Annual enrollment is from
October 29 through November 11, 2012

A decision guide to open enrollment for **Retired Employees/Dependents Under Age 65**

2013 **health**choice

Savannah River Nuclear Solutions and Savannah River Remediation

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Enroll October 29-November 11, 2012

Annual Open Enrollment

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 2013. 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.

Several benefit changes have been implemented for 2013 that warrant your careful consideration to obtain the maximum benefit for you and your family.

- A Health Savings Account option is now available when you are enrolled in the Basic Medical Plan.
- Changes have been made to the prescription drug benefits.
- All eligible pre-age 65 retirees and dependents, including those enrolled in Medicare, will be on the same pre-age 65 retiree premium schedule.
- Your son or daughter can be covered under your medical and dental plan options up to age 26 if they are not eligible for their own employer coverage.

Your opportunity to enroll ends on Nov. 11, 2012, at midnight.

For more information on new benefit aspects for 2013, please see the "What's New" section on Pages 2 and 3, and the individual sections in this booklet.

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.

Do I need to change my current elections?

If you retired prior to 1998, you will need to complete and submit an election for a medical and dental plan during this open enrollment period. If you retired prior to 1998 and do not submit a new election, you and your covered dependents will be enrolled in the Standard Medical and Standard Dental plans for the 2013 calendar year at the 2013 rates.

If you retired after 12/31/1997 and do not submit a change to your current benefit elections, your current benefit plans and covered dependents will remain in effect for calendar year 2013 at the 2013 rates.

In either case, you should review your benefit plan elections, your covered dependents, and your 2013 benefit costs.

How to change your benefit elections or dependent information

This year a project is under way to allow you to complete your benefits enrollment via a secure site on the Internet. Additional instructions and your initial log-in are included on a separate sheet in this packet of information. Or, as in the past, you may also mark up and submit your paper enrollment form in the enclosed envelope.

If you need to add a dependent that is not included in your list of dependents, contact the Benefits Solution Service Center at (803) 725-7772 or (800) 368-7333 for guidance. You may be requested to supply documentation to support your request to add a dependent such as a marriage certificate or adoption/guardianship documents.

You are responsible for reviewing your benefit elections and all elections remain in effect for calendar year 2013 unless you have a qualifying event.

Qualifying events can allow you to enroll in coverage, drop coverage, and add or drop dependents. There are no qualifying events that allow you to change plans mid-year.

Also, you are responsible for removing any dependents that are no longer eligible for coverage.

For more information on qualifying events, see the applicable benefit Summary Plan Description located on the company external website at www.srs.gov.

What's

Regarding Medicare Eligibility

- Effective Jan. 1, 2013, retirees age 65 and over and/or their spouses who are age 65 and over will no longer be eligible for the SRNS or SRR Health Choice Plans.
- Retirees and/or spouses reaching age 65 will be transitioned off the group Medical and Dental plans to purchase individual plans. The company will provide an annual contribution in a Retiree Reimbursement Account (RRA) to assist eligible participants with premiums and additional expenses. An advocacy service, My Medicare Advocate (MMA), will reach out to you and/or your spouse two to three months prior to your 65th birthday.
- Eligible retirees and/or their dependents who are under age 65 can elect to continue their coverage in the SRNS or SRR Retiree Medical and Dental Plans.

Please note that the Medicare Primary "carve out" provisions of the Medical Plan will apply for Medicare eligible participants who are under age 65. For more information on Coordination of Benefits, see the Medical Plan Summary Plan Description located on the company external website at www.srs.gov.

Basic Medical Plan Partnered with a Health Savings Account

- A Health Savings Account (HSA) will be offered when you enroll in the Basic Medical Plan. An HSA is a tax-favored benefit that allows you to save for qualified medical expenses. The company will provide a lump sum contribution amount of $250 for single coverage and $500 for family coverage for 2013. The company will process after-tax payroll deductions (from pension checks) for you to fund your account.
- The deductibles for the Basic Medical Plan will change to $1,250 for single and $2,500 for family to meet Internal Revenue Service (IRS) guidelines for a Consumer Driven High Deductible Health Plan. Note that if you cover one or more dependents, the Family deductible applies before reimbursement and before the Family out-of-pocket applies.

