

Annual enrollment is from October 31 through November 11, 2011,
using the PeopleSoft eBenefits™ web site on InSite



SRNS and/or SRR

2012 **health**choice

DECISION GUIDE TO ONLINE ENROLLMENT FOR ACTIVE EMPLOYEES

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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.

It's Online Only

(except for Option A employees)

Annual Open Enrollment will only be available through PeopleSoft eBenefits™ Web site on InSite for your 2012 benefits.

If you are making changes to your Health Choice benefits for 2012, you must use the PeopleSoft eBenefits™ web site on InSite to make any changes to your Health Choice Benefits enrollment.

If you do not enroll by November 11, 2011, your 2012 Health Choice benefits and covered dependents will remain the same as in 2011, but at the 2012 contribution rate.

Option A Employees will complete the enclosed Personalized Enrollment Form and return the form in the enclosed envelope.

What's new?

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. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Things to remember

about your 2012 Health Choice Benefits

Health Care Options

Health Care FSA:

Mid-year changes will only be allowed for the Health Care FSA consistent with a qualified change in status.

Dependent Care FSA:

Your Dependent Care FSA account is for day care expenses for your eligible dependents so you can work; it is not for Dependent Health Care expenses!

FSA Copays:

If you participate in the Health Care FSA, most copays and deductibles will automatically be reimbursed from the account without the need to file forms. See Page 8 of this booklet for more information.

FSA Elections:

Employees with a Health Care FSA can no longer use their account funds to be reimbursed for over-the counter (OTC) drugs and medicines unless they have a prescription for those drugs from their doctor or it is insulin.



Eligible Dependents

If you are divorced, your ex-spouse is no longer eligible to be covered as of the date of your divorce. And 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.

Reviewing your enrollment information

Begin by asking: What benefits do I currently have?

Learn all you can about your options and choices by reviewing the materials in this booklet. If you want to view your current benefit elections, visit the eApplications Section on the Human Resources Home Page on InSite.

(Option A employees will review their enclosed Personalized Enrollment Form.)

Do I need to change my current elections?

If you want to keep all your benefits and dependents the same, do nothing. Your Personalized Confirmation Statement verifying your 2012 benefits will be available through eApplications Section on the HR Home Page in InSite in mid-December. (Option A employees will be mailed a Confirmation Statement to their homes in mid-December).

How to change your benefit elections or dependent information

- Make sure your dependent information is correct. If necessary, you'll be able to deselect coverage for a dependent in eBenefits™. To add (and/or delete) eligible dependents, use Form OSR 5-200, Health Care Programs Enrollment/Change Form, which is available from FORMS on InSite. You'll need to mail this form to the Benefits Solutions Service Center at 703-47A or fax to (803) 725-4556. You can contact the Benefits Solutions Service Center at 5-7772 if you have any questions.
- Review your Flexible Spending Account elections. If you do nothing, your 2011 elections will remain in effect for 2012.



Did you know?

All elections on file, including FSA amounts, will continue for 2012 unless you make a change through eBenefits™.

Your Health Care benefits options

for active employees

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.
- 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.

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 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 a 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.

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.
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.

Dental Options

(Option A employees excluded)

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 (filings, 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.

Vision Options

(Option A employees excluded)

The vision plan network includes Pearle Vision, Lenscrafters, Sears Optical, Target Optical and JC Penney Optical.

Vision Care Choice provides coverage for routine eye exams and purchases of glasses or contacts. The plan also provides coverage at Vision network locations and participating EyeMed Vision Care doctors, and provides non-network average maximum benefit at any other eye doctor or optician. EyeMed providers are listed on the Internet, at www.eyemedvisioncare.com.

If your actual charges are below the maximum benefit allowances, the remaining balance will not be available for future use during the calendar year. For example, Vision Care provides up to \$145 for contact lenses. If you go to your vision care provider on February 3 and you purchase \$40 worth of contact lenses, the remaining \$105 (\$145-\$40 = \$105) will not be available for you to purchase additional contact lenses when you return to your Vision Care provider later in the year.

