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Introduction

BENEFITS ADMINISTRATORS AND OTHERS CHOSEN BY YOUR EMPLOYER WHO MAY ASSIST WITH INSURANCE ENROLLMENT AND ADJUSTMENTS, 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. 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 THE STATE. 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.

The section "What's New for 2009?" highlights major changes in insurance programs offered through the Employee Insurance Program (EIP). There also are some changes in this book.

New symbols have been added to boxes. A box with a book will tell you where to go for more information about a topic. An apple marks information about how to stay healthy or manage diseases.

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

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 administrator, such as BlueCross BlueShield of South Carolina or FBMC; or EIP. The IBG's index has been expanded. Turn to it for help in finding information about specific topics, including definitions of terms.

Every year there are changes in the programs offered by the Employee Insurance Program. To avoid mistakes, please recycle your 2008 *Insurance Benefits Guide* and use this one.

Remember, only information concerning those programs for which you are eligible and in which you are enrolled applies to you. The word "you," as used in this book, means anyone insured through EIP, you and/or your covered dependents.

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 third-party administrator listed on the inside cover of the IBG.

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.**
- **You may make changes in your coverage within 31 days of a qualifying event, such as birth, adoption, marriage or involuntary loss of other coverage. To do so, contact your benefits administrator.**
- **Whether you are covered by the State Health Plan or a Health Maintenance Organization (HMO), some services must be approved by your plan before you receive them. Check preauthorization requirements now so you will be familiar with them when you need services.**

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) of 1996, 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 is on page 215 and on the EIP Web site, www.eip.sc.gov. In addition, the Web site 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 available on EIP's Web site. Choose your category and then select "Forms." Under "Forms," select "Other Forms" then "HIPAA Information" 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

What's New for 2009?

WHAT'S NEW FOR 2009?

General Information

- **Retirees, survivors and COBRA subscribers**, as well as **active subscribers**, can now update their contact information and beneficiaries and print a copy of their benefits statement year-round on MyBenefits, EIP's online enrollment system. During October, they can also make their own enrollment changes.

For details, see page 24 and www.eip.sc.gov.

State Health Plan

- The State Health Plan now covers certain services related to autism spectrum disorders.

For details, see page 45.

Health Maintenance Organizations

- The HMOs offered through the Employee Insurance Program now cover certain services related to autism spectrum disorders.

For details, see page 66 (BlueChoice HealthPlan) and page 76 (CIGNA HMO).

- **MUSC Options**, a point of service plan offered in the Charleston area, is no longer offered.

Long Term Care

- The Prudential Insurance Company of America has replaced Aetna as the EIP's long term care insurance provider.

For details, see pages 127-134.

MoneyPlu$

- Eligible Savings Plan subscribers may now open a Health Savings Account online.

For details, see page 153.

Retirement/Disability Retirement

- Employees who began service with an employer participating in the state insurance program on or after May 2, 2008, are covered under new retiree insurance eligibility rules.

For details, see page 163.

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Your Insurance Benefits: Help When You Need It Most

Your insurance, offered through the Employee Insurance Program, provides a financial safety net when you are ill or injured. Several health plans are available.

Through the **State Health Plan**, you may enroll in the Standard Plan, the Savings Plan or, if you are a retiree and eligible for Medicare, the Medicare Supplemental Plan.

Health Maintenance Organizations are also offered:

- BlueChoice HealthPlan is available statewide.
- CIGNA HMO is available in all counties **except** Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda.

Active employees who enroll in a health plan receive Basic Life Insurance and Basic Long Term Disability Insurance at no charge.

For more information on retiree health insurance options, including options for retirees who are returning to work, refer to the Retirement/Disability Retirement chapter, which begins on page 159.

Eligible employees and retirees may also enroll in the State Dental Plan and in Dental Plus. Dental Plus supplements State Dental Plan coverage. It pays a higher amount for the same services covered by the State Dental Plan except orthodontics, which Dental Plus does not cover.

ENROLLING IN A HEALTH OR DENTAL PLAN

ELIGIBILITY

An eligible active employee:

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

Eligible employees also include clerical and administrative employees of the S.C. General Assembly and judges in the state courts. S.C. General Assembly members and 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. Members of other governing boards are not eligible for coverage. If you work for more than one *participating group*, please contact your benefits administrator for further information.

Retiree insurance eligibility is explained on pages 161-163.

A *local subdivision* is any *participating group* other than a state agency, higher education institution or a school district. Examples of local subdivisions 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. Since 1985, the General Assembly has passed legislation extending voluntary participation in the state insurance benefits 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 1976 S.C. Code of Laws, as amended).

An eligible dependent spouse is:

- A lawful spouse, or
- A former spouse who is required to be covered by a divorce decree, but not both spouses.

A spouse who is eligible for coverage as an employee of any participating group, including a local subdivision, may not be covered as a dependent in any program. A spouse who is a permanent, part-time teacher may be covered as an employee or as a dependent, but not as both.

An eligible dependent child:

- Must be unmarried and younger than age 19
- Must be principally dependent (more than 50 percent) on the subscriber for maintenance and support
- Must be the natural child, adopted child, stepchild, foster child or child for whom the subscriber has legal custody and
- Must reside in the subscriber's home in a parent-child relationship unless the subscriber has been directed to provide coverage by a court order.

For information about coverage of full-time students, ages 19-24, and incapacitated children, age 19 and older, see pages 15-16.

Please note: You may cover an eligible dependent child age 19-24 if he is a full-time student. You may cover an eligible incapacitated child age 19 and older.

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

Initial Enrollment

If you are an eligible employee or retiree of a *participating group* in South Carolina, you can enroll in a health plan and the dental plan within 31 days of the date you are hired or the date you retire. You can also enroll your eligible dependents. A *participating group* is a state agency, school district, county, municipality or other group that is authorized by statute to participate in, and is participating in, the state insurance plan.

To enroll in a health or dental plan, you must complete the required forms, including a *Notice of Election (NOE)* form. An *NOE* is used to: enroll in benefits; add or drop dependents; or change a subscriber's coverage level, beneficiary, name or address. Coverage is not automatic.

To enroll in Dental Plus, you must be enrolled in the State Dental Plan. You must cover the same family members under both plans.

After you enroll, please check your payroll stub to make sure the correct premiums are deducted. Your health and dental coverage will continue from one year to the next as long as you are a full-time, permanent employee or an eligible retiree. Your coverage begins on the first day of the month if you are *actively at work* on the first working day of the month.

An employee is considered *actively at work* on his employer's scheduled workday if he is performing the regular duties of his occupation. He may be working at his usual work place or at another place, if he is required to travel. An employee is considered actively at work on a paid

Your *benefits administrator*, or "BA," helps you enroll in or change your insurance coverage.

Your employer's human resources staff is your BA if you are:

- **An active employee of a state agency, higher education institution or school district**
- **An active employee, retiree, survivor or COBRA subscriber of a local subdivision.**

The Employee Insurance Program is your BA if you are:

- **A retiree, survivor or COBRA subscriber of a state agency, higher education institution or school district.**

vacation day or on one of his employer's normal holidays only if he was actively at work on the last day before the vacation day or holiday.

If you are not actively at work on the first working day of the month, your coverage starts on the first day of the next month. Your enrolled dependents' coverage begins on the same day your coverage begins.

INSURANCE CARDS

If you enroll in the Standard Plan, Savings Plan or Medicare Supplemental Plan, BlueCross BlueShield of South Carolina will send you insurance cards for you and your covered family members. BlueChoice HealthPlan and CIGNA Healthcare 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 BlueCross BlueShield of South Carolina.

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 e-mails and written communication between you and your dependents and EIP. It is designed to make your personal information more secure. When you contact EIP, you may give your SSN or your BIN, and the Customer Service staff will be able to assist you.

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

Keep a record of your BIN in a safe place. All subscribers need it to use MyBenefits, EIP's online enrollment system. However, you can also get your BIN through MyBenefits. For more information, see page 24.

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 only. This includes changing to or from 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. You may also change **dental coverage**.

Changing Plans or Coverage

You can change to or from the Savings Plan, the Standard Plan, a health maintenance organization (HMO) or the Medicare Supplemental Plan (if you are retired) only during October enrollment periods. 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.

Please don't use a highlighter on any document or form you send to EIP or to any third-party administrator.

Retirees and survivors and their eligible dependents 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.

If you are retired and eligible for Medicare, you may not enroll in the Savings Plan. Active employees of any age and retired employees who are not eligible for Medicare may enroll in the Savings Plan.

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 insurance coverage are explained in *The Insurance Advantage,* which you receive each September. Changes made during open or annual enrollment become effective the following January 1.

Pre-Existing Condition Exclusions

Most of the health plans offered through EIP exclude coverage for a *pre-existing condition*. This means that if you have a medical condition before coming to the plan, you may have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. The pre-existing exclusion does not apply to pregnancy nor to a child who is enrolled within 31 days of birth; adoption, if the child is younger than age 18; or placement for adoption, if the child is younger than age 18.

This exclusion may last up to 12 months (18 months if you are a late entrant) from your enrollment date. However, you can reduce the length of this exclusion period by the number of days of your prior creditable coverage. Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a *significant break in coverage,* a period of more than 62 days in which you did not have insurance. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you must present to your benefits administrator a creditable coverage letter or a letter on letterhead from your previous employer or insurance company that includes the dates coverage began and ended, the names of all individuals covered and the types of coverage.

The State Dental Plan and Dental Plus do not have pre-existing condition exclusions.

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 dependents 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 dependents will be subject to an 18-month pre-existing condition exclusion period, which may be reduced by prior creditable coverage.

SPECIAL ELIGIBILITY SITUATIONS

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

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

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents in health and/or dental coverage. However, you must complete an NOE within **31 days** of the date of the marriage, birth, adoption or placement for adoption. A salary increase does not create a special eligibility situation.

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

Marriage

If you, as a covered subscriber, wish to add a dependent spouse because you marry, you can do so by completing an NOE within 31 days of the date of your marriage. Coverage becomes effective with the date of marriage. You cannot cover your spouse as a dependent if he is eligible, or becomes eligible, for coverage as an employee or as a retiree of a participating group. If you do not add your spouse within 31 days of the date of marriage, you cannot add him until the next open enrollment period or within 31 days of a special eligibility situation.

Legal Separation

If you and your covered spouse separate, your spouse may remain on your health, dental and Dependent Life/Spouse coverage until the divorce is final.

To drop your spouse when you separate, you must submit a copy of a court order signed by the judge to your benefits administrator. It must state that the divorce is in progress, and it 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 health insurance coverage for your spouse, coverage 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 for pre-existing conditions until 18 months after enrollment. If he enrolls due to a special eligibility situation, he will not be eligible for coverage for 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 year-round if you submit medical evidence of good health and it is approved by The Hartford. Dental coverage can be reinstated during the next open enrollment period or within 31 days of a special eligibility situation.

Divorce

If you, as a subscriber, divorce, you must drop your spouse from your coverage by completing an NOE and submitting **a complete copy** of the divorce decree within 31 days of the date the divorce decree is signed. Your divorced spouse's coverage ends the last day of the month after the divorce decree is signed. You can continue to cover your eligible dependent children if they live with you and you are financially responsible for them.

You may continue to provide health, dental and Dependent Life coverage for your former spouse only if the Family Court requires that you do so. You must give a complete copy of the Family Court decree or a complete copy of the divorce decree, as well as an NOE, to your benefits administrator, who will send both to EIP. The document must list the programs 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.

If you remarry, you can cover your divorced spouse or your current spouse, but you cannot cover both under any EIP program. Dependent 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 **no later than** within 60 days of the event or from when coverage would have been lost due to the event, whichever is later.

Adding Children

Eligible children may be added by completing an NOE **within 31 days** of the date of birth, gaining legal custody, adoption or placement for adoption. **Children must be listed on your NOE to be covered, even if you already have full family or employee/children coverage. Notification to Medi-Call of the delivery of your baby does not add the baby to your health insurance.**

To add adopted children to your policy, you must submit a copy of the legal adoption documentation from the court, verifying the completed adoption; or a letter of placement from an attorney, adoption agency or the S.C. Department of Social Services (DSS) verifying the adoption is in progress, as well as an NOE. An adopted child will be covered on the date of adoption or when the child has been placed in a subscriber's home, a petition for adoption has been filed and the petitioner has temporary custody of the child.

To verify custody or guardianship of a child, you must submit a copy of the court order or other legal documentation from a placement agency or DSS granting you custody or guardianship of the child or foster child. 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 dependent child, you must notify your employer and EIP within 31 days of the date the court order was issued and elect coverage for that child and 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 program. However, 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.

Gaining Other Coverage

If you or your dependents gain other **group** coverage, you have 31 days to cancel your coverage 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 dates of coverage, names of all individuals covered and types of coverage gained.

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

Involuntary Loss of Other Coverage

If you or your dependents are covered under another health or dental plan and you lose that coverage involuntarily because it was discontinued or the covered employee left his job, you have 31 days from the last day of coverage to enroll through EIP. To enroll, you must complete an NOE and return it to your benefits office. To document that you have lost coverage, you must attach a creditable coverage letter or a letter on company letterhead that includes dates of coverage, names of all individuals who lost coverage, the types of coverage and the reason for the loss. Dependents must be listed on the NOE to be covered. Only family members who actually lost coverage may enroll. If you fail to enroll within the 31 days, you must wait until the next open enrollment, which occurs in October of odd-numbered years, or within 31 days of a special eligibility situation.

COVERAGE OF DEPENDENT CHILDREN AGE 19 AND OLDER

Full-time Students, Ages 19-24

You may cover your dependent children, ages 19-24, who are full-time students. They must meet these requirements:

- At the beginning of the semester, a student must be enrolled in and attending an accredited high school, vocational/trade school or college or university **full-time**, as defined by the institution he attends. He must remain a full-time student throughout the semester.
- While summer school is not required for maintaining student status, a dependent who enrolls in summer school full-time may become eligible. However, the student will lose eligibility if he does not re-enroll full-time the next semester/quarter.
- Enrollment in adult education night classes and correspondence courses is not considered full-time attendance. Internet courses from the accredited educational institution the student is attending do count toward the hours needed for him to be considered a full-time student.

If your child is not a full-time student, his coverage ends the last day of the month in which he turns 19, unless he is covered as an incapacitated dependent. Your child's eligibility for coverage also ends if he gets married.

About 90 days before your dependent's 19th birthday, you will receive a Student Certification letter. To continue coverage, complete and return this letter to your benefits administrator within 31 days of the child's 19th birthday. You must also include a statement on letterhead from the educational institution he is attending that confirms he is a full-time student as of the date of his 19th birthday and gives his dates of enrollment. Evidence of pre-registration is not adequate. If the child's 19th birthday occurs during the summer, return the Student Certification letter with the "Pending Student Certification" block marked to your BA. (Retirees of state agencies, higher education institutions and school districts should return the letter to EIP.) You must submit the letter from the institution verifying that your child is a full-time student by September 30.

If the letter is not returned by September 30, the child will lose eligibility for coverage on October 1. You will be able to add the child to your coverage, again:

- At open enrollment
- Within 31 days of the date he first becomes eligible due to a special eligibility situation
- Within 31 days of the date the child first returns to school full-time.

If your dependent, age 19-24, goes back to school full-time, you may put him back on your health coverage. Within 31 days of eligibility, submit an NOE and a statement on letterhead from the educational institution that verifies your dependent is a full-time student and gives his dates of enrollment. In this case, that would be the date he is again a full-time student.

If your 19-year-old is certified as a full-time student **while he is in high school,** you must notify your benefits administrator within 31 days of the date he leaves high school if he will not be returning to school in the fall.

When your child is covered as a full-time student, his coverage ends the last day of the month in which he graduates, is no longer a full-time student, marries or turns age 25, unless he is covered as an incapacitated dependent.

If a child does not remain a full-time student for the entire semester, his coverage ends the last day of the month in which he becomes ineligible. His 60-day COBRA notification period begins the first day of the month after he becomes ineligible.

If a child remains a full-time student through the semester and does not graduate, EIP will assume the child intends to enroll as a full-time student the next semester. If a child is not a full-time student by September 1, for the fall semester (or by February 1 for the spring semester) his 60-day COBRA notification period will begin on this date. You must notify your benefits office that the child is no longer a full-time student and submit an NOE, dropping him from your coverage. If notification is received within 60 days of when coverage would have been lost due to the event, continuation of insurance under COBRA will be offered. Otherwise, it will not be offered.

EIP conducts periodic audits of the eligibility of covered dependents ages 19-24. If your child is found to be ineligible, his coverage will be canceled, and EIP will seek repayment of any benefits paid for him while he was ineligible.

If a dependent whose eligibility is audited is a graduate of a community or technical college, a four-year college or a university and will return to school when the next term begins, you will be asked to provide EIP with a letter from the school he hopes to attend acknowledging his application or a letter of acceptance from the school he will attend.

Incapacitated Children

You can continue to cover your child, who is age 19 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 19th birthday, but no later than 31 days after the date he is no longer covered as an eligible, full-time student. 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 and for compliance with the Plan of Benefits. 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.

If the child became incapacitated while enrolled as a full-time student, you must also include a letter from the school he was attending stating that he was a full-time student up to the date of incapacitation and that he is no longer a full-time student.

Also complete and attach an Authorized Representative Form signed by the incapacitated child. If applicable, you may forward a copy of guardianship papers from the probate court for your incapacitated child. Either of these documents gives EIP permission to discuss or disclose the child's protected health information with the child's Authorized Representative.

ENROLLMENT OF A TRANSFERRING EMPLOYEE

As an active employee, you are considered a transfer if you change employment from one participating group to another with no more than a 15 calendar-day break in employment or in insurance coverage.

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

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 actively at work.

A transfer is not considered a new hire for insurance purposes. When you transfer, you must remain enrolled in all of the same insurance programs in which you were enrolled at your former employer.

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), leave because of a disability approved by the Workers' Compensation Benefits Program or disability leave. Leave must be approved by your employer.

WHEN YOU BECOME ELIGIBLE FOR MEDICARE

If You Are an Active Employee When You or Your Spouse Turns 65

If you are actively working and/or covered under a state health plan for active employees when you turn 65, you may delay enrollment in Part B because your insurance as an active employee remains primary. However, if you are planning to retire within three months of age 65, you should contact the Social Security Administration to learn about your Medicare enrollment options.

When you do retire, you should sign up for Part B within 31 days of retirement. Medicare will then be your primary coverage, and you need Part A and Part B for full coverage. It is strongly advised that you enroll in Medicare Part B coverage. **If you are not enrolled in Part B at retirement, you will be required to pay the portion of your healthcare costs that Part B would have paid.**

For more information about Medicare eligibility, see page 168.

If you are an active employee when your spouse turns 65, your spouse should enroll in Medicare Part A but may defer enrollment in Part B until you retire or leave covered employment.

Most Medicare recipients covered by health insurance offered through EIP should not sign up for Medicare Part D, the prescription drug program. Your drug expenses will continue to be covered under your health insurance.

Medicare at Age 65 When You Are Retired

The Social Security Administration should notify you or any dependents of Medicare eligibility approximately 90 days before turning 65 if you are receiving a Social Security check. If you are not notified, contact your local Social Security office immediately. If you are already receiving Social Security benefits when you turn 65, Medicare Part A and Part B will start automatically. It is strongly advised that you enroll in Medicare Part B coverage. **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.** Even if you have not reached the age to qualify for full Social Security benefits, you should sign up for Medicare within three months of your 65th birthday.

If you are not receiving Social Security benefits when you turn 65 and you wish to wait to receive them until you reach full retirement age, you must contact the Social Security Administration to enroll in Medicare Part A. It is strongly advised that you enroll in Medicare Part B coverage. Medicare becomes your primary health insurance at age 65, regardless of whether you are receiving Social Security benefits.

Most Medicare recipients covered by health insurance offered through EIP should not sign up for Medicare Part D, the prescription drug program. Your drug expenses will continue to be covered under your health insurance.

Medicare Before Age 65

If you or your covered dependent becomes eligible for Medicare before age 65 due to disability or end-stage renal disease (ESRD), the Social Security Administration will notify you. **You must notify EIP within 31 days of Medicare eligibility.** When you notify EIP, please submit a copy of your Medicare card.

If Medicare is your primary insurance, it is strongly advised that **you enroll in Medicare Part B,** which helps cover doctors' services and outpatient hospital care. **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. Not enrolling in Part B may substantially increase the amount you pay.**

If you or one of your dependents become eligible for Medicare, notify EIP within 31 days of Medicare 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:

- **Immediately begin paying benefits as if you were enrolled in Medicare**
- **Seek reimbursement for overpaid claims back to the date you or your dependent(s) became eligible for Medicare.**

WHEN YOUR COVERAGE ENDS

Your coverage will end:

- The last day of the month in which you were actively at work, 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 employees or
- If you do not pay a required premium when it is due. (For example, if you are on leave without pay or on COBRA and are paying the full cost, you must make a monthly payment.)

Dependent coverage will end:

- The date your coverage ends
- The date dependent coverage is no longer offered or
- The last day of the month in which your dependent's eligibility for coverage ends.

If your coverage or your dependent'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 dependent from your coverage, you must complete a Notice of Election (NOE) form within 31 days of the date the dependent is no longer eligible for coverage.

COBRA

COBRA is short for Consolidated Omnibus Budget Reconciliation Act. It requires that continuation of **group health and/or dental insurance coverage** be offered to you and/or your covered dependents 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)
- The covered employee is separated or divorced from his spouse
- A covered child no longer qualifies as a dependent.

For covered dependents to continue coverage under COBRA, the subscriber or a dependent must notify his benefits office **within 60 days of 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.

COBRA Coverage for former full-time students, ages 19-24

If a child does not remain a full-time student for the entire semester, his coverage ends the last day of the month in which he becomes ineligible for coverage. His 60-day COBRA notification period begins the first day of the following month.

If a child remains a full-time student through the semester and does not graduate, EIP will assume the child intends to enroll as a full-time student the next semester. If a child is not a full-time student by September 1 for the fall semester (or by February 1 for the spring semester) his 60-day COBRA notification period will begin on this date.

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 and then elected coverage on August 15. You would be required to pay three premiums: one for the month following the date you lost coverage; one for the month in which you elected coverage; and one for the first full month after you elected coverage.

COBRA coverage becomes effective when the first premium is paid and remains in effect only as long as the premiums are kept up-to-date. EIP is the benefits administrator for COBRA subscribers of state agencies, higher education institutions and school districts. COBRA subscribers from local subdivisions keep the same benefits administrator.

How Medicare Affects COBRA Coverage
If you or your eligible dependent is covered by COBRA and become eligible for Medicare Part A, Part B or both, please notify the Employee Insurance Program. Your COBRA coverage will end.

A subscriber or eligible dependent 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 A COVERED DEPENDENT

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 health and dental coverage and start survivor coverage for any covered dependents. If a state agency, higher education or school district retiree dies, a family member should contact EIP.

If one of your dependents dies, please contact your benefits administrator. EIP is the benefits administrator for retirees of state agencies, higher education institutions and school districts. Survivor subscribers of local subdivisions keep the same benefits administrator.

Survivors

Spouses and children who are covered as dependents under the State Health Plan or an HMO are eligible as survivors for a one-year waiver of health insurance premiums when a covered employee dies.

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

For a list of steps to follow when a loved one dies, see page 26.

Survivors of retirees hired as employees on or after May 2, 2008

When a retiree of a state agency, higher education institution or school district* who was covered by a health plan dies, health insurance funding for his covered dependents is determined by the retiree's number of years of earned service credit.

- If the retiree had five years, but fewer than 15 years, of earned service credit, the survivor may continue coverage by paying the subscriber and the employer parts of the premium.
- If the retiree had 15 years, but fewer than 25 years, of earned service credit, the state will pay 50 percent of the full premium for the first 12 months. After that, the survivor pays both the subscriber and employer parts of the premium.
- If the retiree had 25 or more years of earned service credit, the state waives the full premium for the first 12 months. After that, the survivor pays both the subscriber and the employer parts of the premium.

*If the retiree worked for a local subdivision, ask his employer for information about premiums.

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

If you are a covered spouse or dependent child of a covered employee who was **killed in the line of duty** while working for a participating group, your premium will be waived for the first year after the employee's death. You must submit verification of death in the line of duty. After the one-year waiver, if you are a covered surviving spouse of a state agency or a school district employee you may continue coverage, *at the employer-funded rate*, until you remarry or otherwise become ineligible. If you are a covered surviving dependent child, you may continue coverage at the *employer-funded rate* until you are no longer eligible for coverage as a dependent. Participating local subdivisions may elect to, but are not required to, contribute to your insurance premium, but you may continue coverage, at the full rate, for as long as you are eligible.

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

As a surviving spouse, you can continue coverage until you remarry. If you are a dependent child, you can continue coverage until you are no longer eligible as a dependent. If you are no longer eligible for coverage as a survivor, you may be eligible to continue coverage under COBRA. Contact EIP for details.

As long as a survivor remains covered by either health or dental insurance, he can add the other during open enrollment or within 31 days of a special eligibility situation. If he drops both health 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.

WORKERS' COMPENSATION

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 or EIP.

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 probably pay premiums for both plans. Weigh the advantages and disadvantages carefully before you purchase 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 administrators, such as BlueCross BlueShield of South Carolina or your 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 expenses.**

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 dependent 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.

For more information about how coordination of benefits works, see the section on your health plan.

PREVENTION PARTNERS

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

A major initiative of Prevention Partners is the Preventive Worksite Screening. This comprehensive health screening measures cholesterol levels, blood pressure, triglyceride levels, kidney function and red and white blood cell counts. These measurements indicate if an employee is at risk for developing hypertension, diabetes and anemia.

This benefit is available to active and retired employees and their covered spouses whose primary insurance coverage is the Standard Plan, the Savings Plan, BlueChoice HealthPlan or CIGNA HMO for just a $15 copayment. The cost of the Preventive Worksite Screening does not contribute toward a subscriber's annual deductible or out-of-pocket maximum. Individuals are screened at their current or former worksite. To participate, individuals should contact their benefits administrator to find out when their worksite holds its screening.

Chronic Disease Workshops, another major program, give subscribers and their dependents 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.

Look for apples as you read this guide. They call attention to programs that will help you prevent and control illnesses.

Information offered in the programs can be very helpful. For example, 28 people enrolled in a diabetes control program in 2006. The percentage of participants who were controlling their blood pressure increased from 51 percent to 85 percent during the program. The percentage of participants with desirable blood sugar levels increased from 33 percent to 60 percent.

Other Prevention Partners programs include:

- Spring Wellness Walk
- Lifestyle change workshops on weight loss, exercise and lowering risk factors
- Worksite program consultation
- Volunteer Worksite 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 Web site at www.eip.sc.gov. Then click on "Prevention Partners," which is on the left of the home page.

THE VISION CARE DISCOUNT PROGRAM

This program offers you discounted vision care services. Participating ophthalmologists and optometrists throughout the state have agreed to charge no more than $60[1] for a routine, comprehensive eye examination. If you are fitted for contact lenses, you may pay more because that can require additional services. Participating providers, who include opticians, 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.*

The eye examination should include at least these tests and services:

- Complete eye and medical history review
- Visual acuity far and near, with and without glasses
- Tonometry
- Screening visual fields
- Refraction
- External motility, biomicroscopic and dilated
- Ophthalmoscopic examinations
- Initiation of diagnostic and treatment programs as necessary, including prescription of lenses, medication and other therapy, arranging for special diagnostics or treatment services, consultations, laboratory procedures or radiological services as may be indicated.

Treatment must be within the scope of the license of the provider. Consult your eye care provider for details on any of these services.

You may participate in this program if you are a full-time or part-time employee, retiree, survivor or COBRA participant. Your dependents also are eligible. You do not have to be enrolled in the State Health Plan or a health maintenance organization. It is your responsibility to show your provider some type of employment-related identification to prove you are eligible for the Vision Care Discount Program. If you do not, you may not receive the discount.

If you are covered by more than one vision care program, you can take advantage of the discounts offered under this program or the benefits offered through your other coverage, but you cannot use both at the same time.

Providers Are Available Statewide

To see the list of participating providers, go to EIP's Web site, www.eip.sc.gov. Click on "Choose Your Category" and then select your category (Active Subscribers, etc.). Next, choose "Online Directories" and then select "Vision Care." You can search for providers by county or by state. This is the most up-to-date list.

If your provider is not listed, you may wish to ask if he gives discounts through the state's Vision Care Discount Program. If your provider would like to be part of the program, he should call EIP. Although EIP lists providers who participate in the program, the state does not recommend any specific eye care provider.

If you do not have access to the Internet, ask your benefits administrator 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

The Vision Care Discount Program is a discount program. You do not file claims and will not receive reimbursement for routine eye examinations or eyewear, including contacts. Active employees who have a MoneyPlu$ Medical Spending Account or a limited-use Medical Spending Account can file a reimbursement claim with MoneyPlu$ for vision care expenses.

If you have questions about this program, please contact your benefits office or EIP.

THE INTERNET PROVIDES EASY ACCESS TO YOUR INSURANCE INFORMATION

Like many organizations, EIP offers helpful information through the Internet. Two places to find it are *EIP Direct* and the EIP Web site.

EIP Direct is a bimonthly newsletter sent to your benefits administrator, who may send you the information or the newsletter itself. The newsletter gives you information about changes in benefits, answers questions about benefits and tells you about programs that may be of interest to you, such as Prevention Partners chronic disease workshops. *EIP Direct* can be viewed on the EIP Web site, www.eip.sc.gov. Choose "News & Updates" and then "Newsletters."

The Web site is also the place to find other ideas about how to make the best use of your insurance, as well as links to the Web sites of EIP's third-party administrators. When you go to www.eip.sc.gov, you will see a bar across the top of the home page. It has several tabs, including:

- "News and Updates" (includes a tab that takes you to "Newsletters," such as *EIP Direct* and *Avenues*)
- "FAQ" (general information, as well as questions about the Savings Plan and HSAs)
- "Links" (direct access to Web sites of companies that administer EIP programs).

When you select "Choose Your Category," which is on the left, you will see a list of the types of subscribers served by EIP. Most of you are "Active Subscribers," or employees. When you click on your category, you will receive a list of choices. They include "Eligibility," "Forms," "Online Directories" (lists of providers that are part of the plan networks) and "Rates." Click on "Publications" to see a list that includes this guide. You can use the "binoculars" search feature to help you find specific topics in the guide.

"Prevention Partners" is one of the choices listed on the left of our home page. Click on it for ways to improve your health. Under "Education," for example, you will find the Worksite Screening Guide.

"Insurance Managers" provides direct links to the Web sites of the third-party administrators. These sites give you access to your account information, including claim status, verification of authorization for inpatient and outpatient visits and Explanations of Benefits.

If you need assistance or additional information or would like to make a suggestion, click on "Contact Us" to send EIP an e-mail.

MyBenefits — EIP's Online Enrollment System

Access to your benefits information is just a click away with MyBenefits, EIP's online enrollment system. Through MyBenefits, you can update your beneficiaries and contact information and print a copy of your benefits statement anytime you have access to the Internet – 24 hours a day, seven days a week. During the enrollment period each October, you can make your own coverage changes.

The system is convenient and easy to use. To get started with MyBenefits, go to the EIP Web site, www.eip.sc.gov, and select "MyBenefits" on the left side of the screen. If you are a first-time user, you must register. The federal Health Insurance Portability and Accountability Act (HIPAA) requires that insurance programs protect the confidentiality of subscribers' health information. As part of EIP's effort to do so, you need to answer four questions and create a password when you register. After you register, you will be shown a screen listing your password and your answers to the questions. **Print the information, and keep it in a safe place.**

Information about how to use MyBenefits is offered as you work through the program. During enrollment periods, a tutorial will be available, and links to written instructions will accompany each section.

