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Appendix

Claims Procedures

How to File a State Health Plan Claim

Medical and Mental Health and Substance Abuse Claims

If you received services from a physician, a hospital or another provider that participates in a State Health Plan network, you do not have to file a claim. Your provider will file for you. You are responsible for the usual out-of-pocket expenses (deductibles, copayments, coinsurance and non-covered services).

However, if you did not use a network provider or if you have a claim for a non-network service, you may have to file the claim yourself. You can get medical claim forms from your benefits office, EIP and BlueCross BlueShield of South Carolina (BCBSSC). Claim forms also are on the EIP Web site. Select “Health Expenses Claim Form” for medical claims. For mental health and substance abuse claims, select “Mental Health/Substance Abuse Claim Form.”

Complete a separate claim form for each individual who received care. To file a claim:

- Complete the claim form
- Attach your itemized bills, which must show: the amount charged; the patient’s name; the date and place of service; the diagnosis, if applicable; and the provider’s federal Tax Identification Number or National Provider Identifier (NPI), if available
- File claims within 90 days of the date you receive services or as soon as reasonably possible.

BCBSSC and APS must receive claims by the end of the calendar year after the year in which expenses are incurred. Otherwise, claims cannot be paid.

Mail BCBSSC claims to:

State Business Unit
BlueCross BlueShield of South Carolina
P.O. Box 100605
Columbia, SC 29260-0605

Mail APS claims to:

APS Healthcare
Claims, State of SC
P.O. Box 1307
Rockville, MD 20849

Claims filed to BlueCross BlueShield of South Carolina Only

Generally, if you obtain medical services outside South Carolina or the U.S. 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 provider should submit the claim.

When you receive services from doctors and hospitals that are not part of the BlueCard network, you pay the doctor or hospital for inpatient care, outpatient hospital care and other medical services. You must then complete a BlueCard 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.BCBS.com. At the site, type “BlueCard claim form” in the “Search” box.

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 interactive "Coordination of Benefits Form/ Direct Claim Form." It is available on EIP's Web site, www.eip.sc.gov as "Prescription Drug Claim Form." You may also request a copy by calling Medco's Member Services at 800-711-3450.

Remember that benefits are NOT payable if you use a non-participating pharmacy in the U.S.

How to File a Dental Claim

The easiest way to file a claim is to assign benefits to your dentist. Assigning benefits means that you authorize your dentist to file claims for you and to receive payment from the plan for your treatment. To do this, you must show a staff member in your dentist's office your dental identification card and ask that the claim be filed for you. Be sure to sign the payment authorization block of the claim form. BlueCross BlueShield of South Carolina (BCBSSC) will then pay your dentist directly. You are responsible for the difference between the benefit payment and the actual charge.

If your dentist will not file your claims, you can file to BCBSSC. The claim form is available on EIP's Web site, www.eip.sc.gov. Complete items 1-11 on the claim form, and ask your dentist to complete items 12-29.

If your dentist will not complete his portion of the form, get an itemized bill showing this information:

1. The dentist's name and address and federal tax identification number or National Provider Identifier (NPI)
2. The patient's name
3. The date of each service
4. The name of 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 disclose your health information to an actuary to make decisions regarding premium rates, or it may share your personal health information with other business associates that, through written agreement, provide services to EIP. These business associates, such as consultants or third-party administrators, are required to protect the privacy of your personal health information.

