 1 year old — five visits
- 1 year old — three visits
- 2 through 18 years old — one visit a year. (The Well Child Care exam must occur after the child's birthday.)

Immunizations

Benefits are provided for all immunizations at the appropriate ages recommended by the Centers for Disease Control for children through age 18. To be sure the immunization will be covered, the child must have reached the age at which the schedule says the immunization should be given.

If your covered child has delayed or missed receiving immunizations at the recommended times, the plan will pay for catch-up immunizations through age 18, subject to the limitations outlined above. The schedule on page 66 provides general information but is subject to change. **Please contact your State Health Plan pediatrician or call Medi-Call for the most up-to-date information about how to immunize your child properly.**

Disease	Recommended Immunization Schedule
Hepatitis B (HepB)	Birth 1-2 months 6 months 2 dose series, 11-15 years if not previously vaccinated
Rotavirus	2 months 4 months 6 months
Inactivated Poliovirus	2 months 4 months 6-18 months 4-6 years
Diphtheria- Tetanus- Pertussis (Whooping cough)	2 months 4 months 6 months 15-18 months 4-6 years 11-12 years
Haemophilus (HIB)	2 months 4 months 6 months (optional) 12-15 months
Pneumococcal Conjugate (PCV7)	2 months 4 months 6 months 12-15 months
Influenza	Yearly for children ages 6 months-18 years
Measles- Mumps- Rubella	12-15 months 4-6 years
Varicella (Chickenpox)	12-15 months 11-12 years if child has not already had disease or vaccine
Hepatitis A	12-23 months (two doses at least six months apart)
Meningococcal	11-12 years
Human Papillomavirus (HPV)	1st dose at 11-12 years 2nd dose 2 months after 1st dose 3rd dose 6 months after 1st dose

Natural Blue^{sm} and Other Discount Programs

Natural Blue^{sm} is a discount program available to State Health Plan subscribers and offered by BCBSSC. The program has a network of licensed acupuncturists, massage therapists and fitness clubs that may be used at lower fees, often as much as a 25 percent discount. Natural Blue also offers discounts on health products, such as vitamins, herbal supplements, books and tapes.

Added Value programs are discounts on products and services that BCBSSC makes available but that are not State Health Plan benefits. Discounts are available on LASIK vision correction, hearing aids, cosmetic dentistry, cosmetic surgery, hair restoration, weight loss, allergy control and children's fitness.

Members may use their Medical Spending Account (MSA) funds tax free for LASIK, contacts, eyeglasses, hearing aids and many other services. For more information, see IRS Publication 969, "Health Savings Accounts and Other Tax-Favored Health Plans." It is available on the IRS website, www.irs.gov.

For more information on Natural Blue or Added Values, go to the BCBSSC website, www.SouthCarolinaBlues.com. On the home page, select "Discounts & Added Values."

Additional Benefits for Savings Plan Participants

As a participant in the Savings Plan, you are taking greater responsibility for your healthcare. To make that easier, your plan offers extra preventive benefits. They include:

- The allowed amount for a yearly flu immunization for each eligible participant. (If the member does not go to a network physician, he may be billed for the difference between the charge and the allowed amount.)
- Access to a telephone service through which registered nurses provide personal, immediate assistance 24 hours a day, seven days a week. Subscribers also have access to the Playback Audio Library, which includes information in English and Spanish on hundreds of topics. The toll-free number is listed on the back of your health plan ID card.
- A monthly *Healthy Life* newsletter and a copy of a self-care handbook.

Physical Exam

Savings Plan participants age 19 and older may receive an annual physical from a network provider in his office that includes:

- A preventive, comprehensive examination
- A complete urinalysis, if coded as a preventive screening
- A preventive EKG
- A fecal occult blood test, if coded as a preventive screening
- A general health laboratory panel blood work, if coded as a preventive screening. (This benefit does not include a more comprehensive executive blood panel test.)
- A preventive lipid panel once every five years (for testing cholesterol and triglycerides).

Note: If your network physician sends tests to a non-network physician or lab, the tests will not be covered.

When you check out, you may wish to remind your physician's staff that you are covered under the Savings Plan and your exam should be coded as a routine physical. If a service that would have otherwise been covered is coded as a diagnostic procedure, it will apply to the member's deductible or be paid as a diagnostic procedure at the contract rate.

Prescription Drug Benefits

Prescription Drugs – 800-711-3450

Prescription drugs are a major benefit to you and a major part of the cost of our self-insured health plan. Using generic drugs saves you and the plan money. You also can save money, and receive the same FDA-approved drugs, when you refill prescriptions through The Medco Pharmacy, the mail-order prescription service. **Remember, benefits are paid only for prescriptions filled at network pharmacies or through the mail-order pharmacy.** Prescription drugs, including insulin or other self-injectable drugs (drugs administered at home), are covered subject to plan exclusions and limitations, provided you use a participating pharmacy. Drugs in FDA Phase I, II or III testing are not covered. Prescription drugs associated with infertility treatments have a different coinsurance rate. See page 60 for more information.

Standard Plan

The prescription drug benefit, administered by Medco Health Solutions, Inc., is easy and convenient to use.

With this program, you show your SHP identification card when you purchase prescriptions from a participating retail pharmacy and pay a copayment of $9 for Tier 1 (generic – lowest cost), $30 for Tier 2 (brand – higher cost) or $50 for Tier 3 (brand – highest cost) for up to a 31-day supply. If the price of your prescription is less than the copayment, you pay the lesser amount.

A *copayment* is a fixed amount a subscriber must pay for a covered expense in addition to what the insurance plan pays. There are no individual exceptions made to the copayment established for a particular prescription drug.

Prescription drug benefits are payable without an annual deductible. There are no claims to file. The prescription drug benefits are the same for the Standard Plan and the Medicare Supplemental Plan.

The prescription drug benefit has a separate annual copayment maximum of $2,500 per person. This means that after you spend $2,500 in prescription drug copayments, the plan will pay 100 percent of the allowed amount for your covered prescription drugs for the rest of the year. Drug expenses do not count toward your medical annual deductible or coinsurance maximum.

To find the copayment for a prescription drug, check it under "Price a Medication" on Medco's website.

Savings Plan

With this plan, you show your SHP identification card when you purchase your prescriptions from a participating retail pharmacy and pay the full allowed amount for your prescription drugs. There is no copayment.

This cost is transmitted electronically to BCBSSC. If you have not met your annual deductible, the full allowed amount for the drug will be credited to it. If you have met your deductible, you will be reimbursed for 80 percent of the drug's allowed amount. The remaining 20 percent of the cost will be credited to your coinsurance maximum.

Nonsedating antihistamines and drugs for erectile dysfunction are not covered under the Savings Plan.

Pay-the-Difference Policy

Under the State Health Plan, there is a "pay-the-difference" policy. If you purchase a brand-name drug when an FDA-approved generic equivalent is available, the payment will be limited to what the plan would have paid for the generic equivalent. This policy will apply even if the doctor prescribes the drug as "Dispense as Written" or "Do Not Substitute." **No individual exceptions are made to the pay-the-difference policy.**

Under the **Standard Plan and the Medicare Supplemental Plan,** if you purchase a Tier 2 or Tier 3 (brand) drug over a Tier 1 (generic) drug, you will be charged the generic copayment, PLUS the difference between the allowed amount for the brand and the generic drug. If the total amount is less than the Tier 2 or Tier 3 (brand) copayment, you will pay the brand copayment.

Please note: Only the copayment for the Tier 1 (generic) drug will apply toward a member's annual prescription drug copayment maximum.

Here are examples of how pay-the-difference works under the Standard Plan and the Medicare Supplemental Plan:

This is what you pay for a Tier 2 (brand) drug when a Tier 1 (generic) drug is <u>not</u> available.

	Tier 1 (generic)	Tier 2 (brand)
Allowed amount for the drug	N/A	$125
Generic copayment	N/A	N/A

Amount you pay	N/A	**$30** (the brand copayment only)

This is what you pay when a Tier 1 (generic) drug is available and you choose the Tier 2 (brand) drug.

	Tier 1 (generic)	Tier 2 (brand)
Allowed amount for the drug	$65	$125
Generic copayment	$9	N/A
Amount you would have paid had you chosen the generic drug	**$9** (the generic copayment only)	
Amount you pay because you chose the brand drug		**$69** (The generic copayment [$9] **plus** the difference between the allowed amount for the generic drug and the brand drug [$60])

Under the **Savings Plan**, if you purchase a Tier 2 or Tier 3 (brand) drug over a Tier 1 (generic) drug, only the allowed amount for the generic drug will apply toward your deductible. After you have met your deductible, only the patient's 20 percent share of the allowed amount for the generic drug will apply toward your coinsurance maximum.

If you are taking a Tier 2 or Tier 3 drug, you may wish to ask your doctor about using a generic drug, if one is available. If appropriate, the doctor may note on the prescription that substitution is permitted.

My Rx Choices

My Rx Choices is an online tool that may help you and your doctor make more economical decisions about your long-term prescriptions. Go to www.medco.com, log in and select "My Rx Choices." You can search for the medications you take, learn what you will pay for them and find out how much you could save by using lower-cost alternatives that are available under your plan. Your options could include generic drugs, less expensive brand-name drugs or use of Medco's mail-order pharmacy, The Medco Pharmacy.

You can ask your doctor to consider Medco's suggestions. If he thinks any of the alternative drugs are appropriate for you, he can write a new prescription.

Depending on the drugs you take and the alternatives available, a Medco pharmacist may be able to contact your doctor on your behalf. *However, no prescription will ever be changed without your doctor's approval, and you will be notified of the change.*

Preferred Drug Step Therapy Program

This program is designed to encourage use of generics and over-the-counter drugs that have been approved as alternatives to some high-volume, high-priced brand-name drugs. For example, omeprazole is a less expensive alternative to Aciphex®.

If you or your doctor thinks you should not use the lower-cost drug, your prescription may require preauthorization or it may be covered at the Tier 3 (highest cost) rate. You or your doctor may request a coverage review by calling Medco. As part of the process, you may be required to have tried and failed to successfully use the lower-cost drug. If as a result of the review, the drug is approved, it will be covered at the appropriate tier. If approval is denied, your health plan will not cover the drug.

For more information, call Medco at 800-711-3450.

Tier 1 (Generic – Lowest Cost)

Under both plans, prescription drug choices are divided into three categories: Tier 1 (generic – lowest cost),

Tier 2 (brand – higher cost) and Tier 3 (brand – highest cost).

Generic drugs may differ in color, size or shape, but the FDA requires that the active ingredients be the chemical equivalent of the brand-name alternative and have the same strength, purity and quality. Prescriptions filled with generic drugs often have a lower allowed amount, under the Savings Plan, and a lower copayment, under the Standard Plan. Therefore, you typically get the same health benefits for less.

You may wish to ask your doctor to mark "substitution permitted" on your prescription. If he does not, your pharmacist will have no choice but to give you the brand-name drug, if that is the drug your doctor wrote on the prescription.

Tier 2 (Brand – Higher Cost)

These are drugs Medco's Pharmacy and Therapeutics Committee has determined to be safe, effective and available at a lower cost than Tier 3 drugs. The list may be updated during the year. It is available online at www.medco.com. You may reach the Medco website through the EIP website by clicking on "Links."

Tier 3 (Brand – Highest Cost)

These medications carry a higher copayment or higher price. **Tier 3 contains drugs that may be considered preferred or nonpreferred on the formulary**, the list of prescription drugs approved by your plan. There are no individual exceptions made to the copayment established for a particular prescription drug.

Compound Prescriptions

A compound prescription is a medication that requires a pharmacist to mix two or more drugs, based on a doctor's prescription, when such a medication is not available from a manufacturer. It is handled the same way any prescription is handled and must be purchased from a participating pharmacy.

If the pharmacy does not file your claim, you must pay the entire cost of the prescription and then submit a claim to Medco. Information on how to file a claim to Medco is on page 240. Claims must be accompanied by an itemized list of the ingredients. Ask your pharmacist to provide you with this list when you fill your prescription. Please be sure it includes:

- The name of each ingredient
- The valid National Drug Code (NDC) for each ingredient
- The quantity of each ingredient.

This information allows Medco to process your claim based on the actual ingredients in your medication.

When you file your own claim, your reimbursement may be less than what you paid for the drug because it will be limited to the plan's allowed amount minus the copayment for the actual ingredients in the compound prescription.

Some compound drugs may be available through The Medco Pharmacy. Please contact Medco to see if they are available before ordering.

Preauthorization

Some medications will be covered by the plan only if they are prescribed for certain uses. These drugs must be authorized in advance, or they will not be covered under the plan. If the prescribed medication must be preauthorized, you or your pharmacist may begin the review process by contacting Medco at 800-711-3450.

Retail Pharmacies

You must use a participating pharmacy, and you must show your health plan identification card when purchasing medications. The State Health Plan participates in Rx Selections®, Medco's pharmacy network. Most major pharmacy chains and independent pharmacies participate in this network. A list of network pharmacies is available through the EIP website, www.eip.sc.gov, or at www.medco.com. You may also get a list of network pharmacies from your benefits administrator.

Retail Maintenance Network

If you are enrolled in the *Standard Plan* or the *Medicare Supplemental Plan*, you may buy 90-day supplies of prescription drugs at mail-order prices at local pharmacies belonging to the Retail Maintenance Network. You pay the same copayment as you would pay through mail order. This applies only to prescriptions filled for a 63-90 day supply at a network pharmacy. Copayments for prescriptions filled for a 0-62 day supply at these retail pharmacies remain the same. The copayments also remain the same at all other network pharmacies. A list of the pharmacies is on the EIP website, www.eip.sc.gov, under "Online Directories." If you do not have Internet access, ask your benefits administrator to print the list for you. For more information, call Medco at 800-711-3450.

Mail-Order: The Medco Pharmacy

The Standard Plan and the Savings Plan offer mail-order service for 90-day supplies of prescriptions. By using this service, you receive a discount on the same FDA-approved prescription drugs that you would buy at a retail pharmacy. Mail order is an ideal option for anyone with a recurring prescription, such as birth control medicine, or a chronic condition, such as asthma, high cholesterol or high blood pressure. Some controlled substances may not be available by mail. Please call Medco before submitting your prescription.

Please be sure your physician writes your prescription for a 90-day supply. If it is written for a 31-day supply, you will be charged for a 90-day supply but will be sent a 31-day supply. If you have any questions before you order a 90-day supply of a drug, call Medco at 800-711-3450.

Standard Plan

The copayments for up to a 90-day supply are: Tier 1 (generic) – $22, Tier 2 (brand) – $75, and Tier 3 (brand) – $125. There are no individual exceptions made to the copayment for a particular prescription drug.

Savings Plan

You pay the full allowed amount when you order prescription drugs through the mail. However, that cost for a 90-day supply will typically be less than you would pay at a retail pharmacy.

How to Order Drugs by Mail

This is how the mail-order service works:

- Ask your physician to write your prescription for a single 31-day supply and for a 90-day supply with refills.
- Fill your prescription for the 31-day supply at a participating retail pharmacy.
- Complete a mail-order prescription form and mail it to Medco. (Interactive forms are available through the EIP website, www.eip.sc.gov, under "Forms" or on Medco's website: www.medco.com.)
- Your order will be sent to your home, typically within 10-14 business days. Meanwhile, use your prescription from the retail pharmacy.

Once the initial prescription has been entered and filled, you may order refills online or by phone using Medco's toll-free number: 800-711-3450.

If you want to save money by ordering a 90-day supply by mail, be sure to ask your doctor to write a prescription for a **90-day supply with refills**. Under the **Standard Plan,** prescriptions written for a 31-day supply with refills will be filled for a 31-day supply, and you will be charged the same copayment that is charged for a 90-day supply. Under the **Savings Plan**, you can buy less than a 90-day supply.

Coordination of Benefits

The State Health Plan coordinates prescription drug benefits, as well as medical benefits. This ensures that if you are covered by more than one health plan, both plans pay their share of the cost of your care. See pages 12 and 45 for more information.

Exclusions

Some prescription drugs are not covered under the plan. See page 62 for more information.

Mental Health and Substance Abuse Benefits

For Customer Service and Claims – 800-868-2520

For customer service and information about claims for mental health and/or substance abuse care, call BlueCross BlueShield of South Carolina (BCBSSC).

How are Mental Health/Substance Abuse Claims Filed?

Claims for mental health and substance abuse are subject to the same deductibles, coinsurance and coinsurance maximums as medical claims. There is no limit on the number of provider visits allowed as long as the care is medically necessary. There is not a separate annual and lifetime maximum for mental health and substance abuse benefits.

If you use a network provider, the provider is responsible for submitting claims for services. If you receive care from a provider who is not a member of the network, see page 239 for information about how to file a claim. Your mental health and substance abuse provider will be required to conduct periodic medical necessity reviews (similar to Medi-Call).

The Mental Health/Substance Abuse Provider Network

Medically necessary mental health and substance abuse services are covered when rendered by network and out-of-network providers. Just like benefits for medical services, a higher percentage of the cost of your care is covered if you use network services.

The most up-to-date list of providers is on the BCBSSC website. Under "Online Directories" on the EIP website, select "State Health Plan Doctor/Hospital Finder." To see a printable directory of network providers in South Carolina and surrounding counties in Georgia and North Carolina, go to CompanionBenefitAlternatives.com and select "Members." **To learn more about how to use these directories, see page 46.**

Paper copies of lists of providers from the directory are available from your benefits office or, if you are a retiree, survivor or COBRA subscriber, from BCBSSC. **If you have questions about these or other network providers, call BSBSSC.** Remember, if you use an out-of-network provider, you will pay more.

For Preauthorization and Case Management – 800-868-1032

Preauthorization and case management of mental health and substance abuse benefits are handled by Companion Benefit Alternatives (CBA). CBA is the mental health/substance abuse division of BCBSSC.

Office visits to a mental health or substance abuse provider, such as a psychologist, a clinical social worker or a professional counselor, no longer require preauthorization **except** for the services listed below under "Mental Health Professional Services."

These services must be preauthorized by CBA:

- **Inpatient Hospital Care**
- **Intensive Outpatient Hospital Care**
- **Partial Hospitalization Care**
- **Outpatient Electroshock Therapy – Hospital and Physician Services**
- **Mental Health Professional Services – Applied Behavior Analysis Therapy (ABA) and Psychological/Neuropsychological Testing.**

To preauthorize services, your provider must call CBA at 800-868-1032 before you are admitted or, in an emergency situation, within 48 hours or the next working day. For professional services listed above, your provider must call before services are rendered. To assess medical necessity, CBA will require clinical information from the mental health or substance abuse provider currently treating you. Although your provider may make the call for you, **it is your responsibility to see that the call is made and the preauthorization has been granted**. A determination by CBA does not guarantee payment. Other conditions, including eligibility requirements, other limitations and exclusions, payment of deductibles and other provisions of the plan must be satisfied before BCBSSC makes payment.

What are the Penalties for not Calling CBA for Preauthorization?

Mental Health Professional Services
If mental health and substance abuse outpatient services that require preauthorization, (**Applied Behavior Analysis Therapy** and **Psychological/Neuropsychological Testing)** are not preauthorized, they will not be covered.

Facility Services
If your provider does not call CBA when required, you will pay a $200 penalty for each hospital admission. In addition, the coinsurance maximum will not apply. You will continue to pay your coinsurance, no matter how much you pay out-of-pocket.

Case Management

Case management is designed to support members with catastrophic or chronic illness. Participants are assigned a case manager, who will help educate them on the options and services available to meet their mental health and substance abuse needs and assist in coordinating needed services.

Case managers are licensed nurses and social workers. They assist members by answering questions and helping them get the most out of their mental health, medical and pharmacy benefits. This may include care planning, patient/family education, benefits review and coordinating other services and community resources. Covered members enrolled in this program receive access to a personal case manager, educational resources, and web tools that help them learn more about their health and how they can better manage their condition. Participation is voluntary and confidential.

Quit For Life® Program

The research-based Quit For Life® Program is brought to you by the American Cancer Society® and Alere Wellbeing. It is available at no charge to State Health Plan subscribers, their spouses and covered dependents age 13 or older.

One of the most successful programs of its kind, the Quit For Life Program helps participants stop using cigarettes, cigars, pipes and smokeless tobacco. A professionally trained Quit Coach™ works with each participant to create a personalized quit plan. As part of the 12-month program, participants receive a complete Quit Guide and five telephone calls from a Quit Coach. Participants may call the toll-free support line as often as they wish. For members age 18 and older, the program also provides free nicotine replacement therapy, such as patches, gum or lozenges, if appropriate. Your Quit Coach may also recommend that your doctor prescribe a smoking cessation drug, such as bupropion or Chantix, which is available through your prescription drug coverage.

Registration is available 24 hours a day, seven days a week, and coaches are available from 8 a.m. to 3 a.m., ET, seven days a week. If the participant still needs help after the 12-month program ends, he may re-enroll.

Call 866-QUIT-4-LIFE (866-784-8454) or visit www.quitnow.net/ScStatehealthPlan to enroll in the Quit For Life Program. After your eligibility is verified, you will be transferred to a Quit Coach for your first call. You may also go to the EIP website and select "Prevention Partners" then "Tobacco Cessation" and then "State Health Plan Quit for Life Program."

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®The American Cancer Society name and logo are trademarks of the American Cancer Society, Inc.

Exclusions: Services Not Covered

There are some medical expenses the State Health Plan does not cover. The Plan of Benefits (available in your benefits office or through EIP) contains a complete list of the exclusions. Some expenses that are not covered are charges for:

1. Services or supplies that are not medically necessary
2. Routine procedures not related to the treatment of injury or illness, except for those specifically listed under the Preventive Benefits section
3. For insured persons age 19 and older, services related to a pre-existing condition in the first 12 months of coverage (or 18 months for late entrants). This may be reduced by any creditable coverage the member brings to the plan. This exclusion does not apply to insured persons age 18 and younger.
4. Routine physical exams, checkups (except Well Child Care and Preventive Benefits according to guidelines), services, surgery (including cosmetic surgery) or supplies that are not medically necessary. (The Savings Plan covers an annual physical by a network physician for each participant age 19 and older.)
5. Routine prostate exams, screenings or related services are not covered under the plan. (A diagnostic prostate exam may be covered when medically necessary but **not** as part of the Savings Plan annual physical exam. The diagnostic exam will be subject to the State Health Plan's usual deductibles and coinsurance.)
6. Diabetic education and training are not covered
7. Eyeglasses
8. Contact lenses, unless medically necessary after cataract surgery and for the treatment of keratoconus, a corneal disease affecting vision
9. Routine eye examinations
10. Refractive surgery, such as radial keratotomy, laser-assisted in situ keratomileusis (LASIK) vision correction, and other procedures to alter the refractive properties of the cornea
11. Hearing aids and examinations for fitting them

12. Dental services, except for removing impacted teeth or treatment within one year of a condition resulting from an accident
13. TMJ splints, braces, guards, etc. (Medically necessary surgery for TMJ is covered if preauthorized by Medi-Call.) TMJ, temporo mandibular joint syndrome, is often characterized by headache, facial pain and jaw tenderness caused by irregularities in the way joints, ligaments and muscles in the jaws work together.
14. Custodial care, including sitters and companions or homemakers/caretakers
15. Admissions, or portions thereof, for custodial care or long-term care, including:
    - Rest care
    - Long-term acute or chronic psychiatric care
    - Care to assist a member in the performance of activities of daily living (including, but not limited to, walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation and taking medication)
    - Care in a sanitarium or
    - Psychiatric or substance abuse residential care, including: therapeutic schools, wilderness/boot camps, therapeutic boarding homes, half-way houses and therapeutic group homes
16. Any item that may be purchased over the counter, including but not limited to, medicines and contraceptive devices
17. Services related to a vasectomy or tubal ligation performed within one year of enrollment
18. Surgery to reverse a vasectomy or tubal ligation
19. Treatment for infertility for a subscriber or spouse who has had a prior tubal ligation or vasectomy
20. Assisted reproductive technologies (fertility treatment) except as noted on page 60 of this chapter
21. Diet treatments and all weight loss surgery, including, but not limited to: gastric bypass, gastric banding or stapling; intestinal bypass and any related procedures; the reversal of such procedures; and conditions and complications as a result of such procedures or treatment
22. Equipment that has a nontherapeutic use (such as humidifiers, air conditioners, whirlpools, wigs, artificial hair replacement, vacuum cleaners, home and vehicle modifications, fitness supplies, speech augmentation or communication devices, including computers, etc.), regardless of whether the equipment is related to a medical condition or prescribed by a physician
23. Air quality or mold tests
24. Supplies used for participation in athletics (that are not necessary for activities of daily living), including but not limited to, splints or braces
25. Physician charges for medicine, drugs, appliances, supplies, blood and blood derivatives, unless approved by Medi-Call
26. Medical care by a doctor on the same day or during the same hospital stay in which you have surgery, unless a medical specialist is needed for a condition the surgeon could not treat
27. Physician's charges for clinical pathology, defined as services for reading any machine-generated reports or mechanical laboratory tests. Interpretation of these tests is included in the allowance for the lab service.
28. Fees for medical records and claims filing
29. Food supplements, including but not limited to, formula, enteral nutrition, Boost/Ensure or related supplements
30. Services performed by members of the insured's immediate family
31. Acupuncture
32. Chronic pain management programs
33. Transcutaneous (through the skin) electrical nerve stimulation (TENS), whose primary purpose is the treatment of pain
34. Complications arising from the receipt of noncovered services
35. Psychological tests to determine job, occupational or school placement or for educational purposes; milieu therapy; or to determine learning disability
36. Any service or supply for which a covered person is entitled to payment or benefits pursuant to federal or state law (except Medicaid), such as benefits payable under Workers' Compensation laws
37. Charges for treatment of illness or injury or complications caused by acts of war or military service, injuries received by participating in a riot, insurrection, felony or any illegal occupation (job)

38. Intentionally self-inflicted injury that does not result from a medical condition or domestic violence
39. Cosmetic goods, procedures or surgery or complications resulting from such procedures or services
40. Tobacco cessation or deterrence products and services, including prescribed drugs used to alleviate the effects of nicotine withdrawal, except those authorized for eligible participants enrolled in the Quit for Life® Program brought to you by the American Cancer Society® and Alere Wellbeing.
41. Sclerotherapy (treatment of varicose veins), including injections of sclerosing solutions for varicose veins of the leg, unless a prior-approved ligation (tying off of a blood vessel) or stripping procedure has been performed within three years and documentation submitted to Medi-Call with a preauthorization request establishes that some varicosities (twisted veins) remained after the procedure
42. Services performed by service or therapy animals or their handlers
43. Abortions, except for an abortion performed in accordance with federal Medicaid guidelines
44. Pregnancy of a covered child
45. Storage of blood or blood plasma
46. Experimental or investigational surgery or medical procedures, supplies, devices or drugs.
    Any surgical or medical procedures determined by the medical staff of the third-party claims processor, with appropriate consultation, to be experimental or investigational or not accepted medical practice. Experimental or investigational procedures are those medical or surgical procedures, supplies, devices, or drugs, which at the time provided, or sought to be provided:
    - Are not recognized as conforming to accepted medical practice in the relevant medical specialty or field of medicine; or
    - The procedures, drugs or devices have not received final approval to market from appropriate government bodies; or
    - Are those about which the peer-reviewed medical literature does not permit conclusions concerning their effect on health outcomes; or
    - Are not demonstrated to be as beneficial as established alternatives; or
    - Have not been demonstrated, to a statistically significant level, to improve the net health outcomes; or
    - Are those in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting.

Additional Limits under the Standard Plan

- **Chiropractic benefits under the Standard Plan are limited to $2,000 per person per year.**
- Chiropractic benefits for Manual Therapy are limited to one per visit per person.

Additional Limits and Exclusions under the Savings Plan

- **Chiropractic benefits under the Savings Plan are limited to $500 per covered person per year.**
- Chiropractic benefits for Manual Therapy are limited to one per visit per person.
- Nonsedating antihistamines and drugs for treating erectile dysfunction are not covered under the Savings Plan.

Helpful Information May be Found on the Internet

Website: www.SouthCarolinaBlues.com

The BlueCross BlueShield of South Carolina (BCBSSC) website offers a quick, easy way to manage your benefits and learn more about staying healthy. Go to the site, www.SouthCarolinaBlues.com, and select "Members" or go to the EIP website, www.eip.sc.gov, and click on "Links." Under "State Health Plan," you can choose "Medical (BlueCross BlueShield of South Carolina)" or "My Health Toolkit."

When you go to "My Health Toolkit" you must create a profile to log in. Once you do, you can do a variety of things, including:

- Find a doctor, a hospital or another provider, including a medical or mental health/substance abuse

provider
- See how much of your deductible and coinsurance maximum you have satisfied
- Check the status of claims, preauthorizations and bills
- Choose to view your Explanation of Benefits (EOB) online rather than receiving a paper copy in the mail. You will be notified by email when an EOB is ready.
- Request an ID card
- Create a Personal Health Record
- Take a Personal Health Assessment
- Enroll in the "Coming Attractions" maternity program
- Find estimates of the cost of treatment
- Ask Customer Service a question.

Website: www.CompanionBenefitAlternatives.com

The Companion Benefit Alternatives (CBA) website offers a variety of ways to learn more about mental health and health in general. Go to the EIP website, www.eip.sc.gov, and click on "Links." Under "State Health Plan," you can choose "Mental Health/substance abuse (Companion Benefit Alternatives)." At the CBA website select "Members." You can sign up for an email newsletter. Other tools include:

- "Caring for Your Mental Health," which includes information on ADHD, alcohol and drug dependence, depression, and eating disorders
- "Find a Provider," which offers a printable provider directory
- "Health Education Answers," which provides information about a variety of physical and mental health topics
- A description of CBA's case management program
- Links to other resources, including phone numbers for financial assistance hotlines.

Appeals

The Employee Insurance Program (EIP) contracts with third-party claims processors, BlueCross BlueShield of South Carolina and Medco Health Solutions, Inc., to handle claims for your State Health Plan benefits and Companion Benefit Alternatives (CBA), to manage mental health and substance abuse benefits. You have the right to appeal their decisions.

If you want a review of a decision made by National Imaging Associates (NIA), your physician should first appeal though the NIA website. If you believe the decision on his appeal was incorrect, you may then ask BlueCross BlueShield to review NIA's decision.

If all or part of your claim or your request for preauthorization is denied, you will be informed of the decision promptly and told why it was made. If you have questions about the decision, check the information in this book, or call the company that made the decision for an explanation.

If you believe the decision was incorrect, you may ask the company to re-examine its decision. This request should be in writing and should be made within six months after notice of the decision. You (or your physician, on your behalf) may submit any additional information you wish to support this appeal. If you wait too long, the original decision will be considered final, and you will not have any further appeal rights. To begin an appeal, follow the instructions in your denial letter.

If you are still dissatisfied after the decision is re-examined, you may ask EIP to review the matter by making a written request to EIP within 90 days of notice of the denial. If the denial is upheld by the EIP Appeals Committee, you have 30 days to seek judicial review as provided by Sections 1-11-710 and 1-23-380 of the S.C. Code of Laws, as amended.

Health Maintenance Organizations

What Are My Choices?

Health Maintenance Organizations (HMOs) are health plans in which members must use only healthcare providers, including hospitals, within the HMO's network. If you receive care outside this network, the plan will not pay benefits unless the care was preauthorized or deemed an emergency. You must choose a Primary Care Physician (PCP) who coordinates your healthcare. To receive benefits when you see a specialist, you must first receive a referral from your PCP. HMOs available to you through the Employee Insurance Program (EIP) are **BlueChoice HealthPlan HMO, which is offered statewide,** and **CIGNA HMO, which is offered in all counties except Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda.**

If you no longer live or work in your HMO's service area, contact your benefits administrator.

Plan Descriptions

The HMOs are described in this section of the chapter. If you would like to use specific physicians, hospitals and other providers, you may wish to check to see if they are part of the network of the plan you are considering. You can only receive benefits if your provider is part of your HMO's network.

Refer to pages 14-15 for a comparison of benefits and pages 227-230 for premiums. For more information, active employees should contact their benefits administrator, the HMO or EIP. Retirees, COBRA subscribers and survivors should contact the HMO or EIP. Telephone numbers and websites are listed on the inside cover of this book.

BlueChoice HealthPlan HMO

BlueChoice is offered statewide.

With BlueChoice, you select a Primary Care Physician (PCP) to coordinate your healthcare. If you need services your PCP does not offer, he or she will refer you to a qualified specialist in the network.

To be covered, services must be provided by your PCP or authorized in advance by your PCP and BlueChoice HealthPlan, unless otherwise noted. The Plan of Benefits governs all health benefits offered through EIP.

Benefits at a Glance: BlueChoice HealthPlan

Benefits	Member Pays
Deductible per Calendar Year	
Per member	$250
Per family	$500
Coinsurance Maximum per Calendar Year	
Per member	$2,000
Per family	$4,000
Primary Care Physicians	
Office services, including routine and preventive care	$15 copayment per visit
Hospital services	$0
Routine mammogram	$0

Benefits	Member Pays
Specialty Care Physicians	*All services must be preauthorized*
Office services	$40 copayment per visit
Maternity care	$40 copayment first visit, then 15%
Hospital services	Deductible, then 15%
Emergency room care	Deductible, then 15%
Routine GYN exam – two per calendar year	$15 copayment per visit *(authorization not required)*
Chiropractic care – $1,000 maximum per calendar year	$40 copayment per visit
Facility Services	*All services, except emergency care, must be preauthorized*
Inpatient admission	$200 copayment per admission, then 15%
Skilled nursing facility and/or long-term acute care facility – 120-day maximum per calendar year	Deductible, then 15%
Outpatient services/ambulatory surgical centers	$100 copayment and 15% for first 3 visits per calendar year; 15% for visit 4 and each visit thereafter
Emergency room services	$125 copayment per visit, then 15%
Urgent Care	
Inside the local service area	$35 copayment per visit at a participating urgent care provider
Prescription Medication	
Retail copayment *(up to a 31-day supply)*	$8 Value generic drug $15 Regular generic drug $35 Preferred brand-name drug $55 Nonpreferred brand-name drug
Mail-order copayment *(up to a 90-day supply)*	$20 Value generic drug $37.50 Regular generic drug $87.50 Preferred brand-name drug $137.50 Nonpreferred brand-name drug
Specialty Pharmaceuticals	$125 copayment per 31-day supply–nonpreferred specialty brands $80 copayment per 31-day supply–preferred specialty brands
Mental Health/Substance Abuse Care	
Inpatient	$200 copayment per admission then 15%
Outpatient	$40 copayment per visit
Other Services	*All services, except emergency care, must be preauthorized*
Ambulance	Deductible, then 15%
Hospice	Deductible, then 15%
Medical supplies	Deductible, then 15%
Initial prosthetic appliances	Deductible, then 15%
Occupational therapy – 20 visits per benefit period	Deductible, then 15%
Physical therapy – 20 visits per benefit period	Deductible, then 15%
Speech therapy – 20 visits per benefit period	Deductible, then 15%
Outpatient private duty nursing and home health	Deductible, then 15%
Dental services due to accidental injury	Deductible, then 15%
Durable medical equipment (DME)	Deductible, then 15%
Human Organ Transplants	
Covered Transplants: Kidney (single) Pancreas/kidney Heart Lung (single) Lung (double) Liver Pancreas Heart/lung Bone marrow/stem cell Cornea	Transplants must occur at a Blue Distinction Centers for Transplants to be covered.

Network Benefits

With BlueChoice HealthPlan, benefits are provided only when you go to participating (network) physicians, hospitals and other healthcare providers. Network providers will:

- File covered expense claims for you
- Ask you to pay only the deductible, copayment and/or coinsurance (if any) for covered expenses
- Accept the plan's payment for covered expenses as payment-in-full, minus any copayment or coinsurance.

Primary Care Physician

At enrollment, you must select a *Primary Care Physician* (PCP) from BlueChoice HealthPlan's network. Your PCP coordinates all health services covered under your plan. Each member of your family may select a different PCP. When you need to see a specialist or another healthcare professional, your PCP will refer you to a network provider. BlueChoice HealthPlan will cover those services according to the Schedule of Benefits.

You may change your PCP at any time by calling Member Services at 800-868-2528 or visiting the BlueChoice HealthPlan website at www.BlueChoiceSC.com.

Referrals

If you need medical care your PCP cannot provide, he or she will refer you to another network provider. Remember, to ensure that BlueChoice HealthPlan will pay for the visit to the specialist, make sure your doctor makes the referral before you visit the specialist. You can check for referrals on the BlueChoice HealthPlan website at www.BlueChoiceSC.com.

Note: Women may go to a participating gynecologist twice a year without a referral from their PCP. Women may also go to any participating obstetrician for prenatal care.

If you receive care from a specialist without a referral from your PCP, BlueChoice HealthPlan will cover the services only if they are related to a medical emergency.

Finding a Network Provider

A complete list of providers is at www.BlueChoiceSC.com. If you would like a list of providers in your area, you may request one by calling Member Services at 800-868-2528. You may also ask Member Services for more information about providers, including their qualifications and experience. Member Services can give you the most up-to-date information about changes in providers and about which ones are accepting new patients.

Deductibles

A deductible is the amount you must pay each year before the plan begins to pay for certain benefits. BlueChoice HealthPlan's annual deductible is $250 for individuals and $500 for families. The deductible does not apply to:

- Any services from your PCP, such as office visits, routine physicals and well child care and immunizations
- Office visits to specialists
- Retail and mail-order pharmacy benefits
- Specialty drugs
- Routine mammograms.

Coinsurance

Coinsurance is the percentage of the cost of certain benefits that you pay. As a BlueChoice HealthPlan member, you pay 15 percent of the cost of these benefits. Please see the Schedule of Benefits for more information. After you spend either $2,000 (individual coverage) or $4,000 (family coverage) in coinsurance for network benefits in a calendar year, the plan will pay 100 percent of your medical costs for network benefits for the remainder of the calendar year, excluding appropriate copayments. Copayments do not count toward your out-of-pocket coinsurance limit or your deductible.

Copayments

A *copayment* is the fixed dollar amount you pay when you receive a benefit. The copayment will vary depending on the type of care you receive. Your annual deductible does not affect copayments. You must make your copayments whether or not you have met your deductible.

Covered Benefits

To be covered, benefits must be provided by your PCP or another network provider. Benefits provided by another network provider must be authorized in advance by your PCP and BlueChoice HealthPlan, unless it is a medical emergency or otherwise noted in the Schedule of Benefits.

Ambulance Benefits

Charges for emergency ambulance transportation, provided by a licensed ambulance service to the nearest hospital where emergency covered services can be provided, are covered. Coverage includes transportation between acute care facilities when a medically indicated transfer is needed.

Autism Spectrum Disorder Benefits

Behavioral Therapy, also known as Applied Behavior Analysis (ABA), for children diagnosed with an Autism Spectrum Disorder (ASD) at age 8 or younger is covered. A child must be younger than 16 years of age to receive benefits. There is a $51,400 maximum for 2012. Services must be provided by, or under the direction of, a participating provider. Prior authorization requests and treatment plans must be approved by Companion Benefit Alternatives (CBA). For services or more information, call CBA at 800-868-1032.

Treatment of ASD, other than Behavioral Therapy, will be treated in the same manner as other medical conditions. These benefits may include, but are not limited to, physical therapy, speech therapy or office visits.

All covered treatment is subject to deductibles, copayments and coinsurance.

Behavioral Health Benefits

You are covered for treatment of mental health conditions and substance abuse. Companion Benefit Alternatives (CBA) coordinates these benefits. To receive services from a mental health or substance abuse professional, you or your primary care physician may call CBA at 800-868-1032 for authorization and/or more information. Services provided at a residential treatment center are not covered.

Chiropractic Benefits

You are covered for office services from a chiropractor, including detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference and the effects of such nerve interference, where such interference is the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column. Diagnostic X-rays are covered if medically necessary. Other services that are within the scope of the practice of chiropractic are also

covered. Chiropractic benefits are limited to a maximum of $1,000 annually.

Dental Benefits for Accidental Injuries

You are covered for dental services performed by a Doctor of Dental Surgery (DDS) or a Doctor of Medical Dentistry (DMD) to sound natural teeth when required because of accidental injury. For purposes of this benefit, an accidental injury is defined as an external traumatic force, such as a car accident or blow by a moving object. The first (emergency) visit to the dentist does not require authorization. However, the dentist must submit an outline of the plan for future treatment to BlueChoice HealthPlan for review and approval before continuing with follow-up care for that care to be covered. Follow-up care must be completed within six months of the accident.

Doctor Visits

Charges from your PCP for office visits, including routine examinations, preventive care, injections, immunizations, well-child care and health education, are covered. Charges from specialists for treatment or consultation are also covered.

Durable Medical Equipment

Charges for medically necessary durable medical equipment, such as wheelchairs, braces, hospital beds, traction equipment, inhalation therapy equipment and suction machines, and other equipment as approved by BlueChoice HealthPlan for outpatient use, are covered. Equipment is covered only when ordered, delivered and used while you are enrolled with BlueChoice HealthPlan. *Durable medical equipment is not covered out of network.*

Repair, replacement or duplicates of durable medical equipment are not covered, except when medically necessary due to a change in your medical condition. Appliances that serve no medical purpose and are solely for your comfort, such as a whirlpool bath, air conditioner or dehumidifier, are not covered.

Emergency Services and Urgent Care

Emergency Services

You are covered for treatment of a true medical emergency anywhere in the world. If practical, you should call your PCP first and follow his or her directions. However, in a serious medical emergency, go to the nearest hospital or treatment center for help or call 911. You should then have someone notify your doctor and BlueChoice HealthPlan.

To learn more about receiving emergency services outside the BlueChoice HealthPlan service area, read the BlueCard® program section on page 46.

BlueChoice HealthPlan will cover emergency room care only if you are seeking treatment for symptoms that are severe and need immediate medical attention, or if your doctor authorized the emergency room visit. Conditions that are considered a medical emergency include those so severe that if you do not get immediate medical attention, one of the following could occur:

- Severe risk to your health, or with respect to pregnancy, the health of your unborn child
- Serious damage to body function
- Serious damage to any organ or body part.

Follow-up care for emergency services must be received from providers within the BlueChoice HealthPlan network or arranged by BlueChoice HealthPlan.

Urgent Care

Urgent care is a medical condition that is serious but not life- or limb-threatening. If you need urgent care, you should call your PCP. If you have an illness or injury that requires urgent care and you cannot get to your doctor or wait until normal business hours, you should go to a participating urgent care center. Please refer to the BlueChoice HealthPlan Provider Directory for the list of participating urgent care centers.

Urgent care required within South Carolina is covered when provided by a participating urgent care provider. Urgent care required outside South Carolina is covered when coordinated through the BlueCard program.

Hospice

You are covered for hospice care provided by a licensed hospice.

Human Organ Transplant Benefits

You are covered for certain human organ transplants. The organ must be provided from a human donor to you (the transplant recipient), and the transplant must occur at a Blue Distinction Centers for Transplants to be covered. Covered transplants include kidney (single), pancreas/kidney, heart, lung (single), lung (double), liver, pancreas, heart/lung, bone marrow/stem cell and cornea. All solid organ (complete organ or segmental, cadaveric or living donor) procurement services, including donor organ harvesting, typing, storage and transportation, are covered.

Coverage for charges incurred by a living donor are limited to those for medical and surgical expenses for care and treatment, but only if the donor and recipient are both covered by the Employee Insurance Program.

Transplants that are experimental, investigational or unproven are not covered. Transplants that are not determined by BlueChoice HealthPlan to be medically necessary are not covered.

Inpatient Hospital Benefits

You are covered for inpatient hospital services at an acute care hospital, a skilled nursing facility, or a long-term acute care hospital, including room and board, physician visits and consultations.

Maternity Care

You and your covered spouse are covered for hospital care, hospital-based birthing center care, and prenatal and postpartum care, including childbirth, miscarriage and complications related to pregnancy. Inpatient benefits are provided for the mother and newborn for 48 hours after normal delivery, not including the day of delivery, or 96 hours after caesarean section, not including the day of surgery. Coverage for the newborn includes, but is not limited to, routine nursery care and/or routine well-baby care during this period of hospital confinement. Charges for home births are not covered. Pregnancy is not considered a pre-existing condition.

Medical Supplies

Charges are covered for medical supplies, including, but not limited to:

- Dressings requiring skilled application, for conditions such as cancer or burns
- Catheters
- Colostomy bags and related supplies
- Medically necessary supplies for renal dialysis equipment or machines
- Surgical trays
- Splints or such supplies as needed for orthopedic conditions
- Syringes, test tapes and other related diabetic supplies not covered under other provisions of the plan.

Outpatient Hospital Benefits, Including Ambulatory Surgical Centers

Charges for outpatient laboratory, X-ray, surgery and diagnostic tests are covered. Physical therapy, occupational therapy and speech therapy are also covered, subject to the limits listed in the Schedule of Benefits.

Outpatient Private Duty Nursing Care and Home Health Benefits

You are covered for special or private duty nursing care provided by a registered nurse or a licensed practical nurse, on an outpatient basis, for up to 60 days each calendar year. Services must be provided in lieu of inpatient care.

You are also covered for home health services provided by a licensed home health agency. Services must be provided in lieu of inpatient care.

Prescription Medicine

Prescription drugs, including insulin, are covered, subject to plan exclusions and limitations, if you use a participating pharmacy. You may purchase up to a 31-day supply of a covered prescription medication at a participating retail pharmacy and up to a 90-day supply through a participating mail-order pharmacy. Not all medications are available through the mail-order pharmacy. Please refer to the BlueChoice HealthPlan Preferred Drug List for a list of prescription drugs covered under your pharmacy benefits. The list is available by going to www.BlueChoiceSC.com and selecting "My Pharmacy Manager"℠ or by contacting BlueChoice Member Services at 800-868-2528 (803-786-8476 in the Columbia area).

Value Generics

BlueChoice HealthPlan now has another class of generic drugs, Value generics. These drugs cost less than $15 for a 31-day supply and, therefore, have a lower copayment. Regular generics cost more than $15. Here are the copayments:

Retail (up to a 31-day supply)
- $8 for Value generics
- $15 for regular generics

Mail-order (up to a 90-day supply)
- $20 for Value generics
- $37.50 for regular generics

If the cost of the drug is less than the copayment, the member will pay the lower cost. For example: if a drug costs $4 for a 31-day supply, the member will pay $4, rather than the $8 copayment.

Generics Now℠

Generic drugs are equivalent in composition and effect to their brand-name counterparts but are generally less expensive. Generics Now encourages the use of generic drugs. If your doctor prescribes a brand-name drug but allows you to substitute an equivalent generic drug if one is available, you should consider buying the generic drug. Here is why – if you request the brand-name drug over the generic drug, you will be required to pay the difference between the cost of the brand-name drug and the generic drug. You will also have to pay the brand-name drug copayment. However, you will never be charged more than the retail cost of the brand-name drug.

Specialty Pharmaceuticals

Specialty pharmaceuticals are prescription drugs used to treat complex clinical conditions with complex delivery of care and distribution requirements. They include, but are not limited to, infusible specialty drugs for chronic disease, injectable and self-injectable specialty drugs for acute and chronic disease, and specialty oral drugs. Specialty pharmaceuticals are covered when purchased from a designated participating provider and prescribed by a participating physician. You may obtain a list of specialty pharmaceuticals by going to www.BlueChoiceSC.com or by contacting BlueChoice Member Services at 800-868-2528 (803-786-8476 in the Columbia area).

Prior Authorization

Certain prescription drugs require prior authorization to be covered, and certain drugs have dosage limits as determined by BlueChoice. Please refer to the BlueChoice HealthPlan Preferred Drug List for information on which drugs require prior authorization and/or have dosage limits.

Prosthetics

You are covered for a prosthetic device, other than a dental or cranial prosthetic, that is a replacement for a body part and meets minimum specifications. Only the initial prosthesis is covered.

Reconstructive Surgery after a Medically Necessary Mastectomy

If you are receiving benefits in connection with a mastectomy and/or elective breast reconstruction in connection with the mastectomy, you are covered for mastectomy-related services including:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications during all stages of mastectomy, including lymphedemas.

This coverage is in compliance with the Women's Health and Cancer Rights Act of 1998.

Rehabilitation Benefits

Physical therapy, occupational therapy and speech therapy are covered. Benefits are limited to 20 visits per benefit period for each type of therapy.

Therapeutic Benefits

Charges for radiation therapy, cancer chemotherapy and respiratory therapy are covered.

Other Plan Features

Great Expectations® *for health*

As your partner in good health, one way BlueChoice can help you reach your health goals is through Great Expectations *for health* programs. They are designed to help you improve your health by providing you with educational information and professional support from a team of health specialists. BlueChoice members may participate in these programs at no charge or for a small, one-time fee.

For more information, call the BlueChoice HealthPlan Health Management department at 800-327-3183, ext. 25541, or visit www.BlueChoiceSC.com.

Great Expectations *for health* offers programs for:

- **Asthma**
- **Back Care**
- **Children's Health**
- **Chronic Kidney Disease**
- **Chronic Obstructive Pulmonary Disease**
- **Depression**
- **Diabetes**
- **Heart Disease**
- **Heart Failure**
- **Irritable Bowel Syndrome**
- **Maternity**
- **Men's Health**
- **Migraine**
- **Quit Smoking**
- **Weight Management**
- **Women's Health**

Away From Home Care

If you or a family member will be out of South Carolina for more than 90 days, you may become a guest member of an affiliated BlueCross and BlueShield health plan near your destination. Call BlueChoice and

explain your situation. Students and long-term travelers are groups that may benefit from Away From Home Care. If you need to use the Away From Home Care program, call Member Services at 800-868-2528 (803-786-8476 in the Columbia area) and ask to speak to the Away From Home Care program coordinator. More information on the program is under "Products and Services" at www.BlueChoiceSC.com.

