

Annual enrollment is from October 31 through November 11, 2011



SRNS and/or SRR

# 2012**health**choice

DECISION GUIDE TO ENROLLMENT FOR RETIREES AND SURVIVORS

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## **Annual enrollment is October 31 through November 11, 2011.**

**So, it's time again to look at your health care options and decide if you need to make any changes.**

**This brochure contains important information about your Health Choice benefits for 2012, as well as changes to this year's enrollment process. By taking the time to read this information, you'll have a better understanding of your benefits and what steps you'll need to take if you wish to change your current elections.**

# What's new?

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## Dispensing of Generic Prescriptions

Members that request a brand name drug that has a generic equivalent, when your doctor has authorized a substitution, will pay the appropriate brand cost share plus the cost difference between the brand and the generic.

## Health Care Reform

### Annual Maximum

The annual maximum for health care insurance has increased from \$1 million to \$1.25 million.

### Children to Age 26

Health care coverage will continue to be offered to dependents, up to age 26, regardless of marital status or student status, unless the dependent has access to other employer coverage.

### Grandfathered Status

The SRNS and SRR group health plans believe their plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, such as coverage for adult children up to age 26.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health status can be directed to the Benefits Solutions Service Center by calling (803) 725-7772. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

## Future: Plan Changes for 2013

As previously communicated, there will be changes to the Retiree Medical benefits in 2013 including:

- *Transferring Medicare Eligible retirees for the SRNS and SRR Health Plans to Individual Medicare Advantage/Medigap plans with a Company funded Health Reimbursement Account facilitated through a Medicare Coordinator*
- *Changing how costs are shared for retirees that are not yet Medicare eligible to be more accurately based on their actual health costs.*

More information on the 2013 Retiree Medical changes will be communicated during the summer of 2012 as Plan details are finalized.

# Things to remember

*about your 2012 Health Choice Benefits*

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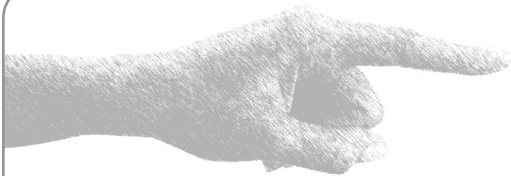
## Eligible Dependents

If you are divorced, your ex-spouse is no longer eligible to be covered as of the date of your divorce. In order for your “children” to be eligible, they must meet all of the following criteria:

- be under age 26, irregardless if a full-time student or married – and is not eligible for other employer health care coverage.

## Returning Your Forms

Return both your and your spouse’s Personalized Enrollment Forms in the same postage-paid envelope to ensure that your elections are coordinated with your spouse’s elections.



### Did you know?

If you are making changes to your Health Choice Benefits, you must complete the Personalized Enrollment Form enclosed with this packet and return it in the enclosed envelope. If you do not return your form by November 11, 2011, your 2012 Health Choice benefits and covered dependents will remain the same as they were in 2011, but at the 2012 contribution rates.

# Coordination with Medicare

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When you become eligible for Medicare, it becomes your primary medical coverage.

The Health Choice Plan, as the secondary medical plan for Medicare Parts A and B, “carves out” (or subtracts) the amount that Medicare would pay for your covered medical expenses and then pays the remainder of the normal medical Health Choice Plan benefit up to the appropriate amount allowed by Medicare. You are then responsible to the medical provider for any remaining amount.

The Health Choice Plan is not considered a Medicare Supplemental Plan.

It is important for you to understand when Medicare is primary that BCBS-SC will calculate the payment of a claim with the “carve out” approach for Medicare Parts A and B eligible claims as described above, **even if you have not enrolled** in Medicare Part B coverage.

When Medicare is primary and you do not enroll in Medicare Part B, the Health Choice Plan will not pay for what would have been covered under Medicare Part B and your out of pocket cost will increase.

You should also be aware that Medicare has penalties, both in delayed coverage start dates and increased cost of coverage, for not enrolling in Part B when you are first eligible after employment terminates or you become disabled. You may wish to contact your Social Security Office for more information on Medicare coverage and enrollment. (Please note that if you or your spouse is an active employee at another employer (including SRS contractors) this Plan will remain secondary (and apply the carve-out provision) to Medicare, since your coverage under Health Choice is as a retiree (non-current employment status).