Your Vision Plan Options

Vision Care Services	Employee Cost	Out-of-Network Allowance
Exam with dilation as necessary Exam Options:	\$15 copay	\$35
• Standard Contact Lens fit and follow-up	Up to \$55	N/A
• Premium Contact Lens fit and follow-up	10% off retail price	N/A
Standard Plastic Lenses:		
• Single vision	\$0 copay	\$25
• Bifocal	\$0 copay	\$40
• Trifocal, Standard Progressive	\$0 copay	\$55
Frames: any frame available at provider location	\$0 copay to \$100 allowance for any frame plus 20% off balance over \$100	\$50
Lens Options:		
• UV Coating	\$15	N/A
• Tint (solid and gradient)	\$0	N/A
• Standard Scratch-Resistant	\$0	N/A
• Standard Polycarbonate	\$40	N/A
• Standard Anti-Reflective	\$45	N/A
• Other Add-Ons and Services	20% discount*	N/A
Contact Lenses (includes fit, follow-up and materials)		
• Conventional	\$0 copay; 15% discount off balance over \$145	Up to \$116
• Disposables	\$0 copay; balance over \$145	Up to \$116
• Medically Necessary	\$0 copay; paid-in-full	Up to \$200
Laser Vision Correction		
• Lasik or PRK from U.S. Laser Network	15% off retail price OR 5% off promotional price	N/A
Frequency: Examination, Frame, Lenses or Contact Lenses	Once every calendar year	Once every calendar year

* 40% discount on a complete pair of eyeglasses after initial benefit is exhausted

Flexible Spending Accounts

Spending accounts allow you to set aside money to meet expenses not covered under any benefit plans. Money directed to these accounts is not taxed when it is deducted from your pay or when it is distributed. The following is a review of FSAs:

- FSAs are an alternative to tax deductibles and credits—you can elect to contribute to a Health Care Account and/or a Dependent Day Care Account.
- Maximum annual contributions: \$4,000 in the Health Care Account and \$5,000 per family in the Dependent Day Care Account
- Eligible expenses must be for services incurred by you and your legal dependents, when the coverage is in force.
- Money for 2012 claims that have not been filed by April 15, 2013, will be forfeited.
- See the FSA section of your Benefits Handbook (Benefits home page in InSite) and IRS Publications #502 and #503 for information on allowable expenses.

Employees can no longer use their account funds to purchase over-the counter (OTC) drugs and medicines unless they have a prescription for those drugs from their doctor or it is insulin.

- Kindergarten expenses are not eligible under the Dependent Care FSA.
- Dependent Care FSA covers expenses for the personal care (not dependent health care) expenses of your dependents so you and your spouse can work. Dependent refers to a child under the age 13 or a dependent of any age who is incapable of caring for him or herself in accordance with federal tax regulations.
- Remember, the Health Care FSA has automatic rollover/filing for claims that have been paid by BCBS-SC under the Prime, Standard and Basic Medical plans when you and your dependents have no other health coverage.

If you have a qualifying life event change during the year, you can:

- Enroll in, cancel or change your Health Care Account contributions, as long as your change is consistent with your qualifying event.
- Enroll in, cancel or change your Dependent Day Care Account contribution, as long as your change is consistent with your qualifying event. (See “Mid-Year Changes” for examples of qualifying life event changes.)

Automatic Filing for 2012 Health Care FSA Participants: Inclusions and Exclusions

- Includes:
- Deductibles and office visit copays and other coinsurance paid by BCBSSC under the Prime and Standard Medical and Dental Plans and under the Basic Medical Plan
 - All 2012 Health Care FSA participants (except those people for whom BCBSSC has noted there is other coverage present with Coordination of Benefits—where the Health Choice Plan is primary and/or secondary) will be enrolled in the automatic roll-over/ filing feature for their 2012 Health Care FSA claims. For example, if your spouse has coverage through their employer, you will not be enrolled in the Health Care FSA automated claim roll-over and will have to manually submit claim forms for reimbursement. Unfortunately, there are a number of systems and IRS rules on FSA Claims Administration that prohibits us from extending, at this time, the automatic roll-over/filing feature to those people with possible Coordination of Benefits.

- Excludes:
- Other non-covered expenses (for example, amounts in excess of R&C, charges not covered by the Plan, etc.) that are listed as your part of responsibility for payment on your BCBSSC Medical and/or Dental Plan explanation of benefits
 - BCBSSC adjustments to prior claim payments
 - Claims paid by EyeMed Vision Care

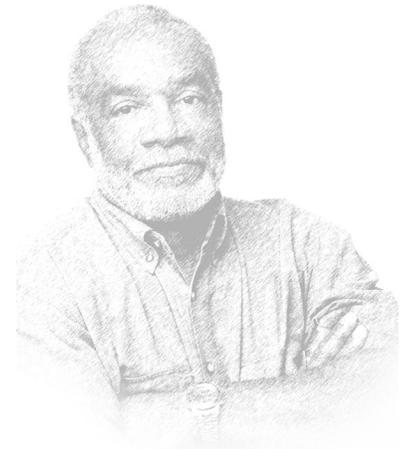
You will still be able to submit the hard copy OSR 5-343 Health Care Reimbursement Claim Form and Medical and/or Dental Plan explanation of benefits to BCBSSC for eligible covered claims that are not automatically rolled over/ filed for your 2012 Health Care FSA Plan.