Retirees, survivors and COBRA subscribers, as well as active employees, may update their contact information and make annual and open enrollment changes using MyBenefits. However, COBRA subscribers must pay their initial COBRA premiums before they can register to use MyBenefits.

APPEALS

What If I Disagree With A Decision About Eligibility?

This section contains 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 for a review by writing to EIP within 90 days of notice of the decision. If the decision is upheld by EIP, you have 30 days to seek judicial review as provided by S.C. Code Ann. 1-11-710 and 1-23-380.

CHECKLISTS: QUICK GUIDES TO YOUR BENEFITS

These lists will help you quickly locate information in the *Insurance Benefits Guide* when you find yourself in a new situation.

RETIREE CHECKLIST

Before you retire, review your benefits. You can obtain a copy of your benefits statement from MyBenefits, the online enrollment system. Go to the EIP Web site, www.eip.sc.gov, and click on the "MyBenefits" button. After you log in, click on "Review Benefits."

Eligibility

- Before you set your retirement date, check with your benefits administrator to see if you are eligible to continue your insurance. See page 161.

Funding

- Find out if your employer will pay part of your health insurance premium. See page 162.

Enrollment

- You must complete a Retiree NOE form and an Employment Verification Record within 31 days of your retirement date. See page 164.

Returning to Work

- If you plan to return to work for a participating employer after you retire, see page 166.

Benefits 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 165. For premiums, see pages 200-201.
- Notify your benefits administrator within 31 days of the date you, or a dependent you cover, become eligible for **Medicare. Enroll in Part A and Part B**. In most cases, you should **not** enroll in Part D. For details, see page 168.
- **Dental –**You are eligible for the State Dental Plan and Dental Plus. For benefits information, see page 181. For premiums, see pages 200-201.
- **MoneyPlu$ –**Your eligibility ends at retirement. For details, see page 182.
- **Long Term Care –**You can continue, or may be eligible to enroll in, Long Term Care coverage. For details, see page 182.
- **Life Insurance –**You may continue your **Basic Life, Optional Life** and **Dependent Life** insurance. For details, see page 183.
- **Long Term Disability –**Your **Basic Long Term Disability** insurance ends with retirement. You may continue **Supplemental Long Term Disability** coverage under certain circumstances. For details, see page 184.

Your Benefits Administrator in Retirement

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

SURVIVOR CHECKLIST

It is never easy when a loved one dies. We hope this list will help you during a difficult time.

Contacts

If the deceased was a retiree of a state agency, higher education institution or school district, or one of their covered dependents:

- Notify EIP.

If the deceased was an active employee, a retiree of a local subdivision or one of their covered dependents:

- Notify the subscriber's employer.

When Coverage Ends for the Deceased

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

Health and Dental Insurance

Please read the "Survivors" section, beginning on page 19.

- Spouses or children who were covered as dependents 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.
- Survivors may continue dental coverage, but **the premium is not waived**.

Life Insurance

A certified, raised-seal death certificate is needed to apply for benefits from The Hartford. See page 102.

- Basic Life insurance, $3,000, is provided to all full-time, active employees enrolled in a health insurance program. See page 93.
- If the deceased was covered by Optional Life insurance, see page 99.
- If the deceased was covered by Dependent Life insurance, see page 107.
- The Beneficiary Assist® Program is free and available to beneficiaries of Basic, Optional and Dependent Life policies. See page 109.
- 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). Contact SCRS for more information.

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 payment. See page 125.

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 pages 222-228 and on the EIP Web site under "Publications."
- Medical Spending Accounts (MSAs) and Dependent Care Spending Accounts (DCSAs) end on the date the employee died. See page 157.

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 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. This account is used 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 7.

CaringBridge®: Communication in a Crisis

CaringBridge® offers free, personalized Web sites that make it easier for you and your dependents to communicate with family and friends in a health crisis. To create a site, go to www.caringbridge.org and follow the directions. Creating a site does not require any technical expertise. Tell your family and friends about your site so they can keep up-to-date.

If you are an active or a retired employee and the Standard Plan, the Savings Plan or one of the HMOs is your primary coverage, you and your covered spouse may participate yearly in a Prevention Partners worksite screening. For $15, you will receive a comprehensive health appraisal that includes a blood test and an evaluation of your risk factors. Ask your benefits administrator when a screening is scheduled.

The State Health Plan

The State Health Plan (SHP) offers active employees the **Standard Plan** and the **Savings 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 allowable charge. (The *allowable charge* is the maximum amount a health plan will pay for a covered service or product, such as a drug. Network providers have agreed to accept the allowable charge.) 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. 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.

BENEFITS AT A GLANCE

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, no family member will receive benefits, other than preventive, until the $6,000 annual family deductible is met.)
Per-occurrence Deductibles: Emergency Care[1]	$125	None
Outpatient Hospital[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	$1,000,000	$1,000,000
Prescription Drug Deductible per Year[4]	No Annual Deductible	**Prescription Drugs** You must use participating pharmacies. You pay the full allowable charge for prescription drugs, and the cost is applied to your annual deductible. After you reach your deductible, you continue to pay the full allowable charge for prescription drugs. However, the plan will reimburse you for 80% of the allowable charge. You pay the remaining 20% coinsurance. Drug costs are applied to your plan's in-network coinsurance maximum: $2,000 – individual; $4,000 – family. After the coinsurance maximum is met, the plan pays 100% of allowable charges.
Retail Copayments for up to a 31-day supply (Participating pharmacies only)[4]	$10 Tier 1 (Generic – lowest cost) $25 Tier 2 (Brand – higher cost) $40 Tier 3 (Brand – highest cost)	
Mail Order and Retail Maintenance Network Copayments for up to a 90-day supply[4]	$25 Tier 1 (Generic – lowest cost) $62 Tier 2 (Brand – higher cost) $100 Tier 3 (Brand – highest cost)	
Prescription Drug Copayment Maximum[4]	$2,500 per person (applies to prescription drugs only)	
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 smear, routine mammograms and well child care.*
[4] *Mental health and substance abuse services and prescription drugs are not covered out of network.*

How SHP Benefits are Paid

EIP contracts with companies, such as BlueCross BlueShield of South Carolina, to process medical claims; APS Healthcare, Inc., to process mental health and substance abuse claims; and Medco Health Solutions, Inc., to process prescription drug claims. Subscribers share the cost of their covered benefits by paying deductibles, coinsurance and copayments for covered services.

HOW THE STANDARD PLAN WORKS

Annual Deductible

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

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

If you have Standard Plan individual coverage, once you meet the $350 deductible, the Standard Plan will begin to pay a percentage of your covered medical expenses.

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. However, if only one person has met the $350 individual deductible, only he will begin receiving benefits. No family member may pay more than $350 toward the family deductible.

If the employee and his spouse, who is also covered as an employee or retiree, wish to share the same family deductible, both must select the same health plan.

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

Per-occurrence Deductibles

A per-occurrence deductible is the amount you must pay before the Standard Plan begins to pay benefits for services in a professional provider's office, emergency room care or outpatient hospital services. 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 each outpatient hospital service is $75. This deductible is waived for dialysis,

routine mammograms, routine Pap tests, clinic visits (an office visit at an outpatient facility), and 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 your covered medical, mental health and substance abuse covered expenses if you use network providers. You pay the remaining 20 percent as coinsurance. If you use non-network providers, the plan pays 60 percent of your covered expenses. You pay the remaining 40 percent of the billed charges as coinsurance. This is applied to your coinsurance maximum. Even after you meet your annual deductible under the Standard Plan, you must continue to pay per-occurrence deductibles, and they do not apply to your coinsurance maximum.

How are you affected if your provider is not in the network? For information on providers who are not in the network and the "out-of-network differential," see page 38.

If you use a provider outside the State Health Plan network, you must pay any amount above the plan's allowable charge for a covered medical expense. You also will have to pay an additional 20 percent in coinsurance. **Prescription drugs and mental health and substance abuse 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 pages 46-47.

Coinsurance Maximum (Out-of-pocket Limit)

The maximum amount in coinsurance you must pay for covered services each year under the Standard Plan is $2,000 for individual coverage or $4,000 for family coverage for network services and $4,000 for individual coverage and $8,000 for family coverage for non-network services. The State Health Plan will then pay 100 percent of the allowable charges. Your payments for non-covered services, prescription drugs, per-occurrence and annual deductibles and penalties for not calling Medi-Call or APS Healthcare do not count toward your coinsurance maximum.

Before the plan will begin paying 100 percent of a covered person's covered prescription drug expenses, the person must pay $2,500 in prescription drug copayments.

HOW THE SAVINGS PLAN WORKS

Annual Deductible

The annual deductible is the amount of covered medical expenses (including medical, prescription drugs and mental health and substance abuse) you must pay each year before the Savings Plan begins to pay a percentage of your covered medical expenses. 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. The family deductible is not considered met for any covered individual until total covered expenses exceed $6,000. For example, even if one family member has $3,001 in covered medical expenses, he will not begin receiving benefits until his family has $6,000 in covered expenses. However, if the subscriber has $1,000 in expenses, the spouse has $3,001 in expenses and a child has $2,000 in expenses, all family members will begin to receive benefits.

If you are covered under the Savings Plan, you pay the full allowable charge for covered prescription drugs, and the amount is applied to your deductible. After your deductible has been met, you receive reimbursement for 80 percent of your allowable charges. After your coinsurance maximum has been met, you receive reimbursement for 100 percent of your allowable charges.

There are **no** per-occurrence deductibles under the Savings Plan. You pay the full allowable charge 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 your covered medical, prescription drug, mental health and substance abuse expenses if you use network providers. You pay the remaining 20 percent as coinsurance.

If you use non-network providers, the plan pays 60 percent of your covered expenses. You pay the remaining 40 percent as coinsurance, and any charge above the plan's allowable charge for a covered medical expense is your responsibility. You will also have to pay the additional 20 percent in coinsurance, a total of 40 percent. See page 38 to learn more about this "out-of-network differential." Prescription drug and mental health and substance abuse benefits will be paid **only** if you use a network provider.

A different coinsurance rate applies for infertility treatments and prescription drugs associated with infertility, see pages 46-47.

Coinsurance Maximum (Out-of-pocket Limit)

The maximum amount in coinsurance you must pay for covered services each year under the Savings Plan 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. The Savings Plan will then pay 100 percent of the allowable charges. Your payments for non-covered services, annual deductibles and penalties for not calling Medi-Call or APS Healthcare do not count toward your coinsurance maximum.

LIFETIME MAXIMUM

The maximum amount the State Health Plan will pay for each person for all benefits is $1,000,000. This lifetime maximum includes all payments made for a person while covered under any State Health Plan option, including the Savings, Standard and Medicare Supplemental plans and the Economy Plan, which is no longer offered. It applies regardless of any break in coverage or whether the person is enrolled in one of the plans as a dependent, an employee or a retiree.

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 administrators determine which plan pays first, see page 21.

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 administrator, BlueCross BlueShield of South Carolina (BCBSSC), may ask you this question every year, by sending you a questionnaire. **Please 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.

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

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

- The SHP will pay the lesser of: 1) what it would pay if it were the primary payer; or 2) the part of the covered charge not paid by the primary payer.
- The SHP's limit on balance billing does not apply. This means if the provider charges more than the plan's allowable charge, you will be responsible for the extra cost.
- You will also be responsible for your deductible, if it has not been satisfied, and for your coinsurance.
- For a medical claim, you or your provider must file the Explanation of Benefits from your primary plan directly with BCBSSC.
- For mental health and substance abuse benefits, you must file the Explanation of Benefits from your primary plan directly with APS Healthcare, Inc.
- 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 indicate 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 available on the EIP Web site, www.eip.sc.gov. Choose your category, and then click on "Forms." You may also ask your benefits administrator for the form.

SUBROGATION

To the extent provided by South Carolina law, the State Health Plan has 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.

USING SHP PROVIDER NETWORKS

The choice is yours. When you are ill or injured, you decide where to go for your care. The SHP is a *preferred provider organization (PPO).* As such, it has networks of physicians, hospitals, ambulatory surgical centers and mammography testing centers. There are also networks available to subscribers for 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 our networks, to accept the plan's allowable charges for covered medical services as payment in full and will not balance bill you. **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 provider or your physician sends your laboratory tests to an out-of-network provider, your costs will increase. This applies to your medical benefits. Prescription drug and mental health and substance abuse benefits are only paid if you use a network provider.

How to Find a Medical Network Provider

Paper copies of the SHP provider directory are no longer distributed. There are two ways to view the online directory. On EIP's Web site, www.eip.sc.gov, choose your category and then select "Online Directories." Click on "State Health Plan Doctor/Hospital Finder." You may also go directly to the BCBSSC Web site, www.SouthCarolinaBlues.com. At the site:

- Under "Find a Doctor Or Other Healthcare Provider," choose "South Carolina."
- Choose "Blue Cross and Blue Shield" as the directory. Check to show whether you want to look for a

provider by "Location" or by "Name." Then select a "Healthcare Professional Type" from the menu.
- A menu will enable you to select a city or county, a health plan (State Health Plan) and a specialty.

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 request that a list of SHP providers in your area be mailed to you.

BLUECARD® AND BLUECARD WORLDWIDE®

When you need medical care **outside South Carolina**, you have access to doctors and hospitals throughout the United States and around the world through the BlueCard Program and Blue Cross Blue Shield provider networks. If you need mental health or substance abuse care outside South Carolina, call APS Healthcare at 800-221-8699.

Inside the U.S.

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

1. Always carry your State Health Plan ID card.
2. In an emergency, go directly to the nearest hospital.
3. To find the names and addresses of nearby doctors and hospitals, visit the BlueCard Doctor and Hospital Finder Web site (www.BCBS.com) or call BlueCard *Access* at 800-810-2583.
4. **Call Medi-Call within 48 hours of receiving emergency care.** The toll-free number is on your State Health Plan ID card.
5. When you arrive at the participating doctor's office or hospital, show your identification card. As a BlueCard program member, the doctor will recognize the logo, which will ensure that you will get the highest level of benefits with no balance billing.
6. The provider should file claims with the Blue Cross Blue Shield affiliate in the state where the services were provided.

After you receive care, 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). You will be mailed an EOB by BCBSSC.

Outside the U.S.

Through the BlueCard Worldwide program, your SHP ID 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 SHP ID card.
2. In an emergency, go directly 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 SHP benefits and for preauthorization, if necessary. (Your healthcare benefits may be different outside the U.S.)
   - Call the BlueCard Worldwide Service Center toll-free at 800-810-2583 or collect at 804-673-1177 to find providers in the area where you will be traveling.
4. During your trip:
   - If you need to locate a doctor or hospital or need medical assistance, 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 the SHP 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 will need to pay the bill up front and file a claim.

5. For outpatient care and doctor visits, pay the provider when you receive care and file a claim.
6. 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 with the itemized bill(s) to the BlueCard Worldwide Service Center. The claim form is available online at www.BCBS.com. Type "BlueCard claim form" in the "Search" box. You may also call the BlueCard Worldwide 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.

Prescription Drug and Mental Health/Substance Abuse Provider Networks

Because the State Health Plan offers no out-of-network coverage for prescription drugs or mental health/substance abuse care, it is important that you find a participating network provider for these services. The most up-to-date lists of network providers are on Web sites sponsored by Medco Health Solutions, Inc., the prescription drug benefit manager, and APS Healthcare, Inc., the mental health and substance abuse manager. These sites are accessible through the EIP Web site, www.eip.sc.gov. Choose your category and then select "Online Directories." You will see a list of links to provider directories. You can also go there directly:

- To see the list of network pharmacies, go to www.medco.com. Sign in and click on "Locate a pharmacy."
- Mental health and substance abuse providers include: physicians, psychiatrists, health professionals or institutional care providers under agreement to participate in the network administered by APS Healthcare. To see the list, go to the APS Healthcare, Inc., Web site at www.apshealthcare.com. Click on "Information for Members." Then select "State of South Carolina" from the drop-down list under "Employers." Then click on "Online Provider Locator." The access code is "statesc." Finally, click on "Submit." You also may call APS Healthcare toll-free at 800-221-8699 to be directed to a network provider and to receive the required preauthorization.

For more information on your prescription drug benefits, see page 53. For more information on your mental health and substance abuse benefits, see page 57.

If you do not have access to the Internet, paper copies of the provider directories are available from your benefits office or, if you are a retiree, survivor or COBRA participant, from APS.

OUT-OF-NETWORK BENEFITS FOR MEDICAL CARE

Remember, there is no out-of-network coverage for **prescription drugs**. For **mental health and substance abuse care**, there is no coverage if you use an out-of-network provider or if you fail to have services preauthorized.

You can use providers who are not part of the network and still receive some coverage for medical care. However, before the State Health Plan will pay 100 percent of allowable charges:

- **Standard Plan and Savings Plan** subscribers must pay a $4,000 individual coinsurance maximum for out-of-network services and an $8,000 family coinsurance maximum for out-of-network services.

Subscribers to both plans may also have to fill out claim forms.

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 services except for copayments, coinsurance and deductibles. However, a non-network provider may choose to bill you for more than the plan's allowable charge for the covered service. The difference between what the non-network provider charges and the allowable charge 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 choose a provider that does not participate in the State Health Plan or BlueCard network, you will pay 40 percent, instead of the usual 20 percent, in coinsurance. These examples show how it will cost you more money to use a non-network provider:

You have employee-only coverage under the SHP and you have not met your deductible. The non-network provider charges $5,000 for the covered services you receive, but the SHP maximum allowance is $4,000.

Standard Plan

Your out-of-pocket costs for services from a **network provider** would have been $1,080.

However, if you had 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 billing" 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 allowance
- 350	Standard Plan deductible for 2009
$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 any 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.

However, if you had 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, or $600. The remaining $400 coinsurance, as well as the $1,000 "balance billing" 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 allowance
- 3,000	Savings Plan deductible for 2009
$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

Some services provided under the State Health Plan require preauthorization before you receive them as a covered benefit. A phone call gets things started. While your healthcare provider may make the call for you, it is your responsibility to see that the call is made.

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 do fax information 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.

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, economical 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
- You need outpatient or inpatient surgery for a hysterectomy
- You need sclerotherapy performed in an inpatient, outpatient or office setting
- You need an MRA, MRI, PET or CT Scan
- 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 MediCall within the first three months of your pregnancy.)**
- You have an emergency admission during pregnancy[2]
- Your baby is born[2]
- Your baby has complications at birth
- You are to be, or have been, admitted to a long-term acute care facility, skilled nursing facility, need home healthcare, hospice care or 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.

A preauthorization request for any procedure that may potentially be considered cosmetic in nature 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.

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

[1]For mental health or substance abuse services, you must call APS Healthcare at 800-221-8699 for preauthorization before a non-emergency admission or within 24 hours of an emergency admission.
[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 within 31 days of birth for benefits to be payable.

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 choose a non-network provider, your financial responsibility will be greater.

Are There Penalties for Not Calling?

Yes. If you do not call Medi-Call when required, you will pay a $200 penalty for **each** hospital or skilled nursing facility **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. If you do not obtain preauthorization from APS HealthCare, no mental health or substance abuse benefits will be paid.

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 pregnancy benefits, you must notify Medi-Call during the first trimester (three months) of your pregnancy.** You do not have to wait until you have seen your physician.

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 within 31 days of his birth.

While you can call Medi-Call, 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 www.SouthCarolinaBlues.com and log into My Health Toolkit. Then select Personal Health Record.

If you do not notify Medi-Call during the first trimester, or if you refuse to participate in the Maternity Management Program, you will pay a $200 penalty for **each** maternity-related hospital or skilled nursing facility **admission**. This penalty will be in addition to the Medi-Call preauthorization penalty and there will not be a $2,000 limit on the amount of coinsurance you must pay.

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 phone call from a Medi-Call nurse and a packet of information, including a copy of *Caring for Tomorrow's Children – Having a Healthy Baby.*

A Medi-Call maternity nurse will complete a Maternity Health Assessment form when you enroll. This assessment 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 send you a reminder card with benefit information during your third trimester, and she will 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 case manager 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 throughout your pregnancy.

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 803-264-3100 (Greater Columbia area) or 800-334-7287 (toll-free outside the Columbia area).

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.

WELLNESS MANAGEMENT

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. Food Awareness Training and realistic goal setting are key parts of this program. Program candidates are identified through claims analysis, authorizations, doctor referral or self-referral.

If you think you qualify, but have not received an invitation to participate, call Medi-Call at 803-699-3337 (Greater Columbia area) or 800-925-9724 (South Carolina, the U.S. and Canada). Follow the prompts. As a "Member," press 2. Then press 2, the number for "all other inquiries." When you reach an operator, ask to speak with a coordinator in the Weight Management Program.

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 may help.

Three case management programs are available to those enrolled in the State Health Plan. Each program includes teams of specially trained nurses and doctors. The goal of the programs is to assist participants in coordinating, assessing and planning healthcare. They do so by giving each patient control over his healthcare and respecting his right to knowledge, choice, a direct relationship with his physician, privacy and dignity. None of the programs provide medical treatment, and 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 case management program is designed for State Health Plan enrollees 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 enrollees 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 Medi-Call nurse will act as a liaison with the Alere nurse. This Medi-Call 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 enrollees 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. He 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 that are covered by the plan.

ONLINE HEALTH TOOLS

Personal Health Record

Your Personal Health Record, which is available on the BCBSSC Web site, 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. 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 www.SouthCarolinaBlues.com and log into "My Health Toolkit."

Personal Health Assessment

An online Personal Health Assessment (PHA) is available to State Health Plan subscribers who are 18 years and older through the BlueCross BlueShield of South Carolina Web site, www.SouthCarolinaBlues.com. Log on the "Member My Insurance Manager" and then click on the "My HealthCenter" link, which is under "Access Online Programs and Added Values." Select your name from the drop-down menu on the next page and then click on "Personal Health Assessment" to take the survey.

The survey asks questions in nine categories and then provides a wellness score based on your responses. It enables you to evaluate your health and gives suggestions for lifestyle changes.

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

Provider Report Card

BlueCross BlueShield of South Carolina gives you access to a Provider Report Card through its Web site, www.SouthCarolinaBlues.com. With this tool, you can compare hospitals in the same part of the state to determine the number of patients treated, complication rates and how long patients usually stay in the hospital. This information can help you choose a hospital.

Medical Cost Estimator

The cost estimator is available on the BCBSSC Web site, www.SouthCarolinaBlues.com. It can help you determine the cost of a medical service or procedure. 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 treatments require preauthorization by Medi-Call or APS Healthcare. Be sure to read the Medi-Call section beginning on page 39 and the mental health and substance abuse section on page 57 for details.

A *medically necessary* service or supply is:

- Required to identify or treat an 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 prevailing in the medical specialty or field of medicine at the time provided and
- Required for reasons other than the convenience of the patient. The fact that a service is prescribed by a physician does not necessarily mean that the service is medically necessary.

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

Ambulance service, to or from a local hospital outpatient department, is covered when used to provide necessary service in connection with an injury or a medical emergency and to or from the nearest hospital providing necessary service in connection with inpatient care. 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.

Ambulatory Surgical Centers

The Standard Plan has per-occurrence deductibles for some services. See page 32 for details.

These facilities provide some of the same services offered in the outpatient department of a hospital. Centers in the network accept the State Health Plan allowable charges. You just pay the applicable deductible and coinsurance. Medically necessary services at non-network ambulatory surgical centers are covered, but you may pay more.

Autism Spectrum Disorder Benefits

Effective with the 2009 plan year, Applied Behavior Analysis (ABA) for children diagnosed with an Autism Spectrum Disorder at age 8 or younger will be covered, subject to APS guidelines and preauthorization requirements, for up to a maximum of $50,000 per plan year. A child must be younger than 16 years of age to receive benefits. All services must be approved by APS Healthcare and performed by an in-network 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 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.

Colonoscopies

Routine colonoscopies are covered once every ten years, starting at age 50, even when no symptoms are apparent. The plan also covers diagnostic colonoscopies. All colonoscopies are subject to the plan's deductibles and coinsurance.

Contraceptives

For employees 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 expense.

Cranial Remodeling Band or Helmet

The plan covers the use of 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 be initiated 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 $25 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 $10 copayment, per item, for each supply of up to 31 days. Claims for diabetic durable medical equipment should be filed with BCBSSC.

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. For mental health and substance abuse services to be

covered, you must use a participating provider, and all mental health and substance abuse services must be preauthorized by APS Healthcare. For details on mental health and substance abuse services, see page 57.

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 non-therapeutic 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. These contracting providers can offer you discounts while providing you with high-quality products and care.

Extended-Role Nurse

Expenses for services received from a licensed, independent extended-role nurse are covered, even if these services are not performed under the immediate direction of a doctor. An extended-role nurse 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 for purposes of midwife coverage. A certified nurse midwife (CNM) is an advance-practice registered nurse who is licensed by the State Board of Nursing as a midwife. Lay midwives and certified midwives licensed only by the S.C. Dept. of Health and Environmental Control (DHEC) are not reimbursed.

For more information about Medi-Call, see page 39. You may contact Medi-Call at 803-699-3337 (Greater Columbia area) or 800-925-9724 (South Carolina, nationwide and Canada).

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 subscriber'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 subscriber's family or the spouse's family. Benefits are limited to $5,000 or 100 visits per year, whichever is less. These services must be preauthorized by Medi-Call.

Hospice Care

The plan will pay benefits for a terminally ill patient's hospice care. The maximum benefit is $6,000 per covered person, including a maximum of $200 for bereavement counseling. These services must be preauthorized by Medi-Call.

Infertility

The plan will pay benefits for the diagnosis and treatment of infertility for enrollees for whom infertility is not a result of a prior tubal ligation or a vasectomy.

The benefits are limited to a lifetime maximum payment of $15,000 for any covered medical expenses and covered prescription drug expenses incurred by the subscriber or the covered spouse whether covered as a dependent 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/or 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 allowable charges. Your share of the expenses does not count toward your coinsurance maximum. All procedures related to infertility must be preauthorized by Medi-Call.

The plan will not provide infertility benefits to a subscriber who has had a tubal ligation. **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 does apply to both plans' $15,000 maximum lifetime benefit for infertility treatments. Call Medco's Member Services at 800-711-3450 for more information.

Inpatient Hospital Services

Inpatient hospital care, including 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 (see page 39).**

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 39). You must call Medi-Call, even before you or a covered family member is evaluated for a transplant.

Through the BDCT network, SHP enrollees 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 allowable charges 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 allowable charges 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 choose care 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 Services

Outpatient services and supplies include:

- Laboratory services
- X-ray and other radiological services
- Emergency room services
- Radiation therapy
- Pathology services
- Outpatient surgery and
- Diagnostic tests (If the diagnosis is psychiatric, only services provided at APS network facilities are covered.)

For more information about the Standard Plan's per-occurrence deductibles, see page 32.

For more information about balance billing, see page 37.

If you are covered under the Standard Plan and you receive your outpatient services at a hospital, 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 dependent wives of male employees or retirees. **Dependent children do not have maternity benefits**. Maternity benefits include necessary prenatal and postpartum care, including childbirth, miscarriage and complications related to pregnancy. **You must call Medi-Call within the first three months of your pregnancy to enroll in the Maternity Management Program.** See page 40 for more 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 following normal, vaginal delivery or fewer than 96 hours following a caesarean section. Neither can they require a provider to obtain authorization from the plan for prescribing a length of stay within the above periods. The attending provider, may, however, in consultation with the mother, decide to discharge the mother or newborn earlier.

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 medications associated with infertility treatments have a different coinsurance rate. Please refer to page 46 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 and
- 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

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)
- Behavior therapy, including speech therapy associated with behavior
- Cognitive (mental) retraining
- Community re-entry programs
- Long-term rehabilitation after the acute phase
- Work-hardening programs.

Rehabilitation – Acute
The plan provides limited rehabilitation benefits. Often acute-phase rehabilitation 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 for that opinion. These procedures include surgery as well as treatment (including hospitalization). If APS Healthcare advises you to seek a second opinion before receiving treatment for mental health or substance abuse services, the plan will pay 100 percent of the cost for that opinion.

Skilled Nursing Facility

The plan will pay limited benefits for room and board in a skilled nursing facility for up to 60 days or $6,000, based on a per-day rate, whichever is less. 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:

- Language delay
- Communication delay
- Developmental delay
- 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. Please call Customer Service or Medi-Call before beginning the service if you need help in interpreting the list above.

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 Expenses

These expenses 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.

Mammography Program for Women

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 every 365 days.

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.

For more information about staying healthy, see page 21 or go to the EIP Web site, www.eip.sc.gov, and click on "Prevention Partners."

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.

For women, age 40 and older, covered as retirees and enrolled in Medicare, Medicare pays for one screening mammogram every 12 months. The State Health Plan is primary for women covered as active employees, regardless of Medicare eligibility.

Pap Test Program

The plan will pay for a Pap test each year, without any requirement for a deductible or coinsurance, for covered women age 18 through 65. This benefit includes payment for an appropriate-level office visit associated with the Pap test.

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

How Does it Work?

This benefit covers regular doctor visits and timely immunizations. When services are received from a doctor in the State Health Plan Physician Network, benefits will be paid at 100 percent. **Benefits will not be paid 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.

Checkups

This is the schedule of regular checkups for which the plan pays 100 percent when a network doctor provides the services:

- Younger than 1 year old — five visits
- 1 year old — three visits
- 2 through 18 years old — one visit a year.

Immunizations

This schedule shows routine immunizations for which the plan pays 100 percent when a network doctor provides the services. To ensure that 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, for the vaccines listed, and subject to the limitation outlined above. Please contact your State Health Plan pediatrician or call Medi-Call for more information on how to immunize your child properly.

Disease	Recommended Immunization Schedule
Hepatitis B	Birth-2 months 1-4 months 6-18 months 11-12 years if child has not had it before
Polio	2 months 4 months 6-18 months 4-6 years
Diphtheria-Tetanus-Pertussis	2 months 4 months 6 months 15-18 months 4-6 years 11-12 years if child has not had one in last 5 years
Haemophilus (Hib)	2 months 4 months 6 months 12-15 months
Pneumococcal Conjugate (PCV7)	2 months 4 months 6 months 12-15 months
Measles-Mumps-Rubella	12-15 months 4-6 years 11-12 years if child has not already had second dose
Chickenpox	12-18 months 11-12 years if child has not already had disease or vaccine
Influenza	Yearly for children ages 6 months-18 years
Meningococcal	11-12 years
Hepatitis A	12-23 months
Human Papillomavirus (HPV)	11-12 years for females

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^{sm} also offers discounts on health products, such as vitamins, herbal supplements, books and tapes.

Value Added 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 a complete list of qualified medical expenses for MSAs or Health Savings Accounts, go to www.irs.gov/publications/p502.

For more information on Natural Blue or Value Added, log on to the BCBSSC Web site at www.SouthCarolinaBlues.com. Under "Looking for...," 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 at no cost. They include:

- A yearly flu immunization for each eligible participant.
- Access to the 24-hour Health at Home® Nurseline, through which registered nurses provide personal, immediate assistance. Subscribers also have access to Healthline Audiotape Library, which includes more than 400 topics. The toll-free number is listed on the back of your health plan ID card and on the cover of the self-care handbook.
- A copy of a self-care handbook, *Health at Home®—Your Complete Guide to Symptoms, Solutions & Self-Care,* and a subscription to the monthly *HealthyLife Wellness Newsletter.*

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
- An EKG
- A fecal occult blood test
- A general health laboratory panel blood work
- A lipid panel once every five years.

