DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Wells / Bowling	6-15-07

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000785	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Deps Copy of original attached give Faye original copy. Jen 7/10/07	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

log: Wells/Bowl
C: Depr
na

June 12, 2007

Ms. Susan B. Bowling, Acting Director
South Carolina Department of Health & Human Services
P. O. Box 8206
Columbia, South Carolina 29202-8206

Dear Ms. Bowling:

We are pleased to inform you of the approval of South Carolina's Medicaid State Plan Amendment (SPA) 07-003. This SPA provides for the implementation of flexibilities granted under section 6044 of the Deficit Reduction Act of 2005 (DRA), State Flexibility in Benchmark Benefit Packages, which provided the addition of section 1937 of the Social Security Act (the Act). This approval will provide for voluntary enrollment in the benchmark plan for most categorically eligible families and children, as well as individuals in disability-based eligibility groups. The SPA is effective April 1, 2007.

The benchmark plan benefits will be the high deductible health plan of the State Employee's Health Plan, which is the health plan that is offered and generally available to South Carolina State employees. Initial implementation will be limited to 1,000 beneficiaries who live in Richland County, South Carolina. The State will comply with Federal requirements of advance public notice, which can include, but is not limited to State website posting or public service announcements.

A formal hard copy of the SPA and 179 will follow in the mail. If you have any questions, please contact Ms. Elaine Elmore at (404) 562-7408. We congratulate your State's pioneering efforts to implement the flexibility afforded to states under section 1937 of the Act.

Sincerely,

Renard L. Murray

Renard L. Murray, D.M.
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc: Cheryl Powell

RECEIVED
JUN 15 2007
Department of Health & Human Services
OFFICE OF THE DIRECTOR

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

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Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc: Cheryl Powell

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: SC07-003

2. STATE: South Carolina

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2007

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1937(b) of the Social Security Act.

7. FEDERAL BUDGET IMPACT:
a. FFY 2007 $ 3,700,000
b. FFY 2008 $ 1,600,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Section 3.1-C; Pages 1 thru 8
Attachment 1 to Section 3.1-C
Attachment 2 to Section 3.1-C

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
ALTERNATIVE BENEFITS STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Mr. Kerr was designated by the Governor to review and approve all State Plans.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Robert M. Kerr

13. TYPED NAME:
Robert M. Kerr

14. TITLE:
Director

15. DATE SUBMITTED:
March 14, 2007

16. RETURN TO:

South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
March 19, 2007

18. DATE APPROVED:
June 12, 2007

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
April 1, 2007

20. SIGNATURE OF REGIONAL OFFICIAL:
Renard L Murray

21. TYPED NAME:
Renard L. Murray, D.M.

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health Ops

23. REMARKS: Approved with the following changes to Items 8 and 9 as authorized by the SA on e-mail dated June 5, 2007: Item 8 changed to read: "Attachment 3.1-C, Pages 1 thru 9; Attachment 1 to Attachment 3.1-C; Attachment 2 to Attachment 3.1-C, Pages 1 thru 33" and Item 9 changed to read "NEW".

ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

1937(a), 1937(b)

_X_ / The State elects to provide alternative benefits under Section 1937 of the Social Security Act.

A. Populations

The State will provide the benefit package to the following populations:

a. __ / Required Populations who are full benefit eligible individuals in a category established on or before February 8, 2006, will be required to enroll in an alternative benefit package to obtain medical assistance except if within a statutory category of individuals exempted from such a requirement.

List the population(s) subject to mandatory alternative coverage:

_____

_X_ / Opt-In Populations who will be offered opt-in alternative coverage and who will be informed of the available benefit options prior to having the option to voluntarily enroll in an alternative benefit package.

List the populations/individuals who will be offered opt-in alternative coverage:

Eligibility Group	Statutory Citation
Transitional Medical Assistance	Section 1902(a)(10)(A)(i)(I)/Section 1925
General Hospital	Section 1902 (a)(10)(A)(ii)(I)
TEFRA – Katie Beckett Children	Section 1902(e)(3)
Breast and Cervical Cancer Program	Section 1902(a)(10)(A)(ii)(XVIII)
Partners for Healthy Children	Section 1902(a)(10)(A)(i)(VI) and (VII)
Working Disabled	Section 1902(a)(10)(A)(ii)(XIII)
Pregnant Women and Infants	Section 1902(a)(10)(A)(i)(IV)
Aged, Blind and Disabled	Section 1902 r(2)(A)
Section 1931 Low Income Families	Section 1902(a)(10)(A)(i)(I) and Section 1931
SSI	Section 1902(a)(10)(A)(i)(II)
Pass-along Categories	Section 1634(b), (c) and (d), Section 503 of Public Law 94-566
Ribicoff	Section 1902(a)(10)(A)(i)(I)

For the opt-in populations/individuals, describe the manner in which the State will inform each individual that such enrollment is voluntary, that such individual may opt out of such alternative benefit package at any time and regain immediate eligibility for the regular Medicaid program under the State plan.

Beneficiary Counselors: Independent of this option, a beneficiary counselor program is being implemented in the State to assist client selection of appropriate delivery models. The counselor will discuss this option with the beneficiary at time of application, provide a comparison of the alternative plan to the regular Medicaid program, make sure the beneficiary knows that participation in the alternate plan is optional. The beneficiary will also be informed that after selection of the alternate plan, the beneficiary has the right to return to the regular Medicaid plan at any time. The member contacts the broker to request the change and it is effective the first day of the following month.

For the opt-in populations/individuals, provide a description of the benefits available under the alternative benefit package and a comparison of how they differ from the benefits available under the regular Medicaid program, as well as an assurance that the State will inform each individual of this information.

SEE ATTACHMENT 1 to ATTACHMENT 3.1-C

c. _X_ / Geographical Classification

States can provide for enrollment of populations on a statewide basis, regional basis, or county basis.

List any geographic variations:

Initial implementation in Richland County.

Please provide a chart, listing eligible populations (groups) by mandatory enrollment, opt-in enrollment, geography limitations, or any other requirements or limitations.

Initial enrollment limited to 1000 beneficiaries in Richland County.

The State understands that the implementation of the 1000 volunteers cannot discriminate on the basis of sex, race, color, national origin, handicap, disability and age. The State will operationalize the 1000 volunteer limit by:

- Enrolling volunteers on a first come, first serve basis
- Establishing a waiting list should volunteers exceed 1000
- As volunteers withdraw or are otherwise removed from the program, the next beneficiary on the waiting list will be contacted to determine continued interest in the plan
- If the volunteer indicates continued interest, the plan is again reviewed to ensure understanding of the differences from regular Medicaid and the member is enrolled for the next month.