Pharmacy Changes

- **Step Therapy:** For some medications, you will be required to try "First Choice" medications before trying (or "stepping up" to) "Second Choice" medications. For more information see http://www.southcarolinablues.com/members/prescriptiondruginformation/druglists/drugmanagement.aspx.
- **Quantity Management:** This will limit the amount of reimbursable benefits for some covered medications, based on U.S. Food and Drug Administration (FDA) and manufacturer dosing guidelines, medical literature, safety, accepted medical practice and appropriate use and benefit design. For more information and list of impacted drugs see http://www.southcarolinablues.com/members/prescriptiondruginformation/druglists/drugmanagement.aspx
- **Mandatory Generics:** If a generic equivalent is available and you fill a prescription with a brand name, you will pay the appropriate brand cost share plus the cost difference between the brand and the generic, regardless if the physician prescribes a brand name drug. You should always ask your physician if a generic equivalent medication is available.

Diagnostic Imaging

Pre-certification will be required for out-patient major diagnostic procedures (e.g. MRI, MRA, CT scans, PET scans, etc.).

new for 2013

Eligibility

Eligibility for spouses will be defined with validation of a state-recognized marriage certificate, including same sex marriage when recognized by state law through a valid marriage license. South Carolina common law will continue to have the same documentation requirements for attestation. Note that same sex marriage does not have the same tax treatment for benefits. The employee will have to pay imputed income tax for the employer contribution portion of the insurance for the domestic partner and/or his or her children. To add spouses, including domestic partners, contact the Benefits Solutions Service Center at (803) 725-7772 or (800) 368-7333.

Wellness

The annual deductible for 2014 is planned to increase by $200 for the Prime and Standard Plans. However, you and your spouse will each have the opportunity in 2013 to each earn up to $250 in wellness credits to be applied to this deductible or added to your HSA if enrolled in the Basic Medical Plan. The Blue Cross Blue Shield (BCBS) Wellness Program will include:

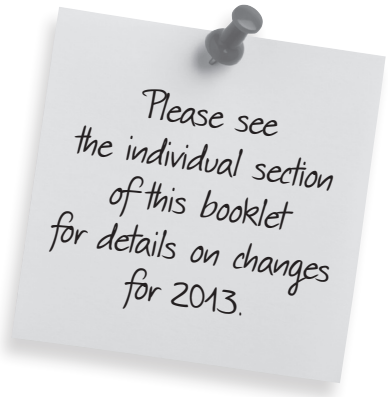
- Completing an annual wellness exam
- Completing an on-line personal health assessment
- Completing a weight loss program
- Completing a smoking cessation program
- Working out at a gym, with a minimum number of visits

A wellness value of $125 is assigned to each of these programs, with a maximum credit of $250 per employee and $250 per spouse. A rollout of this new Wellness incentive program with additional details will be provided in a separate communication at a later date.

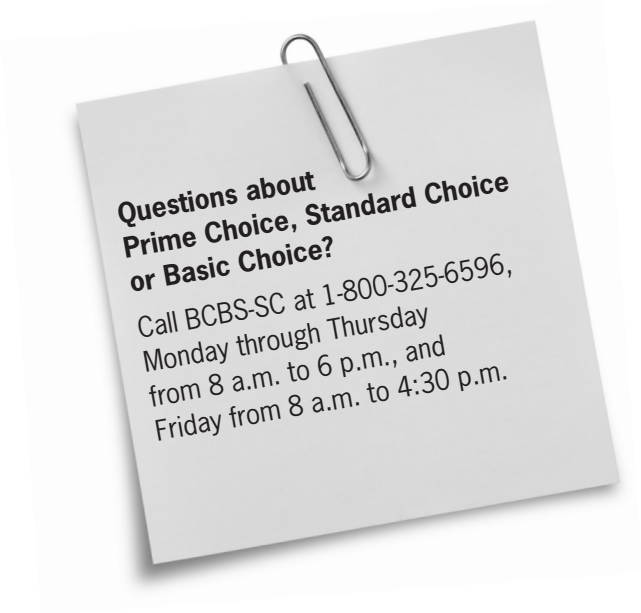
BCBS-SC approved smoking cessation programs will be added to the Medical plan coverage.

2013 Dental Plan Changes

- Sealants will now be available to dependent children under age 20, one per 60 months.
- Fluoride treatments will have no age limits for high risk adults.