Quit For Life® Program

The research-based Quit For Life® Program is brought to you by the American Cancer Society® and Alere Wellbeing. It is available at no charge to BlueChoice HealthPlan subscribers and their covered family members age 18 or older. Alere WellBeing administers this tobacco cessation program for BlueChoice HealthPlan.

One of the most successful programs of its kind, the Quit For Life Program helps participants stop using cigarettes, cigars, pipes and smokeless tobacco. A professionally trained Quit Coach® works with each participant to create a personalized quit plan. As part of the 12-month program, participants receive a comprehensive Quit Guide and five telephone calls from a Quit Coach. Participants may call the Quit for Life toll-free Support Line as often as they wish. The program also provides free nicotine replacement therapy, such as nicotine patches or nicotine gum, if appropriate. Your Quit Coach may also recommend your doctor prescribe a smoking cessation drug, such as bupropion or Chantix, which is available through your prescription drug benefit. BlueChoice will cover Chantix at no charge for six months. Registration is available 24 hours a day, seven days a week, and coaches are available from 8 a.m. to 3 a.m., ET, seven days a week. If help is needed after the 12-month program ends, you may re-enroll.

Call 866-QUIT-4-LIFE (866-784-8454) or visit www.quitnow.net to enroll in the Quit For Life Program. After your eligibility is verified, you will be transferred to a Quit Coach for your first call. You may also go to EIP's website and select "Prevention Partners" then "Tobacco Information" followed by "Tobacco Cessation" and then "BlueChoice Quit for Life Program."

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®The American Cancer Society name and logo are trademarks of the American Cancer Society, Inc.

Added Value Discount Programs

There are many ways to stay healthy. These services and discounts are in addition to (but are not a part of) the services and benefits covered under a BlueChoice policy.

Through the Natural Blue℠ program, you have access to discounts on services from a network of acupuncturists, massage therapists, chiropractors, day spas and fitness centers in South Carolina and nationwide.

For more information or to find a provider, call Member Services at 800-868-2528 or go to www.BlueChoiceSC.com and click on "Discounts & Added Values."

Other Added Value discounts include:
- **LASIK services**
- **Alternative medicine**
- **Hearing tests and aids**
- **Weight loss programs and centers**
- **Magazine subscriptions**
- **Cosmetic surgery**
- **Cosmetic dentistry.**

Exclusions and Limitations

No coverage is provided for the following, unless otherwise specified in the Schedule of Benefits or the Covered Services section.

1. Any services or supplies that are not medically necessary
2. Any services or supplies for which you are not legally obligated to pay
3. Any services or supplies for treatment of military service-related disabilities when you are legally

entitled to other coverage and for which facilities are reasonably available to you

4. Any services or supplies for which benefits are paid under Workers' Compensation, occupational disease law or similar legislation
5. Treatment of an illness contracted or injury sustained while engaged in the commission of or attempt to commit an assault or a felony; treatment of an injury or illness incurred while engaged in an illegal act or occupation (job); or treatment of an injury or illness due to voluntary participation in a riot or civil disorder
6. Any charges for services provided before your effective date or after termination of coverage
7. Admissions or portions thereof for sanitarium care, rest cures or custodial care
8. Any services or procedures for transsexual surgery or related services provided as a result of complications of such transsexual surgery
9. All services and supplies related to pregnancy of a dependent child (complication of pregnancy is covered. However, abortion is not considered a complication of pregnancy.)
10. Services, supplies or drugs for the treatment of infertility, including, but not limited to, artificial insemination and in vitro fertilization, fertility drugs, reversal of sterilization procedures and surrogate parenting
11. Preconception testing, preconception counseling or preconception genetic testing
12. Any drugs, services, treatment or supplies determined by the medical staff of BlueChoice HealthPlan to be experimental, investigational or unproven
13. Drugs for which there is an over-the-counter equivalent; all vitamins, except prenatal vitamins; drugs not approved by the Food and Drug Administration; drugs for non-covered therapies, services or conditions; and drugs prescribed for obesity or weight control, cosmetic purposes, hair growth, fertility or for smoking cessation, except in conjunction with the Quit for Life® Program brought to you by the American Cancer Society® and Alere Wellbeing.
14. Plastic or cosmetic surgical procedures or services performed to improve appearance or to correct a deformity without restoring a bodily function, unless such services are medically necessary and due to physical trauma, surgery or congenital anomaly (birth defect)
15. Therapy or services for learning disabilities, speech delay, stuttering, perceptual disorders, mental retardation, behavioral disorders, vocational rehabilitation or marriage counseling
16. Any drugs, services, treatment or supplies for the diagnosis or treatment of sexual dysfunction unless medically necessary for the treatment of a medical condition or organic disease, and then only with prior authorization. This includes, but is not limited to, drugs, laboratory and X-ray tests, counseling, and penile implants or prostheses
17. Services or supplies related to dysfunctional conditions of the muscles of mastication; malpositions or deformities of the jaw bone(s); and orthognathic deformities or temporomandibular joint (TMJ) disorders, including, but not limited to, appliances and orthodontia
18. Dental work or treatment that includes hospital or professional care in connection with:
    a. Any operation or treatment for the fitting or wearing of dentures, regardless if needed due to injury to natural teeth due to an accident
    b. Orthodontic care or treatment of malocclusion
    c. Operations on, or treatment of or to, the teeth or supporting bones and/or tissues of the teeth, except for removal of malignant tumors or cysts or treatment of an injury to natural teeth due to an accident
    d. Removal of teeth, whether impacted or not
    e. Any operation, service, prosthesis, supply or treatment for the preparation for, and the insertion or removal of, a dental implant

    This exclusion does not apply if the dental work involves facility or anesthesia services that are medically necessary because of a specific organic medical condition, such as congestive heart failure or chronic obstructive pulmonary disease, that requires hospital-level monitoring
19. Hearing aids
20. Charges incurred as the result of a missed scheduled appointment and charges for the preparation, reproduction or completion of medical records, itemized bills or claims forms
21. Services or supplies not specifically listed in the Schedule of Benefits and the Covered Services section

22. Transplants other than as specified in the Schedule of Benefits
23. Complications arising during, from or related to the receipt of non-covered services. "Complications," as used in this exclusion, includes any medically necessary services or supplies which, in BlueChoice HealthPlan's judgment, would not have been required by you had you not received non-covered services
24. The purchase or rental of air conditioners, air purifiers, motorized transportation equipment, escalators or elevators, swimming pools, water beds, exercise equipment or other similar items or equipment
25. Any service or supply provided by a member of your family or by yourself, including the dispensing of drugs. A member of your family means your spouse, parent, grandparent, brother, sister, child or your spouse's parent
26. Charges for acupuncture, hypnotism, biofeedback and TENS unit. Services for chronic pain management programs or any program developed by centers with multidisciplinary staffs intended to provide the interventions necessary to allow you to develop pain-coping skills and freedom from dependence of analgesic medications
27. Treatment with respect to a specific condition for which a person refused to comply with a physician's prescribed course of treatment, or complications that arise from failure to follow the physician's prescribed course of treatment
28. Services not provided by or under the direction of your Primary Care Physician, except covered services or referred services authorized in advance by BlueChoice HealthPlan
29. Treatment or surgery for obesity, morbid obesity, weight reduction or weight control, including, but not limited to, gastric bypass or stapling, intestinal bypass and related procedures, the reversal of such procedures, and services required as a result of complications from such procedures including reconstructive procedures necessitated by weight loss
30. Orthomolecular therapy, including infant formula, nutrients, vitamins and food supplements
31. Radial keratotomy, myopic keratomileusis, LASIK surgery, and any surgery that involves corneal tissue for the purpose of altering, modifying or correcting vision problems, such as myopia, hyperopia or stigmatic error
32. Treatment of weak, strained or flat feet, including orthopedic shoes or other supportive devices; for services and supplies for non-surgical treatment of the feet; and cutting, removal or treatment of corns, calluses or nails. This exclusion does not include corrective surgery, or treatment for metabolic or peripheral vascular disease
33. Nutrition counseling, lifestyle improvements and physical fitness programs
34. Communications, travel time and transportation, except for professional ambulance services
35. Cranial orthotics used on infants with misshapen heads to progressively mold the skull to a normal shape
36. Sclerotherapy, including injections of sclerosing solution for varicose veins of the leg, unless a prior covered ligation or stripping procedure was performed within three years and documentation establishes that some varicosities remained after the prior procedure
37. Growth hormone therapy for patients older than age 18. Growth hormone therapy for patients age 18 and younger with documented growth hormone deficiency is covered
38. Pulmonary rehabilitation, except in conjunction with a covered lung transplant
39. Any procedures, drugs, treatment or services for or related to an elective abortion
40. Charges for services or supplies from an independent healthcare professional whose services are normally included in facility charges
41. Behavioral Therapy for autism spectrum disorders does not include educational or alternative programs, such as, but not limited to: TEAACH, Auditory Integration Therapy, Higashi Schools/Daily Life, Facilitated Communication, Floor Time (DIR, Developmental Individual-difference Relationship-based model), Relationship Development Intervention (RDI), Holding Therapy, Movement Therapies, Music Therapy and/or Pet Therapy.

Website: www.BlueChoiceSC.com

BlueChoice's website is a protected, secure and convenient way for you to have access to timely information about your health benefits on your own schedule. The site is at www.BlueChoiceSC.com. You may also reach the site by selecting "Links" and then "BlueChoice HealthPlan (medical)" on the EIP website, www.eip.sc.com.

At the site, you can:
- Learn about Discounts and Added Values
- Find a provider using the Doctor and Hospital Finder
- Create a user name and password, which will enable you to use "My Health Toolkit."

With **My Health Toolki**t you can:
- Review the status of your claims
- View and print a copy of your Explanation of Benefits
- See how much you have paid toward your deductible or out-of-pocket limit
- Ask a customer-service question through secure email
- Request a new ID card

The site also gives you access to information about your pharmacy benefits. These benefits are offered through Caremark. To use the Caremark site, you will need to register. Once you do, you can:
- View your prescription history
- Find information about medications you are taking or are considering taking
- Learn about therapeutic options to discuss with your physician
- Compare drug costs.

Appeals

You have the right to appeal any decision by BlueChoice HealthPlan to deny an authorization for services you have requested or deny payment for services you have received. To request an appeal, you (or your designated representative) may call Member Services at 803-786-8476 (Columbia area) or 800-868-2528 (toll-free outside the Columbia area). If you prefer, you may send a written appeal request to:

BlueChoice HealthPlan
Member Services (AX-435)
P.O. Box 6170
Columbia, SC 29260-6170.

To learn more about appeals, contact BlueChoice HealthPlan by phone, letter or email.

You may also email your appeal request to BlueChoice HealthPlan through its website at www.BlueChoiceSC.com. Sign on to "My Health Toolkit" and click on "Ask Customer Service."

You must file your appeal within six months of the date you were notified that the authorization or claim was denied. BlueChoice HealthPlan will reach a decision on your appeal and send you notification of that decision within 30 days of receipt of your appeal request.

If you are dissatisfied with the decision, you may ask for a review by sending a written request to the Employee Insurance Program (EIP) within 90 days of receiving notice of the decision on your appeal. If the decision is upheld by the EIP Appeals Committee, you have 30 days to seek judicial review as provided by Sections 1-11-710 and 1-23-380 of the S.C. Code of Laws, as amended.

BlueChoice HealthPlan and BlueCross BlueShield of South Carolina are independent licensees of the Blue Cross and Blue Shield Association.

CIGNA HMO

CIGNA HMO, a plan administered by CIGNA HealthCare, is available in all counties in the state **except**: Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda.

Benefits at a Glance: CIGNA HMO

Benefits	Member Pays
Deductible per Calendar Year	**None**
Coinsurance Maximum per Calendar Year Per member Per family	 $2,000 $4,000
Lifetime Benefit Maximum – none	
Preventive Care Routine preventive care (Well baby, well child, adult and well woman) Immunizations Mammogram, pap smear, PSA	 $15 copayment per visit No charge No charge
Physician Office Visits Primary care physicians (includes family practice, general practice, internists, gynecologists, pediatricians) Specialists	 $15 copayment per visit $30 copayment per visit
Inpatient Services Hospital charges Physician and professional services	*(Prior authorization required)* $500 copayment, plus 20% of charges 20% of charges
Outpatient Services Hospital charges Physician and professional services	*(Prior authorization required)* $250 copayment, plus 20% of charges 20% of charges
Emergency Care Emergency room (all related services) Urgent care facility	 $100 copayment $50 copayment
Prescription Medication Retail copayment (up to a 30-day supply) Mail-order copayment (up to a 90-day supply)	 $7 Generic drug $25 Preferred brand-name drug $50 Nonpreferred brand-name drug $14 Generic drug $50 Preferred brand-name drug $100 Nonpreferred brand-name drug
Mental Health/Substance Abuse Care Inpatient/Outpatient	*(Prior authorization required)* Same as other illnesses
Other Services Ambulance (emergency care only) External prosthetic appliance Durable medical equipment Home health services (60 visits per calendar year) Short-term rehabilitation, chiropractic (20 visits per calendar year)	(Prior authorization required, except emergency care) 20% of charges No charge No charge No charge $30 copayment

Benefits	Member Pays
Human Organ Transplants Covered transplants Heart Liver Bone Marrow Heart/Lung Lung Pancreas Kidney Kidney/Pancreas Lifetime travel maximum – $10,000 per transplant when using Lifesource facility	Same as any other illness

Claims

There is no paperwork for in-network care. Just show your CIGNA plan ID card and pay your copayment. Your provider will complete and submit the paperwork. If you visit an out-of-network provider, you or your provider must file a paper claim. You will receive an Explanation of Benefits identifying the costs covered by your plan and the charges you must pay. For more information on the claims process, please contact CIGNA HealthCare at 800-244-6224.

Copayments

As shown on the chart above, copayments vary depending on the services you receive. The CIGNA HMO plan has no annual deductible.

Coinsurance

You are responsible for 20 percent of the cost of hospital services received from network providers, in addition to the copayments. Emergency room services are covered at 100 percent after the copayments.

Coinsurance Maximum

Once you have spent either $2,000* (individual coverage) or $4,000* (family coverage) out of your pocket in a year for network services, the plan will pay 100 percent of your covered medical costs for the rest of the year.

Inpatient and outpatient hospital copayments and coinsurance count toward your out-of-pocket maximum. However, other copayments do not.

Primary Care Physician

With CIGNA HMO, your primary care physician (PCP) is your first and primary source of medical care. The PCP you choose coordinates your medical care, including checkups, referrals to specialists, lab and X-ray services and hospital admissions.

When you enroll in CIGNA HMO, you and each covered member of your family chooses his or her own PCP. A woman may select an OB/GYN in addition to her PCP. A PCP can be a family/general practitioner, internist or pediatrician. PCPs are available to you 24 hours a day, seven days a week. If your personal doctor is not available, he will arrange for another doctor to take care of you.

The CIGNA Customer Service line, 800-244-6224, is available 24 hours a day, seven days a week.

Network Benefits

With CIGNA HMO, services are normally covered **only** when you receive them from participating physicians, hospitals and other healthcare providers. Network providers will:

- File claims for covered benefits for you
- Ask you to pay only the copayment and coinsurance amounts, if any, for covered benefits.

Prescription Drugs

The CIGNA plan provides prescription drug coverage. With CIGNA HMO, you **must** use a participating pharmacy (or mail service) when purchasing your medications. Benefits are not covered if you use a non-participating pharmacy. Check the benefits chart for copayments for up to a 30-day supply.

CIGNA HMO offers a mail-order prescription program (CIGNA Tel-Drug) that allows you to order a three-month supply of prescriptions for home delivery at a savings. Online access is also available through www.myCIGNA.com to order refills, review the list of covered drugs and check the status of recent orders. Check the benefits chart for copayments for up to a 90-day supply.

Autism Spectrum Disorder Benefits

CIGNA HMO offers coverage of services related to Autism Spectrum Disorders, which include Autistic Disorder, Asperger's Syndrome and Pervasive Developmental Disorder – Not Otherwise Specified. To be eligible, a child must have been diagnosed at age 8 or younger. Coverage is provided to eligible children until age 16. The maximum yearly payment for behavioral therapy is $51,400 for 2012. Coverage is subject to the plan's standard copayments and coinsurance. For more information, call customer service at 800-244-6224.

Out-of-Network Benefits

You may receive emergency services from out-of-network providers. If you have a life- or limb-threatening illness or injury, please go to the nearest hospital or treatment center, whether or not it is in the network. You or a family member should tell your primary care physician and CIGNA HMO about the emergency as soon as possible.

Members living in a state other than South Carolina are eligible for the Guest Privileges Program, a guest membership in an HMO in the community where they live, for up to two years.

If you or someone you cover will be out of your service area for more than 60 days, call 800-244-6224 to be set up with a provider network away from home. When you return, you can switch back to the South Carolina network.

Special Features of the CIGNA Plan

The CIGNA 24-Hour Health Information Line® gives members access to registered nurses who provide medical information and level-of-care counseling, an audio library of hundreds of health and wellness topics and guidance to network providers. Call 800-564-8982.

Healthy Rewards® offers discounts on a variety of wellness programs including: Weight Watchers®, fitness club memberships, acupuncture, hearing aids and exams, chiropractic services and massage therapy. For information, call 800-870-3470 or go to www.myCIGNA.com.

Nationwide access to specially trained experts and nationally recognized facilities through the CIGNA LIFESOURCE Organ Transplant Network. For information, call 800-244-6224.

Lifestyle Management Programs

CIGNA Quit Today® Tobacco Cessation Program helps you quit smoking or chewing tobacco. The year-long program includes unlimited calls to your coach, an optional telephone relapse support group and over-the-counter nicotine gum or patches, if appropriate.

Strength & Resilience Stress Management Program® includes a stress risk assessment with your health coach, up to six coaching sessions during the first six months and unlimited calls to your coach for support.

CIGNA Healthy Steps to Weight Loss® Weight Management Program takes a nondiet approach to weight control. You will learn how to become more active, eat healthier and change bad habits.

Well-Aware for Better Health® helps you manage chronic conditions, such as asthma, diabetes, COPD, low back pain and heart conditions, and maintain good health.

The programs are free. You can participate in them on the telephone or online or both. To enroll, call 866-417-7848 or go to www.myCIGNA.com.

Exclusions: Services Not Covered

These are examples. The complete list of exclusions is in your Certificate or Summary Plan Description. If there are differences, the terms of the Certificate or the Summary Plan Description control your benefits.

1. Any service or supply not described as covered in the Covered Expenses section of the plan
2. Any medical service or device that is not medically necessary
3. Treatment of an illness or injury that is due to war or care for military service disabilities treatable through governmental services
4. Any services and supplies for, or in connection with, experimental, investigational or unproven services
5. Dental treatment of the teeth, gums or structures directly supporting the teeth. However, charges for services or supplies provided for, or in connection with, an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of the accident
6. Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, including clinically severe (morbid) obesity, including: medical surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity, and weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision
7. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations
8. Court-ordered treatment or hospitalizations
9. Infertility services, infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
10. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction
11. Medical and hospital care and costs for the child of a dependent, unless the infant child is otherwise eligible under the plan
12. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance
13. Consumable medical supplies other than ostomy supplies and urinary catheters
14. Private hospital rooms and/or private duty nursing, except as provided under the Home Health Services provision

15. Artificial aids, including but not limited to, hearing aids, semi-implantable hearing devices, audiant bone conductors, bone-anchored hearing aids, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs
16. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery)
17. Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy
18. Non-prescription drugs and investigational and experimental drugs, except as provided in the plan
19. Routine foot care. However, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.
20. Genetic screening or pre-implantation genetic screening
21. Fees associated with the collection or donation of blood or blood products
22. Cost of the biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks
23. All nutritional supplements and formulae are excluded, except infant formula needed for the treatment of inborn errors of metabolism
24. Services for, or in connection with, an injury or illness arising out of, or in the course of, any employment for wage or profit
25. Expenses incurred for medical treatment by a person age 65 or older, who is covered under the plan as a retiree, or his dependent, when payment is denied by the Medicare plan because treatment was not received from a participating provider of the Medicare plan
26. Expenses incurred for medical treatment when payment is denied by the primary plan because treatment was not received from a participating provider of the primary plan
27. The following services are excluded from coverage regardless of clinical indications: massage therapy; cosmetic surgery and therapies; macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty/panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; transsexual surgery; non-medical counseling or ancillary services; assistance in the activities of daily living; cosmetics; personal or comfort items; dietary supplements; health and beauty aids; aids or devices that assist with non-verbal communications; treatment by acupuncture; dental implants for any condition; telephone consultations; email and Internet consultations; telemedicine; health club membership fees; weight loss program fees; smoking cessation program fees; reversal of male and female voluntary sterilization procedures; and extracorporeal shock wave lithotripsy for musculoskeletal and orthopedic conditions.

Website: www.myCIGNA.com

At CIGNA's secure, personalized website, www.myCIGNA.com, you can:

- Compare medical costs and providers
- Get prescription drug information and prices
- Keep track of your health information and take a health risk assessment
- Learn more about medical topics, health and wellness
- Order a new ID card, choose your doctor and learn more about your plan's benefits and features.

Appeals

These steps must be followed if you have a concern or an appeal:

- Call or write CIGNA's Member Services Department, and a representative will work with you to resolve your concern.
- If it is not resolved to your satisfaction, you may appeal the decision to CIGNA's Appeal Committee. This is called a Level One Appeal. The Appeal Committee will notify you in writing of its decision within 30 calendar days.
- If you do not agree with the decision, you may appeal to CIGNA's Grievance Committee. This is a Level

Two Appeal. The Grievance Committee will notify you in writing of its decision within 30 calendar days.

If you are still dissatisfied after CIGNA HealthCare has reviewed its decision, you may ask the Employee Insurance Program (EIP) to review the matter by making a written request to EIP within 90 days of notice of the denial. If the decision is upheld by the EIP Appeals Committee, you have 30 days to seek judicial review as provided by Sections 1-11-710 and 1-23-380 of the S.C. Code of Laws, as amended.

For more information on appeals, contact CIGNA Healthcare at 800-244-6224 or write CIGNA Healthcare at P.O. Box 5200, Scranton, PA 18505.

Dental Insurance

Dental Insurance
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Introduction

Your teeth are important to your health. That is why EIP offers the State Dental Plan, which helps offset your dental expenses, and Dental Plus, a supplement to the State Dental Plan. To participate in Dental Plus, you must be enrolled in the State Dental Plan and cover the same family members under both plans.

State Dental Plan

The State Dental Plan offers these levels of treatment: diagnostic and preventive; basic; prosthodontics; and orthodontics. They are described on the next page. The lifetime orthodontics payment is $1,000 for each covered child age 18 and younger. State Dental Plan benefits are paid based on the allowed amounts for each dental procedure listed in the plan's Schedule of Dental Procedures and Allowed Amounts. Your dentist's charge may be greater than the plan's allowed amount.

The maximum yearly benefit for the State Dental Plan alone is $1,000 for each subscriber or covered person. The State Dental Plan deductible is $25 annually for each covered person who has dental services under Class II or Class III. The deductible for family coverage is limited to three per family per year, $75.

If you enroll in the State Dental Plan or Dental Plus, you may not drop that coverage until the next open enrollment, which will be in October 2013, or until you become eligible to change coverage due to a special eligibility situation. Special eligibility situations are explained on pages 24-28.

Dental Plus

Dental Plus covers the first three levels of treatment at the same percentage as the State Dental Plan. However, the allowed amount is higher. **Dental Plus does not cover orthodontics.**

Under Dental Plus, payment for a covered service is based on the lesser of the dentist's charge or the Dental Plus allowed amount. This means you may only be responsible for any deductibles and coinsurance that apply. If your dentist charges more for covered services than the Dental Plus allowed amount, **you will be responsible for paying the difference (plus deductibles and coinsurance)**, unless your dentist has agreed to accept the Dental Plus allowed amount as part of participation in the Dental Plus provider network.

Premiums for employees are on the next page. Premiums for all subscribers are on pages 227-230.

EIP offered agreements to all South Carolina dentists to accept the lesser of their usual charge or the Dental Plus allowed amount. For a list of dentists who have accepted the agreement, go to the EIP website, www.eip.sc.gov. Select "Links" then under "State Dental Plan/Dental Plus," select "BlueCross BlueShield of SC." At the BlueCross BlueShield of South Carolina (BCBSSC) website, select "Physician Network" and then "Find a Provider." Under "Doctor & Hospital Finder," select "Dental Care." Now select "General Dental Practitioners." Under "Specialty Category" select "State Dental Plus."

If your dentist has not accepted EIP's agreement, your benefits under Dental Plus will not be reduced. However, you will be responsible for the difference between your dentist's charge and the Dental Plus allowed amount plus deductibles and coinsurance.

The maximum yearly benefit for a person covered by **both** the State Dental Plan and Dental Plus is $2,000. **There are no additional deductibles under Dental Plus.**

BCBSSC is the third-party claims processor for the State Dental Plan and Dental Plus. Its address is P.O. Box 100300, Columbia, SC 29202-3300. Its Customer Service number is 888-214-6230 or 803-264-7323 (Greater Columbia area). The fax number is 803-264-7739.

Dental Benefits at a Glance

Not all dental procedures are covered. Reimbursement is based on the lesser of the dentist's actual charge or the plan's allowed amount. Please see page 101 for more information.

Class	Covered Benefits	Plan	Yearly Deductible	Percent Covered	Maximum Payment
I Diagnostic and Preventive	Diagnostic and preventive procedures Cleaning and scaling of teeth Fluoride treatment Space maintainers (child) Emergency pain relief X-rays	**State Dental Plan alone**	None	100% of allowed amount	$1,000 per person each year, combined for Classes I, II and III
		with Dental Plus	None	100% of allowed amount	$2,000[2] per person each year, combined for Classes I, II and III.
II Basic Benefits	Fillings Extractions Oral surgery Endodontics (root canals) Periodontal procedures	**State Dental Plan alone**	$25 per person. If you have services in Classes II and III, you pay only one deductible. Limited to three per family per year.	80% of allowed amount	$1,000 per person each year, combined for Classes I, II and III
		with Dental Plus	No additional deductible	80% of allowed amount	$2,000[2] per person each year, combined for Classes I, II and III
III Prosthodontics	Onlays Crowns Bridges Dentures Repair of prosthodontic appliances	**State Dental Plan alone**	$25 per person. If you have services in Classes II and III, you pay only one deductible. Limited to three per family per year.	50% of allowed amount	$1,000 per person each year, combined for Classes I, II and III
		with Dental Plus	No additional deductible	50% of allowed amount	$2,000[2] per person each year, combined for Classes I, II and III
IV Orthodontics[1]	Limited to covered children age 18 and younger. Correction of malocclusion Consisting of: diagnostic services (including models and X-rays) Active treatment (including necessary appliances)	**State Dental Plan alone**	None	50% of allowed amount	$1,000 lifetime benefit for each covered child
		Dental Plus	**Dental Plus does not cover orthodontic benefits**	**Dental Plus does not cover orthodontic benefits**	**Dental Plus does not cover orthodontic benefits**

[1] *A subscriber must submit a letter from his provider for a covered child, age 18 and younger, stating that the child's orthodontic treatment is not for cosmetic purposes for it to be covered by the State Dental Plan.*

[2] *$2,000 is the maximum yearly payment for benefits when a member is enrolled in both the State Dental Plan and Dental Plus.*

Active Employee Monthly Premiums (Rates for local subdivisions may vary. To check these rates, employees should contact their benefits office.)		Dental	Dental Plus	Combined Dental/Dental Plus
	Employee	$ 0.00	$22.36	$22.36
	Employee/spouse	$ 7.64	$45.16	$52.80
	Employee/children	$13.72	$52.06	$65.78
	Full family	$21.34	$67.50	$88.84

Claim Example (using Class III procedure)

Under the State Dental Plan and Dental Plus, Class III dental benefits (prosthodontics) are paid at 50 percent of the allowed amount after the $25 deductible is met. The table below illustrates how the two plans work together using a crown (porcelain with predominantly base metal) as an example. The example assumes the $25 deductible has been met. The Dental Plus payment is based on the 2011 allowed amount for the Columbia area and may differ slightly depending on where your dentist is located. The Dental Plus allowed amounts are updated yearly.

State Dental Plan Only

Dentist's charge	**$1,000**
State Dental Plan allowed amount	**$409.60**
State Dental Plan payment (50% of the allowed amount)	**$204.80**
Subscriber enrolled only in the State Dental Plan pays	**$795.20**

State Dental Plan with Dental Plus

Dentist's Charge	**$1,000**
Total payment for subscriber enrolled in State Dental Plan and Dental Plus (The Dental Plus payment is 50% of the dentist's charge or 50% of the allowed amount, whichever is less)	**$500** (This includes the State Dental Plan payment of $204.80 and the Dental Plus payment of $295.20.)
Additional benefit with Dental Plus	**$295.20**
Subscriber enrolled in the State Dental Plan and Dental Plus pays	**$500**

How to File a Dental Claim

The easiest way to file a claim is to assign benefits to your dentist. *Assigning benefits* means that you authorize your dentist to file claims for you and to receive payment from the plan for your treatment. To do this, show a staff member in your dentist's office your dental identification card and ask that the claim be filed for you. Be sure to sign the payment authorization block of the claim form. BCBSSC will then pay your dentist directly. **You are responsible for the difference between the plan's payment and the actual charge.**

If you are covered under Dental Plus, BCBSSC will process your claims under the State Dental Plan and then under Dental Plus. You do not have to submit additional claims. If you are covered under the State Dental Plan and Dental Plus, you will receive an Explanation of Benefits (EOB) from each plan. State Dental Plan EOBs have "State Dental Plan" above the Summary Information block on the form. The claim number begins with a "T." "Dental Plus Plan" is printed in the same place on the Dental Plus EOBs. The claim number begins with a "V." The digits after the letter should be the same for both claims.

If your dentist will not file your claims, you can file them to BCBSSC. See page 240 for information on how to file a dental claim.

Special Provisions of the State Dental Plan

Alternate Forms of Treatment

If you or your dentist selects a more expensive or personalized treatment, the plan will cover the less costly procedure that is consistent with sound professional standards of dental care. BCBSSC uses guidelines based on usually and customarily provided services and standards of dental care to determine benefits and/or denials. Your dentist may bill you for the difference between his charges for the more costly procedure and what the plan allows for the alternate procedure. The plan will not allow you to apply the payment for the alternate procedure to the cost of the more expensive procedure, if the more expensive procedure is not a covered benefit. (For example, if you choose an implant, the plan will not allow you to apply the payment for a three-unit bridge to the cost of the implant, because an implant is not a covered benefit.) Examples of when a less costly procedure may apply are:

- An amalgam (silver-colored) filling is less costly than a composite (white) filling placed in a posterior (rear) tooth.
- Porcelain fused to a predominantly base metal crown is less costly than porcelain fused to a noble metal crown.

Pretreatment Estimates

Although it is not required, EIP suggests that you obtain a Pretreatment Estimate of your non-emergency treatment if the charges will exceed $500. To do this, you and your dentist should fill out a claim form before any work is done. The form should list the services to be performed and the charge for each one. Mail the claim form to BlueCross BlueShield of South Carolina, State Dental Claims Department, P.O. Box 100300, Columbia, SC 29202-3300. **Emergency treatment does not need a Pretreatment Estimate.**

You and your dentist will receive a Pretreatment Estimate form, which will show what part of the expenses your dental plan will cover. This form can be used to file for payment as the work is completed. Just fill in the date(s) of service, ask your dentist to sign the form and submit it to BCBSSC. Your Pretreatment Estimate is valid for one year from the date of the form. However, the date of service may affect the payment allowed. For example, if you have reached your maximum yearly payment when you have the service performed, you will not receive the amount that was approved on the Pretreatment Estimate form.

To determine the allowed amount for a procedure, ask your dentist for the procedure code. Then call BCBSSC Dental Customer Service at 888-214-6230.

If the State Dental Plan is your secondary insurance, the Pretreatment Estimate will not reflect the estimated coordinated payment, because BCBSSC will not know what your primary insurance will pay.

Exclusions: Dental Benefits not Offered

There are some dental benefits the State Dental Plan and Dental Plus do not offer. The dental plan document, which is available in your benefits administrator's office, lists all exclusions. The list below includes many of them. You may wish to take it with you when you discuss treatment with your dentist.

General Benefits not Offered

- Treatment received from a provider other than a licensed dentist. Cleaning or scaling of teeth by a licensed dental hygienist is covered when performed under the supervision and direction of a dentist.
- Services beyond the scope of the dentist's license.
- Services performed by a dentist who is a member of the covered person's family or for which the covered person was not previously charged or did not pay the dentist.
- Dental services or supplies that are rendered before the date you are eligible for coverage under this plan.

- Charges made directly to a covered person by a dentist for dental supplies (i.e., toothbrush, mechanical toothbrush, mouthwash or dental floss).
- Non-dental services, such as broken appointments and completion of claim forms.
- Nutritional counseling for the control of dental disease, oral hygiene instruction or training in preventive dental care.
- Services and supplies for which no charge is made or no payment would be required if the person did not have this benefit, including non-billable charges under the person's primary insurance plan.
- Services or supplies not recognized as acceptable dental practices by the American Dental Association.

Benefits Covered by Another Plan

- Treatment for which the covered person is entitled under any Workers' Compensation law.
- Services or supplies that are covered by the armed services of a government.
- Dental services for treatment of injuries as a result of an accident that are received during the first 12 months from the date of the accident. These services are covered under the member's health plan.

Specific Procedures not Covered

- Implants and related services, including prosthodontics (crowns, abutments, dentures) placed on implants.
- Space maintainers for lost deciduous (primary) teeth if the covered person is age 19 or older.
- Experimental services or supplies.
- Onlays or crowns, when used for preventive or cosmetic purposes or due to erosion, abrasion or attrition.
- Services and supplies for cosmetic or esthetic purposes, including charges for personalization or characterization of dentures, except for orthodontic treatment as provided for under this plan.
- Myofunctional therapy (i.e., correction of tongue thrusting).
- Appliances or therapy for the correction or treatment of temporo mandibular joint (TMJ) syndrome.
- Services to alter vertical dimension and/or for occlusion purposes or due to erosion, abrasion or attrition.
- Splinting or periodontal splinting, including extra abutments for bridges.
- Services for these tests and laboratory examinations: bacterial cultures for determining pathological agents, caries (tooth or bone destruction), susceptibility tests, diagnostic photographs and histopathologic exams.
- Pulp cap, direct or indirect (excluding final restoration).
- Provisional intracoronal and extracoronal (crown) splinting.
- Tooth transplantation or surgical repositioning of teeth.
- Occlusal adjustment (complete). Occlusal guards are covered for certain conditions. The provider should file office notes with the claim for review by the dental consultant.
- Temporary procedures, such as temporary fillings or temporary crowns.
- Rebase procedures.
- Stress breakers.
- Precision attachments.
- Procedures that are considered part of a more definitive treatment (i.e., an X-ray taken on the same day as a procedure).
- Inlays (cast metal and/or composite, resin, porcelain, ceramic). Benefits for inlays are based on the allowance of an alternate amalgam restoration.
- Gingivectomy/gingivoplasty in conjunction with or for the purpose of placement of restorations.
- **Topical application of sealants per tooth for patients age 16 and older.**

Limited Benefits

- More than two of these procedures during any plan year: oral examination, consultations (must be provided by a specialist) and prophylaxis (cleaning of the teeth).
- More than two periodontal prophylaxes. (Periodontal prophylaxes, scaling or root planing are available only to patients who have a history of periodontal treatment/surgery.) Four cleanings a year (a combina-

tion of prophylaxes and periodontal prophylaxes) are allowed for patients with a history of periodontal treatment/surgery.
- Bitewing X-rays more than twice during any plan year or more than one series of full-mouth X-rays or one panoramic film in any 36-month period, unless a special need for these services at more frequent intervals is documented as medically necessary by the dentist and approved by BSBSSC.
- More than two topical applications of stannous fluoride or acid fluoride phosphate during any plan year.
- Topical application of sealants for patients age 15 and younger, payment is limited to one treatment every three years and **applies to permanent unrestored molars only.**
- More than one root canal treatment on the same tooth. Additional treatment (retreatment) should be submitted with the appropriate American Dental Association procedure code and documentation from your dentist.
- More than four quadrants in any 36-month period of gingival curettage, gingivectomy, osseous (bone) surgery or periodontal scaling and root planing.
- Bone replacement grafts performed on the same site more than once in any 36-month period.
- Full mouth debridement for treatment of gingival inflammation if performed more than once per lifetime.
- Tissue conditioning for upper and lower dentures is limited to twice per unit in any 36-month period.
- The application of desensitizing medicaments is limited to two times per quadrant per year, and the sole purpose of the medication used must be for desensitization.
- No more than one composite or amalgam restoration per surface in a 12-month period.
- Replacement of cast restorations (crowns, bridges) or prosthodontics (complete and partial dentures) within five years of the original placement unless evidence is submitted and is satisfactory to the third-party claims processor that: 1) the existing cast restoration or prosthodontic cannot be made serviceable; or 2) the existing denture is an immediate temporary denture and replacement by a permanent denture is required, and that such replacement is delivered or seated within 12 months of the delivery or seat date of the immediate temporary denture.
- Addition of teeth to an existing removable partial or fixed bridge unless evidence is submitted and is satisfactory to the third-party claims processor that the addition of teeth is required for the initial placement of one or more natural teeth.

Prosthodontic and Orthodontic Benefits

Benefits are not payable for prosthodontics (ie., crowns, bridges, partial or complete dentures) until they are seated or delivered. Other exclusions and limitations for these services include:

- Prosthodontics (including bridges and crowns) and their fitting that were ordered while the person was covered under the plan, but were delivered or seated more than 90 days after termination of coverage.
- Replacement of lost or stolen prosthodontics, space maintainers or orthodontic appliances or charges for spare or duplicate dentures or appliances.
- Replacement of broken orthodontic appliances.
- Replacement of existing cast prosthodontics unless otherwise specified in the dental plan document.
- Orthodontic treatment for employees, retirees, spouses or covered children age 19 and older.
- Payment for orthodontic treatment over the lifetime maximum.
- Orthodontic services after the month a covered child becomes ineligible for coverage.

Please note: Dental Plus does not cover orthodontic services.

Coordination of Benefits

If you are covered by more than one dental plan, you may file a claim for reimbursement from both plans. Coordination of benefits enables both plans' administrators to work together to give you the maximum benefit allowed. However, the sum of the combined payments will never be more than the *allowed amount* for your covered dental procedures. (The *allowed amount* is the amount the State Dental Plan lists for each dental procedure in the Schedule of Dental Procedures and Allowed Amounts. Dental Plus allowed amounts are higher.) **When your state dental coverage is secondary, it pays up to the allowed amount of your state dental coverage minus what the primary plan paid. See the following examples.**

You will never receive more from your state dental coverage than the maximum yearly benefit, which is $1,000 for a person covered by the State Dental Plan and $2,000 for a person covered by both the State Dental Plan and Dental Plus. The maximum lifetime benefit for orthodontic services is $1,000, and it is limited to covered children age 18 and younger.

How Coordination of Benefits Works with Dental Coverage

Example 1 (Using an adult cleaning, a Class I procedure, which has no deductible and which is payable at 100 percent of the allowed amount.) The Dental Plus payment is based on the 2011 allowed amount for the Columbia area and may differ slightly based on where your dentist is located. The Dental Plus allowed amounts are updated yearly.

Dentist's Charge	$100
Benefit payable under primary plan (assuming $60 is the allowed amount and payable at 100 percent)	**$60**
Benefit payable if the State Dental Plan were primary ($30.10, the allowed amount, is payable at 100 percent)	**$30.10**
State Dental Plan's payment	**$0** (No benefit is payable under the State Dental Plan, since the sum of total benefits paid under all dental plans cannot exceed the State Dental Plan allowed amount of $30.10.)
You pay if you have primary coverage and State Dental Plan coverage	**$40**
Dental Plus allowed amount	**$72**
Dental Plus payment	**$12** (An additional $12 is payable if you have Dental Plus, due to higher Dental Plus allowed amount of $72.)
You pay if you have primary coverage, State Dental Plan coverage and Dental Plus coverage	**$28**

Example 2 (Using a porcelain crown fused to a predominantly metal base, a Class III procedure for which the deductible has been paid and which is payable at 50 percent of the allowed amount.) The Dental Plus payment is based on the 2011 allowed amount for the Columbia area and may differ slightly based on where your dentist is located. The Dental Plus allowed amounts are updated yearly.

Dentist's charge	$1,000
Benefit payable under primary plan (assuming $1,000 is the allowed amount and payable at 50 percent)	**$500**
Benefit payable if State Dental Plan were primary ($409.60, the allowed amount, is payable at 50 percent)	**$204.80**
State Dental Plan's payment	**$0** (No benefit is payable under the State Dental Plan, since the sum of total benefits paid under all dental plans cannot exceed the State Dental Plan allowed amount of $409.60.)
You pay if you have primary coverage and State Dental Plan coverage	**$500**
Dental Plus allowed amount	**$1,000**
Dental Plus payment	**$500** (An additional $500 is payable if you have Dental Plus, due to the higher Dental Plus allowed amount of $1,000.)
You pay if you have primary coverage, State Dental Plan coverage and Dental Plus coverage	**$0**

For detailed information about coordination of benefits, including how to determine which plan pays first, see page 12. If your state dental coverage is secondary, you must send the Explanation of Benefits you receive from your primary plan with your claim to BCBSSC.

If you have questions, contact BCBSSC toll-free at 888-214-6230 or 803-264-7323 (Greater Columbia area), your benefits office or the Employee Insurance Program.

Appeals

If BCBSSC denies all or part of your claim or proposed treatment, you will be informed promptly. If you have questions about the decision, check the information in this book or call for an explanation. If you believe the decision was incorrect, you may ask BCBSSC to re-examine its decision. The request for review should be made in writing within six months after notice of the decision by writing to BCBSSC, Attn: State Dental Appeals, AX-B15, P.O. Box 100300, Columbia, SC 29202.

If you are still dissatisfied after BCBSSC has reviewed the decision, you have 90 days to request, in writing, that EIP review the decision. If the decision is upheld by the EIP Appeals Committee, you have 30 days to seek judicial review as provided by Sections 1-11-710 and 1-23-380 of the S.C. Code of Laws, as amended.

Vision Care

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Vision Care Discount Program 114

Introduction

Good vision is crucial for work and play. It is also a significant part of your overall health. A yearly eye exam can help detect serious illnesses, such as high blood pressure, heart disease and diabetes. That is why the Employee Insurance Program (EIP) offers vision care benefits through the State Vision Plan, which is provided through EyeMed Vision Care®.

State Vision Plan

The State Vision Plan is available to eligible active employees, retirees, survivors, permanent, part-time teachers and COBRA subscribers and their covered family members. Subscribers pay the premium without an employer contribution.

The program covers comprehensive eye examinations, frames, lenses and lens options, and contact lens services and materials. It also offers discounts on additional pairs of eyeglasses and contact lenses. A discount of 15 percent on the retail price and 5 percent on a promotional price is offered on LASIK and PRK vision correction through the U.S. Laser Network. Medical treatment of your eyes, such as eye surgery, is covered by your health plan.

The applicable sales tax on any benefit, such as eyeglasses or contact lenses, is not covered by the State Vision Plan.

Vision Benefits at a Glance

Service	In-Network – Member Cost	Out-of-Network Reimbursement
Comprehensive Exam *(limited to once a year)*	Member pays $10 copay	Member is reimbursed up to $35
Eyeglasses		
Frames *(limited to once every two years)*	$0 copay, member receives $140 allowance and pays 80% of balance over $140 (This benefit cannot be used with any promotion.)	Member is reimbursed up to $70
Lenses* *(limited to once a year)*		
Single Vision	Member pays $10 copay	Member is reimbursed up to $25
Bifocal	Member pays $10 copay	Member is reimbursed up to $40
Trifocal	Member pays $10 copay	Member is reimbursed up to $55
Lenticular	Member pays $10 copay	Member is reimbursed up to $55
Progressive lenses	See chart on next page	See chart on next page
Lens Add-ons		
UV Treatment, Tint (solid, gradient), Standard Scratch Coating and Standard Polycarbonate lens (under age 19 only)	Member pays $0 (for each option)	Member is reimbursed up to $5 (for each option)
Polycarbonate lens (adults)	Member pays $30 copay	Member is reimbursed up to $5
Anti-reflective coating	Fixed pricing starting at $45	N/A
Photochromatic/Transition plastic lenses	Member pays $60 copay	Member is reimbursed up to $5

*Glass eyeglass lenses are not covered under the plan. As a non-covered item, they are offered at a 20% discount. Members also receive a 40% discount on the purchase of a complete pair of eyeglasses once the funded benefit has been used.

Service	In-Network – Member Cost	Out-of-Network Reimbursement
Contact Lenses *(available in place of eyeglass lens benefit; limited to once per year)**		
Conventional	$0 copay, member receives $130 allowance and pays 85% of balance over $130	Member is reimbursed up to $104
Disposable	$0 copay, member receives $130 allowance and pays balance over $130	Member is reimbursed up to $104
Medically Necessary Contact Lenses	Member pays $0 copay, paid in full	Member is reimbursed up to $200
Contact Lens Fit and Follow-Up	*Standard:* $0 copay, paid in full fit and two follow-up visits *Premium:* member *receives* 10% off retail then $55 allowance is applied	*Standard:* Member is reimbursed up to $40 *Premium:* Member is reimbursed up to $40
Additional Savings		
Savings on Additional Pairs	Members receive 40% off complete pairs of eyeglass purchases and 15% off conventional contact lenses once the funded benefit has been used.	N/A

* Your allowance for disposable contact lenses is $130. You do not need to use this allowance all at once. For example, you can use $50 of the allowance when you purchase your first supply of disposable contacts and the remainder of the allowance later.

- A *standard* contact lens fitting includes clear, soft, spherical, daily wear contact lenses for single-vision prescriptions. It does not include extended/overnight wear lenses.
- A *premium* contact lens fitting is more complex and may include fitting for bifocal/multifocal, cosmetic color, post-surgical and gas-permeable lenses. It also includes extended/overnight wear lenses.

Plan exclusions and limitations may apply. Please refer to page 113 for details.

Members also receive a 15% discount on the purchase of conventional contact lenses once the funded benefit has been used.

Progressive Lens and Anti-Reflective Coating Schedules

Service	In-Network – Member Cost	Out-of-Network Reimbursement
Progressive Lens Price List*		
Standard Progressive Lenses	Member pays $45	Member is reimbursed up to $55
Premium Progressives Schedule*		
Image, Kodak Precise, Kodak Concise, Outlook, SOLAMAX, Gradal Top, Gradal Brevity, Ovation, Natural, Compact Ultra, Short Fit, “MVP”	Member pays $71 copay	Member is reimbursed up to $55
Varilux Comfort, AO Easy, Hoyalux GP Wide, Genesis	Member pays $77 copay	Member is reimbursed up to $55
SOLAOne, Varilux Panamic, Varilux Ellipse, Definity, Hoyalux Summit	Member pays $83 copay	Member is reimbursed up to $55
Premium Progressives (other)	Member receives $75 allowance and pays 80% of balance over $75	Member is reimbursed up to $55
Anti-reflective Coating Price List*		
Standard Anti-reflective Coating	Member pays $45	N/A
Premium Anti-reflective Coatings Schedule*		
Crizal, Zeiss Carat, High Vision	Member pays $57	N/A
Crizal Alize, Teflon, Super High Vision, RF Endura EZ	Member pays $68	N/A
Luxottica Anti-reflective Coatings (EZ Clean, Scotchgard Protector, EZClear, EasyCare, Other LensCrafters and Pearle Premium AR)	Member pays $68	N/A

Premium Anti-reflective Coatings (other)	Member pays 80% of charge	N/A
*As a result of changes in market conditions and new product development, the brands of premium progressive lenses and premium anti-reflective coatings available through the plan will change periodically. The copay listed is for a particular brand listed. Providers are not required to carry all brands at all levels.		

The Importance of Eye Exams

Eye exams are important for good health. A comprehensive eye exam not only detects the need for vision correction, but it can also reveal early signs of many medical conditions, including diabetes and high blood pressure. A comprehensive exam is covered as part of your EyeMed benefit once a year with a $10 copay.

Frequency of Benefits

The State Vision Plan covers:

- A comprehensive eye exam once a year
- Standard plastic lenses for eyeglasses or contact lenses, instead of eyeglass lenses, once a year
- Frames once every two years.

Examples of Vision Coverage

Here are estimates of what you might pay for vision services if you are covered by the State Vision Plan.

Example 1

Service	Average Retail Prices*	State Vision Plan benefits	In-Network Cost (Member out-of-pocket)
Eye examination	$88	$10 copay	$10
Frames	$200	$140 allowance, plus 20% off balance	$48
Lenses Single vision Polycarbonate (adults) Premium anti-reflective (Crizal Alize)	 $72 $62 $97	 $10 copay $30 copay $68 copay	 $10 $30 $68
Totals	$519		$166
*Based on industry averages. Prices and costs will vary by market and provider type. Premiums are not included.			

Example 2

Service	Average Retail Prices*	State Vision Plan benefits	In-Network Cost (Member out-of-pocket)
Eye examination	$88	$10 copay	$10
Frames	$140	$140 allowance, plus 20% off balance	$0
Lenses Premium progressive (Varilux Comfort) Premium anti-reflective (Crizal Alize)	 $230 $97	 $77 copay $68 copay	 $77 $68
Totals	$555		$155
*Based on industry averages. Prices and costs will vary by market and provider type. Premiums are not included.			