The FSA employee direct deposit option is also available by completing the Employee Direct Authorization Agreement Flex Spending Account form, found in http://InSite01.srs.gov/hr/benefits/direct_deposit_auth_form.pdf.

Mid-year changes

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 on the Benefits Home Page in InSite.

COBRA Continuity

Dependents that 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 5-7772.

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.

Did you know?

- If you do not enroll online by November 12, 2011, your Health Choice benefits and covered dependents will remain the same, but at 2012 premiums.
- Check your personalized benefits summaries online to make sure these options are right for you.
- All changes must be consistent with the qualifying event.
- Re-enroll dependents by completing an OSR 5-200.

How to enroll online

You are now ready to enroll

- You can access the 2012 Benefits Enrollment site on the HR Home Page in InSite while at work by clicking on PeopleSoft eApplications™. If you do not have direct access to a computer, check with your manager or HR Representative for alternative arrangements.
- Once you are on the eApplications™ Page, click on the login button. This will take you to the Sign-in Screen.
- Enter your Computer User ID and password (which is your Windows Domain password) and click on the Sign-In button, which will take you to PeopleSoft's HR Home Page.
- Next, click on the Benefits icon.
- To begin your enrollment, click on the Benefits Enrollment icon.
- The Benefits Enrollment screen will show your name and job title. If you click on the Info button, you will go to a screen with additional information about your enrollment.
- If you click on the Select button, you will go to the Open Enrollment screen, which lists a summary of your benefit options for 2012.

Did you know?

On November 1, you can contact the Benefits Solutions Service Center if you need assistance with your password.

How to enroll online

(continued)

Making Your Selections

- On the Open Enrollment screen, you will see your current benefit elections, which will remain in effect if you decide not to make any changes for 2012. You will also see the new “per-pay-period” costs. If you decide to continue with your current benefits, click on the “I Have No Changes” button at the bottom of the screen and your enrollment process is complete.
- If you need to make changes, click on the Edit button for each of the benefit plans listed and your other choices will appear along with your per-pay-period costs. You can change your options by clicking on the button next to the option of your choice.
- Click on the Waive button if you are not interested in participating in a benefit.
- Once you’ve reviewed all of your choices and pay-per-period costs, and verified which of your dependents should be enrolled in the benefit, click on the Continue button at the bottom of the page and continue to review your benefit plans on the Open Enrollment screen. A confirmation of your benefit selections will appear on the screen. If you wish to make a change, click on the Edit button to go back and change your choices. If you agree with your selection, click on the OK button at the bottom of the page and you will return to the Enrollment Summary Screen where you may either click on the Submit button or continue to edit your selections.
- Once you have made your final selections, you must click the Submit button to complete your enrollment. You can submit your enrollment as many times as you wish between October 31 and midnight of November 11. The last submittal on file will be the one used for open enrollment.

Submit your choices

When you are finished making all of your selections on the Enrollment Summary screen and are certain they are correct, click on the Submit button.

You will be taken to the Submit Your Benefit Choices screen, where you will authorize your elections by clicking on the Submit button. Your choices will be submitted to the Benefits Solutions Service Center. If you made a mistake or wish to change your mind, click on the Cancel button and repeat the selection process.

To exit the system, click the Sign Out button at the top of the screen.

After the enrollment period is completed, you will view your Personalized Confirmation Statement in December showing your benefit elections for 2012 by using the PeopleSoft eBenefits™ web site in InSite. Review it carefully, save this statement for your personal records and compare it to your first paycheck in 2012, to ensure that your changes have been made correctly.

Your enrollment isn’t finalized until you click the Submit button.

Notes

A Final Word

Decide which plans make the most sense for you before you begin the enrollment process. Remember, you must enter your changes to your 2012 benefits coverage by midnight on November 11, 2011, by using the PeopleSoft eBenefits™ web site on InSite.



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