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

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 Medco by Mail, 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. Please refer to page 46 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 your prescriptions from a participating retail pharmacy and pay a copayment of $10 for Tier 1 (generic – lowest cost), $25 for Tier 2 (brand – higher cost) or $40 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 dollar 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 your allowable prescription drug charges for the rest of the year.

Drug expenses do not count toward your medical annual deductible, coinsurance maximum or lifetime maximum benefit.

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 allowable charge 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 allowable charge 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 allowable charge. 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.

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, Medco by Mail.

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.*

Generic Drugs (Tier 1 – 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 medications 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 lower allowable charges, under the Savings Plan, and lower copayments, under the Standard Plan. Therefore, you 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 way the prescription is written.

"Pay-the-Difference" Policy

Under the State Health Plan, there is a "pay-the-difference" policy. This means if you purchase a brand-name drug when an equivalent generic drug is available, the benefit will be limited to that for the generic drug. This policy will apply even if the doctor prescribes the medication as "Dispense as Written" or "Do Not Substitute."

Under the **Standard Plan,** if you purchase a brand-name drug over a generic, you will be charged the generic copayment, PLUS the difference between the allowable charge for the brand name and the generic drug. If the total amount is less than the Tier 2 or Tier 3 (brand-name) copayment, you will pay the brand copayment. Only the copayment for the generic drug will apply toward your copayment maximum.

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

If you are taking a Tier 2 or Tier 3 (brand-name) 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.

Tier 2 (Brand – Higher Cost)

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

Tier 3 (Brand – Highest Cost)

These medications carry a higher copayment or higher price. Tier 3 contains medication 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.

Be sure to select a participating pharmacy that will file your compound prescription claim. If the pharmacy does not file for you, 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 213. Claims must be accompanied by an itemized list of the ingredients for you to be reimbursed. 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 allowable charge minus the copayment for the actual ingredients in the compound prescription.

Some compound medications may be available through Medco by Mail. 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 PHARMACY

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 Web site, www.eip.sc.gov (choose your category, then select "Online Directories"), or at www.medco.com. You may also obtain 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 will pay the same copayment as you would pay through mail order. This applies only to prescriptions filled for a 63-90 day supply at one of the pharmacies participating in the network. Copayments for prescriptions filled for a 0-62 day supply at these retail pharmacies will remain the same. The copayments will also remain the same at all other network pharmacies. To see a list of the pharmacies, go to the EIP Web site, www.eip.sc.gov, choose your category and select "Online Directories." If you do not have Internet access, ask your benefits administrator to print a copy of the list for you. For more information, call Medco Customer Service at 800-711-3450.

MAIL-ORDER 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 customer service 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) – $25, Tier 2 (brand) – $62, and Tier 3 (brand) – $100. There are no individual exceptions made to the copayment established for a particular prescription drug.

Savings Plan

You pay the full allowable charge 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. (Forms are available through the EIP Web site, www.eip.sc.gov, under "Forms" or on Medco's Web site: 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 21 and 34 for more information.

EXCLUSIONS

Some prescription drugs are not covered under the plan. See pages 48 and 54 for more information.

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

For Preauthorization – 800-221-8699

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.

All services (outpatient office visits, inpatient hospital admissions, etc.) must be preauthorized by APS Healthcare to be covered.

Here is how the mental health and substance abuse program works:

- When you need care inside or outside South Carolina, call APS Healthcare, Inc., the behavioral health manager, at 800-221-8699 to receive preauthorization and to be directed to a network of providers. A *provider* is a physician, psychiatrist, health professional or institutional care provider under agreement to participate in the network administered by APS Healthcare.
- If you need inpatient care, you must call APS Healthcare for preauthorization or within 24 hours of an emergency admission.
- The provider network is open, which means that any eligible provider can participate. You may nominate providers for inclusion in the network. If you do not call APS Healthcare or if you choose to use a non-participating provider, no benefits will be paid.

- To review the network of providers, log on to the EIP Web site at www.eip.sc.gov, then choose your category and select "Online Directories," or go directly to www.apshealthcare.com. Once you are on APS' Web site, click on "Information for Members." Then select "State of South Carolina" from the drop down list under "EMPLOYERS." Click on "Online Provider Locator." At the user login, enter the State Health Plan's access code, which is "statesc" (all lower case). Finally, click on "Submit."
- You will then be able to search the directory by either entering a provider's name or a geographic area. If you would like to view or download the directory, go back to the main South Carolina page and click on "Access the Printable Directory," then enter "statesc."

Paper copies of the provider directory are available from your benefits office or, if you are a retiree, survivor or COBRA subscriber, from APS customer service.

No Claims to File

There are no claims to file. Your network provider is responsible for submitting claims for these services. Remember, no benefits will be paid if you receive care from a provider who is not a member of the network. Your participating mental health and substance abuse provider will be required to conduct periodic medical necessity reviews (similar to Medi-Call). For claims or customer service assistance for mental health and/or substance abuse care, call APS Healthcare at 800-221-8699.

The Free & Clear® Quit For Life™ Program

The research-based Quit For Life Program is available at no charge to State Health Plan subscribers and their covered dependents.

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 Quit Guides and five telephone calls from a Quit Coach. A participant may call Free & Clear's toll-free support line as often as he wishes. The program also provides free nicotine replacement products (patches, gum or lozenges) if appropriate. Your Quit Coach may also recommend your doctor prescribe a smoking cessation drug, such as bupropion or Chantix, which are available through your prescription drug coverage. The support line is available from 8 a.m. to midnight, seven days a week. If the participant still needs help after the 12-month program ends, he may re-enroll in the program.

To enroll in the Quit For Life Program, call 1-866-QUIT-4-LIFE (1-866-784-8454). After your eligibility is verified, you will be transferred to a Quit Coach for your first call.

APS Helplink™

APS Helplink™ provides tools to help with behavioral health problems, financial and legal issues, child and eldercare concerns and work/life issues. Go to the APS Web site. Follow the instructions above that you use to get to the "Provider Locator," and then click on the "Access APSHelpLink" button. Enter the State Health Plan's "Company Code," which is "statesc."

EXCLUSIONS

Services Not Covered by the State Health Plan

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. 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 you bring to the plan
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. (Please note: The Savings Plan covers an annual physical by a network physician for each participant age 19 and older)
5. Eyeglasses
6. Contact lenses, unless medically necessary after cataract surgery and for the treatment of keratoconus, a corneal disease affecting vision
7. Routine eye examinations
8. 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
9. Hearing aids and examinations for fitting them
10. Dental services, except for removing impacted teeth or treatment within one year of a condition resulting from an accident
11. 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
12. Custodial care, including sitters and companions or homemakers/caretakers
13. Over-the-counter medicine and contraceptive devices
14. Services related to a vasectomy or tubal ligation performed within one year of enrollment
15. Surgery to reverse a vasectomy or tubal ligation
16. Treatment for infertility resulting from a previous tubal ligation or vasectomy
17. Assisted reproductive technologies (fertility treatment) except as noted on page 46 of this chapter
18. 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
19. 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
20. Air quality or mold tests
21. Supplies used for participation in athletics (that are not necessary for activities of daily living), including but not limited to, splints or braces
22. Physician charges for medicine, drugs, appliances, supplies, blood and blood derivatives, unless approved by Medi-Call
23. 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
24. 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
25. Fees for medical records and claims filing
26. Food supplements, including but not limited to formula, enteral nutrition, Boost/Ensure or related supplements
27. Services performed by members of the insured's immediate family
28. Acupuncture
29. Chronic pain management programs
30. Transcutaneous (through the skin) electrical nerve stimulation (TENS), whose primary purpose is the treatment of pain
31. Complications arising from the receipt of noncovered services

32. Psychological tests to determine job, occupational or school placement or for educational purposes; milieu therapy; or to determine learning disability
33. Services or supplies payable by Workers' Compensation, the Veterans Administration or any other governmental or private program (including Employee Assistance Program services)
34. 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)
35. Intentionally self-inflicted injury that does not result from a medical condition or domestic violence
36. Cosmetic goods, procedures or surgery or complications resulting from such procedures or services
37. Nicotine patches used in smoking cessation programs, as well as prescribed drugs used to alleviate the effects of nicotine withdrawal, except as authorized for eligible participants enrolled in the Free & Clear® tobacco cessation program
38. Vocational rehabilitation, pulmonary rehabilitation (except in conjunction with a covered and approved lung transplant), behavior therapy, including speech therapy associated with behavior, cognitive (mental) retraining, community re-entry programs or long-term rehabilitation after the acute phase of treatment for the injury or illness (See Rehabilitation Care on page 49 and Speech Therapy on page 49)
39. 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
40. Services performed by service or therapy animals or their handlers.
41. Abortions, except for an abortion performed in accordance with federal Medicaid guidelines
42. Pregnancy of a covered dependent child
43. Speech therapy for the treatment of a language/communication or developmental delay (See page 49)
44. Storage of blood or blood plasma
45. 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 administrator 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 exclusions under the Savings Plan:

- Chiropractic benefits, under the Savings Plan only, are limited to $500 per covered person after the annual deductible is met.
- Nonsedating antihistamines and drugs for treating erectile dysfunction are not covered under the Savings Plan.

WEB SITE: WWW.SOUTHCAROLINABLUES.COM

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

After you log in, with *My Insurance Manager* you can:

- See how much of your deductible and out-of-pocket limit you have satisfied
- Print an Explanation of Benefits
- Request an ID card
- Ask a question.

To find a network provider, go to the BCBSSC Web site and click on "Find a Doctor or Other Healthcare Provider."

With *My Health Toolkit*, you can:

- Create a Personal Health Record
- Take a Personal Health Assessment
- Find estimates of the cost of treatment.

APPEALS

WHAT IF MY CLAIM OR REQUEST FOR PREAUTHORIZATION IS DENIED?

The Employee Insurance Program (EIP) contracts with claims processors, BlueCross BlueShield of South Carolina, Medco Health Solutions, Inc., and APS Healthcare, Inc., to handle claims for your State Health Plan benefits. You have the right to appeal their decisions.

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 EIP, you have 30 days to seek judicial review as provided by S.C. Code Ann. 1-11-710 and 1-23-380.

Health Maintenance Organizations

WHAT ARE MY CHOICES?

HMO Plans

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** and **CIGNA HealthCare.**

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 198-203 for premiums and a comparison of benefits. 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 Web sites are listed on the inside covers of this book.

HMO SERVICE AREAS

	Counties	HMO Choices
1	Anderson, Greenville, Oconee, Pickens	BlueChoice HealthPlan, CIGNA
2	Cherokee, Spartanburg, Union	BlueChoice HealthPlan, CIGNA
3	Chester, Lancaster, York	BlueChoice HealthPlan, CIGNA
4	Abbeville, Greenwood, Laurens, McCormick, Saluda	BlueChoice HealthPlan
5	Fairfield, Kershaw, Lexington, Newberry, Richland	BlueChoice HealthPlan, CIGNA
6	Aiken, Barnwell, Edgefield	BlueChoice HealthPlan
7	Allendale, Bamberg, Calhoun, Orangeburg	BlueChoice HealthPlan, CIGNA
8	Clarendon, Lee, Sumter	BlueChoice HealthPlan, CIGNA
9	Chesterfield, Darlington, Dillon, Florence, Marion, Marlboro, Williamsburg	BlueChoice HealthPlan, CIGNA
10	Georgetown, Horry	BlueChoice HealthPlan, CIGNA
11	Berkeley, Charleston, Colleton, Dorchester	BlueChoice HealthPlan, CIGNA
12	Beaufort, Hampton, Jasper	BlueChoice HealthPlan, CIGNA

BlueChoice HealthPlan

BlueChoice HealthPlan is an HMO offered statewide.

With BlueChoice HealthPlan, 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.

BlueChoice HealthPlan offers many preventive programs to keep you healthy. As a member, you pay a small copayment for well child visits and immunizations, as well as for primary care visits.

BENEFITS AT A GLANCE

To be covered, services must be provided by your Primary Care Physician (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	MEMBER PAYS
Deductible per Calendar Year	
Per member	$250
Per family	$500
Coinsurance Maximum per Calendar Year	
Per member	$1,500
Per family	$3,000
Lifetime Benefit Maximum - $1,000,000	
Primary Care Physicians	
Office services, including routine and preventive care	$15 Copayment per visit
Hospital services	$0
Routine mammogram	$0
Specialty Care Physicians	*All services must be preauthorized*
Office services	$30 Copayment per visit
Maternity care	$30 Copayment first visit, then 10%
Hospital services	Deductible, then 10%
Emergency room care	Deductible, then 10%
Routine GYN exam - two per calendar year	$15 Copayment per visit *(authorization not required)*
Chiropractic care - $1,000 maximum per calendar year	$30 Copayment per visit
Facility Services	*All services, except emergency care, must be preauthorized*
Inpatient admission	$200 Copayment per admission, then 10%
Skilled nursing facility and/or long-term acute care facility - 120-day maximum per calendar year	Deductible, then 10%
Outpatient services/ambulatory surgical centers	$100 Copayment and 10% for first 3 visits per calendar year; 10% for visit 4 and each visit thereafter
Emergency room services	$125 Copayment per visit, then 10%
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)*	$7 Generic drug $35 Preferred brand-name drug $55 Nonpreferred brand-name drug
Mail-order copayment *(up to a 90-day supply)*	$14 Generic drug $70 Preferred brand-name drug $110 Nonpreferred brand-name drug
Specialty Pharmaceuticals	$100 Copayment per 31-day supply
Mental Health/Substance Abuse Care	
Inpatient	$200 Copayment per admission then 10%
Outpatient	$30 Copayment per visit

BENEFITS	MEMBER PAYS
Routine Vision Care - Physicians Eyecare Network (PEN) Providers Only (Refer to Provider Directory)	
One routine eye exam for eyeglasses per calendar year	$0
One pair of eyewear from a designated selection every other calendar year *(other discounts and/or fees will apply to glasses and contact lenses outside of the designated selection)*	$0
Fitting exam for contact lenses per calendar year	$45
Other Services	*All services, except emergency care, must be preauthorized*
Ambulance	Deductible, then 10%
Hospice	Deductible, then 10%
Medical supplies	Deductible, then 10%
Initial prosthetic appliances	Deductible, then 10%
Occupational therapy – 20 visits per benefit period	Deductible, then 10%
Physical therapy – 20 visits per benefit period	Deductible, then 10%
Speech therapy – 20 visits per benefit period	Deductible, then 10%
Outpatient private duty nursing and home health	Deductible, then 10%
Dental services due to accidental injury	Deductible, then 10%
$500 maximum per calendar year	
Durable medical equipment (DME)	Deductible, then 10%
$5,000 maximum per calendar year	
Human Organ Transplants	
Lifetime Transplant Maximum	$250,000
Covered Transplants:	Maximum benefit per transplant:
Kidney (single)	$60,000
Pancreas/kidney	$80,000
Heart	$120,000
Lung (single)	$130,000
Lung (double)	$250,000
Liver	$225,000
Pancreas	$80,000
Heart/lung	$175,000
Bone marrow/stem cell	$250,000
Cornea	$25,000

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 healthcare services according to this Plan of Benefits.

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

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.

NETWORK BENEFITS

With BlueChoice HealthPlan, you receive benefits for covered services 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 due.

Referrals

Should 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 has made the referral before you visit the specialist. You can check for referrals on the BlueChoice HealthPlan Web site 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.

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 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 services that you pay. As a BlueChoice HealthPlan member, you pay 10 percent of the cost of these services. Please see the Schedule of Benefits for more information. After you spend either $1,500 (individual coverage) or $3,000 (family coverage) in coinsurance for network services in a calendar year, the plan will pay 100 percent of your medical costs for network services 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 service. 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 SERVICES

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

Ambulance Services

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 Services

Effective with the 2009 plan year, Behavioral Therapy, also known as Applied Behavior Analysis (ABA), for children diagnosed with an Autism Spectrum Disorder (ASD) at age 8 or younger will be covered. A child must be younger than 16 years of age to receive benefits. There is a $50,000 maximum per plan year. 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, contact CBA at 800-868-1032.

Treatment of ASD, other than Behavioral Therapy, will be treated in the same manner as other medical conditions. These services 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 Services

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

Chiropractic Care

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.

Dental Services 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 in order 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, vision and hearing screenings, 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.

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.

For more information about receiving emergency services outside the BlueChoice HealthPlan service area, read the BlueCard® program section on page 36.

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 Services

You are covered for certain human organ transplants. The organ must be provided from a human donor to you (the transplant recipient) and provided at a designated transplant facility. 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 also not covered.

Inpatient Hospital Services

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 dependent 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 Services, 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 Services

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.

Generics Now℠
Generic drugs are equivalent in composition and effect to their brand-name counterparts but are generally less expensive. BlueChoice HealthPlan has implemented a program called “Generics Now” to encourage 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 copayment for the brand-name drug. 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 contacting BlueChoice HealthPlan Member Services at 800-868-2528 (803-786-8476 in the Columbia area).

Prior Authorization
Certain prescription drugs require prior authorization in order to be covered, and certain drugs have dosage limits as determined by BlueChoice HealthPlan. 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 Services

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

Therapeutic Services

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

Vision Services

You are covered for one comprehensive vision examination each calendar year to determine the need for corrective eyeglass lenses. A member of the Physicians Eyecare Network must perform the exam. Additional charges for a contact lens examination and contact lens fitting are not covered.

You are covered for one pair of eyeglasses from a designated selection of lenses and frames from a member of the Physicians Eyecare Network every other calendar year. If you prefer contact lenses, the eyeglass benefit may be used as a credit toward a contact lens package. No other vision or eye examination is covered unless determined to be medically necessary to treat a medical condition and preauthorized by your PCP and BlueChoice HealthPlan.

For a list of Physicians Eyecare Network providers, please visit the BlueChoice HealthPlan Web site at www.BlueChoiceSC.com. If you do not have access to the Internet, call BlueChoice HealthPlan and ask for a list of providers in your area.

EXCLUSIONS AND LIMITATIONS

No benefits are 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 Free and Clear Quit for Life Program
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.

OTHER PLAN FEATURES

Away From Home Care

If you or one of your family members 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. Just call BlueChoice HealthPlan and explain your situation. Students and long-term travelers are two 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. You will find more information on the program under "Products and Services" at www.BlueChoiceSC.com.

Great Expectations® *for health*

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

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**
- **Maternity**
- **Men's Health**
- **Migraine**
- **Quit Smoking**
- **Weight Management**
- **Women's Health**

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

The Free & Clear® Quit For Life™ Program

The research-based Quit For Life Program is available at no charge to BlueChoice HealthPlan subscribers and their dependents age 18 or older. Free & Clear, an independent company, administers this smoking cessation program on behalf of 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 Quit Guides and five telephone calls from a Quit Coach. A participant may call Free & Clear's toll-free support line as often as he wishes. The program also provides free nicotine replacement products (patches, gum or lozenges), if appropriate. Your Quit Coach may also recommend your doctor prescribe a smoking cessation drug, such as bupropion or Chantix, which are available through your prescription drug coverage. The support line is available from 8 a.m. to midnight, seven days a week. If help is still needed after the 12-month program ends, you may re-enroll.

To enroll in the Quit For Life Program, call 1-866-QUIT-4-LIFE (1-866-784-8454). After your eligibility is verified, you will be transferred to a Quit Coach for your first call.

Value Added Discount Programs

There are many ways to stay healthy. That is why Value Added Discount Programs are offered to BlueChoice HealthPlan members. These services and discounts are in addition to (but are not a part of) the services and benefits covered under a BlueChoice HealthPlan policy.

Through the Natural Blue[sm] program, you have access to special discounts on services from a network of acupuncturists, massage therapists, chiropractors, day spas and fitness centers in South Carolina and throughout the country.

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."

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

WEB SITE: WWW.BLUECHOICESC.COM

If you wish to download forms, learn specifics about your health plan, send BlueChoice HealthPlan an e-mail, review the Prescription Drug List or read about wellness programs, you can do all that and more by visiting www.BlueChoiceSC.com. This Web site is a protected, secure and convenient way for you to have access to timely information on your own schedule.

My Insurance Manager[sm] enables you to:

- 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 e-mail
- Request a new ID card
- Access *My Pharmacy Manager*.

My Pharmacy Manager[sm] enables you to:

- View your prescription history
- Find information about medications you are taking or are considering taking
- Learn about potential 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 contact 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.

You may also e-mail your appeal request to BlueChoice HealthPlan through its Web site at www.BlueChoiceSC.com. Just sign on to *My Insurance Manager* and click on "Ask Customer Service."

? Do you need more information on appeals? If so, contact BlueChoice HealthPlan by phone, letter or e-mail.

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 EIP Appeals Committee upholds BlueChoice HealthPlan's decision, you will have 30 days to seek judicial review as provided by S.C. Code Ann. 1-11-710 and 1-23-380.

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

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CIGNA HMO

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

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.

NETWORK BENEFITS

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

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

Copayments

Copayments vary depending on the services you receive. The CIGNA HMO plan has no annual deductible. Copayments for doctor and hospital services under the plan are:

- $15 PCP office visit
- $15 OB/GYN visit
- $30 specialist office visit
- $30 chiropractic office visit
- $30 short-term rehabilitation visit
- $500 per inpatient hospital admission, then 20 percent
- $250 outpatient surgery and medical care per visit, then 20 percent
- $100 emergency care (waived if admitted)
- $500 per admission for inpatient mental health and substance abuse care
- $30 outpatient mental health and substance abuse office visit.

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.

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 payable if you use a non-participating pharmacy. Copayments for up to a 30-day supply are:

- $7 for generics
- $25 for preferred brands
- $50 for nonpreferred brands.

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. The copayments for up to a 90-day supply are:

- $ 14 for generics
- $ 50 for preferred brands
- $100 for nonpreferred brands.

Autism Spectrum Disorder Benefits

On January 1, 2009, the CIGNA HMO began offering 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 will be provided to eligible children until age 16. The maximum yearly benefit for behavioral therapy is $50,000, which will be adjusted for inflation. 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 who are 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 your dependent will leave 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.

EXCLUSIONS

These are examples of the exclusions in your plan. 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; e-mail 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.

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.

- **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.

- **Vision care.** Subscribers receive a $10 eye exam every two years. Not all providers participate, and you must use a participating provider.

- **Nationwide access** to specially trained experts and nationally recognized facilities through the CIGNA LIFESOURCE Organ Transplant Network.

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.

Both programs are free. To enroll, call 866-417-7848 or go to www.myCIGNA.com.

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.

WEB SITE: WWW.MYCIGNA.COM

At CIGNA's secure, personalized Web site, 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.

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

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 EIP Appeals Committee upholds the denial, you have 30 days to seek judicial review as provided by S.C. Code Ann. 1-11-710 and 1-23-380.

Dental Insurance

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Introduction

Keeping your teeth healthy is important to your health. That is why we offer help with dental expenses through the State Dental Plan and Dental Plus, a supplemental program. To participate in Dental Plus, you must be enrolled in the State Dental Plan, and you must 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 benefits is $1,000 for each covered dependent child age 18 and younger. All State Dental Plan benefits are paid on the basis of allowed amounts for each dental procedure listed in the plan's Schedule of Dental Procedures and Allowable Charges. Your dentist's charge for a procedure 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 dependent. The State Dental Plan deductible is $25 annually for each subscriber or covered dependent who has dental services under Class II or Class III. The deductible for family coverage is limited to three per family per year, or $75.

If you enroll in the State Dental Plan or Dental Plus, you may not drop that coverage until the next open enrollment period, which will be in October 2009, or until you become eligible to change your coverage due to a special eligibility situation. Special eligibility situations are explained on page 12.

Dental Plus
Dental Plus covers the first three levels of service 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.

The Employee Insurance Program (EIP) offered agreements to all South Carolina dentists to accept the lesser of their usual charge or the Dental Plus allowed amount. To find the list of dentists who have accepted the agreement, go to the EIP Web site, www.eip.sc.gov, and select "Links" and then "State Dental Plan/Dental Plus." You may also go directly to the BlueCross BlueShield of South Carolina (BCBSSC) Web site, www.SouthCarolinaBlues.com. Follow the prompts. Under "Select a Specialty," choose "Dentist" or "Oral Surgeon."

Dental and Dental Plus premiums are on pages 200-203.

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 subscriber or a dependent 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 administrator for the State Dental Plan and Dental Plus. Its address is P.O. Box 100300, Columbia, SC 29202-3300. Customer Service can be reached at 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 85 for more information.

Class	Services Covered	Plan	Yearly Deductible	Percent Covered	Maximum Benefit
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 benefit year combined for Classes I, II and III
		with Dental Plus	None	100% of allowed amount or actual charge	$2,000[2] per person each benefit 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 benefit year combined for Classes I, II and III
		with Dental Plus	No additional deductible	80% of allowed amount after State Dental Plan deductible is met	$2,000[2] per person each benefit 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 benefit year combined for Classes I, II and III
		with Dental Plus	No additional deductible	50% of allowed amount after State Dental Plan deductible is met	$2,000[2] per person each benefit year combined for Classes I, II and III
IV Orthodontics[1]	Limited to covered dependent 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**	None	50% of allowed amount	$1,000 lifetime benefit for each covered child
		Dental Plus	**Dental Plus does not cover orthodontic services.**	**Dental Plus does not cover orthodontic services.**	**Dental Plus does not cover orthodontic services.**

[1] A subscriber must submit a letter from his provider for the covered dependent children age 18 and younger stating that their orthodontic treatment is not for cosmetic purposes for it to be covered by the State Dental Plan.

[2] $2,000 is the maximum yearly benefit an individual may receive when enrolled in both the State Dental Plan and Dental Plus.

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.

STATE DENTAL PLAN ONLY

Dentist's charge	**$750**
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	**$545.20**

STATE DENTAL PLAN WITH DENTAL PLUS

Dentist's Charge	**$750**
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)	**$375** (This includes the State Dental Plan payment of $204.80 and the Dental Plus payment of $170.20.)
Subscriber enrolled in Dental Plus pays	**$375**
Additional benefit with Dental Plus	**$170.20**

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. 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 claims for you, you can file them with BCBSSC. See page 214 for information on how to file a dental claim.

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 from each plan. State Dental Plan EOBs have "State Dental Plan" at the top left of the form. The claim number, at the bottom left, begins with a "T." "Dental Plus Plan" is printed at the top of the Dental Plus EOBs. The claim number, which is at the bottom left, begins with a "V." The numbers after the letter should be the same for both plans.

SPECIAL PROVISIONS OF THE STATE DENTAL PLAN

Alternate Forms of Treatment

If you or your dentist selects a more expensive or personalized treatment, benefits will be allowed for the less costly procedure consistent with sound professional standards of dental care. BCBSSC uses guidelines based on usual and customarily provided services and standards of dental care to determine benefits and/or denials.

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.**

To determine the allowed amount for a specific procedure, ask your dentist for the procedure code. You can then call BlueCross BlueShield of S.C. Customer Service at 888-214-6230.

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 benefits 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 benefits allowed. For example, if you have reached your maximum benefit when you have the service performed, you will not receive the amount that was approved on the Pretreatment Estimate form.

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.

DENTAL SERVICES NOT COVERED

There are some dental services the State Dental Plan and Dental Plus do not cover. The dental plan document, which is available in your benefits administrator's office, lists all these exclusions. The list below includes many of them. You may wish to take it with you when you discuss treatment with your dentist.

General Services not Covered

- 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 and 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.
- Services or supplies not recommended or approved by the attending dentist.
- Services or supplies not recognized as acceptable dental practices by the American Dental Association.

Services 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

- Space maintainers for lost deciduous (primary) teeth if the dependent 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 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).
- Temporary procedures, such as temporary fillings or temporary crowns.
- Rebase procedures.
- Implants and related services, including prosthodontics (crowns, abutments) placed on implants.
- 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.

Limited Services

- 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.) Two periodontal prophylaxes may be performed in addition to two prophylaxes provided above.
- 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.
- More than two topical applications of stannous fluoride or acid fluoride phosphate during any plan year.
- Topical application of sealants per tooth for patients age 16 and older. 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 should be submitted with the appropriate American Dental Association procedure code and documentation.
- 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.
- Additional sites in excess of two bone replacement grafts performed on the same day. (Payment is limited.)
- 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.
- 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 administrator 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 administrator that the addition of teeth is required for the initial placement of one or more natural teeth.

Prosthodontic and Orthodontic Services

Benefits are not payable for prosthodontics (ie., crowns, bridges, partial or complete dentures) until they are seated or delivered. This includes:

- 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 or covered dependents age 19 and older.
- Payment for orthodontic treatment over the lifetime maximum.
- Orthodontic services after the month a covered dependent child becomes ineligible for coverage

Please note: Dental Plus does not cover orthodontic services.

To learn how to continue your dental coverage when it ends, please refer to the section on COBRA on page 18.

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 Allowable Charges. 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 examples below.

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 dependent children age 18 and younger.

How Coordination of Benefits Works with Dental Coverage

Example 1 (Using an adult cleaning, a Class 1 procedure, which has no deductible and which is payable at 100 percent of the allowed amount)

Dentist's Charge	**$100**
Benefit payable under primary plan ($60, the allowed amount, is 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 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	**$100**
Dental Plus payment	**$40** (An additional $40 is payable if you have Dental Plus, due to higher Dental Plus allowed amount of $100.)
You pay if you have primary coverage, State Dental Plan coverage and Dental Plus coverage	**$0**

Example 2 (Using porcelain crown fused to a predominantly metal base, a Class 3 procedure for which the deductible has been paid and which is payable at 50 percent of the allowed amount)

Dentist's charge	**$750**
Benefit payable under primary plan ($750, the allowed amount, is payable at 50 percent)	**$375**
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	**$34.60** ($34.60 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	**$340.40**
Dental Plus allowed amount	**$750**
Dental Plus payment	**$340.40** (An additional $340.40 is payable if you have Dental Plus, due to the higher Dental Plus allowed amount of $750.)
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 21. If your State dental coverage is secondary, you must send the Explanation of Benefits you receive from your primary plan with your claim to BlueCross BlueShield of South Carolina.

If you have questions, contact BlueCross BlueShield of South Carolina toll-free at 888-214-6230 or 803-264-7323 (Greater Columbia area), your benefits office or the Employee Insurance Program.

APPEALS

If BlueCross BlueShield of South Carolina (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 at 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 the Employee Insurance Program (EIP) review the decision. If the denial is upheld by EIP, you have 30 days to seek judicial review as provided by S.C. Code Ann. 1-11-710 and 1-23-380.

Life Insurance

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Basic Life Insurance Program

Who is Eligible?

The Basic Life Insurance program provides $3,000 life insurance coverage 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 program, you are eligible for this benefit.

Enrollment

The Basic Life Insurance benefit is provided free of charge to all eligible employees. Enrollment in the program is automatic with enrollment in a state health insurance program for active employees.

Your coverage begins on the first day of the calendar month coinciding with or the first of the month following your date of employment 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 and your coverage is approved on the first day of the month, the effective date for the amount of coverage requiring medical evidence will be the first day of the month, if you are actively at work on that day. If your coverage is approved later in the month, your coverage will become effective on the first day of the month following approval. **All effective dates of coverage are subject to the Deferred Effective Date provision (see page 96).**

Schedule of Accidental Losses and Benefits

The Hartford 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.