Example 3

Service	Average Retail Prices*	State Vision Plan benefits	In-Network Cost (Member out-of-pocket)
Eye examination	$88	$10 copay	$10
Contact lens fit and follow-up (standard)	$71	$0 copay	$0
Disposable contact lenses	$130	$130 allowance	$0
Totals	$289		$10
*Based on industry averages. Prices and costs will vary by market and provider type. Premiums are not included.			

Please note: The applicable sales tax on any benefit, such as eyeglasses or contact lenses, is not covered by the State Vision Plan.

Using the EyeMed Provider Network

The EyeMed network includes private practitioners and optical retailers in South Carolina and nationwide. Retailers include LensCrafters®, Sears Optical℠, Target Optical®, JCPenney® Optical and participating Pearle Vision® locations. When you use a network provider, you are only responsible for copayments and any charges that remain after allowances and discounts have been applied to your bill. Also, the network provider will file your claim.

To find a network provider:

- Check network providers in or near your ZIP code on the list that comes with your membership card.
- To review the online directory, which is the most up-to-date, go to the EIP website, www.eip.sc.gov. Select "Online Directories," and then click on "State Vision Plan – State of South Carolina Access Network (EyeMed)." That will take you to the provider directory on the EyeMed website. You may enter your ZIP code or address to find a provider close to you.
- Use the Interactive Voice Response system or speak with a representative at the Customer Care Center at 877-735-9314. To speak with a customer service representative, choose your language ("1" is for English) and then say, "Customer Service."
- You may also ask your provider if he accepts EyeMed coverage.

When you make an appointment, tell the office staff you are covered by EyeMed. It is best to bring your State Vision Plan identification card to your appointment. However, you are not required to do so.

How to Order Contact Lenses by Mail

You can also save money by ordering replacement contact lenses at competitive prices through www.eyemedcontacts.com. Log on to the site and follow the instructions for ordering. You will be asked to select your doctor and will also need to have a valid prescription. Your contacts will be delivered directly to your home. **Please note:** Your plan allowance and discounts do not apply to this service, so it is best to wait to use it until after you have exhausted your benefit.

Out-of-network Benefits

Your benefits are lower when you use a provider outside the network. To learn what you will be reimbursed if you use an out-of-network provider for covered services and supplies, see the charts on pages 109-111.

To receive out-of-network services:

- Request an out-of-network claim form from EyeMed's Customer Care Center. You may also print one from EIP's website, www.eip.sc.gov. Select "Forms." The out-of-network claim form is listed under "Vision Care Benefits."

- When you receive services, pay for them and ask your provider for an itemized receipt.
- Send the claim form and a copy of your receipt to: EyeMed Vision Care, Attn: OON Claims, P.O. Box 8504, Mason, Ohio 45040-7111. Your reimbursement will be sent to you.

If you have questions about out-of-network services, call the Customer Care Center at 877-735-9314. Please have your State Vision Plan ID card handy.

Exclusions and Limitations

Some services and products are not covered by your vision care benefits. They include:

1. Orthoptic (problems with the use of eye muscles) or vision training, subnormal vision aids and any associated supplemental testing
2. Aniseikonic lenses (lenses to correct a condition in which the image of an object in one eye differs from the image of it in the other eye)
3. Medical and/or surgical treatment of the eye, eyes or supporting structures
4. Any eye or vision examination, or any corrective eyewear required by an employer as a condition of employment; safety eyewear
5. Services that would be provided by the government under any workers' compensation law, or similar legislation, whether federal, state or local
6. Plano (non-prescription) lenses and/or contact lenses
7. Non-prescription sunglasses
8. Two pairs of glasses instead of bifocals
9. Services provided by any other group benefit plan offering vision care
10. Services provided after the date the enrollee is no longer covered under the policy, except when vision materials ordered before coverage ended are delivered and the services are provided to the enrollee within 31 days from the date the materials were ordered
11. Lost or broken lenses, frames, glasses or contact lenses will not be replaced until they are next scheduled to be replaced under Frequency of Benefits.
12. A benefit may not be combined with any discount, promotional offering or other group benefit plans.

Access to Information about Your Vision Benefits

Website: www.eyemedvisioncare.com

At EyeMed's website click on "Members" and login. Then you can:
- Monitor the status of your claim.
- Print an I.D. card.
- Go paperless and receive Explanations of Benefits (EOBs) electronically.
- Check benefit information. You must register and log in to check your benefits, find out which members of your family are covered and learn when you are next eligible for service. You may also find a network provider. Providers are available in South Carolina and nationwide.
- Print an out-of-network claim form.
- Order replacement contact lenses and learn about LASIK vision correction.
- Find answers to "Common Questions." Select "Member Resources."

Under "Wellness 101," you can watch videos about eye exams and learn about selecting eyewear. Under "Disease Awareness," you can read about children's vision care, eye diseases and vision and aging.

Contacting EyeMed Vision Care

You can reach EyeMed's Customer Care Center by telephone or by selecting "Contact Us" on EyeMed's home page. Be sure to have this information ready:
- The first and last name of the subscriber

- The subscriber's Benefits ID Number or Social Security Number
- The Group Number for the State Vision Plan: **9756347**
- A fax number or address, if you are asking for information by fax or mail.

Department	Hours	Number
Customer Care Center and Interactive Voice Response	7:30 a.m. – 11 p.m., ET, Mon. – Sat. 11 a.m. – 8 p.m., ET, Sun.	877-735-9314

Appeals

If a claims question cannot be resolved by EyeMed's Customer Care Center, the subscriber may write to the Quality Assurance Team at EyeMed Vision Care, Attn: Quality Assurance Dept., 4000 Luxottica Place, Mason, OH 45040. Information may also be faxed to 866-552-9115. This team will work with the subscriber to resolve the issue within 30 days. If the subscriber is dissatisfied with the team's decision, he may appeal to an appeals subcommittee, whose members were not involved in the original decision. All appeals are resolved within 30 days of the date the subcommittee received the appeal.

Vision Care Discount Program

This program offers discounted vision care services. Providers throughout the state have agreed to charge no more than $60[1] for a routine, comprehensive eye exam. If you are fitted for contact lenses, you may pay more because that can require additional services. Providers, including opticians, also have agreed to give a 20-percent[1] discount on all eyewear except disposable contact lenses.

[1]*These amounts can change yearly. Contact your benefits office, provider or EIP for the current amounts.*

Full-time and part-time employees, retirees, survivors and COBRA subscribers, as well as their family members, are eligible. You do not have to be enrolled in a health plan. You may need to show employment-related identification to prove you are eligible for the program.

A member may not use the discount program and State Vision Plan benefits at the same time. However, if he is enrolled in the vision plan and wants a second eye exam during the year, he can have one for $60 through the discount program.

Providers are Available Statewide

To see participating providers listed by county in South Carolina, North Carolina and Georgia, go to EIP's website, www.eip.sc.gov. Choose "Online Directories" and then "Vision Care Discount Program."

If your provider is not listed, you may wish to ask if he gives discounts through the state's discount program. If he would like to participate, he should call EIP. Although EIP lists participating providers, the state does not recommend any specific provider. If you do not have Internet access, ask your BA to print a copy of the list for you. You can also request one by writing to EIP at P.O. Box 11661, Columbia, SC 29211, or by calling 803-734-0678 (Greater Columbia area) or 888-260-9430 (toll-free outside the Columbia area).

No Claims to File

With the Vision Care Discount Program, you do not file claims and will not receive reimbursement for vision examinations or eyewear, including contacts. Active employees who have a MoneyPlu$ Medical Spending Account or a limited-use Medical Spending Account can file for reimbursement for vision care expenses. If you have questions about this program, please contact your benefits office or EIP.

Life Insurance

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Basic Life Insurance Program

Who is Eligible?

The Basic Life Insurance program provides $3,000 in *term life insurance* to all eligible employees under age 70 and $1,500 to eligible employees age 70 or older. If you are an active, permanent, full-time employee who is enrolled in a state health insurance plan, you are eligible for this benefit.

Enrollment

Basic Life Insurance is provided at no cost to all eligible employees. Enrollment is automatic with enrollment in a state health insurance plan for active employees.

Your coverage begins on the first day of the month if you are actively at work on that day as a permanent, full-time employee. If you begin work as a permanent, full-time employee, or if your coverage is approved, later in the month, your coverage begins on the first day of the following month. **All effective dates of coverage are subject to the Deferred Effective Date provision (see page 120).**

Basic Life, like all life insurance offered through EIP, is *term life insurance*. Term life insurance provides coverage for a specific period of time. The policy has no cash value.

Schedule of Accidental Losses and Benefits

In addition to any life insurance benefit, MetLife® will pay a benefit according to the schedule below if:

1. You suffer accidental bodily injury while your insurance is in force;
2. A loss results directly from such injury, independent of all other causes; and
3. Such a loss occurs within 365 days after the date of the accident causing the injury.

Loss of a hand or foot, means actual and permanent severance from the body at or above the wrist or ankle joint. Loss of sight, speech or hearing, means entire and irrecoverable loss. Loss of both a thumb and index finger of same hand, means actual and permanent severance from the body at or above the metacarpophalangeal joints.

Description of Loss	Benefit
Life	Maximum Benefit
Both Hands or Both Feet or Sight of Both Eyes	Maximum Benefit
One Hand and One Foot	Maximum Benefit
Speech, and Hearing in Both Ears	Maximum Benefit
Either Hand or Foot and Sight of One Eye	Maximum Benefit
Movement of Both Upper and Lower Limbs (Quadriplegia)	Maximum Benefit
Movement of Both Lower Limbs (Paraplegia)	Three-quarters of Maximum Benefit
Movement of Three Limbs (Triplegia)	Three-quarters of Maximum Benefit
Movement of the Upper and Lower Limbs of One Side of the Body (Hemiplegia)	One-half of Maximum Benefit
Either Hand or Foot	One-half of Maximum Benefit
Sight of One Eye	One-half of Maximum Benefit
Speech, or Hearing in Both Ears	One-half of Maximum Benefit
Movement of One Limb (Uniplegia)	One-quarter of Maximum Benefit
Thumb and Index Finger of Same Hand	One-quarter of Maximum Benefit

The Maximum Benefit is equal to your amount of Life Insurance.

What is Not Covered?

No **accidental death or dismemberment benefits** are payable if the loss is caused, or contributed to, by:

- Sickness or any other cause that is not considered accidental
- Intentionally self-inflicted injury
- Suicide or attempted suicide, whether sane or insane
- War or act of war, whether declared or not
- Injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority
- Injury sustained while committing or attempting to commit a felony
- Injury sustained while taking drugs, including, but not limited to, sedatives, narcotics, barbiturates, amphetamines or hallucinogens, unless prescribed by, or administered by, a physician, or
- Injury sustained while intoxicated. *Intoxicated* means the blood alcohol content; the results of other means of testing blood alcohol level; or the results of other means of testing other substances that meet or exceed the legal presumption of intoxication or under the influence, under the law of the state where the accident occurred.

How Claims are Paid

Benefits are paid within 60 days after acceptable proof of loss is received. Benefits for loss of life are paid to your named beneficiary. Benefits other than loss of life will be paid directly to you. To pay benefits, MetLife must be given a written proof of loss. This means a claim must be filed as described below.

First, a claim form should be requested from your benefits office. This should be done within 30 days after the loss occurs or as soon as reasonably possible. Next, the claim form should be completed and signed. If a physician must complete part of the claim form, he must also sign that part.

Finally, the claim form and an original death certificate with a raised seal or a red seal (if filing a death claim) should be returned to the employee's benefits office.

The claim form should be filed within 90 days after the loss occurs or as soon as reasonably possible. Claims must be filed no later than 15 months after the loss occurs, unless the person filing the claim is not legally capable of doing so.

Retired employees: For questions about coverage, conversion, etc., call Life Recordkeeping Customer Service at 866-492-6983. For questions about claims, call the Life Claim Department Customer Service at 800-638-6420.

Extension of Benefits

When your health coverage as an active employee ends, you will no longer be eligible for Basic Life coverage. However, you may convert your coverage.

Conversion

If you are terminating employment, you may convert your coverage to an individual *whole life* policy. To do so, contact your benefits administrator, who will complete the Notice of Group Life Insurance Conversion Privilege form and fax it to MetLife. A MetLife representative will contact you to discuss your options for converting the coverage and what the premiums will be. The form must be received by MetLife **within 31 days of the date your Basic Life coverage ends**.

Note: *Whole life* is a permanent form of life insurance.

Optional Life Insurance Program

The Contract

The contract for the Optional Life Insurance program, term life insurance with Accidental Death and Dismemberment Coverage, consists of: the policy, which is issued to EIP; EIP's application, which is attached to the policy; and your application, if required. The policy is held by EIP. This section of the *Insurance Benefits Guide* is the summary of your coverage.

Changes in the Insurance Contract

The insurance contract may be changed at any time as long as MetLife and EIP agree on the change. No one else has the authority to change the contract. Changes in the contract may affect any class of insured people and do not require your or your beneficiary's consent. All changes must be in writing, made a part of the policy and signed by an official of MetLife and of EIP.

Applications

The Notice of Election (NOE) and/or Statement of Health form that you complete to be covered by this plan are considered your application for life insurance coverage. MetLife may use misstatements or omissions in your application to contest the validity of insurance or to deny a claim. However, MetLife must first give you or your beneficiary a copy of the application that is being contested. MetLife will not use your application to contest insurance that has been in force for two years or more during your lifetime.

Cafeteria Plan (MoneyPlu$) Election Restrictions

This policy is part of a cafeteria plan (MoneyPlu$) sponsored by your employer and governed by the requirements of Sections 105, 125 and 129 of the Internal Revenue Code. The rules of the cafeteria plan will supersede any parts of the policy that are in conflict with them. By law, cafeteria plans are subject to the following restrictions: The benefits you elect during the enrollment period will remain in effect until the next enrollment period. Section 125 allows exceptions to this rule only in specified situations, including change in family status and commencement or termination of employment as described in the MoneyPlu$ section. Active employees can pay Optional Life insurance premiums for coverage up to $50,000 before taxes through the MoneyPlu$ Pretax Group Insurance Premium Feature (see page 161). Retired employees are not eligible.

Legal Action

No legal action can be brought against MetLife sooner than 60 days after the date proof of loss is furnished or more than six years after the date that written proof of loss is required.

Contract Terms

For the purposes of your Optional Life coverage, the following terms apply:

Actively at Work

As an employee, you will be considered actively at work with your employer on a day that is one of your employer's scheduled workdays. On that day, you must be performing, for wage or profit, all of the regular duties of your job in the usual way and for your usual number of hours. You will also be considered to be actively at work on any regularly scheduled vacation day or holiday, only if you were actively at work on the preceding scheduled work day.

Accidental Death and Dismemberment (AD&D)

Accidental death and dismemberment. See pages 125-126 for information on AD&D benefits.

Amount of Life Insurance

The benefit amount payable upon your death.

Basic Salary

The actual amount you are compensated by your employer per year, including merit and longevity increases. It does not include commissions, annuities, bonuses, overtime or incentive pay. If you are a teacher, it does not include compensation for summer school.

Beneficiaries

The person(s) to whom MetLife will pay insurance if you die. You may change your Optional Life beneficiaries at any time.

Deferred Effective Date

If you are absent from work due to a physical or mental condition, including absence due to maternity/birth, on the date your insurance would otherwise have become effective or would have been increased, the effective date of insurance or the effective date of any increase in insurance will be deferred until the date you return to work as an active, permanent, full-time employee for one full day.

EIP

The Employee Insurance Program.

Employee

A person who is classified as a full-time, permanent employee who receives compensation from a department, agency, board, commission or institution of the state; public school districts; county governments (including county council members); local subdivisions; and other eligible employers approved by state law and participating in the state insurance program. Members of the South Carolina General Assembly, clerical and administrative employees of the General Assembly, and judges in the state courts are also considered employees eligible for coverage. An employee is classified for insurance purposes as full-time if he works at least 30 hours per week in a permanent position. Active employees who work at least 20 hours per week may also be eligible if the covered employer has elected, and EIP has approved, an irrevocable option to elect the definition of full-time to mean at least 20 hours per week. Employees must be citizens or legal residents of the United States, its territories and its protectorates, excluding temporary, leased or seasonal employees.

Injury

Injury means bodily injury resulting directly from an accident and independently of all other causes, which occurs while you or your spouse are covered under the policy. Loss resulting from sickness or disease, except a pus-forming infection that occurs through an accidental wound or medical or surgical treatment of a sickness or disease, is not considered as resulting from injury.

Maximum Amount of Life Insurance

Medical evidence of good health may be required for the amount of coverage that you select. The maximum eligible amount for all eligible employees is $500,000.

MetLife®

Metropolitan Life Insurance Company.

Notice of Election Form (NOE)

The application form you use to enroll or change your coverage level or beneficiary.

Statement of Health Form

The form used to provide medical evidence of good health to MetLife.

Physician

A person who is a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that MetLife recognizes or is required by law to recognize, licensed to practice in the jurisdiction where care is being given, practicing within the scope of that license and not related to the employee by blood or marriage.

Pretax Group Insurance Premium Feature

This feature allows you to pay your Optional Life insurance premiums for coverage up to $50,000 before taxes are taken out of your paycheck. Retirees are not eligible to participate in the Pretax Group Insurance Premium Feature.

Sickness

A disease, disorder or condition that requires treatment by a physician.

Special Eligibility Situation

An event that allows an eligible employee to enroll himself or make changes in the state Optional Life program. Examples include: birth, marriage, adoption or divorce. Involuntary loss of other group life benefits provided by the spouse's group life plan applies only to those who lost the coverage. They are eligible to enroll in coverage with medical evidence of good health. Enrollment changes must be requested within 31 days of the qualifying event. **A salary increase does not constitute a special eligibility situation.**

Transferring Employee

As an active employee, you can move from one participating employer to another as a transfer, provided there is no more than a 15 calendar-day break in employment. In addition, if there is not a break in your insurance coverage, you are considered a transfer. Academic employees who complete a school term and move to another academic setting at the beginning of the next school term are also considered transfers. A transferring employee is not considered a new hire for insurance program purposes. At the time of transfer, you will transfer to your new employer with all insurance programs in effect with your previous employer as any other continuing employee. Refer to the Enrollment and Eligibility section in this chapter for rules and procedures.

When you terminate employment, tell your benefits administrator that you are transferring from one participating employer to another. EIP will produce a transfer form that will be sent to the benefits administrator at your new employer.

You

A person who is insured under the policy.

Enrolling in Optional Life Insurance

Participation in the Optional Life Insurance Program with Accidental Death and Dismemberment Coverage is on a voluntary, employee-pay-all basis. All premiums are paid by the participants with no contribution by the Employee Insurance Program or the State of South Carolina.

Premiums

Optional Life premiums are determined by your age on the preceding December 31 and the amount of insurance you select. Active employees can pay premiums before taxes through MoneyPlu$ (see page 157). Retired employees are not eligible for the Pretax Group Insurance Premium Feature. Optional Life premiums begin on page 231.

Initial Enrollment

If you are an employee of a participating employer of the State of South Carolina, you can enroll in Optional Life Insurance within 31 days of the date you are hired. To enroll, you must complete the required forms, including an NOE. Coverage is not automatic. You can elect coverage, in $10,000 increments, up to the lesser of three times your basic annual earnings (rounded down to the nearest $10,000) or $500,000 without providing medical evidence of good health. You can apply for a higher benefit level, in increments of $10,000, up to a maximum of $500,000, by providing medical evidence of good health.

Your coverage begins on the first day of the month coinciding with or the first of the month following the date in which you enroll in the Optional Life plan if you are actively at work on that day as a permanent, full-time employee. If you enroll for an amount of coverage that requires medical evidence of good health, your coverage effective date for the amount requiring medical evidence will be the first of the month following approval. **All effective dates of coverage are subject to the Deferred Effective Date provision (see page 120).**

Late Entry With the Pretax Group Insurance Premium Feature

If you participate in the MoneyPlu$ Pretax Group Insurance Premium Feature and do not enroll within 31 days of the date you begin employment, you can enroll only within 31 days of a special eligibility situation (see page 121) or during an enrollment period. **In certain special eligibility situations, you may purchase coverage, in $10,000 increments, up to a maximum of $50,000 without providing medical evidence of good health.** Coverage will be effective the first of the month after you complete and file the NOE. Otherwise, you must complete an NOE and a Statement of Health form during annual enrollment for review of medical evidence of good health and return these forms to your benefits office. If approved, your coverage will be effective on the first day of January after annual enrollment or, if approved after January 1, coverage will be effective the first of the month after approval as long as you are actively at work on that day as a permanent, full-time employee. **All effective dates of coverage are subject to the Deferred Effective Date provision (see page 120).**

Changing Coverage Amount With Pretax Group Insurance Premium Feature

If you participate in the MoneyPlu$ Pretax Group Insurance Premium Feature, you can increase, decrease or drop your coverage only during each October enrollment period or within 31 days of a special eligibility situation (see above).

To increase your coverage during the annual enrollment period, you must provide medical evidence of good health and be approved by MetLife. If approved, coverage will be effective on the first day of January following the annual enrollment period as long as you are actively at work on that day as a full-time employee. **All effective dates of coverage are subject to the Deferred Effective Date provision (see page 120). If you are increasing your coverage due to a special eligibility situation, you can increase, in increments**

of $10,000, up to $50,000 ($500,000 maximum coverage amount) without providing medical evidence of good health. If you are enrolling in Optional Life for the first time due to a special eligibility situation, you may enroll, in $10,000 increments, up to a maximum of $50,000 without providing medical evidence of good health.

Late Entry Without Pretax Group Insurance Premium Feature

If you do **NOT** participate in the MoneyPlu$ Pretax Premium Feature and do not enroll within 31 days of the date you begin employment, you can enroll throughout the year as long as you provide medical evidence of good health and it is approved by MetLife. To enroll, you must complete an NOE and a Statement of Health form and return these forms to your benefits office for processing. Your coverage will be effective on the first day of the month coinciding with, or the first of the month following, approval as long as you are actively at work on that day as a permanent, full-time employee. **In certain special eligibility situations, you may purchase coverage, in $10,000 increments, up to a maximum of $50,000 without providing medical evidence of good health.** Coverage will be effective the first of the month after you complete and file the NOE. **All effective dates of coverage are subject to the Deferred Effective Date provision (see page 120).**

Changing Coverage Amount Without Pretax Group Insurance Premium Feature

If you do **NOT** participate in the MoneyPlu$ Pretax Group Insurance Premium Feature, you can apply to increase your amount of coverage at any time during the year by providing medical evidence of good health and being approved by MetLife. Your coverage at the new level will be effective on the first day of the month following the date of approval as long as you are actively at work on that day. **In certain special eligibility situations, you may purchase coverage, in $10,000 increments, up to a maximum of $50,000 without providing medical evidence of good health.** Coverage will be effective the first of the month after you complete and file the NOE. **All effective dates of coverage are subject to the Deferred Effective Date provision (see page 120).** You can decrease or cancel your coverage at any time. However, if you later want to increase coverage or re-enroll in the plan, you must provide medical evidence of good health and be approved.

What if My Age Category Changes?

If your age category changes, your premium will change January 1 of the next calendar year. Your coverage will be reduced at age 70, 75 and 80. Please see the charts beginning on page 231.

Your Life Insurance Benefits

Your Benefits and How Claims Are Paid

Life Insurance Benefits and benefits for loss of life under the Accidental Death and Dismemberment Benefits will be paid in accordance with the life insurance Beneficiary Designation. If no beneficiary is named, or if no named beneficiary survives you, MetLife may, at its option, pay the executors or administrators of your estate; or all to your surviving spouse; or if your spouse does not survive you, in equal shares to your surviving children; or if no child survives you, in equal shares to your surviving parents. In addition, MetLife may, at its option, pay a portion of your life insurance benefit, up to $2,000, to any person equitably entitled to payment because of expenses from your burial. Payment to any person, as shown above, will release MetLife from liability for the amount paid. If any beneficiary is a minor, MetLife may pay his or her share, until a legal guardian of the minor's estate is appointed, to a person who at MetLife's option and in MetLife's opinion is providing financial support and maintenance for the minor. MetLife will pay $200 at your death and monthly installments of not more than $200. Payment to any person as shown above will release MetLife from all further liability for the amount paid.

Your Accelerated Benefit Option

If you are an active employee under age 60, and you are diagnosed by a physician as having a terminal illness, you may request that MetLife pay up to 80 percent of your life insurance prior to your death (this is a one-time request). The remaining benefit will be paid to your beneficiary upon your death. A terminal illness means that you have a life expectancy of 12 months or less. MetLife may require proof that you are terminally ill before benefits are paid.

Method of Payment

Beneficiaries with proceeds of $5,000 or more choose, when they fill out the claim form, whether they want a lump sum check, installment payments or an interest bearing Total Control Account (TCA). In the TCA program, MetLife, when the claim is approved, establishes a TCA Money Market Option for the beneficiary and sends the beneficiary a TCA Customer Agreement and other materials, including a checkbook that gives the beneficiary access to his proceeds. When the TCA is established, it begins earning interest immediately. Once the TCA has been set up, the beneficiary may transfer some or all of the funds to guaranteed-interest certificates, which lock in competitive interest rates for periods of from six months to seven years; or annuity options, which can provide a guaranteed income for life. The beneficiary can draw a draft on the TCA for the entire amount at any time, by writing one of the checks. There is no charge for checks, there are no transaction fees or monthly fees, and there are no penalties for withdrawing all or part of the money.

All methods are paid within the same time frame. There is no timing advantage to choosing one settlement option over another. A beneficiary who receives proceeds of less than $5,000 or who lives in a foreign country will generally receive a lump sum check, unless installment payments are chosen.

How to Change Your Beneficiary or Method of Payment

You can change your beneficiary at any time (unless you have given up that right). You may make the change online through MyBenefits or by notifying your benefits office and completing an NOE. When processed, the change will be effective on the date the request is signed. However, the change will not apply to any payments or other action taken before the request was processed. **Note:** Under no circumstances may a beneficiary be changed by a Power of Attorney.

Assignment

MetLife is not responsible for the validity or tax consequences of any assignment. No assignment will be binding on MetLife until MetLife records and acknowledges it. Collateral assignments are not permitted.

Suicide Provision

No Optional Life, Dependent Life-Spouse or Dependent Life-Child benefit will be payable if death results from suicide, whether the covered person is sane or insane, within two years of the effective date. If suicide occurs within two years of a coverage increase, the death benefit payable is limited to the amount of coverage in force prior to the increase.

Will Preparation and Estate Resolution Services Available Through MetLife

MetLife offers a Will Preparation Service to employees covered under Optional Life and to their spouses and an Estate Resolution Service to the estate representative and beneficiaries of employees covered under Optional Life. There is no charge for these services.

- A subscriber and/or his spouse may meet with a local attorney who is part of the Hyatt Legal Plans network. The attorney may prepare or update a will, even a complex will, for each of them. A subscriber or spouse who uses an attorney who is not part of the network will be reimbursed according to a fee schedule.
- Through MetLife Estate Resolution Services℠, a local attorney who is part of the Hyatt Legal Plans network will help the estate representative with the paperwork associated with distribution of assets after

a death. This includes preparing documents and appearing in court to help transfer assets; transferring non-probate assets, such as joint bank accounts; and assisting with tax preparation. Beneficiaries may receive advice about the employee's estate in person or over the phone.

Please note: These services are available to retirees who continue their Optional Life as term insurance through MetLife but not to those who convert their insurance to a whole life policy.

Contact Hyatt Legal Plans at 800-821-6400 for more information. **You should tell Hyatt you are covered under the State of South Carolina or Group Number 143046.**

Your Accidental Death and Dismemberment Benefits

(This provision does not apply to retirees.)

Schedule of Accidental Losses and Benefits

In addition to any life insurance benefit, MetLife will pay a benefit according to the schedule below if:

1. You suffer accidental bodily injury while your insurance is in force;
2. A loss results directly from such injury, independent of all other causes; and
3. Such a loss occurs within 365 days after the date of the accident causing the injury.

Loss of a hand or foot, means actual and permanent severance from the body at or above the wrist or ankle joint. Loss of sight, speech or hearing, means entire and irrecoverable loss. Loss of both a thumb and index finger of same hand, means actual and permanent severance from the body at or above the metacarpophalangeal joints.

Description of Loss	Benefit
Life	Maximum Benefit
Both Hands or Both Feet or Sight of Both Eyes	Maximum Benefit
One Hand and One Foot	Maximum Benefit
Speech, and Hearing in Both Ears	Maximum Benefit
Either Hand or Foot and Sight of One Eye	Maximum Benefit
Movement of Both Upper and Lower Limbs (Quadriplegia)	Maximum Benefit
Movement of Both Lower Limbs (Paraplegia)	Three-quarters of Maximum Benefit
Movement of Three Limbs (Triplegia)	Three-quarters of Maximum Benefit
Movement of the Upper and Lower Limbs of One Side of the Body (Hemiplegia)	One-half of Maximum Benefit
Either Hand or Foot	One-half of Maximum Benefit
Sight of One Eye	One-half of Maximum Benefit
Speech, or Hearing in Both Ears	One-half of Maximum Benefit
Movement of One Limb (Uniplegia)	One-quarter of Maximum Benefit
Thumb and Index Finger of Same Hand	One-quarter of Maximum Benefit

The Maximum Benefit is equal to your amount of Life Insurance.

What Is Not Covered?

MetLife will not pay **accidental death or dismemberment benefits** for a loss that results from:

- Sickness or any other cause that is not considered accidental
- Intentionally self-inflicted injury
- Suicide or attempted suicide, whether sane or insane

- War or act of war, whether declared or not
- Injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority
- Injury sustained while committing or attempting to commit a felony
- Injury sustained while taking drugs, including, but not limited to, sedatives, narcotics, barbiturates, amphetamines or hallucinogens, unless prescribed by, or administered by, a physician, or
- Injury sustained while intoxicated. *Intoxicated* means the blood alcohol content; the results of other means of testing blood alcohol level; or the results of other means of testing other substances; that meet or exceed the legal presumption of intoxication or under the influence, under the law of the state where the accident occurred.

Other Benefits

Seat Belt and Air Bag Rider

If you or your spouse sustain an injury which results in a loss payable under the Accidental Death and Dismemberment Benefit, MetLife will pay an additional Seat Belt and Air Bag benefit if the injury occurred while the injured person was a passenger riding in, or the licensed operator of, a properly registered motor vehicle and was wearing a seat belt at the time of the accident as verified on the police accident report. This benefit will be paid after MetLife receives proof of loss in accordance with the proof of loss provision and according to the general provisions of the policy. If a Seat Belt benefit is payable, MetLife will also pay an Air Bag benefit if the injured person was positioned in a seat equipped with a factory-installed air bag and properly strapped in the seat belt when the air bag inflated.

The Seat Belt benefit is an additional 25 percent of your accidental death benefit. As an example, if your amount of life insurance is $20,000 and you die in an accident, an additional $20,000 accidental death benefit will be payable (according to the Accidental Death provision explained above). The Seat Belt rider increases this accidental death benefit by 25 percent, or $5,000. The total accidental death benefit will then be $25,000, which means the entire death benefit will be $45,000. The Air Bag benefit is an additional 5 percent, or $5,000, whichever is less, of your accidental death benefit. As an example, if your amount of life insurance is $20,000 and you die in an accident, an additional $20,000 accidental death benefit will be payable (according to the Accidental Death provision explained above). The Seat Belt rider increases the accidental death benefit by $5,000, and the Air Bag rider increases the accidental death benefit by $1,000 (5 percent of $20,000 = $1,000), which means the entire death benefit will be $46,000.

This rider will not apply to the driver who caused the accident if he was under the influence of drugs or alcohol, or if the death was the result of a sickness.

Day Care Benefit

A day care benefit will be paid to each dependent who is younger than age 7 (at the time of the insured's death) and who is enrolled in a day care program. For each dependent who qualifies, payments will be issued quarterly for no more than two years. The benefit is five percent of the face value of the policy, or $10,000 (whichever is less) per year.

Education Benefit

An education benefit is paid for each dependent who qualifies as a student. A qualified dependent must be either a post-high school student who attends a school for higher learning on a full-time basis at the time of the insured's death or in the 12th grade and will become a full-time post-high school student in a school for higher learning within 365 days after the insured's death. Payments will be issued quarterly (four payments for each 12-month period, with a maximum of 16 payments). The qualified dependent must be enrolled continuously for four consecutive academic years to receive the maximum 16 quarterly payments. The benefit is five percent of the face value of the policy, or $5,000 (whichever is less) per year.

Felonious Assault Benefit

A felonious assault benefit is paid if the employee is injured in a felonious assault and the injury results in a loss for which benefits are payable under the Accidental Death and Dismemberment (AD&D) benefit. The benefit is the least of one times the annual earnings, $25,000, or the AD&D maximum.

Repatriation Benefit

MetLife will pay a Repatriation Benefit if you die in a way that would be covered under the Accidental Death and Dismemberment Benefit and if the death occurs more than 100 miles from your principal residence.

The Repatriation Benefit will be the least of:

1. The actual expenses incurred for:
   - Preparation of the body for burial or cremation; and
   - Transportation of the body to the place of burial or cremation;
2. The amounts resulting from multiplying the amount of your Maximum Benefit by the Repatriation Benefit percentage (5 percent) or
3. The maximum amount for this benefit ($5,000).

Claims

To pay benefits, MetLife must be given a written proof of loss. This means a claim must be filed as described below.

How to File A Claim

First, a claim form should be requested from your benefits office. This should be done within 30 days after the loss occurs or as soon as reasonably possible. Next, the claim form should be completed and signed. If a physician must complete part of the claim form, he must also sign that part.

Finally, the claim form and an original death certificate with a raised seal or a red seal (if filing a death claim) should be returned to the employee's benefits office.

The claim form should be filed within 90 days after the loss occurs or as soon as reasonably possible. Claims must be filed no later than 15 months after the loss occurs, unless the person filing the claim is not legally capable of doing so.

Retired employees: For questions about coverage, conversion, etc., call Life Recordkeeping Customer Service at 866-492-6983. For questions about claims, call the Life Claim Department Customer Service at 800-638-6420.

How Claims Are Paid

Benefits are paid as soon as MetLife receives acceptable proof of loss. Benefits for loss of life are paid as described on pages 123-124 of this section. Benefits other than loss of life will be paid directly to you, except that benefits unpaid at your death may be paid, at MetLife's option, to your beneficiary or to your estate.

Examinations and Autopsies

MetLife sometimes requires that a person filing a claim for the Accelerated Benefit Option be examined by a physician of MetLife's choice. MetLife will not require more than a reasonable number of examinations. Required examinations will be paid for by MetLife. Where it is not prohibited by law, MetLife may require an autopsy. A required autopsy will be paid for by MetLife.

Extension of Benefits

An extension of benefits is provided according to the requirements below. MetLife is not required by contract to provide these benefits unless you meet these requirements.

Leave of Absence

If you are on leave of absence approved by your employer, you can continue your group Optional Life Insurance for up to 12 months from the first of the month after the last day worked, as long as you pay the required premiums. If you become totally disabled, apply for a conversion policy or if you die, MetLife will require written proof of your leave of absence approval.

Military Leave of Absence

If you enter active military service and are granted a military leave of absence in writing, your coverage (including Dependent Life coverage) may be continued for up to 12 months from the first of the month after the last day worked, as long as you pay the required premiums. If the leave ends before the agreed-upon date, this continuation will end immediately. If you return from active military duty after being discharged and you qualify to return to work under applicable federal or state law, you may be eligible for the coverage you had before the leave of absence began, provided you are rehired by the same employer and request reinstatement within 31 days of returning to work.

Disability

If you become totally disabled, your life insurance can be continued for up to 12 months from your last day worked provided:

- Your total disability began while you were covered by this group Optional Life Insurance Plan;
- Your total disability began before you reached age 69;
- You continue to pay the premiums and
- The group Optional Life Insurance policy does not end.

If, at the end of 12 months, you have not returned to work as a permanent, full-time employee, you will be eligible to continue coverage through conversion (see below). However, if you are eligible for service retirement or approved for disability benefits, you may be eligible to continue your Optional Life Insurance under continuation (portability) until age 75. **MetLife must receive your Continuation of Group Life Continuation Coverage form within 31 days of termination of your active employee coverage.**

A total disability is a disability that prevents you from engaging in any occupation or employment for which you are reasonably qualified by education or training. MetLife will also consider the following injuries a total disability:

- Loss of sight in both eyes
- Loss of both hands
- Loss of both feet
- Loss of one hand and one foot.

Loss of a hand or foot means the severance at or above the wrist or ankle joint.

If the group Optional Life Insurance policy ends while you are continuing your benefits because of total disability, your coverage will end the earlier of:

- The date total disability ends or
- The first of the month following the end of the 12-month continuation period.

When Your Coverage Ends

Termination of Coverage

Your insurance will end at midnight on the earliest of:

- The last day of the month you terminate your employment
- The last day of the month you go on unapproved leave of absence
- The last day of the month you enter a class of employees not eligible for coverage (for example, a change from full-time to part-time status)
- The date EIP's policy ends
- The last day of the month you do not pay the required premium for that month, or

If you are a retiree:

- January 1 after the day you become age 70, if you continued coverage and retired before January 1, 1999; January 1 after the day you become age 75, if you continue coverage and retired January 1, 1999, and later.

Claims incurred before the date insurance ends will not be affected by coverage termination.

Conversion

If your life insurance ends because your employment or eligibility for coverage ends, you may apply for an individual *whole life* insurance policy without providing medical evidence of good health. This is called a conversion policy. To apply for an individual conversion policy, contact your benefits administrator. Your BA will complete the Notice of Group Life Insurance Conversion Privilege form and fax it to MetLife. A MetLife representative will contact you and discuss your options for converting the coverage and the premiums.

This form must be received by MetLife within 31 days of the date your group Optional Life Insurance coverage ends. When your application is approved, your individual policy will be issued on the 32nd day after your group coverage ends. When applying for coverage, keep these rules in mind:

ATTENTION RETIREES:
If you retired on or after January 1, 2001, you may continue your coverage in $10,000 increments, up to your active coverage level, until age 75. See pages 190-191 of the Retirement/Disability Retirement chapter for more information.

1. You may apply for an amount of life insurance that is not more than the amount of life insurance you had under your terminated group Optional Life Insurance.
2. Your new premium for the conversion policy will be set at MetLife's standard rate for the amount of coverage that you wish to convert and your age.

Note: *Whole life* is a permanent form of life insurance.

If the Group Policy is Terminated

If your group Optional Life Insurance ends because of termination by the state of the group Optional Life policy or termination of a class, and you have been insured under the policy at least five years, you may apply for a conversion policy within 31 days of the event. However, your converted life insurance amount may not exceed the lesser of $2,000 or the amount of your terminated group Optional Life Insurance, less the amount of any other group insurance for which you become eligible within 31 days of the termination. If you are issued a conversion policy and you again become eligible for group Optional Life Insurance with EIP, your group coverage will become effective only if you terminate the conversion policy.

Death Benefit During Conversion Period

If you die within the 31-day continuation or conversion period, MetLife will pay the amount of life insurance you were entitled to continue or convert. Proof of your death (a certified death certificate with a raised seal or a red seal) must be accepted by MetLife for this benefit to be paid.

Dependent Life Insurance Program

Enrollment and Eligibility

Who is Eligible?

All Optional Life and Dependent Life policies are subject to the Deferred Effective Date provision. See page 120 and page 132.

You may enroll your eligible dependents in Dependent Life Insurance, a term life insurance program, even if you do not have Optional Life coverage or other state group benefits. Your eligible dependents include:

- Your lawful spouse. If your spouse is eligible for coverage as an employee of a participating employer, you cannot cover him as a dependent.
- Your children, who must be:

  1. Natural children, legally adopted children, children placed for adoption (from the date of placement with the adopting parents until the legal adoption), stepchildren or children for whom you have legal guardianship, provided the child lives with you and is supported by you
  2. Unmarried
  3. Older than 14 days but younger than age 19, or 19 years old but younger than age 25, who attend school on a full-time basis (as defined by the institution) as their principal activity and are primarily dependent upon you for financial support. A child cannot be employed on a full-time basis.

Insurance eligibility changes made by the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, do not apply to Dependent Life-Child insurance. When you file a claim for a dependent child, age 19-24, you will be required to show the child was a full-time student at the time of enrollment and at the time of the claim. For information about how to file a claim for a dependent child, age 19-24, see page 133.

Dependent children who are incapable of self-sustaining employment due to mental retardation, mental illness or physical handicap are not subject to the above age limitations. Information about covering an incapacitated child is on page 11. Please also see your benefits administrator for more information.

EIP may conduct an audit of the eligibility of an insured dependent. If the dependent is found to be ineligible, no benefits will be paid.

If both husband and wife are state employees, only one can carry dependent coverage for eligible dependent children, and the spouses cannot cover each other.

Excluded Dependents

Any dependent who is eligible as an employee for Optional Life Insurance coverage, or who is in full-time military service, will not be considered a dependent.

A former spouse cannot be covered under Dependent Life, even with a court order.

Dependent Life – Spouse, Child Monthly Premiums

Optional Life premiums are determined by the subscriber's age on the preceding December 31 and the amount of insurance selected. Premiums for Dependent Life-Spouse coverage are also determined by the subscriber's age. For the premiums, see pages 231-233.

The premium for Dependent Life-Child is $1.24 for $15,000 coverage, regardless of the number of children covered.

How to Enroll

You can enroll in Dependent Life Insurance without having to provide medical evidence of good health within 31 days of the date you are hired. You must complete a Notice of Election (NOE) form and return it to your benefits office. You must list each dependent you wish to cover on the NOE. If a dependent is not listed on the NOE, he is not covered.

Coverage is effective on the first day of the month coinciding with or the first of the month following your date of employment.

Adding Your New Spouse

If you wish to add a spouse because you marry, you can add coverage of $10,000 or $20,000 for your new spouse without providing medical evidence of good health by completing an NOE within 31 days of the date of marriage. Coverage becomes effective the first of the month after you complete and file the NOE. You cannot cover your spouse as a dependent if your spouse is or becomes an employee of an employer that participates in the plan. If you divorce, you must drop your spouse from your coverage by completing an NOE within 31 days of the date of divorce. You can continue to cover your children if they meet the requirements on page 130.

Loss of Coverage

If your spouse is employed by an employer that participates in this plan and his employment ends, you can enroll your spouse in Dependent Life coverage up to $20,000 within 31 days of his termination without having to provide medical evidence of good health. If your spouse terminates active employment because of a disability, your spouse can be added to your Dependent Life Insurance only within 31 days of the date his Optional Life coverage as an active employee ends. If your spouse loses life insurance through an employer that does not participate in EIP, he can enroll with medical evidence of good health.

Adding Children

Eligible children may be added throughout the year, without providing medical evidence of good health, by completing an NOE. Coverage will be effective the first of the month after you complete and file the NOE. However, for a newborn, coverage will be effective the first of the month after you complete and file the NOE or the child is 15 days old, whichever is later. Children must be listed on your NOE to be covered. You must list each child on the NOE, even if you have Dependent Life Insurance coverage when you gain a new child. **All effective dates of coverage are subject to the Deferred Effective Date provision (see page 132).**

Late Entry

If you do not enroll within 31 days of the date you begin employment or when you acquire an eligible dependent, you can enroll your spouse throughout the year as long as you provide medical evidence of good health and it is approved by MetLife. To provide medical evidence of good health, you must complete a Statement of Health form. Coverage will be effective on the first day of the month coinciding with or the first of the month following approval provided the employee is actively at work. **All effective dates of coverage are subject to the Deferred Effective Date provision (see page 132).**

What is the Deferred Effective Date for Dependents?

If a dependent, other than a newborn, is confined in a hospital or elsewhere* because of a physical or mental condition on the date insurance would otherwise have become effective, the effective date of insurance will be deferred until the dependent is discharged from the hospital or no longer confined and has engaged in substantially all the normal activities of a healthy person of the same age for a period of at least 15 days in a row.

**"Confined elsewhere" means the individual is unable to perform, unaided, the normal functions of daily living, or leave home or another place of residence without assistance.*

Dependent Life Benefits

Dependent Life-Spouse coverage and Dependent Life-Child coverage are separate programs for which a subscriber pays separate premiums.

Dependent Life-Spouse Coverage

If you are currently enrolled in Optional Life, you may cover your spouse in increments of $10,000 for up to 50 percent of your Optional Life coverage or $100,000, whichever is less. However, an employee who is enrolled for $10,000, $20,000 or $30,000 can enroll his spouse for $10,000 or $20,000. Medical evidence of good health is required for late entry (see page 131) and for coverage amounts greater than $20,000. If you are not enrolled in Optional Life, you may cover your spouse for $10,000 or $20,000.

Premiums for Dependent Life-Spouse coverage are the same as the Optional Life premiums, which are based on the **employee's** age. Your spouse's coverage will be reduced at ages 70, 75 and 80 based on the employee's age. See the rate charts beginning on page 231. Premium payments are paid entirely by you, with no contribution from the state, and are payable through payroll deduction.

Spouses enrolled in Dependent Life are covered for Accidental Death and Dismemberment benefits. They also receive the Seat Belt Benefit with the Air Bag rider, the Day Care Benefit, the Education Benefit and Repatriation Benefit (see pages 126-127).

Dependent Life-Child Coverage

You can cover your eligible dependent children. For information, see page 130. The benefit is $15,000, and it includes repatriation benefits. The monthly premium for Dependent Life-Child coverage is $1.24, regardless of the number of children covered. Premiums are paid entirely by you, with no contribution from the state, and are payable through payroll deduction.

Payment of Claims

When MetLife receives acceptable proof of a covered dependent's death, the amount of life insurance will be paid based on the coverage you selected.

MetLife will pay the Life Insurance Benefit at your dependent's death to you, if you are living. Otherwise, it will be paid, at MetLife's option, to your surviving spouse or the executor or administrator of your estate.

How to File Claims

To pay benefits, MetLife must be given written proof of loss. This means a claim must be filed as described below.

First, a claim form should be requested from your benefits office. This should be done within 30 days after

the loss occurs or as soon as reasonably possible. Next, the claim form should be completed and signed. If a physician must complete part of the claim form, he must also sign that part.

To file a claim under Dependent Life-Child for a child age 19-24, a subscriber must obtain a statement on letterhead from the educational institution the child was attending that verifies he was a full-time student and gives his dates of enrollment. The statement should be given to the subscriber's BA, who will send it to MetLife with the claim form.

To file a claim for an incapacitated child, the subscriber must give certification of incapacitation to his BA, who will send it to MetLife with the claim form.

The claim form and an original copy of the death certificate with a raised seal or a red seal should be returned to the employee's benefits office. The claim form should be filed within 90 days after the loss occurs or as soon as reasonably possible. Claims must be filed no later than 15 months after the loss occurs, unless the person filing the claim is not legally capable of doing so.

For retiree dependent coverage, claims should be filed with MetLife. For information and forms, contact MetLife at 800-638-6420, prompt 2.

When Claims Are Paid

Benefits are paid as soon as MetLife receives acceptable proof of loss.

Autopsies

Where it is not prohibited by law, MetLife may require an autopsy. A required autopsy will be paid for by MetLife.

When Dependent Life Insurance Coverage Ends

Termination of Coverage

Your dependent's coverage will terminate at midnight on the earliest of:

- The day EIP's policy ends
- The day you, the employee, are no longer eligible to purchase the Dependent Life Insurance Plan
- The last day of the month in which the dependent no longer meets the definition of a dependent
- The day any premiums for Dependent Life Insurance coverage are due and unpaid for a period of 31 days.

Claims incurred before the date insurance ends will not be affected by coverage termination.

If you are called up for active duty military service and your spouse has Dependent Life coverage, he may continue his coverage for 12 months and then convert it. See page 128 for more information.

Conversion

If your dependent's coverage terminates because of one of the reasons listed above, coverage may be converted to an individual *whole life* insurance policy. Contact your benefits administrator, who will complete a Notice of Group Life Insurance Conversion Privilege form and fax it to MetLife. The form must be received by MetLife **within 31 days of the date insurance under this plan is terminated.** A MetLife representative will contact your dependent to discuss his options, including premiums for individual life insurance based on the dependent's age and class of risk and a billing fee.

When an employee dies, Dependent Life-Spouse and/or Dependent Life-Child coverage may be converted to an individual policy. This policy will:

- Be issued without medical evidence of good health
- Be on one of MetLife's non-term policy forms
- Be for no more than the amount for which the dependent was last insured under this Dependent Life Insurance Plan
- Contain no disability or supplementary benefits
- Be effective on the 32nd day after the group life insurance on the dependent's life terminates.

Note: *Whole life* is a permanent form of life insurance.

Policy Termination

If you have had this Dependent Life Insurance Plan for at least five years, and your dependent's insurance terminates because MetLife or EIP terminates the Dependent Life Insurance Plan or amends the plan so your dependent is not eligible, your dependent can convert coverage to an individual whole life insurance policy subject to:

- The same conditions and limitations that apply to an insured person whose employment terminates
- A limit of the least of:
  1. The amount for which the dependent was last insured under this benefit, reduced by any amount for which he is eligible under any other group life insurance policy within 31 days of the termination of insurance or
  2. $2,000.

Such a policy will be effective on the 32nd day after the group life insurance terminates. Any individual life insurance policy issued under this conversion privilege is in lieu of all other benefits provided by this policy. If your dependent dies during the 31-day conversion period, MetLife will, when provided with due proof of loss, pay the amount of life insurance the dependent was entitled to convert.

Long Term Disability

Long Term Disability

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Basic Long Term Disability

Introduction

The Basic Long Term Disability (BLTD) Plan, administered by Standard Insurance Company (The Standard), is an employer-funded disability plan provided by the state. It helps protect a portion of your income if you become disabled. This benefit is provided at no cost to you.

If you have questions or need more information, please contact The Standard at 800-628-9696 or on the Web at www.standard.com.