You may also wish to note that if you are eligible for and elect Medicare Part D, the new Medicare prescription drug program, it will also become your primary (first payor) for prescription drug coverage. However, unlike Medicare Part B, the Health Choice Plan will not use a “carve out” benefits coordination approach when calculating Health Choice Plan payments involving Medicare prescription drug program benefits.



**Did you know?**

The medical claims for Medicare Part A and B covered expenses will be paid as described here by BCBS-SC by subtracting the amount payable under Medicare after you (or your eligible dependent) become eligible for Medicare even if you (or your eligible dependent) have not elected Medicare Part B coverage.

# Your Health Care benefits options

for retirees and survivors

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## Medical Options

You have three medical options for 2012, plus the option of electing no medical coverage.



### **Prime Choice and Standard Choice**

- Preferred Provider Organization (PPO) plans
- Provide network and non-network benefits
- You can lower your out-of-pocket expenses when using network providers (you receive discounts when using network providers; non-network providers can bill you for amounts over the BCBS-SC Allowable Charge/discounts)
- Prescription drugs are paid at 90% after the deductible has been met for generic prescriptions, 80% after the deductible has been met for preferred prescriptions and 70% after the deductible has been met for non-preferred prescriptions
- Mail-order prescriptions for a 90-day supply will be available in 2012 (90-day retail fill supply for non-generics will not be available)
- Prescription drug claims are filed electronically when using a network pharmacy
- Network providers are listed on the Internet at [www.bluecard.com](http://www.bluecard.com).
- A brand name drug that has a generic equivalent will be charged the appropriate brand cost share plus the cost difference between the brand and the generic, when your doctor has authorized a generic substitution.

### **Basic Choice**

- Lowest level of coverage among the options
- High deductible must be met before plan payments begin
- Lower premiums than other options
- No network

## **Questions about Prime Choice, Standard Choice or Basic Choice?**

Call BCBS-SC at 1-800-325-6596, Monday through Thursday between 8 a.m. and 6 p.m., and Friday from 8 a.m. to 4:30 p.m.

This chart is a brief outline of benefits and covered services and is not a contract. Please refer to your Benefits Handbook/ Summary Plan Description for more information of covered services, limits and exclusions.

Expenses	Prime Choice		Standard Choice		Basic Choice
	Network	Non-Network	Network	Non-Network	
Annual deductible • Individual • Family	\$200 \$400	\$200 \$400	\$400 \$800	\$400 \$800	\$1,200 (6) \$2,400 Family (all members combined)
Out-of-pocket maximum (3) • Individual • Family	\$1,000 \$2,000	\$1,000 \$2,000	\$2,000 \$4,000	\$2,000 \$4,000	\$4,500 \$9,000 Family (all members combined)
Physician office visit (4) Primary Specialist	\$10 copay \$20 copay	90% allowable charge after deductible	\$20 copay \$30 copay	90% allowable charge after deductible	80% allowable after deductible
Preventive care office visits (1) (based on schedule)	\$10 copay (1)	Not covered	\$20 copay (1)	Not covered	80% allowable after deductible (1)
Allergy or hormone injections by nurse in physician's office	90% allowable (\$10 copay if other services provided)	90% allowable charge after deductible	90% allowable (\$20 copay if other services provided)	90% allowable charge after deductible	80% allowable after deductible
Chiropractic treatment (2)	90% allowable no deductible	80% allowable after deductible	90% allowable no deductible	80% allowable after deductible	80% allowable after deductible
Ambulance service	90% allowable no deductible	90% allowable no deductible	90% allowable no deductible	90% allowable no deductible	80% allowable after deductible
Hospital, surgical and most other medical services (4)	90% allowable charges	90% allowable charge after deductible	90% allowable charges	90% allowable charge after deductible	80% allowable after deductible
Emergency Room services (life threatening acute or urgent care)	90% allowable no deductible	90% allowable no deductible	90% allowable no deductible	90% allowable no deductible	80% allowable after deductible
Diagnostic services (lab, x-ray and other tests) when not performed in a physician's office	90% allowable no deductible	90% allowable charge after deductible	90% allowable no deductible	90% allowable charge after deductible	80% allowable after deductible
Prescription drugs (5) • Generic • Preferred • Non-preferred	90% 80% 70%	90% 80% 70%	90% 80% 70%	90% 80% 70%	80% after deductible