With respect to a hand or foot, loss means actual and permanent severance from the body at or above the wrist or ankle joint. With respect to sight, speech or hearing, loss means entire and irrecoverable loss thereof. With respect to thumb and index finger of same hand, loss 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 Either 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:

- 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.

If you are a beneficiary of any life insurance policy offered by The Hartford through the Employee Insurance Program, you are eligible for Beneficiary Assist®. See page 109 for more information.

How Claims are Paid

Benefits are paid as soon as 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. Proof of loss must be provided within 90 days after the date of the loss. If that is not possible, it must be provided as soon as reasonably possible, but not later than one year after that 90-day period. The Hartford will pay benefits within 60 days after proof of loss is satisfied.

Extension of Benefits

When your health coverage as an active employee is terminated, you will no longer be eligible for Basic Life coverage. However, you will be allowed to convert your coverage.

Conversion

If you are terminating employment, you may convert your coverage to an individual policy. To do so, you must complete and submit a conversion form to The Hartford **within 31 days after your Basic Life coverage ends**. The form is available through your benefits office, from EIP or on the EIP Web site, www.eip.sc.gov. Choose your category, "Active Subscribers," and then select "Forms." Under "Life Insurance," select "Notice of Continuation of Coverage."

Optional Life Insurance Program

The Contract

The Optional Life Insurance contract 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 The Hartford 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 The Hartford and EIP.

Applications

The Notice of Election (NOE) and/or Personal Health Application that you complete to be covered by this plan are considered your application for life insurance coverage. The Hartford may use misstatements or omissions in your application to contest the validity of insurance or to deny a claim. However, The Hartford must first give you or your beneficiary a copy of the application that is being contested. The Hartford 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 139). Retired employees are not eligible.

Legal Action

No legal action can be brought against The Hartford sooner than 60 days after the date proof of loss is furnished or more than three 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 page 100 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

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 entities approved by state legislation 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 continuously for at least one year in a full-time, permanent position. Active employees who work at least 20 hours per week may also be eligible at the covered entity's option. 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.

Notice of Election Form (NOE)

The application form you use to enroll or change your coverage level, beneficiary, name or address.

Personal Health Application

The form used to provide medical evidence of good health to The Hartford.

Physician

A person who is a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that The Hartford 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 for $10,000 to $20,000 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.**

The Hartford

Hartford Life and Accident Insurance Company.

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 entity.

You

A person who is insured under the policy.

ENROLLING IN OPTIONAL LIFE INSURANCE

Initial Enrollment

If you are an employee of a participating entity of the state of South Carolina, you can enroll in the Optional Life Insurance Plan 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 select 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 calendar 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 96).**

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 97) or during an enrollment period. In 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 on the date of the qualifying event. Otherwise, you must complete an NOE and a Personal Health Application 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 96).**

Changing Coverage Amount With the 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 page 97).

To increase your coverage during the annual enrollment period, you must provide medical evidence of good health and be approved by The Hartford. 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 96).** 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 The Hartford. To enroll, you must complete an NOE and a Personal Health Application and return these forms to your benefits office for processing. Your coverage will be effective on the first day of the calendar 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 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 on the date of the qualifying event. **All effective dates of coverage are subject to the Deferred Effective Date provision (see page 96).**

Changing Coverage Amount Without the Pretax Group Insurance Premium Feature

If you do **NOT** participate in the MoneyPlu$ Pretax Group Insurance Premium Feature, you can increase your amount of coverage at any time during the year by providing medical evidence of good health and being approved by The Hartford. Your coverage at the new level will be effective on the first day of the calendar month following the date of approval as long as you are actively at work on that day. In 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 on the date of the qualifying event. **All effective dates of coverage are subject to the Deferred Effective Date provision (see page 96).** 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.

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 pages 137 and 139). Retired employees are not eligible for the Pretax Group Insurance Premium Feature. Optional Life premiums begin on page 206.

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 206.

YOUR LIFE INSURANCE BENEFITS

YOUR BENEFITS AND FACILITY OF PAYMENT OF CLAIMS

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, The Hartford 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, The Hartford 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 The Hartford from liability for the amount paid. If any beneficiary is a minor, The Hartford may pay his or her share, until a legal guardian of the minor's estate is appointed, to a person who at The Hartford's option and in The Hartford's opinion is providing financial support and maintenance for the minor. The Hartford will pay $200 at your death and monthly installments of not more than $200. Payment to any person as shown above will release The Hartford from all further liability for the amount paid.

Your Living Benefit

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 The Hartford 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. The Hartford may require proof that you are terminally ill before benefits are paid.

Method of Payment

The Hartford will pay benefits in a lump sum.

How to Change Your Beneficiary or Method of Payment

You can change your beneficiary at any time (unless you have given up that right). To make a change, you should notify your benefits office and complete 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

The Hartford is not responsible for the validity or tax consequences of any assignment. No assignment will be binding on The Hartford until The Hartford records and acknowledges it. Collateral assignments are not permitted.

Suicide Provision

No Optional Life or Dependent Life Spouse 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 death 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.

YOUR ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

(This provision does not apply to retirees.)

Accidental Death

If you or your spouse die accidentally, The Hartford will pay an additional benefit equal to your amount of life insurance. To receive the additional benefit, death must not be due to a sickness or any other cause that is not considered accidental. Benefits will be paid according to the life insurance benefits provisions listed in this section.

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, The Hartford 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 The Hartford 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, The Hartford 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.

Dismemberment

Dismemberment benefits will be paid according to the Schedule of Accidental Losses and Benefits shown below. The Maximum Benefit refers to the amount of Optional Life insurance you have elected. If an injury causes more than one benefit to be payable according to the schedule listed below, only the largest benefit will be paid.

The Hartford 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.

With respect to a hand or foot, loss means actual and permanent severance from the body at or above the wrist or ankle joint. With respect to sight, speech or hearing, loss means entire and irrecoverable loss thereof. With respect to thumb and index finger of same hand, loss means actual and permanent severance from the body at or above the metacarpophalangeal joints.

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, one payment is issued per year 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, with one payment issued per 12-month period to a maximum of four consecutive periods. 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. The benefit is five percent of the face value of the policy, or $5,000 per year (whichever is less).

Felonious Assault Benefit

A felonious assault benefit is paid if the insured 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) and Loss of Sight benefit. The benefit is one times the annual earnings, $25,000, or the AD&D maximum (whichever is less). The benefit is payable only if the loss is policyholder-related.

Schedule of Accidental Losses and Benefits

The Hartford 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.

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 Either Hand	One-quarter of Maximum Benefit

The maximum benefit is equal to your amount of Life Insurance.

What Is Not Covered?

The Hartford will not pay accidental death or dismemberment benefits for a loss that results from:

- 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.

CLAIMS

To pay benefits, The Hartford must be given a written proof of loss. This means a claim must be filed as described below.

How to File Claims

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.

If you are a beneficiary of any life insurance policy offered by The Hartford through the Employee Insurance Program, you are eligible for Beneficiary Assist®. See page 109. for more information.

For retired employees, claims should be filed with The Hartford (for information and forms, contact The Hartford at 888-803-7346, extension 33666).

How Claims Are Paid

Benefits are paid as soon as The Hartford receives acceptable proof of loss. Benefits for loss of life are paid as described on pages 101-102 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 The Hartford's option, to your beneficiary or to your estate.

Examinations and Autopsies

The Hartford sometimes requires that a person filing the claim for the living benefit be examined by a physician of The Hartford's choice. The Hartford will not require more than a reasonable number of examinations. Required examinations will be paid for by The Hartford. Where it is not prohibited by law, The Hartford may require an autopsy. A required autopsy will be paid for by The Hartford.

EXTENSION OF BENEFITS

An extension of benefits is provided according to the requirements below. The Hartford 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 last day worked as long as you pay the required premium. If you become totally disabled, apply for a conversion policy or die, The Hartford will require written proof of your leave of absence approval.

If you are called up for active duty military service, you can continue your Optional Life Insurance coverage for 12 weeks. You can then convert your coverage. If your spouse is covered under Dependent Life Insurance, he can also continue his coverage for 12 weeks, and then he can convert his coverage.

Disability

If you become totally disabled, your life insurance will 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; and
- The group Optional Life Insurance policy does not end.

Your premiums will be waived for up to 12 months from the last day worked while you are totally disabled, as determined by your employer. The 12-month period begins the first of the month following your last day worked. In order for your premiums to be waived, you must provide proof of disability to your benefits administrator within one year after the last day you were actively at work.

If you return to work during the 12-month waiver period and work one full week, the premium waiver period ends. If you must leave employment again due to total disability, the 12-month waiver will start over from the last day you were physically at work.

If your 12-month waiver ends and you have not returned to work as a permanent, full-time employee, you will be eligible to continue coverage through conversion (see page 104). However, if you are eligible for service retirement or approved for disability benefits you may be eligible to continue your Optional Life Insurance under portability until age 75. **You must file for continuation 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. We will also consider the following injuries a total disability:

- Loss of sight in both eyes;
- Loss of both hands;
- Loss of both feet; and
- 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

With respect to retirees:

- The day you become age 70, if you continued coverage as a retiree with a date of retirement before January 1, 1999; the day you become age 75, if you continue coverage as a retiree with a date of retirement 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 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 or EIP. They will send you an application to convert your coverage. The conversion form is also available on the EIP Web site, www.eip.sc.gov. **You are responsible for completing and submitting this application and your first conversion premium to The Hartford within 31 days after your group Optional Life Insurance coverage ends.** Your conversion policy is then effective on the 32nd day after your group coverage ends. When applying for coverage, keep these rules in mind:

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 The Hartford's standard rate for the amount of coverage that you wish to convert and your age.

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 183-184 of the Retirement/Disability Retirement chapter for more information.

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, The Hartford 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 The Hartford for this benefit to be paid.

Dependent Life Insurance Program

ENROLLMENT AND ELIGIBILITY

Who is Eligible?

You may enroll in the Dependent Life Insurance program for your eligible dependents 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 entity, you cannot cover him as a dependent.
- Your children, who must be:

  1. Natural children, legally adopted children, stepchildren or children for whom you have legal guardianship
  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.

All Optional Life and Dependent Life policies are subject to the Deferred Effective Date provision. See page 96 and page 106.

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. Please see your benefits administrator for more information.

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.

How to Enroll

You can enroll in the Dependent Life Insurance plan 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 calendar month coinciding with or the first of the month following your date of employment.

Marriage

If you wish to add a dependent spouse because you marry, you can add 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 with the date of marriage. You cannot cover your spouse as a dependent if your spouse is or becomes an employee of a state entity 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 live with you and you are financially responsible for them, or if you are required to cover them by court order.

Loss of Coverage

If your spouse is employed by an entity 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 and remains on the active group in a waiver status under Optional Life coverage, your spouse can be added to your Dependent Life Insurance only within 31 days of the date his Optional Life waiver ends.

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. 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. Coverage for each new dependent begins on the date the dependent child is acquired. **All effective dates of coverage are subject to the Deferred Effective Date provision (see below).**

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 The Hartford. To provide medical evidence of good health, you must complete a Personal Health Application. Coverage will be effective on the first day of the calendar 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 below).**

Excluded Dependent

Any dependent who is eligible as an employee for Optional Life Insurance Plan coverage, or who is in full-time military service, will not be considered a dependent.

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.*

SCHEDULE OF BENEFITS

Dependent Life/Spouse coverage and premiums are not combined with the Dependent Life/Child coverage and 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. Medical evidence of good health is required for late entry (see the previous page) 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 206. 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 (see page 100).

Dependent Life/Child Coverage

You can cover your eligible dependent children. For information, see page 105. The benefit is $15,000, and 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 The Hartford receives acceptable proof of a covered dependent's death, the amount of life insurance will be paid based on the coverage you selected.

The Hartford will pay the Life Insurance Benefit at your dependent's death to you, if you are living. Otherwise, it will be paid, at The Hartford's option, to your surviving spouse or the executor or administrator of your estate.

How to File Claims

In order to pay benefits, The Hartford 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.

Finally, 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 The Hartford. For information and forms, contact The Hartford at 888-803-7346, ext. 33666.

When Claims Are Paid

Benefits are paid as soon as The Hartford receives acceptable proof of loss.

Autopsies

Where it is not prohibited by law, The Hartford may require an autopsy. A required autopsy will be paid for by The Hartford.

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.

Conversion

If your dependent's coverage terminates because of one of the reasons listed above, coverage may be converted to an individual life insurance policy. The dependent must apply to The Hartford in writing **within 31 days of the date insurance under this plan is terminated** and pay the required premiums for individual life insurance for the dependent's age and class of risk and a billing fee.

When an employee dies, Dependent Life/Spouse and/or Dependent Life/Child insurance coverage may be converted to an individual policy. This policy will:

- Be issued without medical evidence of good health
- Be on one of The Hartford'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.

If you are called up for active duty military service and your spouse has Dependent Life coverage, he may continue his coverage for 12 weeks and then convert it. See page 103 for more information.

Policy Termination
If you have had this Dependent Life Insurance Plan for at least five years, and your dependent's insurance terminates because The Hartford 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 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, The Hartford will, when provided with due proof of loss, pay the amount of life insurance the dependent was entitled to convert.

The Beneficiary Assist® Program

Counseling is available to beneficiaries of the Basic Life, Dependent Life and Optional Life insurance policies offered by The Hartford through the Employee Insurance Program (EIP). The Beneficiary Assist® program, for which there is no charge, may include telephone and face-to-face sessions with grief counselors, attorneys and financial planners. More information on the program is available in a brochure on the EIP Web site, www.eip.sc.gov. Select "Choose your Category," and then select "Survivors," and then "Publications."

Travel Assistance

When you're traveling, emergencies can occur. Now help is only a phone call away. As a Basic, Optional or Dependent Life subscriber, you are eligible for the travel assistance services provided by The Hartford through Europ Assistance USA, a leader in the travel assistance industry. When you travel 100 miles or more from home for 90 consecutive days or less, **the Europ Assistance program** gives you 24-hour, toll-free access to emergency assistance. Before you accept a service, you may wish to ask if you will be required to pay for it.

The length of time it will take to receive the assistance depends on the situation. These benefits and services are also available for your covered dependents — regardless of whether they're traveling with you.

Europ Assistance offers a wide range of services both before you leave home as well as in emergency situations.

Emergency Medical Assistance

The travel assistance services are not intended to replace your health insurance or traditional travel insurance. Before you leave on a trip, you may want to turn to the chapter on your health plan or call your plan's customer service line to learn how urgent and emergency care are handled when you are away from home.

If you feel you may need additional insurance when you travel, consult a travel agent.

The travel assistance services are not available to retirees.

- **Medical Referrals —** Upon request, Europ Assistance will assist you in locating physicians, dentists and medical facilities that can take care of your medical needs. Whenever possible, Europ Assistance will refer you to English-speaking medical providers.
- **Medical Monitoring —** While being treated for a medical emergency, professional case managers (including physicians and nurses) will communicate with your attending local physicians to make sure that you receive an appropriate level of care and to determine if further intervention, medical evacuation or even repatriation (return to U.S.) is needed.

Before your trip, the program can provide information on:

- **Visas, passports, inoculations and immunizations**
- **Embassy and consular referrals requirements**
- **Foreign exchange rates**
- **Cultural information**
- **Travel advisories**
- **Temperature and weather.**

- **Medical Evacuation —** If Europ Assistance's physicians, in consultation with your local attending physician, determine that the care you receive is sub-standard, Europ Assistance will recommend that you be transported to the closest adequate medical facility that can provide relevant care for your medical emergency. Europ Assistance will make all arrangements and will pay for all associated evacuation expenses. And Europ Assistance's physician team makes all decisions as to the medical necessity of such a transport.
- **Medical Repatriation —** If Europ Assistance's physician, after consulting with your local attending physician, determines that you need further medical hospital care or long-term rehabilitation, Europ Assistance will arrange and pay for you to be brought back to your home. Europ Assistance's physician team makes all decisions as to the medical necessity of such a transport.
- **Traveling Companion Assistance —** If your travel companion loses previously made travel arrangements due to your medical emergency, Europ Assistance will arrange and pay for your companion's return home by the most direct and economical route.
- **Dependent Children Assistance —** If any dependent children traveling with you are left unattended because you are hospitalized, Europ Assistance will arrange and pay for their economy-class transportation home with a qualified escort, if necessary.
- **Visit by a Family Member or Friend —** If you are traveling alone and must be hospitalized for at least seven consecutive days, are likely to be hospitalized at least seven consecutive days or are in critical condition, Europ Assistance will, upon your request, arrange and pay for economy-class round trip transportation for one member of your immediate family, or one friend you designate, from his or her home to the place where you are hospitalized.
- **Emergency Medical Payments —** When it is necessary for you to obtain needed medical services, Europ Assistance will, upon your request, advance funds to cover on-site medical expenses. The advance of funds will be made to the medical provider after Europ Assistance has secured funds (usually by debiting a credit card) from you or your family.
- **Return of Mortal Remains —** In case of death while traveling, Europ Assistance will arrange and pay for the proper return of remains to the deceased's place of residence for burial, including all necessary government authorizations and transportation.
- **Replacement of Medication and Eyeglasses —** Europ Assistance can arrange to fill a prescription that has been lost, stolen, or requires a refill, subject to local law, whenever possible. Europ Assistance will also arrange for shipment of replacement eyeglasses. Costs for shipping medication, eyeglasses or a prescription refill are your responsibility.

You can reach Europ Assistance USA by:
Phone —800-243-6108
E-mail — ops@europassistance-usa.com
Fax— 202-331-1528
Web site— www.europassistance-usa.com.

Emergency Personal Services

- **Urgent Messages —** While you are traveling, Europ Assistance can receive and relay urgent messages for you and your family.
- **Emergency Travel Arrangements —** If appropriate, Europ Assistance can make new travel arrangements or change airline, hotel and car rental reservations.
- **Emergency Cash —**Europ Assistance can advance funds after satisfactory guarantee of reimbursement from you (usually a credit card). Any fees associated with the transfer or delivery of funds are your responsibility.
- **Lost/Stolen Luggage/Personal Possessions —**Europ Assistance can assist in locating and replacing lost or stolen luggage, documents, and personal possessions.
- **Legal Assistance/Bail —**Europ Assistance can locate an attorney and advance bail funds, where permitted by law, with satisfactory guarantee of reimbursement. (Attorney fees are your responsibility.)
- **Interpretation/Translation —**Europ Assistance can assist with the telephone interpretation in all major languages or will refer you to an interpretation or translation service for written documents.

How to Obtain Services

If you or your dependents need emergency help or other services, contact Europ Assistance 24 hours a day. Call 800-243-6108 in the U.S. and Canada. From other locations, call collect: 202-828-5885. You will be asked to provide:

- You/your dependents' names
- Nature of your condition
- Your employer's name
- Phone number where you can be reached
- The policyholder's name — S.C. Budget and Control Board, Division of Insurance and Grants Services, Employee Insurance Program
- The policy number — 674267 or 033913
- The Hartford ID Number — GLD-09012.

Paying For Services

After verifying coverage eligibility, Europ Assistance will pay for the following emergency medical assistance services previously described. **These services are only eligible for payment or reimbursement by Europ Assistance if Europ Assistance was contacted at the time of service and arranged and/or pre-approved the service. Before you accept a service, you may wish to ask if you will be required to pay for it.**

- Medical Evacuation/Return Home
- Return of Mortal Remains
- Traveling Companion Assistance
- Internal Expenses, including telephone calls, medical monitoring fees, or time dedicated to managing your medical care
- Dependent Children Assistance
- Visit by a Family Member or Friend.

If costs are incurred for any other Europ Assistance services, you are responsible for paying those costs or reimbursing the costs if initially paid by Europ Assistance. Europ Assistance will ask for your credit card information and debit your account for the required amount.

Service Exclusions and Limitations

Europ Assistance will not evacuate or repatriate you if you have infections under treatment that have not yet healed; you are pregnant and are either in or have passed your sixth month of pregnancy; or if the Europ Assistance-designated physician determines that such transport is not medically advisable or necessary.

For a complete list of Europ Assistance's service exclusions and limitations, please refer to the Europ Assistance Web site at www.europassistance-usa.com.

Optional Life, Dependent Life/ Spouse, Child Monthly Premiums

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. For the premiums, see pages 206-209.

The premium for Dependent Life/Child is $1.24 for $15,000 coverage, regardless of the number of children covered.

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 Standard Insurance Company 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: 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 Plan of Benefits. 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. Before you leave your job, 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 Web site, www.eip.sc.gov. Choose your category, and select "Forms." The master Plan Document 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 can be found on the EIP Web site. This 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 Standard Insurance Company. Your complete medical records should accompany the Attending Physician's Statement. You may fax these forms to 800-437-0961; original forms must follow. If you have questions, please contact Standard Insurance Company at 800-628-9696.

You should provide these completed claim forms to Standard Insurance Company 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, Standard Insurance Company may deny your claim.

Active Work Requirement

If physical disease, mental disorder, injury or pregnancy prevents you from working the day before the scheduled effective date of your coverage, your coverage will not become effective until the day after you complete one full day of active work.

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 Standard Insurance Company, 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 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[1] 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.

[1]*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 *own occupation* period you are working while disabled and 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 and 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 122); 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 while you are still in service or before you leave employment.

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 Standard Insurance Company, 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 116)
- 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 EIP, you may seek judicial review within 30 days of the date of receipt of the denial letter from EIP.

Supplemental Long Term Disability

Introduction

Most people probably think a disability only happens to other people. 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

SLTD insurance provides:

- Competitive group rates
- Survivors benefits for eligible dependents
- 24-hour 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: 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 eligible employer approved by state legislation; 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 insurance 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 Standard Insurance Company with medical evidence of good health and be approved to become insured. You may enroll with medical evidence of good health at any time 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 either 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 for consideration for approval.

Certificate

The SLTD certificate is available through your benefits administrator and is on the EIP Web site, www.eip.sc.gov. Choose your category, and select "Forms." Please read it carefully. The master Plan Document 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. Standard Insurance Company 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 can also can be found on the EIP Web site, www.eip.sc.gov, under "Forms." This 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 Standard Insurance Company. Your complete medical records should accompany the Attending Physician's Statement. If you also have BLTD coverage, only one claim packet needs to be completed. These forms may be faxed to 800-437-0961; original forms must follow. If you have questions, please contact Standard Insurance Company at 800-628-9696.

You should provide these completed claim forms to Standard Insurance Company 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 period, barring a court's determination of your legal incapacity, Standard Insurance Company 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 complete one full day of active work.

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 Standard Insurance Company, 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 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 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 disability, 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 124 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	.00065	.00050
31 through 40	.00089	.00069
41 through 50	.00179	.00137
51 through 60	.00360	.00277
61 through 65	.00433	.00333
66 or older	.00528	.00406

Example:
Mary is 38 years old, earns $3,000 per month and selected plan two. Her monthly premium is $3,000 x .00069=$2.08 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 .00360=$8.10 per month.

[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 Plan of Benefits.

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 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 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 122).

Definition Three: Partial Disability —

A) During the *own occupation* period, you are working while disabled and 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 and 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 while you are still in service or before you leave employment. 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 Standard Insurance Company, 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 make a required premium contribution
   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 are a citizen or resident of the United States or Canada.
5. 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 800-368-1135. 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, Standard Insurance Company 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, and 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 assistance 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-based setting, such as an adult day care center.

By assisting in paying the cost of these services, long term care insurance helps individuals retain their independence as long as possible, makes it more likely they will have a choice in 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 at LTC4me@prudential.com.

As you review this information about your long term care policy, you may wish to consider some facts about the long term care situation 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 for the life of your plan, regardless of your age or health status 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 plan details for specifics on your plan. You will also want to familiarize yourself with the many features offered through Prudential's plan. They are explained in the Plan Details section, beginning on page 130.

[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, 2008.*

IMPORTANT POINTS ABOUT THE PLAN

Premiums

Your premium is based on your age when you enroll. If you enroll now, at your current age, 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 for all members of your insured class. Premium charts for the plans are on pages 204-205.

Payment Method

Long Term Care Insurance premiums will no longer be available for payroll/pension deduction under the Employee Insurance Program, effective January 1, 2009. Employees, retirees and qualified family members can select a direct billing method, which provides discounts for semi-annual (2.83 percent) and annual (5.58 percent) payments. 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 that requires 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, log in to Prudential's customized enrollment Web site at www.prudential.com/gltcweb. Group Name: **eipltc**. Access Code: **carolina**.

Prudential's customer service representatives are there to help if you have any questions or would like to request that a paper enrollment kit 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 from February 16, 2009, through March 6, 2009, or within 31 days of their date of hire, will be guaranteed coverage without medical evidence of good health.

Medical Evidence of Good Health Requirements

All applicants, other than those described under "Guaranteed Coverage," 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.*

BASE PLAN FEATURES

Alternate Plan of Care

This insurance plan takes into account the institutional and home and community-based care settings that are currently 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 to reserve your bed in a nursing home or assisted living/residential care facility for up to 21 days per calendar year, should 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 you would rather use care management services other than Prudential Care Counselors, Prudential will reimburse you for eligible charges up to the private care management calendar year benefit limit. That limit is 12 times the Daily Benefit Maximum.

Caregiver Training

If someone will be providing care for the insured but 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 Maximum for facility care, or 75 percent of the Home and Community-based Care Daily Benefit Maximum for home care, for up to 365 days, for care received outside the United States. International coverage will reduce the Lifetime Maximum and is subject to the waiting period. The exclusion for services and supplies outside the United States does not apply to the International Coverage Benefit.

Marital Discount

If a married person purchases long term care insurance, the premium will be discounted by 10 percent, 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 an optional Automatic Inflation Protection (see Optional Plan Features section below). 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 will be based on your age at the time the inflation offer is accepted.

Optional Automatic Compound 5 Percent Inflation Protection

It is very likely that you may not need to 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 the effects of inflation, regardless of changes in your health. Should 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. 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 as if you had never 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 to pay 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.

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 United States, 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.

If you kept your long term care policy with Aetna, you can reach Aetna Customer Service by calling 800-537-8521.

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.

The MoneyPlu$ program is governed by Sections 105, 125, 129 and 223 of the Internal Revenue Service code. Fringe Benefits Management Company (FBMC) is the third-party administrator of the program. Each account has an administrative charge, which is designed to be minimal compared to your tax savings.

For more detailed information about this program, ask your benefits administrator for a copy of the *MoneyPlu$ Tax-Favored Accounts Guide.* The booklet is also available online at www.eip.sc.gov.

Pretax Premiums

The Pretax Group Insurance Premium Feature allows you to pay premiums only for the State Health Plan or an HMO, the State Dental Plan, Dental Plus and Optional Life (for coverage up to $50,000) before taxes are taken from your paycheck.

Flexible Spending Accounts

MoneyPlu$ allows you to 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 kinds of Flexible Spending Accounts: a **Dependent Care Spending Account**, a **Medical Spending Account** 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 both a Dependent Care Spending Account and a Medical Spending Account (or a limited-use Medical Spending Account if you contribute to an HSA).

Health Savings Accounts

A MoneyPlu$ Health Savings Account (HSA) is available to employees enrolled in the State Health Plan Savings Plan and can be used to pay healthcare expenses. Unlike money in a MoneyPlu$ 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 33.

MoneyPlu$ Example

This example shows how paying eligible expenses with a pretax payroll deduction increases 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	- 613.00
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	$1,729.72
Payroll Taxes (estimate)	- 696.78	- 513.50
Eligible Expenses[1]	- 613.00	- 0.00
Spendable Income	$1,040.22	$1,216.22

Increase in Spendable Income: $176 per month ($2,112 per year)

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	$142.46
Dental Premium	$ 13.72
Dependent Care Expenses	$400.00
Out-of-pocket Medical Expenses	$ 56.82
Total	$613.00

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]
EZ REIMBURSE® Card	$10 per year[2]
Health Savings Account	$1 per month[3] $10 per year or $1 per month (your choice)[4] 35 cents per 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 FBMC fee is deducted from your paycheck.
[4]This bank fee, which is deducted from your account, is waived if the balance in your account is over $2,500. If you prefer to pay it annually rather than monthly, call 877-362-4472 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 only your State Health Plan, HMO, State Dental Plan, Dental Plus and Optional Life premiums before taxes are taken out of your paycheck. This feature is beneficial to all employees who pay these premiums.

Your entire Optional Life Insurance premium is deducted from your paycheck before taxes, but only premiums for coverage up to $50,000 are tax exempt. Any premiums for coverage more than $50,000 will be added to your earnings at the end of the year and reflected on your W-2 form.

Eligibility

You are enrolled in this feature automatically if you pay a health, dental 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," page 12.)

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, 2010, to spend funds deposited in your MSA or limited-use MSA between January 1 and December 31, 2009.
   - However, you must submit all reimbursement requests by March 31, 2010. 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 yet received.

If you would like to know if you qualify to enroll in a spending account or if you wish to make a change, call FBMC 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, available at www.eip.sc.gov. Choose your category (Active Subscribers) and then select "Forms." *Be conservative in your estimates.* **Any money remaining in your Dependent Care Spending Account after December 31, 2009, and any money remaining in your Medical Spending Account or in your limited-use Medical Spending Account after March 15, 2010, cannot be returned to you or carried forward to the next plan year. However, you have until March 31 to submit requests for reimbursement for expenses incurred before December 31 for your Dependent Care Spending Account and incurred on or before March 15 for your Medical Spending Account.**

For details on IRS rules for dependent care expenses, go to the IRS Web site at www.irs.gov. Enter "Publication 503" in the "Search" window.

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, **except when**:

- Your W-2 income, before Dependent Care Spending Account salary reductions, is approximately $35,000 to $39,000, you have only one qualifying individual and your eligible dependent care expenses for the tax year are less than $3,000 **or**
- Your W-2 income is approximately $12,000 to $15,000 or less.

If either applies to you, the Child and Dependent Care Credit may be a better option.

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.*

To use FBMC's Tax Analysis Calculation software to determine which may be your better choice, go to the "Tax Calculators" link at www.myFBMC.com. You may also call FBMC Customer Service at 800-342-8017 for assistance. 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 Taxpayer Identification Number (TIN). The TIN is an individual's Social Security Number, unless he or she is a resident or non-resident alien who does not have a Social Security Number. If you are unable to obtain a dependent care provider's TIN, 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*: *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 (25 percent), South Carolina state tax (7 percent) and Social Security taxes (7.65 percent).

Taxpayers may consult IRS Publication 502 for additional information, 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.

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 $5,000, depending on your tax status. Don't forget to consider vacation and holiday time when you may not have to pay for dependent care. During the year, make sure you are filing all of your claims for reimbursement. Remember, according to IRS guidelines, any money in your account after you have claimed all of your expenses at the end of the year cannot be returned to you or be carried over into the next calendar year. You have until March 31 of the new plan year to file claims for services provided the previous year.
2. The annual amount you contribute to your account will be divided into equal installments and deducted from each paycheck before taxes. It is then credited to your Dependent Care Spending Account.
3. After incurring dependent care expenses, submit a MoneyPlu$ Claim Form and a copy of your expense documentation from your dependent care provider to FBMC. 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 FBMC 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," page 12 and "Changing Your Flexible Spending Account Coverage," page 151). 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 12 years old or younger
- 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.

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 more quickly, sign up for Direct Deposit.

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 FBMC to reimburse you for part of the amount on the documentation when there are enough funds in your account.