Eligibility

You are eligible for BLTD if you are covered under a health plan offered through the Employee Insurance Program (EIP) and are an active, permanent full-time employee as defined by the plan or a full-time academic employee and you: are employed by a department, agency, board, commission or institution of the state; a public school district; a county government (including county council members); or another group participating in the state's insurance program. BLTD is provided at no cost to you.

Members of the General Assembly and judges in the state courts are also eligible for coverage. BLTD is provided at no cost to you.

You must be actively employed when the disability occurs.

If you become disabled, you may be eligible for benefits through the S.C. Retirement Systems. Call 803-737-6800 (Greater Columbia area) or 800-868-9002 (elsewhere in South Carolina) or visit www.retirement.sc.gov for more information.

Benefit Waiting Period

The *benefit waiting period* is the length of time you must be disabled before benefits are payable. No benefits are paid during this period. The BLTD plan has a 90-day benefit waiting period.

Certificate

The BLTD certificate is available through your benefits administrator and is on the EIP website, www.eip.sc.gov, under "Forms." The contract contains the controlling provisions of this insurance plan. Neither the certificate nor any other material can modify those provisions.

Claims

As soon as it appears you will be disabled for 90 days or more or your employer is modifying your duties due to a health condition, ask your benefits administrator for a claim form packet, which is on the EIP website. The packet contains these forms: Employee's Statement, Authorization to Obtain Psychotherapy Notes, Authorization to Obtain Information, Attending Physician's Statement and Employer's Statement. You are responsible for making sure these forms are completed and returned to The Standard. Your complete medical records should accompany the Attending Physician's Statement. You may fax the forms to 800-437-0961; original forms must follow. If you have questions, contact The Standard at 800-628-9696.

You should provide these completed claim forms to The Standard within 90 days of the end of the benefit waiting period. If you cannot meet this deadline, you must submit these forms as soon as reasonably possible, but no later than one year after that 90-day period. If you do not provide these forms within this time, barring a court's determination of legal incapacity, The Standard may deny your claim.

Active Work Requirement

If physical disease, mental disorder, injury or pregnancy prevent you from working the day before the scheduled effective date of your coverage, your coverage will not become effective until the day after you are actively at work for one full day.

Pre-existing Conditions

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 your BLTD coverage became effective. No benefits will be paid for a disability caused or contributed to by a pre-existing condition unless on the date you become disabled:

- You have been continuously covered under the plan for at least 12 months (*Exclusion Period*) or
- You have not consulted a physician, received medical treatment or services or taken prescribed drugs during any 12 consecutive months between your date of disability and six months before the date your BLTD coverage became effective (*Treatment Free Period*).

Exclusions and Limitations

- Disabilities resulting from war or any act of war are not covered.
- Intentional self-inflicted injuries are not covered.
- No BLTD benefits are payable when you are not under the ongoing care of a physician.
- No BLTD benefits are payable for any period when you are not participating, in good faith, in a course of medical treatment, vocational training or education approved by The Standard, unless your disability prevents you from participating.
- No BLTD benefits are payable for any period of disability when you are confined for any reason in a penal or correctional institution.
- **No BLTD benefits are payable after you have been disabled for 24 months, excluding the benefit waiting period:**
    - During your entire lifetime for a disability caused, or contributed to, by a mental disorder, unless you are continuously confined to a hospital solely because of a mental disorder at the end of the 24 months.
    - During your entire lifetime for a disability caused, or contributed to, by your use of alcohol, alcoholism, use of any illicit drug, including hallucinogens, or drug addiction.
    - During your entire lifetime for a disability caused, or contributed to, by chronic pain, musculoskeletal or connective tissue conditions.
    - During your entire lifetime for a disability caused, or contributed to, by chronic fatigue or related conditions.
    - During your entire lifetime for a disability caused, or contributed to, by chemical and environmental sensitivities.

- During the first 24 months of disability, after the 90-day benefit waiting period, no BLTD benefits will be paid for any period of disability when you are able to work in your **own** occupation and you are able to earn at least 20 percent of your predisability earnings, adjusted for inflation, but you choose not to work. Thereafter, no BLTD benefits will be paid for any period of disability when you are able to work in **any** occupation and able to earn at least 20 percent of your predisability earnings, adjusted for inflation, but choose not to work.
- While living outside the United States or Canada, payment of LTD benefits is limited to 12 months for each period of continuous disability.

BLTD Plan Benefits Summary

- **Benefit waiting period:** 90 days
- **Monthly BLTD benefit* percentage:** 62.5 percent of your predisability earnings, reduced by deductible income
- **Maximum benefit:** $800 per month
- **Maximum benefit period:** To age 65 if you become disabled before age 62. If you become disabled at age 62 or older, the maximum benefit period is based on your age at the time of disability. The maximum benefit period for age 69 and older is one year.

**BLTD benefits are subject to federal and state income taxes. Check with your accountant or tax advisor regarding your tax liability.*

Predisability Earnings

Predisability earnings are the monthly earnings, including merit and longevity increases, from your covered employer as of the January 1 preceding your last full day of active work, or on the date you became a member if you were not a member on January 1. It does not include your bonuses, commissions, overtime or incentive pay. If you are a teacher, it does not include your compensation for summer school, but it does include compensation earned during regular summer sessions by university staff.

When Are You Considered Disabled?

You are considered disabled and eligible for benefits if you cannot fulfill the requirements of your occupation due to a covered injury, physical disease, mental disorder or pregnancy. You also will need to satisfy the benefit waiting period and meet one of the following definitions of disability during the period to which it applies.

Definition One: *Own Occupation* Disability—You are unable to perform, with reasonable continuity, the *material duties*[1] of your *own occupation* during the benefit waiting period and the first 24 months of disability.

"Own Occupation" means any employment, business, trade, profession, calling or vocation that involves *material duties*[1] of the same general character as your regular and ordinary employment with the employer. Your own occupation is not limited to your job with your employer, nor is your own occupation limited to when your job is available.

Definition Two: *Any Occupation* Disability—You are unable to perform, with reasonable continuity, the *material duties*[1] of *any occupation*.

"Any Occupation" means any occupation or employment you are able to perform, due to education, training or experience, which is available at one or more locations in the national economy and in which you can be expected to earn at least 65 percent of your predisability earnings (adjusted for inflation) within 12 months following your return to work, regardless of whether you are working in that or any other occupation. The any occupation period begins at the end of the own occupation period and continues to the end of the maximum benefit period.

Definition Three: Partial Disability—

A) During the benefit waiting period and the *own occupation* period you are working while disabled but you are unable to earn more than 80 percent of your predisability earnings, adjusted for inflation, while working in your own occupation.

B) During the *any occupation* period you are working while disabled but you are unable to earn more than 65 percent of your predisability earnings, adjusted for inflation, while working in any occupation.

[1] *"Material duties" means the essential tasks, functions and operations, and the skills, abilities, knowledge, training and experience generally required by employers from those engaged in a particular occupation.*

Deductible Income

Your BLTD benefits will be reduced by your *deductible income* – income you receive, or you are eligible to receive – from other sources. **Deductible income includes: sick pay or other salary continuation (including sick-leave pool); primary Social Security benefits; Workers' Compensation; other group disability benefits (except SLTD benefits, which are described on page 144); maximum plan retirement benefits; etc. In addition, TERI funds, at the time you receive them, are deductible income back to the time you began receiving disability benefits.** For example, your BLTD benefit, before reduction by deductible income, is 62.5 percent of your covered pre-disability earnings, with a maximum monthly amount of $800. The benefit will then be reduced by the amount of any deductible income you receive or are eligible to receive. The total of the reduced benefit, plus the deductible income, will provide at least 62.5 percent of your covered predisability earnings, but no more than $800 a month.

You are required to meet deadlines for applying for all deductible income you are eligible to receive. Please note that the S.C. Retirement Systems requires you to file an application for disability benefits within 90 days of the date you leave your job.

When other benefits are awarded, they may include payments due to you while you were receiving BLTD benefits. If the award includes past benefits, or if you receive other income before notifying The Standard, your BLTD claim may be overpaid. This is because you received benefits from the plan and income from another source for the same period of time. You will be required to repay the plan for this overpayment.

When Benefits End

Your benefits end automatically on the earliest of these dates:

- The date you are no longer disabled
- The date your maximum benefit period ends (refer to "Exclusions and Limitations" on page 138
- The date benefits become payable under any other group long term disability insurance policy under which you became insured during a period of temporary recovery
- The date of your death.

If you are an employee of a local subdivision, your employer becomes responsible for your BLTD benefit payments if your employer stops participating in the state insurance program.

When BLTD Coverage Ends

Your coverage ends automatically on the earliest of:

- The date the plan ends
- The date you no longer meet the requirements noted in the "Eligibility" section of this chapter
- The date your health coverage as an active employee ends
- The date your employment ends.

Appeals

If Standard Insurance Company denies your claim for long term disability benefits, you can appeal the decision by writing to Standard Insurance Company, P.O. Box 2800, Portland, OR 97208, within 180 days of receipt of the denial letter. If the company upholds its decision after a review by its Administrative Review Unit, you may appeal that decision by writing to EIP within 90 days of the notice of denial. If the denial is upheld by the EIP Appeals Committee, you have 30 days to seek judicial review as provided by Sections 1-11-710 and 1-23-380 of the S.C. Code of Laws, as amended.

Supplemental Long Term Disability

Introduction

Many people think they will never become disabled. Consider these statistics:

- In 2006, disabling injuries occurred at an average rate of 2,990 an hour.[1]
- In 2005, 46.4 percent of disabling injuries occurred in and around the home, followed by 14.2 percent involving sports and recreation and 13.3 percent on highways and streets and in parking lots.[1]

Many people would not be able to meet their financial obligations if they became disabled and could not work for an extended period of time. EIP offers an optional disability insurance plan that provides additional protection for you and your family if your monthly gross income is more than $1,280 ($15,360 annually). This program, Supplemental Long Term Disability Insurance (SLTD), is insured by Standard Insurance Company (The Standard).

[1]*National Safety Council Injury Facts, 2008.*

What SLTD Insurance Provides

- Competitive group rates
- Survivors benefits for eligible dependents
- Coverage for injury, physical disease, mental disorder or pregnancy
- A return-to-work incentive
- SLTD conversion insurance
- A cost-of-living adjustment
- Lifetime Security Benefit.

Eligibility

You are eligible for SLTD insurance if you are an active, permanent full-time employee as defined under the plan, or a full-time academic employee, and you: are employed by a department, agency, board, commission or institution of the state; a public school district; a county government (including county council members); or another eligible employer approved by law and participating in the state insurance program; or are a member of the General Assembly or a judge in the state courts.

You are not eligible for this coverage if you are an employee of an employer that is covered under any other group long term disability plan that insures any portion of your predisability earnings (other than the BLTD Plan); if you are receiving retirement benefits from the S.C. Retirement Systems and you have waived active coverage under the State Health Plan or a health maintenance organization; if you are a temporary or seasonal employee; or if you are a full-time member of the armed forces of any country.

Enrollment

You can enroll in the SLTD program within 31 days of eligibility. You may choose from one of two benefit waiting periods. If, however, you do not enroll within 31 days after you first become eligible for SLTD, you must provide The Standard with medical evidence of good health and be approved to become insured. You may enroll with medical evidence of good health throughout the year.

Benefit Waiting Period

The Benefit Waiting Period is the length of time you must be disabled before benefits are payable. You may choose a 90-day or a 180-day benefit waiting period.

You may change from one benefit waiting period to the other at any time.

- To change from a **90-day to a 180-day** benefit waiting period, you must complete a Notice of Election (NOE) form and return it to your benefits administrator.
- To change from a **180-day to a 90-day** benefit waiting period, you must complete an NOE and provide medical evidence of good health, which The Standard will consider in determining whether to approve your application.

Certificate

The SLTD certificate is available through your benefits administrator and is on the EIP website, www.eip.sc.gov, under "Forms." Please read it carefully. The contract contains the controlling provisions of this insurance plan. Neither the certificate nor any other material can modify those provisions.

Physical Exam

If you fail to enroll within 31 days of your hire date, you must complete a medical history statement. The Standard may require you to undergo a physical examination and blood test at your own expense.

Claims

As soon as it appears you will be disabled for 90 days or more, ask your benefits administrator for a claim form packet. The packet is also on the EIP website, www.eip.sc.gov, under "Forms." It contains these forms: Employee's Statement; Authorization to Obtain Psychotherapy Notes; Authorization to Obtain Information; Attending Physician's Statement; and Employer's Statement. You are responsible for making sure these forms are completed and returned to The Standard. Your complete medical records should accompany the Attending Physician's Statement. If you have BLTD coverage, only one claim packet must be completed. The forms may be faxed to 800-437-0961; original forms must follow. If you have questions, contact The Standard at 800-628-9696.

You should provide these completed claim forms to The Standard within 90 days of the end of the benefit waiting period. If you cannot meet this deadline, you must submit the forms as soon as reasonably possible, but no later than one year after that 90-day period. If you do not provide the forms within this period, barring a court's determination of your legal incapacity, The Standard may deny your claim.

Salary Change

Your SLTD premium will be recalculated based on your age as of the preceding January 1. Any change in your predisability earnings after you become disabled will have no effect on the amount of your SLTD benefit.

Active Work Requirement

If physical disease, mental disorder, injury or pregnancy prevents you from working the day before the scheduled effective date of your insurance coverage, your coverage will not become effective until the day after you are actively at work for one full day.

Pre-existing Conditions

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 or medications during the six-month period before your SLTD coverage became effective. No benefits will be paid for a disability caused, or contributed to, by a pre-existing condition unless on the date you become disabled:

- You have been continuously covered under the plan for at least 12 months (*Exclusion Period*) or
- You have not consulted a physician, received medical treatment or services or taken prescribed drugs or

medications during any 12-consecutive-month period between your date of disability and six months before the date your SLTD insurance became effective (*Treatment Free Period*).

The Pre-existing Condition Exclusion also applies when you change from the plan with the 180-day benefit waiting period to the plan with the 90-day benefit waiting period. The Pre-existing Condition Period, Treatment Free Period and Exclusion Period for the new plan will be based on the effective date of your coverage under the 90-day plan. However, if benefits do not become payable under the 90-day plan because of the Pre-existing Condition Exclusion, your claim will be processed under the 180-day plan as if you had not changed plans.

Exclusions and Limitations

- Disabilities resulting from war or any act of war are not covered.
- Intentional self-inflicted injuries are not covered.
- No SLTD benefits are payable when you are not under the ongoing care of a physician.
- No SLTD benefits are payable for any period when you are not participating, in good faith, in a course of medical treatment, or vocational training, or education approved by The Standard, unless your disability prevents you from participating.
- No SLTD benefits are payable for any period of disability when you are confined for any reason in a penal or correctional institution.
- **No SLTD benefits are payable after you have been disabled for 24 months, excluding the benefit waiting period:**
    - During your entire lifetime for a disability caused or contributed to by a mental disorder, unless you are continuously confined to a hospital solely because of a mental disorder at the end of the 24 months.
    - During your entire lifetime for a disability caused or contributed to by your use of alcohol, alcoholism, use of any illicit drug, including hallucinogens, or drug addiction.
    - During your entire lifetime for a disability caused or contributed to by chronic pain, musculoskeletal or connective tissue conditions.
    - During your entire lifetime for a disability caused or contributed to by chronic fatigue or related conditions.
    - During your entire lifetime for a disability caused or contributed to by chemical and environmental sensitivities.

- During the first 24 months of disability, after the benefit waiting period, no SLTD benefits will be paid for any period of disability when you are able to work in your **own** occupation and you are able to earn at least 20 percent of your predisability earnings, adjusted for inflation, but you choose not to work. Thereafter, no SLTD benefits will be paid for any period of disability when you are able to work in any occupation and able to earn at least 20 percent of your predisability earnings, adjusted for inflation, but choose not to work.
- No SLTD benefits are payable for any period of disability when you are not also receiving disability benefits under the State of South Carolina Basic Long Term Disability plan. There are certain exceptions to this limitation. Please see your certificate of coverage for details.
- While living outside the United States or Canada, payment of LTD benefits is limited to 12 months for each period of continuous disability.

SLTD Plan Benefits Summary

Benefit waiting period: Plan one: 90 days
Plan two: 180 days

Maximum SLTD-covered predisability earnings: $12,307 per month

Monthly benefit[1] percentages: 65 percent of the first $12,307 of your monthly predisability earnings, reduced by deductible income

Minimum benefit: $100 per month

Maximum benefit: $8,000 per month

Cost-of-living adjustment: After 12 consecutive months of receiving LTD benefits, effective on April 1 of each year thereafter; based on the prior year's CPI-W (Consumer Price Index) up to 4 percent. This cost-of-living adjustment does not apply when you are receiving the minimum monthly benefit or a monthly benefit of $25,000 as a result of these adjustments.

Maximum benefit period: To age 65 if you become disabled before age 62. If you become disabled at age 62 or older, the maximum benefit period is based on your age at the time of disability. The maximum benefit period for age 69 and older is one year. In certain circumstances, benefits may continue after the maximum benefit period. See "Lifetime Security Benefit" on page 146 for more information.

Monthly premium[2] rate: Multiply the premium factor for your age and plan selection by your monthly earnings.

Your age as of the preceding January 1	Plan one	Plan two
Under age 31	.00050	.00039
31 through 40	.00069	.00053
41 through 50	.00138	.00105
51 through 60	.00277	.00213
61 through 65	.00333	.00256
66 or older	.00407	.00313

Example:
Mary is 38 years old, earns $3,000 per month and selected plan two. Her monthly premium is $3,000 x .00053=$1.60 per month. (The premium was rounded up $0.01 because it must be an even amount.)

John is 52 years old, earns $2,250 per month and selected plan one. John's monthly premium is $2,250 x .00277=$6.24 per month. (The premium was rounded up $0.01 because it must be an even amount.)

[1]*These benefits are not taxable provided you pay the premium on an after-tax basis.*
[2]*Premium must be an even amount (amount is rounded up to next even number).*

How Does SLTD Insurance Work?

SLTD insurance is designed to provide additional financial assistance if you become disabled. Your benefit will be based on a percentage of your predisability earnings. This program is customized for you. The SLTD plan benefits summary will provide more information about your plan, including:

- Your level of coverage
- How long benefits payments would continue if you remain disabled
- The maximum benefit amount
- Your choice of benefit waiting periods
- Your premium schedule.

You can apply for SLTD if you are:

- An active, permanent, full-time employee as defined by the plan or
- A full-time academic employee, and
- You receive compensation from:
    - A department, agency, board, commission or institution of the state
    - A public school district
    - A county government (including county council members) or
    - Another group participating in the state's insurance program.

Members of the General Assembly and judges in the state courts are also eligible. If your group offers other supplemental long term disability coverage, you must choose one or the other.

Predisability Earnings

Predisability earnings are the monthly earnings, including merit and longevity increases, from your covered employer as of the January 1 before your last full day of active work, or on the date you became a member if you were not a member on January 1. It does not include your bonuses, commissions, overtime pay or incentive pay. If you are a teacher, it does not include your compensation for summer school, but it does include compensation earned during regular summer sessions by university staff.

When Are You Considered Disabled?

You are considered disabled and eligible for benefits if you cannot work due to a covered injury, physical disease, mental disorder or pregnancy. You will also need to satisfy the benefit waiting period and meet one of these definitions of disability.

Definition One: *Own Occupation* Disability – You are unable to perform, with reasonable continuity, the *material duties*[1] of your *own occupatio*n during the benefit waiting period and the first 24 months SLTD benefits are payable.

"Own occupation" means any employment, business, trade, profession, calling or vocation that involves *material duties*[1] of the same general character as your regular and ordinary employment with the employer. Your "own occupation" is not limited to your job with your employer, nor is it limited to when your job is available.

Definition Two: *Any Occupation* Disability – You are unable to perform, with reasonable continuity, the *material duties*[1] of *any occupation*.

[1] *"Material duties" means the essential tasks, functions and operations, and the skills, abilities, knowledge, training and experience generally required by employers from those engaged in a particular occupation.*

"Any occupation" means any occupation or employment you are able to perform, due to education, training or experience, which is available at one or more locations in the national economy and in which you can be expected to earn at least 65 percent of your predisability earnings (adjusted for inflation) within 12 months following your return to work, regardless of whether you are working in that or any other occupation. The any occupation period begins at the end of the own occupation period and continues to the end of the maximum benefit period (see page 144).

Definition Three: Partial Disability —

A) During the during the benefit waiting period and the *own occupation* period, you are working while disabled but you are unable to earn more than 80 percent of your predisability earnings, adjusted for inflation, while working in your own occupation.

B) During the *any occupation* period, you are working while disabled but you are unable to earn more than 65 percent of your predisability earnings, adjusted for inflation, while working in any occupation.

Deductible Income

Your SLTD benefits will be reduced by your *deductible income* – income you receive, or you are eligible to receive – from other sources. **Deductible income includes: sick pay or other salary continuation (including sick leave pool), primary and dependent Social Security benefits, Workers' Compensation, BLTD benefits, other group disability benefits, maximum plan retirement benefits, etc. In addition, TERI funds, at the time you receive them, are deductible income back to the time you began receiving disability benefits.** For example, your SLTD benefit before reduction by deductible income is 65 percent of your covered predisability earnings. The benefit will then be reduced by the amount of any deductible income that you receive or are eligible to receive, so the total of the reduced SLTD benefit plus the deductible income will provide at least 65 percent of your covered predisability earnings. The guaranteed minimum SLTD benefit is $100, regardless of the amount of deductible income.

You are required to meet deadlines for applying for all deductible income you are eligible to receive. Please note that the S.C. Retirement Systems requires you to file an application for disability benefits within 90 days of the date you leave your job. When other benefits are awarded, they may include payments due to you while you were receiving LTD benefits. If the award includes past benefits, or if you receive other income before notifying The Standard, your SLTD claim may be overpaid. This is because you received benefits from your plan and income from another source for the same period of time. You will be required to repay the plan for this overpayment.

Lifetime Security Benefit

This coverage provides lifetime long term disability benefits if, on the last day of the regular maximum benefit period, the disabled person is unable to perform two or more activities of daily living and/or suffers from a severe cognitive impairment that is expected to last 90 days or more. The benefit will be equal to the benefit that was being paid on the last day of the regular long term disability period.

Conversion

When your insurance ends, you may buy SLTD conversion insurance if you meet all of these criteria:

1. Your insurance ends for a reason other than:
   a. Termination or amendment of the group policy
   b. Your failure to pay a required premium
   c. Your retirement.
2. You were insured under your employer's long term disability insurance plan for at least one year as of the date your insurance ended.
3. You are not disabled on the date your insurance ends.
4. You will not be eligible for long term disability insurance through another employer.

5. You are a citizen or resident of the United States or Canada.
6. You apply in writing and pay the first premium for SLTD conversion insurance within 31 days after your insurance ends.

If you have questions about converting your SLTD policy, call The Standard at 800-378-4668. You will need to know the State of South Carolina's group number, which is **621144**.

Death Benefits

If you die while SLTD benefits are payable,The Standard will pay a lump-sum benefit to your eligible survivor. This benefit will be equal to three months of your SLTD benefit, not reduced by deductible income. Eligible survivors include your surviving spouse; surviving, unmarried children younger than age 25; or any person providing care and support for any of them.

This benefit is not available to any eligible survivors if your SLTD benefits and claim have reached the Maximum Benefit Period before your death. Also, this benefit is not available if you have been approved for and/or are receiving the Lifetime Security Benefit.

When Benefits End

Your benefits end automatically on the earliest of:

- The date you are no longer disabled
- The date your Maximum Benefit Period ends, unless LTD benefits are continued by the Lifetime Security Benefit
- The date of your death
- The date benefits become payable under any other employer's group LTD policy.

When SLTD Coverage Ends

Your insurance ends automatically on the earliest of:

- The last day of the month for which you paid a premium
- The date the group policy ends
- The date you no longer meet the requirements noted in the "Eligibility" section of this chapter.

Appeals

If Standard Insurance Company denies your claim for long term disability benefits, you can appeal the decision by writing to Standard Insurance Company, P.O. Box 2800, Portland, OR 97208, within 180 days of the receipt of the denial letter. If the company upholds its decision, the claim will receive an independent review by The Standard's Administrative Review Unit.

Long Term Care

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Long Term Care Insurance

What is Long Term Care Insurance?

Why Do You Need It?

Long term care refers to a broad range of medical, personal and social services provided to people who are unable to care for themselves over an extended period of time. It usually involves severe cognitive impairment (severe loss or deterioration of intellectual capacity) or a need for help in performing everyday functions, such as toileting, bathing, eating and dressing. Long term care is not limited to care in a nursing home. Services are often provided in an assisted-living facility or at home by caregivers, such as home healthcare workers, nurses or therapists, or in a community setting, such as an adult day care center.

By assisting in paying for these services, long term care insurance helps individuals stay independent as long as possible, makes it more likely they can choose where they receive assistance and helps preserve their assets.

For more information about Prudential Long Term Care Insurance, contact customer service at 877-214-6588 or go to the EIP website, click on "Links" and then select "Prudential" under "Long Term Care."

As you review this information you may wish to consider some facts about long term care in the United States, what long term care is and what the chances are that you will need it:

- You may be surprised to learn that 40 percent of long term care insurance benefit recipients are younger than age 65.[1]
- The younger you are when you first purchase long term care insurance, generally the lower your premium will be for the life of your plan, regardless of your age or health in later years.[2]
- More than 2 in 5 persons older than age 65 will require nursing home care at some time in their lives.[3]
- Nursing home care alone can cost, on a national average, $79,000 a year.[4]

With Prudential's Long Term Care[SM] Insurance plan, you select the amounts you would like to be reimbursed for daily nursing home and home- and community-based care. The benefits you receive are determined by your Daily Benefit Maximum option and your Lifetime Maximum option. Once you qualify for benefits, you must satisfy the one-time waiting period. Please review the details of your plan. You will also want to familiarize yourself with the features offered through Prudential's plan. They are explained in the Plan Details section, beginning on page 152.

[1] *Americans for Long-Term Care Security (ALTCS), "Did You Know," 2005, http://www.ltcweb.org/learn.html#did.*
[2] *Prudential reserves the right to change premium rates in the future, but only on a class basis.*
[3] *"Long Term Care Insurance: Who Really Needs It?," Journal of Financial Planning, Sept. 2004.*
[4] *Prudential Financial Long Term Care Cost Survey, 2010.*

Important Information About the Plan

Premiums

Your premium is based on your age when you enroll. If you enroll now, you will pay a lower premium than if you wait until you are older to enroll. This premium can change only if Prudential changes premiums on a rate-class basis for all members of an insured class. **Premium charts are on pages 234-235.**

Payment Method

Long Term Care Insurance premiums may not be paid through payroll or pension deduction under the

Employee Insurance Program. Employees, retirees and qualified family members can select a direct billing method, which provides a 2.83 percent discount for semi-annual payments and a 5.58 percent discount for annual payments. Quarterly direct billing is available upon request. You may also select the monthly Electronic Funds Transfer (EFT) option and have the premium withdrawn automatically from your checking or savings account.

Portability

You may keep this coverage, even if you change jobs or retire. Your coverage will remain in effect as long as you continue to pay your premiums on a timely basis and do not exhaust your benefits.

Qualifying For Benefits

To qualify for benefits, you must be confirmed as having a Chronic Illness or Disability. A *Chronic Illness or Disability* is an illness or disability certified by a Licensed Health Care Practitioner in which there is:

1. A loss of the ability to perform, without substantial assistance, at least two of the six Activities of Daily Living. This loss must be expected to continue for 90 days or more. *Activities of Daily Living* include bathing, continence, dressing, eating, toileting and transferring.
2. A severe cognitive impairment is one that requires you have substantial supervision to protect you from threats to your health or safety.

Once you are determined to be eligible for benefits and have satisfied the waiting period, benefits will be payable according to the plan of care developed for you by the Licensed Health Care Practitioner responsible for your care.

Access to Benefits

To begin the benefits process, call Prudential's Long Term Care Customer Service Center toll-free at 877-214-6588 before you incur charges for long term care services. You can arrange for your own assessment or Prudential can do it for you.

How Do I Enroll?

To enroll, go to Prudential's customized enrollment website. Click on the "Links" tab on the EIP website, www.eip.sc.gov and then go to "Long Term Care" and select "Prudential." Log in with the Group Name, **eipltc**, and Access Code, **carolina**.

Prudential's customer service representatives are there to help from 8 a.m. to 8 p.m. ET if you have any questions or would like for a paper enrollment kit to be shipped to you. Call Prudential at 877-214-6588.

Plan Details

Eligibility

Eligible participants include:

- All actively-at-work, full-time, permanent employees
- Persons who are related to an eligible employee in one of the following ways: spouses, parents, parents-in-law, grandparents, grandparents-in-law, siblings, adult children age 18 and older and their spouses
- Retirees and their spouses
- Surviving spouses.

Guaranteed Coverage

All actively-at-work, full-time, permanent employees who enroll 31 days from their date of hire will be guaranteed coverage without medical evidence of good health.

Medical Evidence of Good Health Requirements

Eligible applicants, other than those described under "Guaranteed Coverage," may enroll at any time but must provide medical evidence of good health. **Note:** Applicants age 72 and older will receive an in-person assessment to supplement the information provided on the enrollment form.

Coverage Amounts

Plans	Nursing Home Care & Assisted Living Daily Benefit Maximum[1]	Home & Community-Based Care Daily Benefit Maximum[1]	Lifetime Maximum[2]
Plan 1	$100	$ 50	$182,500
Plan 2	$150	$ 75	$273,750
Plan 3	$200	$100	$365,000
Plan 4	$250	$125	$456,250
Plan 5	$300	$150	$547,500
Plan 6	$350	$175	$638,750
Plan 7	$100	$100	$182,500
Plan 8	$150	$150	$273,750
Plan 9	$200	$200	$365,000
Plan 10	$250	$250	$456,250
Plan 11	$300	$300	$547,500
Plan 12	$350	$350	$638,750

[1]*Benefits are paid, up to the Daily Benefit Maximum.*
[2]*All benefits paid will be deducted from the Lifetime Maximum.*

For Plans 1-6, the Home & Community-Based Care Daily Benefit Maximum is 50 percent of the Nursing Home Care Daily Benefit Maximum. For Plans 7-12, the Home & Community-Based Care Daily Benefit Maximum is 100 percent of the Nursing Home Care Daily Benefit Maximum.

Base Plan Features

Alternate Plan of Care

This insurance plan takes into account the institutional and home- and community-based care settings that are now available. Prudential will consider a claim for benefits for care received in an alternate setting or for non-institutional services designed to help you remain independent in your home. Determination of eligibility for this benefit amount will be made on an individual basis at the sole discretion of Prudential.

Bed Reservation Benefit

Families may spend a great deal of time locating a suitable nursing home or assisted living/residential care facility, only to lose the bed because of a short absence due to a hospital stay. This benefit helps reserve your bed in a nursing home or assisted living/residential care facility for up to 21 days per calendar year, if you require a hospital stay.

Benefit Waiting/Elimination Period

Before benefits are payable, you must satisfy the 90-day Benefit Waiting/Elimination Period. The period is

counted in calendar days and begins on the date you are assessed (assuming you are determined to be eligible for benefits). You do NOT need to receive formal long term care services to satisfy the waiting period. This waiting period needs to be satisfied only once during your lifetime. **Note:** There is no waiting period for hospice care, independence support, caregiver training, information referral services or private care management.

Private Care Management

If you decide to use care management services other than Prudential Care Counselors, Prudential will reimburse you for eligible charges up to the benefit limit for private care management in a calendar year. That limit is 12 times the Daily Benefit Maximum.

Caregiver Training

If someone who will provide care for the insured requires caregiver training, there is a benefit equal to five times the Daily Benefit Maximum you selected, and no waiting period is required. In certain situations, caregiver training may be applied toward requirements for state licensure or certification. A licensed or state-certified caregiver may then be eligible for benefits under the Home & Community-Based Care benefit. For more information, contact Prudential at 877-214-6588.

Cash Alternative

This feature provides you with an option to address your long term care needs in any manner you choose. It provides a monthly fixed benefit in lieu of reimbursement for eligible charges for Home & Community-Based Care. The benefit is equal to 50 percent of the Daily Benefit Maximum for Home & Community-based Care. The Cash Alternative benefit will reduce the Lifetime Maximum Benefit and is subject to the Elimination Period.

Death Benefit

A portion of premiums an insured has already paid into the plan is returned if the insured dies. The refund of premiums is based on the insured's age at death and is decreased by any benefits paid under the plan. There is a 100 percent refund through age 64, reduced by 10 percent each year, starting at age 65.

Independence Support Benefit

Often a few modifications to your residence can mean the difference between going to a nursing home and remaining at home. This benefit allows you, when not in a nursing home, to receive benefits for expenses, such as home modifications or medical alert systems, to help you maintain your independence. You must meet Prudential's benefit eligibility criteria to be eligible. No waiting period is required. The benefit is limited to 50 times the elected Daily Benefit Maximum and is deducted from the Lifetime Maximum.

Information/Referral Services

Prudential is dedicated to helping provide you with as much freedom as possible in making long term care decisions. Information/Referral Services, advice and care counseling are provided by Prudential Care Counselors, who are available to you at any time, even if you have not been determined to be eligible to receive benefits. Prudential Care Counselors may be reached toll-free at 877-214-6588.

International Coverage Benefit

To meet the needs of diverse and geographically dispersed families, you can receive reimbursement for eligible charges up to 75 percent of the Daily Benefit Maximum for facility care, or 75 percent of the Home & Community-Based Care Daily Benefit Maximum for home care, for up to 365 days, for care received outside the U.S. International coverage will reduce the Lifetime Maximum and is subject to the waiting period. The exclusion for services and supplies outside the U.S. does not apply to the International Coverage Benefit.

Marital Discount

A married person who buys long term care insurance receives a 10 percent premium discount, regardless of whether the spouse is covered under the plan.

Periodic Inflation Protection

Inflation protection will be offered at least every three years to anyone who does not elect optional Automatic Inflation Protection. No medical evidence of good health is required unless you decline two consecutive inflation offerings. Coverage amounts are increased by at least 5 percent per year, compounded annually. Rates for this additional coverage are based on your age at the time the inflation offer is accepted.

Optional Automatic Compounded 5 Percent Inflation Protection

It is likely that you will not use your long term care insurance coverage for 10, 20 or even 30 years. For this reason, Prudential offers you the choice of inflation protection. This feature will help protect your benefits against inflation, regardless of changes in your health. If you elect this option, plan benefits will increase 5 percent per year, compounded annually. These increases occur without a premium increase if you elect Automatic Inflation Protection. However, your initial premium will be higher than it would be without this feature. If you do not elect this option, Prudential will offer you opportunities to increase your coverage over time, but the rates for the increase will be based on your age when the increase takes effect.

Respite Care

Most people would rather be taken care of by someone they know. This benefit provides relief for a family member who normally provides you with unpaid care. Prudential's plan pays for up to 21 days of respite care per calendar year, 100 days per lifetime. The benefits are paid up to the elected Daily Benefit Maximum, regardless of the type of services used, and will be deducted from the Lifetime Maximum. To receive this benefit, Prudential must be notified before you use services.

Restoration of Benefits

If, after submitting a claim, you return to normal activities (no activity of daily living limitations or cognitive impairment) for at least six consecutive months, your Lifetime Maximum will be restored to the level in effect before you made a claim.

Waiver of Premium

Once you meet the benefit eligibility criteria and satisfy the Benefit Waiting/Elimination Period, Prudential will waive your premium payments.

Points to Remember

Deferred Effective Date

If you are an employee, your coverage will be delayed if you are not actively at work on the day your insurance would otherwise become effective. If you are confined for medical care or treatment on the day the insurance is to be effective, your effective date will be delayed until the first day of the month after the date you are discharged and are no longer receiving such care.

Coordination of Benefits

Your benefits under this plan may be coordinated with other coverage that provides benefits for the same services covered by this insurance. Consult your insurance certificate for more information.

Exclusions

This plan is designed to provide coverage for the long term care you need when you need it. However, there are some circumstances in which benefits are limited or excluded under this plan. While state variations may apply to specific limitations and exclusions, generally, no benefits will be payable in any of these situations:

- **Work-connected Conditions Charge**
  A charge covered by a workers' compensation law, an occupational disease law or a similar law.

- **Government Plan Charge**
  A charge for a service or supply: (a) furnished by or for the United States government or any other government, unless payment of the charge is required by law; or (b) to the extent that the service or supply, or any benefit for the charge, is provided by any law or governmental plan under which the patient is, or could be, covered. This (b) does not apply to a state plan under Medicaid or to any law or plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program. When this (b) is applied to Medicare, the benefits provided by Medicare will be deemed to include any amount that would have been payable by Medicare in the absence of a deductible or coinsurance requirement under that program.

  In other words: Your long term care plan will not reimburse you for any services or supplies covered by Medicare or any other government program, unless required to do so by law.

- **Self-inflicted Injury or Suicide**
  Charges arising from intentionally self-inflicted injury or attempted suicide, while sane or suffering from inorganic-based insanity.

- **Services and Supplies Outside the United States**
  Charges for services or supplies outside the U.S., except as described in the International Coverage Benefit.

- **Treatment for Chronic Alcoholism or Chemical Dependency**
  Charges in connection with the treatment of chronic alcoholism or chemical dependency.

- **War, Felony, Riot or Insurrection**
  Charges for a condition due to war or any act of war while you are insured or due to the insured's participation in an act of felony, riot or insurrection. *War* means declared or undeclared war and includes resistance to armed aggression. *Riot* means a wild, violent, public disturbance of the peace.

Appeals

You have the right to appeal decisions made about your claims. The Explanation of Benefits will explain the procedure you should follow if you choose to appeal a claim decision. Prudential will send you a written acknowledgment of your appeal. If no additional information is required and the appeal is denied, the acknowledgment will include a detailed explanation of the reasons for the denial. If additional information is required, Prudential will explain what information is needed. Upon receipt and review of the additional information, Prudential will notify you in writing of the results of the review. If you still disagree with the decision, you can request in writing within 60 days of the decision that the matter be submitted to the Claim Appeal Committee. This committee includes, but is not limited to, clinical consultants, legal consultants and product management staff. After a thorough review, the committee will send you written notification of its decision.

MoneyPlu$

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MoneyPlu$ — Your Tax-favored Accounts Program

What is MoneyPlu$?

MoneyPlu$ offers tax-favored accounts – IRS-approved, tax-free benefits. If you are an active employee, these accounts save you money on eligible medical and dependent care costs by enabling you to pay these expenses with funds deducted from your salary before it is taxed.

For more information, see the *Tax-Favored Accounts Guide*, which is on EIP's website, www.eip.sc.gov.

MoneyPlu$ is governed by Sections 105, 125, 129 and 223 of the Internal Revenue Service code. Fringe Benefits Management Company, a Division of WageWorks, Inc., (FB-WW) is the program's third-party claims processor. Each account has an administrative charge, which is designed to be minimal compared to your tax savings.

Pretax Premiums

The Pretax Group Insurance Premium Feature allows you to pay premiums for the State Health Plan or an HMO (including the tobacco-use surcharge), the State Dental Plan, Dental Plus, State Vision Plan and Optional Life (for coverage up to $50,000) before taxes are taken from your paycheck.

Flexible Spending Accounts

Through MoneyPlu$ you can pay eligible medical and dependent care expenses with money you set aside before it is taxed. You authorize deposits to your MoneyPlu$ account every pay period. As you incur eligible expenses, you request tax-free withdrawals from your account to reimburse yourself. There are three Flexible Spending Accounts: a **Dependent Care Spending Account (DCSA)**, a **Medical Spending Account (MSA)** and a **limited-use Medical Spending Account**, which can accompany a Health Savings Account (HSA). If you incur dependent care and medical expenses, you can establish a DCSA and an MSA (or a limited-use MSA, if you contribute to an HSA).

Retirees Returning to Work

A retiree who returns to work in an insurance-eligible position under the active group is eligible for the Pretax Group Insurance Premium Feature, a Dependent Care Spending Account and a Medical Spending Account (MSA). However, he must have completed one year of continuous state-covered employment by January 1 after October enrollment to qualify for an MSA.

Health Savings Accounts

A Health Savings Account (HSA) is available to employees enrolled in the Savings Plan and can be used to pay health care expenses. Unlike money in a Medical Spending Account, the funds do not have to be spent in the year they are deposited. Money in the account accumulates tax free, so the funds can be used to pay qualified medical expenses in the future. An important advantage of an HSA is that you own it. If you leave your job, you can take the account with you and continue to use it for qualified medical expenses.

Would you like more information about the Savings Plan? Turn to page 44.

MoneyPlu$ Example

This is how paying eligible expenses with a pretax payroll deduction may increase your spendable income. The figures used are monthly and for a single person with two dependents.

	Without MoneyPlu$	With MoneyPlu$
Gross Monthly Pay	$2,500.00	$2,500.00
State Retirement	- 150.00	- 150.00
Pretax Payroll Deduction	- 0.00	- 614.40
Administrative Fees	- 0.00	
Pretax Group Insurance Premium Feature		.28
Dependent Care Spending Account		3.50
Medical Spending Account		3.50
Taxable Gross Income	$2,350.00	$1,728.32
Payroll Taxes (estimate)	- 696.78	- 513.50
Eligible Expenses[1]	- 614.40	- 0.00
Spendable Income	$1,038.82	$1,214.82

Increase in Spendable Income: $176 per month ($2,112 per year, rounded)

Note: "Spendable income" is your net pay, plus the reimbursement from your Medical Spending Account or Dependent Care Spending Account.

[1] In this illustration, these examples of monthly pretax payroll deductions and eligible, after-tax expenses were used:

Health Premium	$143.86
Dental Premium	$ 13.72
Dependent Care Expenses	$400.00
Out-of-pocket Medical Expenses	$ 56.82
Total	$614.40

Administrative Fees

Pretax Group Insurance Premium Feature	$0.28 per month[1]
Dependent Care Spending Account	$3.50 per month[1]
Medical Spending Account or limited-use MSA	$3.50 per month[1]
myFBMC Card®	$10 per year[2]
Health Savings Account	$1 per month[3] $10 per year or $1 per month (your choice)[4] 35 cents to process each check if you are reimbursed by check[5] No charge if you use your Visa® debit card

[1]This fee is deducted from your paycheck before taxes.
[2]The fee for this optional card will be deducted from your Medical Spending Account at the beginning of the year.
[3]This fee is deducted from your paycheck.
[4]This fee, which is for HSAs established at NBSC through MoneyPlu$, is deducted from your account. It is waived if the balance in your account is over $2,500. If you prefer to pay it annually rather than monthly, call 877-367-4472 within 60 days of opening the account.
[5]There may be additional fees for other services. All fees are deducted from your HSA.

Pretax Group Insurance Premium Feature

With this feature, you can pay your State Health Plan or HMO, State Dental Plan, Dental Plus, State Vision Plan and Optional Life premiums before taxes are taken out of your paycheck. You may also pay the tobacco-use surcharge. This feature is beneficial to all employees who pay these premiums.

Optional Life Insurance premiums for coverage up to $50,000 are tax exempt.

Eligibility

You are enrolled in this feature automatically if you pay a health, dental, vision care or Optional Life premium, unless you decline on your Notice of Election form. If you declined the Pretax Group Insurance Premium Feature in the past, you can enroll during annual enrollment or within 31 days of an approved change in status. (See "Special Eligibility Situations," pages 24-28.)

Flexible Spending Accounts

IRS Guidelines for Flexible Spending Accounts

1. The IRS does not allow you to pay any insurance premiums through any type of spending account.
2. You cannot transfer money between MoneyPlu$ accounts or pay a dependent care expense from your Medical Spending Account or vice versa.
3. The IRS gives you until March 15 to spend any remaining funds deposited in your **Medical Spending Account** or your **limited-use Medical Spending Account** from January through December of the previous year. For example: You have until March 15, 2013, to spend funds deposited in your MSA or limited-use MSA between January 1 and December 31, 2012.
   - However, you must submit all reimbursement requests by March 31, 2013. Any money in your **Medical Spending Account** or your **limited-use Medical Spending Account** after your reimbursable requests have been processed *cannot be returned to you or carried over to the next year.*
4. You have until March 31 after the end of the year to submit for reimbursement eligible **Dependent Care Spending Account** expenses incurred during your period of coverage, January through December. Any money in your **Dependent Care Spending Account** after your reimbursable requests have been processed *cannot be returned to you or carried over to the next year.*
5. You may not be reimbursed through your MoneyPlu$ accounts for expenses paid by insurance or by any other source.
6. You cannot deduct reimbursed expenses from your income tax.
7. You may not be reimbursed for a service that you have not received.

To learn if you qualify to enroll in a spending account or if you wish to make a change, call Customer Care at 800-342-8017 or EIP at 803-734-0678 (Greater Columbia area) or 888-260-9430 (toll-free outside the Columbia area).

Written Certification

When enrolling in either or both MoneyPlu$ spending accounts, you must agree to the following in writing on your enrollment form:

- I will only use my MoneyPlu$ account to pay for IRS-qualified expenses eligible under my employer's plan and only for me and my IRS-eligible dependents.
- I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s), before seeking reimbursement from my MoneyPlu$ spending account.
- I will not seek reimbursement through any additional source.
- I will collect and maintain sufficient documentation to validate the requirements above.

Deciding How Much to Contribute to Your Flexible Spending Accounts

To estimate how much to deposit in your Dependent Care Spending Account or Medical Spending Account, complete the MoneyPlu$ Worksheets, which are at www.eip.sc.gov under "Forms." *Be conservative in your estimates.*

- Money remaining in your **Dependent Care Spending Account** after the plan year and any grace period ends, cannot be returned to you or carried forward to the next plan year. However, you have until March 31, 2013, to submit requests for reimbursement **for expenses incurred on or before December 31, 2012.**
- Money remaining in your **Medical Spending Account** or in your **limited-use Medical Spending Account** after the plan year and any grace period ends, cannot be returned to you or carried forward to the next plan year. However, you have until March 31, 2013, to submit requests for reimbursement for expenses incurred **on or before March 15, 2013, for either of the Medical Spending Accounts.**

Earned Income Tax Credit

Contributions made before taxes to a Dependent Care Spending Account or a Medical Spending Account lower your taxable earned income. The lower the earned income, the higher the Earned Income Tax Credit (EITC). If you qualify for the EITC, contributions to one or both of these accounts will help. Taxpayers may consult IRS Publication 596 for additional information, use the services of a tax professional or get assistance from a Volunteer Income Tax Assistance site. To find the closest site, call the IRS at 800-829-1040.

Dependent Care Spending Account vs. Child and Dependent Care Credit

If you pay for the care of a child or another dependent so you can work, you may be able to reduce your taxes by claiming those expenses on your federal income tax return through the Child and Dependent Care Credit. Depending on a taxpayer's circumstances, participating in a Dependent Care Spending Account on a salary-reduction basis will generally produce the greater tax benefit. However, it is important to look at your unique circumstances. Go to www.myFBMC.com, and select the Tax Calculators link at the top of the home page. Follow the prompts. For more information about the Dependent Care Spending Account, go to the FAQs section on the same website.

In addition to the tax benefit of participating in a Dependent Care Spending Account, a partial Child and Dependent Care Credit may be available to you. For example, you may be able to claim an additional tax credit in an amount equal to a percentage of $1,000 if you have:

- Two or more qualifying individuals
- A maximum Dependent Care Spending Account tax filing status of $5,000 **and**
- $6,000 or more in eligible dependent care expenses.

Note: *You cannot use the Child and Dependent Care Credit if you are married and filing separately. Dependent care expenses reimbursed through a Dependent Care Spending Account cannot be filed for the credit.*

For assistance, call the Customer Care Center at 800-342-8017.

For more information on the Child and Dependent Care Credit, refer to IRS Publication 503.

Note: *If you participate in the Dependent Care Spending Account or if you file for the Child and Dependent Care Credit, you must attach IRS Form 2441 to your 1040 income tax return. If you do not, the IRS may not allow your pretax exclusion. To claim the income exclusion for dependent care expenses on IRS Form 2441, you must be able to list each dependent care provider's Social Security Number (SSN) or Employer Identification Number (EIN). If you are unable to obtain a dependent care provider's SSN or EIN, you must send with your IRS Form 2441 a written statement that explains the circumstances and states that you made a serious effort to get the information.*

MoneyPlu$ Medical Spending Account vs. Claiming Expenses on IRS Form 1040

Unless your itemized medical and dental expenses exceed 7.5 percent of your adjusted gross income*, you cannot claim them on your IRS Form 1040. However, you can save taxes by paying for your uninsured, out-of-pocket medical expenses through a tax-free Medical Spending Account.

**Note*: *If filing a joint tax return, your adjusted gross income includes both your income and your spouse's.*

With a Medical Spending Account, the money you set aside for medical expenses is deducted from your salary before it is taxed, so you save on taxes. For example, if your adjusted gross income were $45,000, the IRS would only allow you to deduct itemized expenses that exceed $3,375, or 7.5 percent of your adjusted gross income. But if you have $2,000 in eligible medical expenses, the MoneyPlu$ account saves you $656 on your medical expenses in federal income tax (15 percent), South Carolina state tax (7 percent) and Social Security taxes (7.65 percent).

For additional information about the tax credit, consult IRS Publication 502, use the services of a tax professional or get assistance from a Volunteer Income Tax Assistance site. To find the nearest site, call the IRS at 800-829-1040. You may also consult the FAQs at www.myFBMC.com for additional information on MSAs.