B. Description of the Benefits

_X_ / The State will provide the following alternative benefit packages (check all that apply).

1937(b)

1. _X_ / Benchmark Benefits

a. __ / **FEHBP-equivalent Health Insurance Coverage –** The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(l) of Title 5, United States Code.

b. _X_ / **State Employee Coverage** – A health benefits coverage plan that is offered and generally available to State employees within the State involved. The State has sought to make this plan as close as possible to the Standard State Health Plan. Certain policy exceptions apply:

- There is no pre-existing condition;
- Maternity coverage for dependent is provided;
- Pharmacy payments are made without payment from the beneficiary (pass through).

Additionally, the following chart describes differences/limitations in coverage between Medicaid State Plan and the Benchmark Plan.

Purpose: This chart identifies the differences in coverage between the Medicaid State Plan and the Benchmark Plan.

Service	State Health Plan	Medicaid
Ambulance	No benefits are payable for service used for routine, non-emergent transportation including but not limited to, travel to a facility for scheduled medical or surgical treatments, such as dialysis or cancer treatment.	Emergency transport or non-emergency transport to a non-scheduled medical service (i.e. transport from nursing home to hospital, home to hospital or scene to hospital) or when the beneficiary is non-ambulatory and a health care professional certifies that the health condition requires an ambulance.
Chiropractor	Neuromuscular condition only; spinal axis aches, sprains, nerve pains and functional disabilities of the spine; limited to $500/year after annual deductible met.	Manual manipulation of the spine, to correct a subluxation identified by x-ray; 1 treatment/visit, 1 visit/day, 12 visits/year, 2 x-ray/year.
Complications of non covered service, including complications from a covered person's use of discount services	No benefit	Covered if medically necessary
Over the counter (OTC) medicines	No benefit	Member must obtain a written prescription from their provider for the OTC. The OTC counts in the limit of 4.
Routine physical exams	One per year (including OB-GYN annual)	Once every 5 years.
Smoking cessation or deterrence products	No benefit.	Coverage of certain pharmaceuticals used to facilitate the discontinuance of tobacco products. A written prescription is required.
Out of network service	No benefit	Covers Medicaid covered service provided by a Medicaid enrolled provider

Attach a copy of the State's employee benefits plan package.

SEE ATTACHMENT 2 to ATTACHMENT 3.1-C
With link to www.eip.sc.gov

c. __/ **coverage Offered Through a Health Maintenance Organization (HMO)** – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State involved. Attach a copy of the HMO's benefit package.
d. __/ **Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide a description of the State's plan. Provide a full description of the benefits package including the benefits provided and any applicable limits.

2. __/ Benchmark-Equivalent Benefits.

Specify which benchmark plan or plans this benefit package is equivalent to, and provide the information listed above for that plan: .

a. __/ The State assures that the benefit package(s) have been determined to have an actuarial value equivalent to the specified benchmark plan or plans in an actuarial report that: 1) has been prepared by an individual who is a member of the American Academy of Actuaries; 2) using generally accepted actuarial principles and methodologies; 3) using a standardized set of utilization and price factors; 4) using a standardized population that is representative of the population being served; 5) applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and 6) takes into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage. Attach a copy of the report.

b. __/ The State assures that if the State provides additional

services under the benchmark benefit package(s) from any one of all the following categories: 1) prescription drugs; 2) mental health services; 3) vision services, and/or 4) hearings services, the coverage of the related benchmark-equivalent benefit package(s) will have an actuarial value that is at least 75 percent of the actuarial value of the coverage of that category of services included in the benchmark benefit package. Attach a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c. __/ The State assures that the actuarial report will select and specify the standardized set and populations used in preparing the report.

(1) __/ **Inclusion of Basic Services –** This coverage includes benefits for items and services within the following categories of basic services: (Check all that apply).

__/ Inpatient and outpatient hospital services;
__/ Physicians' surgical and medical services;
__/ Laboratory and x-ray services;
__/ Well-baby and well-child care services as defined by the State, including age-appropriate immunizations in accordance with the Advisory Committee on Immunization Practices
__/ Other appropriate preventive services, as designated by the Secretary.
__/ Clinic services (including health center services) and other ambulatory health care services.
__/ Federally qualified health care services
__/ Rural health clinic services
__/ Prescription drugs
__/ Over-the-counter medications
__/ Prenatal care and pre-pregnancy family services and supplies
__/ Inpatient Mental Health Services not to exceed 30 days in a calendar year
__/ Outpatient mental health services furnished in a State-operated facility and including community-based services
__/ Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices)
__/ Disposable medical supplies including diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formulas and dietary supplements.
__/ Nursing care services, including home visits for private duty

nursing, not to exceed 30 days per calendar year
__/ Dental services
__/ Inpatient substance abuse treatment services and residential substance abuse treatment services not to exceed 30 days per calendar year
__/ Outpatient substance abuse treatment services
__/ Case management services
__/ Care coordination services
__/ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders __/ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. __/ Premiums for private health care insurance coverage __/ Medical transportation
__/ Enabling services (such as transportation, translation, and outreach services
__/ Any other health care services or items specified by the Secretary and not included under this section

(2) Additional benefits for voluntary opt-in populations: __/ Home and community-based health care services
__/ Nursing care services, including home visits for private duty nursing

Attach a copy of the benchmark-equivalent plan(s) including benefits and any applicable limitations.

3. Wrap-around/Additional Services

a. X / The State assures that wrap-around or additional benefits will be provided for individuals under 19 who are covered under the State plan under section 1902(a)(10)(A) to ensure early and periodic screening, diagnostic and treatment services are provided when medically necessary. Wraparound benefits must be sufficient so that, in combination with the benchmark or benchmark-equivalent benefits package, these individuals receive the full EPSDT benefit, as medically necessary. Attach a description of the manner in which wrap-around or additional services will be provided to ensure early and period screening, diagnostic and treatment services are provided when medically necessary (as determined by the State).

Any medically necessary services that are identified as a result of an EPSDT screening but not covered by the benchmark plan, will be forwarded to Medicaid for payment.

b. _/ The State has elected to also provide wrap-around or additional benefits.