1. Limited to \$250 per person/year
2. Limited to \$750 total per person/year under Prime, Standard and Basic Options
3. Your deductibles and coinsurance amounts (10%, 20% or 30% for most services) count toward your out-of-pocket maximums.
4. Includes eligible mental health and chemical dependency services (as a Primary Office Visit) after pre-certification.
5. All prescription drugs filled by network providers will be covered at negotiated rates after deductibles and all prescription drugs filled by non-network providers will be covered at retail amount after deductible.
6. If you cover one or more dependents, the family deductible applies before reimbursement.

# Your Health Care benefits options *(continued)*

## for retirees and survivors

### Mental Health and Substance Abuse Services managed by BCBS-SC

Mental health and substance abuse treatment is covered under all three medical options.

As long as you use the BCBS-SC network of providers, the company pays 90% for inpatient care, with no deductible. For office visits, you pay a primary physician office visit copay of \$10 for the Prime Medical Option and \$20 for the Standard Medical Option per visit. If you go to non network provider, the company pays 90% of the allowable charge after the deductible and the provider can balance bill you for the difference between his/her charge and the plan payment. (Note: the allowable charge may be lower than the out-of-network charges.)

Pre-authorization is required. BCBS-SC Clinical Care Managers are available 24 hours a day, seven days a week, at 1-800-868-1032. The number for Mental Health and Substance Abuse is shown on your ID card.

### Dental Options

*(Long-Term Disability participants excluded from this benefit)*

The following is a review of your dental coverage:

- Preventive care is covered at 100% of allowable charges under both options.
- Prime Choice offers higher coverage on restorative services; TMJ treatment and orthodontics are covered at 50% of allowable with no annual deductible.
- Standard Choice offers a lower coverage level on restorative services; no coverage for TMJ treatment or orthodontics; an annual deductible applies to non-preventive care services.
- As of 1-1-2011, implants are covered under Major Restorative Services for both the Prime and Standard Options.

### Your Dental Plan Options

	Prime Choice Dental	Standard Choice Dental
Preventive (oral exams, cleaning, x-rays)	100% allowable	100% allowable
Minor Restorative (fillings, root canals, periodontics)	80% allowable	50% allowable
Major Restorative (prosthodontics, crowns, bridge work, dentures, dental implants)	60% allowable	50% allowable
TMJ and TMD 50% R&C	50% allowable \$500 Lifetime Maximum	None
Orthodontics 50% R&C \$1,500 lifetime maximum (child and adult)	50% allowable \$1,500 lifetime maximum (child and adult)	None
Annual Deductible	None	\$25 per person/ \$50 per family on covered non-preventive services
Maximum Annual Benefit*	\$2,000 per person per year	\$1,000 per person per year

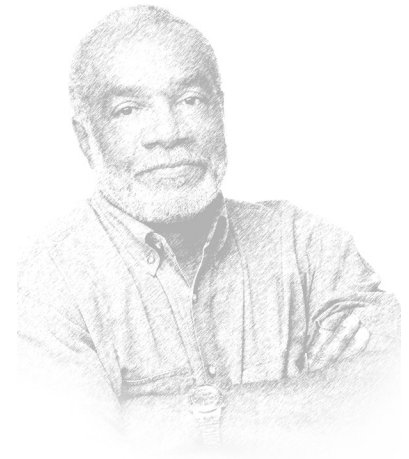
\* Dental option payments for preventive and minor and major restorative care have a combined dollar limit for each person. This limit — the maximum annual benefit — is available each year. However, payments for TMJ/TMD and orthodontics do not count toward the maximum annual benefit amount under the Prime Choice Dental option.