Dependent Care Spending Account

How the Dependent Care Spending Account Works

1. Estimate the amount you will spend during the year on dependent care, up to $5,000, depending on your tax status. Don't forget to consider vacation and holiday time when you may not have to pay for dependent care. During the year, make sure you file all your claims for reimbursement. Remember, according to IRS guidelines, any money in your account after you have claimed all your expenses at the end of the year cannot be returned to you or be carried over into the next calendar year. You have until March 31 of the new plan year to file claims for services provided the previous year.
2. The annual amount you contribute to your account will be divided into equal installments and deducted from each paycheck before taxes. It is then credited to your Dependent Care Spending Account.
3. After incurring dependent care expenses, submit a MoneyPlu$ Claim Form and a copy of your expense documentation from your dependent care provider to Fringe Benefits Management Company, a Division of WageWorks (FB-WW). The MoneyPlu$ Claim Form may serve as documentation if it includes the provider's signature. The provider's Tax ID Number or Social Security Number is not requested on the claim form. However, you should be prepared to give it to the IRS if asked to do so.
4. Your claim will be processed within five working days of when FB-WW receives it, if it is properly completed and signed, and **only if there are enough funds in your account**. Then a direct deposit will be issued to your account, or a check will be mailed, up to your current account balance. You will be reimbursed for any remaining expenses when money is available in your account.

Eligibility

You must be eligible for state group insurance benefits to participate in MoneyPlu$. However, you are *not* required to be enrolled in an insurance program to participate in MoneyPlu$, nor do you have to enroll in the Pretax Group Insurance Premium Feature to participate in the Dependent Care or Medical Spending Accounts.

Enrollment

You can enroll in the Dependent Care Spending Account within 31 days of your hire date. If you do not enroll then, you can enroll during the next enrollment period, October 1-31. You also can enroll in, or make changes to, this account within 31 days of an approved change in status (see "Special Eligibility Situations," pages 24-28 and "Changing Your Flexible Spending Account Coverage," page 172). You **must** re-enroll each year during the October enrollment period to continue your account the next year.

The Dependent Care Spending Account allows you to pay dependent care expenses with your pretax income. Here are the limits on how much you may set aside:

- If you are married and filing separately, your maximum is $2,500.
- If you are single and head of household, your maximum is $5,000.
- If you are married and filing jointly, your maximum is $5,000.
- If either you or your spouse earns less than $5,000 a year, your maximum is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum is $3,000 a year for one dependent and $5,000 a year for two or more dependents.

You may use your Dependent Care Spending Account to receive reimbursement for eligible dependent care expenses for qualified individuals. A qualified individual includes a qualified child if he or she:

- Is a U.S. citizen, a U.S. national or a resident of the U.S., Mexico or Canada
- Has a specified family-type relationship to you
- Lives in your household for more than half of the tax year
- Is under age 13
- Has not provided more than one-half of his own support during the tax year.

For more information, talk with your benefits administrator or a tax professional, or contact the Internal Revenue Service at 800-829-1040 or www.irs.gov.

Eligible Expenses

Generally, child, adult and elder care costs that allow you and your spouse to work or actively look for work are eligible for reimbursement. If you are married, your spouse must work, be a full-time student or be mentally or physically incapable of self-care. Examples:

- Day care facility fees
- Local day camp fees
- Baby-sitting fees for at-home care while you and your spouse are working (you, your spouse or another tax dependent cannot provide the care).

Ineligible Expenses

- Child support payments or child care if you are a non-custodial parent
- Payments for dependent care services provided by your dependent, your spouse's dependent or your child who is under age 19
- Healthcare costs or educational tuition
- Overnight care for your dependents (unless it allows you and your spouse to work during that time)
- Nursing home fees
- Diaper services
- Books and supplies
- Activity fees
- Kindergarten tuition.

Reimbursement of Eligible Expenses

To request reimbursement, you must complete and submit a MoneyPlu$ Claim Form, along with expense documentation showing the following:

- The dates your dependent received the care (for example, October 1-October 31), **not** the date you paid for the service

- The name and address of the facility
- The name, address **and signature** of the individual who provided the dependent care.

This information is required with each request for reimbursement. The MoneyPlu$ Claim Form may serve as documentation if it includes the provider's signature. The provider's Tax ID Number or Social Security Number is not requested on the claim form. However, you should be prepared to give it to the IRS if asked to do so.

An approved expense will not be reimbursed until after the last date of service for which you are requesting reimbursement. For example, if you pay your dependent care provider on October 1 for the month of October, you can submit your reimbursement request for the entire month. However, payment will not be made until you receive the last day of care for that month.

An approved expense will not be reimbursed until enough funds are in your Dependent Care Spending Account to cover the expense. On your claim form, you may divide the dates of service into periods that correspond with your payroll cycle. This will allow you to be reimbursed for part of the amount on the documentation when there are enough funds in your account.

Please Remember —
Although claims are processed in five working days, it may take as long as two weeks to get your check because of time in the mail and weekends. To receive your reimbursement faster, sign up for Direct Deposit.

You may also file your claims online. For more information, go to www.myFBMC.com. Log in and select "Claims" and then "Online FSA Claim Submission."

Medical Spending Account

How the Medical Spending Account Works

1. Estimate the amount you and your family want to set aside in your Medical Spending Account, up to $5,000 per calendar year. If you are married and your spouse is eligible for coverage, you may each set aside up to $5,000. Consider only those expenses you and your family can expect to incur between January 1 and December 31.

   - According to IRS regulations, if you have money left in your MSA on December 31, you have until March 15 of the new year (a grace period) to spend funds deposited in the account during the previous year.
   - **You have until March 31 to ask for reimbursement and submit documentation for eligible expenses incurred during the calendar year and the grace period. This includes documentation for myFBMC Card® transactions.** Check www.myFBMC.com for any outstanding transactions that may need documentation.
   - Between January 1 and March 15, any myFBMC Card® swipes or paper claims filed will be paid from funds remaining in your MSA from the previous year. For example, if you have 2011 MSA funds you would like to use, submit all of your 2011 claims before you begin turning in claims for 2012 expenses. Once your 2011 funds are exhausted, you will begin to be reimbursed from your 2012 account.
   - Remember, any money in your account after you have claimed all of your expenses cannot be returned to you or carried over beyond March 15 of the new year.

   If you had a myFBMC Card® during the old plan year and signed up for it for the new plan year, you can continue to use it to pay eligible expenses from your previous year's MSA until March 15. If you have *not* signed up for the card or an MSA again, you cannot use your myFBMC Card® after December 31. However, you may submit paper claims until March 31 for expenses incurred until March 15 of the new plan year.

To enroll in an MSA, you must have completed one year of continuous state-covered service by January 1 after October enrollment.

2. The yearly amount you elect to contribute to your account will be divided into equal installments and deducted from each paycheck before taxes. It is then credited to your Medical Spending Account.

3. After incurring medical or dental expenses, submit a MoneyPlu$ Claim Form and a copy of the expense documentation or the Explanation of Benefits for these expenses to FB-WW. File the claim only for your **unreimbursed** expenses. Approved claims will be paid until you have reached the annual amount you chose to have deducted. Your claim will be processed within five working days of its receipt by FB-WW. **Then a direct deposit will be issued to your account within 48 hours of your claim approval, or a check will be mailed**. Because of weekends and time in the mail, it may take up to two weeks for you to receive your check.

4. If you have a myFBMC Card®, present it when you incur eligible medical expenses, including prescriptions or dental expenses. If the provider accepts the card, the funds will be automatically withdrawn from your account, and you will not have to wait for reimbursement. Instructions on when to submit expense documentation will be provided on your monthly statement, or you may check www.myFBMC.com.

Eligibility

You must be eligible for active group insurance to participate in MoneyPlu$. However, you are *not* required to be enrolled in an insurance program to participate in MoneyPlu$, nor do you have to enroll in the Pretax Group Insurance Premium Feature to participate in a Dependent Care or Medical Spending Account.

Enrollment

To continue your Medical Spending Account each year, you **must** re-enroll during the annual enrollment period, October 1-31. If you have a myFBMC Card®, you must also re-enroll for it each year. You can enroll in, or make changes to, your MSA within 31 days of an approved change in status (see "Special Eligibility Situations," pages 24-28 and "Changing Your Flexible Spending Account Coverage," page 172). Complete a MoneyPlu$ Enrollment Form, available from your benefits administrator or on EIP's website at www.eip.sc.gov. Submit the completed form to your benefits administrator. You may set aside up to $5,000 annually to pay your medical, vision and dental expenses that are not reimbursed by insurance.

Your MoneyPlu$ MSA may be used to reimburse eligible expenses incurred by:

- Yourself
- Your spouse (even if he has a Medical Spending Account)
- Your qualifying child or
- Your qualifying relative.

An individual is a *qualifying child* if he is not someone else's qualifying child, and:

- Does not reach age 27 during the taxable year
- Has a specified family-type relationship to you: son/daughter, stepson/stepdaughter, eligible foster child, legally adopted child, or child placed for legal adoption
- Is a U.S. citizen, a U.S. national or a resident of the U.S., Mexico or Canada.

An individual is a *qualifying relative* if he is a U.S. citizen, a U.S. national or a resident of the U.S., Mexico or Canada and:

- Has a specified family-type relationship to you, is not someone else's qualifying child and receives more than one-half of his support from you during the tax year or
- If no specified family-type relationship to you exists, is a member of and lives in your household (without violating local law) for the entire tax year and receives more than one-half of his support from you during the tax year.

***Note**: There is no age requirement for a qualifying child if he is physically and/or mentally incapable of self care. An eligible child of divorced parents is treated as a dependent of both, so either or both parents can establish a MoneyPlu$ MSA.*

For more information, contact your benefits administrator or tax advisor or the Internal Revenue Service at 800-829-1040 or at www.irs.gov.

Eligible Expenses — Medical Spending Account

Expenses eligible for reimbursement include your deductibles, coinsurance and copayments. In addition to these expenses, your MSA is an excellent way to help pay for:

- Annual physical exams
- Vision care
- Out-of-pocket dental fees (including orthodontia, if medically necessary, but not if cosmetic)
- Over-the-counter drugs, but only if prescribed by a physician
- Non-medicinal over-the-counter items, including diabetic supplies, are still reimbursable without a prescription
- Any other out-of-pocket medical expenses deductible under current tax laws, including travel to and from medical facilities.

***Note**: Orthodontia treatment designed to treat a specific medical condition can be reimbursed. However, you will have to submit additional documentation each year. For more information, call the Customer Care Center at 800-342-8017.*

Eligible Expenses — Limited-use Medical Spending Account

If you have a Health Savings Account (HSA), you are eligible for a limited-use Medical Spending Account. This account may be used to pay expenses not covered by the Savings Plan, such as dental and vision care. You may use your HSA, but not your limited-use MSA, for deductibles and coinsurance.

Over-the-Counter Medicine

Under the Patient Protection and Affordable Care Act, an MSA can only be used to pay for over-the-counter drugs if those drugs are prescribed by a physician. A list of categories of over-the-counter items that the IRS has approved for reimbursement is available at www.myFBMC.com.

Ineligible Expenses

- Insurance premiums
- Vision warranties and service contracts
- Health or fitness club membership fees
- Cosmetic surgery not deemed medically necessary to alleviate, mitigate or prevent a medical condition.

Availability

Once you sign up for an MSA and decide how much to contribute, the entire amount will be available on January 1. You do not have to wait for the funds to accumulate in your account before being reimbursed for eligible medical expenses.

Medical Spending Account Reimbursement

If you use a myFBMC Card®, funds will be transferred automatically from your MSA. You will not need to wait for reimbursement. Please note that the myFBMC Card® is not available to limited-use MSA participants. The myFBMC Card® is discussed in detail on pages 168-171.

If you file by mail, your reimbursement will be issued within five business days from the time your properly completed and signed claim form is received. However, weekends and time in the mail may mean it will take longer than that to receive your check. The minimum reimbursement is $5, except for the last reimbursement, which brings your account balance to zero.

Direct Deposit

Your MoneyPlu$ reimbursement checks can be deposited automatically into your checking or savings account. There is no extra fee for this service, and you will still be notified that your claim has been processed. To apply, complete a MoneyPlu$ Direct Deposit Authorization Form available from your benefits office or on EIP's website at www.eip.sc.gov. Processing your direct deposit application may take four to six weeks.

MoneyPlu$ spending accounts are tax-favored accounts and must follow the guidelines under Section 125 of the Internal Revenue Code. Your signature on the form submitted for reimbursement serves as a required certification that you are abiding by the plan rules. Your request cannot be processed without it.

Requesting Manual Reimbursement

Claims must first be filed for any health plan benefits, provided by your employer, for which you are eligible. Any remaining out-of-pocket expenses may then be submitted for reimbursement from your MSA.

To request reimbursement from your MSA, fax or mail a completed MoneyPlu$ Claim Form (the fax number and address are on the form), along with one of these:

- An invoice or bill from your healthcare provider listing the date you received the service, the cost of the service, the type of service and the person for whom the service was provided
- An Explanation of Benefits (EOB) from your health insurance provider that shows the type of service you received, the date and cost of the service and any uninsured portion of the cost. In certain circumstances, a written statement from your healthcare provider that the service was medically necessary may be required. This Letter of Medical Need is available by calling 800-342-8017.

Do not use a highlighter on any forms or other documents you send. It will make them impossible to read when they are photocopied or faxed.

MyFBMC Card® Visa® Card

You may use the myFBMC Card® to draw funds from your MoneyPlu$ MSA to pay eligible, uninsured medical expenses for yourself and for your covered family members.

There is no risk of overspending. If you try to spend more than you will deposit into the account during the year, the transaction will be denied.

Like any MSA expense, myFBMC Card® transactions must be documented for the IRS. See page 170 for more information.

The myFBMC Card® is not available if you have a limited-use MSA, which is associated with the State Health Plan Savings Plan and the Health Savings Account.

Enrollment

When you sign up for an MSA, you may request a myFBMC Card® on your enrollment form. If you wish to continue your myFBMC Card® from year to year, you must re-enroll in it each year. There is a $10 annual fee for the card. The fee will be deducted from your MSA at the beginning of the year. You will receive two cards; you can give one to your spouse or child.

Activating the Card

You must activate your myFBMC Card® before you use it for the first time. To do so, log on to www.myFBMC.com. Be sure to sign the back of the card. If you continue to sign up for the card and a MoneyPlu$ MSA from year to year, you will continue to use the same plastic card until its expiration date.

Using the Card

You may use the card for:

- Copayments and deductibles at physician, dentist and optometrist offices
- Vision and dental expenses
- Prescription copayments and uncovered prescriptions at participating pharmacies
- IRS-approved over-the-counter items
- Over-the-counter drugs with a prescription, if filled by the pharmacy
- Mail-order prescriptions.

If you are enrolled in the State Health Plan, BlueChoice HealthPlan HMO or CIGNA HMO, you may use your myFBMC Card® for mail-order prescriptions. No documentation is required.

Your myFBMC Card® may only be used for eligible medical expenses not covered by your insurance. You may not use it for cosmetic dental costs and eyeglass warranties.

When you use the card to pay a healthcare provider, such as a physician or a stand-alone drug store, swipe it as you would a credit card. No PIN is needed. Please remember to keep documentation of your expenses, as stated in the IRS regulations.

The card will only be accepted at IIAS merchants. The latest list of stores meeting the federal electronic coding requirements is at www.myFBMC.com. After you log in, click on "Inventory Information Approval Systems (IIAS)" in the box on the left under "FAQs." On the website, you will also find a list of categories of over-the-counter items that the IRS has approved for reimbursement.

The pharmacy must also participate in your health plan's network. A list of pharmacies that are part of your network is on the EIP website under "Online Directories." If you use a pharmacy that is not part of your plan's network, you will pay the full cost for the drug. The cost will not apply to your deductible.

When using your myFBMC Card® at a pharmacy, just swipe the card as you would any credit or debit card. A PIN is not needed. Your receipt will show the name of the drug and the amount of the copayment that was taken from your MSA.

If a provider does not accept the card, you must use a MoneyPlu$ Claim Form to file for reimbursement. The form is available on the EIP website at www.eip.sc.gov.

Up to five prescriptions with fixed copayments (such as $9, $30 and $50 under the Standard Plan) on one card transaction will be *auto-adjudicated*. *Auto-adjudicated* means they will be verified and approved when you make the purchase without requiring documentation later. If you have more than five prescriptions on one card transaction, all of the prescriptions will require documentation.

Documentation **will be** required when you use the card for any transaction that does not have a fixed copayment.

If prescription drugs are purchased through your health plan's mail-order pharmacy, documentation **will not be required** for any prescriptions and IRS-approved over-the-counter items.

Documenting MyFBMC Card® Transactions

According to the IRS, it is not necessary to submit documentation for:

- Up to five for prescriptions with fixed copayments on one card transaction. (These prescriptions will be *auto-adjudicated*, verified and approved when you make the purchase without requiring documentation later.)
- Known copayments for services provided through health plans offered by EIP (the State Health Plan, BlueChoice HealthPlan HMO and CIGNA HMO)
- Eligible prescriptions purchased through your health plan's mail-order pharmacy
- IRS-approved over-the-counter items.

On page 165 you will find information about how the run-out period and grace period apply to the myFBMC Card®.

However, documentation is needed for other healthcare expenses. When you receive your monthly statement, transactions requiring documentation will be highlighted in blue. If an expense appears in this section you must **fax a copy** of your documentation and a MoneyPlu$ Claim Form to FB-WW. No cover sheet is needed.

Documentation can be an Explanation of Benefits from your health plan or a statement or bill showing the name of the patient, the date of service, the type of service, the service provider and the cost of service. **If the documentation is for a drug, be sure it includes the prescription number and the name of the drug.** Most drug store receipts do not show the name of the drug. You may need to submit a print-out that includes the name of the drug. It may be from the pharmacy, from your prescription drug program's website or from the pharmacy's website. The name also may be on a note stapled to the bag from the pharmacy.

The claim form is available on the EIP website at www.eip.sc.gov under "Forms." You may also get a copy from www.myFBMC.com, or from your benefits administrator. **The claim form is necessary to process the documentation.**

When an outstanding myFBMC Card® transaction has appeared in blue on two monthly statements, the next time you submit an approved paper claim, enough money will be kept in your account to make up for the card transaction that you have not documented. You will be reimbursed for the difference between the new claim and the undocumented claim. This is called "automatic substitution." You may also satisfy any outstanding myFBMC Card® transactions by submitting a check to Fringe Benefits Management Company, a Division of WageWorks, made out to your employer in the amount of the outstanding transaction.

If an undocumented transaction appears in blue on more that two consecutive monthly statements and no automatic substitution has occurred, your myFBMC Card® will be suspended until:

- Your documentation is received and/or
- Automatic substitution occurs and/or
- You repay your account by check.

When the transaction in question is cleared by one of these methods, your card will be automatically reinstated. Any amounts from January 1, 2011, to March 15, 2012, that are not cleared by March 31, 2012, violate IRS guidelines and will be taxed as income. Also, your myFBMC Card® will be canceled permanently.

Please submit documentation for items listed in blue on your monthly statement. If you do not send in documentation after a transaction has appeared in blue on two monthly statements, your card will be suspended on the last working day of the month.

You must keep all documents substantiating your claims for at least one year and submit them immediately upon request.

Lost Cards

If your myFBMC Card® is lost or stolen, call 888-462-1909 immediately.

Limited-use Medical Spending Account

Savings Plan subscribers who contribute to an HSA may enroll in a limited-use Medical Spending Account (MSA) to pay dental and vision care expenses, as these are not covered by the Savings Plan. Except for the restrictions regarding which expenses are reimbursable, a MoneyPlu$ limited-use MSA works the same as a MoneyPlu$ MSA.

Using your limited-use MSA
Since you can pay your out-of-pocket medical expenses with your MoneyPlu$ HSA, some MoneyPlu$ MSA features are not available with a MoneyPlu$ limited-use MSA, including:

- No reimbursement of out-of-pocket medical expenses, such as deductibles, coinsurance and copayments
- No reimbursement for over-the-counter items and
- No myFBMC Card® option.

Remember, MoneyPlu$ limited-use MSAs are available only to HSA participants. Dependent Care Spending Account eligibility is not affected by your HSA participation.

Access to Information About Your Flexible Spending Account

A Word About Your Interactive Voice Response PIN

To use the Interactive Voice Response (IVR) system, all you need is your Social Security Number (SSN). When you call the IVR for the first time, you will be asked to use the telephone pad to key in your SSN. The last four digits of your SSN will be your first Personal Identification Number (PIN). Then you will be asked to select your own confidential PIN, which should be between four and eight digits. Please use numbers only. Once you have selected your new PIN, you have access to information about your benefits. **Please keep your PIN in a safe place.** This PIN has no connection with the myFBMC Card® .

If you have trouble registering, it may be because the information you entered does not match what is on file for you. During business hours, a customer care representative can help you register.

Website: www.myFBMC.com

The website of Fringe Benefit Management Company, a Division of WageWorks, provides information about your tax-favored accounts. To register, enter your name, ZIP code, email address and Social Security Number and then select a password. To log in to the site, enter your email address and password. After you log in, you have access to this benefit information 24 hours a day:

- **Benefits.** You may check your benefit status, read benefit descriptions, use the tax calculator and much more.
- **Claims.** You may now file your DCSA and MSA claims online. Log in and click on "Claims" and then "Online Claims Submission." You may also check the status of your claim, download forms, get more information about mailing and faxing your claim or see transactions that need documentation.
- **Accounts.** View your account balance and contributions. You may also view monthly statements and review your transaction history.
- **Payment Card (myFBMC Card®).** Check your account regularly to review your account balance and any outstanding myFBMC Card® transactions that require documentation. You may download a card

If you are enrolled in an MSA or a DCSA, you can re-enroll online during open or annual enrollment in October. If you have an MSA, you can also add a DCSA.

If you are covered by the Savings Plan, you can open an HSA online.

fact sheet or transmittal form and read detailed instructions about using the card. You can also view outstanding transactions.
- **Profile.** Change your email address, complete your online registration or select a new PIN.
- **Resources.** Look through an extensive resource library, including benefit material, surveys, over-the-counter item lists and benefit tips.
- **Forms.** Download a variety of forms you may need as you use your account.
- **Contact.** Send a question to the Customer Care Center.

Email Notification

You will be notified by email of a variety of events related to your Flexible Spending Accounts. They include receipt of claims, payment or rejection of claims, a need for myFBMC Card® documentation, suspension or reinstatement of your myFBMC Card® and more. To sign up, go to www.myFBMC.com, log in and click on "Go Green" under "Account Access."

Telephone

The 24-hour automated phone system enables you to check a MoneyPlu$ claim, request forms and more. Getting connected to your benefits is easy. Call the Interactive Voice Response Line at 800-865-3262.

Contacts for Fringe Benefit Management Company, a Division of WageWorks

Department	Hours	Phone
Customer Care Center	M – F, 7 a.m. – 10 p.m., ET	800-342-8017 800-955-8771 (TDD)
Interactive Voice Response	10 p.m. - 7 a.m., 24 hours a day weekends and holidays	800-865-3262
Dispute Line	M – F, 7 a.m. – 10 p.m., ET	800-342-8017
Toll-free Claims Fax		888-800-5217

Changing Your Flexible Spending Account Coverage

You can start or stop your MoneyPlu$ Flexible Spending Accounts or vary the amounts you contribute to the account only under limited circumstances. MoneyPlu$ program and IRS regulations establish which "changes in status" allow you to change contributions to your account. The change you wish to make to your Dependent Care Spending Account (DCSA) or Medical Spending Account (MSA) must be consistent with the event that triggers the change. For example, you may wish to start a DCSA if you have a baby or adopt a child. You may want to decrease your MSA contribution if you get a divorce and will no longer be paying for your ex-spouse's out-of-pocket medical expenses.

Within 31 days of one of the events listed below, you must complete and submit a Change in Status Form to your benefits administrator if you wish to make changes in your account. The form is available on the EIP website at www.eip.sc.gov and from your benefits administrator. If you wish to continue to have a myFBMC Card®, you must re-elect it on the form. **Your benefits administrator must complete and review the form, along with any necessary documentation, authorize it and forward the form in a timely manner.** Any related claims you submit in the interim will be held until FB-WW receives and processes the Change in Status Form. Some changes in status that permit changes to your account are:

- Marriage, divorce
- Birth, placement for adoption, adoption
- Death of spouse or child
- Gain or loss of employment
- Begin or end unpaid leave of absence

- Change from full-time to part-time employment or vice versa
- Change in day-care provider.

Please note: You cannot change your MoneyPlu$ account because you are in the process of a divorce. When a divorce is final, it is a change-in-status event that does permit you to change your MoneyPlu$ account.

This is a partial list. For more information, contact your benefits administrator or call the Customer Care Center at 800-342-8017.

How Changes Affect Your Period of Coverage

Your MoneyPlu$ spending account is set up for the entire calendar year (your period of coverage). However, if you are permitted to change it during the year (an approved, mid-plan-year election change), you have more than one period of coverage. Money you deposit during the original period of coverage may be combined with money you deposit after the mid-year change. However, expenses you incurred before the mid-year change cannot be reimbursed for more money than was in the MoneyPlu$ account before the change.

How Leaving Your Job Affects Your Flexible Spending Account

Medical Spending Account

COBRA coverage under a MoneyPlu$ MSA will be offered only if you have an *under-spent account*. An account is under spent if the amount you elected to contribute to your account for the plan year, minus any reimbursable claims you have submitted up to the date of the COBRA qualifying event, is equal to or more than the amount you would have contributed to the account had you remained employed for the remainder of the plan year. COBRA coverage will consist of the amount you have in your MSA at the time of the qualifying event, plus additional contributions up to the annual amount you elected to contribute. You will be charged a 2 percent administrative fee. The use-it-or-lose-it rule will continue to apply. You will lose any funds remaining in your account at the end of the grace period, and COBRA coverage will end. FB-WW, the third-party claims processor, will contact you regarding continuation of coverage.

If you know in advance that you will be leaving your job, you can prepay your account. See page 191 for more information.

If you leave your job, your myFBMC Card® will be canceled.

If you choose not to continue your MSA, you have 90 days, from your last day at work, to submit eligible MSA expenses incurred before you left employment. Any funds remaining in your account will not be returned to you.

The Family and Medical Leave Act (FMLA) may affect your rights to continue coverage while on leave. Please contact your employer for further information.

Dependent Care Spending Account

If you leave your job **permanently** or take an **unpaid leave of absence**, you cannot continue contributing to your Dependent Care Spending Account. You can, however, request reimbursement for eligible expenses incurred while you were employed, until you exhaust your account or the plan year ends.

Health Savings Account

The State Health Plan Savings Plan enables subscribers who are willing to take greater responsibility for their healthcare costs to reduce their insurance premiums and to save money for qualified medical expenses when coupled with a Health Savings Account (HSA).

Eligibility

To be eligible for the state's HSA, a subscriber must be covered by the Savings Plan, which is a High Deductible Health Plan (HDHP). He cannot be covered by any other health plan that is not a HDHP, including Medicare. However, he can be covered for specific injuries, accidents, disability, dental care, vision care and long-term care. He cannot be claimed as a dependent on another person's income tax return.

An eligible subscriber may establish an HSA offered through any qualified financial institution. However, to contribute to an HSA on a pretax basis through payroll deduction, he must enroll in the MoneyPlu$ HSA. NBSC, a division of Synovus Bank[1], is the trustee for these accounts. The accounts are administered by FB-WW.

Retirees please note:
A retiree who is **not enrolled in Medicare** may be covered by the Savings Plan and contribute to an HSA.

If you are **retired** and **eligible for and enrolled in Medicare,** you may not contribute to an HSA.

[1] NBSC is a division of Synovus Bank. Synovus Bank, Member FDIC, is chartered in the state of Georgia and operates under multiple trade names across the Southeast. Divisions of Synovus Bank are not separately FDIC-insured banks. The FDIC coverage extended to deposit customers is that of one insured bank.

A MoneyPlu$ MSA, even a spouse's MSA, is considered *other health insurance* under HSA regulations. However, if you have no funds in your MSA on December 31, you may begin contributing to an HSA on January 1.

If you have a *limited-use* MSA, you may begin making HSA contributions on January 1. A limited-use MSA may only be used for dental and vision expenses, so it does not meet the definition of *other health insurance.*

Enrolling in an HSA

When you have met the eligibility requirements for an HSA, complete a MoneyPlu$ enrollment form choosing the HSA option. Give the form to your benefits administrator. If you would like to open an HSA at NBSC, go to EIP's website, www.eip.sc.gov and click on "Links." Under "MoneyPlu$," select "Open HSA Bank Account." You will see links to enrollment forms for **eligible active employees** and **eligible retirees**.

Complete the application. When you are finished, print and sign the application, and mail it to HSA Operations: P.O. Box 1828, Columbus, GA 31902, as stated on the application. Be sure to include: 1) one photo ID (a copy of your driver's license, passport or alien registration card); **and** 2) a copy of one of the following: a statement from a major credit card, a utility bill or an insurance voucher. The address on both forms of identification must match the home street address you listed on your HSA application. You have 30 days from the date you completed your online application to send in this material. (Federal law requires that all financial institutions obtain, verify and record information that identifies each person who opens an account.) Accounts are usually opened within two days of receipt of the completed application and identification.

If you don't have Internet access and would like to open a MoneyPlu$ HSA, check with your benefits administrator.

Once you enroll in an HSA, you do not have to re-enroll in it as long as you remain eligible for it.

Active subscribers enrolled in the Savings Plan, upon turning 65, remain eligible to contribute to an HSA, if they delay enrollment in Medicare Part A by delaying taking Social Security. (A person can delay enrolling in Social Security until age 70½.) Once this subscriber enrolls in Social Security (Part A of Medicare), usually at retirement, he can no longer make contributions to an HSA, including catch-up contributions. However, the funds already in the HSA can be withdrawn to pay Medicare premiums (not Medigap), deductibles and coinsurance, which are qualified expenses.

Retirees enrolled in the Savings Plan are eligible to contribute to an HSA (although not through MoneyPlu$). They may enroll in the HSA at NBSC, or any other institution that offers an HSA, and make catch-up contributions. S.C. Retirement Systems (SCRS) has arranged with NBSC to allow HSA contributions to be deducted from monthly retirement checks and sent to NBSC. Contact the Benefit Payments Department at SCRS to learn how to do this. The retiree may claim his HSA contribution on his income tax return.

Limited-use Medical Spending Account

If you have an HSA, you can also have a limited-use MSA. That account may be used for expenses not covered by your health insurance, the Savings Plan. Eligible expenses include dental and vision care. See page 163 for more information.

If you enrolled in a full MSA instead of an HSA, you cannot sign up for an HSA until the next enrollment period or until a special eligibility situation occurs that allows you to end your MSA within 31 days of the event.

Contributions

The maximum contribution to an HSA is indexed for inflation. In 2012, a subscriber with single coverage can contribute $3,100, and a subscriber who covers himself and any other family member can contribute $6,250. Total contributions for the entire year may not exceed these limits.

- For example, a subscriber with single coverage under the Savings Plan can contribute $3,100 to his HSA for the 12 months beginning January 1, 2012. Contributions may be paid in a lump sum, in equal amounts for 12 months (such as through payroll deduction with MoneyPlu$) or in any combination of payments during the year, as long as the total does not exceed $3,100.
- A subscriber with the same coverage who enrolls by December 1, 2012, may also contribute $3,100. However, he must remain eligible for a full 12 months after the end of the plan year. Contributions may be paid in a lump sum, in equal amounts during the months he is eligible (such as through payroll deduction with MoneyPlu$) or in any combination of payments during the year, as long as the total does not exceed $3,100.
- **A subscriber who had funds in an MSA on December 31, 2011**, may not begin contributing to an HSA until the day after the end of the MSA run-out period, April 1, 2012. However, his maximum contribution would still be $3,100. Contributions may be paid in a lump sum, in equal amounts for nine months (such as through payroll deduction with MoneyPlu$) or in any combination of payments during the year, as long as the total does not exceed $3,100. He must remain eligible for 12 months after the end of the plan year.
- **A subscriber who had no funds in his MSA on December 31, 2011,** may make the maximum contribution to his HSA in 2012 and may begin contributing on January 1, 2012. Contributions may be paid in a lump sum, in equal amounts for 12 months (such as through payroll deduction with MoneyPlu$) or in any combination of payments during the year, as long as the total does not exceed $3,100.

Subscribers age 55 and older may make additional “catch-up” contributions to an HSA. The amount for 2012 is $1,000.

There is no minimum contribution, but remember that certain administrative fees will be deducted from your account. HSAs established at NBSC through MoneyPlu$ include a FB-WW, fee of $1 per month and a bank fee of $10 per year, or $1 per month, until your account exceeds $2,500.

Transfers from Individual Retirement Accounts (IRAs)

You may make a one-time, irrevocable transfer from an IRA to your HSA as long as the amount transferred does not exceed the annual HSA contribution limit. There will be no tax penalty. However, any transfer from an IRA to an HSA will reduce the maximum amount you may contribute to your HSA during the tax year.

Changing Contributions

Unlike an MSA, you may enroll, change or stop your contributions to your MoneyPlu$ HSA through payroll deduction once a month. To make the change, fill out a new MoneyPlu$ Enrollment Form and complete Box A.

You may make regular and catch-up contributions to your HSA up to the time your federal income tax return is due, usually April 15.

Contributions Over Federal Limits

FB-WW will monitor your HSA contributions and send an alert to your benefits administrator if you are exceeding your contribution limit.

However, the best way to avoid problems is to divide your annual contribution among the number of paychecks you receive. For example, if you have single coverage, you can deduct a maximum of $3,100 for 2012. If you receive 24 paychecks each year, you could deduct $129.16 (rounded down) each pay period. If you have family coverage, you can deduct a maximum of $6,250 for 2012. If you receive 24 paychecks a year, you could deduct $260.41 (rounded down) each pay period.

The HSA Custodial Account disclosure statement and funds availability disclosure agreement is on the EIP website. Select "Publications" and then "MoneyPlu$." Information is also available by contacting Customer Care at 800-342-8017 or at www.myFBMC.com.

For information about an NBSC HSA go to www.bankNBSC.com or call 877-367-4472.

General HSA information is available from the U.S. Dept. of the Treasury at www.treas.gov/offices/public-affairs/hsa/.

Using HSA Funds

After you enroll in an HSA, you will receive up to two Visa® debit cards from NBSC. You may order additional cards by calling NBSC at 877-367-4HSA (4472). You should receive the card within 10 business days. You can also order your free starter supply of checks by calling this number. You may use the card or the checks to reimburse yourself from your HSA. Using a check may result in additional fees.

One important difference between an HSA and an MSA is that on January 1, after October enrollment, you have immediate access to your full yearly contribution to an MSA. This is not true of an HSA. **You can only withdraw HSA funds that are actually in your account.** If you use your debit card for a transaction and you do not have enough money in your account, the transaction will not go through or you will be charged an overdraft fee. If you write a check and you do not have enough money in your account, you will be charged for writing a check with insufficient funds.

Availability of Funds

Each contribution to your MoneyPlu$ HSA will be available after your employer's payroll is received and processed by FB-WW, transferred to NBSC and deposited in your account. Deposits are sent to NBSC twice a week. Funds should **generally** be available in your HSA no later than a week after your pay date. Remember, this depends on when your employer submits the deductions and payroll reports.

You will receive monthly statements from NBSC. You may also check your balance by visiting any NBSC branch or by signing up for online access. There is no charge for access-only services. Once you register, it takes 5-7 business days before you will have online access to your account.

You can make deposits to, or withdrawals from, your account at any NBSC branch. Any withdrawals must be for medical expenses that qualify under IRS guidelines. If they do not qualify, they may be subject to taxes and penalties.

You cannot use your HSA debit card to get cash at an automatic teller machine.

Eligible Expenses

You may use the funds in your HSA, tax free, to pay for **unreimbursed** eligible medical expenses for yourself, your spouse and your children. Medical expenses include the costs of diagnosis, cure, treatment or prevention of physical or mental defects or illnesses. HSA funds can only be used tax-free to pay for over-the-counter drugs if the drugs were prescribed by a physician. For more information, contact the IRS.

Documentation of Eligible Expenses

You should keep receipts for expenses paid from your HSA with your tax returns in case the IRS audits your tax return and requests copies.

If you use HSA funds for ineligible expenses, you will be subject to taxes on the amount you took from your HSA, as well as a 20-percent penalty if you are younger than age 65.

HSA Fees

If you deposit funds to your HSA through payroll deduction, administrative fees will be deducted. They include:

- $1 per month (an FB-WW fee that is deducted from your paycheck)

and these NBSC fees:

- $10 per year or $1 per month (your choice)* (This fee is deducted from your account.)
- 35 cents to process each check (If you use your debit card, there will be no transaction fees.)
- $4 for each additional Visa® debit card.
- $4 to replace a lost or stolen Visa® debit card.

Other fees may apply, such as those for insufficient funds.

The $1 monthly service charge continues, even when your HSA balance reaches $0. As a result, your account will be overdrawn, and you will be subject to additional charges.

*Call 877-367-4472 within 60 days of opening the account if you would prefer to pay the $10 annual fee. Otherwise, the $1 monthly fee will apply. You will pay this fee until the balance in your account reaches $2,500.

If you will not contribute to your MoneyPlu$ HSA in 2012 but want to keep your account with NBSC open, you must continue to pay the $10 annual fee, until you have a minimum balance of $2,500.

If you do not make any deposits or withdrawals for 12 months you will be charged a monthly fee of $5, in addition to the $10 annual fee (if the fee applies). If your balance drops below $25, you must use the funds and close the account until you are again eligible to contribute.

Investment of HSA Funds

One of the advantages of an HSA is that you do not have to spend all the funds during the year in which they are deposited, as you do with a MSA. The funds can accumulate and can be used for eligible medical expenses in the future.

Your funds will initially be held in an interest-bearing checking account at NBSC. As the account grows, you may be eligible to place your funds into the HSA Investment Option, which features nine Fidelity Investment® mutual funds. Once your balance reaches $3,500 or more, NBSC will send you information about the investment opportunities available to you through their broker, Synovus Securities, Inc. (SSI)[1].

Unlike funds in an interest-bearing checking account, money invested in a mutual fund is not FDIC-insured. You have the opportunity to earn a higher rate of return on your investment, but that is not guaranteed. There is a possibility you will lose money, including the original amount invested.

[1] *The registered broker-dealer offering brokerage products for Synovus is Synovus Securities, Inc., member FINRA/SIPC. Investment products and services* ***are not FDIC Insured, are not deposits of or obligations of Synovus Bank, are not guaranteed by Synovus Bank and involve investment risk, including possible loss of principal amount invested****.*

Portability (Continuing Your Coverage)

If you leave your job, you can take your HSA with you and continue to use it for qualified medical expenses.

Tax Reporting

After year end, NBSC will send you tax filing information to use in reporting your HSA contributions and withdrawals when you file your taxes. It is important to save documentation, including receipts, invoices and explanations of benefits from your health insurance carrier, in case you are asked to show the IRS proof that your HSA funds were used for qualified expenses.

If you participate in MoneyPlu$, pretax HSA contributions will appear on your W-2 Form as employer-paid contributions. This is because this money was deducted from your salary before it was taxed. Do not deduct this money on your return. Only after-tax contributions may be deducted. Consult your tax advisor for more information.

If you have questions about how your HSA contributions were reported on your W-2 Form, contact your benefits office.

Closing Your HSA

If you are no longer eligible to contribute to an HSA, or no longer wish to do so, you must go to your BA and complete a MoneyPlu$ Enrollment Form. Enter "$0" in Section A to stop contributions to the account. You and your BA must sign the form before your BA submits it.

If money remains in the account, you may continue to use it for qualified, unreimbursed medical expenses. When the balance drops below $25, you must use the rest and close the account. To do so, call NBSC at 800-708-5687 and press "0" for a customer service representative. He will transfer you to the appropriate person.

How Death Affects Your MoneyPlu$ Accounts

Flexible Spending Accounts

Medical Spending Accounts (MSA) and **Dependent Care Spending Accounts** (DCSA) end on the date the employee dies. They are not refunded to the survivor.
An IRS-qualified dependent/beneficiary may continue an MSA through the end of the plan year under COBRA. Contact FB-WW, or your benefits administrator for more information. If the MSA is not continued through COBRA, the beneficiary has 90 days from the date of death to submit claims for eligible expenses incurred through the date of death.

DCSA claims incurred through the date of death may be submitted until the account is exhausted or through the end of the year.

The death of a spouse or child creates a "change in status" that makes it possible to stop, start or vary the amount contributed to an MSA or DCSA. You have 31 days from the date of death to make the change. See page 172 for information about changing your contribution.

Health Savings Accounts

If the beneficiary of the Health Savings Account (HSA) is the account owner's spouse, the HSA will become the spouse's HSA. If the beneficiary is not the spouse, the account will cease to be an HSA on the date of death. If the beneficiary is the account owner's estate, the fair market value of the account on the date of death will be taxable on the account owner's final return. For beneficiaries other than the spouse or the estate, the fair market value of the account is taxable to the beneficiary for the tax year in which the account owner died.

For more information, see Section VII of the Health Savings Account Custodial Agreement. A copy of the agreement is on the EIP website, www.eip.sc.gov. Select "Publications" and then "MoneyPlu$." To settle the account, contact NBSC.

Appeals

If your request for reimbursement, claim for benefits or mid-plan-year election change is denied, in full or in part, you have the right to appeal the decision by sending a written request within 30 days of the denial for review to Fringe Benefits Management Company, a Division of WageWorks, (Attn: Appeals Process, P.O. Box 1878, Tallahassee, FL 32302-1878).

Your appeal must include:

- The name of your employer
- The date of the services for which your request was denied
- A copy of the denied request
- A copy of the denial letter you received
- Why you think your request should not have been denied and
- Any additional documents, information or comments you think may have a bearing on your appeal.

Your appeal will be reviewed when it and its supporting documentation are received. You will be notified of the results of this review within 30 business days from receipt of your appeal. In unusual cases, such as when an appeal requires additional documentation, the review may take longer than 30 business days. If your appeal is approved, additional processing time is required to modify your benefit elections.

If you are still dissatisfied after the decision is re-examined, you may ask EIP to review the matter by making a written request to EIP within 90 days of notice of the denial. If the denial is upheld by the EIP Appeals Committee, you have 30 days to seek judicial review as provided by Sections 1-11-710 and 1-23-380 of the S.C. Code of Laws, as amended.

Note: Appeals are approved only if the extenuating circumstances and supporting documentation are within your employer's, your insurance provider's and IRS' regulations governing the plan.

Retirement/ Disability Retirement

Retirement/Disability Retirement

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Benefits for Retirees

This chapter provides information for eligible participants in the state insurance program who are considering retirement or who have retired. For detailed information on specific programs, refer to the previous chapters in this guide.

If you or a family member you cover is eligible for Medicare, you will find helpful information in the Medicare chapter, as well as in this one. **Please read both chapters.**

If you have questions or need more information about your insurance, contact the Employee Insurance Program (EIP) through its website at www.eip.sc.gov or call 803-734-0678 (Greater Columbia area) or 888-260-9430 (toll-free outside the Columbia area).

If you are eligible for retiree insurance, you must enroll within 31 days of your eligibility date or a special eligibility situation, or during open enrollment. See pages 186-187 for more information.

Are You Eligible for Retiree Insurance?

Eligibility for *retirement* is not the same as eligibility for *retiree group insurance.* EIP and S.C. Retirement Systems (SCRS) have different requirements. We recommend you review the requirements for retiree group insurance in this section before you confirm your retirement date.

You may be eligible for health, vision and dental coverage in retirement if you meet all three of these criteria:

1. You are eligible to retire:

   Due to years of service

   - SCRS and Optional Retirement Program (ORP) participants are eligible for retirement with 28 years of service credit.
   - Police Officers Retirement System (PORS) participants are eligible for retirement with 25 years of service credit.

   or

   Due to age

   - SCRS and ORP participants are eligible for retirement at age 60.
   - PORS participants are eligible for retirement at age 55.
   - SCRS participants are eligible for early retirement at age 55 with at least 25 years of service credit.

   or

   On approved disability

   - SCRS and PORS participants must be approved for disability by SCRS.
   - Participants in ORP must be approved by The Standard Insurance Company for Basic Long Term Disability and/or Supplemental Long Term Disability.

2. You retire from an employer that participates in the state insurance program.

3. Your last five years of employment were served consecutively in a full-time, permanent position with an employer that participates in the state insurance program.

For more information about state retirement eligibility, call the S.C. Retirement Systems at 803-737-6800 (Greater Columbia area) or 800-868-9002 (toll-free outside the Columbia area but in South Carolina) or go to its website, www.retirement.sc.gov.

Exceptions:

- Former municipal and county council members who served on council for at least 12 years and were covered under the state plan by a participating employer when they left council may be eligible for

retiree insurance if the county or municipal council on which they served allows coverage for former members.

- If you retire from a local subdivision that does not participate in SCRS you must have 28 years of service, have reached age 60 or be approved for disability through Standard Insurance Company.

Please note: EIP cannot confirm eligibility over the telephone. If your anticipated retirement date is **within 90 days**, please submit an Employment Verification Record with a Retiree Notice of Election form. If your anticipated retirement date is **three to six months away**, you may submit a written request, which includes your anticipated retirement date, and your Employment Verification Record, and EIP will give you a written confirmation of your eligibility. EIP will not confirm eligibility more than six months before your retirement date.

How TERI Affects Retiree Insurance

If you are a Teacher and Employee Retention Incentive (TERI) program participant in a permanent, full-time position, your insurance benefits as an active employee continue. When your TERI employment ends, you must apply for continuation of your insurance as a retiree (if eligible) within 31 days of your date of termination. Your service as a TERI participant in a full-time, permanent position with a participating employer may be applied toward retiree insurance eligibility.

Will Your Employer Pay Part of Your Premiums?

As an active employee, your employer must pay part of the cost of your health and dental insurance. When you retire, the amount your employer contributes to your retiree insurance premiums is based on several factors, including the type of agency from which you retired.

State Agency, Higher Education and Public School District Retirees:
You may be eligible for a state contribution to your retiree insurance premiums based on **when you began employment** and on your **number of years of earned service credit** with an employer that participates in the state insurance program.

Local Subdivision Retirees:
Retiree eligibility guidelines are the same for local subdivision retirees as they are for state, higher education and public school district retirees. However, the funding may be different. Local subdivisions may or may not pay a portion of the cost of their retirees' insurance premiums. Each local subdivision develops its own policy for funding retiree insurance premiums for its eligible retirees. **If you are a local subdivision employee, contact your benefits office for information about retiree insurance premiums.**

Employees Hired Before May 2, 2008

If you worked in an insurance-eligible position before May 2, 2008, with an employer participating in the state insurance program, your health insurance premiums are based on the number of years of earned service with an employer participating in the state insurance program.

For insurance eligibility purposes, earned service credit includes time that you worked for an employer that participates in EIP, even if you did not participate in EIP's programs. Earned service credit does not include non-qualified service, federal employment, military service, out-of-state employment, educational service, leave of absence, unused sick leave, or service with employers that do not participate in EIP. Service as a TERI participant in a full-time, permanent position with a participating employer may be applied toward earned service credit to determine retiree insurance eligibility.

Retirees hired before May 2, 2008, may be funded or non-funded. A funded retiree's former employer contributes to his retiree insurance premiums. A non-funded retiree receives no contribution. He is responsible for the entire cost.

Funded Retirees (Employer pays its part of the premium)

To be eligible for funded retiree insurance, you must be **eligible to retire** and must meet one of these criteria:

- You left employment when you were eligible to retire and you have at least 10 years of earned SCRS service credit with an employer that participates in the state insurance program. The last five years must be served consecutively in a full-time, permanent position.

  You may enroll within 31 days of your retirement or a special eligibility situation, or during open enrollment.

- You left employment before you were eligible to retire but when you left, you had at least 20 years of earned SCRS service credit with an employer that participates in the state insurance program. The last five years must be served consecutively in a full-time, permanent position.

  You may enroll within 31 days of your 60th birthday (when you become eligible to receive a retirement check) or a special eligibility situation, or during open enrollment. Employees who qualify to retire under PORS become eligible at age 55.

Non-funded Retirees (You pay all of the premium)

To be eligible for non-funded retiree insurance, you must be **eligible to retire** and must meet one of these criteria:

- You have at least five years, but fewer than 10 years, of earned SCRS service credit with an employer that participates in the state insurance program. The last five years must be served consecutively in a full-time, permanent position.

  You may enroll within 31 days of your retirement or a special eligibility situation, or during open enrollment.

- You retire at age 55 with at least 25 years of SCRS service credit. **The last five years must be served consecutively in a full-time, permanent position.** You must pay the full insurance premium until you reach age 60 or the date you would have had 28 years of service credit, whichever occurs first. At the end of this period, you may be eligible for funded retiree rates. This rule applies only to SCRS participants, not to ORP participants.

  You may enroll within 31 days of your retirement or a special eligibility situation, or during open enrollment.

- You are a former municipal or county council member who served on council for at least 12 years and were covered under the state's plan when you left the council. It is up to the county or municipal council to decide whether to allow former members to have this coverage.

Employees Hired on or After May 2, 2008

Retiree insurance provisions, created by Act 195 of 2008, apply to new employees hired **on or after May 2, 2008.** At retirement, you must meet established insurance eligibility rules. Funding for your health insurance will be determined by calculating the number of years of earned service with an employer participating in the state insurance program.

For insurance eligibility purposes, earned service credit includes time that you worked for an employer that participates in EIP, even if you did not participate in EIP's programs. Earned service credit does not include non-qualified service, federal employment, military service, out-of-state employment,

educational service, leave of absence, unused sick leave, or service with employers that do not participate in EIP. Service as a TERI participant in a full-time, permanent position with a participating employer may be applied toward earned service credit to determine retiree insurance eligibility.

These funding provisions apply to retirees of state agencies, public school districts and higher education institutions.

Funded Retirees (Employer pays its part of the premium)

To be eligible for funded retiree insurance, you must be **eligible to retire** and have at least 25 years of earned service credit with an employer that participates in the state insurance program. The last five years of service must be served consecutively in a full-time, permanent position. Your former employer pays 100 percent of the employer's share, and you pay the retiree's share.