Attach a list of all wrap-around or additional benefits and a list of the populations for which such wrap-around or additional benefits will be provided.

C. Service Delivery System

Check all that apply.

1. __/ The alternative benefit package will be furnished on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider.

2. __/ The alternative benefit package will be furnished on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1915(b)(1).

3. __/ The alternative benefit package will be furnished through a managed care entity consistent with applicable managed care requirements.

4. __/ Alternative benefits provided through premium assistance for benchmark-equivalent in employer-sponsored coverage.

5. _X_/ Alternative benefits will be provided through a combination of the methods described in items 1-4. Please specify how this will be accomplished.

The alternative benefits will be provided through a fee for service basis administered through a Third Party Administrator (TPA) type arrangement. Since the plan is a high-deductible model, claims will be submitted to the TPA for consideration. If the service is a covered service under the State Health Plan, the allowable amount will be reported to the provider, the account manager and the recipient. The allowable amount is based on the State Health Plan fee schedule effective on the date of service. As the State Health Plan fee schedule is updated, it will be used for this option. There will be no agreement between the provider and the State to transfer back to the Medicaid Agency any amount of the payment the provider receives which is in excess of the standard Medicaid fee schedule rate for the service. A deduct for the allowable amount will be made from the recipient's account

by the account manager and remitted to the provider. If the member obtains services that are not covered, the amount will not count toward the deductible nor will a payment be made.

Once the annual deductible of $3000 for an individual and $6000 for a family has been met, regular state plan cost sharing rules apply. The TPA will make payments to the providers at its normal fee for service rates. The TPA is not under risk and bills the State a single invoice for the monthly provider payments with a backup file of services and its administrative fee.

The State Health Plan High Deductible plan includes instances of member penalties for inappropriate utilization. For the Medicaid option, these penalties are administrative. Specifically, the member receives a warning letter naming the inappropriate utilization and prescribing proper behavior. The second occurrence will cause the member to be removed from the plan and returned to regular Medicaid.

D. Additional Assurances

a. _X_ / The State assures that individuals will have access, through benchmark coverage, benchmark-equivalent coverage, or otherwise, to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

b. _X_ / The State assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb).

E. Cost Effectiveness of Plans

Benchmark or benchmark-equivalent coverage and any additional benefits must be provided in accordance with economy and efficiency principles.

F. Compliance with the Law

_X_ / The State will continue to comply with all other provisions of the Social Security Act in the administration of the State plan under this title.

G. Implementation Date

_X_ / The State will implement this State Plan amendment on **April 1, 2007**.

Services	CMS Classification	Current Medicaid Coverage	Benchmark Plan
Inpatient Hospital Services	Mandatory	✓	✓
Outpatient Hospital Services	Mandatory	✓	✓
Laboratory and X-ray	Mandatory	✓	✓
Rural Health Clinics	Mandatory	✓	✓
Federally Qualified Health Clinics	Mandatory	✓	✓
Indian Health Services	Mandatory	✓	✓
Family Planning	Mandatory	✓	✓
Oral Surgery	Mandatory	✓	✓
Emergency Transportation	Mandatory	✓	✓
Organ Transplants	Mandatory	✓	✓
Midwife	Mandatory	✓	✓
Nurse Practitioners	Mandatory	✓	✓
Extended Svs-Pregnant Women	Mandatory	✓	Extended Services not covered by the State healthplan are covered by regular Medicaid
Physician Services	Mandatory	✓ adult limited	✓
Home Health	Mandatory	✓ 75 visit limit	✓
Durable Medical Equipment	Optional	✓	✓
Pharmacy	Optional	✓ adult limited/override	✓
Podiatry	Optional	✓	✓
Optometry	Optional	✓ adult limited	
Physical Therapy	Optional	✓ with limitations	✓
Occupational Therapy	Optional	✓ with limitations	✓
Speech/Language/Audiology	Optional	✓ with limitations	✓
Non-Emergency Transportation	Optional	✓	
CRNA	Optional	✓	✓
Psychology	Optional	✓	✓
Clinic Services	Optional	✓	
Prosthetic/Orthotics	Optional	✓	✓
Family Support Services/PSPCE	Optional	✓	
Birthing Centers	Optional	✓	
Chiropractic	Optional	✓ 12 visit limit	✓
Dental	Optional	EPSDT	
Preventive Services	Optional	✓	✓
Hospice	Optional	✓ 6 months or less life expectancy	✓
ICF/MR's	Not Applicable	N/A	N/A
Nursing Facilities	Not Applicable	N/A	N/A
CLTC	Not Applicable	N/A	N/A
Targeted Case Management	Not Applicable	N/A	N/A
Behavioral Health Rehab Svs	Not Applicable	N/A	N/A

Legend
✓ = Covered
N/A = Not Applicable

State Health Plan

State Health Plan Table of Contents

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Your State Health Plan in 2007

The State Health Plan, which includes the **Standard Plan,** the **Savings Plan** and the **Medicare Supplemental Plan,** provides you and your family with valuable medical coverage when you are sick or injured. With the plan, you have extensive coverage when you need it most.

The State Health Plan is self-insured. This means the Employee Insurance Program (EIP) determines the plan's coverage and benefits. EIP does not pay premiums to an insurance company. Your monthly premium, the amount you pay for insurance coverage, is combined with premiums paid by all other subscribers and your employer's contributions. Then these funds are placed in a trust account maintained by the state to pay claims and administrative costs. Any interest earned on this trust account is used to help fund the plan.

In 2007, the State Health Plan is expected to pay more than one billion dollars in claims for its subscribers. 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, to process prescription drug claims. About four percent of EIP's budget goes to pay these claims processors.

To learn about enrollment, eligibility and other features that are common to this health program and others offered by EIP, see the General Information chapter beginning on page 7. This chapter will help you understand the different requirements and benefits of the Standard Plan and the Savings Plan. It also discusses the features they share. Check the Premiums chapter on page 195 to learn about the rates for each plan.

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

Your State Health Plan at a Glance

The State Health Plan offers two choices: the **Standard Plan** and the **Savings Plan.** Regardless of which plan you choose, 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 receive the prescription drug benefit.

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. Because it is a tax-qualified, high deductible health plan, eligible subscribers who enroll in the Savings Plan and who have *no other health coverage, including Medicare,* unless it is another high deductible health plan, may establish a Health Savings Account. Funds in this account may be used to pay qualified medical expenses now and in the future.