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 EZ REIMBURSE® Card transactions.** Check the FBMC Web site at www.myFBMC.com for any outstanding transactions that may need documentation.
   - Between January 1 and March 15, any EZ REIMBURSE® Card swipes or paper claims filed will be paid from funds remaining in your MSA from the previous year. For example, if you have 2009 MSA funds you would like to use, submit all of your 2009 claims before you begin turning in claims for 2010 expenses. Once your 2009 funds are exhausted, FBMC will begin to reimburse you from your 2010 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 an EZ REIMBURSE® 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 EZ REIMBURSE® Card after December 31. However, you may submit paper claims until March 31 for expenses incurred until March 15 of the new plan year.

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 FBMC. 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 FBMC. **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.

If you have questions about filing MoneyPlu$ claims, call FBMC at 800-342-8017.

4. If you have an EZ REIMBURSE® 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 the FBMC Web site.

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 yearly enrollment period, October 1-31. If you have an EZ REIMBURSE® 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," page 12 and "Changing Your Flexible Spending Account Coverage," page 151). Complete a MoneyPlu$ Enrollment Form, available from your benefits administrator or on EIP's Web site at www.eip.sc.gov. Submit the completed form to your benefits administrator.

You may set aside up to $5,000 annually to pay your medical, vision and dental expenses that are not reimbursed by insurance. Your MoneyPlu$ Medical Spending Account 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.

To participate in a Medical Spending Account, you must have completed one year of continuous state-covered service by January 1 after annual enrollment.

An individual is a *qualifying child* if he is not someone else's qualifying child and:

- 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 18 years old or younger (23 years, if a full-time student) at the end of the tax year and
- Has not provided more than one-half of his own support during the tax year (and receives more than one-half of his support from you during the tax year if he is a full-time student age 19 through 23 at the end of the tax year).

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$ Medical Spending Account.*

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 Accounts

Expenses eligible for reimbursement include your deductibles, coinsurance and copayments. In addition to these expenses, your Medical Spending Account 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)
- Certain approved over-the-counter medicines
- Any other out-of-pocket medical expenses deductible under current tax laws, including travel to and from medical facilities.

Like any MSA expense, EZ REIMBURSE® Card transactions must be documented for the IRS. See page 148 for more information.

***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 FBMC Customer Service at 800-342-8017.*

Eligible Expenses — Limited-use Medical Spending Accounts

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 Medicines

You may use your MSA to pay for some over-the-counter (OTC) drugs, including allergy, antacid, cold, cough and pain-relief medicines. The Treasury Department and IRS ruled that OTC drugs may be purchased with pretax dollars through healthcare flexible spending accounts, such as a MoneyPlu$ Medical Spending Account. This does not change the rules about itemizing medical expense deductions. The costs of OTC drugs are still not deductible on tax returns. You may now use your EZ REIMBURSE® Card to buy over-the-counter drugs. Please note that OTC drug expenses are not eligible for reimbursement under a limited-use MSA.

FBMC reviews and updates the partial list of OTC drugs eligible for reimbursement quarterly. **It is your responsibility to remain informed about updates to this list**, which can be found at www.myFBMC.com.

When a drug or medicine is added to the list, it can be reimbursed from January 1 of the year in which it is added. You may resubmit a copy of your receipt if a rejected OTC expense becomes eligible for reimbursement later in the same year. **Remember that you have only until March 15 to spend funds deposited**

during the previous year. You have until March 31, after the end of the year, to submit eligible expenses for reimbursement.

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 a Medical Spending Account 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 getting reimbursed for eligible medical expenses.

Medical Spending Account Reimbursements

If you use an EZ REIMBURSE® Card, funds will be transferred automatically from your Medical Spending Account. You will not need to wait for reimbursement. Please note that the EZ REIMBURSE® Card is not available to limited-use MSA participants. The EZ REIMBURSE® Card is discussed in detail on the next page.

If you file by mail, your reimbursement will be issued within five business days from the time FBMC receives your properly completed and signed claim form. 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

You can have your MoneyPlu$ reimbursement checks deposited automatically into your checking or savings account. There is no extra fee for this service, and you will still receive notification that your claim has been processed. To apply, complete a MoneyPlu$ Direct Deposit Authorization Form available from your benefits office or on EIP's Web site at www.eip.sc.gov. Please note that 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. FBMC cannot process your request 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 Medical Spending Account.

To request reimbursement from your Medical Spending Account, 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

Do not use a highlighter on any forms or other documents you send to FBMC. It will make them impossible to read when they are photocopied or faxed.

- 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 from FBMC by calling 800-342-8017.

EZ REIMBURSE® MASTERCARD® CARD

You may use the EZ REIMBURSE® Card to draw funds from your MoneyPlu$ Medical Spending Account (MSA) to pay eligible, uninsured medical expenses for yourself and for your eligible dependents.

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.

The EZ REIMBURSE® Card is not available to you if you have a limited-use Medical Spending Account, which is associated with the State Health Plan Savings Plan and the Health Savings Account.

If you are enrolled in the State Health Plan, BlueChoice or CIGNA HMO, you may use your EZ REIMBURSE® Card for mail-order prescriptions. No documentation is required.

To Enroll

When you sign up for an MSA, you may request an EZ REIMBURSE® Card on your enrollment form. If you wish to continue your EZ REIMBURSE® 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 a dependent.

Activating the Card

You must activate your EZ REIMBURSE® Card before you use it for the first time. To do so, call the toll-free number on the sticker on the front of the card. Be sure to sign the back of the card. If you continue to sign up for the card and MoneyPlu$ Medical Spending Account 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
- Mail-order prescriptions.

Your EZ REIMBURSE® 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 any other credit card. No PIN is needed. Please remember to keep documentation of your expenses, as stated in the IRS regulations.

Effective January 1, 2009, the card will only be accepted at IIAS-certified merchants. The latest list of stores meeting the federal electronic coding requirements is at www.myFBMC.com. After you log on, click on "Inventory Information Approval Systems (IIAS)" in the box on the left under "FAQs." You will also find a list of IRS-approved over-the-counter items on the Web site.

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 Web site 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 EZ REIMBURSE® 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 Web site at www.eip.sc.gov. Choose your category (Active Subscribers) and select "Forms." The form is listed under "MoneyPlu$."

On page 143 you will find information about how the run-out period and grace period apply to the EZ REIMBURSE® Card.

Up to five transactions for prescriptions with fixed copayments (such as $10, $25 and $40 under the Standard Plan) will be "auto-adjudicated," verified and approved when you make the purchase without requiring documentation later.

Documentation **will be** required when you use the card for any transaction that does not have a fixed copayment.

Documentation **will not be** required for prescription drugs purchased through your health plan's mail-order pharmacy, prescriptions with fixed copayments and IRS-approved over-the-counter items.

Documenting EZ REIMBURSE® Card Transactions

According to the IRS, it is not necessary to submit documentation to FBMC for:

- Up to five transactions for prescriptions with fixed copayments (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 and CIGNA HMO)
- Eligible prescriptions purchased through your health plan's mail-order pharmacy
- IRS-approved over-the-counter items.

However, documentation is needed for other healthcare expenses. When you receive your monthly statement from FBMC, 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 FBMC. 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 Web site or from the pharmacy's Web site. The name also may be on a note stapled to the bag from the pharmacy.

The claim form is available on the EIP Web site at www.eip.sc.gov. Choose your category (Active Subscribers) and select "Forms." You may also get a copy from the FBMC Web site, www.myFBMC.com, or from your benefits administrator. **FBMC must have this claim form to process the documentation.**

When an outstanding EZ REIMBURSE® Card transaction has appeared in blue on two monthly statements, the next time you submit an approved paper claim, FBMC will keep enough money 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 EZ REIMBURSE® Card transactions by submitting a check to FBMC 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 EZ REIMBURSE® Card will be suspended until:

- FBMC receives your documentation and/or
- Automatic substitution occurs and/or
- You repay your account by check.

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.

When the transaction in question is cleared by one of these methods, your card will be automatically reinstated. Any amounts from January 1, 2009, to March 15, 2010, that are not cleared by March 31, 2010, violate IRS guidelines and will be taxed as income. Also, your EZ REIMBURSE® Card will be canceled permanently.

You must keep all documents substantiating your claims for at least one year and submit them immediately to FBMC or the IRS upon request.

Lost Cards

If your EZ REIMBURSE® Card is lost or stolen, call 800-689-0821 immediately.

Limited-use Medical Spending Accounts

Savings Plan subscribers who contribute to an HSA may enroll in a limited-use Medical Spending Account 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 Medical Spending Account works the same as a MoneyPlu$ Medical Spending Account.

Using your limited-use MSA
Since you can pay your out-of-pocket medical expenses with your MoneyPlu$ HSA, some MoneyPlu$ Medical Spending Account features are not available with a MoneyPlu$ limited-use Medical Spending Account, including:

- No reimbursement of out-of-pocket medical expenses, such as deductibles, coinsurance and copayments
- No reimbursement for over-the-counter items and
- No EZ REIMBURSE® Card option.

Remember, MoneyPlu$ limited-use Medical Spending Accounts 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 EZ REIMBURSE® Card.

If you have trouble registering, it may be because the information you entered does not match what FBMC has on file for you. During business hours, a customer service representative can help you register.

FBMC Web Site

FBMC's Web site, www.myFBMC.com, provides information about your tax-favored accounts. To register, enter your name, zip code, e-mail address and Social Security Number and then select a password. To log in to the site, enter your e-mail 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.** Not only can you check the status of your claim, but you may download forms, get more information about mailing and faxing your claim to FBMC 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 (EZ REIMBURSE® Card).** Check your account regularly to review your account balance and any outstanding EZ REIMBURSE® Card transactions that require documentation. You may download a card fact sheet or transmittal form and read detailed instructions about using the card. You can also view outstanding transactions.
- **Profile.** Change your e-mail address in FBMC's files, complete your online registration or select a new PIN.
- **Resources.** Look through an extensive resource library, including benefit materials, surveys, over-the-counter drug lists and benefit tips.
- **Forms.** Download a variety of forms you may need as you use your account.
- **Contact.** Send a question to FBMC Customer Service.

If you are enrolled in a Medical Spending Account (MSA) or a Dependent Care Spending Account (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.

Telephone

FBMC's 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-FBMC (3262).

FBMC Contact Information

Department	Hours	Phone
FBMC Customer Service	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
Fax		850-425-4608

CHANGING YOUR FLEXIBLE SPENDING ACCOUNT COVERAGE

You can start or stop your MoneyPlu$ 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 or Medical Spending Account must be consistent with the event that triggers the change. For example, you may wish to start a Dependent Care Spending Account if you have a baby or adopt a child. You may want to decrease your Medical Spending Account 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 Web site at www.eip.sc.gov and from your benefits administrator. If you wish to continue to have an EZ REIMBURSE® 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 to FBMC in a timely manner.** Any related claims you submit in the interim will be held until FBMC receives and processes the Change in Status Form. Some changes in status that permit changes to your account are:

- Marriage, legal separation, divorce
- Birth, placement for adoption, adoption
- Dependent becomes ineligible (by age, marriage, etc.)
- Death of spouse, dependent
- 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.

This is a partial list. For more information, contact your benefits administrator or call FBMC Customer Service 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 Accounts

If you leave your job **permanently** or take an **unpaid leave of absence**, you may continue your Medical Spending Account, through COBRA, until the end of the plan year, including the grace period, which is discussed on page 143. If, during the October enrollment period, you know the date you will be leaving your job, you can divide your MSA contribution by the number of paychecks you will receive. For example, if you are leaving your job at the end of June, you could have your contribution divided among half the number of your annual paychecks. You can also prepay your contribution on a pretax basis by having the remaining amount of your annual contribution withheld from your final paychecks. If you wish to continue your account, contact your benefits administrator within 31 days of the your last day at work and complete the appropriate forms.

If you choose not to continue your Medical Spending Account, you have 90 days, from your last day at work, to submit eligible Medical Spending Account expenses incurred before you left employment.

If you leave your job, your EZ REIMBURSE® Card will be canceled.

MoneyPlu$

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 Accounts

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.

APPEALS

If your request for a mid-plan-year election change, a MoneyPlu$ Spending Account reimbursement claim or a similar request 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 FBMC (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 FBMC receives it and its supporting documentation. 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.

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.

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, coupled with a Health Savings Account (HSA), to save money for qualified medical expenses.

Eligibility

To be eligible for a Health Savings Account, a subscriber must be covered by a high-deductible health insurance plan, such as the Savings Plan. He cannot be covered by any other health insurance, 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, active 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, an affiliate of Synovus Financial Corp., is the trustee for these accounts. The accounts are administered by Fringe Benefits Management Company (FBMC).

Please note: If you are **retired** and **eligible for Medicare,** you may not enroll in the Savings Plan or contribute to an HSA.

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. Then go to EIP's Web site, 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 for eligible retirees.

Complete the application. When you are finished, print and sign the application. Mail it to HSA Operations at the address 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 application.

If you don't have access to the Internet 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.

A MoneyPlu$ Medical Spending Account (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.*

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 has arranged with NBSC to allow HSA contributions to be deducted from monthly retirement checks and forwarded to NBSC.

Limited-use Medical Spending Account

If you have an HSA, you can also have a limited-use Medical Spending Account. 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 149 for more information.

If you enrolled in a full Medical Spending Account 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 2009, a subscriber with single coverage can contribute $3,000, and a subscriber who covers himself and any other family member can contribute $5,950. Total contributions for the entire year may not exceed these limits.

- For example, a subscriber with single coverage under the Savings Plan can contribute $3,000 to his HSA for the 12 months beginning January 1, 2009. Contributions may be paid in a lump sum, in equal amounts for 12 months (such as through payroll deduction with MoneyPlu$) or in any combination of payments during the year, as long as the total does not exceed $3,000.
- A subscriber with the same coverage who enrolls by December 1, 2009, may also contribute $3,000. However, he must remain eligible for a full 12 months after the end of the plan year. Contributions may be paid in a lump sum, in equal amounts during the months he is eligible (such as through payroll deduction with MoneyPlu$) or in any combination of payments during the year, as long as the total does not exceed $3,000.
- **A subscriber who had funds in a Medical Spending Account on December 31, 2008**, may not begin contributing to an HSA until the day after the end of the MSA run-out period, April 1, 2009. However, his maximum contribution would still be $3,000. Contributions may be paid in a lump sum, in equal amounts for nine months (such as through payroll deduction with MoneyPlu$) or in any combination of payments during the year, as long as the total does not exceed $3,000. He must remain eligible for 12 months after the end of the plan year.
- **A subscriber who had no funds in his MSA on December 31, 2008,** may make the maximum contribution to his HSA in 2009 and may begin contributing on January 1, 2009. Contributions may be paid in a lump sum, in equal amounts for 12 months (such as through payroll deduction with MoneyPlu$) or in any combination of payments during the year, as long as the total does not exceed $3,000.

Subscribers age 55 and older may make additional "catch-up" contributions to an HSA. The amount for 2009 is $1,000.

There is no minimum contribution, but remember that certain administrative fees will be deducted from your account. They include an FBMC 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

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.

The HSA Custodial Account disclosure statement and funds availability disclosure agreement is on pages 222-228 and is also posted on the EIP Web site. Information is also available by contacting FBMC at 800-342-8017 or at www.myFBMC.com. Information about the Savings Plan begins on page 33 of this guide.

General HSA information is available at www.hsainsider.com and www.irs.gov.

More information about the Savings Plan and the Health Savings Account offered through payroll deduction is available from your benefits administrator or from EIP at 803-734-0678 (Greater Columbia area) or 888-260-9430 (toll-free outside the Columbia area) or at www.eip.sc.gov.

Detailed information on the HSA associated with the Savings Plan is available from NBSC at www.nationalbanksc.com or 877-367-4472.

Contributions Over Federal Limits

FBMC will monitor your HSA contributions and send an alert to your benefits administrator if you are exceeding your contribution limit. NBSC also will send you periodic reminders to check your balance.

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 $3,000 for 2009. If you receive 24 paychecks each year, you could deduct $125 each pay period. If you have family coverage, you can deduct a maximum of $5,950 for 2009. If you receive 24 paychecks a year, you could deduct $247 (rounded) each pay period.

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 dependents. Medical expenses include the costs of diagnosis, cure, treatment or prevention of physical or mental defects or illnesses. For more information, check IRS Publication 502.

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.

One important difference between an HSA and an MSA is that on January 1, after annual 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. 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 FBMC, transferred to NBSC and deposited in your account. Deposits are sent from FBMC to NBSC twice a week. Funds should **generally** be available in your HSA no later than a week after pay date. Remember, this depends on when your employer submits the deductions and payroll reports to FBMC.

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.

For more information about your HSA, see the HSA Custodial Agreement on pages 222-228 and on the EIP Web site, www.eip.sc.gov. Choose your category, and select "Publications" and then "MoneyPlu$."

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.

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 10-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 FBMC 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.

*Contact NBSC at 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 2009 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 Medical Spending Account. The funds can accumulate and can be used for eligible medical expenses in the future.

If you establish an HSA through NBSC, an affiliate of Synovus Financial Corp., the money will first be invested in an interest-bearing checking account. When the balance in your account reaches $3,500, NBSC/Synovus will send you a letter offering you the opportunity to choose from among several Fidelity Investment® mutual funds. The letter will explain any fees and give you a toll-free number to call to request an enrollment package. If you decide to invest in a mutual fund, you must keep $1,000 in your HSA checking account.

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.

Portability

If you leave your job, you can take your HSA with you and continue to use it for qualified medical expenses.

Tax Reporting

After the year ends, NBSC will send you forms 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, because you may be 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.

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 FBMC 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 dependent spouse or dependent 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 151 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 pages 222-228 and on the EIP Web site, www.eip.sc.gov. Choose your category and select "Publications" and then "MoneyPlu$." To settle the account, contact NBSC.

MoneyPlu$

Retirement/ Disability Retirement

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Benefits for Retirees

This chapter provides useful information for eligible participants in the state insurance program who are considering retirement or who have already retired. For detailed information on specific programs, refer to the previous chapters in this guide. If you have questions or need additional information about your insurance, contact the Employee Insurance Program (EIP) through our Web site at www.eip.sc.gov or call 803-734-0678 (Greater Columbia area) or 888-260-9430 (toll-free outside the Columbia area).

A checklist that will help you find information about retiree insurance benefits is on page 25.

ARE YOU ELIGIBLE FOR RETIREE INSURANCE?

You may be eligible for health and dental coverage in retirement through an employer that participates in the state insurance program when you retire:

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

For more information about state retirement eligibility, call 803-737-6800 (Greater Columbia area) or 800-868-9002 (toll-free outside the Columbia area but within South Carolina) or visit the S.C. Retirement Systems Web site at www.retirement.sc.gov.

Regardless of how or when you qualify for retirement, to qualify for the retiree group insurance program, your last five years of employment must be served consecutively and in a full-time, permanent position with an employer that participates in the state insurance program.

Some retirees, who are referred to as "non-funded retirees," are eligible for insurance but must pay the full premium, which includes the retiree share plus the employer contribution. These retirees worked in an insurance-eligible position prior to May 2, 2008, with an employer participating in the state insurance program, and include:

- Employees who retire at age 55 with at least 25 years of retirement service credit (including at least 10 years of earned service credit with an employer that participates in the state insurance program). This is commonly referred to as the "55/25 rule." These retirees must pay the full insurance premium until they reach age 60 or the date they would have had 28 years of service credit, whichever occurs first. At the end of this period, they will be eligible for funded retiree rates. This rule applies only to SCRS participants. If you are retiring from a local subdivision, contact your benefits administrator for premium information.
- Employees who are eligible to retire and have at least five years, but fewer than 10 years, of earned SCRS service credit with a participating state insurance program employer.
- General Assembly members who leave office or retire with at least eight years of General Assembly Retirement System service credit.
- Former municipal and county council members who served on council for at least 12 years and were covered under the state's plan when they left the council. It is up to the county or municipal council to decide whether to allow former members to have this coverage.

If you are eligible for retiree insurance, you must enroll within 31 days of your date of eligibility. See page 163 for more information.

State Optional Retirement Program participants must meet the same retiree insurance eligibility guidelines as SCRS participants, with the exception of the 55\25 year rule.

Whether you are a funded or a non-funded retiree, the following types of service do not count toward your earned service credit requirement for insurance eligibility: non-qualified, federal, military, out-of-state employment, educational service, leave of absence, unused sick leave or service with employers that do not participate in the state insurance program.

If you are not eligible for insurance as a retiree, you may still be eligible to continue coverage under COBRA (see page 18).

TERI Program Participants:
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 benefits 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.

WHO PAYS FOR YOUR INSURANCE?

State Agency, Higher Education and 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:
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.**

A *local subdivision* is a public employer in South Carolina that falls within one of the categories established by Section 1-11-720 of the 1976 S.C. Code of Laws, as amended, (such as a city or county) and participates in the state insurance program.

Employees Hired Before May 2, 2008

If you worked in an insurance-eligible position prior to May 2, 2008, with an employer participating in the state insurance program, your health insurance benefits in retirement are eligible for funding if you fall into one of these categories:

- Employees who leave employment when they are eligible to retire and have at least 10 years of earned SCRS service credit with an employer that participates in the state insurance program.
- Employees who leave employment before they are eligible to retire and who have at least 20 years of earned SCRS service credit with an employer that participates in the state insurance program. These employees are not eligible for insurance coverage until age 60 when they are eligible to receive a retirement check. Employees who qualify under the Police Officers Retirement System (PORS) become eligible at age 55.
- Employees who left employment before 1990 and who were not eligible to retire, but who had 18 years of earned SCRS service credit and returned to work with a participating group, enrolled in a state health and dental plan, and worked for at least two consecutive years in a full-time, permanent position.

Employees Hired on or After May 2, 2008

New retiree insurance provisions were created by Act 195 of 2008 that apply to new employees hired **on or after May 2, 2008.** At retirement, you must meet established insurance eligibility rules, and 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.

These new funding provisions apply to SCRS, ORP, PORS, General Assembly Retirement System and Judges-Solicitors Retirement System participants.

Funded Retirees:
If an employee retires with **25 or more years** of earned service credit, the state pays 100 percent of the employer's share of the premium. The retiree pays the retiree's share.

If you have questions about your insurance benefits at retirement, contact your benefits administrator.

Partially Funded Retirees:
If an employee retires with **15 years, but fewer than 25 years**, of earned service credit, the state 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:
If an employee retires with **5 years, but fewer than 15 years**, of earned service credit, the retiree pays the full premium. There is no state contribution.

Retiree Premiums and Premium Payment

State Agency, Higher Education and School District Retirees:
Your health, State Dental Plan and Dental Plus premiums are deducted from your monthly SCRS pension check.

Tables showing retiree insurance premiums begin on page 200.

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.

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, State Dental Plan and Dental Plus premiums directly to your former employer, which remits them to EIP. Contact your benefits office for information about your insurance premiums in retirement.

ENROLL WITHIN 31 DAYS OF YOUR RETIREMENT

Your insurance will NOT be 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 to arrange for your retiree insurance and to complete the paperwork.** Please visit our office in Suite 300, 1201 Main St., Columbia, if you would like to see an EIP representative. We do not schedule appointments.

You may also request a retiree insurance enrollment packet by calling 803-734-0678 (Greater Columbia area) or 888-260-9430 (toll-free outside the Columbia area) or print forms from the EIP Web site, www.eip.sc.gov. Choose your category, "Retirees," and then "Forms."

You must complete the Retiree Notice of Election form and the Employment Verification Record. You may also need the Notice of Continuation of Coverage (Basic Life, Optional Life and Dependent Life) and the Group Life Insurance Portability Enrollment form.

HOW TO ENROLL

If you are an eligible retiree, you must enroll by completing a Retiree Notice of Election (NOE) form and an Employment Verification Record 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 or
- A *special eligibility situation*.

You may enroll yourself and any eligible dependents. (However, you are not required to cover the same eligible dependents as a retiree that you covered as an active employee.)

If you and/or your eligible dependents are **not covered by a state health plan** at the time of your retirement, you may enroll within 31 days of:

- Your retirement date or
- The date of the letter approving your disability retirement or
- The end of your TERI period or
- A *special eligibility situation*.

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, in retirement, is a member of your employer's human resource staff.

Special Eligibility Situations

A *special eligibility situation* is created by a qualifying event. It allows eligible employees and retirees to enroll in an insurance plan, or to make enrollment changes if requested within 31 days of the *qualifying event*. For more information, see pages 12-14.

Examples of a *qualifying event* include: marriage, birth, adoption or placement for adoption. Involuntary loss of other coverage is a qualifying event only for those who lost coverage.

You will be subject to *pre-existing condition* exclusions for 12 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. Those enrolling who have had a break in health coverage of more than 62 days will be subject to pre-existing condition exclusions for up to 12 months.

Late Entrants

If you and/or your dependents 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 every odd-numbered year (e.g., October 2009). Your coverage will take effect on the following January 1 (January 1, 2010), but, 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.

YOUR HEALTH PLAN CHOICES AS A RETIREE

If You Are Not Eligible for Medicare

If you and your covered dependents **are not** eligible for Medicare, you may be covered under one of these plans:

- The SHP Savings Plan (You may contribute to a Health Savings Account (HSA), but not through MoneyPlu$.*)
- The SHP Standard Plan
- An HMO offered in the county where you live. (See page 62 for counties where each HMO is available.)

Would you like to learn more about the pre-existing condition exclusion? See page 12.

***Please note:** If the retiree is not eligible for Medicare but the spouse is, the retiree can enroll in the Savings Plan and contribute to an HSA.

Your health benefits, which are described in a previous 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. Refer to pages 200-201 for premiums.

If You Are Eligible for Medicare

If you and/or your covered dependents **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 62 for counties where each HMO is available.)

This section provides details on the benefits available to you. Please note that if you are retired and eligible for Medicare, you may not enroll in the Savings Plan, and you cannot contribute to a Health Savings Account associated with the Savings Plan.

WHEN YOUR COVERAGE AS A RETIREE BEGINS

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 qualifying event or the first of the month after the qualifying event, depending on the event. 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 Insurance Identification Card in Retirement

Keep your identification card if you do not change plans when you retire. You and your covered dependents may not receive new cards at retirement if you remain covered under any State Health Plan option or the State Dental Plan and Dental Plus. You will receive a new health identification card if you are changing from an HMO to any State Health Plan option or vice versa and/or if you enroll in the State Dental Plan or Dental Plus for the first time. If your card is lost, stolen or damaged, you may request a new card from EIP or from these third-party administrators:

- State Health Plan — BlueCross BlueShield of South Carolina
- HMOs — CIGNA HealthCare or BlueChoice HealthPlan
- Dental Plus — BlueCross BlueShield of South Carolina.

Contact information for the third-party administrators is on the inside cover of this guide.

Decreasing Coverage

If a covered spouse or dependent child becomes ineligible, you must drop him from your health and/or dental coverage. This may occur because of divorce or separation, a child 19 through 24 is no longer a full-time student, a child turns 25, a child marries or a child is no longer principally dependent (more than 50 percent) on you for support. If you drop a dependent from your coverage, you must complete an NOE within 31 days of the date he becomes ineligible.

MyBenefits, EIP's on-line enrollment system, is available to retirees. To learn more, see page 24.

RETURNING TO EMPLOYMENT AFTER RETIREMENT

If you or your dependents are 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.

As long as you or any of your dependents 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 dependents 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
- Basic and Supplemental Long Term Disability coverage
- $3,000 Basic Life benefit
- Optional Life Insurance
- Dependent Life Insurance.

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 to enroll in Medicare Part A and Part B and to ensure that Medicare will begin on the same date as your retiree group coverage.

If you prefer to continue your retiree group insurance benefits, you must complete and sign an **Active Group Benefits Refusal** form.

IF YOU OR YOUR COVERED DEPENDENTS ARE ELIGIBLE FOR MEDICARE

If you or any of your dependents are, or become, eligible for Medicare, federal law requires that Medicare no longer be your primary payer while employed. To comply with this federal 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 plans 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 elect to retain your Medicare Part B enrollment and continue paying the premium, even though Medicare is a secondary payer, since Medicare imposes late-enrollment premium penalties if you had Part B before and decide to drop it. 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 you carried your Optional Life coverage into retirement and/or converted your Dependent Life coverage and are billed by The Hartford, you must decide if you want coverage as a retiree or as an active employee. You cannot have both.

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:

- The day after your death
- The date it ends for all employees and retirees
- If you do not pay the required premium when it is due.

Dependent coverage will end:

- The date your coverage ends
- The date dependent coverage is no longer offered
- The last day of the month your dependent is no longer eligible for coverage. If your dependent's coverage ends, he may be eligible for continuation of coverage under COBRA (see page 18).

If you are dropping a dependent from your coverage, you must complete a Notice of Election (NOE) form within 31 days of the date the dependent 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 or a dental 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, 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.

State Dental Plan and Dental Plus premiums are not waived. However, survivors can continue dental coverage by paying the full premium.

As a surviving spouse, you can continue coverage until you remarry. If you are a dependent child, you can continue coverage until you are no longer eligible as a dependent. 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.

If you were first hired on or after May 2, 2008, the new funding provisions created by Act 195 of 2008 for retiree insurance benefits will also apply to your survivor's benefits in retirement. See page 20 or contact your BA for more information.

As long as a survivor remains covered by health or dental insurance, he can add either at open enrollment. If he has health and dental and drops both, he is no longer eligible as a survivor and cannot re-enroll in coverage, even at open enrollment.

For a checklist of information that may be helpful when a loved one dies, see page 26.

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 termination, if he has not remarried.

When You or Your Dependents Become Eligible for Medicare

About Medicare

Medicare includes *Part A*, *Part B and Part D*. To find out more:

- Read *Medicare & You 2009.*
- Visit the Medicare Web site at www.medicare.gov.
- Call Medicare at 800-633-4227 or 877-486-2048 (TTY).

Medicare Part A

Part A is your 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 your 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 2009, it is $1,068. Part A also covers hospice care and some home healthcare. You must meet certain requirements to be eligible for Part A. Contact Medicare for additional information.

Medicare Part B

Part B is your medical insurance. Most people do pay a premium through the Social Security Administration for Part B. It helps cover doctors' services and outpatient hospital care. It also covers 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 2009, the Part B deductible is $135 a year.

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 dependent of a retiree. Medicare becomes your primary insurance, and your retiree group insurance 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.**

Medicare Part D
Most subscribers covered by the Standard Plan, the Medicare Supplemental Plan or the health maintenance organizations offered through EIP should not sign up for Medicare Part D.

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 expenses will continue to be reimbursed 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. There is a copy of the letter on pages 219-221 (If you become eligible for Medicare before age 65, the letter will not be sent to you.)

If you or your eligible dependent 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.

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 does offer 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 Web site 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 both parts of Medicare, you will be required to pay the portion of your healthcare costs that Medicare would have paid.**

IF YOU OR ONE OF YOUR DEPENDENTS BECOME ELIGIBLE FOR MEDICARE due to age or disability, 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 dependent(s) became eligible for Medicare.**

Medicare Before Age 65: Disability Retirees

If you or your spouse 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 submit 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 that Part B would have paid.**

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.

If you are covered under the Savings 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 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. 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 dependents.)

The coordination period applies whether you are an active employee, a retiree, a survivor or a covered dependent 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-months 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 that Medicare would have paid.**

Medicare's Initial Enrollment Period starts three months before the month you turn age 65 and extends three months past the month you turn 65. If you are not receiving Social Security benefits, you should inquire about filing for 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 and Part B start 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.