Partially Funded Retirees (You split the employer's part of the premium)

To be eligible for partially funded retiree insurance, you must be **eligible to retire** and have at least 15 years, but fewer than 25 years, of earned service credit with an employer that participates in the state insurance program. The last five years of service must be served consecutively in a full-time, permanent position. Your former employer pays 50 percent of the employer's share of the premium. The retiree pays the retiree's share plus the remaining 50 percent of the employer's contribution.

Non-funded Retirees (You pay all of the premium)

To be eligible for non-funded retiree insurance, you must be **eligible to retire** and have at least five years, but fewer than 15 years, of earned service credit with an employer that participates in the state insurance program. The last five years of service must be served consecutively in a full-time, permanent position. As a non-funded retiree, you pay the entire cost of the insurance. There is no contribution from your former employer.

Enrolling as a Retiree

Your insurance is NOT automatically continued when you retire. In addition to completing your paperwork with the S.C. Retirement Systems (SCRS), **you must contact EIP within 31 days of the date you retire or a special eligibility situation to enroll in retiree insurance.**

To enroll in retiree insurance, you must complete the **Retiree Notice of Election** form and the **Employment Verification Record**. To continue or convert your life insurance, you must also complete the Continuation of Group Optional Life Coverage form and/or the Notice of Group Life Insurance Conversion Privilege form.

You can print these forms from the EIP website, www.eip.sc.gov, from your employer or you may ask EIP for a retiree insurance enrollment packet by calling 803-734-0678 (Greater Columbia area) or 888-260-9430 (toll-free outside the Columbia area).

If you would like to meet with an EIP representative, visit Suite 300, 1201 Main St., Columbia. EIP is open Monday through Friday from 8:30 a.m. to 5 p.m. Appointments are not scheduled, but walk-ins are welcome.

Within 31 Days of Retirement

If you are an eligible retiree, you must enroll within 31 days of:

- Your retirement date or
- The end of your TERI period or

- The date on the letter approving your SCRS disability retirement if you participate in the SCRS or
- The date on the letter approving your BLTD/SLTD retirement if you are retiring under ORP or from an employer that is not covered under the SCRS.

You may enroll yourself and any eligible family members. (However, you are not required to cover the same eligible family members as a retiree that you covered as an active employee.)

A chart describing health plan benefits for retirees who are not eligible for Medicare begins on page 198.

You may be required to submit the appropriate documents to show that the family members you wish to cover are eligible for coverage. For more information, see pages 20-21.

After EIP processes your retiree insurance enrollment, you will receive a letter from EIP confirming the coverage selected and the premiums due each month. **You have 31 days from the date your retiree insurance becomes effective to make any corrections or changes to your coverage.** Otherwise, you must wait to make changes until the next October enrollment period or a special eligibility situation.

Note: While some benefits administrators may help you complete your Retiree Notice of Election and Employment Verification Record, it is your responsibility to make sure the forms are completed within 31 days of your retirement date.

How to Continue or Convert Life Insurance in Retirement

To **continue** Optional Life as term life insurance, you must submit a completed Notice of Continuation of Group Optional Life Coverage to MetLife. To **convert** your Basic Life, Optional Life or Dependent Life insurance to a whole life policy, you must submit a completed Notice of Group Life Insurance Conversion Privilege form to MetLife. For more information, see pages 190-191.

Note: MetLife must **receive** the appropriate form within 31 days of the date coverage ends, or you will forfeit your right to continue or convert your life insurance.

MoneyPlu$ Accounts
To learn how retirement affects your Medical Spending Account and your Dependent Care Spending Account, see page 191.

Within 31 days of a Special Eligibility Situation

A *special eligibility situation* is created by a certain events. It allows eligible employees and retirees to enroll in an insurance plan, or to make enrollment changes, if the changes are requested within 31 days of the event. For more information, see pages 24-28.

During Open Enrollment

If you and/or your spouse and children do not enroll within 31 days of retirement, disability approval or a special eligibility situation, you may enroll as a late entrant during open enrollment, which is in October of odd-numbered years. Your coverage will take effect the following January 1. **As a late entrant, your coverage will be subject to pre-existing condition exclusions for 18 months.** Proof of creditable coverage may be used to reduce a pre-existing condition exclusion period, if any break in coverage did not exceed 62 days.

For more information about the pre-existing condition exclusion, see pages 12-13.

Retiree Premiums and Premium Payment

State Agency, Higher Education and School District Retirees

EIP deducts your health, dental and vision premiums from your monthly SCRS pension check.

When you retire, your insurance premiums may be due before your retirement paperwork has been finalized by SCRS or EIP. If this happens, you will receive a monthly bill for the premiums until you receive your first retirement check. If you do not pay the bill, the total premiums due will be deducted from your first retirement check.

Your pension is paid at the end of the month, and your insurance premiums are paid at the beginning of the month. For example: your insurance premiums for April are deducted from your March retirement check. Depending on when your retirement paperwork is processed, **more than one month's premium may be deducted from your first retirement check.**

If, at any time, the total premiums due are greater than the amount of your pension check, EIP will bill you directly for the full amount.

Local Subdivision Retirees

You pay your health, dental and vision premiums directly to your former employer. Your employer sends them to EIP. Contact your benefits office for information about your insurance premiums in retirement.

Failure to Pay Premiums

Health, dental and vision premiums are due by the 10th of the month. If you do not pay the entire bill, including the tobacco-use surcharge, if it applies, all of your coverage will be canceled, including coverage for which you may not pay a premium, such as the State Dental Plan.

Your Health Plan Choices as a Retiree

If You Are Not Eligible for Medicare

If you, your covered spouse and your covered children **are not** eligible for Medicare, you may be covered under one of these plans:

- The SHP Standard Plan
- An HMO offered in the county where you live. (See page 78 for counties where each HMO is available.)

MyBenefits, EIP's online enrollment system, is available to retirees. To learn more, see page 23.

Your health benefits, which are described in the Health Insurance chapter, will be the same as if you were an active employee. However, your premiums may change depending on whether you are a funded or a non-funded retiree. See pages 227-228 for premiums.

If You Are Eligible for Medicare

If you, your covered spouse or your covered children **are** eligible for Medicare, you may be covered under one of these plans:

- The SHP Standard Plan
- The SHP Medicare Supplemental Plan
- An HMO offered in the county where you live. (See page 78 for counties where each HMO is available.)

To learn how Medicare affects your health insurance, see the Medicare chapter, beginning on page 203.

If You Are Considering the Savings Plan ...

If you are a retiree, whether eligible for Medicare or not, and you are considering enrolling in the **Savings Plan**, please call EIP or BCBSSC for rates and information about how the Savings Plan would coordinate with Medicare or with other coverage. If you are retired and are eligible for and enrolled in Medicare, you cannot contribute to a Health Savings Account, which is typically associated with the Savings Plan.

WHEN YOU OR ONE OF YOUR COVERED FAMILY MEMBERS BECOMES ELIGIBLE FOR MEDICARE before age 65, your health insurance options and the way your health insurance is handled changes. You MUST notify EIP within 31 days of eligibility. If you do not notify EIP of your Medicare eligibility, and EIP continues to pay benefits as if it were your primary insurance, when EIP discovers you are eligible for Medicare, EIP will:

- **Begin paying benefits as if you were enrolled in Medicare**
- **Seek reimbursement for overpaid claims back to the date you or your covered family member(s) became eligible for Medicare.**

Dental Benefits

If you retire from a participating employer, you can continue your State Dental Plan and Dental Plus coverage if you meet the eligibility requirements (see pages 183-184). Coverage is not automatic. To maintain continuous coverage, you must file a Retiree Notice of Election (RNOE) form and an Employment Verification Record with EIP within 31 days of your retirement date, the date your TERI plan ends or the date of disability approval.

If you enroll in the State Dental Plan or Dental Plus, you may not drop that coverage until the next open enrollment, October 2013, or until you become eligible to change coverage due to a special eligibility situation.

If you do not enroll within 31 days of your date of retirement, you may enroll during the next open enrollment period (October 2013). Coverage will be effective the following January 1. You also may enroll within 31 days of a special eligibility situation. For information on the State Dental Plan and Dental Plus, see pages 99-106.

Vision Care

State Vision Plan

If you retire from a participating employer, you can continue your State Vision Plan coverage if you meet the eligibility requirements (see page 183). Coverage is not automatic. To maintain continuous coverage, you must file a Retiree Notice of Election (RNOE) form and an Employment Verification Record with EIP within 31 days of your retirement date, the date your TERI plan ends or the date of disability approval.

If you do not enroll within 31 days of your date of retirement, you may enroll during the next October enrollment period. Coverage will be effective the following January 1. For information on vision care benefits, see pages 109-114.

Vision Care Discount Program

This discount program is available at no cost to retirees, as well as to full-time and part-time employees, covered family members, survivors and COBRA subscribers. Refer to page 114 for more information.

Other Insurance Programs EIP Offers

Life Insurance

When you retire, you may choose to continue or convert your life insurance through MetLife. MetLife must **receive** your completed Continuation of Group Optional Life Coverage form and/or Notice of Group Life Insurance Conversion Privilege form within 31 days of the date coverage ends. If you need help completing these forms, contact your benefits administrator or EIP.

Note: If you retired before January 1, 1999, and you continued your coverage, your coverage will end January 1 after the day you become age 70.

Retiree life insurance coverage does not include accidental death and dismemberment benefits.

If you have questions about life insurance coverage, billing, claims, etc., call MetLife's retiree customer service, the "Life Recordkeeping Customer Service," at 866-492-6983.

Please note: You must pay your life insurance premium by the due date. An easy way to ensure that your premiums are on time is to authorize payment through an Electronic Funds Transfer, a bank draft. Contact MetLife to set up one.

$3,000 Basic Life Insurance (Group Number 143046)

This term life insurance is given to you as an active employee and *ends* with retirement or when you leave your job for another reason. You may convert the $3,000 Basic Life to an individual policy within 31 days of the date coverage ends. Contact your benefits office or EIP for additional information.

Optional Life Insurance (Group Number 143046)

You can continue your Optional Life Insurance into retirement through MetLife. Here are your options:

You can continue or you can convert your life insurance coverage within 31 days of the date coverage ends. Your coverage can be continued in $10,000 increments up to the final face value of coverage.

1. Continuation

As a retiree, you may continue your Optional Life coverage at the same rates you paid while you were an employee. The minimum amount that can be continued is $10,000. You cannot increase your coverage, but you can decrease it. Rates are based on your age and will increase when your age category changes. Your coverage will reduce by 35 percent at age 70 and then end January 1 after the day you turn age 75 if you continued coverage and retired on or after January 1, 1999. When your amount either reduces or ends, you can convert the amount of reduced or lost coverage **within 31 days,** as described in Section 2 below. **Continued coverage is term life insurance.**

Term life insurance provides coverage for a specific period of time. It has no cash value.

To continue your coverage, you and your BA (or an EIP staff member) must complete the Continuation of Group Optional Life Coverage Form. You must also complete the Beneficiary Designation Form. You must mail or fax both documents to MetLife so they are received within 31 days of your loss of coverage.

2. Conversion

Within 31 days of loss of coverage, you may convert your Optional Life coverage to an individual whole life policy.

To convert your coverage, the Notice of Group Life Conversion Privilege form must be faxed to MetLife and received within 31 days of the date coverage ends. Your BA can help you, but it is your responsibility to see that it is done. A MetLife representative will contact you to discuss your options, premiums and designation of beneficiaries. If you are interested in converting your coverage as a retiree, contact your benefits office.

***Whole life* is a permanent form of life insurance.**

3. Continuation and Conversion

You may also split your coverage between individual whole life insurance (conversion) and term life insurance (continuation).

If you participate in the TERI program, you can continue your benefits as an active employee, if you are eligible. When the TERI period ends, you must file for retiree benefits within 31 days, as explained above.

If you are not approved for retirement or Long Term Disability, you have 31 days from the date your coverage ends to convert your policy. Please see your BA for more information.

If you return to work as a full-time, active employee with a participating employer, you must choose whether to enroll in Optional Life insurance coverage as an active employee or to continue your retiree coverage. If you refuse to enroll as an active employee, you also refuse the $3,000 Basic Life benefit, and Optional and/or Dependent Life coverage. Your active group coverage will become effective only if you discontinue the retiree continuation coverage.

If you converted your Optional Life coverage and are rehired within two years of the date the coverage was converted, you must cancel your converted coverage in order to enroll in Optional Life as an active employee. **If you return to work more than two years after your policy was converted, you can enroll in active coverage and keep your converted policy.**

For information about converting a group life policy to an individual policy, call 877-275-6387, prompt 1.

Dependent Life Insurance (Group Number 143046)

Any Dependent Life Insurance coverage you have will end when you leave active employment. Your covered spouse or child may convert the insurance coverage to an individual whole life policy. The spouse or child must complete a Notice of Group Life Conversion Privilege form. It must be received by MetLife and the premium paid within 31 days of the date of coverage ends.

MoneyPlu$

MoneyPlu$ is not available in retirement. However, when you retire, you may be able to continue your **Medical Spending Account** (MSA) through the end of the plan year, including the grace period. If you know your retirement date during the October enrollment period, you can divide your MSA contributions by the number of paychecks you will receive before retirement. For example, if you are retiring in June, you could divide your contributions among half of the paychecks you receive annually. Another option is to deduct the amount remaining in your yearly contribution from your last few paychecks. You may also be able to continue your account on an after-tax basis through COBRA. See page 173 for more information. If you wish to continue your account, contact your BA within 31 days of your last day at work and fill out the appropriate forms.

If you do not wish to continue your MSA, you have 90 days from your last day at work to submit claims for eligible expenses incurred before you left employment.

You cannot continue contributing to your **Dependent Care Spending Account** after you retire. However, you can request reimbursement for eligible expenses incurred while you were employed until you exhaust your account or the plan year ends.

The Pretax Group Insurance Premium Feature, which allows you to pay health, vision, dental and some life insurance premiums before taxes, is not available in retirement.

Long Term Care

Long Term Care (LTC) refers to a wide range of services for people of all ages who suffer from chronic conditions. These individuals need assistance with day-to-day activities, such as bathing, eating, continence, toileting, transferring and/or dressing, or supervision due to cognitive impairment, such as Alzheimer's disease. Care can be provided in a nursing home, in an assisted living facility, at home or in the community, such as in an adult day care center.

If you have questions about LTC, contact Prudential customer service at 877-214-6588 or go to the EIP website, www.eip.sc.gov, and click on the "Links" tab. Then, under "Long Term Care," select "Prudential."

Long Term Care Services Already Covered
Medicare covers some home healthcare and skilled nursing facility services. However, there are limits on the dollar amounts paid and the number of visits allowed. Neither the State Health Plan nor Medicare covers custodial care. To qualify for Medicaid, you must exhaust most of your assets and income.

Continuing Coverage Into Retirement

You and your family members may keep this coverage when you retire. Your coverage will remain in effect as long as you continue to pay your premiums on a timely basis and do not exhaust your benefits.

Enrolling in Coverage at Retirement

You and/or your spouse/surviving spouse may apply to enroll in LTC at any time by providing medical evidence of good health. Applicants age 72 and older will receive an in-person assessment to supplement the information provided on the enrollment form. See "How Do I Enroll?" on page 152 for more information.

Premiums

You pay the entire cost of LTC coverage for yourself and your spouse, if he or she is enrolled. Premiums are based on your age when you enroll. Premiums are on pages 234-235.

LTC insurance premiums may not be deducted from your payroll or pension check. Retirees and qualified family members can select a direct billing method, which provides a 2.83 percent discount for semi-annual payments and a 5.58 percent discount for annual payments. Quarterly direct billing is available upon request. You may also select the monthly Electronic Funds Transfer (EFT) option and have the premium withdrawn automatically from your checking or savings account.

Long Term Disability

Disability insurance protects an employee and his family from loss of income due to an injury or an extended illness that prevents the employee from working. When you leave active employment and retire, your Basic and Supplemental Long Term Disability end. Neither policy may be continued or converted to individual coverage.

When Your Coverage as a Retiree Begins

Enrollment in retiree insurance is not automatic. Even if you go directly from active employment to retirement, you still have to enroll as a retiree. Your retiree coverage will begin the day after your active coverage ends. If you are enrolling due to a special eligibility situation, your effective date will be either the date of the event or the first of the month after the event, depending on the event. For more information, see pages 24-28. If you enroll during open enrollment your coverage will be effective the following January 1.

Information You Will Receive

After you enroll, you will receive a letter from the Employee Insurance Program that confirms you have retiree group coverage. Because your coverage as an active employee is ending, federal law requires that you also be sent:

- A **Certificate of Creditable Coverage**, which gives the dates of your active coverage, the names of the individuals covered and the types of coverage
- A **Qualifying Event Notice**, which tells you that you may continue your coverage under COBRA.

Typically, these letters require no action on your part.

Your Benefits Administrator, or "BA," helps you enroll in or change your insurance coverage.

If you worked for a state agency, higher education institution or school district, your BA, in retirement, is the Employee Insurance Program.

If you worked for a local subdivision, your BA remains the same after retirement.

Your Insurance Identification Card in Retirement

Keep your identification cards if you do not change plans when you retire. Your Benefits ID Number will not change, and your health and dental cards will still be valid. You will receive a new health identification card only if you are changing from an HMO to any State Health Plan option or vice versa and/or if you enroll in a dental plan or the State Vision Plan for the first time. If your card is lost, stolen or damaged, you may request a new card from these third-party claims processors:

- State Health Plan — BlueCross BlueShield of South Carolina
- HMOs — CIGNA HealthCare HMO or BlueChoice HealthPlan HMO
- Dental Plus — BlueCross BlueShield of South Carolina
- State Vision Plan — EyeMed Vision Care.

Contact information for the third-party claims processors is on the inside cover of this guide.

Changing Coverage

Every October, you may change your **health coverage** without regard to special eligibility situations.

- During *annual enrollment,* which occurs in even-numbered years, eligible employees, retirees, survivors and COBRA subscribers may change health plans only. This includes changing to the Medicare Supplemental Plan, if you are retired.
- During *open enrollment*, which occurs in odd-numbered years, eligible subscribers may enroll in or drop their own health coverage and add or drop eligible dependents.
- During every enrollment period, eligible subscribers may add or drop **State Vision Plan** coverage.

For more information, see page 23 in the General Information chapter.

Dropping a Covered Spouse or Child

If a covered spouse or child becomes ineligible, you must drop him from your health, dental and vision coverage. This may occur because of divorce or separation, a spouse or a child gains coverage as an employee of an EIP participating group, a child turns 26, or a child becomes eligible for a group health plan sponsored by his employer (or by his spouse's employer). If you drop a spouse or child from your coverage, you must complete an NOE and provide documentation within 31 days of the date he becomes ineligible.

When your child becomes ineligible for coverage because of age, he will be dropped automatically. If he is your last covered child, your level of coverage will be changed.

Returning to Employment After Retirement

If you, your spouse or your children are covered under retiree group insurance and you become eligible for insurance benefits because you have returned to work for an employer participating in the state insurance program, you will need to make decisions regarding your coverage.

As long as you or any of your covered family members are not eligible for Medicare, you can decide whether to return to coverage under active group employee benefits or to continue your retiree group benefits. You cannot be covered under both. **If you or any of your covered family members are eligible for Medicare, you cannot remain on retiree group coverage while employed,** as explained below.

If you refuse to enroll as an active employee, you are also refusing benefits that are available only to active employees:

- MoneyPlu$ benefits (You must have completed one year of continuous state-covered service by January 1 after October enrollment to qualify for a Medical Spending Account.)
- Basic and Supplemental Long Term Disability coverage
- $3,000 Basic Life benefit
- Optional Life Insurance
- Dependent Life Insurance.

If you prefer to continue your retiree group insurance benefits, you must complete and sign an **Active Group Benefits Refusal** form.

Retirees Who Continued or Converted Life Insurance

Retirees Hired in a Benefits-Eligible Position
If you continued your Optional Life coverage, you must cancel it if you choose active benefits. You may then enroll in Optional Life as an active employee.

If you converted your Optional Life coverage to a whole life policy and are rehired within two years of the date the coverage was converted, you must cancel your converted policy in order to enroll in Optional Life as an active employee. **If you return to work more than two years after your policy was converted, you can enroll in active coverage and keep your converted policy.**

If You or Your Covered Family Members Are Enrolled in Medicare

Medicare cannot be the primary insurance for you, or for any of your covered family members, while you are employed, according to federal law. To comply with this regulation, you are required to suspend your retiree group coverage and enroll as an active employee with Medicare as the secondary payer, or refuse all EIP-sponsored health coverage for yourself and your eligible family members and have Medicare coverage only.

If you enroll in active group coverage, you must notify the Social Security Administration (SSA), since Medicare will pay after your active group coverage. You may remain enrolled in Medicare Part B and continue paying the premium, and Medicare will be the secondary payer. You may also delay or drop Medicare Part B without a penalty while you have active group coverage. Contact the SSA for additional information. When you stop working and your active group coverage ends, you must re-enroll in retiree group coverage within 31 days of your active termination date. In addition, you must notify the SSA that you are no longer covered under an active group so that you can re-enroll in Medicare Part B, if you dropped it earlier.

If your new position does not make you eligible for benefits, your retiree group coverage continues, and Medicare remains the primary payer.

When Coverage Ends

Your coverage will end:

- If you do not pay the required premium when it is due
- The date it ends for all employees and retirees
- The day after your death.

Coverage of your family members will end:

- The date your coverage ends
- The date spouse or children coverage is no longer offered
- The last day of the month your spouse or child is no longer eligible for coverage. If your spouse or child's coverage ends, he may be eligible for continuation of coverage under COBRA (see pages 30-32).

When you leave work and return to retiree group coverage before age 65, be sure to contact the Social Security Administration within 60 days of turning 65. You should enroll in Medicare Part A and Part B.

If you are dropping a spouse or child from your coverage, you must complete a Notice of Election (NOE) form within 31 days of the date the spouse or child is no longer eligible for coverage.

Death of a Retiree

If a retiree dies, a surviving family member should contact EIP to report the death and end the retiree's health coverage. If the deceased was a retiree of a local subdivision, contact his benefits administrator.

Survivors of a Retiree

Spouses or children who are covered as dependents under the State Health Plan, an HMO, a dental plan or the State Vision Plan are classified as "survivors" when a covered employee or retiree dies. Survivors of funded retirees of a state agency, a higher education institution or a school district may be eligible for a one-year waiver of health insurance premiums. Survivors of non-funded retirees may continue their coverage. However, they must pay the full premium.

Participating local subdivisions may, but are not required to, waive the premiums of survivors of retirees, but a survivor may continue coverage, at the full rate, for as long as he is eligible. If you are a retiree of a participating local subdivision, check with your benefits administrator to see whether the waiver applies.

After the first year, a survivor who qualifies for the waiver must pay the full premium to continue coverage. At the end of the waiver, health coverage can be canceled or continued for all covered family members. If coverage is continued, no covered family members can be dropped until open enrollment or within 31 days of a special eligibility situation.

If you and your spouse are both covered employees or funded retirees at the time of death, your surviving spouse is not eligible for the premium waiver.

Dental and vision premiums are not waived. However, survivors can continue coverage by paying the full premium.

As a surviving spouse, you can continue coverage until you remarry. If you are a child, you can continue coverage until you are no longer eligible. If you are no longer eligible for coverage as a survivor, you may be eligible to continue coverage under COBRA. If your spouse retired from a state agency, a higher education institution or a school district, contact EIP for more information. If your spouse retired from a local subdivision, contact his benefits administrator.

For a checklist of information that may be helpful when a loved one dies, see page 36.

As long as a survivor remains covered by health, vision or dental insurance, he can add the other coverage at open enrollment. If he has health, vision and dental, and drops all three, he is no longer eligible as a survivor and cannot re-enroll in coverage, even at open enrollment.

If a surviving spouse becomes an active employee of a participating employer, he can switch to active coverage. When he leaves active employment, he can go back to survivor coverage within 31 days of the date his coverage ends, if he has not remarried.

Until you become eligible for Medicare, your health insurance, whether it is the State Health Plan, BlueChoice HealthPlan HMO or CIGNA HMO, pays claims the same way it did when you were an active employee. For more information, see the Health Insurance chapter and the chart on the following pages.

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Comparison of Health Plans for Retirees &

Type	**High Deductible Health Plan**		**Preferred Provider Organization**	
	After the deductible is met, other benefits are paid at the same level as the SHP Standard Plan.		To receive the higher level of benefits, subscribers should use a network provider.	
Plan	**SHP Savings Plan**		**SHP Standard Plan**	
Availability	Coverage worldwide		Coverage worldwide	
Annual Deductible *Single* *Family*	**$3,000** **$6,000**[1]		**$350** **$700**	
Coinsurance	**In-network** Plan pays 80% You pay 20%	**Out-of-network** Plan pays 60% You pay 40%	**In-network** Plan pays 80% You pay 20%	**Out-of-network** Plan pays 60% You pay 40%
Coinsurance Maximum *Single* *Family*	**$2,000** **$4,000** (excludes deductibles)	**$4,000** **$8,000** (excludes deductibles)	**$2,000** **$4,000** (excludes deductibles)	**$4,000** **$8,000** (excludes deductibles)
Physician Office Visit	Chiropractic benefits limited to **$500** a year, per person		Chiropractic benefits limited to **$2,000** a year, per person	
	No per-occurrence deductibles		**$10** per-occurrence deductible, then	
	Plan pays 80% You pay 20%	Plan pays 60% You pay 40%	Plan pays 80% You pay 20%	Plan pays 60% You pay 40%
Hospitalization/ Emergency Care	No per-occurrence deductibles or copays		Outpatient facility services: **$75** per-occurrence deductible Emergency care: **$125** per-occurrence deductible	
Prescription Drugs	Participating pharmacies and mail order only: You pay 100% of the plan's allowed amount until the annual deductible is met. Afterward, the plan will reimburse 80% of the allowed amount. The remaining 20% will be credited to your coinsurance maximum. (Pay-the-difference applies, see p. 68)		Participating pharmacies only (up to 31-day supply): **$9** Tier 1 (generic—lowest cost), **$30** Tier 2 (brand—higher cost), **$50** Tier 3 (brand—highest cost) Mail order (up to 90-day supply): **$22** Tier 1, **$75** Tier 2, **$125** Tier 3 Copay maximum: **$2,500** (Pay-the-difference applies, see p. 68)	
Mental Health/ Substance Abuse	Preauthorization required for some services. Call 800-868-1032. Subject to above deductibles and coinsurance.		Preauthorization required for some services. Call 800-868-1032. Subject to above deductibles and coinsurance.	
Lifetime Maximum	**None**		**None**	

[1] *If more than one family member is covered, no family members will receive benefits, other than preventive, until the $6,000*

Please Note: *This chart is a summary of your benefits. More information is available earlier in the Retirement/Disability*

Family Members NOT Eligible for Medicare

	HMOs	
	All care must be directed by a primary care physician (PCP) and approved by the HMO.	
	BlueChoice HealthPlan HMO	**CIGNA HMO**
	Available in all counties in South Carolina	Available in all S.C. counties, **except**: *Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda*
	$250 **$500** (Does not apply to some services. See p. 80)	None
	HMO pays 85% after deductible or hospital copays You pay 15%	HMO pays 80% after copays You pay 20%
	$2,000 **$4,000** (excludes deductibles)	**$2,000** **$4,000** (includes inpatient and outpatient copays and 20% coinsurance)
	$15 PCP copay **$15** OB/GYN well woman exam **$40** specialist copay	**$15** PCP copay **$15** OB/GYN exam **$30** specialist copay
	Inpatient: **$200** copay Outpatient: **$100** copay/first 3 visits Emergency care: **$125** copay HMO pays 85% after copay. You pay 15% **$35** Urgent care copay, then HMO pays 100%	Inpatient: **$500** copay Outpatient: **$250** copay HMO pays 80% after copay Emergency care: **$100** copay. Urgent care: **$50** copay HMO pays 100% after copay
	Participating pharmacies only (up to 31-day supply): **$8/$15** generic, **$35** preferred brand, **$55** non-preferred brand. **$125/$80** specialty pharmaceuticals Mail order (up to 90-day supply): **$20/$37.50** generic, **$87.50** preferred brand, **$137.50** non-preferred brand	Participating pharmacies only (up to 30-day supply): **$7** generic, **$25** preferred brand, **$50** non-preferred brand Mail order (up to 90-day supply): **$14** generic, **$50** preferred brand, **$100** non-preferred brand
	Participating providers only. Call 800-868-1032 Inpatient: **$200** copay, then HMO pays 85% Outpatient: $40 specialist copay	Participating providers only. Inpatient: **$500** copay, then 80% covered Outpatient: **$30** specialist copay
	None	**None**

annual family deductible is met.

Retirement chapter and in the Health Insurance chapter.

Comparison of Health Plans for Retirees &

Plan	SHP Savings Plan	SHP Standard Plan	
Inpatient Hospital Days[1]	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call or CBA preauthorization required)	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call or CBA preauthorization required)	
Skilled Nursing Care	Plan pays 80% up to 60 days (Medi-Call required)	Plan pays 80% up to 60 days (Medi-Call required)	
Private Duty Nursing	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call required)	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call required)	
Home Healthcare	100 visits, if Medi-Call approved	100 visits, if Medi-Call approved	
Hospice Care	**$6,000** maximum, including **$200** bereavement counseling	**$6,000** maximum, including **$200** bereavement counseling	
Durable Medical Equipment	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call required)	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call required)	
Routine Mammography Screening	Ages 35-74 in participating facilities only; guidelines apply	Ages 35-74 in participating facilities only; guidelines apply	
Pap Test	Ages 18-65 Routine or diagnostic	Ages 18-65 Routine or diagnostic	
Ambulance	Plan pays 80% You pay 20% with coinsurance maximum for emergency transport	Plan pays 80% You pay 20% with coinsurance maximum for emergency transport	
Eyeglasses	None, except for prosthetic lenses from cataract surgery	None, except for prosthetic lenses from cataract surgery	

[1]*Semi-private room and board, physician/surgeon charges, operating/delivery room and recovery room, general nursing and miscellaneous hospital services and supplies.*

WHEN YOU OR YOUR ELIGIBLE FAMILY MEMBERS BECOME ELIGIBLE FOR MEDICARE before age 65, notify EIP within 31 days of eligibility. If you do not notify EIP and EIP continues to pay benefits as if it were your primary insurance, when EIP discovers you are eligible for Medicare, EIP will:

- **Begin paying benefits as if you were enrolled in Medicare**
- **Seek reimbursement for overpaid claims back to the date you or your covered family members became eligible for Medicare.**

When you become eligible for Medicare, it is strongly advised you ENROLL IN MEDICARE PART A AND PART B if you are covered as a retiree or as a spouse or child of a retiree. Medicare becomes your primary insurance. If you are not enrolled in Part B, you will be required to pay the portion of your healthcare costs that Part B would have paid.

Family Members NOT Eligible for Medicare

	BlueChoice HealthPlan HMO	CIGNA HMO
	Plan pays 85% You pay 15% with a **$200** copay and coinsurance	Plan pays 80% You pay 20% with **$500** copay and coinsurance maximum
	Plan pays 85% You pay 15% up to 120 days	Plan pays 80% You pay 20% up to 180 days
	Plan pays 85% You pay 15% up to 60 days	Plan pays 100%
	Plan pays 85% You pay 15%	Plan pays 100% up to 60 visits
	Plan pays 85% You pay 15%	Inpatient: Plan pays 80%, you pay 20% Outpatient: Plan pays 100%
	Plan pays 85% You pay 15%	Plan pays 100%
	Plan pays 100%; guidelines apply	Plan pays 100%
	Routine: any age; 2 per year; **$15** copay Diagnostic: copay/coinsurance	Plan pays 100% for test You pay **$15** PCP copay
	Plan pays 85% You pay 15%	Plan pays 80% You pay 20%
	None	None

Medicare

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Medicare

Introduction

This chapter is for participants in a state health insurance plan and their covered family members who are eligible for Medicare or who soon will be. It provides information about how health insurance offered through the Employee Insurance Program (EIP) works with Medicare. For more information about your health plan, refer to the Health Insurance chapter, which begins on page 40. and the chart, which begins on page 220. You may also contact your plan's third-party claims processor:

- Medicare Supplemental Plan — BlueCross BlueShield of South Carolina
- Standard Plan — BlueCross BlueShield of South Carolina
- BlueChoice HealthPlan HMO — BlueChoice HealthPlan of South Carolina
- CIGNA HMO — CIGNA Healthcare HMO

(Contact information is on the inside cover of this guide.)

Please note: Companion Benefit Alternatives (CBA), the mental health and substance abuse division of BlueCross BlueShield of South Carolina (BCBSSC), is now the mental health/substance abuse manager for the State Health Plan, which includes the Medicare Supplemental Plan and the Standard Plan. BCBSSC handles customer service and processes your claims. Claims are reported to you on your Explanation of Benefits from BCBSSC. CBA handles preauthorization, provider networks and case management.

The Retirement/Disability Retirement chapter offers information on topics such as eligibility, enrollment and when coverage begins and ends. It also discusses how other insurance offered through EIP is affected by retirement. **Please continue to refer to the Retirement/Disability Retirement chapter, as well as to the chapters on specific insurance coverage.**

If you have questions or need additional information, contact EIP through its website, www.eip.sc.gov, or call 803-734-0678 (Greater Columbia area) or 888-260-9430 (toll-free outside the Columbia area).

When You or Someone You Cover Becomes Eligible for Medicare

About Medicare

Information in this section relates to Medicare *Part A*, *Part B* and *Part D*. To learn more:

- Read *Medicare & You 2012*
- Visit the Medicare website at www.medicare.gov
- Call Medicare at 800-633-4227 or 877-486-2048 (TTY).

Medicare Part A
Part A is hospital insurance. Most people do not pay a premium for Part A because they or their spouse paid Medicare taxes while they were working. Part A helps cover inpatient care in hospitals, in critical access hospitals in rural areas and in skilled nursing facilities. Part A has an inpatient hospital deductible for each benefit period. For 2012, it is $1,156. Part A also covers hospice care and some home healthcare. You must meet certain requirements to be eligible for Part A. If you are not eligible for free Part A coverage, you may purchase it. Contact Medicare for additional information.

Medicare Part B
Part B is medical insurance. Most people do pay a premium through the Social Security Administration for Part B. It helps cover doctors' services, durable medical equipment and outpatient hospital care. It also cov-

ers some medical services that Part A does not cover, such as some services of physical and occupational therapists and home healthcare. Part B pays for these covered services and supplies when they are medically necessary. In 2012, the Part B deductible is $140 a year.

When you become eligible for Medicare, it is important to be enrolled in Medicare Part A and Part B if you are covered as a retiree or as a spouse or child of a retiree. Medicare becomes your primary insurance, and your retiree group insurance becomes the secondary payer. **If you are not enrolled in Part A and Part B, you will be required to pay the portion of your healthcare costs that Part A and Part B would have paid.**

Note: Medicare has added some preventive benefits, including a free yearly wellness checkup. For detailed information, see *Medicare & You 2012* or *Your Guide to Medicare's Preventive Services* or contact Medicare.

Medicare Part D

Most subscribers covered by the Medicare Supplemental Plan, the Standard Plan or the health maintenance organizations offered through EIP should not sign up for Medicare Part D.

If you or your eligible spouse or child enrolls in Medicare Part D, you, or he, will lose the prescription drug coverage provided by your health plan with EIP. However, the premium for your health plan will not be reduced.

For most people, the prescription drug benefit provided through their health plan is as good as, or better than, Part D. Because you have this coverage, your drug benefits will continue to be paid through your health insurance. Before you turn 65 and become eligible for Medicare, you will receive a Notice of Creditable Coverage from EIP officially notifying you that you do not need to sign up for Part D. (If you become eligible for Medicare before age 65, the letter will not be sent to you. You must notify EIP of your Medicare eligibility.)

You may have heard that if you do not sign up for Part D when you are first eligible — then later do so — you will have to pay higher premiums for Part D. For EIP subscribers, this is not true. According to Medicare rules, Medicare recipients who have "creditable coverage" (drug coverage that is as good as, or better than, Part D) and who later sign up for Part D, will not be penalized by higher Part D premiums. Subscribers to the health plans offered through EIP have creditable coverage. However, please save your Notice of Creditable Coverage from EIP in case you need to prove you had this coverage when you became eligible for Part D.

Most people should not respond to information they may get from Medicare or advertisements from companies asking them to buy Part D prescription drug plans.

The federal government offers extra help in paying for Medicare Part D, but not EIP drug coverage, for people with limited income and resources. If you think you may qualify for this assistance, go to the Social Security Administration's website at www.socialsecurity.gov or call 800-772-1213 or 800-325-0778 (TTY).

Please remember: Medicare Part D does not affect your need to enroll in Medicare Part B (medical insurance). As a retiree covered under EIP's insurance, you must enroll in Part A, and it is strongly advised that you enroll in Part B when you become eligible for Medicare due to a disability or due to age. **If you are not enrolled in Parts A and B of Medicare, you will be required to pay the portion of your healthcare costs that Medicare would have paid.**

Medicare Before Age 65: Disability Retirees

If you or your eligible spouse or child becomes eligible for Medicare before age 65 due to disability, including end-stage renal disease (ESRD), you must notify EIP within 31 days of Medicare eligibility. When you notify EIP, please send a copy of your Medicare card.

Because Medicare is primary (pays first) over your retiree health insurance (except during the 30-month ESRD coordination of benefits period), when you become eligible for Medicare, you must enroll in Medicare Part A, and it is strongly advised that you enroll in Part B. **If you are not enrolled in Part B, you will be required to pay the portion of your healthcare costs Part B would have paid.**

If you are covered under the Savings Plan or Standard Plan, you will automatically be switched to the Medicare Supplemental Plan the first of the month after EIP is notified that you are enrolled in Medicare.

If you or a covered family member becomes eligible for Medicare before age 65, you MUST notify EIP within 31 days of eligibility. If you do not notify EIP of your Medicare eligibility, and EIP continues to pay benefits as if it were your primary insurance, when EIP discovers you are eligible for Medicare, EIP will:

- **Begin paying benefits as if you were enrolled in Medicare**
- **Seek reimbursement for overpaid claims back to the date you or your covered family member(s) became eligible for Medicare.**

End-stage Renal Disease

If you have end-stage renal disease you will become eligible for Medicare three months after beginning dialysis. At this point, a 30-month "coordination period" begins. During this period, your health coverage through EIP is primary, which means it pays your medical claims first. After 30 months, Medicare becomes your primary coverage. Please notify EIP within 31 days of the end of the coordination period. If you are covered as a retiree, you will then have the option of changing to the Medicare Supplemental Plan. (The Medicare Supplemental Plan is not available to active employees or their covered family members.)

The coordination period applies whether you are an active employee, a retiree, a survivor or a covered spouse or child and whether you were already eligible for Medicare for another reason, such as age. If you were covered by the Medicare Supplemental Plan, your claims will be processed under the Standard Plan for the 30-month coordination period.

Medicare at 65 if You Are Retired

At age 65, Medicare is primary (pays first) over your retiree health insurance. You must enroll in Medicare Part A, and it is strongly advised that you enroll in Part B. **If you do not enroll in Medicare Part A and Part B, you will be required to pay the portion of your healthcare costs Medicare would have paid.**

Medicare's Initial Enrollment Period starts three months before your 65th birthday, includes the month of your birthday and extends three months past the month you turn 65. If you are not receiving Social Security benefits, you should ask about enrolling in Medicare three months before you turn age 65 so your Medicare coverage can start the month you turn 65.

If you are receiving Social Security benefits, you should be notified of Medicare eligibility by the Social Security Administration three months before you reach age 65. Medicare Part A starts automatically. It is strongly advised that you enroll in Part B. If you are not notified, contact your local Social Security office immediately.

If you decide not to receive Social Security benefits until you reach **your** full Social Security retirement age, you must still apply for Medicare Part A and Part B. We recommend you contact the Social Security Administration within three months of your 65th birthday to enroll. The Social Security Administration will bill you quarterly for the premium for Part B.

If You Are an Active Employee at Age 65

If you are actively working and/or covered under a state health insurance plan for active employees, you may delay enrollment in Part B because your insurance as an active employee remains primary. If you are an active employee but your spouse is eligible for Medicare, your spouse should enroll in Part A but may delay enrollment in Part B until you retire and your active coverage ends.

Note: If you are an active employee, you cover your spouse under a state health insurance plan for active employees and your spouse is eligible for Medicare due to disability, your spouse may delay enrollment in Part B because your insurance as an active employee remains primary. If your spouse's eligibility is due to end-stage renal disease, contact EIP.

When You Leave Active Employment After Age 65

Social Security has a special enrollment rule for employees ending active employment after age 65. You should contact the Social Security Administration at least 90 days before you retire to ensure that you or your covered spouse or child's Medicare Part A and Part B coverage begins on the same date as your retiree coverage.

Please check with the Social Security Administration to make sure you are enrolled in Medicare Part A. **It is strongly advised that you enroll in Part B because Medicare becomes your primary coverage.**

If you wish to switch to the Medicare Supplemental Plan, you may do so within 31 days after your active coverage ends.

Sign up for Parts A and B of Medicare

You must enroll in both Part A and Part B of Medicare to receive full benefits with any state-offered retiree group health plan. If you are not enrolled in both parts of Medicare, you will be required to pay the portion of your healthcare costs Medicare Part B would have paid.

How Turning Down Part B Affects Medicare Coverage

If you turn down Medicare Part B when you are first eligible, you must wait until Medicare's General Enrollment Period. This period is from January 1 to March 31 of each year, and coverage begins on July 1. Your Medicare premium will be 10 percent higher for each year you were not covered by Part B after you were first eligible. Contact Medicare for enrollment details and for premium information that applies specifically to you.

Returning to Employment After Retirement

If you or your spouse or child is covered under the retiree group insurance program and you become eligible for insurance benefits because you have returned to work for an employer participating in the state insurance program, you will need to make decisions regarding your coverage.

If You or Someone You Cover is Enrolled in Medicare

Medicare cannot be the primary insurance and coverage through EIP cannot be secondary insurance for you, or for anyone you cover, while you are employed, according to federal law. To comply with this regulation, you must suspend your retiree group coverage and enroll as an active employee with Medicare as the secondary payer, or refuse all EIP-sponsored health coverage for yourself, your spouse and your children and have Medicare coverage only.

These benefits are only available to you if you are covered as an active employee:

- MoneyPlu$ benefits (You must have completed one year of continuous state-covered service by January 1 after October enrollment to qualify for a Medical Spending Account.)
- Basic and Supplemental Long Term Disability coverage
- $3,000 Basic Life benefit
- Optional Life Insurance
- Dependent Life Insurance.

If you enroll in active group coverage, you must notify the Social Security Administration (SSA), since Medicare will pay after your active group coverage.

If you continued or converted your life insurance when you retired, please see pages 190-191.

You may remain enrolled in Medicare Part B and continue paying the premium, and Medicare will be the secondary payer. You may also delay or drop Medicare Part B without a penalty while you have active group coverage. Contact the SSA for additional information.

When you stop working and your active group coverage ends, you must re-enroll in retiree group coverage within 31 days of your active termination date. In addition, you must notify the SSA that you are no longer covered under an active group so that you can re-enroll in Medicare Part B, if you dropped it earlier.

If your new position does not make you eligible for benefits, your retiree group coverage continues, and Medicare remains the primary payer.

How Medicare Affects COBRA Coverage

If you or your eligible spouse or child is covered by COBRA and becomes eligible for Medicare Part A, Part B or both, please notify EIP. Your COBRA coverage will end.

A subscriber or eligible spouse or child who is covered by Medicare and then becomes eligible for COBRA can enroll in COBRA for secondary coverage. Medicare will be his primary coverage.

Your Health Insurance Options With Medicare

When you and/or your eligible spouse or children are covered under retiree group health insurance and become eligible for Medicare, Medicare becomes the primary payer, and your health options change. Before you turn 65, EIP will send you a letter offering you and your eligible spouse or children a choice of:

- The Standard Plan
- The Medicare Supplemental Plan
- CIGNA HMO or BlueChoice HealthPlan HMO. (The HMO must be offered in the county where you live.)

If you become eligible for Medicare due to age, and you are covered by the Standard Plan or the Savings Plan, you will be automatically enrolled in the Medicare Supplemental Plan unless you respond to the notification letter by choosing another plan. Coverage changes must be made within 31 days of the date you become eligible for Medicare.

If you or your covered spouse or child is enrolled in the Medicare Supplemental Plan, the claims of covered family members without Medicare are paid through the Standard Plan's provisions.
Please note: If you are a retiree and you are considering enrolling in the **Savings Plan**, please call EIP or BCBSSC for information about how the Savings Plan would coordinate with Medicare or with other coverage. If you are retired and are eligible for and enrolled in Medicare, you cannot contribute to a Health Savings Account, which is typically associated with the Savings Plan.

Medicare Assignment: How Medicare Shares the Cost of Your Care

When you choose a provider, you may wish to determine if:
- He accepts assignment
- He may accept assignment on an individual claim or
- He has opted out of Medicare.

Medicare *assignment* is a yearly agreement between Medicare and individual providers. After you meet your deductible and pay your coinsurance, if it applies, some doctors and suppliers will accept the Medicare-approved amount as payment in full for services payable under Medicare Part B. This is called "accepting assignment."

A provider who accepts assignment also submits his claims directly to Medicare, so you don't have to pay the full amount up front and wait for reimbursement. A provider may choose whether to accept assignment on each individual claim. Before you receive services from a physician, ask if he will accept assignment. If a doctor does not accept assignment, you may pay more for his services. However, your provider may not charge you more than 15 percent above Medicare's approved amount.

If a doctor decides to accept assignment from Medicare, he cannot drop out in the middle of the year. Independent laboratories and doctors who perform diagnostic laboratory services and non-physician practitioners must accept assignment.

For a list of physicians, suppliers of medical equipment and other providers who accept assignment, visit www.medicare.gov. For more information, call 800-633-4227. TTY/TDD users should call 877-486-2048.

The Medicare Supplemental Plan

If you are a retiree enrolled in the Standard Plan or the Savings Plan and become eligible for Medicare **due to your age**, you will receive a letter from EIP stating that you will be enrolled automatically in the Medicare Supplemental Plan. If you prefer another health plan, you must inform EIP by responding to the letter within 31 days of Medicare eligibility.

If you are enrolled in a health plan offered through EIP, you may change to the Medicare Supplemental Plan within 31 days of Medicare eligibility. During the yearly October enrollment period, you can change from the Standard Plan or an HMO available in the county in which you live, to the Medicare Supplemental Plan. Plan changes are effective on January 1 after the enrollment period. If you move out of the country you may be eligible to change from the Medicare Supplemental Plan to another health plan.

This section explains the Medicare Supplemental Plan, which is available to a retiree and his covered spouse or children who are enrolled in Medicare Parts A and B. This plan coordinates benefits with the original Medicare plan only. **No benefits are provided for coordination with Medicare Advantage plans (Part C) .** For more information, visit www.medicare.gov or call 800-633-4227. If you or your covered spouse or child is enrolled in the Medicare Supplemental Plan, the claims of covered family members without Medicare are paid through the Standard Plan's provisions.

General Information

The Medicare Supplemental Plan is similar to a Medigap policy — it "fills the gap" or pays the portion of Medicare-approved charges that Medicare does not, such as Medicare's deductibles and coinsurance. The Medicare Supplemental Plan payment is based on the Medicare-approved amount. Except as specified on pages 211-212 charges that are not covered by Medicare will not be payable as benefits under the supplemental plan.

For example:
In an outpatient setting, such as an emergency room, Medicare does not cover *self-administered drugs*, which are drugs that a person usually takes on his own, such as pills. This means that if a patient receives pain pills in an emergency room, the hospital will bill him for the drugs. Because Medicare does not pay for the pills, the Medicare Supplemental Plan will not pay for them either.

If your medical provider does not accept Medicare assignment, and charges you more than what Medicare allows, you pay the difference. Your provider may not charge you more than 15 percent above Medicare's approved amount, unless he has opted out of Medicare.

Using Medi-Call and Companion Benefit Alternatives for Preauthorization

You need to call Medi-Call or Companion Benefit Alternatives (CBA) only when Medicare benefits are exhausted for inpatient hospital services and for extended care services, such as skilled nursing facilities, private duty nursing, home healthcare, durable medical equipment and Veterans Administration hospital services. Medicare has its own program for reviewing use of its services.

Filing Claims for Covered Family Members not Eligible for Medicare

Claims for covered family members who are not eligible for Medicare, but who are insured through the Medicare Supplemental Plan, are paid according to the Standard Plan provisions. Remember that some services require preauthorization by Medi-Call, National Imaging Associates or Companion Benefit Alternatives (CBA).

Medicare Deductibles and Coinsurance

Deductibles

Medicare Part A has an inpatient hospital deductible for each *benefit period*. That deductible for 2012 is $1,156. A Medicare benefit period begins the day you go to a hospital or skilled nursing facility and ends when you have not received any hospital or skilled care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. *The Medicare Supplemental Plan will pay the Part A deductible each time it is charged.*

Medicare Part B has a deductible of $140 a year in 2012. Part B, for which you pay a monthly premium, covers physician services, supplies and outpatient care. Please contact Medicare for more information. As a retiree, you must enroll in Part B as soon as you are eligible for Medicare, because Medicare is your primary coverage. If you are not enrolled in Part B, you will be required to pay the portion of your healthcare costs that Part B would have paid. *The Medicare Supplemental Plan pays the Part B deductible.*

Coinsurance

Medicare Part B pays 80 percent of the Medicare-approved amount (60 percent for outpatient mental health care). *The Medicare Supplemental Plan pays the remaining 20 percent (40 percent for outpatient mental health care).*

Medicare Supplemental Plan Deductibles and Coinsurance

The Medicare Supplemental Plan benefit period is January 1-December 31 and includes a $200 deductible each calendar year that applies to private duty nursing services only. If you enroll in Medicare and change to the Medicare Supplemental Plan during the year, you must meet a new $200 deductible for private duty nursing services.