How SHP Benefits are Paid

State Health Plan subscribers share the cost of their covered benefits by paying deductibles and coinsurance for medical and behavioral health services. Standard Plan subscribers pay copayments for prescription drugs.

Benefits at a Glance

This brief overview of your medical plan is for comparison purposes only. The *Plan of Benefits* document 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
Outpatient Office Visit[3]	$10	None
Coinsurance: Network	20% You Pay 80% State Pays	20% You Pay 80% State Pays
Out-of-network[4]	40% You Pay 60% State Pays	40% You Pay 60% State 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 pay the full allowable charge for prescription drugs, and the cost is applied to your annual deductible.
Retail Copayments for up to a 31-day supply (Participating pharmacies only)[4]	$10 Generic $25 Preferred Brand $40 Non-preferred Brand	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 of your prescription. You pay the remaining 20% as coinsurance.
Mail Order and Retail Maintenance Network Copayments for up to a 90-day supply[4]	$25 Generic $62 Preferred Brand $100 Non-preferred Brand	You must use participating pharmacies. Drug costs are applied to your plan's in-network coinsurance maximum: $2,000 - individual; $4,000 - family. After the co-insurance maximum is met, the plan pays 100% of allowable charges.
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, ER, oncology, electro-convulsive therapy, psychiatric medication management and physical therapy visits.*
[3] *Waived for routine Pap smear, routine mammograms and Well Child Care.*
[4] *There are no out-of-network benefits for mental health and substance abuse services or prescription drugs.*

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 the 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' individual 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. Once any one person has paid the $350 individual deductible, he will begin receiving benefits. No one 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 plan family deductible, both spouses 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 Deductible

A per-occurrence deductible is the amount you must pay before the Standard Plan begins to pay benefits each time you receive services in a professional provider's office, visit an emergency room or receive outpatient hospital services. It does not apply to your annual deductible or to your coinsurance maximum.

The 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 SHP Standard Plan allowed $49 for a physician's visit, you would first pay the $10 per-occurrence deductible. Then, if you have not met your annual deductible, the remaining $39 would apply toward your annual deductible. (You owe $49.)

- If you have met your annual deductible, the Standard Plan would pay 80 percent of the $39, or $31.20, and you would be responsible for the remaining $7.80, as well as for your $10 per occurrence deductible. (You owe $17.80.)

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, psychiatric medication management and physical therapy visits.

Coinsurance

After your annual deductible has been met, the Standard Plan pays 80 percent of your covered medical, 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. 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. Mental health and substance abuse benefits are paid only if you use network providers.

If you use a provider outside the SHP 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. See page 31 to learn more about this "out-of-network differential." Prescription drugs and mental health and substance abuse benefits will be paid **only** if you use a network provider.

What does it mean when a provider does not participate in the network?

For information on providers who do not participate in the network and the "out-of-network differential," see page 31.

Coinsurance Maximum (Out-of-pocket Limitation)

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, or 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 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 another 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. The amount you pay to network providers contributes to your coinsurance maximum. If you use non-network providers, the plan pays 60 percent of your covered expenses. You pay the remaining 40 percent as coinsurance.

If you use a non-network provider, 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 31 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 page 39.

Coinsurance Maximum (Out-of-pocket Limitation)

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 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, or 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 17.

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

On your Notice of Election form, you are asked if you are covered by more than one group insurance plan. Your response is recorded and is placed in your file. However, the third-party administrator, BlueCross BlueShield of South Carolina, may ask you this question every year, by sending you a questionnaire. Please complete this form and return it to BCBSSC in a timely manner, since claims may be will be held for final disposition until your information is received.

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

- 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 copayments and for your deductible, if it has not been satisfied.
- For a medical claim, you or your provider must file the Explanation of Benefits from your primary plan directly with BlueCross BlueShield of South Carolina.
- For mental health and substance abuse benefits, you must file the Explanations 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 any secondary benefits to be paid. Prescription drug claim forms are available on the EIP Web site at www.eip.sc.gov. Choose your category, and then click on "Forms." You may also ask your benefits administrator for a copy of the form.

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

SUBROGATION

To the extent provided by South Carolina law, the State Health Plan has the right to recover damages 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, however, a covered person receives payment for such medical expenses from another who allegedly 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).* It has arrangements with physicians, hospitals, ambulatory surgical centers and mammography testing centers that 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.

If your physician sends your laboratory tests to an out-of-network provider, you may be subject to additional expenses.

This applies to your medical benefits only. 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

A link to the most up-to-date SHP provider directory is on EIP's Web site, www.eip.sc.gov. Choose your category and then select "Online Directories." Choose "State Health Plan Doctors/Hospital Finder." At the BlueCross BlueShield site, select "South Carolina" under "Find a Doctor." Then choose the kind of provider you need and "State Health Plan." Network providers include these specialties:

- Allergy
- Anesthesiology
- Cardiology (heart and blood vessels)
- Chiropractic
- CNM (Certified Nurse Midwife)
- CRNA (nurse anesthetist)
- Dermatology (skin)
- Endocrinology (hormones, glands)
- Family Practice
- General Practice
- General Surgery
- Geriatrics (the elderly)
- Gynecology (women's reproductive health)
- Internal Medicine (non-surgical diseases in adults)
- Laboratory
- Nephrology (kidney disease)
- OB/GYN (women's reproductive health and child bearing)
- Obstetric (child bearing)
- Oncology (cancer)
- Ophthalmology (eye diseases)
- Optometry (measuring and treating vision problems)
- Oral Surgery (mouth surgery)
- Orthopedic Surgery (bone surgery)
- Otolaryngology (ear, nose and throat)
- Pathology (examination of body tissue and fluids)
- Pediatrics (treatment of children)
- Plastic Surgery (reconstruction of tissue and bone)
- Podiatry (feet)
- Proctology (rectum)
- Pulmonary Disease (lungs)
- Radiology (X-ray)

- Neurological Surgery (nervous system and brain surgery)
- Neurology (nervous system)
- Nurse Practitioner
- Rheumatology (joints and muscles)
- Thoracic Surgery (chest)
- Urology (bladder, kidney and urinary tract)

A *provider* is a physician, extended role nurse, behavioral health provider or hospital as those terms are defined in the *Plan of Benefits,* which is available from your benefits administrator or EIP.

Please note: Network providers are allowed to charge you for your deductibles and coinsurance.