When you enroll in Medicare, you should notify EIP and send in a copy of your Medicare card.

If You Are an Active Employee at Age 65

If you are actively working and/or covered under a state health plan for active employees, you may defer 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.

Social Security has a special enrollment rule for employees ending active employment after age 65. You should contact the Social Security Administration within 90 days of your retirement date to ensure that your Medicare Part A and Part B coverage begins on the same date as your retiree coverage.

Remember: Within 31 days of retirement, you must sign up for Part A, and it is strongly advised that you enroll in Part B because Medicare becomes your primary coverage.

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 that Medicare Part B would have paid.

How Medicare Affects COBRA Coverage

If you or your eligible dependent 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 dependent who is covered by Medicare and then becomes eligible for COBRA can enroll in COBRA for secondary coverage. Medicare will be his primary coverage.

Medicare Assignment: How Medicare Pays Its Share of the Cost of Your Care

Under Medicare assignment, the Medicare subscriber agrees to have Medicare's share of the cost of services paid directly ("assigned") to a provider. Participating providers have agreed to submit all of their Medicare claims on an assigned basis. Non-participating providers may choose whether to accept assignment on each individual claim. If you receive services from a non-participating physician, ask if he will accept assignment.

Each year, doctors and suppliers have the opportunity to participate in Medicare. After you meet your deductible and pay your coinsurance, if it applies, doctors and suppliers participating in the program will accept the Medicare-approved amount as payment in full. If a doctor does not accept assignment, you may pay more for his services.

If a doctor decides to participate, 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.

YOUR HEALTH OPTIONS WITH MEDICARE

When you and/or your eligible dependents 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 dependents a choice of the Standard Plan, the Medicare Supplemental Plan, CIGNA Healthcare HMO or BlueChoice HealthPlan. (To enroll in an HMO, it must be offered in the county in which 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 letter by choosing another plan. Coverage changes must be made within 31 days of the date you become eligible for Medicare.

If you are enrolled in the Medicare Supplemental Plan, the claims of your eligible dependent(s) without Medicare are paid through the Standard Plan's provisions.

The Savings Plan is not available to you if you are retired and eligible for Medicare.

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 or vice versa. Plan changes are effective on January 1 after the enrollment period.

This section explains the Medicare Supplemental Plan, which is available to retirees and covered dependents 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.** For more information, visit www.medicare.gov or call 800-633-4227.

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 173-175, 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 drugs that a person usually administers to himself, 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.

Would you like more information about your health insurance choices when you become eligible for Medicare? See the charts on pages 190-193.

Using Medi-Call
Medicare has its own program for reviewing use of its services. You need to call Medi-Call 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.

Note: *Any covered family members who are not eligible for Medicare and whose claims are processed under the Standard Plan must call Medi-Call.*

MEDICARE DEDUCTIBLES AND COINSURANCE

Deductibles

Medicare Part A has an inpatient hospital deductible for each *benefit period*. That deductible for 2009 is $1,068. 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 $135 a year in 2009. 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 (50 percent for outpatient mental healthcare). *The Medicare Supplemental Plan pays the remaining 20 percent (50 percent for outpatient mental healthcare).*

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 become eligible for Medicare and change to the Medicare Supplemental Plan during the year, you must meet a new $200 deductible for private duty nursing services. You do not have to meet another $200 deductible for private duty nursing services if you remain enrolled in the Standard Plan.

WHAT THE MEDICARE SUPPLEMENTAL PLAN COVERS

Hospital Admissions

The Medicare Supplemental Plan pays these expenses for Medicare-covered services after Medicare Part A benefits have been paid during a benefit period:

- The Medicare Part A hospital deductible
- The coinsurance, after Medicare pays, for days 61-150 of hospitalization, up to the Medicare-approved amount (Medicare pays 100 percent for the first 60 days)
- 100 percent of the Medicare-approved amount for hospitalization through 60 days if you have used up your lifetime reserve and if medically necessary*
- The coinsurance for durable medical equipment up to the Medicare-approved amount.

**Must call Medi-Call or APS for approval.*

Additional Days in a Hospital

If you are enrolled in Medicare, Medicare is the primary payer, and you may go to any hospital you choose. However, Medicare pays nothing for hospital stays beyond 150 days.

If You Exceed the Number of Inpatient Hospital Days Allowed Under Medicare
If you are enrolled in the Medicare Supplemental Plan and you exhaust all Medicare-allowed inpatient hospital days, you must call Medi-Call for approval of any additional inpatient hospital days. If your extended stay is approved, the Medicare Supplemental Plan will pay for the Medicare-approved expenses. So, if you are enrolled in the Medicare Supplemental Plan and you think your hospital stay may exceed the number of days allowed under Medicare, you should choose a hospital within the SHP network or BlueCard Program so that any days beyond what Medicare allows will be covered by the Medicare Supplemental Plan.

You must also call Medi-Call 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 Medicare-approved rates beyond 100 days in a skilled nursing facility if medically necessary. (Medicare does not pay beyond 100 days.)* The maximum benefit per year for covered services beyond 100 days is $6,000.

**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, 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 injury, 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 or $5,000 per benefit year, whichever occurs first. 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, managed by Medco. For more information, see pages 53-57.

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 subscribers.

Mental Health and Substance Abuse Services

If your claims are processed under the Medicare Supplemental Plan, you are encouraged, but not required, to call APS, the SHP's behavioral health manager, because Medicare guidelines will apply. However, if you exhaust Medicare's allowed inpatient hospital days, you must call APS for approval of any additional inpatient hospital days, including those in Veterans Administration hospitals. However, you are not required to use an APS network provider.

Note: *Any covered family members who are not eligible for Medicare and whose claims are processed under the Standard Plan must call to register with APS and must use an APS network provider.*

Pap Test Benefit

If you are enrolled in Medicare, Medicare covers a Pap test, pelvic exam and clinical breast exam every other year. (These tests are covered yearly if you are at high risk. Check with Medicare for more information.) Medicare pays 100 percent for the Pap lab test and 80 percent of the Medicare-approved amount for the Pap test collection and the pelvic and breast exam. The Medicare Supplemental Plan pays the 20 percent coinsurance.

Medicare Assignment: How Medicare Pays Its Share of the Cost of Your Care

If the provider accepts Medicare assignment, the provider accepts Medicare's payment plus the Medicare Supplemental Plan's payment as payment in full. 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
-1,068	Medicare Part A deductible for 2009
$6,432	Medicare payment
$1,024	Balance of the bill

Next, the Medicare Supplemental Plan benefits are applied:

$1,068	Balance of the bill
-$1,068	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 your primary insurance. In most cases, your provider will file your Medicare claims.

Claims Filed in South Carolina

The Medicare claim should be filed first. Claims for Medicare-approved charges incurred in South Carolina should be transferred automatically from Medicare to the SHP. Your mental health and substance abuse provider should file claims to APS with Medicare payment information. 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, claims administrator for the SHP, a claim form and a copy of your Medicare Summary Notice with your Benefits ID Number or Social Security Number written on it.

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 Medicare Summary Notice you must send it to BCBSSC for medical or surgical services or to APS for mental health and substance abuse services. You also must include a claim form and an itemized bill.

Railroad Retirement Board (RRB) Claims

If you receive benefits from the RRB, you must first file claims with the RRB. When you get an explanation of benefits, mail it, along with an itemized bill and claim form, to BCBSSC for processing.

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 or APS Healthcare.

THE STANDARD PLAN

The SHP 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 healthcare. **You must also call APS Healthcare, Inc., the SHP's behavioral health manager, for preauthorization before you receive mental health or substance abuse care.**

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 your claims. It is described on page 178.

HOW THE STANDARD PLAN AND MEDICARE WORK TOGETHER

Using Medi-Call as a Retiree

Medicare has its own program for reviewing use of its benefits. However, you still need to call Medi-Call 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 facilities, private duty nursing, home healthcare, durable medical equipment and Veterans Administration hospital services.

Note: Any covered family members who are not eligible for Medicare and have their claims processed under the Standard Plan must call Medi-Call.

Please remember that while your physician or hospital may call Medi-Call for you, it is your responsibility to see that the call is made.

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. *Note: Mental health and substance abuse services are covered only at APS Healthcare, Inc., network facilities.*

You must also call Medi-Call for approval of any additional inpatient 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.

Private Duty Nursing if You Have Medicare

Medicare does not cover private duty nursing. However, the Standard Plan does cover medically necessary, intermittent private duty nursing services. The regular coinsurance rate and the deductible, if you have not satisfied it, apply for approved charges. Remember to call Medi-Call for private duty nursing services.

When Traveling Outside South Carolina

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. If you are admitted to a hospital outside the state or the country as a result of an emergency, notify Medi-Call and follow the BlueCard guidelines. For more information, see page 36.

Mental Health and Substance Abuse: Using APS as a Retiree

If you are enrolled in Medicare and covered under the Standard Plan, you must call APS Healthcare, Inc., the SHP's behavioral health manager, at 800-221-8699 for approval of inpatient hospital stays. Preauthorization and continued-stay authorizations by APS are required for inpatient care, including care in a Veterans Administration hospital. If your Medicare benefits are exhausted, you must call APS to receive authorization for continued benefits under the Standard Plan. To receive benefits, you must use an APS network provider.

For information about services that require preauthorization under the State Health Plan, see
- **Medi-Call: page 39**
- **APS: page 57.**

Note: Any covered family members who are not eligible for Medicare and have their claims processed under the Standard Plan must also call to register with APS and use an APS network provider.

Prescription Drug Program

The Standard Plan covers prescription drugs when purchased from a participating pharmacy. Please refer to page 53 for more information on the State Health Plan Prescription Drug Program.

Ambulatory Surgical Center Network

These facilities provide some of the same services offered in the outpatient department of a hospital. 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 Testing 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 365 days if you are age 40-74. There is no charge if you use a facility that participates in the program's network.

Medicare allows a routine mammogram every 12 months for women ages 40 and older and pays 80 percent of Medicare-approved amount. Check with the testing facility to see if it accepts Medicare 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 other year*. (If you are at high risk, you may have one yearly. Check with Medicare for more information.) Medicare pays 100 percent for the test, 80 percent for the exam and collection. Please note that the Standard Plan will pay for Pap tests every year.

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 dependent children.) Covered dependent children ages 18 and younger are eligible for Well Child Care check-ups. On page 52 of the SHP section is a schedule of routine immunizations for which the plan pays 100 percent 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 the vaccines listed.

"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 allows, 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
- 1,068	Medicare Part A deductible for 2009
$6,432	Medicare payment
$1,068	Balance of the bill

Next, Standard Plan benefits are applied to the Medicare-approved amount:

$7,500	SHP allowable charge
- 350	Standard Plan deductible for 2009
$7,150	Standard Plan's responsibility after deductible
x 80%	Standard Plan coinsurance
$5,720	Standard Plan payment
- 6,432	Medicare payment is "carved out" of the Standard Plan payment.
$ 0	Standard Plan pays nothing. You pay $1,068.

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 $1,068, so you pay the lesser amount, $1,068.

Once you reach your $2,000 coinsurance maximum, all claims will be calculated at 100 percent of the allowable charge 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

If you are retired and enrolled in Medicare, Medicare is your primary carrier. 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 charges incurred in South Carolina should be transferred automatically from Medicare to the SHP. Your mental health and substance abuse provider should file your claims with APS, including Medicare payment information. 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, claims administrator for the SHP, a claim form and a copy of your Medicare Summary Notice (MSN), with your Benefits Identification Number or Social Security Number written on it.

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, claims administrator for the SHP, a claim form and a copy of your MSN, with your Benefits Identification Number or Social Security Number written on it. For mental health and substance abuse claims, you must send your MSN to APS Healthcare, Inc.

If Medicare Denies Your Claim

If Medicare denies your claim, you are responsible for filing the denied claim to BCBSSC. You may use the same SHP claim form active employees use. These forms are available on the EIP Web site, www.eip.sc.gov, or from EIP or BCBSSC. You will need to attach your MSN and an itemized bill to your claim form.

Railroad Retirement Board (RRB) Claims

If you receive benefits from the RRB, you must first file claims with the RRB. When you get an explanation of benefits, mail it, along with an itemized bill and claim form, to BCBSSC for processing.

HMO PLANS

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. Not all HMOs are available in all South Carolina counties. A list of counties where each HMO is offered is on page 62.

IF YOU ARE ELIGIBLE FOR MEDICARE

BlueChoice HealthPlan and CIGNA HMO are available if you live in a county where they are offered. This section will focus on these plans.

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. If you receive care outside the network, benefits are not paid. 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 HealthPlan 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

Each HMO offered for 2009 includes a prescription drug program with participating pharmacies.

HOW BLUECHOICE HEALTHPLAN AND MEDICARE WORK TOGETHER

BlueChoice HealthPlan 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 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 dependent 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 HealthPlan 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 HealthPlan's as payment in full. If a provider does not accept Medicare assignment, the provider may charge more than what Medicare and BlueChoice HealthPlan 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
-1,068	Medicare Part A deductible for 2009
$6,432	Medicare payment
$1,068	Balance of the bill

BlueChoice HealthPlan pays all Medicare deductibles and coinsurance:

$1,068	BlueChoice HealthPlan pays Medicare Part A deductible
+6,432	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.

Additional information about BlueChoice HealthPlan is in the HMO section of the Health Insurance chapter of this guide.

HOW CIGNA HMO AND MEDICARE WORK TOGETHER

CIGNA HMO pays the lesser of the subscriber's unreimbursed allowable charge under Medicare or CIGNA's normal liability. If the balance due on the claim is less than the normal liability, CIGNA will pay the balance due.

CIGNA's benefit credit saving provisions apply. A *benefit credit* is the portion 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 additional information.

Example:

Medicare is primary. The bill is submitted to Medicare for a January hospital admission:

$7,500	Hospital bill
- 1,068	Medicare Part A deductible for 2009
$6,432	Medicare payment
$1,068	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
- 1,068	Amount paid by CIGNA in coordination with Medicare
$4,532	Benefit credit savings with CIGNA

Filing Claims as a Retiree

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.

For more information, contact CIGNA.

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 page 161). Coverage is not automatic. To maintain continuous coverage, you must file a Retiree Notice of Election (NOE) 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 are not eligible for retiree insurance, you may request COBRA continuation coverage within 60 days of loss of coverage or notification of the right to continue coverage, whichever is later.

If you enroll in the State Dental Plan or Dental Plus, you may not drop that coverage until the next open enrollment period, which will be in October 2009, or until you become eligible to change your 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 2009). 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 81-90.

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 151 for more information. If you wish to continue your account, contact your benefits administrator 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 expense 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, 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.

Prudential Insurance Company is now EIP's LTC insurer. If you have questions, contact customer service at 877-214-6588 or LTC4me@prudential.com.

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 SHP nor Medicare covers custodial care services. 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 130 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 204-205. Beginning January 1, 2009, LTC insurance premiums will no longer be available for payroll/pension deduction under the EIP. Retirees and qualified family members can select a direct billing method, which provides discounts for semi-annual (2.83 percent) and annual (5.58 percent) payments. You may also select the monthly Electronic Funds Transfer (EFT) option and have the premium withdrawn automatically from your checking or savings account.

LIFE INSURANCE

You may want to think about your life insurance needs in retirement. If you continue or convert your policy, your premiums may increase.

$3,000 BASIC LIFE INSURANCE

This benefit 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

You can carry your Optional Life Insurance into retirement through The Hartford. Here are your options.

Service Retirement

If you retired on or after January 1, 2001, you have two options: you can Port your Life Insurance coverage or you can Convert your Life Insurance coverage. You may continue your coverage in $10,000 increments up to the final face value of coverage.

1. Portability
You may continue your Optional Life coverage at the same rates you paid while you were an employee. Your coverage will reduce by 35 percent at age 70 and then terminate at age 75. When your amount either reduces or terminates, you can Convert the amount of reduced or lost coverage as described in Section 2 below. Portability is term life insurance.

2. Conversion
You may Convert your Optional Life coverage to an individual whole life policy.

You may also split your coverage between individual whole life insurance (Conversion) and term life insurance (Portability).

To continue your coverage, you must complete the required enrollment forms within 31 days of your date of retirement. If you have questions about continuing your coverage as a retiree, contact your benefits office or EIP.

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 indicated above.

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.

Premiums are on pages 206-209.

Disability Retirement

If you become totally disabled while covered as an active employee, your life insurance will be continued for up to 12 months from the first of the month following the last day you are physically at work, provided:

- Your total disability began while you were covered by this Optional Life Insurance plan
- Your total disability began before you reached age 69 and
- The group Optional Life Insurance policy does not end.

Your premiums will be waived for up to 12 months from the first of the month following the last day you were physically at work as long as you are totally disabled. The 12-month waiver period begins the first of the month following your last day physically at work. For your premiums to be waived, you must provide proof of disability to your benefits administrator within one year after the last day you were physically at work. Your benefits administrator must submit the Optional Life waiver form to start the waiver.

Retiree life insurance coverage does not include the Living Benefit Option, the Accidental Death and Dismemberment Option or the Europ Assistance Program.

If you return to work during the 12-month waiver period and work one full week, the premium waiver period ends. If you must leave employment again due to total disability, the 12-month waiver will start over from the last day you were physically at work.

If you wish to continue coverage, you must file for continuation through The Hartford within 31 days of the date your 12-Month Waiver period ends. Your options at this point are Portability and Conversion, which are discussed above. Contact your benefits office for additional information.

Premiums are on pages 206-209.

DEPENDENT LIFE INSURANCE

Any Dependent Life Insurance coverage you have will end when you leave active employment. Your covered dependent may convert the insurance coverage to an individual policy. The dependent must apply to The Hartford, in writing, within 31 days of the date of coverage ends and pay the required premiums.

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.

BASIC LONG TERM DISABILITY

This benefit may not be continued or converted to an individual policy.

SUPPLEMENTAL LONG TERM DISABILITY

Generally, you may not continue Supplemental Long Term Disability coverage in retirement. However, if you are retiring or leaving employment, but plan to be self employed or work for an employer that does not have a supplemental long term disability program, see page 124 for information about continuing coverage.

THE VISION CARE DISCOUNT PROGRAM

This discount program is available to retirees, as well as to full-time and part-time employees, dependents, survivors and COBRA subscribers. Refer to page 22 for more information.

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 choose 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**	
Hospitalization/ Emergency Care	No per-occurrence deductibles or copays		Outpatient hospital: **$75** per-occurrence deductible Emergency care: **$125** per-occurrence deductible	
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)
Physicians Office Visits	Chiropractic benefits limited to **$500** a year, per person, after deductible		**$10** per-occurrence deductible, then:	
	No per-occurrence deductibles		Plan pays 80% You pay 20%	Plan pays 60% You pay 40%
	Plan pays 80% You pay 20%	Plan pays 60% You pay 40%		
Prescription Drugs	Participating pharmacies and mail order only: You pay 100% of the plan's allowable charge until the annual deductible is met. Afterward, the plan will reimburse 80% of the allowable charge. The remaining 20% will be credited to your coinsurance maximum.		Participating pharmacies only (up to 31-day supply): **$10** Tier 1 (generic—lowest cost), **$25** Tier 2 (brand—higher cost), **$40** Tier 3 (brand—highest cost) Mail order (up to 90-day supply): **$25** Tier 1, **$62** Tier 2, **$100** Tier 3 Copay maximum: **$2,500**	
Mental Health/ Substance Abuse	Participating providers only. Call 800-221-8699. Subject to above deductibles and coinsurance.		Participating providers only. Call 800-221-8699. Subject to above deductibles and coinsurance.	
Lifetime Maximum	**$1,000,000**		**$1,000,000**	

[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 just a summary of your benefits. More information is available earlier in the Retirement/Disability*

and Dependents NOT Eligible for Medicare

	HMOs	
	All care must be directed by a primary care physician (PCP) and approved by the HMO.	
	BlueChoice HealthPlan	**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 copays)	None
	Inpatient: **$200** copay Outpatient: **$100** copay/first 3 visits Emergency care: **$125** copay HMO pays 90% after copays and deductible. You pay 10% **$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
	HMO pays 90% after deductible and copays You pay 10%	HMO pays 80% after copays You pay 20%
	$1,500 **$3,000** (excludes deductibles)	**$2,000** **$4,000** (includes inpatient and outpatient copays and 20% coinsurance)
	$15 PCP copay **$15** OB/GYN well woman exam **$30** specialist copay	**$15** PCP copay **$15** OB/GYN exam **$30** specialist copay
	Participating pharmacies only (up to 31-day supply): **$7** generic, **$35** preferred brand, **$55** non-preferred brand, **$100** specialty pharmaceuticals Mail order (up to 90-day supply): **$14** generic, **$70** preferred brand, **$110** 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 90% Outpatient: **$30** specialist copay	Participating providers only. Inpatient: **$500** copay, then 80% covered Outpatient: **$30** specialist copay
	$1,000,000	**$1,000,000**

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 required)	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call required)
Skilled Nursing Care	Plan pays 80% You pay 20% up to **$6,000** or 60 days, whichever is less (Medi-Call required)	Plan pays 80% You pay 20% up to **$6,000** or 60 days, whichever is less (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	**$5,000** or 100 visits, whichever is less, if Medi-Call approved	**$5,000** or 100 visits, whichever is less, if Medi-Call approved
Hospice Care	**$6,000** lifetime maximum, including **$200** bereavement counseling	**$6,000** lifetime 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/Hearing Aid	None, except for prosthetic lenses from cataract surgery Discount under the Vision Care Program	None, except for prosthetic lenses from cataract surgery Discount under the Vision Care Program

[1]*Semi-private room and board, physician/surgeon charges, operating/delivery room and recovery room, general nursing and*

WHEN YOU OR YOUR ELIGIBLE DEPENDENTS BECOME ELIGIBLE FOR MEDICARE due to age or disability, 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 dependents 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 dependent 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.

and Dependents NOT Eligible for Medicare

	BlueChoice HealthPlan	CIGNA HMO
	Plan pays 90% You pay 10% with a **$200** copay and coinsurance	Plan pays 80% You pay 20% with **$500** copay and coinsurance maximum
	Plan pays 90% You pay 10% up to 120 days	Plan pays 80% You pay 20% up to 180 days
	Plan pays 90% You pay 10% up to 60 days	Plan pays 100%
	Plan pays 90% You pay 10%	Plan pays 100% up to 60 visits
	Plan pays 90% You pay 10%	Inpatient: Plan pays 80%, you pay 20% Outpatient: Plan pays 100%
	$5,000 maximum Plan pays 90% You pay 10%	**$3,500** maximum 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% You pay **$15** copay
	Plan pays 90% You pay 10%	Plan pays 80% You pay 20%
	One exam for glasses or contacts per year (**$45** copay for contacts exam). One pair glasses every other year (from designated selection)	One exam every two years (**$10** copay) Must use a participating provider

miscellaneous hospital services and supplies.

Comparison of Health Plans for Retirees

Type			PPO	
			To receive a higher level of benefits, subscribers should choose an in-network provider.	
Plan	**Medicare**	**Medicare Supplemental**	**SHP Standard Plan**	
Availability	United States (Contact Medicare for information about any services outside the United States)	Same as Medicare	Coverage worldwide	
Cancellation Policy	None	Canceled upon request or for failure to pay premiums	Canceled upon request or for failure to pay premiums	
Annual Deductible	Part A: **$1,068** (per benefit period) Part B: **$135**	Pays Medicare Part A and Part B deductibles	**$350** (single) **$700** (family) Carve-out method applies	
Per-occurrence Deductible	Inpatient hospital: Part A deductible (**$1,068** 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: **$75** deductible Emergency care: **$125** deductible (Call Medi-Call for hospital stays over 150 days, skilled nursing, private duty 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	Plan pays 80% You pay 20% Routine annual physicals and OB/GYN exams not covered	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): **$10** Tier 1 (generic—lowest cost), **$25** Tier 2 (brand—higher cost), **$40** Tier 3 (brand—highest cost) Mail-order (up to 90-day supply): **$25** Tier 1, **$62** Tier 2, **$100** Tier 3 Copay max: **$2,500**	Participating pharmacies only (up to 31-day supply): **$10** Tier 1 (generic—lowest cost), **$25** Tier 2 (brand—higher cost), **$40** Tier 3 (brand—highest cost) Mail order (up to 90-day supply): **$25** Tier 1, **$62** Tier 2, **$100** Tier 3 Copay max: **$2,500**	
Mental Health/ Substance Abuse	Inpatient: Plan pays 100% for days 1-60 (Part A deductible applies); You pay **$267**/day for days 61-90; You pay **$534**/day for days 91-150 (subject to 60 lifetime reserve days); You pay all costs after 150 days. Outpatient: Plan pays 50% (Part B deductible applies)	Inpatient: Plan pays Medicare deductible; **$267** coinsurance for days 61-90; **$534** coinsurance for days 91-150; 100% after 150 days (APS approval required). Outpatient: Plan pays Medicare deductible, 50% coinsurance	Carve-out method applies Plan allows 80% in-network (APS participating providers only if hospital stay exceeds 150 days)	
Lifetime Maximum	**None**	**$1,000,000**	**$1,000,000**	

and Dependents Eligible for Medicare

	HMOs	
	All care must be directed by a primary care physician (PCP) and approved by the HMO.	
	BlueChoice HealthPlan	**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 upon request or for failure to pay premiums	Canceled upon request or for failure to pay premiums
	Pays Medicare Part A and Part B deductibles	No deductible; Pays lesser of unreimbursed Medicare-allowed expenses 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 expenses or plan's normal benefit
	Pays Part B coinsurance of 20%	Plan pays lesser of unreimbursed Medicare-allowed expenses 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 expenses or plan's normal benefit
	Participating pharmacies only (up to 30-day supply): **$7** generic **$35** preferred brand **$55** non-preferred brand **$100** specialty pharmaceuticals Mail order (up to 90-day supply): **$14** generic **$70** preferred brand **$110** 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 No copay max
	Inpatient: Plan pays Medicare deductible; **$267** coinsurance for days 61-90; **$534** coinsurance for days 91-150; 100% beyond 150 days Outpatient: Plan pays Medicare deductible, 50% coinsurance	Participating providers only: **$30** copay per office visit Inpatient: **$500** copay per admission, then 80% Plan pays lesser of unreimbursed Medicare-allowed expenses or plan's normal benefit
	$1,000,000	**$1,000,000**

Comparison of Health Plans for Retirees

Plan	Medicare	Medicare Supplemental	SHP Standard Plan
Inpatient Hospital Days	Plan pays 100% for days 1-60 (Part A deductible applies); You pay **$267**/day for days 61-90; You pay **$534** for days 91-150 (subject to 60 lifetime reserve days); You pay all costs beyond 150 days	Plan pays: Medicare deductible; **$267** coinsurance for days 61-90; **$534** coinsurance for days 91-150; 100% beyond 150 days (Medi-Call approval required)	Carve-out method applies Plan allows 80% (Call Medi-Call if hospital stay exceeds 150 days)
Skilled Nursing Care	Plan pays 100% for days 1-20; You pay **$133.50** for days 21-100	Plan pays **$133.50** for days 21-100; Plan pays 100% beyond 100 days (Medi-Call approval required) up to **$6,000** or 60 days, whichever is less	Carve-out method applies Plan allows 80%, up to **$6,000** or 60 days, whichever is less. (Call Medi-Call 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	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call approval required)
Home Healthcare	Plan pays 100%	Medi-Call available to assist with referrals Up to **$5,000** or 100 visits, whichever is less	Carve-out method applies Plan allows 80% You pay 20% up to **$5,000** or 100 visits, whichever is less
Hospice Care	Plan pays 100%	Medi-Call available to assist with referrals	Medi-Call available to assist with referrals
Durable Medical Equipment	Plan pays 80% (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	Age 40 and older, one every 12 months. Plan pays 80% You pay 20%	Plan pays 20% coinsurance	Ages 35-74 at participating facilities only; guidelines apply
Pap Test	Routine every two years (yearly if high risk) Plan pays 100% for Pap test Plan pays 80% for exam	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	Plan pays 80% You pay 20%	Plan pays 20% coinsurance	Carve-out method applies Plan allows 80%
Eyeglasses/ Hearing Aid	None, except for prosthetic lenses from cataract surgery. Discount under the Vision Care Program	None, except for prosthetic lenses from cataract surgery. Discount under the Vision Care Program	None, except for prosthetic lenses from cataract surgery. Discount under the Vision Care Program

WHEN YOU OR YOUR ELIGIBLE DEPENDENTS BECOME ELIGIBLE FOR MEDICARE due to age or disability, 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 dependents 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 dependent 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.

and Dependents Eligible for Medicare

	BlueChoice HealthPlan	CIGNA HMO
	Plan pays: Medicare deductible; **$267** coinsurance for days 61-90; **$534** coinsurance for days 91-150; 100% beyond 150 days	Plan pays 80% or unreimbursed Medicare-allowed expenses after **$500** copay
	Plan pays **$133.50** for days 21-100; Plan pays 100% beyond 100 days (limited to 120 days)	Plan pays 80% or unreimbursed Medicare-allowed expenses, up to 180 days
	Plan pays 80%; You pay 20% and **$200** annual deductible **$5,000** annual maximum **$25,000** lifetime maximum (limited to 120 days)	Plan pays 100%
	(Medicare pays 100% of covered charges)	Plan pays 100% or unreimbursed Medicare-allowed expenses, 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 expenses or plan's normal benefit
	Plan pays 20% coinsurance	**$3,500** maximum Plan pays 100% or unreimbursed Medicare-allowed expenses
	Plan pays 20% coinsurance	Plan pays 100% or unreimbursed Medicare-allowed expenses
	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 expenses after **$15** copay
	Plan pays 20% coinsurance	Plan pays 80% or unreimbursed Medicare-allowed expenses
	One exam for glasses or contacts per year (**$45** copay for contacts exam). One pair of glasses every other year (from designated selection)	One exam every two years (**$10** copay) Must use a participating provider

Please note: *This chart is just a summary of your benefits. Please consult the previous sections of the Retirement/Disability Retirement chapter, the Health Insurance chapter, your health insurance plan or Medicare for details.*

Premiums

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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*	**$ 9.28** **$ 72.56** **$ 20.28** **$108.56**		**$ 93.46** **$237.50** **$142.46** **$294.58**	
	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		**$10** per-occurrence deductible, then:	
	No per-occurrence deductibles			
	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 hospital: **$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 allowable charge until the annual deductible is met. Afterward, the Plan will reimburse 80% of the allowable charge; you pay 20%. When coinsurance maximum is reached, the Plan will reimburse 100% of the allowable charge.		Participating pharmacies only (up to 31-day supply): **$10** tier 1 (generic—lowest cost), **$25** tier 2 (brand—higher cost), **$40** tier 3 (brand—highest cost) Mail order (up to 90-day supply): **$25** tier 1, **$62** tier 2, **$100** tier 3 Copay max: **$2,500**	

[1]This table is for comparison purposes only.
[2]Refer to the Retirement/Disability Retirement 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 2009[1]

	BlueChoice HealthPlan[2]	CIGNA HMO[2]	Medicare Supplemental Plan[2]
	Available in all South Carolina counties Urgent and emergency coverage worldwide	*Not offered in Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda counties.* *Urgent and emergency coverage worldwide*	Same as Medicare Available to retirees and covered dependents/survivors who are eligible for Medicare
	$148.50 **$423.84** **$320.28** **$629.70**	**$192.30** **$477.80** **$414.90** **$752.52**	Refer to the premium tables on pages 200-202 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 90% after copays You pay 10%	HMO pays 80% after copays You pay 20% (Only applies to inpatient/outpatient hospital expenses)	Pays Part B coinsurance of 20%
	$1,500 **$3,000** **(excludes deductible)**	**$2,000** **$4,000** **(includes inpatient and outpatient copays and 20% coinsurance)**	None
	$15 PCP copay **$15** OB/GYN well-woman exam **$30** 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 90% after copays You pay 10% **$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	**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 $6,000 per year.
	Participating pharmacies only (31-day supply): **$7** generic, **$35** preferred brand, **$55** non-preferred brand, **$100** specialty pharmaceuticals Mail order (Up to 90-day supply): **$14** generic, **$70** preferred brand, **$110** 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): **$10** tier 1 (generic—lowest cost), **$25** tier 2 (brand—higher cost), **$40** tier 3 (brand—highest cost) Mail order (up to 90-day supply): **$25** tier 1, **$62** tier 2, **$100** tier 3 Copay max: **$2,500**

2009 ACTIVE EMPLOYEE AND FUNDED RETIREE HEALTH, DENTAL AND DENTAL PLUS RATES

2009 Active Employee Monthly Premiums[1]						
	Savings	Standard	BlueChoice HealthPlan	CIGNA HMO	Dental	Dental Plus
Employee	$ 9.28	$ 93.46	$148.50	$192.30	$ 0.00	$20.60
Employee/spouse	$ 72.56	$237.50	$423.84	$477.80	$ 7.64	$39.00
Employee/children	$ 20.28	$142.46	$320.28	$414.90	$13.72	$42.56
Full family	$108.56	$294.58	$629.70	$752.52	$21.34	$60.96

[1] Rates for employees of local subdivisions may vary. To verify your rates, contact your benefits office.