What the Medicare Supplemental Plan Covers

Hospital Admissions

The Medicare Supplemental Plan pays for these services during a benefit period after Medicare has paid:

- The Medicare Part A inpatient hospital deductible
- The Medicare coinsurance amount for days 61 through 90 of a hospital stay in each Medicare benefit period
- The Medicare coinsurance amount for days 91 through 150 of a hospital stay for each of Medicare's 60 lifetime reserve days (The lifetime reserve days can be used once.)
- After all Medicare hospital benefits are exhausted, 100 percent of the Medicare Part A-eligible hospital expenses, if medically necessary*

- The coinsurance for durable medical equipment up to the Medicare-approved amount.

**Must call Medi-Call or Companion Benefit Alternatives (CBA) for approval.*

If You Exhaust the Inpatient Hospital Days Medicare Allows

If you are enrolled in the Medicare Supplemental Plan and you exhaust all Medicare-allowed inpatient hospital days, you must call Medi-Call or Companion Benefit Alternatives (CBA) for approval of any additional inpatient hospital days. Also, if you are enrolled in the Medicare Supplemental Plan, and you think that a hospital stay may exceed the number of days allowed under Medicare, you should choose a hospital within the SHP networks or BlueCard Program so that any days beyond what Medicare allows will be covered as an in-network benefit by the Medicare Supplemental Plan.

You must also call Medi-Call or CBA for preauthorization for services related to home healthcare, hospice, durable medical equipment and Veterans Administration hospital services.

Skilled Nursing Facilities

The Medicare Supplemental Plan will pay these benefits after Medicare has paid benefits during a benefit period:

- The coinsurance, after Medicare pays, up to the Medicare-approved amount for days 21-100 (Medicare pays 100 percent for the first 20 days)
- 100 percent of the approved rates beyond 100 days in a skilled nursing facility, if medically necessary. (Medicare does not pay beyond 100 days.)* The maximum benefit under the plan per year for covered services beyond 100 days is 60 days.

**Must call Medi-Call for approval.*

Physician Charges

The Medicare Supplemental Plan will pay these benefits related to physician services approved by Medicare:

- The Medicare Part B deductible
- The coinsurance for the Medicare-approved amount for physician's services for surgery, necessary home and office visits, inpatient hospital visits and other covered physician's services
- The coinsurance for the Medicare-approved amount for physician's services provided in the outpatient department of a hospital for treatment of accidental injuries and medical emergencies; minor surgery; and diagnostic services.

Home Healthcare

The Medicare Supplemental Plan will pay these benefits for medically necessary home healthcare services:

- The Medicare Part B deductible
- The coinsurance for any covered services or costs Medicare does not cover (Medicare pays 100 percent of Medicare-approved amount), up to 100 visits per benefit year. The plan does not cover services provided by a person who ordinarily resides in the home, is a member of the family or a member of the family of the spouse of the covered person.
- 20 percent of Medicare-approved amount for durable medical equipment.

Private Duty Nursing Services

Private duty nursing services are services that are provided by a registered nurse (RN) or a licensed practical nurse (LPN) and that have been certified in writing by a physician as medically necessary. There is a $200 annual deductible that applies, regardless of the time of year you enroll in the plan. Medicare does NOT cover this service. Once the deductible is met, the Medicare Supplemental Plan will pay 80 percent of

covered charges for private duty nursing in a hospital or in the home. Coverage is limited to no more than three nurses per day, and the maximum annual benefit per year is $5,000. The lifetime maximum benefit under the Medicare Supplemental Plan is $25,000.

Prescription Drugs

The Medicare Supplemental Plan covers prescription drugs when purchased from a participating pharmacy under the SHP's Prescription Drug Program. For more information, see pages 67-72. For information about how the plan relates to Medicare Part D, see page 206.

When Traveling Outside the U.S.

Medicare does not cover services outside the United States and its territories. Because the Medicare Supplemental Plan does not allow benefits for services not covered by Medicare (other than private duty nursing), **out-of-country coverage is not available to Medicare Supplemental Plan members if Medicare is their primary coverage.**

Pap Test Benefit

If you are enrolled in Medicare, Medicare covers a Pap test, pelvic exam and clinical breast exam every 24 months. These tests are covered yearly if you are at high risk. There is no patient liability if you receive the tests from a doctor who accepts assignment. Check with Medicare for more information.

Opting Out: If a Provider Does not Accept Medicare

Some providers choose not to accept any payment from Medicare. If a provider has made this decision, Medicare covers none of that provider's services, and no Medicare payment can be made to him. If Medicare doesn't pay anything, neither will the Medicare Supplemental Plan.

A provider who opts out of Medicare signs a two-year contract. The contract can be renewed.

Medicare Assignment: How Medicare Pays Its Share of the Cost of Your Care

If a provider accepts Medicare assignment, the provider accepts Medicare's payment plus the Medicare Supplemental Plan's payment as payment in full for covered services. If the provider does not accept Medicare assignment, the provider may charge more than what Medicare and the Medicare Supplemental Plan pay combined. You pay the difference.

Example:
Medicare is primary. The hospital bill for a January admission is submitted to Medicare. If you are enrolled in Medicare and the Medicare Supplemental Plan, your Medicare claim will be processed like this:

$7,500	Medicare-approved amount
-1,156	Medicare Part A deductible for 2012
$6,344	Medicare payment
$1,156	Balance of the bill

Next, the Medicare Supplemental Plan benefits are applied:

$1,156	Balance of the bill
-$1,156	Medicare Supplemental Plan pays Medicare Part A deductible
$ 0	You pay nothing.

Filing Medicare Claims as a Retiree

If you are retired and enrolled in Medicare, Medicare is primary (pays first). In most cases, your provider will file your Medicare claims for you.

Claims Filed in South Carolina

The Medicare claim should be filed first. Claims for Medicare-approved medical charges incurred in South Carolina should be transferred automatically from Medicare to the SHP. If you or your doctor have not received payment or notification from the plan within 30 days after the Medicare payment is received, one of you must send BCBSSC, third-party claims processor for the SHP, a claim form and a copy of your Medicare Summary Notice (MSN) with your Benefits ID Number or Social Security Number written on it. Your mental health and substance abuse claims also should be filed with BCBSSC and should include your MSN with your Benefits ID Number or Social Security Number written on it. See page 239 if you need to file your own claim.

Claims Filed Outside South Carolina

If you receive services outside South Carolina, your provider will file its claim to the Medicare carrier in that state. When you receive your MSN you must send it to BCBSSC for medical, surgical or mental health and substance abuse services. You also must include a claim form and an itemized bill.

The Standard Plan

The Standard Plan offers worldwide coverage. It requires Medi-Call approval for inpatient hospital admissions; all maternity benefits (you must call in the first trimester); outpatient surgical services in a hospital or clinic; the purchase or rental of durable medical equipment; and skilled nursing care, hospice care and home health care. You must call National Imaging Associates for office-based or outpatient advanced radiology services, such as CT, MRI, MRA and PET scans (866-500-7664). You must also call Companion Benefit Alternatives (CBA), the SHP's mental health/substance abuse manager, for preauthorization before you receive some mental health or substance abuse benefits. See page 73 in the Health Insurance chapter.

The plan has deductibles and coinsurance. Once you become eligible for Medicare, Medicare becomes your primary insurance. The Standard Plan uses a carve-out method to pay claims. It is described on page 216.

How the Standard Plan and Medicare Work Together

Using Medi-Call and CBA Preauthorization as a Retiree with Medicare

You still need to call Medi-Call or Companion Benefit Alternatives (CBA) when Medicare benefits are exhausted for inpatient hospital services (including hospital admissions outside South Carolina or the U.S.), and for extended care services, such as skilled nursing, home healthcare, durable medical equipment and Veterans Administration hospital services. Medicare has its own program for reviewing use of its benefits.

Note: Covered family members who are not eligible for Medicare and whose claims are processed under the Standard Plan must call Medi-Call or Companion Benefit Alternatives (CBA).

Please remember that while your physician or hospital may call Medi-Call or CBA for you, it is your responsibility to see that the call is made.

For information about services that require preauthorization under the State Health Plan, see:
- **Medi-Call: page 50**
- **National Imaging Associates: page 51**
- **Companion Benefit Alternatives: page 73.**

Hospital Network

When you are enrolled in Medicare, Medicare is the primary payer, and you may go to any hospital you choose. Medicare limits the number of days of a hospital stay that it will cover. If you are enrolled in the Standard Plan and your hospital stay exceeds the number of days allowed under Medicare, it may be important to you that you are admitted to a hospital within the SHP network or BlueCard Program so that you will not be charged more than what the Standard Plan allows.

You must also call Medi-Call or Companion Benefit Alternatives (CBA) for approval of any additional in-patient hospital days beyond the number of days approved under Medicare and for services related to home healthcare, hospice, durable medical equipment and Veterans Administration hospital services.

When Traveling Outside the U.S.

You are not generally covered outside the United States under Medicare. However, if you are enrolled in the Standard Plan, you have worldwide access to doctors and hospitals through the BlueCard Worldwide program.

Emergency Hospital Admissions Outside South Carolina or the U.S.
If you are admitted to a hospital outside the state or the country as a result of an emergency, notify Medi-Call or Companion Benefit Alternatives (CBA) and follow the BlueCard guidelines. For more information about BlueCard Worldwide, see page 46.

Prescription Drug Program

The Standard Plan covers prescription drugs when purchased from a participating pharmacy. See page 67 for more information on the State Health Plan Prescription Drug Program.

Outpatient Facility Services

Outpatient services may be provided in the outpatient department of a hospital or a freestanding facility. If you are enrolled in Medicare, there is no need to call Medi-Call for preauthorization, nor do you need to select a center that participates in the network.

Transplant Contracting Arrangements

As part of this network, you have access to the leading transplant facilities in South Carolina and throughout the nation. If you are enrolled in Medicare, there is no need to call Medi-Call for preauthorization, nor do you need to select a facility that participates in the network.

Mammography Benefit

The State Health Plan pays for routine mammograms for covered women ages 35-74. You may have one baseline mammogram if you are age 35-39 and one routine mammogram every calendar year if you are age 40-74. There is no charge if you use a facility that participates in the program's network.

Medicare covers a screening mammogram every 12 months for women age 40 and older. Medicare pays 100 percent of its allowance for covered routine mammograms. There is no patient liability if you receive the test from a doctor who accepts assignment.

Pap Test Program

The SHP will pay for a Pap test each year, without any requirement for a deductible or coinsurance, for covered women ages 18-65. Medicare covers a Pap test, pelvic exam and clinical breast exam every 24 months. If you are at high risk, you may have one every 12 months. Medicare offers the benefit at 100 percent of its allowance if you receive the test from a doctor who accepts assignment. Check with Medicare for more information.

Maternity Management and Well Child Care Benefits

The SHP offers two programs geared toward early detection and prevention of illness among children. The Maternity Management benefit helps mothers-to-be receive necessary prenatal care. (This benefit applies to covered retirees and their spouses. It does not apply to covered children.) Covered children ages 18 and younger are eligible for Well Child Care check-ups. The plan pays 100 percent for routine immunizations when a network doctor provides the services. If your covered child has delayed, or missed, receiving

immunizations at the recommended time, the plan will pay for "catch-up" immunizations through age 18 for some vaccines. Check with your pediatrician to find out which immunizations are covered.

"Carve-out" Method of Claims Payment

When a retired subscriber is covered by Medicare, Medicare pays first, and the Standard Plan pays second. If your provider accepts the amount Medicare allows as payment in full, the Standard Plan will pay the lesser of:

1. The amount Medicare allows, minus what Medicare reported paying or
2. The amount the State Health Plan would pay in the absence of Medicare, minus what Medicare reported paying.

If your provider does not accept the amount Medicare allows as payment in full, the Standard Plan pays the difference between the amount the SHP allows and the amount Medicare reported paying. The Standard Plan will never pay more than the SHP allows. If the Medicare payment is more than the amount the SHP allows, the Standard Plan pays nothing.

***Example**:*
Medicare is primary. The hospital bill for a January admission is $7,500. If you are enrolled in the Standard Plan and Medicare, your Medicare claim will be processed like this:

$7,500	Medicare-approved amount
- 1,156	Medicare Part A deductible for 2012
$6,344	Medicare payment
$1,156	Balance of the bill

Next, Standard Plan benefits are applied to the Medicare-approved amount:

$7,500	SHP allowed amount
- 350	Standard Plan deductible for 2012
$7,150	Standard Plan's allowance after deductible
x 80%	Standard Plan coinsurance
$5,720	Standard Plan payment in the absence of Medicare
- 6,344	Medicare payment is "carved out" of the Standard Plan payment.
$ 0	Standard Plan pays nothing. You pay $1,156.

Under the carve-out method, you pay the Standard Plan deductible and coinsurance or the balance of the bill, whichever is less. In this example, the $350 deductible and your 20 percent coinsurance is $1,780. However, the balance of the bill is $1,156, so you pay the lesser amount, $1,156.

Once you reach your $2,000 coinsurance maximum, all claims will be calculated at 100 percent of the allowed amount based on the carve-out method of claims payment. All of your Medicare deductibles and your Medicare Part B 20 percent coinsurance should be paid in full for the rest of the calendar year after you reach your $2,000 coinsurance maximum.

Filing Claims As a Retiree with Medicare

If you are retired and enrolled in Medicare, Medicare is primary (pays first). In most cases, your provider will file your Medicare claims for you.

Claims Filed in South Carolina

The Medicare claim should be filed first. Claims for Medicare-approved medical charges incurred in South Carolina should be transferred automatically from Medicare to the SHP. If you or your doctor have not received payment or notification from the plan within 30 days after the Medicare payment is received, one of you must send BCBSSC, third-party claims processor for the SHP, a claim form and a copy of your Medicare Summary Notice (MSN) with your Benefits ID Number or Social Security Number written on it. Your

mental health and substance abuse claims should also be filed with BCBSSC and should include your MSN with your Benefits ID Number or Social Security Number on it. See page 239 if you need to file your own claim.

Claims Filed Outside South Carolina

If you receive services outside South Carolina, your provider will file the claim with the Medicare carrier in that state. If you or your doctor have not received payment or notification from the SHP within 30 days after the Medicare payment is received, one of you must send BCBSSC, third-party claims processor for the SHP, a claim form and a copy of your MSN, with your Benefits ID Number or Social Security Number written on it. For mental health and substance abuse claims, you must also send your MSN to BCBSSC.

If Medicare Denies Your Claim

If Medicare denies your claim, you are responsible for filing the denied claim with BCBSSC. You may use the same SHP claim forms active employees use. These forms are available on the EIP website, www.eip.sc.gov, or from EIP or BCBSSC. You will need to attach your MSN and an itemized bill to your claim form.

Health Maintenance Organizations

This section explains some key features of the Health Maintenance Organizations (HMOs) and how they work with Medicare. For a more complete overview of the plans, refer to the HMO section of the Health Insurance chapter of this guide or contact the HMO.

An HMO typically does not cover care outside its network, except in an emergency. If it is important to you to use particular providers, including physicians and hospitals, it is best to check to see if those providers participate in the HMO you wish to join.

Remember, you must live in an HMO's service area to enroll. BlueChoice HealthPlan HMO is offered statewide. CIGNA HMO is offered in all counties **except** Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda.

Provider Networks

An HMO provides a list of participating network doctors from which you choose a primary care physician. This doctor coordinates your care, which means you must contact him to be referred to specialists who also participate in the HMO's network. Network providers file the claims for you. If you belong to an HMO, the plan covers only medical services received from network providers. Typically, the only services from out-of-network providers that most HMOs cover are those for medical emergencies.

When Traveling Outside the Network or the U.S.

When traveling outside the CIGNA or BlueChoice networks, you will be covered for emergency medical care. If your insurance identification cards are not recognized by the hospital, you may be required to pay for the services and then later file a claim for reimbursement.

Prescription Drug Programs

Both HMOs offered for 2012 include a prescription drug program with participating pharmacies.

How BlueChoice HealthPlan HMO and Medicare Work Together

BlueChoice pays only charges approved by Medicare. It supplements Medicare by paying the Medicare Part A (hospital) and Part B (medical) deductibles in full. The plan also pays the 20 percent coinsurance after Medicare pays 80 percent for approved Part A and Part B services.

When you become eligible for Medicare, it is important to be enrolled in Part B if you are covered as a retiree or as a spouse or child of a retiree. Medicare becomes your primary insurance, and your health plan offered through EIP becomes the secondary payer. If you are not enrolled in Part B, you will be required to pay the portion of your healthcare costs that Part B would have paid.

This plan pays the coinsurance for hospitalization after the first 60 days in a general hospital or after the first 20 days in a skilled nursing facility. (Medicare pays 100 percent of the Medicare-approved amount for the first 60 days in a general hospital and for the first 20 days of skilled nursing care.) BlueChoice also pays the Medicare coinsurance for days 21-100 for skilled nursing care.

If a provider accepts Medicare assignment, the provider will consider Medicare's payment plus BlueChoice's as payment in full. If a provider does not accept Medicare assignment, the provider may charge more than what Medicare and BlueChoice pay combined. You pay the difference.

Example:

Medicare is primary. The bill is submitted to Medicare for a January hospital admission:

$7,500	Hospital bill
-1,156	Medicare Part A deductible for 2012
$6,344	Medicare payment
$1,156	Balance of the bill

BlueChoice HealthPlan pays all Medicare deductibles and coinsurance:

$1,156	BlueChoice pays Medicare Part A deductible
+6,344	Amount paid by Medicare
$7,500	Bill paid in full

If you are retired and enrolled in Medicare, Medicare is your primary coverage. In most cases, your provider will file your Medicare claims. The Medicare claim should be filed first.

More information about BlueChoice is in the HMO section of the Health Insurance chapter of this guide.

How CIGNA HMO and Medicare Work Together

CIGNA pays the lesser of the member's unreimbursed allowed amount under Medicare or CIGNA's normal liability. If the balance due on the claim is less than the normal liability, CIGNA pays the balance due.

CIGNA's benefit credit saving provisions apply. A *benefit credit* is the part of the claim that CIGNA does not have to pay as a result of a coordination of benefits with Medicare. It may be applied to future claims during the calendar year. *Benefit credit saving* is the difference between what CIGNA would normally be responsible for paying and CIGNA's actual payment. It applies only to the family member who incurs the charge, and it expires at the end of the calendar year in which it is gained. Contact CIGNA for more information.

Example:

Medicare is primary. The bill is submitted to Medicare for a January hospital admission:

$7,500	Hospital bill
- 1,156	Medicare Part A deductible for 2012
$6,344	Medicare payment
$1,156	Balance of the bill

If you are enrolled in CIGNA's HMO your claim will be paid like this:

$7,500	Hospital bill
- 500	CIGNA's inpatient per occurrence copayment
$7,000	
x 80%	CIGNA's coinsurance
$5,600	CIGNA's liability in absence of Medicare
- 1,156	Amount paid by CIGNA in coordination with Medicare
$4,444	Benefit credit savings with CIGNA

Filing Claims as a Retiree

If you are retired and enrolled in Medicare, Medicare is primary (pays first). In most cases, your provider will file your Medicare claims. The Medicare claim should be filed first. For more information, contact CIGNA.

Comparison of Health Plans for Retirees

Type			PPO To receive a higher level of benefits, subscribers should use an in-network provider.	
Plan	**Medicare**	**Medicare Supplemental**	**SHP Standard Plan**	
Availability	United States (Contact Medicare about any services outside the U.S.)	Same as Medicare	Coverage worldwide	
Cancellation Policy	None	Canceled for failure to pay premiums	Canceled for failure to pay premiums	
Annual Deductible	Part A: **$1,156** (per benefit period) Part B: **$140**	Pays Medicare Part A and Part B deductibles	**$350** (single) **$700** (family) Carve-out method applies	
Per-occurrence Deductible	Inpatient hospital: Part A deductible (**$1,156** per benefit period)	Pays Medicare Part A deductible (Call Medi-Call for hospital stays over 150 days, skilled nursing, private duty nursing, home healthcare, durable medical equipment and VA hospital services)	Outpatient hospital, outpatient surgery centers: **$75** deductible Emergency care: **$125** deductible (Call Medi-Call for hospital stays over 150 days, skilled nursing, home healthcare, durable medical equipment and VA hospital services)	
Coinsurance	Part A: 100% Part B: 80% (You pay 20%)	Pays Part B coinsurance of 20%	Carve-out method applies Plan allows 80%	
Coinsurance Maximum	None	None	**In-network** **$2,000** (single) **$4,000** (family) **Out-of-network** **$4,000** (single) **$8,000** (family) Excludes deductible	
Physician Visits	Medicare pays 80% You pay 20% Medicare covers a "Welcome to Medicare" physical exam and a yearly "Wellness" checkup. No charge if they are from a doctor who accepts assignment.	Plan pays Part B coinsurance of 20%	Carve-out method applies; **$10** per-occurrence deductible; Plan allows 80% in-network, 60% out-of-network Well Child Care visits and immunizations paid at 100% in-network up to age 18.	
Prescription Drugs	Covered under Medicare Part D. However, subscribers to health plans offered through the Employee Insurance Program have creditable coverage and therefore do not need to sign up for Part D.	Participating pharmacies only (up to 31-day supply): **$9** Tier 1 (generic—lowest cost), **$30** Tier 2 (brand—higher cost), **$50** Tier 3 (brand—highest cost) Mail-order (up to 90-day supply): **$22** Tier 1, **$75** Tier 2, **$125** Tier 3 Copay max: **$2,500** (Pay the difference applies, p. 68)	Participating pharmacies only (up to 31-day supply): **$9** Tier 1 (generic—lowest cost), **$30** Tier 2 (brand—higher cost), **$50** Tier 3 (brand—highest cost) Mail order (up to 90-day supply): **$22** Tier 1, **$75** Tier 2, **$125** Tier 3 Copay max: **$2,500** (Pay the difference applies, p. 68)	
Mental Health/ Substance Abuse	Inpatient: Medicare pays 100% for days 1-60 (Part A deductible applies); You pay **$289**/day for days 61-90; You pay **$578**/day for days 91-150 (subject to 60 lifetime reserve days); You pay all costs after 150 days. Outpatient: Medicare pays 60% (Part B deductible applies)	Inpatient: Plan pays Medicare deductible; **$289** coinsurance for days 61-90; **$578** coinsurance for days 91-150; After 150 days CBA approval required. Outpatient: Plan pays Medicare deductible, 40% coinsurance	Carve-out method applies Plan allows 80% in-network	
Lifetime Maximum	**None**	**None**	**None**	

Medicare

& Family Members Eligible for Medicare

	HMOs	
	All care must be directed by a primary care physician (PCP) and approved by the HMO.	
	BlueChoice HealthPlan HMO	**CIGNA HMO**
	Available in all South Carolina counties	Available in all S.C. counties, **except**: *Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda*
	Canceled for failure to pay premiums	Canceled for failure to pay premiums
	Pays Medicare Part A and Part B deductibles	No deductible; Pays lesser of unreimbursed Medicare allowed amount or plan's normal benefit
	Pays Medicare Part A deductible	Inpatient: **$500** copay Outpatient facility: **$250** copay Emergency care: **$100** copay Plan pays lesser of unreimbursed Medicare-allowed amount or plan's normal benefit
	Pays Part B coinsurance of 20%	Plan pays lesser of unreimbursed Medicare allowed amount or plan's normal benefit.
	None	**$2,000** (single) **$4,000** (family) (includes inpatient and outpatient copays and 20% coinsurance)
	Plan pays Part B coinsurance of 20%	**$15** PCP copay **$15** OB/GYN copay **$30** specialist copay Plan pays lesser of unreimbursed Medicare allowed amount or plan's normal benefit
	Participating pharmacies only (up to 30-day supply): **$8/ $15** generic **$35** preferred brand **$55** non-preferred brand Specialty pharmaceuticals: **$125/$80** preferred brand, Mail order (up to 90-day supply): **$20/ $37.50** generic, **$87.50** preferred brand, **$137.50** non-preferred	Participating pharmacies only (up to 30-day supply): **$7** generic **$25** preferred brand **$50** non-preferred brand Mail-order (up to 90-day supply): **$14** generic **$50** preferred brand **$100** non-preferred brand No copay max
	Inpatient: Plan pays Medicare deductible; **$289** coinsurance for days 61-90; **$578** coinsurance for days 91-150; 100% beyond 150 days Outpatient: Plan pays Medicare deductible, 40% coinsurance	Participating providers only: **$30** copay per office visit Inpatient: **$500** copay per admission, then 80% Plan pays lesser of unreimbursed Medicare-allowed amount or plan's normal benefit
	None	**None**

Medicare

Comparison of Health Plans for Retirees

Plan	Medicare	Medicare Supplemental	SHP Standard Plan
Inpatient Hospital Days	Medicare pays 100% for days 1-60 (Part A deductible applies); You pay **$289**/day for days 61-90; You pay **$578** for days 91-150 (subject to 60 lifetime reserve days); You pay all costs beyond 150 days	Pays Part A deductible for days 1-60; coinsurance beyond 60 days until Part A benefits exhausted; and covered hospitalization after Part A benefits exhausted (Medi-Call or CBA approval required when Part A exhausted).	Carve-out method applies Plan allows 80% (Call Medi-Call if hospital stay exceeds 150 days)
Skilled Nursing Care	Medicare pays 100% for days 1-20; You pay **$144.50** for days 21-100	Plan pays **$144.50** for days 21-100; With Medi-Call approval, Plan pays 100% beyond 100 days (limited to 60 days)	Carve-out method applies. Plan allows 80%, up to 60 days. (Call Medi-Call or CBA if hospital stay exceeds 100 days)
Private Duty Nursing	Not covered	**$200** annual deductible Plan pays 80% if Medi-Call approved You pay 20% **$5,000** annual maximum **$25,000** lifetime maximum	Not covered.
Home Healthcare	Medicare pays 100%	Medi-Call available to assist with referrals Up to 100 visits.	Carve-out method applies Plan allows 80% You pay 20% Up to 100 visits.
Hospice Care	Plan pays 100%	Medi-Call available to assist with referrals	Medi-Call available to assist with referrals
Durable Medical Equipment	Medicare pays 80% of Medicare-approved amount (Medicare approval required) You pay 20%	Plan pays 20% coinsurance (Medi-Call required)	Carve-out method applies Plan allows 80% (Medi-Call approval required)
Routine Mammography Screening	No charge if the doctor accepts assignment; guidelines apply.	Plan pays 20% coinsurance	Ages 35-74 at participating facilities only; guidelines apply
Pap Test	Routine every 24 months (yearly if high risk) No patient liability if the doctor accepts assignment.	Plan pays 20% coinsurance. Otherwise, plan pays yearly for one routine Pap test for covered women ages 18-65. Diagnostic only age 66 and older.	Routine yearly, ages 18-65; Diagnostic only, age 66 and older; Plan allows 100% for Pap test (Carve-out method applies when Medicare pays)
Ambulance	Medicare pays 80% You pay 20%	Plan pays 20% coinsurance	Carve-out method applies Plan allows 80%
Eyeglasses	None, except for prosthetic lenses from cataract surgery.	None, except for prosthetic lenses from cataract surgery.	None, except for prosthetic lenses from cataract surgery.

WHEN YOU OR YOUR ELIGIBLE FAMILY MEMBERS BECOME ELIGIBLE FOR MEDICARE before age 65, notify EIP within 31 days of eligibility. If you do not notify EIP and EIP continues to pay benefits as if it were your primary insurance, when EIP discovers you are eligible for Medicare, EIP will:

- **Begin paying benefits as if you were enrolled in Medicare**
- **Seek reimbursement for overpaid claims back to the date you or your family members became eligible for Medicare.**

When you become eligible for Medicare, it is strongly advised you ENROLL IN MEDICARE PART A AND PART B if you are covered as a retiree or as a spouse or child of a retiree. Medicare becomes your primary insurance. If you are not enrolled in Part A and Part B, you will be required to pay the portion of your healthcare costs that Part B would have paid.

& Family Members Eligible for Medicare

	BlueChoice HealthPlan	CIGNA HMO
	Plan pays: Medicare deductible; **$289** coinsurance for days 61-90; **$578** coinsurance for days 91-150; 100% beyond 150 days	Plan pays 80% or unreimbursed Medicare-allowed amount after **$500** copay
	Plan pays **$144.50** for days 21-100; Plan pays 100% beyond 100 days (limited to 120 days)	Plan pays 80% or unreimbursed Medicare-allowed amount, up to 180 days
	Plan pays 85% You pay 15% (limited to 60 days)	Plan pays 100%
	(Medicare pays 100% of covered charges)	Plan pays 100% or unreimbursed Medicare-allowed amount, up to 60 visits
	(Medicare pays 100% of covered charges)	Inpatient: Plan pays 80% of covered expenses. Outpatient: Plan allows 100% of covered expenses. Plan pays lesser of unreimbursed Medicare-allowed amount or plan's normal benefit
	Plan pays 20% coinsurance	Plan pays 100% or unreimbursed Medicare-allowed amount
	Plan pays 20% coinsurance	Plan pays 100% or unreimbursed Medicare-allowed amount
	Plan pays 20% coinsurance. Otherwise, pays routine OB/GYN exam two times per year after **$15** copay. Diagnostic: copay/coinsurance	Plan pays 100% or unreimbursed Medicare-allowed amount after **$15** copay
	Plan pays 20% coinsurance	Plan pays 80% or unreimbursed Medicare-allowed amount
	None	None

Please note:
This chart is just a summary of your benefits. Please consult the previous sections of the Medicare chapter, the Retirement/Disability Retirement chapter, the Health Insurance chapter, your health insurance third-party claims processor or Medicare for details.

The chart for subscribers and covered family members who are not eligible for Medicare is in the Retirement/Disability Retirement chapter beginning on page 181.

Premiums

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2012 Active Employee and Funded Retiree Health, Dental, Dental Plus and Vision Premiums

2012 Active Employee Monthly Premiums[1]

Tobacco users will pay a $40- or $60-per-month surcharge *in addition* to health premiums

	Savings	Standard	BlueChoice HealthPlan	CIGNA HMO	Dental	Dental Plus[2]	State Vision Plan
Employee	$ 9.70	$ 97.68	$201.82	$379.18	$ 0.00	$22.36	$ 7.76
Employee/spouse	$ 77.40	$253.36	$558.76	$891.48	$ 7.64	$45.16	$15.52
Employee/children	$ 20.48	$143.86	$384.74	$712.96	$13.72	$52.06	$16.48
Full family	$113.00	$306.56	$769.48	$1,282.60	$21.34	$67.50	$24.24

[1] Rates for employees of local subdivisions may vary. To verify your rates, contact your benefits office.
[2] If you enroll in Dental Plus, you must also be enrolled in the State Dental Plan. You pay the combined premiums for the plans.

2012 Monthly Employer Contributions[1]

	Health	Dental	Life	LTD
Employee	$291.92	$ 11.72	$0.34	$3.22
Employee/spouse	$578.24	$ 11.72	$0.34	$3.22
Employee/children	$448.06	$ 11.72	$0.34	$3.22
Full family	$724.00	$ 11.72	$0.34	$3.22

[1] Rates for employers of local subdivisions may vary. To check these rates, contact your benefits office.

2012 Regular Retiree (State-funded Benefits) Monthly Premiums[1]

Tobacco users will pay a $40- or $60-per-month surcharge *in addition* to health premiums

(Retiree eligible for Medicare/spouse eligible for Medicare)

	Savings	Standard	Medicare Supplemental[2]	BlueChoice HealthPlan	CIGNA HMO	Dental	Dental Plus[3]	State Vision Plan
Retiree	N/A	$ 79.68	$ 97.68	$201.82	$379.18	$ 0.00	$22.36	$ 7.76
Retiree/spouse	N/A	$217.36	$253.36	$558.76	$891.48	$ 7.64	$45.16	$15.52
Retiree/children	N/A	$125.86	$143.86	$384.74	$712.96	$13.72	$52.06	$16.48
Full family	N/A	$270.56	$306.56	$769.48	$1,282.60	$21.34	$67.50	$24.24

(Retiree eligible for Medicare/spouse **not** eligible for Medicare)

	Savings	Standard	Medicare Supplemental[2]	BlueChoice HealthPlan	CIGNA HMO	Dental	Dental Plus[3]	State Vision Plan
Retiree/spouse	N/A	$235.36	$253.36	$558.76	$ 891.48	$ 7.64	$45.16	$15.52
Full family	N/A	$281.54	$299.54	$769.48	$1,282.60	$21.34	$67.50	$24.24

(Retiree **not** eligible for Medicare/spouse eligible for Medicare)

	Savings	Standard	Medicare Supplemental[2]	BlueChoice HealthPlan	CIGNA HMO	Dental	Dental Plus[3]	State Vision Plan
Retiree/spouse	$ 77.40	$235.36	$253.36	$558.76	$ 891.48	$ 7.64	$45.16	$15.52
Full family	$113.00	$281.54	$299.54	$769.48	$1,282.60	$21.34	$67.50	$24.24

(Retiree **not** eligible for Medicare/spouse **not** eligible for Medicare)

	Savings	Standard	Medicare Supplemental[2]	BlueChoice HealthPlan	CIGNA HMO	Dental	Dental Plus[3]	State Vision Plan
Retiree	$ 9.70	$ 97.68	N/A	$201.82	$ 379.18	$ 0.00	$22.36	$ 7.76
Retiree/spouse	$ 77.40	$253.36	N/A	$558.76	$ 891.48	$ 7.64	$45.16	$15.52
Retiree/children	$ 20.48	$143.86	N/A	$384.74	$ 712.96	$13.72	$52.06	$16.48
Full family	$113.00	$306.56	N/A	$769.48	$1,282.60	$21.34	$67.50	$24.24

(Retiree **not** eligible for Medicare/spouse **not** eligible for Medicare/one or more children eligible for Medicare)

	Savings	Standard	Medicare Supplemental[2]	BlueChoice HealthPlan	CIGNA HMO	Dental	Dental Plus[3]	State Vision Plan
Retiree/children	$ 20.48	$143.86	$161.86	$384.74	$ 712.96	$13.72	$52.06	$16.48
Full family	$113.00	$306.56	$324.56	$769.48	$1,282.60	$21.34	$67.50	$24.24

[1] Rates for local subdivisions may vary. To verify your rates, contact your benefits office.
[2] If the Medicare Supplemental Plan is elected, claims for covered persons not eligible for Medicare will be based on the Standard Plan provisions.
[3] If you enroll in Dental Plus, you must also be enrolled in the State Dental Plan. You pay the combined premiums for the plans.

2012 Non-funded Retiree and COBRA Health, Dental, Dental Plus and Vision Premiums

2012 Retiree Full Cost (Non-funded) Monthly Premiums[1]

Tobacco users will pay a $40- or $60-per-month surcharge *in addition* to health premiums

(Retiree eligible for Medicare/spouse eligible for Medicare)

	Savings	Standard	Medicare Supplemental[2]	BlueChoice HealthPlan	CIGNA HMO	Dental	Dental Plus[3]	State Vision Plan
Retiree	N/A	$371.60	$ 389.60	$ 493.74	$ 671.10	$11.72	$22.36	$ 7.76
Retiree/spouse	N/A	$795.60	$ 831.60	$1,137.00	$1,469.72	$19.36	$45.16	$15.52
Retiree/children	N/A	$573.92	$ 591.92	$ 832.80	$1,161.02	$25.44	$52.06	$16.48
Full family	N/A	$994.56	$1,030.56	$1,493.48	$2,006.60	$33.06	$67.50	$24.24

(Retiree eligible for Medicare/spouse **not** eligible for Medicare)

	Savings	Standard	Medicare Supplemental[2]	BlueChoice HealthPlan	CIGNA HMO	Dental	Dental Plus[3]	State Vision Plan
Retiree/spouse	N/A	$ 813.60	$ 831.60	$1,137.00	$1,469.72	$19.36	$45.16	$15.52
Full family	N/A	$1,005.54	$1,023.54	$1,493.48	$2,006.60	$33.06	$67.50	$24.24

(Retiree **not** eligible for Medicare/spouse eligible for Medicare)

	Savings	Standard	Medicare Supplemental[2]	BlueChoice HealthPlan	CIGNA HMO	Dental	Dental Plus[3]	State Vision Plan
Retiree/spouse	$655.64	$ 813.60	$ 831.60	$1,137.00	$1,469.72	$19.36	$45.16	$15.52
Full family	$837.00	$1,005.54	$1,023.54	$1,493.48	$2,006.60	$33.06	$67.50	$24.24

(Retiree **not** eligible for Medicare/spouse **not** eligible for Medicare)

	Savings	Standard	Medicare Supplemental[2]	BlueChoice HealthPlan	CIGNA HMO	Dental	Dental Plus[3]	State Vision Plan
Retiree	$301.62	$ 389.60	N/A	$ 493.74	$ 671.10	$11.72	$22.36	$ 7.76
Retiree/spouse	$655.64	$ 831.60	N/A	$1,137.00	$1,469.72	$19.36	$45.16	$15.52
Retiree/children	$468.54	$ 591.92	N/A	$ 832.80	$1,161.02	$25.44	$52.06	$16.48
Full family	$837.00	$1,030.56	N/A	$1,493.48	$2,006.60	$33.06	$67.50	$24.24

(Retiree **not** eligible for Medicare/spouse **not** eligible for Medicare/one or more children eligible for Medicare)

	Savings	Standard	Medicare Supplemental[2]	BlueChoice HealthPlan	CIGNA HMO	Dental	Dental Plus[3]	State Vision Plan
Retiree/children	$468.54	$ 591.92	$ 609.92	$ 832.80	$1,161.02	$25.44	$52.06	$16.48
Full family	$837.00	$1,030.56	$1,048.56	$1,493.48	$2,006.60	$33.06	$67.50	$24.24

[1] Rates for local subdivisions may vary. To verify your rates, contact your benefits office.
[2] If the Medicare Supplemental Plan is elected, claims for covered persons not eligible for Medicare will be based on the Standard Plan provisions.
[3] If you enroll in Dental Plus, you must also be enrolled in the State Dental Plan. You pay the combined premiums for the plans.

2012 COBRA Monthly Premiums

Tobacco users will pay a $40- or $60-per-month surcharge *in addition* to health premiums

18 and 36 months

	Savings	Standard	BlueChoice HealthPlan	CIGNA HMO	Dental	Dental Plus[1]	State Vision Plan
Subscriber	$307.66	$397.40	$ 503.62	$ 684.52	$11.95	$22.82	$ 7.92
Subscriber/spouse	$668.76	$848.24	$1,159.74	$1,499.12	$19.75	$46.06	$15.84
Subscriber/children	$477.92	$603.76	$ 849.46	$1,184.24	$25.95	$53.10	$16.82
Full family	$853.74	$1,051.18	$1,523.36	$2,046.74	$33.72	$68.86	$24.72
Children (to age 18)	$170.26	$206.36	$ 345.84	$ 499.72	$14.00	$30.28	$ 8.90

29 Months (These rates go into effect in the 19th month of coverage for 29-month COBRA subscribers)

	Savings	Standard	BlueChoice HealthPlan	CIGNA HMO	Dental	Dental Plus[1]	State Vision Plan
Subscriber	$ 452.44	$ 584.40	$ 740.62	$1,006.66	$11.95	$22.82	$ 7.92
Subscriber/spouse	$ 983.46	$1,247.40	$1,705.50	$2,204.58	$19.75	$46.06	$15.84
Subscriber/children	$ 702.82	$ 887.88	$1,249.20	$1,741.54	$25.95	$53.10	$16.82
Full family	$1,255.50	$1,545.84	$2,240.22	$3,009.90	$33.72	$68.86	$24.72
Children (to age 18)	$ 250.38	$ 303.48	$ 508.58	$ 734.88	$14.00	$30.28	$ 8.90

[1] If you enroll in Dental Plus, you must also be enrolled in the State Dental Plan. You pay the combined premiums for the plans.

2012 Survivor

Health, Dental, Dental Plus and Vision Premiums

2012 Survivor Full Cost (Non-funded) Monthly Premiums[1]								Tobacco users will pay a $40- or $60-per-month surcharge *in addition* to health premiums
(Spouse eligible for Medicare/children eligible for Medicare)								
	Savings	**Standard**	**Medicare Supplemental[2]**	**BlueChoice HealthPlan**	**CIGNA HMO**	**Dental**	**Dental Plus[4]**	**State Vision Plan**
Spouse	N/A	$371.60	$389.60	$493.74	$ 671.10	$11.72	$22.36	$ 7.76
Spouse/children	N/A	$573.92	$609.92	$832.80	$1,161.02	$25.44	$52.06	$16.48
Children only	N/A	$202.32	$220.32[3]	$339.06	$ 489.92	$13.72	$29.70	$ 8.72
(Spouse eligible for Medicare/children **not** eligible for Medicare)								
	Savings	**Standard**	**Medicare Supplemental[2]**	**BlueChoice HealthPlan**	**CIGNA HMO**	**Dental**	**Dental Plus[4]**	**State Vision Plan**
Spouse	N/A	$371.60	$389.60	$493.74	$ 671.10	$11.72	$22.36	$ 7.76
Spouse/children	N/A	$573.92	$591.92	$832.80	$1,161.02	$25.44	$52.06	$16.48
Children only	$166.92	$202.32	N/A	$339.06	$ 489.92	$13.72	$29.70	$ 8.72
(Spouse **not** eligible for Medicare/children eligible for Medicare)								
	Savings	**Standard**	**Medicare Supplemental[2]**	**BlueChoice HealthPlan**	**CIGNA HMO**	**Dental**	**Dental Plus[4]**	**State Vision Plan**
Spouse	$301.62	$389.60	N/A	$493.74	$ 671.10	$11.72	$22.36	$ 7.76
Spouse/children	$468.54	$591.92	$609.92[3]	$832.80	$1,161.02	$25.44	$52.06	$16.48
Children only	N/A	$202.32	$220.32[3]	$339.06	$ 489.92	$13.72	$29.70	$ 8.72
(Spouse **not** eligible for Medicare/children **not** eligible for Medicare)								
	Savings	**Standard**	**Medicare Supplemental[2]**	**BlueChoice HealthPlan**	**CIGNA HMO**	**Dental**	**Dental Plus[4]**	**State Vision Plan**
Spouse	$301.62	$389.60	N/A	$493.74	$ 671.10	$11.72	$22.36	$ 7.76
Spouse/children	$468.54	$591.92	N/A	$832.80	$1,161.02	$25.44	$52.06	$16.48
Children only	$166.92	$202.32	N/A	$339.06	$ 489.92	$13.72	$29.70	$ 8.72

[1] Rates for local subdivisions may vary. To verify your rates, contact your benefits office.
[2] If the Medicare Supplemental Plan is elected, claims for covered subscribers not eligible for Medicare will be based on the Standard Plan provisions.
[3] This premium applies only if one or more children are eligible for Medicare.
[4] If you enroll in Dental Plus, you must also be enrolled in the State Dental Plan. You pay the combined premiums for the plans.

2012 Monthly Insurance Premiums for Permanent, Part-time Teachers

2012 Permanent, Part-Time Teachers Monthly Premiums

Tobacco users will pay a $40- or $60-per-month surcharge in addition to health premiums.

Category I. 15-19 Hours							
	Savings	Standard	BlueChoice HealthPlan	CIGNA HMO	Dental	Dental Plus[1]	State Vision Plan
Employee only	$155.66	$243.64	$ 347.78	$ 525.14	$ 5.86	$22.36	$ 7.76
Employee/spouse	$366.52	$542.48	$ 847.88	$ 1,180.60	$13.50	$45.16	$15.52
Employee/children	$244.50	$367.88	$ 608.76	$ 936.98	$19.58	$52.06	$16.48
Full family	$475.00	$668.56	$1,131.48	$1,644.60	$27.20	$67.50	$24.24
Category II. 20-24 Hours							
	Savings	Standard	BlueChoice HealthPlan	CIGNA HMO	Dental	Dental Plus[1]	State Vision Plan
Employee only	$106.02	$194.00	$ 298.14	$ 475.50	$ 3.86	$22.36	$ 7.76
Employee/spouse	$268.22	$444.18	$ 749.58	$1,082.30	$ 11.50	$45.16	$15.52
Employee/children	$168.34	$291.72	$ 532.60	$ 860.82	$17.58	$52.06	$16.48
Full family	$351.92	$545.48	$1,008.40	$1,521.52	$25.20	$67.50	$24.24
Category III. 25-29 Hours							
	Savings	Standard	BlueChoice HealthPlan	CIGNA HMO	Dental	Dental Plus[1]	State Vision Plan
Employee only	$ 59.32	$147.30	$251.44	$ 428.80	$ 2.00	$22.36	$ 7.76
Employee/spouse	$175.70	$351.66	$657.06	$ 989.78	$ 9.64	$45.16	$15.52
Employee/children	$ 96.64	$220.02	$460.90	$ 789.12	$15.72	$52.06	$16.48
Full family	$236.08	$429.64	$892.56	$1,405.68	$23.34	$67.50	$24.24

[1]If you enroll in Dental Plus, you must also be enrolled in the State Dental Plan. You will pay the combined premiums for the plans.

2012 Monthly Employer Contributions[1]

	Category I. 15-19 Hours		Category II. 20-24 Hours		Category III. 25-29 Hours	
	Health	Dental	Health	Dental	Health	Dental
Employee only	$145.96	$5.86	$195.60	$7.86	$242.30	$9.72
Employee/spouse	$289.12	$5.86	$387.42	$7.86	$479.94	$9.72
Employee/children	$224.04	$5.86	$300.20	$7.86	$371.90	$9.72
Full family	$362.00	$5.86	$485.08	$7.86	$600.92	$9.72

[1] Rates for employers of local subdivisions may vary. To check these rates, contact your benefits office.

Optional Life, Dependent Life–Spouse Monthly Premiums

Please note: These schedules are for active employees. If you have questions about continuing your coverage as a retiree, see your benefits administrator or EIP.

Optional Life premiums are determined by your age on the preceding December 31 and the amount of insurance you select. Premiums for Dependent Life-Spouse coverage are the same as the Optional Life premiums, which are based on the **employee's** age.