# Mid-year changes

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Your elections are effective January 1, 2012. You can only change certain benefit elections during the calendar year if you experience a qualifying life event change as defined by the Health Choice Plan and the IRS. If at any time you experience a life event change, you must notify the Benefits Solutions Service Center within 60 days of the event and submit the proper paperwork. The Health Choice Plan and the IRS define life event changes to be major changes in your family situation, such as:

- Marriage, death of spouse, divorce or annulment
- A change in the number of dependents, including birth, adoption, placement for adoption, death of a dependent child or becoming responsible for a stepchild
- A change in the eligibility status of dependents because of their age,
- Termination or commencement of employment by the employee, spouse or dependent child



## Requests to Change Benefit Elections

Requests to change your benefit elections (outside the annual enrollment period) that are not submitted to the Benefits Solutions Service Center within 60 days after the date of a qualifying event will not be recognized unless it is to remove an ineligible dependent.

- You will be allowed to make changes during the next annual enrollment period, effective January 1 of the following year.
- However, if a dependent has become ineligible and you do not notify the Benefits Solutions Service Center within 60 days after the qualifying event has occurred, then
  - (1) your ineligible dependent will be removed retroactively from your coverage once the dependent's ineligibility is known,
  - (2) you will not be refunded any premium contributions, and
  - (3) any claims paid after the dependent became ineligible will be recovered by the Claims Administrator and/or the company.

For a complete list of qualifying life event changes, please refer to your Benefits Overview and General Information Summary Plan Description located at [www.srs.gov.careers](http://www.srs.gov.careers).

## COBRA Continuity

Dependents who become ineligible for Health Choice coverage must be removed from your coverage, but they may be eligible for COBRA continuation coverage.

Health Choice coverage for a dependent ends on the date the dependent becomes ineligible. If the ineligible dependent is not removed from your coverage at this time, you will be responsible for any Health Choice claims incurred after the dependent became ineligible.

An ineligible dependent may qualify for COBRA continuation coverage if you notify the Benefits Solutions Service Center within 60 days of your dependent's loss of eligibility. If elected, your dependent's COBRA continuation coverage will become effective the date dependent coverage under Health Choice is terminated.

Your notice within the 60-day period also will entitle you to a refund of any Health Choice premium contribution made for this dependent's coverage after the event date, if any.

Questions on Health Choice benefit options or qualifying change in status requirements may be directed to the Benefits Solutions Service Center by calling extension 803-725-7772.

Remove ineligible dependents from all benefits within 60 days of your dependents' loss of eligibility in order for them to be eligible for COBRA coverage.

# Tips for enrollment

## Review your form

Carefully review your enclosed Personalized Enrollment Form to be sure:

- You want the same coverage for 2012
- Your dependent information is accurate and complete
- You know your benefit costs for 2012

## Marking your changes

It's easy to make changes to your coverage elections! Use the Personalized Enrollment Form to select or make changes to:

- Your medical and dental options (prime, standard, basic, or waive coverage, etc.)
- Your eligible dependents effective January 1, 2012.

Be sure to follow the instructions on the form. If you do not return your form by November 11, 2011, your 2012 Health Choice benefits and covered dependents will remain the same as they were in 2011, but at the 2012 contribution rates. You will receive a new confirmation of your 2012 benefits coverage in December.

## Example

Let's assume David Smith wants to change his current elections, which are indicated by the Option Code in bold type on his Personalized Enrollment Form. David wants to change his coverage for 2012 from Medical Prime (Employee + 2 or More) as noted in bold on his form to:

### **Medical Standard (Employee + 2 or More).**

Using a pen, David completes the following steps to select the coverage he wants:

- (1) He circles the desired option (e.g., RSB) and cost in the Price and Options Code Table
- (2) He fills in the new option code (e.g., RSB) and pay period cost in the space to the right of the table

The following is an example of the form—your personalized form will show your costs and available options. The rates below are examples only and not actual 2012 rates.

PRICE AND OPTIONS CODES				
MEDICAL	Employee Only	Employee + 1	Employee + 2 or More	Cost Per Pay Period
Medical Prime	\$146.00 (RP1)	\$264.98 (RPA)	\$392.99 (RPB)	Pay Period Cost: <b>RSB</b>
Medical Standard	\$31.00 (RP1)	\$77.00 (RSA)	<b>\$144.00 (RSB)</b>	Option Code: <i>\$144.00</i>
Medical Basic	\$0.00 (RS1)	\$12.00 (RBA)	\$25.00 (RBB)	
Waive	\$0.00 (W)			

You are currently covered under "Medical Prime" with "Employee + 2 or More" coverage.





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