2009 Regular Retiree (State-funded Benefits) Monthly Premiums[1] (Retiree eligible for Medicare/spouse eligible for Medicare)							
	Savings	Standard	Medicare Supplemental[2]	BlueChoice HealthPlan	CIGNA HMO	Dental	Dental Plus
Retiree	N/A	$ 75.46	$ 93.46	$148.50	$192.30	$ 0.00	$20.60
Retiree/spouse	N/A	$201.50	$237.50	$423.84	$477.80	$ 7.64	$39.00
Retiree/children	N/A	$124.46	$142.46	$320.28	$414.90	$13.72	$42.56
Full family	N/A	$258.58	$294.58	$629.70	$752.52	$21.34	$60.96
(Retiree eligible for Medicare/spouse **not** eligible for Medicare)							
	Savings	Standard	Medicare Supplemental[2]	BlueChoice HealthPlan	CIGNA HMO	Dental	Dental Plus
Retiree/spouse	N/A	$219.50	$237.50	$423.84	$477.80	$ 7.64	$39.00
Full family	N/A	$268.50	$286.50	$629.70	$752.52	$21.34	$60.96
(Retiree **not** eligible for Medicare/spouse eligible for Medicare)							
	Savings	Standard	Medicare Supplemental[2]	BlueChoice HealthPlan	CIGNA HMO	Dental	Dental Plus
Retiree/spouse	$ 72.56	$219.50	$237.50	$423.84	$477.80	$ 7.64	$39.00
Full family	$108.56	$268.50	$286.50	$629.70	$752.52	$21.34	$60.96
(Retiree **not** eligible for Medicare/spouse **not** eligible for Medicare)							
	Savings	Standard	Medicare Supplemental[2]	BlueChoice HealthPlan	CIGNA HMO	Dental	Dental Plus
Retiree	$ 9.28	$ 93.46	N/A	$148.50	$192.30	$ 0.00	$20.60
Retiree/spouse	$ 72.56	$237.50	N/A	$423.84	$477.80	$ 7.64	$39.00
Retiree/children	$ 20.28	$142.46	N/A	$320.28	$414.90	$13.72	$42.56
Full family	$108.56	$294.58	N/A	$629.70	$752.52	$21.34	$60.96
(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
Retiree/children	$ 20.28	$142.46	$160.46	$320.28	$414.90	$13.72	$42.56
Full family	$108.56	$294.58	$312.58	$629.70	$752.52	$21.34	$60.96

[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.

2009 NON-FUNDED RETIREE AND COBRA HEALTH, DENTAL AND DENTAL PLUS RATES

2009 Retiree Full Cost (Non-funded) Monthly Premiums[1]
(Retiree eligible for Medicare/spouse eligible for Medicare)

	Savings	Standard	Medicare Supplemental[2]	BlueChoice HealthPlan	CIGNA HMO	Dental	Dental Plus
Retiree	N/A	$336.36	$354.36	$ 409.40	$ 453.20	$11.71	$20.60
Retiree/spouse	N/A	$716.20	$752.20	$ 938.54	$ 992.50	$19.35	$39.00
Retiree/children	N/A	$493.60	$511.60	$ 689.42	$ 784.04	$25.43	$42.56
Full family	N/A	$861.14	$897.14	$1,232.26	$1,355.08	$33.05	$60.96
(Retiree eligible for Medicare/spouse **not** eligible for Medicare)							
	Savings	**Standard**	**Medicare Supplemental[2]**	**BlueChoice HealthPlan**	**CIGNA HMO**	**Dental**	**Dental Plus**
Retiree/spouse	N/A	$734.20	$752.20	$ 938.54	$ 992.50	$19.35	$39.00
Full family	N/A	$871.06	$889.06	$1,232.26	$1,355.08	$33.05	$60.96
(Retiree **not** eligible for Medicare/spouse eligible for Medicare)							
	Savings	**Standard**	**Medicare Supplemental[2]**	**BlueChoice HealthPlan**	**CIGNA HMO**	**Dental**	**Dental Plus**
Retiree/spouse	$587.26	$734.20	$752.20	$ 938.54	$ 992.50	$19.35	$39.00
Full family	$711.12	$871.06	$889.06	$1,232.26	$1,355.08	$33.05	$60.96
(Retiree **not** eligible for Medicare/spouse **not** eligible for Medicare)							
	Savings	**Standard**	**Medicare Supplemental[2]**	**BlueChoice HealthPlan**	**CIGNA HMO**	**Dental**	**Dental Plus**
Retiree	$270.18	$354.36	N/A	$ 409.40	$ 453.20	$11.71	$20.60
Retiree/spouse	$587.26	$752.20	N/A	$ 938.54	$ 992.50	$19.35	$39.00
Retiree/children	$389.42	$511.60	N/A	$ 689.42	$ 784.04	$25.43	$42.56
Full family	$711.12	$897.14	N/A	$1,232.26	$1,355.08	$33.05	$60.96
(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**
Retiree/children	$389.42	$511.60	$529.60	$ 689.42	$ 784.04	$25.43	$42.56
Full family	$711.12	$897.14	$915.14	$1,232.26	$1,355.08	$33.05	$60.96

[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.

2009 COBRA Monthly Premiums
18 and 36 months

	Savings	Standard	BlueChoice HealthPlan	CIGNA HMO	Dental	Dental Plus
Subscriber	$275.58	$361.46	$ 417.60	$ 462.26	$11.94	$21.02
Subscriber/spouse	$599.02	$767.24	$ 957.32	$1,012.36	$19.74	$39.78
Subscriber/children	$397.22	$521.84	$ 703.22	$ 799.72	$25.94	$43.42
Full family	$725.34	$915.08	$1,256.92	$1,382.18	$33.71	$62.18
Children (to age 18)	$121.64	$160.38	$ 285.62	$ 337.46	$13.99	$22.40
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**
Subscriber	$ 405.28	$ 531.54	$ 614.10	$ 679.80	$11.94	$21.02
Subscriber/spouse	$ 880.90	$1,128.30	$1,407.82	$1,488.76	$19.74	$39.78
Subscriber/children	$ 584.14	$ 767.40	$1,034.14	$1,176.06	$25.94	$43.42
Full family	$1,066.68	$1,345.72	$1,848.40	$2,032.62	$33.71	$62.18
Children (to age 18)	$ 178.86	$ 235.86	$ 420.04	$ 496.26	$13.99	$22.40

2009 SURVIVOR HEALTH, DENTAL AND DENTAL PLUS RATES

2009 Survivor Full Cost (Non-funded) Monthly Premiums[1] (Spouse eligible for Medicare/children eligible for Medicare)							
	Savings	**Standard**	**Medicare Supplemental[2]**	**BlueChoice HealthPlan**	**CIGNA HMO**	**Dental**	**Dental Plus**
Spouse	N/A	$336.36	$354.36	$409.40	$453.20	$11.71	$20.60
Spouse/children	N/A	$493.60	$529.60	$689.42	$784.04	$25.43	$42.56
Children only	N/A	$157.24	$175.24[3]	$280.02	$330.84	$13.72	$21.96
(Spouse eligible for Medicare/children **not** eligible for Medicare)							
	Savings	**Standard**	**Medicare Supplemental[2]**	**BlueChoice HealthPlan**	**CIGNA HMO**	**Dental**	**Dental Plus**
Spouse	N/A	$336.36	$354.36	$409.40	$453.20	$11.71	$20.60
Spouse/children	N/A	$493.60	$511.60	$689.42	$784.04	$25.43	$42.56
Children only	$119.24	$157.24	N/A	$280.02	$330.84	$13.72	$21.96
(Spouse **not** eligible for Medicare/children eligible for Medicare)							
	Savings	**Standard**	**Medicare Supplemental[2]**	**BlueChoice HealthPlan**	**CIGNA HMO**	**Dental**	**Dental Plus**
Spouse	$270.18	$354.36	N/A	$409.40	$453.20	$11.71	$20.60
Spouse/children	$389.42	$511.60	$529.60[3]	$689.42	$784.04	$25.43	$42.56
Children only	N/A	$157.24	$175.24[3]	$280.02	$330.84	$13.72	$21.96
(Spouse **not** eligible for Medicare/children **not** eligible for Medicare)							
	Savings	**Standard**	**Medicare Supplemental[2]**	**BlueChoice HealthPlan**	**CIGNA HMO**	**Dental**	**Dental Plus**
Spouse	$270.18	$354.36	N/A	$409.40	$453.20	$11.71	$20.60
Spouse/children	$389.42	$511.60	N/A	$689.42	$784.04	$25.43	$42.56
Children only	$119.24	$157.24	N/A	$280.02	$330.84	$13.72	$21.96

[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.

2009 MONTHLY INSURANCE RATES FOR PERMANENT, PART-TIME TEACHERS

HEALTH

Category I. 15-19 Hours					
Coverage Level	Savings	Standard	BlueChoice HealthPlan	CIGNA HMO	Employer
Employee only	$139.74	$223.92	$278.96	$ 322.76	$130.46
Employee/spouse	$329.92	$494.86	$681.20	$ 735.16	$257.36
Employee/children	$204.86	$327.04	$504.86	$ 599.48	$184.58
Full family	$409.84	$595.86	$930.98	$1,053.80	$301.28

Category II. 20-24 Hours					
Coverage Level	Savings	Standard	BlueChoice HealthPlan	CIGNA HMO	Employer
Employee only	$ 95.38	$179.56	$234.60	$278.40	$174.80
Employee/spouse	$242.42	$407.36	$593.70	$647.66	$344.86
Employee/children	$142.10	$264.28	$442.10	$536.72	$247.32
Full family	$307.40	$493.42	$828.54	$951.36	$403.72

Category III. 25-29 Hours					
Coverage Level	Savings	Standard	BlueChoice HealthPlan	CIGNA HMO	Employer
Employee only	$ 53.64	$137.82	$192.86	$236.66	$216.56
Employee/spouse	$160.06	$325.00	$511.34	$565.30	$427.20
Employee/children	$ 83.04	$205.22	$383.04	$477.66	$306.40
Full family	$211.00	$397.02	$732.14	$854.96	$500.12

DENTAL

Coverage Level	Category I. 15-19 Hours			Category II. 20-24 Hours			Category III. 25-29 Hours		
	Employee	Employer	Dental Plus	Employee	Employer	Dental Plus	Employee	Employer	Dental Plus
Employee only	$ 5.86	$5.85	$20.60	$ 3.86	$7.85	$20.60	$ 2.00	$9.71	$20.60
Employee/spouse	$13.50	$5.85	$39.00	$ 11.50	$7.85	$39.00	$ 9.64	$9.71	$39.00
Employee/children	$19.58	$5.85	$42.56	$17.58	$7.85	$42.56	$15.72	$9.71	$42.56
Full family	$27.20	$5.85	$60.96	$25.20	$7.85	$60.96	$23.34	$9.71	$60.96

Long Term Care Monthly Premiums

2009 LONG TERM CARE RATES*												
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

2009 LONG TERM CARE RATES*												
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.*

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 Rates 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	$0.68	$0.80	$1.26	$1.76	$2.74	$4.28	$6.56	$9.78
$20,000	$1.36	$1.60	$2.52	$3.52	$5.48	$8.56	$13.12	$19.56
$30,000	$2.04	$2.40	$3.78	$5.28	$8.22	$12.84	$19.68	$29.34
$40,000	$2.72	$3.20	$5.04	$7.04	$10.96	$17.12	$26.24	$39.12
$50,000	$3.40	$4.00	$6.30	$8.80	$13.70	$21.40	$32.80	$48.90
$60,000	$4.08	$4.80	$7.56	$10.56	$16.44	$25.68	$39.36	$58.68
$70,000	$4.76	$5.60	$8.82	$12.32	$19.18	$29.96	$45.92	$68.46
$80,000	$5.44	$6.40	$10.08	$14.08	$21.92	$34.24	$52.48	$78.24
$90,000	$6.12	$7.20	$11.34	$15.84	$24.66	$38.52	$59.04	$88.02
$100,000	$6.80	$8.00	$12.60	$17.60	$27.40	$42.80	$65.60	$97.80
$110,000	$7.48	$8.80	$13.86	$19.36	$30.14	$47.08	$72.16	$107.58
$120,000	$8.16	$9.60	$15.12	$21.12	$32.88	$51.36	$78.72	$117.36
$130,000	$8.84	$10.40	$16.38	$22.88	$35.62	$55.64	$85.28	$127.14
$140,000	$9.52	$11.20	$17.64	$24.64	$38.36	$59.92	$91.84	$136.92
$150,000	$10.20	$12.00	$18.90	$26.40	$41.10	$64.20	$98.40	$146.70
$160,000	$10.88	$12.80	$20.16	$28.16	$43.84	$68.48	$104.96	$156.48
$170,000	$11.56	$13.60	$21.42	$29.92	$46.58	$72.76	$111.52	$166.26
$180,000	$12.24	$14.40	$22.68	$31.68	$49.32	$77.04	$118.08	$176.04
$190,000	$12.92	$15.20	$23.94	$33.44	$52.06	$81.32	$124.64	$185.82
$200,000	$13.60	$16.00	$25.20	$35.20	$54.80	$85.60	$131.20	$195.60
$210,000	$14.28	$16.80	$26.46	$36.96	$57.54	$89.88	$137.76	$205.38
$220,000	$14.96	$17.60	$27.72	$38.72	$60.28	$94.16	$144.32	$215.16
$230,000	$15.64	$18.40	$28.98	$40.48	$63.02	$98.44	$150.88	$224.94
$240,000	$16.32	$19.20	$30.24	$42.24	$65.76	$102.72	$157.44	$234.72
$250,000	$17.00	$20.00	$31.50	$44.00	$68.50	$107.00	$164.00	$244.50
$260,000	$17.68	$20.80	$32.76	$45.76	$71.24	$111.28	$170.56	$254.28
$270,000	$18.36	$21.60	$34.02	$47.52	$73.98	$115.56	$177.12	$264.06
$280,000	$19.04	$22.40	$35.28	$49.28	$76.72	$119.84	$183.68	$273.84
$290,000	$19.72	$23.20	$36.54	$51.04	$79.46	$124.12	$190.24	$283.62

	Employee's Age*							
Employee Age:	**<35**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**
$300,000	$20.40	$24.00	$37.80	$52.80	$82.20	$128.40	$196.80	$293.40
$310,000	$21.08	$24.80	$39.06	$54.56	$84.94	$132.68	$203.36	$303.18
$320,000	$21.76	$25.60	$40.32	$56.32	$87.68	$136.96	$209.92	$312.96
$330,000	$22.44	$26.40	$41.58	$58.08	$90.42	$141.24	$216.48	$322.74
$340,000	$23.12	$27.20	$42.84	$59.84	$93.16	$145.52	$223.04	$332.52
$350,000	$23.80	$28.00	$44.10	$61.60	$95.90	$149.80	$229.60	$342.30
$360,000	$24.48	$28.80	$45.36	$63.36	$98.64	$154.08	$236.16	$352.08
$370,000	$25.16	$29.60	$46.62	$65.12	$101.38	$158.36	$242.72	$361.86
$380,000	$25.84	$30.40	$47.88	$66.88	$104.12	$162.64	$249.28	$371.64
$390,000	$26.52	$31.20	$49.14	$68.64	$106.86	$166.92	$255.84	$381.42
$400,000	$27.20	$32.00	$50.40	$70.40	$109.60	$171.20	$262.40	$391.20
$410,000	$27.88	$32.80	$51.66	$72.16	$112.34	$175.48	$268.96	$400.98
$420,000	$28.56	$33.60	$52.92	$73.92	$115.08	$179.76	$275.52	$410.76
$430,000	$29.24	$34.40	$54.18	$75.68	$117.82	$184.04	$282.08	$420.54
$440,000	$29.92	$35.20	$55.44	$77.44	$120.56	$188.32	$288.64	$430.32
$450,000	$30.60	$36.00	$56.70	$79.20	$123.30	$192.60	$295.20	$440.10
$460,000	$31.28	$36.80	$57.96	$80.96	$126.04	$196.88	$301.76	$449.88
$470,000	$31.96	$37.60	$59.22	$82.72	$128.78	$201.16	$308.32	$459.66
$480,000	$32.64	$38.40	$60.48	$84.48	$131.52	$205.44	$314.88	$469.44
$490,000	$33.32	$39.20	$61.74	$86.24	$134.26	$209.72	$321.44	$479.22
$500,000	$34.00	$40.00	$63.00	$88.00	$137.00	$214.00	$328.00	$489.00

**Premiums for the spouse's coverage will be based on the employee's age. Spouse's coverage cannot exceed 50% of the employee's Optional Life coverage or $100,000, whichever is less.*

Monthly Rates 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**	$30.80	**$12,600**	$32.40	**$9,510**	$40.90
$40,000	**$26,000**	$41.08	**$16,800**	$43.20	**$12,680**	$54.52
$50,000	**$32,500**	$51.36	**$21,000**	$54.00	**$15,850**	$68.16
$60,000	**$39,000**	$61.62	**$25,200**	$64.80	**$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**	$92.42	**$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**	$118.80	**$34,870**	$149.94
$120,000	**$78,000**	$123.24	**$50,400**	$129.62	**$38,040**	$163.58
$130,000	**$84,500**	$133.50	**$54,600**	$140.42	**$41,210**	$177.20
$140,000	**$91,000**	$143.78	**$58,800**	$151.22	**$44,380**	$190.82
$150,000	**$97,500**	$154.10	**$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**	$195.12	**$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**	$236.20	**$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**	$267.16	**$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**	$297.82	**$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**	$318.36	**$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**	$338.90	**$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
$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**	$441.60	**$180,600**	$464.50	**$136,310**	$586.12

Coverage	Coverage	Ages 70 - 74	Coverage	Ages 75 - 79	Coverage	Ages 80+
$440,000	**$286,000**	$451.88	**$184,800**	$475.30	**$139,480**	$599.76
$450,000	**$292,500**	$462.16	**$189,000**	$486.10	**$142,650**	$613.40
$460,000	**$299,000**	$472.42	**$193,200**	$496.90	**$145,820**	$627.02
$470,000	**$305,500**	$482.70	**$197,400**	$507.70	**$148,990**	$640.66
$480,000	**$312,000**	$492.96	**$201,600**	$518.52	**$152,160**	$654.30
$490,000	**$318,500**	$503.22	**$205,800**	$529.32	**$155,330**	$667.92
$500,000	**$325,000**	$513.50	**$210,000**	$540.12	**$158,500**	$681.56

Dependent Life/Child Monthly Premium

The monthly premium for Dependent Life/Child coverage is $1.24, regardless of the number of children covered.

Appendix

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Appendix

Claims Procedures

HOW TO FILE A STATE HEALTH PLAN CLAIM

If you received services from a physician or hospital that participates in a State Health Plan network, you do not have to file a claim. Your doctor or hospital 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 physician or hospital, or 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 or BlueCross BlueShield of South Carolina (BCBSSC). Claim forms also are available on the EIP Web site. Go to www.eip.sc.gov, then choose your category and select "Forms."

To file a claim you need to:

- Complete the front of 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 medical claims by the end of the calendar year after the year in which expenses are incurred. Otherwise, claims cannot be paid.

Complete a separate claim form for each individual who received care, and mail the form to:

State Business Unit
BlueCross BlueShield of South Carolina
P.O. Box 100605
Columbia, SC 29260-0605.

In most cases, if you obtain medical services outside South Carolina or the United States from a BlueCard doctor or hospital, you should not need to pay up-front for medical care, except for the usual out-of-pocket expenses (deductibles, copayments, coinsurance and non-covered services). The doctor or hospital should submit your 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 an international claim form and send it to the BlueCard Worldwide Service Center. The claim form is available from your benefits administrator or online through www.SouthCarolinaBlues.com.

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 allowable charge, 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 Prescription Drug Claim Form (Coordination of Benefits/Direct). It is available on EIP's Web site, www.eip.sc.gov. Choose your category and then select "Forms." The form is listed under "State Health Plan." 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 United States.

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 at www.eip.sc.gov. Choose your category and then select "Forms." 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 each service
5. The charge for each service.

Complete items 1-11 of the claim form, attach the bill and mail it to:

BlueCross BlueShield of South Carolina
State Dental Claims Department
P.O. Box 100300
Columbia, SC 29202-3300.

X-rays 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 Health Care 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 dis-

close 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 Web site,** 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, 61 Forsyth Street, SW, Suite 3B70, Atlanta, GA 30323-8908. Phone number: 404-562-7886. 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 Web site 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.

Part D Creditable Coverage Letter

Important Notice from the Employee Insurance Program (EIP) About Your State Prescription Drug Coverage and Medicare

On January 1, 2006, Medicare began offering a prescription drug plan, Medicare Part D. The drug coverage most subscribers have through health plans offered by the Employee Insurance Program is as good as, or better than, drug coverage offered by Part D. Therefore, they do not need to sign up for Part D. Subscribers are sent this letter to let them know that they have what Medicare calls "creditable coverage."

This notice is your creditable coverage letter. Please read it carefully and keep it where you can find it. Here is a summary:

1. **This notice contains information about your prescription drug coverage with EIP and about prescription drug coverage that became available January 1, 2006, to people with Medicare.**
2. **Medicare Part D prescription drug coverage is available to all people on Medicare.**
3. **EIP has determined that the state drug coverage offered through your health plan (the Standard Plan, the Medicare Supplemental Plan, BlueChoice HealthPlan or CIGNA Healthcare HMO) is, on average for all plan participants, as good as or better than the standard Medicare prescription drug coverage.**
4. **This notice explains options you have under Medicare prescription drug coverage and can help you decide whether or not to enroll.**

Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans might offer more coverage for a higher monthly premium.

If you enroll in a Medicare prescription drug plan, you will lose your state drug coverage through EIP. Before you decide to switch to Medicare drug coverage and drop your EIP coverage, you should compare your EIP coverage, including which drugs are covered, with the coverage and cost of any plans offering Medicare prescription drug coverage in your area.

You may have heard that if you decide to enroll in Part D after your initial eligibility period, you will have to pay a higher premium because you did not enroll in Part D when you first had the opportunity. However, because you now have prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later without a penalty. Every year you will have the opportunity to enroll in a Medicare prescription drug plan between November 15 and December 31.

If you drop or lose your coverage with EIP, you have 63 days to enroll in a Medicare drug plan. If you do not enroll in Medicare prescription drug coverage when your coverage ends, you may pay more if you later enroll in Medicare prescription drug coverage. If, after May 15, 2006, or after your initial eligibility date, you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium for Medicare Part D will go up at least one percent a month for every month after May 15, 2006, (or after your initial eligibility date, whichever is later) that you did not have coverage. For example, if you go 19 months without coverage, your premium will always be at least 19 percent higher than the national average Medicare Part D premium. You will have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until the next November to enroll in Medicare prescription drug coverage.

Please keep this notice, your creditable coverage letter, in a safe place. If you later decide to enroll in Part D, you may need to present it to show that you had coverage that was as good as or better than Part D, and therefore, you are not subject to higher premiums.

To learn more about your drug coverage, consult your 2009 *Insurance Benefits Guide* (IBG) or call your health plan or prescription drug plan at the number listed on the inside cover of the IBG.

Your coverage through EIP pays for other health expenses, as well as for prescription drugs. If you enroll in a Medicare prescription drug plan, you will no longer receive the prescription drug benefits offered by your health plan. However, there will be no reduction in your health insurance premium.

For more information about this notice, contact EIP.

You can reach EIP at 803-734-0678 (Greater Columbia area) or 888-260-9430 (toll-free outside the Columbia area).

Note: You may receive copies of this notice again, such as before the next period in which you can enroll in Medicare prescription drug coverage, and if your coverage through EIP changes. You also may request a copy.

For more information about your options under the Medicare prescription drug coverage:

More detailed information about Medicare plans that offer prescription drug coverage is available in the *Medicare & You 2009* handbook, which you got in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov for personalized help
- Call your State Health Insurance Assistance Program (see your copy of the *Medicare & You 2009* handbook for the telephone number)
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

Extra help paying for a Medicare prescription drug plan is available to people with limited income and resources. Contact the Social Security Administration (SSA) for more information about this assistance. You may visit SSA online at www.socialsecurity.gov, or call 800-772-1213. TTY users should call 800-325-0778.

Remember: Keep this notice. If you enroll in one of the new Medicare prescription drug plans after your initial enrollment date, you may need to present a copy of this notice when you join to show that you are not required to pay a higher premium.

Contact the Employee Insurance Program below for further information. **Note:** You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through the Employee Insurance Program changes. You may also request a copy.

South Carolina Budget and Control Board
Employee Insurance Program
1201 Main Street, Suite 300
P.O. Box 11661
Columbia, SC 29211

803-734-0678 (Greater Columbia area)
888-260-9430 (toll-free outside the Columbia area)
cs@eip.sc.gov
www.eip.sc.gov

MEDICARE PART D: FREQUENTLY ASKED QUESTIONS

Q: I received a notice recently about Medicare Part D from the Employee Insurance Program (EIP). What is this?

A: Even though the Medicare prescription drug benefit went into effect on January 1, 2006, EIP will continue to provide you and your covered dependents with your state prescription drug coverage. The notice tells you this coverage is at least as good as the Medicare drug benefit, and it is proof of such coverage. Please keep this notice where you can easily find it.

Q: Do I need to do anything right now?

A: No. There is nothing you need to do if you plan to keep your state coverage through EIP.

Q: What do I need to do if I want to switch to a Medicare plan?

A: If you switch to a Medicare drug plan, you need to enroll within the seven-month initial enrollment period of your Medicare eligibility. More information is available by calling Medicare at 800-MEDICARE (800-633-4227) or at 877-486-2048 (TTY). However, enrolling in a Medicare drug plan will disqualify you from prescription drug coverage under your EIP plan. If you enroll in a Medicare drug plan, you will lose your EIP drug coverage, and there will be no reduction in you health insurance premium.

Q: If I keep my current coverage, can I switch to a Medicare plan later?

A: Yes. Open enrollment for Medicare coverage is held yearly between November 15 and December 31.

Q: Will I pay higher premiums for a Medicare prescription drug plan if I keep my state coverage through EIP and switch later?

A: No. Since Medicare recognizes your current state coverage through EIP is at least as good as the standard Medicare plan, you will not pay more if you later enroll in a Medicare plan. Remember that you may only enroll in a Medicare prescription drug plan during: 1) open enrollment for Medicare, which is November 15 to December 31 of each year; or 2) if your EIP coverage ends.

Q: Is extra help or limited-income assistance available for prescription drug coverage?

A: Limited-income assistance is not available for your EIP coverage, but it is available for the Medicare benefit. If you think you may qualify, you can apply for assistance by filling out an application online at www.socialsecurity.gov or by calling the Social Security Administration at 800-772-1213 or 800-325-0778 (TTY). Remember: You can only receive limited-income assistance if you enroll in a Medicare prescription drug plan.

Health Savings Account Custodial Agreement

ADDITIONAL INFORMATION

Purpose. This Organizer contains documents necessary to establish a Health Savings Account (HSA). It meets the requirements of Internal Revenue Code (IRC) Section 223, other relevant IRC sections, and all additional Internal Revenue Service (IRS) guidance. An HSA is established after the Organizer is fully executed by both you (account owner) and the custodian and must be completed no later than the due date (excluding extensions) of your income tax return for the tax year. Do not file the HSA Custodial Account Agreement with the IRS. Instead, keep it with your records.

How to use this HSA Organizer. You must complete and sign the Application. An original signed copy of the Application should be kept by the custodian for its records. You should receive a copy of the Application and keep the remaining contents of the HSA Organizer. Community or marital property state laws may require spousal consent for nonspouse beneficiary designations.

Definitions

HSA. An HSA is a tax-exempt trust or custodial account established exclusively for the purpose of paying qualified medical expenses of you, your spouse, and your dependents.

Custodian. An HSA custodian must be a bank, an insurance company, a person previously approved by the IRS to be a custodian of an individual retirement account (IRA) or Archer Medical Savings Account (MSA), or any other person approved by the IRS.

Account Owner. The account owner is the person who establishes the custodial account. For HSA purposes, the account owner is you.

Additional Documents

Applicable law or policies of the HSA custodian may require additional documentation such as IRS Form W-9, *Request for Taxpayer Identification Number and Certification*.

For Additional Guidance

It is in your best interest to seek the guidance of a tax or legal professional before completing this document. For more information, refer to IRC Section 223, other relevant IRC sections, and all additional IRS guidance; IRS publications that include information about HSAs; instructions to your federal income tax return; your local IRS office; or the IRS's web site at www.irs.gov.

Appendix

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HEALTH SAVINGS CUSTODIAL ACCOUNT

Form **5305-C** (Under section 223(a) of the Internal Revenue Code) (August 2004) Department of the Treasury Internal Revenue Service

Do not File with Internal Revenue Service

☐ Amendment

The account owner and the custodian make the following agreement:

Article I.

1. The custodian will accept additional cash contributions for the tax year made by the account owner or on behalf of the account owner (by an employer, family member or any other person). No contributions will be accepted by the custodian for any account owner that exceeds the maximum amount for family coverage plus the catch-up contribution.

2. Contributions for any tax year may be made at any time before the deadline for filing the account owner's federal income tax return for that year (without extensions).

3. Rollover contributions from an HSA or an Archer Medical Savings Account (Archer MSA) (unless prohibited under this agreement) need not be in cash and are not subject to the maximum annual contribution limit set forth in Article II.

Article II.

1. For calendar year 2004, the maximum annual contribution limit for an account owner with single coverage is the lesser of the amount of the deductible under the HDHP but not more than $2,600. For calendar year 2004, the maximum annual contribution limit for an account owner with family coverage is the lesser of the amount of the deductible under the HDHP but not more than $5,150. These limits are subject to cost-of-living adjustments after 2004. Eligibility and contribution limits are determined on a month-to-month basis.