Monthly Premiums for Employees through Age 69

	Employee's Age*							
	<35	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69
Coverage								
$ 10,000	$ 0.52	$0.68	$ 0.98	$ 1.40	$ 2.06	$ 3.70	$ 5.84	$ 9.78
$ 20,000	$ 1.04	$ 1.36	$ 1.94	$ 2.80	$ 4.12	$ 7.40	$ 11.68	$ 19.56
$ 30,000	$ 1.56	$ 2.04	$ 2.92	$ 4.20	$ 6.18	$ 11.10	$ 17.52	$ 29.34
$ 40,000	$ 2.08	$ 2.72	$ 3.88	$ 5.60	$ 8.24	$ 14.80	$ 23.36	$ 39.12
$ 50,000	$ 2.60	$ 3.40	$ 4.86	$ 7.00	$10.30	$ 18.50	$ 29.20	$ 48.90
$ 60,000	$ 3.12	$ 4.08	$ 5.82	$ 8.40	$12.36	$ 22.20	$ 35.04	$ 58.68
$ 70,000	$ 3.64	$ 4.76	$ 6.80	$ 9.80	$14.42	$25.90	$ 40.88	$ 68.46
$ 80,000	$ 4.16	$ 5.44	$ 7.76	$11.20	$16.48	$ 29.60	$ 46.72	$ 78.24
$ 90,000	$ 4.68	$ 6.12	$ 8.74	$12.60	$18.54	$ 33.30	$ 52.56	$ 88.02
$100,000	$ 5.20	$ 6.80	$ 9.70	$14.00	$20.60	$ 37.00	$ 58.40	$ 97.80
$110,000	$ 5.72	$ 7.48	$10.68	$15.40	$22.66	$ 40.70	$ 64.24	$107.58
$120,000	$ 6.24	$ 8.16	$11.64	$16.80	$24.72	$ 44.40	$ 70.08	$117.36
$130,000	$ 6.76	$ 8.84	$12.62	$18.20	$26.78	$ 48.10	$ 75.92	$127.14
$140,000	$ 7.28	$ 9.52	$13.58	$19.60	$28.84	$ 51.80	$ 81.76	$136.92
$150,000	$ 7.80	$10.20	$14.56	$21.00	$30.90	$ 55.50	$ 87.60	$146.70
$160,000	$ 8.32	$10.88	$15.52	$22.40	$32.96	$ 59.20	$ 93.44	$156.48
$170,000	$ 8.84	$11.56	$16.50	$23.80	$35.02	$ 62.90	$ 99.28	$166.26
$180,000	$ 9.36	$12.24	$17.46	$25.20	$37.08	$ 66.60	$105.12	$176.04
$190,000	$ 9.88	$12.92	$18.44	$26.60	$39.14	$ 70.30	$110.96	$185.82
$200,000	$10.40	$13.60	$19.40	$28.00	$41.20	$ 74.00	$116.80	$195.60
$210,000	$10.92	$14.28	$20.38	$29.40	$43.26	$ 77.70	$122.64	$205.38
$220,000	$11.44	$14.96	$21.34	$30.80	$45.32	$ 81.40	$128.48	$215.16
$230,000	$11.96	$15.64	$22.32	$32.20	$47.38	$ 85.10	$134.32	$224.94
$240,000	$12.48	$16.32	$23.28	$33.60	$49.44	$ 88.80	$140.16	$234.72
$250,000	$13.00	$17.00	$24.26	$35.00	$51.50	$ 92.50	$146.00	$244.50
$260,000	$13.52	$17.68	$25.22	$36.40	$53.56	$ 96.20	$151.84	$254.28
$270,000	$14.04	$18.36	$26.20	$37.80	$55.62	$ 99.90	$157.68	$264.06
$280,000	$14.56	$19.04	$27.16	$39.20	$57.68	$103.60	$163.52	$273.84
$290,000	$15.08	$19.72	$28.14	$40.60	$59.74	$107.30	$169.36	$283.62
$300,000	$15.60	$20.40	$29.10	$42.00	$61.80	$111.00	$175.20	$293.40
$310,000	$16.12	$21.08	$30.08	$43.40	$63.86	$114.70	$181.04	$303.18
$320,000	$16.64	$21.76	$31.04	$44.80	$65.92	$118.40	$186.88	$312.96
$330,000	$17.16	$22.44	$32.02	$46.20	$67.98	$122.10	$192.72	$322.74
$340,000	$17.68	$23.12	$32.98	$47.60	$70.04	$125.80	$198.56	$332.52
$350,000	$18.20	$23.80	$33.96	$49.00	$72.10	$129.50	$204.40	$342.30
$360,000	$18.72	$24.48	$34.92	$50.40	$74.16	$133.20	$210.24	$352.08
$370,000	$19.24	$25.16	$35.90	$51.80	$76.22	$136.90	$216.08	$361.86
$380,000	$19.76	$25.84	$36.86	$53.20	$78.28	$140.60	$221.92	$371.64
$390,000	$20.28	$26.52	$37.84	$54.60	$80.34	$144.30	$227.76	$381.42
$400,000	$20.80	$27.20	$38.80	$56.00	$82.40	$148.00	$233.60	$391.20

**Premiums for the spouse's coverage will be based on the employee's age. Spouse's coverage cannot exceed 50 percent of the employee's Optional Life coverage or $100,000, whichever is less.*

	Employee's Age*							
	<35	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69
Coverage								
$410,000	$21.32	$27.88	$39.78	$57.40	$84.46	$151.70	$239.44	$400.98
$420,000	$21.84	$28.56	$40.74	$58.80	$86.52	$155.40	$245.28	$410.76
$430,000	$22.36	$29.24	$41.72	$60.20	$88.58	$159.10	$251.12	$420.54
$440,000	$22.88	$29.92	$42.68	$61.60	$90.64	$162.80	$256.96	$430.32
$450,000	$23.40	$30.60	$43.66	$63.00	$92.70	$166.50	$262.80	$440.10
$460,000	$23.92	$31.28	$44.62	$64.40	$94.76	$170.20	$268.64	$449.88
$470,000	$24.44	$31.96	$45.60	$65.80	$96.82	$173.90	$274.48	$459.66
$480,000	$24.96	$32.64	$46.56	$67.20	$98.88	$177.60	$280.32	$469.44
$490,000	$25.48	$33.32	$47.54	$68.60	$100.94	$181.30	$286.16	$479.22
$500,000	$26.00	$34.00	$48.50	$70.00	$103.00	$185.00	$292.00	$489.00

**Premiums for the spouse's coverage will be based on the employee's age. Spouse's coverage cannot exceed 50 percent of the employee's Optional Life coverage or $100,000, whichever is less.*

Monthly Premiums for Employees Age 70 and Older

(Retiree coverage ends at age 75)

Coverage	Coverage	Ages 70 - 74	Coverage	Ages 75 - 79	Coverage	Ages 80+
$ 10,000	**$ 6,500**	$ 10.28	**$ 4,200**	$ 10.80	**$3,170**	$13.62
$ 20,000	**$ 13,000**	$ 20.54	**$ 8,400**	$ 21.60	**$ 6,340**	$ 27.26
$ 30,000	**$ 19,500**	$ 30.82	**$ 12,600**	$ 32.42	**$ 9,510**	$ 40.90
$ 40,000	**$ 26,000**	$ 41.08	**$ 16,800**	$ 43.22	**$ 12,680**	$ 54.52
$ 50,000	**$ 32,500**	$ 51.36	**$ 21,000**	$ 54.02	**$ 15,850**	$ 68.16
$ 60,000	**$ 39,000**	$ 61.62	**$ 25,200**	$ 64.82	**$ 19,020**	$ 81.80
$ 70,000	**$ 45,500**	$ 71.90	**$ 29,400**	$ 75.62	**$ 22,190**	$ 95.42
$ 80,000	**$ 52,000**	$ 82.16	**$ 33,600**	$ 86.42	**$ 25,360**	$109.06
$ 90,000	**$ 58,500**	$ 92.44	**$ 37,800**	$ 97.22	**$ 28,530**	$122.68
$100,000	**$ 65,000**	$102.70	**$ 42,000**	$108.02	**$ 31,700**	$136.30
$110,000	**$ 71,500**	$112.98	**$ 46,200**	$118.84	**$ 34,870**	$149.94
$120,000	**$ 78,000**	$123.24	**$ 50,400**	$129.64	**$ 38,040**	$163.58
$130,000	**$ 84,500**	$133.52	**$ 54,600**	$140.44	**$ 41,210**	$177.20
$140,000	**$ 91,000**	$143.78	**$ 58,800**	$151.24	**$ 44,380**	$190.82
$150,000	**$ 97,500**	$154.06	**$ 63,000**	$162.04	**$ 47,550**	$204.48
$160,000	**$104,000**	$164.32	**$ 67,200**	$172.84	**$ 50,720**	$218.10
$170,000	**$110,500**	$174.60	**$ 71,400**	$183.64	**$ 53,890**	$231.72
$180,000	**$117,000**	$184.86	**$ 75,600**	$194.44	**$ 57,060**	$245.36
$190,000	**$123,500**	$195.14	**$ 79,800**	$205.26	**$ 60,230**	$259.00
$200,000	**$130,000**	$205.40	**$ 84,000**	$216.06	**$ 63,400**	$272.62
$210,000	**$136,500**	$215.68	**$ 88,200**	$226.86	**$ 66,570**	$286.26
$220,000	**$143,000**	$225.94	**$ 92,400**	$237.66	**$ 69,740**	$299.88
$230,000	**$149,500**	$236.22	**$ 96,600**	$248.46	**$ 72,910**	$313.50
$240,000	**$156,000**	$246.48	**$100,800**	$259.26	**$ 76,080**	$327.14
$250,000	**$162,500**	$256.76	**$105,000**	$270.06	**$ 79,250**	$340.78
$260,000	**$169,000**	$267.02	**$109,200**	$280.86	**$ 82,420**	$354.40
$270,000	**$175,500**	$277.30	**$113,400**	$291.66	**$ 85,590**	$368.04
$280,000	**$182,000**	$287.56	**$117,600**	$302.48	**$ 88,760**	$381.68
$290,000	**$188,500**	$297.84	**$121,800**	$313.28	**$ 91,930**	$395.30
$300,000	**$195,000**	$308.10	**$126,000**	$324.08	**$ 95,100**	$408.92
$310,000	**$201,500**	$318.38	**$130,200**	$334.88	**$ 98,270**	$422.56
$320,000	**$208,000**	$328.64	**$134,400**	$345.68	**$101,440**	$436.20
$330,000	**$214,500**	$338.92	**$138,600**	$356.48	**$104,610**	$449.82
$340,000	**$221,000**	$349.18	**$142,800**	$367.28	**$107,780**	$463.46
$350,000	**$227,500**	$359.46	**$147,000**	$378.08	**$110,950**	$477.10

Coverage	Coverage	Ages 70 - 74	Coverage	Ages 75 - 79	Coverage	Ages 80+
$360,000	**$234,000**	$369.72	**$151,200**	$388.90	**$114,120**	$490.72
$370,000	**$240,500**	$380.00	**$155,400**	$399.70	**$117,290**	$504.36
$380,000	**$247,000**	$390.26	**$159,600**	$410.50	**$120,460**	$517.98
$390,000	**$253,500**	$400.54	**$163,800**	$421.30	**$123,630**	$531.60
$400,000	**$260,000**	$410.80	**$168,000**	$432.10	**$126,800**	$545.24
$410,000	**$266,500**	$421.08	**$172,200**	$442.90	**$129,970**	$558.88
$420,000	**$273,000**	$431.34	**$176,400**	$453.70	**$133,140**	$572.50
$430,000	**$279,500**	$441.62	**$180,600**	$464.50	**$136,310**	$586.12
$440,000	**$286,000**	$451.88	**$184,800**	$475.32	**$139,480**	$599.76
$450,000	**$292,500**	$462.16	**$189,000**	$486.12	**$142,650**	$613.40
$460,000	**$299,000**	$472.42	**$193,200**	$496.92	**$145,820**	$627.02
$470,000	**$305,500**	$482.70	**$197,400**	$507.72	**$148,990**	$640.66
$480,000	**$312,000**	$492.96	**$201,600**	$518.52	**$152,160**	$654.30
$490,000	**$318,500**	$503.24	**$205,800**	$529.32	**$155,330**	$667.92
$500,000	**$325,000**	$513.50	**$210,000**	$540.12	**$158,500**	$681.56

Please note: For subscribers who retired on or after January 1, 1994, up to December 31, 1998, coverage terminates at age 70, with an option to convert the coverage at that time.

Dependent Life–Child Monthly Premium

The monthly premium for Dependent Life-Child coverage is $1.24, regardless of the number of children covered.

Long Term Care Monthly Premiums

2012 LONG TERM CARE PREMIUMS*												
Basic Plan												
Age	Plan 1 $100	Plan 2 $150	Plan 3 $200	Plan 4 $250	Plan 5 $300	Plan 6 $350	Plan 7 $100	Plan 8 $150	Plan 9 $200	Plan 10 $250	Plan 11 $300	Plan 12 $350
18-30	$ 9.88	$14.82	$ 19.76	$24.69	$ 29.63	$34.57	$ 11.64	$ 17.45	$23.27	$29.09	$34.91	$40.72
31	10.39	15.59	20.79	25.99	31.18	36.38	12.25	18.38	24.50	30.63	36.75	42.88
32	10.92	16.38	21.84	27.30	32.75	38.22	12.87	19.30	25.73	32.17	38.60	45.04
33	11.43	17.15	22.87	28.58	34.30	40.02	13.49	20.24	26.99	33.73	40.48	47.23
34	12.09	18.14	24.18	30.23	36.27	42.32	14.23	21.35	28.46	35.58	42.69	49.81
35	12.74	19.11	25.47	31.85	38.21	44.58	14.98	22.47	29.96	37.45	44.93	52.43
36	13.25	19.88	26.50	33.13	39.75	46.38	15.72	23.57	31.43	39.29	47.15	55.00
37	14.04	21.06	28.08	35.10	42.12	49.14	16.58	24.88	33.17	41.46	49.75	58.04
38	14.69	22.03	29.37	36.71	44.06	51.40	17.45	26.18	34.91	43.63	52.36	61.08
39	15.46	23.20	30.93	38.66	46.39	54.13	18.32	27.48	36.64	45.80	54.96	64.12
40	16.24	24.36	32.48	40.60	48.72	56.84	19.18	28.77	38.36	47.95	57.54	67.13
41	17.15	25.72	34.30	42.87	51.45	60.02	20.42	30.63	40.84	51.06	61.27	71.48
42	18.19	27.29	36.38	45.48	54.57	63.67	21.53	32.30	43.07	53.83	64.60	75.37
43	19.23	28.85	38.46	48.08	57.69	67.31	22.78	34.17	45.55	56.94	68.33	79.72
44	20.27	30.41	40.54	50.68	60.81	70.95	24.13	36.20	48.26	60.33	72.39	84.46
45	21.44	32.17	42.88	53.61	64.33	75.05	25.49	38.24	50.98	63.73	76.48	89.22
46	22.75	34.12	45.49	56.86	68.24	79.61	26.98	40.47	53.95	67.45	80.93	94.42
47	24.04	36.06	48.08	60.10	72.11	84.13	28.59	42.89	57.19	71.49	85.78	100.08
48	25.47	38.21	50.94	63.68	76.42	89.15	30.32	45.48	60.64	75.80	90.96	106.12
49	26.90	40.35	53.79	67.25	80.69	94.14	32.06	48.09	64.11	80.14	96.17	112.20
50	28.46	42.69	56.92	71.15	85.39	99.62	33.92	50.87	67.83	84.79	101.75	118.71
51	30.66	46.00	61.33	76.66	91.99	107.32	36.51	54.77	73.02	91.28	109.53	127.80
52	33.14	49.71	66.28	82.85	99.41	115.99	39.23	58.84	78.46	98.07	117.69	137.30
53	35.73	53.60	71.47	89.33	107.20	125.07	42.21	63.32	84.42	105.52	126.62	147.73
54	38.59	57.89	77.18	96.49	115.78	135.08	45.42	68.13	90.84	113.55	136.26	158.97
55	41.58	62.38	83.16	103.96	124.75	145.54	49.02	73.53	98.03	122.54	147.05	171.56
56	44.83	67.26	89.67	112.09	134.50	156.92	52.72	79.08	105.44	131.81	158.17	184.53
57	48.47	72.71	96.94	121.18	145.41	169.65	56.68	85.02	113.36	141.70	170.04	198.38
58	52.24	78.36	104.47	130.59	156.71	182.83	61.01	91.53	122.03	152.54	183.04	213.55
59	56.40	84.60	112.80	141.00	169.20	197.39	65.72	98.59	131.44	164.31	197.16	230.03
60	60.82	91.23	121.64	152.06	182.47	212.88	70.67	106.01	141.34	176.68	212.01	247.35
61	66.01	99.02	132.03	165.03	198.04	231.05	76.23	114.35	152.47	190.59	228.70	266.82
62	71.60	107.40	143.20	179.00	214.80	250.60	82.30	123.46	164.61	205.77	246.91	288.07
63	76.31	114.46	152.61	190.77	228.92	267.07	87.13	130.70	174.27	217.84	261.40	304.97
64	81.55	122.32	163.09	203.87	244.64	285.42	92.46	138.68	184.91	231.14	277.37	323.59
65	91.62	137.43	183.23	229.05	274.85	320.66	103.22	154.83	206.44	258.06	309.67	361.28
66	99.41	149.13	198.83	248.54	298.24	347.96	111.64	167.46	223.27	279.09	334.91	390.73
67	107.86	161.79	215.72	269.65	323.57	377.51	120.66	181.00	241.33	301.67	361.99	422.33
68	117.09	175.64	234.18	292.73	351.27	409.82	130.45	195.68	260.90	326.13	391.35	456.58
69	126.97	190.46	253.93	317.42	380.90	444.39	141.09	211.64	282.17	352.72	423.26	493.81
70	137.75	206.64	275.51	344.39	413.26	482.14	152.60	228.91	305.20	381.51	457.80	534.11
71	152.95	229.43	305.91	382.39	458.86	535.34	168.69	253.04	337.38	421.73	506.07	590.42
72	169.59	254.39	339.18	423.98	508.77	593.57	186.39	279.58	372.77	465.96	559.16	652.35
73	188.17	282.26	376.35	470.44	564.52	658.61	205.94	308.91	411.88	514.85	617.82	720.79
74	208.83	313.24	417.66	522.07	626.48	730.90	227.60	341.41	455.21	569.01	682.81	796.62
75	231.70	347.56	463.41	579.27	695.11	810.97	251.49	377.24	502.98	628.73	754.47	880.22
76	257.56	386.35	515.12	643.91	772.68	901.47	277.97	416.96	555.94	694.93	833.92	972.90
77	286.42	429.62	572.83	716.04	859.25	1002.46	307.18	460.77	614.36	767.95	921.54	1075.13
78	318.38	477.58	636.76	795.96	955.15	1114.34	339.48	509.22	678.96	848.70	1018.44	1188.18
79	353.98	530.98	707.97	884.96	1061.95	1238.95	375.26	562.88	750.51	938.14	1125.77	1313.39
80	393.50	590.24	786.99	983.74	1180.49	1377.24	414.61	621.91	829.21	1036.51	1243.82	1451.12
81	424.16	636.24	848.32	1060.40	1272.48	1484.56	444.68	667.02	889.37	1111.71	1334.05	1556.39
82	457.17	685.75	914.33	1142.92	1371.50	1600.08	476.74	715.11	953.48	1191.85	1430.22	1668.59
83	492.65	738.98	985.30	1231.62	1477.94	1724.27	511.14	766.71	1022.28	1277.85	1533.42	1788.99
84	531.11	796.67	1062.22	1327.78	1593.33	1858.88	548.15	822.22	1096.29	1370.37	1644.44	1918.52

**All married applicants receive a 10 percent discount.*

Long Term Care Monthly Premiums

2012 LONG TERM CARE PREMIUMS*												
Basic Plan Plus Automatic Inflation												
Age	Plan 1 $100	Plan 2 $150	Plan 3 $200	Plan 4 $250	Plan 5 $300	Plan 6 $350	Plan 7 $100	Plan 8 $150	Plan 9 $200	Plan 10 $250	Plan 11 $300	Plan 12 $350
18-30	$37.17	$55.75	$74.34	$92.92	$111.50	$130.09	$43.44	$65.17	$86.88	$108.61	$130.32	$152.05
31	38.85	58.29	77.71	97.14	116.56	136.00	45.42	68.13	90.84	113.55	136.26	158.97
32	40.67	61.01	81.35	101.69	122.02	142.36	47.40	71.10	94.80	118.50	142.20	165.90
33	42.49	63.74	84.98	106.23	127.47	148.72	49.51	74.27	99.02	123.78	148.53	173.29
34	44.31	66.47	88.62	110.78	132.93	155.09	51.73	77.60	103.46	129.33	155.20	181.06
35	46.26	69.39	92.52	115.65	138.77	161.90	53.96	80.95	107.93	134.92	161.89	188.88
36	48.34	72.51	96.68	120.85	145.02	169.19	56.31	84.47	112.62	140.77	168.92	197.08
37	50.55	75.83	101.10	126.38	151.65	176.93	58.79	88.19	117.58	146.99	176.38	205.78
38	52.89	79.35	105.79	132.24	158.68	185.13	61.39	92.08	122.78	153.47	184.16	214.86
39	55.23	82.84	110.45	138.07	165.68	193.29	64.10	96.16	128.21	160.27	192.31	224.37
40	57.70	86.56	115.40	144.26	173.10	201.96	66.95	100.43	133.91	167.39	200.86	234.34
41	60.43	90.65	120.86	151.08	181.28	211.50	70.05	105.08	140.11	175.13	210.16	245.19
42	63.29	94.93	126.57	158.22	189.86	221.50	73.27	109.90	146.53	183.16	219.80	256.43
43	66.28	99.41	132.55	165.69	198.83	231.97	76.61	114.92	153.22	191.53	229.83	268.13
44	69.40	104.10	138.79	173.50	208.19	242.89	80.07	120.11	160.15	200.18	240.22	280.25
45	72.64	108.96	145.28	181.60	217.92	254.24	83.79	125.68	167.58	209.47	251.37	293.26
46	76.15	114.23	152.31	190.39	228.46	266.54	87.63	131.44	175.26	219.07	262.88	306.70
47	79.66	119.49	159.32	199.15	238.98	278.81	91.59	137.38	183.17	228.97	274.76	320.55
48	83.43	125.14	166.85	208.57	250.28	291.99	95.79	143.68	191.58	239.47	287.37	335.26
49	87.46	131.19	174.91	218.64	262.37	306.10	100.12	150.19	200.24	250.31	300.36	350.43
50	91.62	137.43	183.23	229.05	274.85	320.66	104.71	157.07	209.41	261.77	314.12	366.48
51	96.69	145.04	193.37	241.72	290.06	338.41	110.27	165.41	220.54	275.68	330.82	385.95
52	102.01	153.02	204.02	255.03	306.03	357.04	115.97	173.95	231.94	289.92	347.90	405.89
53	107.60	161.40	215.19	268.99	322.79	376.59	122.03	183.04	244.06	305.07	366.08	427.10
54	113.57	170.37	227.15	283.94	340.72	397.52	128.46	192.70	256.92	321.16	385.39	449.62
55	119.95	179.92	239.90	299.87	359.84	419.82	135.27	202.91	270.54	338.18	405.81	473.45
56	126.57	189.86	253.15	316.43	379.72	443.01	142.33	213.49	284.66	355.82	426.99	498.15
57	133.59	200.39	267.19	333.99	400.78	467.58	149.75	224.63	299.51	374.39	449.26	524.14
58	141.00	211.49	281.99	352.49	422.99	493.49	157.67	236.51	315.34	394.18	473.01	551.85
59	148.79	223.19	297.59	371.98	446.38	520.78	165.84	248.76	331.68	414.61	497.53	580.45
60	156.98	235.48	313.97	392.47	470.95	549.45	174.51	261.76	349.02	436.27	523.52	610.78
61	162.70	244.06	325.40	406.76	488.10	569.46	180.20	270.31	360.41	450.51	540.61	630.71
62	168.68	253.03	337.36	421.71	506.04	590.39	183.81	275.72	367.62	459.53	551.43	643.34
63	171.92	257.88	343.84	429.81	515.77	601.73	187.57	281.36	375.13	468.92	562.70	656.49
64	175.45	263.18	350.89	438.62	526.34	614.07	189.35	284.03	378.71	473.39	568.06	662.74
65	187.78	281.67	375.56	469.45	563.34	657.23	204.59	306.88	409.17	511.46	613.76	716.05
66	198.70	298.05	397.39	496.75	596.09	695.45	215.72	323.57	431.43	539.29	647.15	755.01
67	210.39	315.59	420.79	525.99	631.18	736.38	227.48	341.23	454.96	568.71	682.45	796.19
68	222.60	333.91	445.21	556.51	667.81	779.11	239.73	359.60	479.47	599.33	719.20	839.07
69	235.73	353.60	471.47	589.34	707.20	825.07	252.85	379.29	505.71	632.14	758.56	884.99
70	249.51	374.27	499.02	623.78	748.53	873.29	266.59	399.89	533.18	666.48	799.77	933.07
71	269.65	404.47	539.30	674.12	808.95	934.77	286.76	430.14	573.52	716.90	860.28	1003.66
72	291.35	437.04	582.71	728.39	874.06	1019.75	308.42	462.64	616.85	771.06	925.27	1079.49
73	314.88	472.32	629.76	787.19	944.63	1102.07	331.68	497.53	663.37	829.21	995.05	1160.89
74	340.22	510.33	680.44	850.55	1020.66	1190.77	356.81	535.22	713.63	892.03	1070.44	1248.84
75	367.76	551.64	735.52	919.40	1103.28	1287.16	383.79	575.69	767.58	959.48	1151.37	1343.27
76	400.12	600.18	800.24	1000.30	1200.36	1400.43	415.59	623.39	831.19	1038.99	1246.78	1454.58
77	435.47	653.21	870.94	1088.68	1306.41	1524.15	449.88	674.83	899.77	1124.72	1349.65	1574.60
78	473.80	710.71	947.60	1184.51	1421.40	1658.31	487.13	730.70	974.27	1217.84	1461.40	1704.97
79	515.51	773.28	1031.03	1288.79	1546.54	1804.30	527.36	791.04	1054.72	1318.40	1582.08	1845.76
80	561.00	841.51	1122.01	1402.52	1683.01	1963.52	571.04	856.57	1142.09	1427.61	1713.13	1998.66
81	595.96	893.94	1191.92	1489.90	1787.88	2085.86	604.09	906.14	1208.18	1510.23	1812.27	2114.32
82	633.13	949.69	1266.26	1582.82	1899.39	2215.95	638.99	958.48	1277.97	1597.47	1916.96	2236.45
83	672.63	1008.95	1345.26	1681.58	2017.89	2354.21	675.99	1013.99	1351.99	1689.98	2027.98	2365.98
84	714.61	1071.91	1429.21	1786.52	2143.82	2501.12	715.11	1072.67	1430.22	1787.78	2145.33	2502.89

**All married applicants receive a 10 percent discount.*

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Claims Procedures

How to File a State Health Plan Claim

Medical and Mental Health and Substance Abuse Claims

If you received services from a physician, a hospital or another provider that participates in a State Health Plan network, you do not have to file a claim. Your provider will file for you. You are responsible for the usual out-of-pocket expenses (deductibles, copayments, coinsurance and non-covered services).

However, if you did not use a network provider or if you have a claim for a non-network service, you may have to file the claim yourself. You can get claim forms from your benefits office, EIP and BlueCross BlueShield of South Carolina (BCBSSC). Claim forms also are on the EIP website, www.eip.sc.gov, under "Forms" and "State Health Plan (SHP)." Select "Health Expenses Claim Form" for medical and mental health/substance abuse claims.

Complete a separate claim form for each individual who received care. To file a claim:

- Complete the claim form
- Attach your itemized bills, which must show: the amount charged; the patient's name; the date and place of service; the diagnosis, if applicable; and the provider's federal Tax Identification Number or National Provider Identifier (NPI), if available
- File claims within 90 days of the date you receive services or as soon as reasonably possible.

BCBSSC must receive claims by the end of the calendar year after the year in which expenses are incurred. Otherwise, claims cannot be paid.

Mail claims to:

State Business Unit
BlueCross BlueShield of South Carolina
P.O. Box 100605
Columbia, SC 29260-0605

What if I Need Help?

Call BCBSSC at 803-736-1576 (Greater Columbia area) or 800-868-2520 (toll-free outside the Columbia area).

Claims Filed Outside South Carolina Only

Generally, if you obtain services outside South Carolina or the U.S. from a BlueCard doctor or hospital, you should not need to pay up-front for care, except for the usual out-of-pocket expenses (deductibles, copayments, coinsurance and non-covered services). The provider should submit the claim.

When you receive services from doctors and hospitals that are not part of the BlueCard network, you pay the doctor or hospital for inpatient care, outpatient hospital care and other medical services. You must then complete a BlueCard Worldwide International Claim Form and send it to the BlueCard Worldwide Service Center. The claim form is available from your benefits administrator. It is also on the EIP website, www.eip.sc.gov, under "Forms" and "State Health Plan (SHP)." Select "BlueCard Worldwide International Claim Form."

What if I Need Help?

Call BlueCard Worldwide collect at 804-673-1177 or toll-free at 800-810-2583.

How to File a Medco Prescription Drug Claim

If you fail to show your health plan identification card, or if you incur prescription drug expenses while traveling outside the United States, you will have to pay the full retail price for your prescription and then file a claim with Medco for reimbursement. After you meet your deductible, if any, reimbursement will be limited to the plan's allowed amount, less the copayment or coinsurance. You must file your claim with Medco within one year of the date of service. To file a claim for prescription drug expenses incurred at a participating pharmacy or outside the United States, complete Medco's interactive "Coordination of Benefits Form/Direct Claim Form." It is available on EIP's website, www.eip.sc.gov as "Prescription Drug Claim Form (Coordination of Benefits/Direct)." You may also request a copy by calling Medco's Member Services at 800-711-3450.

Remember that benefits are NOT payable if you use a non-participating pharmacy in the U.S.

How to File a Dental Claim

The easiest way to file a claim is to assign benefits to your dentist. Assigning benefits means that you authorize your dentist to file claims for you and to receive payment from the plan for your treatment. To do this, you must show a staff member in your dentist's office your dental identification card and ask that the claim be filed for you. Be sure to sign the payment authorization block of the claim form. BlueCross BlueShield of South Carolina (BCBSSC) will then pay your dentist directly. You are responsible for the difference between the benefit payment and the actual charge.

If your dentist will not file your claims, you can file to BCBSSC. The claim form is available on EIP's website, www.eip.sc.gov. Complete items 1-11 on the claim form, and ask your dentist to complete items 12-29.

If your dentist will not complete his portion of the form, get an itemized bill showing this information:

1. The dentist's name and address and federal tax identification number or National Provider Identifier (NPI)
2. The patient's name
3. The date of each service
4. The name of and/or procedure code for each service
5. The charge for each service.

Attach the bill to the completed claim form and mail it to:

BlueCross BlueShield of South Carolina
State Dental Claims Department
P.O. Box 100300
Columbia, SC 29202-3300.

X-rays, office records and other diagnostic aids may be needed to determine the benefit for some dental procedures. Your dentist may be asked to provide this documentation for review by BCBSSC's dental consultant. The plan will not pay a fee to your dentist for providing this information. A completed claim form must be received by BCBSSC within 90 days after the beginning of care or as soon as reasonably possible. It must be filed no later than 24 months after charges were incurred, except in the absence of legal capacity, or benefits will not be paid.

What If I Need Help?

You can call BCBSSC at 888-214-6230. If you cannot call, you can visit www.SouthCarolinaBlues.com or write BCBSSC at the address above.

Notice of Privacy Practices

Effective April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Please share this information with your covered adult dependents.

The South Carolina Budget and Control Board Employee Insurance Program (EIP) is committed to protecting the privacy of your health information. EIP receives a copy of your medical claims information and related health information in order to provide you with health insurance and to assist you in claims resolution. This notice explains how EIP may use and disclose your health information, EIP's obligations related to the use and disclosure of your health information and your rights regarding your health information. EIP is required by law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to make sure that health information that identifies you is kept private, to give you this notice of its privacy practices and to follow the terms of its current notice. This notice applies to all of the records of your individual health information maintained or created by EIP. All EIP employees follow the practices described in this notice.

If you have any questions about this Notice of Privacy Practices, please contact:

Privacy Officer
1201 Main Street, Suite 300
Columbia, SC 29201
Phone: 803-734-0678 (Greater Columbia area)
888-260-9430 (toll-free outside the Columbia area)
Fax: 803-737-0825
E-mail: privacyofficer@eip.sc.gov.

How EIP May Use and Disclose Health Information

This is a list of ways EIP may use and disclose your health information. It explains each category of use or disclosure, and may present some examples. Not every use or disclosure in a category will be listed. However, all of the ways that EIP is permitted to use and disclose information will fall within one of the categories.

- **For Treatment.** EIP may use and disclose your health information to coordinate and manage your healthcare-related services by one or more of your healthcare providers. For example, a representative of EIP, a case manager and your doctor may discuss the most beneficial treatment plan for you if you have a chronic condition, such as diabetes.

- **For Payment.** EIP may use and disclose your health information to bill, collect payment and pay for your treatment/services from an insurance company or another third party; to obtain premiums; to determine or fulfill its responsibility for coverage or provision of benefits; or to provide reimbursement for healthcare. For example, EIP may need to give your health information to another insurance provider to facilitate the coordination of benefits or to your employer to facilitate the employer's payment of its portion of the premium.

- **For Healthcare Operations.** EIP may use and disclose health information about you for other EIP operations. EIP may use health information in connection with conducting quality assessment and improvement activities; reviewing the competence or qualifications of healthcare professionals; evaluating practitioner, provider and health plan performance; underwriting, premium rating and other activities relating to health plan coverage; conducting or arranging for medical review, legal services, audit services and fraud- and abuse-detection programs; business planning and development, such as cost

management; and business management and general administrative activities. For example, EIP may disclose your health information to an actuary to make decisions regarding premium rates, or it may share your personal health information with other business associates that, through written agreement, provide services to EIP. These business associates, such as consultants or third-party administrators, are required to protect the privacy of your personal health information.

- **For Purposes of Administering the Plan.** EIP may disclose your health information to its Plan sponsor, the South Carolina Budget and Control Board, for the purpose of administering the Plan. For example, EIP may disclose aggregate claims information to the Plan sponsor to set Plan terms.

- **Treatment Alternatives and Health-Related Benefits and Services.** EIP may use and disclose your health information to contact you about health-related benefits or services that may be of interest to you. For example, you may be contacted and offered enrollment in a program to assist you in handling a chronic disease, such as disabling high blood pressure.

- **Individuals Involved in Your Care or Payment for Your Care.** EIP may, in certain circumstances, disclose health information about you to your representative, such as a friend or family member who is involved in your healthcare or to your representative who helps pay for your care. EIP may disclose your health information to an agency assisting in disaster relief efforts so that your family can be notified about your condition, status and location.

- **Research.** EIP may use and disclose your de-identified health information for research purposes, or EIP may share health information for research approved by an institutional review board or privacy board after review of the research rules to ensure the privacy of your health information. For example, a research project may compare the health/recovery of patients who receive a medication with those who receive another medication for the same condition.

- **As Required By Law.** EIP will disclose health information about you when it is required to do so by federal or South Carolina law. For example, EIP will report any suspected insurance fraud as required by South Carolina law.

- **To Avert a Serious Threat to Health or Safety, or for Public Health Activities.** EIP may use and disclose health information about you, when necessary to prevent a serious threat to your health and safety or to the health and safety of the public or for public health activities.

- **Organ and Tissue Donation.** If you are an organ donor, EIP may disclose your health information to organizations that handle organ, eye or tissue procurement, transplantation or donation.

- **Coroners, Medical Examiners and Funeral Directors.** EIP may share your health information with a coroner/medical examiner or funeral director as needed to carry out their duties.

- **Military and Veterans.** If you are a member of the armed forces, EIP may disclose health information about you after the notice requirements are fulfilled by military command authorities.

- **Workers' Compensation.** EIP may disclose health information about you for Workers' Compensation or similar programs that provide benefits for work-related injuries or illness.

- **Health Oversight Activities.** EIP may disclose your health information to a health oversight agency for authorized activities, such as audits and investigations.

- **Lawsuits and Disputes.** EIP may disclose your health information in response to a court or administrative order, a subpoena, discovery request, or other lawful process if EIP receives assurance from the party seeking the information that you have either been given notice of the request, or that the party seeking the information has tried to secure a qualified protective order regarding this information.

- **Law Enforcement.** EIP may disclose information to a law enforcement official in response to a court order, subpoena, warrant, summons or similar process.

- **National Security, Intelligence Activities and Protective Services.** EIP may disclose your health information to authorized officials for intelligence, counterintelligence and other national security activities; to conduct special investigations; and to provide protection for the President, other authorized persons or foreign heads of state.

- **Inmates.** If you are an inmate of a correctional institution or are in the custody of a law enforcement official, EIP may disclose your health information if the disclosure is necessary to provide you with healthcare or to protect your health and safety or the health and safety of others.

- EIP will not use or release your health information for purposes of fundraising activities.

Your Health Information Rights

You have these rights regarding the health information that EIP has about you:

- **Right to Inspect and Copy.** You have the right to request to see and receive a copy of your health information, or, if you agree to the preparation cost, EIP may provide you with a written summary. Some health information is exempt from disclosure. To see or obtain a copy of your health information, send a written request to the Director, EIP, 1201 Main Street, Suite 300, P.O. Box 11661, Columbia, SC 29211. EIP may charge a fee for the costs associated with your request. In limited cases, EIP may deny your request. If your request is denied, you may request a review of the denial.

- **Right to Amend.** If you believe that your health information is incorrect or incomplete, you may ask EIP to amend the information by sending a written request to the Director, EIP, 1201 Main Street, Suite 300, P.O. Box 11661, Columbia, SC 29211, stating the reason you believe your information should be amended. EIP may deny your request if you ask it to amend information that was not created by EIP, the information is not part of the health information kept by or for EIP, the information is not part of the information you would be permitted to inspect and copy or your health information is accurate and complete. You have the right to request an amendment for as long as EIP keeps the information.

- **Right to an Accounting of Disclosures.** You have the right to request a list of the disclosures of your health information EIP has made. This list will NOT include health information released to provide treatment to you, to obtain payment for services or for healthcare operations; releases for national security purposes; releases to correctional institutions or law enforcement officials as required by law; releases authorized by you; releases of your health information to you; releases as part of a limited data set; releases to representatives involved in your healthcare; releases otherwise required by law or regulation and releases made prior to April 14, 2003. You must submit your request for an accounting of disclosures in writing to the Director, EIP, 1201 Main Street, Suite 300, P.O. Box 11661, Columbia, SC 29211, indicating a time period that may not go back beyond six years and may not include dates before April 14, 2003. Your request should indicate the form in which you want the list (for example, by paper or electronically). The first list that you request within a 12-month period will be provided free of charge; however, EIP may charge you for the cost of providing additional lists within a 12-month period.

- **Right to Request Restrictions of Use and Disclosure and Right to Request Confidential Communications.** You have the right to request a restriction on the health information that EIP uses or discloses. You also have the right to request a limit on the health information that EIP discloses about you to someone who is involved in your care or the payment for your care. For example, you may ask that EIP not use or disclose information about an immunization or a particular service that you received. EIP is not required to agree to your request(s). If EIP does agree, EIP will comply with your request(s) unless the information is needed to provide you with emergency treatment. In your request, you must specify what

information you want to limit and to whom you want the limits to apply. For example, you may request that your claims information not be sent to your home address. In addition, you have the right to request that EIP communicate with you by certain means or at a certain location. EIP will attempt to accommodate reasonable request(s), pursuant to the HIPAA Privacy Rule.

- You must make these request(s), in writing, to the Director, EIP, 1201 Main Street, Suite 300, P.O. Box 11661, Columbia, SC 29211.

- **Right to a Paper Copy of This Notice.** You have the right to request a paper copy of this notice at any time by contacting EIP's Privacy Officer (see the first page of this notice). **You may obtain a copy of this notice at EIP's website,** www.eip.sc.gov.

Complaints

If you believe that your health information rights, as stated in this notice, have been violated, you may file a complaint with EIP's Privacy Officer and/or with the Office for Civil Rights, U.S. Department of Health and Human Services, Atlanta Federal Center, Suite 3B70, 61 Forsyth Street, SW, Atlanta, GA 30303-8909. Phone number: 404-562-7886, FAX: 404-562-7881.

To file a complaint with EIP's Privacy Officer, contact the officer at the address listed on the first page of this notice.

EIP will not intimidate, threaten, coerce, discriminate against or take other retaliatory actions against any individual who files a complaint.

Changes to This Notice

EIP reserves the right to change this notice. EIP may make the changed notice effective for medical information it already has about you as well as for any information it may receive in the future. EIP will post a copy of the current notice on its website and in its office. EIP will mail you a copy of revisions to this policy at the address on file with EIP at the time of the mailing.

Other Uses of Health Information

This notice describes and gives some examples of the permitted ways your health information may be used or disclosed. EIP will ask for your written permission before it uses or discloses your health information for purposes not covered in this notice. If you provide EIP with written permission to use or disclose information, you can change your mind and revoke your permission at any time by notifying EIP in writing. If you revoke your permission, EIP will no longer use or disclose the information for that purpose. However, EIP will not be able to take back any disclosure that it made with your permission.

Initial COBRA Notice

Continuation Coverage Rights under COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires that health, vision, dental and/or Medical Spending Account coverage continue to be offered to you and/or your covered dependents when you are no longer eligible for group coverage.

On the following pages is a copy of your Initial COBRA Notice. When you became covered under group benefits offered by the State of South Carolina through the Employee Insurance Program, you received an Initial COBRA Notice. This notice contains important information about your right to continue your coverage if you lose it under certain circumstances. It also explains what you must do to protect your right to continued coverage.

It is important that you read this notice. It is also important that each family member you cover be familiar with this information.

If you cover a family member who does not live with you, you must notify your benefits office so a COBRA notice can be sent to him. Also, if you move, please inform your benefits office of your new address or change your address through MyBenefits, EIP's online enrollment system.

Under the rules of the plan and federal law, you must notify your benefits office of certain events, including your divorce or legal separation or if a person you cover loses eligibility under the rules of the plan. Please carefully read the section in the notice about your notification responsibilities. If you fail to follow the procedures, your rights under COBRA could be lost.

Additional information about COBRA is on pages 30-32. If you have questions about this notice or your rights and responsibilities under COBRA, please contact your benefits administrator.

* YOUR RIGHTS AND OBLIGATIONS UNDER COBRA *

What is COBRA continuation coverage?

Under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), coverage under the Employee Insurance Program (EIP) may be continued when it otherwise would end due to a qualifying event. This continuation of coverage is typically referred to as "COBRA coverage" but it is actually the same coverage that EIP gives to other participants or beneficiaries under the state insurance program who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA coverage will have the same rights as other participants or beneficiaries, including open enrollment and special enrollment rights.

COBRA (and the description of COBRA coverage contained in this notice) applies only to the group health benefits offered by EIP (the Health, Dental, Dental Plus, Vision, and MoneyPlu$ Medical Spending Account) and not to any other benefits offered by EIP.

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

Who is entitled to elect COBRA coverage?

If a qualified beneficiary loses coverage under group health benefits due to one of the qualifying events listed below, the qualified beneficiary will be allowed to continue group health benefits for a specified period of time at group rates. After a qualifying event occurs and any required notice of that event is properly provided to the benefits office, COBRA coverage will be offered to each qualified beneficiary who is losing coverage as a result of that event.

Who is a qualified beneficiary?

To be a qualified beneficiary, a person:

- Must have been covered (under Health, Dental, Dental Plus, Vision and/or a MoneyPlu$ Medical Spending Account) on the day before the qualifying event; AND
- Must be a covered employee, the covered spouse of the employee or a covered child of the employee.

Two situations may occur during the COBRA coverage period that would cause a child (who was not covered at the time of the qualifying event) to gain the status of a qualified beneficiary. These are addressed later in this notice.

What is a qualifying event?

A qualifying event is a life event that occurs that would cause a qualified beneficiary to lose coverage under group health benefits offered by EIP (Health, Dental, Dental Plus, Vision and/or a MoneyPlu$ Medical Spending Account).

For a Covered Employee – If you are the covered employee, you will experience a qualifying event and will have the right to elect COBRA coverage if you lose your group health benefits because any of the following happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

For a Covered Spouse – If you are the covered spouse of an employee, you will experience a qualifying event and will have the right to elect COBRA coverage if you lose your group health benefits because any of the following happens:

- Your spouse dies;

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- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his gross misconduct; or
- You become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health benefits in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

For a Covered Child – If you are the covered child of an employee, you will experience a qualifying event and will have the right to elect COBRA coverage if you lose your group health benefits because any of the following happens:

- Your parent (the employee) dies;
- Your parent's (the employee) hours of employment are reduced;
- Your parent's (the employee) employment ends for any reason other than his gross misconduct; or
- You stop being eligible for coverage under EIP as a child (for example, you turn age 26 or become eligible, as an employee or as a spouse, for a group health plan sponsored by an employer). For more information about when a child ceases to be eligible for coverage under EIP, please refer to your *Insurance Benefits Guide*.

What do you do when a qualifying event occurs?

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS: divorce, legal separation, and a child loses eligibility for coverage. For these qualifying events, the benefits office will offer you COBRA coverage only if you notify the benefits office within 60 days after the later of: (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under EIP as a result of the qualifying event. To notify the benefits office of these qualifying events, complete the "Notice of COBRA Qualifying Event" form and deliver it to the benefits office at the address on the first page of this document. See "How do you provide a proper and timely notice?" for details.

When the qualifying event is the end of employment or reduction of hours of employment, you do not need to notify the benefits office of any of these qualifying events. The benefits office will offer COBRA coverage to the appropriate qualified beneficiaries. When the qualifying event is the death of the employee, the benefits office will offer survivor coverage. Refer to the *Insurance Benefits Guide* for details.

How do you provide a proper and timely notice?

Any notice that you provide must be in writing and must be submitted on the forms provided by EIP. These forms are available at no cost from the benefits office or EIP at 803-734-0678 (toll-free outside Columbia at 888-260-9430) or can be printed from www.eip.sc.gov under "Forms." Oral notice, including notice by telephone, is not acceptable. Procedures for making a proper and timely notice are:

Step 1- Complete the proper form.
Step 2- Make a copy of the form for your records.
Step 3- Attach the required documentation depending upon the qualifying event (as indicated on the form).
Step 4- Mail or hand-deliver the form and required documentation.
Step 5- Call within 10 days to ensure the form and required documentation have been received.

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the individual at the address specified for delivery no later than the last day of the applicable notice period.

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How can you elect COBRA coverage?

Once the benefits office learns a qualifying event has occurred, the qualified beneficiaries will be notified of their rights to elect COBRA coverage. Each qualified beneficiary has an independent election right and has 60 days to elect coverage. The 60-day election window is measured from the later of the date coverage is lost due to the event or from the date of notification to the qualified beneficiaries. This is the maximum period allowed to elect COBRA coverage. EIP does not provide an extension of the election period beyond what is required by law.

The covered employee or the employee's covered spouse can elect continuation coverage on behalf of all qualified beneficiaries. A parent may elect to continue coverage on behalf of a covered child who is losing coverage as a result of the qualifying event. For each qualified beneficiary who elects to continue group health benefits, COBRA coverage will begin on the date that coverage under EIP would be lost because of the event. **If COBRA coverage is not elected for a qualified beneficiary within the 60-day election window, he will lose all rights to elect COBRA coverage and will cease to be a qualified beneficiary.**

How long does COBRA coverage last for Health, Dental, Dental Plus and/or Vision?

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described here are maximum coverage periods.

18 months – When the loss of coverage is due to the end of employment (other than for reasons of gross misconduct) or reduction in hours of employment, coverage under the Health, Dental, Dental Plus and Vision components generally may be continued up to 18 months. There are three possible situations that may provide coverage beyond 18 months when loss of coverage is due to end of employment or reduction in hours of employment.

1. Medicare Entitlement Rule (for covered dependents only) – 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 during 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. For example, if a covered employee becomes entitled to Medicare eight (8) months before the date on which employment ends, his spouse and children who are qualified beneficiaries who lost coverage as a result of his termination will be offered 28 months of continuation coverage (36-8=28). The covered employee, however, is offered only 18 months. This COBRA coverage period is available only if the covered employee becomes entitled to Medicare during the 18 months before the end of employment or reduction of hours.

2. Social Security Disability Extension – 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 end of employment or reduction of hours (generally 18 months) may be extended to a total of up to 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the employee's termination of employment or reduction of hours. The Social Security Administration must determine that the qualified beneficiary's disability started before the 61st day after the covered employee's termination of employment or reduction of hours *and* the disability must last until at least the end of the 18-month period of continuation coverage.

To qualify for the disability extension, you must notify your COBRA ADMINISTRATOR in writing at the address where you deliver your COBRA premium payments of the Social Security Administration's determination of disability and you must do so within 60 days after the latest of:

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

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You also must provide this notice within 18 months after the covered employee's employment ended or his hours were reduced to be entitled to a disability extension. In providing this notice, you must use EIP's form, "Notice to Extend COBRA Continuation Coverage" (you may obtain a copy of this form from the benefits office or EIP at no charge, or you can print the form at www.eip.sc.gov under "Forms"). You must follow the notice procedures outlined in the section entitled "How do you provide a proper and timely notice?" **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 employment ended or hours were reduced, THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.**

3. Second Qualifying Event Extension – If your family experiences a second qualifying event 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 COBRA coverage period may be extended to a total of up to 36 months from the date of the original qualifying event. Such second qualifying events may include the death of the employee, divorce or legal separation from the employee, or dependent child losing eligibility for coverage under EIP.

This extension due to a second qualifying event is available only if you notify your COBRA ADMINISTRATOR in writing at the address where you deliver your COBRA premium payments of the second qualifying event within 60 days after the date of the second qualifying event. In providing this notice, you must use EIP's form entitled "Notice to Extend COBRA Continuation Coverage." (You may obtain a copy of this form from the Employee Insurance Program at no charge, or you can print the form at www.eip.sc.gov under "Forms.") You must follow the procedures specified in the section entitled "How do you provide a proper and timely notice?" **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.**

36 months – When the loss of coverage is due to the death of the employee, divorce or legal separation from the employee, or a child losing eligibility for coverage under EIP, a spouse or child who is a qualified beneficiary will have the opportunity to continue coverage under Health, Dental, Dental Plus and Vision for 36 months from the date of the original qualifying event.

How long does COBRA coverage last for the MoneyPlu$ Medical Spending Account (MSA)?

COBRA coverage under the MoneyPlu$ Medical Spending Account (MSA) can last only until the end of the plan year, including the grace period, in which the qualifying event occurred. The period of COBRA coverage under the MoneyPlu$ MSA cannot be extended under any circumstances. COBRA coverage under the MoneyPlu$ MSA will be offered only to a qualified beneficiary losing coverage who has an "underspent account." An account is underspent if the annual limit elected under the MoneyPlu$ MSA by the covered employee, reduced by reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the contributions for MoneyPlu$ MSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the MoneyPlu$ MSA 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, so any unused amounts will be forfeited at the end of the plan year, including the grace period. COBRA coverage will terminate at the end of the plan year. Unless otherwise elected, all qualified beneficiaries who were covered under the MoneyPlu$ MSA will be covered together for continuation under COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate annual limit and a separate contribution

How much does COBRA coverage cost?

Generally, each qualified beneficiary is required to pay 100% of the applicable premium for the coverage that is continued, plus a 2% 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

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disabled qualified beneficiary elects the extension, the rate is 150% of the applicable premium. If only non-disabled qualified beneficiaries extend coverage, the rate will remain at 102%.

More information about individuals who may be qualified beneficiaries

Children born to or placed for adoption with the covered employee during COBRA 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 the EIP's plan, 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 EIP's plan, 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 EIP pursuant to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) received by EIP during the covered employee's period of employment is entitled to the same rights to elect COBRA as an eligible child of the covered employee.

For more information

This notice is a summary and does not fully describe COBRA coverage, other rights under EIP, or details about your group health benefits. More information is available in your *Insurance Benefits Guide*, from the benefits office or from EIP.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of the *Insurance Benefits Guide*, contact your benefits office, contact the Employee Insurance Program at 803-734-0678 (toll-free outside Columbia at 888-260-9430), or visit EIP's website (www.eip.sc.gov).

For more information about your rights under COBRA, contact the Centers for Medicare & Medicaid Services at www.cms.gov/COBRAContinuationofCov/ or phig@cms.hhs.gov.

Keep the Benefits Office Informed of Address Changes

To protect your rights, notify the benefits office of any changes in the employee's address and the addresses of covered family members as soon as possible.

Plan Administrator/EIP

The Employee Insurance Program (EIP) is the plan administrator for the group health benefits, which include Health, Dental, Dental Plus, Vision and the MoneyPlu$ Medical Spending Account. You can contact EIP by calling 803-734-0678 (toll-free outside Columbia at 888-260-9430) or visiting EIP's website (www.eip.sc.gov). EIP's mailing address is P.O. Box 11661, Columbia, SC 29211.

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