- **For Purposes of Administering the Plan.** EIP may disclose your health information to its Plan sponsor, the South Carolina Budget and Control Board, for the purpose of administering the Plan. For example, EIP may disclose aggregate claims information to the Plan sponsor to set Plan terms.
- **Treatment Alternatives and Health-Related Benefits and Services.** EIP may use and disclose your health information to contact you about health-related benefits or services that may be of interest to you. For example, you may be contacted and offered enrollment in a program to assist you in handling a chronic disease, such as disabling high blood pressure.
- **Individuals Involved in Your Care or Payment for Your Care.** EIP may, in certain circumstances, disclose health information about you to your representative, such as a friend or family member who is involved in your healthcare or to your representative who helps pay for your care. EIP may disclose your health information to an agency assisting in disaster relief efforts so that your family can be notified about your condition, status and location.
- **Research.** EIP may use and disclose your de-identified health information for research purposes, or EIP may share health information for research approved by an institutional review board or privacy board after review of the research rules to ensure the privacy of your health information. For example, a research project may compare the health/recovery of patients who receive a medication with those who receive another medication for the same condition.
- **As Required By Law.** EIP will disclose health information about you when it is required to do so by federal or South Carolina law. For example, EIP will report any suspected insurance fraud as required by South Carolina law.
- **To Avert a Serious Threat to Health or Safety, or for Public Health Activities.** EIP may use and disclose health information about you, when necessary to prevent a serious threat to your health and safety or to the health and safety of the public or for public health activities.
- **Organ and Tissue Donation.** If you are an organ donor, EIP may disclose your health information to organizations that handle organ, eye or tissue procurement, transplantation or donation.
- **Coroners, Medical Examiners and Funeral Directors.** EIP may share your health information with a coroner/medical examiner or funeral director as needed to carry out their duties.
- **Military and Veterans.** If you are a member of the armed forces, EIP may disclose health information about you after the notice requirements are fulfilled by military command authorities.
- **Workers' Compensation.** EIP may disclose health information about you for Workers' Compensation or similar programs that provide benefits for work-related injuries or illness.
- **Health Oversight Activities.** EIP may disclose your health information to a health oversight agency for authorized activities, such as audits and investigations.
- **Lawsuits and Disputes.** EIP may disclose your health information in response to a court or administrative order, a subpoena, discovery request, or other lawful process if EIP receives assurance from the party seeking the information that you have either been given notice of the request, or that the party seeking the information has tried to secure a qualified protective order regarding this information.

- **Law Enforcement.** EIP may disclose information to a law enforcement official in response to a court order, subpoena, warrant, summons or similar process.
- **National Security, Intelligence Activities and Protective Services.** EIP may disclose your health information to authorized officials for intelligence, counterintelligence and other national security activities; to conduct special investigations; and to provide protection for the President, other authorized persons or foreign heads of state.
- **Inmates.** If you are an inmate of a correctional institution or are in the custody of a law enforcement official, EIP may disclose your health information if the disclosure is necessary to provide you with healthcare or to protect your health and safety or the health and safety of others.
- EIP will not use or release your health information for purposes of fundraising activities.

Your Health Information Rights

You have these rights regarding the health information that EIP has about you:

- **Right to Inspect and Copy.** You have the right to request to see and receive a copy of your health information, or, if you agree to the preparation cost, EIP may provide you with a written summary. Some health information is exempt from disclosure. To see or obtain a copy of your health information, send a written request to the Director, EIP, 1201 Main Street, Suite 300, P.O. Box 11661, Columbia, SC 29211. EIP may charge a fee for the costs associated with your request. In limited cases, EIP may deny your request. If your request is denied, you may request a review of the denial.
- **Right to Amend.** If you believe that your health information is incorrect or incomplete, you may ask EIP to amend the information by sending a written request to the Director, EIP, 1201 Main Street, Suite 300, P.O. Box 11661, Columbia, SC 29211, stating the reason you believe your information should be amended. EIP may deny your request if you ask it to amend information that was not created by EIP, the information is not part of the health information kept by or for EIP, the information is not part of the information you would be permitted to inspect and copy or your health information is accurate and complete. You have the right to request an amendment for as long as EIP keeps the information.
- **Right to an Accounting of Disclosures.** You have the right to request a list of the disclosures of your health information EIP has made. This list will NOT include health information released to provide treatment to you, to obtain payment for services or for healthcare operations; releases for national security purposes; releases to correctional institutions or law enforcement officials as required by law; releases authorized by you; releases of your health information to you; releases as part of a limited data set; releases to representatives involved in your healthcare; releases otherwise required by law or regulation and releases made prior to April 14, 2003. You must submit your request for an accounting of disclosures in writing to the Director, EIP, 1201 Main Street, Suite 300, P.O. Box 11661, Columbia, SC 29211, indicating a time period that may not go back beyond six years and may not include dates before April 14, 2003. Your request should indicate the form in which you want the list (for example, by paper or electronically). The first list that you request within a 12-month period will be provided free of charge; however, EIP may charge you for the cost of providing additional lists within a 12-month period.
- **Right to Request Restrictions of Use and Disclosure and Right to Request Confidential Communications.** You have the right to request a restriction on the health information that EIP uses or discloses. You also have the right to request a limit on the health information that EIP discloses about you to someone who is involved in your care or the payment for your care. For example, you may ask that EIP not use or disclose information about an immunization or a particular service that you received. EIP is not required to agree to your request(s). If EIP does agree, EIP will comply with your request(s) unless the information is needed to provide you with emergency treatment. In your request, you must specify what

information you want to limit and to whom you want the limits to apply. For example, you may request that your claims information not be sent to your home address. In addition, you have the right to request that EIP communicate with you by certain means or at a certain location. EIP will attempt to accommodate reasonable request(s), pursuant to the HIPAA Privacy Rule.