Printed copies of the provider directories are available from your benefits office or, if you are a retiree, survivor or COBRA participant, from EIP.

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 BlueCross BlueShield provider networks. If you need mental health or substance abuse care outside South Carolina, please call APS Healthcare at 800-221-8699.

Are you looking for a provider that participates in your network?

Log onto the EIP Web site at www.eip.sc.gov, choose your category and click on "Online Directories." From the "Online Directories" page, you can check provider lists for the State Health Plan, Dental Plus and the HMOs. Pharmacy and mental health networks also are included.

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 SHP 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 for pre-authorization within 48 hours of receiving emergency care. The toll-free number is on your SHP ID card.
5. When you arrive at the participating doctor's office or hospital, show your SHP ID 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.

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 explanation of benefits by BlueCross BlueShield of South Carolina.

Outside the U.S.

Through the BlueCard Worldwide® program, your State Health Plan ID card gives you access to doctors and hospitals in more than 200 countries and territories around the world and to a broad range of medical assistance services.

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

1. Always carry your current 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 State Health Plan benefits and for pre-authorization, 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 State Health Plan to arrange direct billing with the hospital for your inpatient stay.
   - When direct billing is arranged, you are responsible for the out-of-pocket expenses (non-covered services, deductible, copayment, 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, you will need to pay the provider at the time 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 bill(s) to the BlueCard Worldwide® Service Center. The claim form is available online at www.BCBS. com, or by calling the BlueCard Worldwide® Service Center toll-free at 800-810-2583 or collect at 804-673-1177 or through EIP's Web site. 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

Since the SHP 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.
- Mental health and substance abuse providers include: psychiatrists, clinical psychologists, masters-level therapists and nurse practitioners. To see the list, go to the APS Healthcare, Inc., Web site at www.apshealthcare.com. Click on "Members Learn More" at the top of the page. 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 pre-authorization.

For more information on your prescription drug benefits, see page 45. For more information on your mental health and substance abuse benefits, see page 49.

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 EIP.

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 pre-authorized.

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 allowed charges:

- **Standard Plan** subscribers have to pay $4,000 for individual coverage and $8,000 for family coverage.

- **Savings Plan** subscribers have to pay $4,000 for individual coverage and $8,000 for employee/spouse, employee/children and full-family coverage.

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

Balance Billing

If you use a non-network provider, 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 to your 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 Blue-Card network, you will pay 40 percent, instead of the usual 20 percent, in coinsurance.

These example shows how it would have 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	$3,650	Standard Plan responsibility
- 350	Standard Plan deductible for 2007	-2,190	Standard Plan pays
$3,650	Standard Plan responsibility	1,460	You pay as coinsurance
x 60%	Standard Plan coinsurance	1,000	Your balance bill from provider
$2,190	Standard Plan pays	+ 350	Your out-of-pocket costs
		$2,810	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	$1,000	Savings Plan responsibility
-3,000	Savings Plan deductible for 2007	- 600	Savings Plan pays
$1,000	Savings Plan responsibility	460	You pay as coinsurance
x 60%	Savings Plan coinsurance	1,000	Your balance bill from provider
$ 600	Savings Plan pays	+3,000	Your out-of-pocket costs
		$4,400	for the services of a non-network provider.

MANAGING YOUR MEDICAL CARE

MEDI-CALL

Some services provided under the State Health Plan require pre-authorization 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 call for authorization.

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 health care options and services required to meet an individual's needs. **Participation in Medi-Call is mandatory whether you are enrolled in the Standard Plan or in the Savings Plan.** 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 United States or Canada:

- You need inpatient care in a hospital[1]
- Your pre-authorized 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 a sclerotherapy performed in an inpatient, outpatient or office setting
- You need a MRA, MRI, PET Scan or CT Scan
- You will be receiving 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 call 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 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 pre-authorization 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, abdominoplasy, rhinoplasty or other nose surgery, etc.) Your physician should include photographs if appropriate.

[1]For mental health or substance abuse services, you must call APS Healthcare at 800-221-8699 for pre-authorization 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 BCBSSC makes payment.

Are There Penalties for Not Calling?

Yes. If you do not call Medi-Call in the required situations, you will pay a $200 penalty for each hospital or skilled nursing facility **admission.** In addition, the coinsurance maximum will not apply. In other words, you will continue to pay your coinsurance, no matter how much you pay out-of-pocket. If you do not obtain pre-authorization 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 protect your health and your baby's health. 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 NICU infants or other babies with special needs until they are one year old. You must call Medi-Call during the first trimester (three months) of your pregnancy to pre-authorize your pregnancy benefits. If you do not call 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 pre-authorization penalty, and the $2,000 coinsurance maximum will not apply.

You are automatically enrolled in "Coming Attractions" when you call Medi-Call to pre-authorize your pregnancy. As a participant in the program, you will receive a phone call from a Medi-Call nurse, a welcome letter from Medi-Call and a packet of information to which to refer during your pregnancy.

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.

Also, you can call Medi-Call anytime you have questions. A maternity case management nurse will be there to help you throughout your pregnancy.

MANAGING FOR TOMORROW®

If you have a chronic condition, such as diabetes, asthma, coronary artery disease, chronic obstructive pulmonary disease, congestive heart failure, hyperlipidemia or hypertension, taking care of yourself is a 24-houra-day, seven-day-a-week job. Managing your healthcare starts with understanding your condition and your doctor's plan for your treatment.

Managing for Tomorrow® can help. It is available to active employees, retirees who are not eligible for Medicare, spouses and dependents covered by the Standard Plan and the Savings Plan. You may receive a letter or phone call about this disease-management program, which is sponsored by BlueCross BlueShield of South Carolina in cooperation with Prevention Partners.

The program is designed to help you learn more about your condition and how to improve your health. Often the daily choices made by a person with a chronic disease can improve his health better or make it worse. The program is voluntary and free. You will not be asked to purchase anything, your benefits will not be affected and your premiums or copayments will not increase whether or not you participate in Managing for Tomorrow.®

The program starts with an invitation to participate in a confidential survey. The survey helps determine which programs and services are right for you. You will receive a special Personal Identification Number (PIN). This PIN will allow you to complete the survey by calling an automated phone line or by logging on to a secure Web site. Paper surveys also are available. The survey is designed to determine how the program can help you. You will receive a personalized response to your survey, health guides, home management or testing kits, seasonal newsletters and individual counseling calls.