2. Contributions to Archer MSAs or other HSAs count toward the maximum annual contribution limit to this HSA.

3. For calendar year 2004, an additional $500 catch-up contribution may be made for an account owner who is at least age 55 or older and not enrolled in Medicare. The catch-up contribution increases to $600 in 2005, $700 in 2006, $800 in 2007, $900 in 2008, and $1,000 in 2009 and later years.

4. Contributions in excess of the maximum annual contribution limit are subject to an excise tax. However, the catch-up contributions are not subject to an excise tax.

Article III.

It is the responsibility of the account owner to determine whether contributions to this HSA have exceeded the maximum annual contribution limit described in Article II. If contributions to this HSA exceed the maximum annual contribution limit, the account owner shall notify the custodian that there exist excess contributions to the HSA. It is the responsibility of the account owner to request the withdrawal of the excess contribution and any net income attributable to such excess contribution.

Article IV.

The account owner's interest in the balance in this custodial account is nonforfeitable.

Article V.

1. No part of the custodial funds in this account may be invested in life insurance contracts or in collectibles as defined in section 408(m).

2. The assets of this account may not be commingled with other property except in a common trust fund or common investment fund.

3. Neither the account owner nor the custodian will engage in any prohibited transaction with respect to this account (such as borrowing or pledging the account or engaging in any other prohibited transaction as defined in section 4975).

Article VI.

1. Distributions of funds from this HSA may be made upon the direction of the account owner.

2. Distributions from this HSA that are used exclusively to pay or reimburse qualified medical expenses of the account owner, his or her spouse, or dependents are tax-free. However, distributions that are not used for qualified medical expenses are included in the account owner's gross income and are subject to an additional 10 percent tax on that amount. The additional 10 percent tax does not apply if the distribution is made after the account owner's death, disability, or reaching age 65.

3. The custodian is not required to determine whether the distribution is for the payment or reimbursement of qualified medical expenses. Only the account owner is responsible for substantiating that the distribution is for qualified medical expenses and must maintain records sufficient to show, if required, that the distribution is tax-free.

Article VII.

If the account owner dies before the entire interest in the account is distributed, the entire account will be disposed of as follows:

1. If the beneficiary is the account owner's spouse, the HSA will become the spouse's HSA as of the date of death.

2. If the beneficiary is not the account owner's spouse, the HSA will cease to be an HSA as of the date of death. If the beneficiary is the account owner's estate, the fair market value of the account as of the date of death is taxable on the account owner's final return. For other beneficiaries, the fair market value of the account is taxable to that person in the tax year that includes such date.

Article VIII.

1. The account owner agrees to provide the custodian with information necessary for the custodian to prepare any report or return required by the IRS.

2. The custodian agrees to prepare and submit any report or return as prescribed by the IRS.

Article IX.

Notwithstanding any other article that may be added or incorporated in this agreement, the provisions of Articles I through VIII and this sentence are controlling. Any additional article in this agreement that is inconsistent with section 223 or IRS published guidance will be void.

Article X.

This agreement will be amended from time to time to comply with the provisions of the Code or IRS published guidance. Other amendments may be made with the consent of the persons whose signatures appear on the Application that accompanies this Agreement.

Article XI.

11.01 Your HSA Documents. This Agreement for an HSA, and any amendments or additional provisions to such agreement, set forth the terms and conditions governing the account owner's HSA relationship with us. This Agreement will be accompanied by a disclosure statement, which sets forth various HSA rules in simpler language.

11.02 Definitions. This Agreement refers to you as the account owner, and us as the custodian. References to "you," "your," and "HSA owner" will mean the account owner, and "we," "us," and "our" will mean the custodian. Upon your death, your spouse beneficiary, if applicable, becomes "you" for purposes of this Agreement. In the event you appoint a third party, or have a third party appointed on your behalf to handle certain transactions affecting your HSA, such third party will be considered your agent and, therefore, "you" for purposes of this Agreement. Additionally, references to "HSA" will mean the custodial account.

11.03 Additional Provisions. Additional provisions may be attached to, and made a part of, this Agreement by either party. The provisions must be in writing, agreed to by us, and in a format acceptable to us.

11.04 Our Fees and Expenses. We may charge reasonable fees and are entitled to reimbursement for any expenses we incur

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in establishing and maintaining your HSA. We may change the fees at any time by providing you with notice of such changes. We will provide you with fee disclosures and policies. Fees may be deducted directly from your HSA assets, and/or billed separately to you. Fees billed separately to you and paid by you may be claimed on your federal income tax return as miscellaneous itemized deductions. The payment of fees has no effect on your contributions. Additionally, we have the right to liquidate your HSA assets to pay such fees and expenses. If you do not direct us on the liquidation, we will liquidate the assets of our choice and will not be responsible for any losses or claims that may arise out of the liquidation.

11.05 Amendments. We may amend your HSA in any respect and at any time, including retroactively, to comply with applicable laws governing HSAs and the corresponding regulations. Any other amendments shall require your consent, by action or no action, and will be preceded by written notice to you. Unless otherwise required, you are deemed to automatically consent to an amendment, which means that your written approval is not required for the amendment to apply to the HSA. In certain instances the governing law or our policies may require us to secure your written consent before an amendment can be applied to the HSA. If you want to withhold your consent to an amendment, you must provide us with a written objection within 30 days of the receipt date of the amendment.

11.06 Notice and Delivery. Any notice mailed to you will be deemed delivered and received by you, five days after the postmark date. This fifth day following the postmark is the receipt date. Notices will be mailed to the last address we have in our records. You are responsible for ensuring that we have your proper mailing address. Upon your consent, we may provide you with notice in a delivery format other than by mail. Such formats may include various electronic deliveries. Any notice, including terminations, change in personal information, or contributions mailed to us will be deemed delivered when actually received by us based on our ordinary business practices. All notices must be in writing unless our policies and procedures provide for oral notices.

11.07 Applicable Laws. This Agreement will be construed and interpreted in accordance with the laws of, and venued in, our state of domicile.

11.08 Disqualifying Provisions. Any provision of this Agreement that would disqualify the HSA will be disregarded to the extent necessary to maintain the account as an HSA.

11.09 Interpretation. If any question arises as to the meaning of any provision of this Agreement, then we shall be authorized to interpret any such provision, and our interpretation will be binding upon all parties.

11.10 Representations and Indemnity. You represent that any information you and/or your agents provide to us is accurate and complete, and that your actions comply with this Agreement and applicable laws governing HSAs. You understand that we will rely on the information provided by you, and that we have no duty to inquire about or investigate such information. We are not responsible for any losses or expenses that may result from your information, direction, or actions, including your failure to act. You agree to hold us harmless, to indemnify, and to defend us against any and all actions or claims arising from, and liabilities and losses incurred by reason of your information, direction, or actions. Additionally, you represent that it is your responsibility to seek the guidance of a tax or legal professional for your HSA issues.

We are not responsible for determining whether any contributions or distributions comply with this Agreement and/or the federal laws governing HSAs. We are not responsible for any taxes, judgments, penalties or expenses incurred in connection with your HSA, or any losses that are a result of events beyond our control. We have no responsibility to process transactions until after we have received appropriate direction and documentation, and we have had a reasonable opportunity to process the transactions. We are not responsible for interpreting or directing beneficiary designations or divisions, including separate accounting, court orders, penalty exception determinations, or other similar situations.

11.11 Investment of HSA Assets.

(a) Investment of Contributions. We will invest HSA contributions and reinvest your HSA assets as directed by you based on our then-current investment policies and procedures. If you fail to provide us with investment direction for a contribution, we will return or hold all or part of such contribution based on our policies and procedures. We will not be responsible for any loss of HSA income associated with your failure to provide appropriate investment direction.

(b) Directing Investments. All investment directions must be in a format or manner acceptable to us. You may invest in any HSA investments that you are qualified to purchase, and that we are authorized to offer and do offer at the time of the investment selection, and that are acceptable under the applicable laws governing HSAs. Your HSA investments will generally be registered in our name or our nominee's name (if applicable) for the benefit of your HSA. Specific investment information may be provided at the time of the investment.

Based on our policies, we may allow you to delegate the investment responsibility of your HSA to an agent by providing us with written notice of delegation in a format acceptable to us. We will not review or guide your agent's decisions, and you are responsible for the agent's actions or failure to act. We are not responsible for directing your investments, or providing investment advice, including guidance on the suitability or potential market value of various investments. For investments in securities, we will exercise voting rights and other similar rights only at your direction, and according to our then-current policies and procedures.

(c) Investment Fees and Asset Liquidation. Certain investment-related fees, which apply to your HSA, must be charged to your HSA and cannot be paid by you. We have the right to liquidate your HSA assets to pay fees and expenses, federal tax levies, or other assessments on your HSA. If you do not direct us on the liquidation, we will liquidate the assets of our choice and will not be responsible for any losses or claims that may arise out of the liquidation.

(d) Deposit Investments. The deposit investments provided by us may include savings, share, and/or money market accounts, and various certificates of deposit (CDs).

(e) Non-Deposit Investments. Non-deposit investments include investments in property, annuities, mutual funds, stocks, bonds, and government, municipal and U.S. Treasury securities, and other similar investments. Most, if not all, of the investments we offer are subject to investment risks, including possible loss of the principal amount invested. Specific investment disclosures may be provided to you.

11.12 Distributions. Withdrawal requests must be in a format acceptable to us, and/or on forms provided by us. We may require you, or your beneficiary after your death, to provide documentation and a proper tax identification number before we process a distribution. These withdrawals may be subject to taxes, withholding, and penalties. Distributions will generally be in cash or in kind based on our policies. In-kind distributions will be valued according to our policies at the time of the distribution. Any distribution by check, debit card or other method approved by us will be reported

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as a normal distribution, unless we inform you otherwise or unless - at the time of the distribution - we provide you with a means to state otherwise and you in fact state otherwise. Our policies may permit us to accept the return of a mistaken distribution.

11.13 Transfer and Rollover Contributions. We may accept transfers, rollovers, and other similar contributions, remotely or in person, in cash or in kind from other HSAs and from Archer Medical Savings Accounts (MSAs). Prior to completing such transactions we may require that you provide certain information in a format acceptable to us. In-kind contributions will be valued according to our policies and procedures at the time of the contribution.

11.14 Reports and Records. We will maintain the records necessary for IRS reporting on this HSA. Required reports will be provided to you, or your beneficiary after your death, and the IRS. If you believe that your report is inaccurate or incomplete you must notify us in writing within 30 days following the receipt date. Your investments may require additional state and federal reporting.

11.15 Termination. You may terminate this Agreement without our consent by providing us with a written notice of termination. A termination and the resulting distribution or transfer will be processed and completed as soon as administratively feasible following the receipt of proper notice. At the time of termination we may retain the sum necessary to cover any fees and expenses, taxes, or investment penalties.

11.16 Our Resignation. We can resign at any time by providing you with 30 days written notice prior to the resignation date, or within five days of our receipt of your written objection to an amendment. In the event you materially breach this Agreement, we can terminate this Agreement by providing you with five days prior written notice. Upon our resignation, you must appoint a qualified successor custodian or trustee. Your HSA assets will be transferred to the successor custodian or trustee once we have received appropriate direction. Transfers will be completed within a reasonable time following our resignation notice and the payment of your remaining HSA fees or expenses. We reserve the right to retain HSA assets to pay any remaining fees or expenses. At the time of termination we may retain the sum necessary to cover any fees and expenses, taxes, or investment penalties. If you fail to provide us with acceptable transfer direction within 30 days from the date of the notice, we can transfer the assets to a successor custodian or trustee of our choice, distribute the assets to you in kind, or liquidate the assets and distribute them to you in cash.

11.17 Successor Organization. If we merge with, purchase, or are acquired by, another organization, such organization, if qualified, may automatically become the successor custodian or trustee of your HSA.

11.18 Tax Year of Contributions. Any transaction, including a remote transaction - such as a computer/internet, ATM, or night deposit transaction - that results in a regular contribution to the HSA is considered a current tax year contribution. However, we may allow you to specify the tax year for a regular contribution at the time of the contribution.

IRS FORM 5305-C INSTRUCTIONS (8-2004)

General Instructions

Section references are to the Internal Revenue Code.

Purpose of Form

Form 5305-C is a model custodial account agreement that has been approved by the IRS. An HSA is established after the form is fully executed by both the account owner and the custodian. The form can be completed at any time during the tax year. This account must be created in the United States for the exclusive benefit of the account owner.

Do not file Form 5305-C with the IRS. Instead, keep it with your records. For more information on HSAs, see Notice 2004-2, 2004-2 I.R.B. 269, Notice 2004-50, 2004-33 I.R.B. 196, Publication 969, and other IRS published guidance.

Definitions

Identifying Number. The account owner's social security number will serve as the identification number of this HSA. For married persons, each spouse who is eligible to open an HSA and wants to contribute to an HSA must establish his or her own account. An employer identification number (EIN) is required for an HSA for which a return is filed to report unrelated business taxable income. An EIN is also required for a common fund created for HSAs.

High Deductible Health Plan (HDHP). For calendar year 2004, an HDHP for self-only coverage has a minimum annual deductible of $1,000 and an annual out-of-pocket maximum (deductibles, co-payments and other amounts, but not premiums) of $5,000. For calendar year 2004, an HDHP for family coverage has a minimum annual deductible of $2,000 and an annual out-of-pocket maximum of $10,000. These limits are subject to cost-of-living adjustments after 2004.

Self-only coverage and family coverage under an HDHP. Family coverage means coverage that is not self-only coverage.

Qualified medical expenses. Qualified medical expenses are amounts paid for medical care as defined in section 213(d) for the account owner, his or her spouse, or dependents (as defined in section 152) but only to the extent that such amounts are not compensated for by insurance or otherwise. With certain exceptions, health insurance premiums are not qualified medical expenses. See Notice 2004-25, 2004-15 I.R.B. 727 for transition relief for distributions for qualified medical expenses incurred in calendar year 2004.

Custodian. A custodian of an HSA must be a bank, an insurance company, a person previously approved by the IRS to be a custodian of an individual retirement account (IRA) or Archer MSA, or any other person approved by the IRS.

Specific Instructions

Article XI. Article XI and any that follow it may incorporate additional provisions that are agreed to by the account owner and custodian. The additional provisions may include, for example, definitions, restrictions on rollover contributions from HSAs or Archer MSAs (requiring a rollover not later than 60 days after receipt of a distribution and limited to one rollover during a one-year period), investment powers, voting rights, exculpatory provisions, amendment and termination, removal of custodian, custodian's fees, state law requirements, treatment of excess contributions, distribution procedures (including frequency or minimum dollar amount), use of debit, credit, or stored-value cards, return of mistaken distributions, and descriptions of prohibited transactions. Attach additional pages if necessary.

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HEALTH SAVINGS ACCOUNT DISCLOSURE STATEMENT

This Disclosure Statement. This Disclosure Statement provides you, or your beneficiaries after your death, with a summary of the rules and regulations governing this HSA.

Definitions. The Health Savings Custodial Account agreement contains a detailed definitions section. The definitions found in such section apply to this Agreement. It refers to you as the account owner, and us as the custodian. References to "you," "your," and "HSA owner" will mean the account owner, and "we," "us," and "our" will mean the custodian. Upon your death, your spouse beneficiary, if applicable, becomes "you" for purposes of this Disclosure Statement. In the event you appoint a third party, or have a third party appointed on your behalf to handle certain transactions affecting your HSA, such third party will be considered your agent and, therefore, "you" for purposes of this Disclosure Statement. Additionally, references to "HSA" will mean the custodial account.

For Additional Guidance. It is in your best interest to seek the guidance of a tax or legal professional before completing any HSA establishment documents. Your first reference for questions concerning your HSA should be Internal Revenue Code (IRC) Section 223, other relevant IRC sections, and all additional Internal Revenue Service (IRS) guidance; IRS publications that include information about HSAs; any additional provisions or amendments to such documents; and this Disclosure Statement. For more information, you can also refer to the instructions to your federal income tax return, your local IRS office, or the IRS's web site at www.irs.gov.

HSA Restrictions and Approval.

1. **Health Savings Custodial Account Agreement.** This Disclosure Statement and the Health Savings Custodial Account agreement, amendments, and additional provisions, set forth the terms and conditions governing your HSA. Such documents are the "Agreement."
2. **Individual/Family Benefit.** This HSA must be for the exclusive benefit of you, your spouse, and your dependents and upon your death, your beneficiaries. The HSA must be established in your name and not in the name of your beneficiary, living trust, or another party or entity.
3. **Beneficiary Designation.** By completing the appropriate section on the corresponding Health Savings Account Application you may designate any person(s) as your beneficiary to receive your HSA assets upon your death. You may also change or revoke an existing designation in such manner and in accordance with such rules as your HSA custodian prescribes for this purpose. If there is no beneficiary designation on file at the time of your death, or if none of the beneficiaries on file are alive at the time of your death, your HSA assets will be paid to your estate. Your HSA custodian may rely on the latest beneficiary designation on file at the time of your death, will be fully protected in doing so, and will have no liability whatsoever to any person making a claim to the HSA assets under a subsequently filed designation or for any other reason.
4. **Cash Contributions.** Regular or annual HSA contributions must be in cash, which may include a check, money order, or wire transfer. It is within our discretion to accept in-kind contributions for rollovers, transfers, or similar transactions.
5. **HSA Custodian.** An HSA custodian must be a bank, an insurance company, a person previously approved by the IRS to be a trustee of an individual retirement account (IRA) or Archer Medical Savings Account (MSA) or any other person approved by the IRS.
6. **Prohibition Against Life Insurance and Commingling.** None of your HSA assets may be invested in life insurance contracts, or commingled with other property, except in a common trust fund or common investment fund.
7. **Nonforfeitability.** The assets in your HSA are not forfeitable.
8. **Tax-Free Rollovers.** You may be eligible to make a rollover contribution of your HSA or Archer MSA distribution, in cash or in kind, to an HSA. These and other potential rollovers to and from HSAs are described in greater detail elsewhere in this Disclosure Statement.
9. **No Prohibited Transactions.** If you engage in a prohibited transaction, the HSA loses its tax exempt status as of the first day of the year. You must include the fair market value of your HSA as of that first day in your gross income for the year during which the prohibited transaction occurred, and pay all applicable taxes and penalties.
10. **No Pledging.** If you pledge all or a portion of your HSA as security for a loan, the portion pledged will be treated as a distribution to you, and the taxable portion will be included in gross income, and may be subject to the additional 10 percent tax.
11. **IRS Approval of Form.** This Agreement includes an IRS Forms 5305 series agreement. This IRS document has been approved by the IRS. This approval is not a determination of its merits, and not an endorsement of the investments provided by us or the operation of the HSA.
12. **State Laws.** State laws may affect your HSA in certain situations, including deductions, beneficiary designations, agency relationships, consent, taxes, tax withholding, and reporting.

HSA Eligibility.

1. **Eligibility for an HSA.** You are an eligible individual and may make or receive an HSA regular contribution if, with respect to any month, you:
   - **a.** are covered under a high-deductible health plan (HDHP);
   - **b.** are not covered by any other type of health plan that is not an HDHP (with certain exceptions for plans providing preventive care and limited types of permitted insurance and permitted coverage);
   - **c.** are not enrolled in Medicare; and
   - **d.** may not be claimed as a dependent on another person's tax return.
2. **High-Deductible Health Plan.** Generally, an HDHP is a health plan that satisfies certain requirements with respect to deductibles and out-of-pocket expenses. For purposes of this HSA, a high-deductible health plan is a plan with an annual deductible of at least $1,100 for self-only coverage or $2,200 for family coverage. These amounts are for 2007 and are subject to annual cost-of-living adjustments (COLAs).

   For HSA purposes, the high-deductible health plan must limit out-of-pocket expenses. For 2007, the maximum out-of-pocket expenses, which include money applied to your deductible and your coinsurance for covered charges, must be no more than $5,500 for self-only coverage or $11,000 for family coverage. These amounts are subject to annual COLAs.

   IRS Notice 2004-23 provides a safe harbor for the absence of a preventive care deductible. It states that a plan shall not fail to be treated as an HDHP by reason of failing to have a deductible for preventive care. An HDHP may therefore provide preventive care benefits without a deductible or with a deductible below the minimum annual deductible.
3. **Permitted Insurance.** You are eligible for an HSA if you have coverage for any benefit provided by permitted insurance. See IRS Notice 2004-2 for further information.

   In addition, you are eligible for an HSA if you have coverage (whether provided through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care. If a plan that is intended to be an HDHP is one in which substantially all of the coverage of the plan is through permitted insurance or other coverage described in IRS Notice 2004-2, it is not an HDHP.

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HSA Contributions.

1. **Who Can Make Regular or Annual Contributions.** If you meet the eligibility requirements for an HSA, you, your employer, your family members, or any other person (including nonindividuals) may contribute to your HSA. This is true whether you are self-employed or unemployed.
2. **Regular or Annual Contributions.** The maximum annual contribution to an HSA is the sum of the limits determined separately for each month, based on status, eligibility, and health plan coverage as of the first day of the month. The maximum monthly contribution for eligible individuals is 1/12 of the annual contribution limit. For eligible individuals with self-only coverage under an HDHP, the 2007 annual contribution limit is $2,850. For eligible individuals with family coverage under an HDHP, the annual contribution limit is $5,650. These amounts are subject to annual COLAs.

   Beginning in 2007, a provision is available if you are an eligible individual during the last month of the tax year, but are not an eligible individual for all months of the tax year. If so, you are treated as an eligible individual for all months of such tax year and may contribute up to such year's annual contribution limit. A testing period applies. The testing period for this provision begins with the last month of the contribution year and ends on the last day of the 12th month following such month. If you do not continue to be an eligible individual for the entire testing period, unless you die or become disabled, the amount of the contribution for the months you were not originally eligible will be includable in gross income for the year of the failure and is subject to a 10 percent penalty tax.

   Also beginning in 2007, if you are an eligible individual, you may elect to take a qualified HSA funding distribution from your IRA to the extent such distribution is contributed to your HSA in a direct trustee-to-trustee transfer. This amount is aggregated with all other annual contributions and is subject to your annual contribution limit. A qualified HSA funding distribution election is irrevocable and is generally available once in your lifetime. A testing period applies. The testing period for this provision begins with the month of the contribution to your HSA and ends on the last day of the 12th month following such month. If you are not an eligible individual for the entire testing period, unless you die or become disabled, the amount of the contribution made under this provision will be includable in gross income for the tax year of the month you are not an eligible individual, and is subject to a 10 percent penalty tax.

   If you have more than one HSA, the aggregate annual contributions to all the HSAs are subject to the contribution limit. This limit is decreased by the aggregate contributions to an Archer MSA. The same annual contribution limit applies whether the contributions are made by you, your employer, your family members, or any other person (including nonindividuals). Contributions may be made on your behalf even if you have no compensation or if the contributions exceed your compensation.
3. **Catch-up Contributions.** Catch-up contributions are HSA contributions made in addition to any regular HSA contributions. You are eligible to make catch-up contributions if you meet the eligibility requirements for regular contributions and are age 55 or older by the end of your taxable year and not enrolled in Medicare. As with the annual contribution limit, the catch-up contribution is computed on a monthly basis. The chart that follows shows these additional amounts.

Tax Year	Catch-up Amount
2007	$ 800.00
2008	$ 900.00
2009 and later	$ 1,000.00

4. **One or Both Spouses Have Family Coverage.** You and your spouse are treated as having family coverage if either of you has family coverage. The contribution limit is divided equally between you and your spouse, unless each of you agree on a different division. The family coverage limit is reduced further by any contribution to an Archer MSA. However, each of you may make the catch-up contributions without exceeding the family coverage limit.
5. **Contribution Deductibility.**
   a. **Your Contributions.** Contributions made by you to an HSA, which do not exceed the maximum annual contribution amount, are deductible by you when determining your adjusted gross income. You are not required to itemize deductions in order to take this deduction. However, you cannot also deduct the contributions as medical expenses under section 213. Contributions by family members or any other person (including nonindividuals) on your behalf are also deductible by you. A contribution from an IRA is not deductible.
   b. **Employer Contributions.** Employer contributions are treated as employer-provided coverage for medical expenses under an accident or health plan and are excludable from your gross income. The employer contributions are not subject to withholding from wages for income tax or subject to the Federal Insurance Contributions Act (FICA), the Federal Unemployment Tax Act (FUTA), or the Railroad Retirement Tax Act. Contributions to your HSA through a cafeteria plan are treated as employer contributions. You cannot deduct employer contributions on your federal income tax return as HSA contributions or as medical expense deductions under section 213.
6. **Contribution Deadline.** You may make regular and catch-up HSA contributions any time for a taxable year up to and including your federal income tax return due date, excluding extensions, for that taxable year. The due date for most taxpayers is April 15.

Moving Assets To and From HSAs. There are a variety of transactions that allow you to move assets to and from your HSA. We have sole discretion on whether we will accept, and how we will process, movements of assets to and from HSAs. We or the other financial organization involved in the transaction may require documentation for such activities.

1. **HSA-to-HSA Transfers.** You may transfer all or a portion of your HSA assets from one HSA to another HSA. An HSA transfer means that the HSA assets move from one HSA to another HSA in a manner that prevents you from cashing or liquidating the HSA assets, or even depositing the assets anywhere except in the receiving HSA. You may be required to complete a transfer authorization form prior to transferring your HSA assets.
2. **Archer MSA-to-HSA Transfers.** A transfer of Archer MSA assets to an HSA is permitted. However, HSA assets cannot be transferred to an Archer MSA.
3. **HSA-to-HSA Rollovers.** An HSA rollover is another way to move assets tax-free between HSAs. You may roll over all or a portion of your HSA assets by taking a distribution from an HSA and recontributing it as a rollover contribution into the same or another HSA. Rollovers to HSAs are not allowed from traditional or Roth IRAs and employer-sponsored retirement plans. You must report your HSA rollover to the IRS on your federal income tax return. Your contribution may only be designated as a rollover if the HSA distribution is deposited within 60 calendar days following the date you receive the distributed assets. You are limited to one rollover per HSA per 12 months. The distributing and receiving HSA, including the HSA assets rolled over, are subject to this

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12-month rule. The 12-month period begins on the day after you receive a distribution that will be properly rolled over into an HSA.

4. **Archer MSA-to-HSA Rollovers.** Rollovers from an Archer MSA to an HSA are permitted. However, HSA assets cannot be rolled over to an Archer MSA. The distributing MSA and receiving HSA, including the MSA assets rolled over, are subject to the 12-month rule.
5. **Health Reimbursement Arrangement (HRA)/Health Flexible Spending Account (FSA)-to-HSA Rollovers.** You may be allowed to roll over assets from your HRA or health FSA to an HSA. The rollover from your HRA or health FSA must be contributed by the employer directly to your HSA. This provision is available through tax-year 2011 if you are an eligible individual. A testing period applies. The testing period for this provision begins with the month of the contribution to your HSA and ends on the last day of the 12th month following such month. If you are not an eligible individual for the entire testing period, unless you die or become disabled, the amount of the contribution made under this provision will be includable in gross income for the tax year of the month you are not an eligible individual, and is subject to a 10 percent penalty tax.

HSA Distributions. You or, after your death, your beneficiary may take an HSA distribution, in cash or in kind based on our policies, at any time. However, depending on the timing and amount of your distribution you may be subject to income taxes and/or penalty taxes. HSA custodians/trustees are not required to determine whether HSA distributions are used for qualified medical expenses.

1. **Removal of Excess Contributions.** You may withdraw all or a portion of your excess contribution and attributable earnings by your federal income tax return due date, including extensions, for the taxable year for which the contribution was made. The excess contribution amount distributed will not be taxable, but the attributable earnings on the contribution will be taxable in the year in which the distribution is received. If you timely file your federal income tax return, you may still remove your excess contribution, plus attributable earnings, as late as October 15 for calendar year filers.
2. **Qualified Medical Expenses.** Qualified medical expenses are expenses paid by you, your spouse, or your dependents for medical care as defined in section 213(d) (including nonprescription drugs as described in Revenue Ruling 2003-102, 2003-38 I.R.B. 559), but only to the extent the expenses are not covered by insurance or otherwise. The qualified medical expenses must be incurred only after the HSA has been established.
3. **Death.** Upon your death, any balance remaining in your HSA becomes the property of the beneficiaries named in the HSA agreement.
   a. **Spouse.** If your spouse is the beneficiary of your HSA, the HSA becomes his/her HSA as of the date of your death. We may require your spouse to transfer the assets to an HSA of his/her own. Your spouse is subject to income tax only to the extent distributions from your HSA are not used for qualified medical expenses.
   b. **Nonspouse.** If your beneficiary is not your spouse, the HSA ceases to be an HSA as of the date of your death. If your beneficiary is your estate, the fair market value of your HSA as of the date of your death is taxable on your final return. For other beneficiaries, the fair market value of your HSA is taxable to them in the tax year that includes such date. For such a person (except your estate), this amount is reduced by any payments from the HSA made for your qualified medical expenses, if paid within one year after your death.

Federal Income Tax Status of Distributions.

1. **Taxation.** Distributions from your HSA used exclusively to pay for qualified medical expenses of you, your spouse, or your dependents are excludable from gross income. In general, amounts in an HSA can be used for qualified medical expenses and will be excludable from gross income even if you are not currently eligible for contributions to the HSA. However, any amount of the distribution not used exclusively to pay for qualified medical expenses of you, your spouse, or your dependents is includable in your gross income and is subject to an additional 10 percent tax on the amount includable, except in the case of distributions made after your death, your disability, or your attainment of age 65. HSA distributions which are not rolled over will be taxed as income in the year distributed, unless they are used for qualified medical expenses. You may also be subject to state or local taxes and withholding on your HSA distributions.
2. **Earnings.** Earnings, including gains and losses, on your HSA will not be subject to federal income taxes until they are considered distributed.
3. **Ordinary Income Taxation.** Your taxable HSA distribution is usually included in gross income in the distribution year.

Estate and Gift Tax. The designation of a beneficiary to receive HSA distributions upon your death will not be considered a transfer of property for federal gift tax purposes. Upon your death, the value of all assets remaining in your HSA will usually be included in your gross estate for estate tax purposes, regardless of the named beneficiary or manner of distribution. There is no specific estate tax exclusion for assets held within an HSA.

Federal Income Tax Withholding. If federal withholding is applicable, the custodian may require the completion of a withholding election document.

Annual Statements. Each year we will furnish you and the IRS with IRS-required statements reflecting the activity in your HSA.

Federal Tax Penalties. Several tax penalties may apply to your various HSA transactions, and are in addition to any federal, state, or local taxes. Federal penalties and excise taxes are generally reported and remitted to the IRS along with your federal income tax return. The penalties may include any of the following taxes:

1. **Additional 10 Percent Tax.** Any amount of a distribution not used exclusively to pay for qualified medical expenses of you, your spouse, or your dependents is subject to an additional 10 percent tax on the amount includable in your gross income, except in the case of distributions made after your death, your disability, or your attainment of age 65. In addition, any failure to meet a required testing period resulting in amounts includable in gross income will make such amounts subject to an additional 10 percent tax.
2. **Excess Contribution Penalty Tax.** If a contribution to your HSA exceeds the amount you are eligible for, you have an excess contribution, which is subject to a 6 percent excise tax. The excise tax applies each year that the excess contribution remains in your HSA. If you timely file your federal income tax return, you may still remove your excess contribution, plus attributable earnings, as late as October 15 for calendar year filers.

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