- You must make these request(s), in writing, to the Director, EIP, 1201 Main Street, Suite 300, P.O. Box 11661, Columbia, SC 29211.
- **Right to a Paper Copy of This Notice.** You have the right to request a paper copy of this notice at any time by contacting EIP's Privacy Officer (see the first page of this notice). **You may obtain a copy of this notice at EIP's 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.

Initial COBRA Notice

Continuation Coverage Rights under COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires that health, vision, dental and/or Medical Spending Account coverage continue to be offered to you and/or your covered dependents when you are no longer eligible for group coverage.

On the following pages is a copy of your Initial COBRA Notice. When you became covered under group benefits offered by the State of South Carolina through the Employee Insurance Program, you received an Initial COBRA Notice. This notice contains important information about your right to continue your coverage if you lose it under certain circumstances. It also explains what you must do to protect your right to continued coverage.

It is important that you read this notice. It is also important that each family member you cover be familiar with this information.

If you cover a family member who does not live with you, you must notify your benefits office so a COBRA notice can be sent to him. Also, if you move, please inform your benefits office of your new address or change your address through MyBenefits, EIP's online enrollment system.

Under the rules of the plan and federal law, you must notify your benefits office of certain events, including your divorce or legal separation or if a person you cover loses eligibility under the rules of the plan. Please carefully read the section in the notice about your notification responsibilities. If you fail to follow the procedures, your rights under COBRA could be lost.

Additional information about COBRA is on page 26. If you have questions about this notice or your rights and responsibilities under COBRA, please contact your benefits administrator.

* YOUR RIGHTS AND OBLIGATIONS UNDER COBRA *

What is COBRA coverage?

Under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), coverage under the Plan's group health benefits may be continued when it otherwise would end due to a qualifying event. This continuation of coverage is typically referred to as "COBRA coverage" but it is actually the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights.

COBRA (and the description of COBRA coverage contained in this notice) applies only to the group health benefits offered under the Plan (the Health, Dental, Dental Plus, Vision, and MoneyPlu\$ medical flexible spending account components) and not to any other benefits offered under the Plan.

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

Who is entitled to elect COBRA coverage?

If a qualified beneficiary loses coverage under group health benefits due to one of the qualifying events listed below, the qualified beneficiary will be allowed to continue group health benefits for a specified period of time at group rates. After a qualifying event occurs and any required notice of that event is properly provided to the benefits office, COBRA coverage will be offered to each qualified beneficiary who is losing coverage as a result of that event.

Who is a qualified beneficiary?

To be a qualified beneficiary, a person:

- Must have been covered (under Health, Dental, Dental Plus, Vision, and/or MoneyPlu\$ medical flexible spending account) on the day before the qualifying event; AND
- Must be a covered employee, the covered spouse of the employee, or a covered dependent child of the employee.

There are two situations that may occur during the COBRA coverage period that would cause a child (who was not covered at the time of the qualifying event) to gain the status of a qualified beneficiary. These are addressed later in this notice.

What is a qualifying event?

A qualifying event is a life event that occurs that would cause a qualified beneficiary to lose coverage under group health benefits offered by the Plan (Health, Dental, Dental Plus, Vision, and/or MoneyPlu\$ medical flexible spending account).

For a Covered Employee – If you are the covered employee, you will experience a qualifying event and will have the right to elect COBRA coverage if you lose your group health benefits because any of the following happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

For a Covered Spouse – If you are the covered spouse of an employee, you will experience a qualifying event and will have the right to elect COBRA coverage if you lose your group health benefits because any of the following happens:

- Your spouse dies;

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- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his gross misconduct; or
- You become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health benefits in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

For a Covered Dependent Child – If you are the covered dependent child of an employee, you will experience a qualifying event and will have the right to elect COBRA coverage if you lose your group health benefits because any of the following happens:

- Your parent (the employee) dies;
- Your parent's (the employee) hours of employment are reduced;
- Your parent's (the employee) employment ends for any reason other than his gross misconduct; or
- You stop being eligible for coverage under the Plan as a dependent child (for example, you get married, you turn age 25, you lose full-time student status, or you graduate). For more information about when a dependent ceases to be eligible for coverage under the terms of the Plan, please refer to your Insurance Benefits Guide.