A disease management program can assist you in managing your symptoms by helping you understand your conditions and treatment plan. Disease management nurses may talk with you on the phone or in person to provide the information and support you need to help control symptoms and complications of chronic conditions. They can also help you make lifestyle changes that enable you to be as healthy as possible.

Everyone who receives an invitation is encouraged to take part in the program. If you think you qualify but have not been invited to participate, call Medi-Call, 699-3337 in the Greater Columbia area, and 800-925-9724 in 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 "Managing for Tomorrow" program.

WELLNESS MANAGEMENT

Personal Health Assessment (PHA)

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 the "Access Online Programs and Added Values" heading. Select your name from the drop-down menu on the next page and then click on "Continue." 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 the responses. It enables you to evaluate your health and get 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.

Weight Management Program

The BlueCross Weight Management program, new in 2007, is designed to help you lose weight. 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, 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 Cost Estimator

The cost estimator is available on the BlueCross BlueShield of South Carolina Web site, www.SouthCarolinaBlues.com. It can help you determine how much a medical service or procedure will cost. This can be useful in budgeting for medical expenses and planning for the cost of certain health conditions. The estimator provides a cost range for an illness, breaks 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 flexible spending account or a health savings account.

Provider Report Card

BCBSSC gives you access to a Provider Report Card through its Web site, www.SouthCarolinaBlues.com. This tool allows you to compare hospitals in the same part of the state to determine the number of patients treated, complication rate and how long patients usually stay in the hospital. You can then use this information to help decide which hospital to use.

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 SHP. 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. It does 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 or authorize or deny benefits for medical services. 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. If you would like more information on any of these programs, call 800-925-9724 and ask to be transferred to the case management supervisor.

CaringBridge®: Communication in a Crisis
BlueCross has arranged with CaringBridge® to offer free, personalized Web sites to State Health Plan subscribers to 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 or to the BlueCross BlueShield of South Carolina Web site, www.SouthCarolinaBlues.com. Then click on "Create a CaringBridge site" and follow the directions. Tell your family and friends how they can keep up-to-date on your condition by visiting the site.

BlueCross Medi-Call Case Management Program

This case management program is designed for people enrolled in the SHP who have specific catastrophic or chronic disorders, acute illnesses or serious injuries. It promotes appropriate, high-quality, economical care.

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 longterm. Case managers combine standard pre-authorization 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.

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 and the patient, family members or providers complies with HIPAA privacy requirements. If a patient refuses medical case management, Medi-Call will continue to pre-authorize appropriate treatment.

ParadigmHealth® Complex Care Management Program

Some SHP enrollees are referred to ParadigmHealth® 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 ailment, 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 acts as an advocate for you and your family. He 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 special transportation and lodging for out-oftown 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 in the program is voluntary. You can leave the program at any time, for any reason. Your benefits will not be affected by your participation in the program.

Here is how the program works: BlueCross BlueShield will refer you to ParadigmHealth® if the program may be of benefit to you. You will receive a letter explaining the program, and a ParadigmHealth® 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.

The ParadigmHealth® team comprised 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 ParadigmHealth® team.) Your local care coordinator nurse will be your main program contact. You and your doctor, however, will always make the final decision about your treatment. Complex care management does not replace the care you receive from your doctor. Always check with your doctor before following any medical advice.

A Medi-Call case manager will act as a liaison with the Paradigm 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.

RMS Renal Case Management Program

RMS provides renal disease management care for select SHP 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: SHP subscribers with ESRD are referred to RMS by BCBSSC. A South Carolina-based RMS 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 RMS nurse may visit you in your

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 act as a liaison with the RMS 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.

STATE HEALTH PLAN BENEFITS

The Standard Plan and the Savings Plan pay benefits for *medically necessary* treatments of illnesses and injuries. This section is only a general description of the plan. The *Plan of Benefits* document 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 pre-authorization by Medi-Call or APS Healthcare. Be sure to read the Medi-Call section beginning on page 32 and the mental health and substance abuse section on page 49 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 rendered.

The SHP Standard Plan has per-occurrence deductibles for some services. See page 25 for details.

It must be 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, non-emergency 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

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.

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.

Diabetic Supplies

Insulin is allowed under the prescription drug program or under the medical plan but not under both. Since most insulin is brand name, it 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. Durable medical equipment, which includes insulin and diabetic supplies, is covered under the SHP. Claims for diabetic durable medical equipment should be filed with BlueCross BlueShield of South Carolina.

Doctor Visits

Charges for treatments or consultations for an injury or illness are covered, as long as 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 pre-authorized. For details on mental health and substance abuse services, see page 49.

Durable Medical Equipment (DME)

Generally, durable medical equipment must be pre-authorized 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 non-therapeutic use or a potentially nontherapeutic use
- C-Pap or Bi-Pap machines
- Oxygen and equipment for oxygen use outside a hospital setting, whether purchased or rented
- Any prosthetic appliance or orthopedic brace, crutch or lift, attached to the brace, crutch or lift, whether initial or replacement
- Orthopedic shoes.

DME provider networks are available to SHP 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 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.

Home Healthcare

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 pre-authorized 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 pre-authorized by Medi-Call.

Infertility

The plan will pay for diagnosis and treatment of infertility under these conditions: maximum lifetime benefits are $15,000 incurred by either the subscriber or the covered spouse, whether covered as a dependent or as an employee OR a maximum of three completed cycles of gamete or zygote intrafallopian transfer (GIFT or ZIFT), or In Vitro Fertilization (IVF), whichever comes first, are allowed.

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 pre-authorized 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 33 for more information.)**

Organ Transplants

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

All transplant services must be approved by Medi-Call (see page 33). You must call Medi-Call even before you or a covered family member is evaluated for a transplant.

More information about Medi-Call can be found on page 32.

Contact Medi-Call at 803-699-3337 (Greater Columbia area) or 80-0-925-9724 (South Carolina, nationwide and Canada).

Through the BQCT 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 BQCT network facility or through a local South Carolina network transplant facilities. 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 non-participating facilities will be covered by the plan. However, the SHP will pay only the SHP allowable charges for transplants performed at non-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 non-network facilities are responsible for any amount over the allowed 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.)

Some medical laboratories and radiology service providers are not in the network. If you use the services of a provider that is not in the network, the provider may charge you more than the allowable charge, and you will be billed for the balance.

If you receive your service at a hospital, you will be charged a $75 outpatient per-occurrence deductible, and the service will also be subject to your annual deductible and coinsurance. Where lab work is performed is a decision between you and your doctor. However, some medical and radiological laboratories are not in the network. If you use a non-network provider, you will be balance billed.

Some laboratory, X-ray and diagnostic tests are considered investigational or experimental and are therefore excluded by the plan. Call BCBSSC Customer Service for more information or to find out if a particular service is covered.

Pregnancy and Pediatric Care

Pregnancy benefits are provided to female employees or retirees and the 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 33 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 it 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 45 for more information.

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

Reconstructive Surgery After 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 post-mastectomy cases, and all services must be approved by Medi-Call.

Rehabilitation Care

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

- Pre-authorization 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 Opinion

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 per day. These services require approval by Medi-Call.

Speech Therapy

Speech therapy is the treatment of communication and swallowing disorders to restore speech or swallowing abilities lost due to disease, trauma, previous treatment, injury or illness or congenital anomaly (birth defect). (For speech therapy related to a birth defect to be covered, the person must have been continuously covered under this plan from birth until the time of the treatment. See below for details.)

Speech therapy requires pre-authorization only when provided in an inpatient setting or in the home setting. However, claims for speech therapy that are not pre-authorized 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, BCBSSC 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
- 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.

The plan will pay for extended care 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 the Prevention Partners programs described on page 18. 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. The State Health Plan does not require a referral from your doctor for a routine mammogram. However, your provider may require one.

- If you are age 35 through 39, one baseline mammogram (four-view) will be covered during those years.
- If you are age 40 through 49, one routine mammogram (four-view) every other year will be covered.
- If you are age 50 through 74, one routine mammogram (four-view) a year will be covered.

Charges for routine mammograms performed at non-participating 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.

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

For a woman, age 40 and older, covered as a retiree and enrolled in Medicare, Medicare pays for one routine mammogram every year. The SHP 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.

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 12 are eligible for Well Child Care check-ups.

For more information about preventing illnesses, see page 18 or log onto the EIP Web site at www.eip.sc.gov and click on "Prevention Partners."

How Does it Work?

This benefit covers regular doctor visits and timely immunizations. When services are received from a doctor in the SHP Physician Network, benefits will be paid at 100 percent without any deductible or coinsurance. **Benefits will not be paid for services from non-network providers.** Some services may not be considered part of the 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 deductible 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 5 years old—one visit per year
- 6 through 8 years old—one visit during three-year period
- 9 through 12 years old—one visit during four-year period.

Immunizations

Below is the schedule for 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 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 SHP 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 have not had 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 none 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 not had second dose before
Chickenpox	12-18 months 11-12 years if have not had disease or vaccine before
Influenza	Yearly for healthy children ages 6 months-59 months Yearly for children with risk factors, ages 6 months-12 years
Meningococcal	11-12 years
Hepatitis A	12-23 months
Human Papillomavirus (HPV)	11-12 years for females

Natural Blue and Other Discount Programs

Natural Blue is a discount program available to SHP subscribers. Offered by BlueCross BlueShield of South Carolina, it provides holistic healthcare choices and information. The program has a network of licensed acupuncturists, massage therapists and fitness clubs that may be used at lower fees, often as much as a 25 percent discount. Natural Blue also offers discounts on health products, such as vitamins, herbal supplements, books and tapes.

Value-Added Benefits is a network of providers and suppliers that offer discounts on products and services that BlueCross 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.

For more information on Natural Blue or Value-Added Benefits, log on to the BCBSSC Web site at www.South-CarolinaBlues.com. Under "Looking for...," select "Discounts and Added Values."

ADDITIONAL BENEFITS FOR SAVINGS PLAN PARTICIPANTS

As a participant in the Savings Plan, you are taking greater responsibility for your healthcare costs. 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 to subscribers. 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 the 416-page, full-color self-care handbook, *Health at Home®—Your Complete Guide to Symptoms, Solutions & Self-Care.*

Physical Exam

Children age 12 and younger receive the Well Child Care benefits and women receive the mammogram and Pap test benefits that are offered to those enrolled in the Standard Plan. In addition, Savings Plan participants age 13 and older may receive from a network provider an annual physical 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 laboratory, 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 medications associated with infertility treatments have a different coinsurance rate. Please refer to page 39 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 generic, $25 for preferred brand or $40 for non-preferred brand drugs 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 covered expenses in addition to what the insurance plan pays.

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 expenses for the remainder of the year.

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

Savings Plan

With this program, 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 when you purchase them. There is no copayment.

This cost is transmitted electronically to BlueCross BlueShield of South Carolina. 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 *My Rx Choices* at www.medco.com. There you will find a personalized, confidential comparison of the long-term medications you take, what you pay for them and 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

Under both plans, your prescription drug choices are divided into three categories: *generic, preferred brand* and *non -preferred brand.*

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 there is an equivalent generic drug 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 in the allowable charge between the brand name and the generic drug. If the total amount is less than the preferred or non-preferred brand 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 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 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.

Preferred Brand Drugs

These are medications that Medco's Pharmacy and Therapeutics Committee has determined to be safe, effective and available at a lower cost than non-preferred brand drugs. A list of preferred brand medications is available online at www.medco.com. You may reach the Medco Web site through the EIP Web site by clicking on the "Insurance Managers" link.

Non-Preferred Brand Drugs

These medications are not on the preferred brand list and carry a higher copayment or higher price. All medications that appear on the non-preferred brand have an effective alternate option either as a generic or as a preferred-brand drug.

Compounded Prescriptions

A compounded prescription is a prescription that requires the pharmacist to mix two or more ingredients to make the order. It is handled the same way any prescription is handled. It must be purchased from a network pharmacy for benefits to be payable.

Standard Plan subscribers' copayment, which is based on the main ingredient of the compounded prescription, is $10 for generic, $25 for preferred brand and $40 non-preferred brand drug. Savings Plan subscribers pay 100 percent of the allowable charge.

Pre-authorization

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 pre-authorized, 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 Benefits ID card when purchasing medications. The SHP 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 copy of State Health Plan Provider Directory 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 and select "News and Updates." Under "2006 Updates," you will find an article about the network. At the end of the story, click on "Retail Maintenance Network Pharmacies (effective May 1, 2006)." The cities where the pharmacies are located are in alphabetical order. 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.
Because of state and federal regulations, some medications may only be dispensed in 31-day supplies. Drugs in this category include, but are not limited to, those used to treat pain, anxiety and sleep problems. Before you order a 90-day supply of a drug, call Medco at 800-711-3450 to be sure the drug is available in that quantity. If your prescription calls for a 90-day supply and the drug may not be dispense d in that amount, you will be charged for a 90-day supply but will be sent a 31-day supply.