What do you do when a qualifying event occurs?

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS: divorce, legal separation, and dependent child losing eligibility for coverage. For these qualifying events, the benefits office will offer you COBRA coverage only if you notify the benefits office within 60 days after the later of: (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. To notify the benefits office of these qualifying events, complete the "Notice of COBRA Qualifying Event" form and deliver it to the benefits office at the address on the first page of this document. See "How do you provide a proper and timely notice?" for details.

When the qualifying event is the end of employment or reduction of hours of employment, you do not need to notify the benefits office of any of these qualifying events. The benefits office will offer COBRA coverage to the appropriate qualified beneficiaries. When the qualifying event is the death of the employee, the benefits office will offer survivor coverage. Refer to the Insurance Benefits Guide for details.

How do you provide a proper and timely notice?

Any notice that you provide must be in writing and must be submitted on the forms provided by the Plan. These forms are available at no cost from the benefits office or the Employee Insurance Program at 803-734-0678 (toll-free outside Columbia at 888-260-9430) or can be downloaded from www.eip.sc.gov under COBRA Subscribers. Oral notice, including notice by telephone, is not acceptable. Procedures for making a proper and timely notice are:

- Step 1- Complete the proper form
- Step 2- Make a copy of the forms for your records.
- Step 3- Attach the required documentation depending upon the qualifying event (as indicated on the form).
- Step 4- Mail or hand-deliver the form and required documentation.
- Step 5- Call within 10 days to ensure the form and required documentation have been received.

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the individual at the address specified for delivery no later than the last day of the applicable notice period.

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How can you elect COBRA coverage?

Once the benefits office learns a qualifying event has occurred, the qualified beneficiaries will be notified of their rights to elect COBRA coverage. Each qualified beneficiary has an independent election right and will have 60 days to elect coverage. The 60-day election window is measured from the later of the date coverage is lost due to the event or from the date of notification to the qualified beneficiaries. This is the maximum period allowed to elect COBRA coverage. The Plan does not provide an extension of the election period beyond what is required by law.

The covered employee or the employee's covered spouse can elect continuation coverage on behalf of all of the qualified beneficiaries. A parent may elect to continue coverage on behalf of a covered dependent child who is losing coverage as a result of the qualifying event. For each qualified beneficiary who elects to continue group health benefits, COBRA coverage will begin on the date that coverage under the Plan would be lost because of the event. **If COBRA coverage is not elected for a qualified beneficiary within the 60-day election window, he will lose all rights to elect COBRA coverage and will cease to be a qualified beneficiary.**

How long does COBRA coverage last for Health, Dental, Dental Plus, and/or Vision?

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described here are maximum coverage periods.

18 months – When the loss of coverage is due to end of employment (other than for reasons of gross misconduct) or reduction in hours of employment, coverage under the Health, Dental, Dental Plus, and Vision components generally may be continued up to 18 months. There are three possible situations that may provide coverage beyond 18 months when loss of coverage is due to end of employment or reduction in hours of employment.

1. Medicare Entitlement Rule (for covered dependents only) – When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits during the last 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) can last up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight (8) months prior to the date on which employment terminates, the dependent qualified beneficiaries who lost coverage as a result of his termination will be offered 28 months of continuation coverage (36-8=28). The covered employee, however, is offered only 18 months. This COBRA coverage period is available only if the covered employee becomes entitled to Medicare during the 18 months prior to termination of employment or reduction of hours.

2. Social Security Disability Extension – If any of the qualified beneficiaries is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from a covered employee's termination of employment or reduction of hours (generally 18 months) may be extended to a total of up to 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the employee's termination of employment or reduction of hours. The Social Security Administration must determine that the qualified beneficiary's disability started at some time before the 61st day after the covered employee's termination of employment or reduction of hours *and* the disability must last until at least the end of the 18-month period of continuation coverage.

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

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

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You also must provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. In providing this notice, you must use the Plan's form entitled "Notice to Extend COBRA Continuation Coverage" (you may obtain a copy of this form from the benefits office or the Employee Insurance Program at no charge, or you can download the form at www.eip.sc.gov under COBRA Subscribers), and you must follow the notice procedures outlined in the section entitled "How do you provide a proper and timely notice?" **If these procedures are not followed or if the notice is not provided during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.**

3. Second Qualifying Event Extension – If your family experiences a second qualifying event during the 18 months (or, in the case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction of hours, the maximum COBRA coverage period may be extended to a total of up to 36 months from the date of the original qualifying event. Such second qualifying events may include the death of the employee, divorce or legal separation from the employee, or dependent child losing eligibility for coverage under the Plan.

This extension due to a second qualifying event is available only if you notify your COBRA ADMINISTRATOR in writing at the address where you deliver your COBRA premium payments of the second qualifying event within 60 days after the date of the second qualifying event. In providing this notice, you must use the Plan's form entitled "Notice to Extend COBRA Continuation Coverage" (you may obtain a copy of this form from the Employee Insurance Program at no charge, or you can download the form at www.eip.sc.gov under COBRA Subscribers), and you must follow the procedures specified in the section entitled "How do you provide a proper and timely notice?" **If these procedures are not followed or if the notice is not provided during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

36 months – When the loss of coverage is due to the death of the employee, divorce or legal separation from the employee, or dependent child losing eligibility for coverage under the Plan, each qualified dependent beneficiary will have the opportunity to continue coverage under the Health, Dental, Dental Plus, and Vision components for 36 months from the date of the original qualifying event.

How long does COBRA coverage last for the MoneyPlu\$ medical flexible spending account?

COBRA coverage under the MoneyPlu\$ medical flexible spending account can last only until the end of the plan year in which the qualifying event occurred. The period of COBRA coverage under the MoneyPlu\$ medical flexible spending account cannot be extended under any circumstances. COBRA coverage under the MoneyPlu\$ medical flexible spending account will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected under the MoneyPlu\$ medical flexible spending account by the covered employee, reduced by reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the contributions for MoneyPlu\$ medical flexible spending account COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the MoneyPlu\$ medical flexible spending account coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by reimbursable claims submitted up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and COBRA coverage will terminate at the end of the plan year. Unless otherwise elected, all qualified beneficiaries who were covered under the MoneyPlu\$ medical flexible spending account will be covered together for continuation under COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate annual limit and a separate contribution.

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How much does COBRA coverage cost?

Generally, each qualified beneficiary is required to pay 100% of the applicable premium payment for the coverage that is continued, plus a 2% administration charge. The premium includes both the employee's and employer's share of the total premium. In the case of an extension of continuation coverage due to a disability, if the disabled qualified beneficiary has elected the extension, then the applicable premium rate is 150% of the applicable premium payment. If only non-disabled qualified beneficiaries extend coverage, the premium rate will remain at 102%.

More information about individuals who may be qualified beneficiaries*Children born to or placed for adoption with the covered employee during COBRA coverage period*

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

Alternate recipients under QMCSOs or NMSNs

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

For more information

This notice is a summary and does not fully describe COBRA coverage, other rights under the Plan, or details about your group health benefits. More information is available in your Insurance Benefits Guide, from the benefits office, or from the Employee Insurance Program.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your Insurance Benefits Guide, contact your benefits office, contact the Employee Insurance Program at 803-734-0678 (toll-free outside Columbia at 888-260-9430), or visit the Employee Insurance Program's website (www.eip.sc.gov).

For more information about your rights under COBRA, contact the Centers for Medicare & Medicaid Services at www.cms.hhs.gov/COBRAContinuationofCov/ or phig@cms.hhs.gov.

Keep the Benefits Office Informed of Address Changes

In order to protect your rights, you should notify the benefits office of any changes in the employee's address and the addresses of covered family members as soon as possible.

Plan Administrator/EIP

The Employee Insurance Program is the plan administrator for the group health benefits, which includes Health, Dental, Dental Plus, Vision, and MoneyPlu\$ medical flexible spending account. You can contact the Employee Insurance Program by calling 803-734-0678 (toll-free outside Columbia at 888-260-9430) or visiting the Employee Insurance Program's web site (www.eip.sc.gov). The Employee Insurance Program's mailing address is P.O. Box 11661, Columbia, South Carolina 29211.

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