Standard Plan

Generic drug copayments are $25, preferred-brand drug copayments are $62, and non-preferred brand drug copayments are $100 for up to a 90-day supply.

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 a 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 Website, www.eip.sc.gov, under "Forms" or on Medco's Web site, www.medco.com.)
- Your order will be processed and sent to your home, typically within 10-14 business days. Meanwhile, use your prescription from your retail pharmacy.

The EZ Reimburse® MasterCard®, associated with the MoneyPlu$ Medical Spending Account, may now be used for prescriptions ordered through a plan's mail-order pharmacy. For more information on the EZ Reimburse® MasterCard®, see the MoneyPlu$ chapter, page 152.

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 page 17 for more information.

Exclusions

Some prescription drugs are not covered under the plan. See page 50 for more information.

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

For Pre-authorization—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 pre-authorized by APS Healthcare to be covered.

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

- When you need care inside or outside South Carolina, call APS Healthcare, Inc., the administrator, at 800-221-8699 to receive pre-authorization 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 the behavioral health manager, APS Healthcare.
- If you need inpatient care, you must call APS Healthcare for pre-authorization 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 "Members LEARN MORE" at the top of the page. Then select "State of South Carolina" from the drop down list under "EMPLOYERS." Click on "Online Provider Locator." You will need to enter SHP'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 EIP.

Filing Claims?

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 non-network provider. 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 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 nicotine replacement products (patches, gum or lozenges) if appropriate. 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 866-QUIT-4-LIFE (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. There are two ways to get to APS Web site. The first is to follow the same instructions you use to get to the provider locator, then scroll down the page and follow the instructions for connecting to APS Helplink.™ The second is to go directly to www.apshelplink.com and follow these directions:

First-time visitors:

- At the "New Member" box click on "Create New Account"
- If you agree with the disclaimer, click on the "I Agree" button
- Enter "statesc" in the Company Code field
- Enter a user name
- Enter a password
- Re-enter the same password
- Enter a phrase to help you remember your password
- For future reference, write down your user name, password and "statesc"
- Click on the "Submit" button

Returning visitors:

- Go to the "Returning Member's" box
- Enter "statesc" in the Company Code field
- Enter your user name
- Enter your password
- Click on the "Submit" button

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* document (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
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 Screenings according to guidelines), services, surgery (including cosmetic surgery) or supplies that are not medically necessary. (Please note: Under the Savings Plan, an annual physical by a network physician for each participant age 13 and older is covered.)
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. Bilateral cochlear i mplants
11. D ental services, except for removing impacted teeth or treatment within one year of a condition resulting from an accident
12. TM J splints, braces, guards, etc. (Medically necessary surgery for TMJ is covered if pre-authorized by Medi-Call.) TMJ, temporo mandibular joint syndrome, is headache, facial pain and jaw tenderness caused by irregularities in the way joints, ligaments and muscles in the jaw work together.
13. Cu stodial care, including sitters and companions
14. Over -the-counter medicine and contraceptive devices
15. Services con nected with a vasectomy or tubal ligation performed within one year of enrollment
16. Surger y to reverse a vasectomy or tubal ligation
17. Infertil ity treatment for subscribers who have had a tubal ligation
18. A ssisted reproductive technologies (fertility treatment) except as noted on page 39 of this chapter
19. Diet treat ments 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
20. Equip ment that has a non-therapeutic 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
21. Air qual ity tests
22. Supplies used for participation in athletics (that are not necessary for activities of daily living), including but not limited to, splints or braces
23. Ph ysician charges for medicine, drugs, appliances, supplies, blood and blood derivatives, unless approved by Medi-Call
24. Medical care by a doctor on the sa me 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
25. Ph ysician's charges for clinical pathology, defined as services for reading any machine-generated reports or mechanical laboratory tests. The interpretation of these tests is included in the payment for the lab service.
26. Fees for medical records and claims filing
27. Food supple ments, including but not limited to formula, enteral nutrition, Boost/Ensure or related supplements
28. Services perfor med by members of the insured's immediate family
29. Ac upuncture
30. Chron ic pain management programs
31. T ranscutaneous (through the skin) electrical nerve stimulation (TENS), whose primary purpose is the treatment of pain
32. Co mplications arising from the receipt of non-covered services
33. Psyc hological tests to determine job, occupational or school placement or for educational purposes; milieu therapy; or to determine learning disability
34. Services or s upplies payable by Workers' Compensation or any other governmental or private program (including Employee Assistance Program services)
35. Char ges 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)
36. Intent ionally self-inflicted injury that does not result from a medical condition or domestic violence
37. Cos metic goods, procedures or surgery or complications resulting from such procedures or services
38. Nicotine patche s 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.

39. Vocational rehabilitatio n, 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 41 and Speech Therapy on page 42.)
40. Con genital anomalies (abnormalities existing since birth) are not covered unless the covered person has been continuously covered under the plan from birth until the time of treatment
41. Sclerotherap y (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 perfomed within three years and documentation submitted to Medi-Call with a pre-authorization request establishes that some varicosities (twisted veins) remained after the procedure
42. A nimals trained to aid the physically challenged
43. Abortions, e xcept for an abortion performed in accordance with federal Medicaid guidelines
44. Pregnanc y of a covered dependent child
45. Speech therap y for the treatment of a language/communication or developmental delay (See page 42.)
46. Storage of blood or blood plasma.
47. Experi mental 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:

- Out-of-network inpatient or outpatient charges related to the annual physical benefit under the Savings Plan are not covered.
- Chiropractic benefits, under the Savings Plan only, are limited to $500 per covered person after the annual deductible is met.
- Non-sedating antihistamines and drugs for treating erectile dysfunction are not covered under the Savings Plan.

APPEALS

WHAT IF MY CLAIM OR REQUEST FOR PRE-AUTHORIZATION IS DENIED?

The Employee Insurance Program 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. This is how to do it:

If all or part of your claim or of your request for pre-authorization 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 are unsure whether the decision was fair, you can 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 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 denial is upheld by EIP, you have 30 days to seek judicial review in the Administrative Law Court pursuant to S.C. Code Ann. 1-23-380, as amended on July 1, 2006.