Your Health Care Benefits Options For Retired Employees



Your Medical Options for 2013

You have three medical options for 2013, plus the option of electing no medical coverage (i.e. waiving 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)
- Mail-order prescriptions for a 90-day supply are available (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. Note: This penalty amount will not apply toward your deductible or out-of-pocket maximum.
- 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 with no generic equivalent and 70% after the deductible has been met for non-preferred prescriptions with no generic equivalent. **Note that several changes to pharmacy benefits will be effective Jan. 1, 2013. See the "Pharmacy Benefit Changes" section of this booklet for more details.**

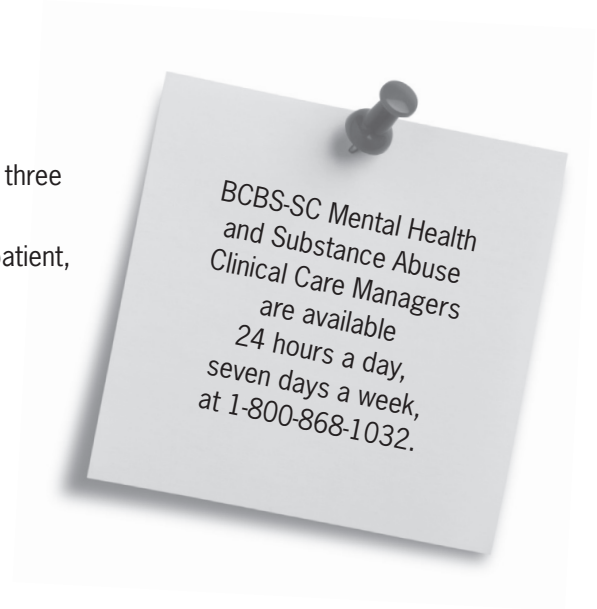
Basic Choice

- Consumer Driven High Deductible Plan
- High deductible must be met before plan payments begin. (If more than one participant is covered, then the Family aggregate deductible must be met prior to Plan payments beginning.)
- Lower premiums than other options
- A company-provided lump sum contribution ($250 for single participants, $500 for families) is an option for eligible participants.
- This plan treats providers the same in determining payment for the same services. The amount the plan pays for covered services is based on the BCBS-SC allowed amount. By using BCBS contracted providers, payments will be based on the BCBS negotiated fees/charges with the providers.
- Preventive care covered at 100% before deductible for services included on the BCBS preventive schedule.

Mental Health and Substance Abuse Services Managed by BCBS-SC

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

Pre-authorization is required for all Behavioral Health Services (in-patient, intensive out-patient and office visits).



Your Medical Benefits at a Glance

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	$1,250 (1) $2,500 Family All Members Combined
Out-Of-Pocket Maximum (2) · Individual · Family	$1,000 $2,000	$1,000 $2,000	$2,000 $4,000	$2,000 $4,000	$4,500 (1) $9,000 Family All Members Combined
Physician Office Visit (3) · Primary · Specialist	$10 Copay $20 Copay	90% BCBS-SC allowable charge after deductible	$20 Copay $30 Copay	90% BCBS-SC allowable charge after deductible	80% allowable after deductible
Preventive Care Office Visits (based on schedule)	$10 Copay	Not covered	$20 Copay	Not covered	100% allowable **BEFORE** deductible
Allergy or hormone injections by nurse in Physician's office	90% ($10 copay if other services provided)	90% BCBS-SC allowable charge after deductible	90% ($20 copay if other services provided	90% BCBS-SC allowable charge after deductible	80% allowable after deductible
Chiropractic Treatment (4)	90% no deductible	80% BCBS-SC allowable after deductible	90% no deductible	80% BCBS-SC allowable after deductible	80% allowable after deductible
Physical/Occupational Therapy (5)	90% no allowable deductible	90% BCBS-SC allowable charge after deductible	90% no deductible	90% BCBS-SC allowable charge after deductible	80% allowable after deductible
Ambulance Service	90% Maximum Payment no deductible	90% Maximum Payment no deductible	90% Maximum Payment no deductible	90% Maximum Payment no deductible	80% Maximum Payment after deductible
Hospital, surgical and most other medical services (3), (5)	90% allowable charges	90% BCBS-SC allowable charge, after deductible	90% allowable charges	90% BCBS-SC allowable charge, after deductible	80% allowable after deductible
Emergency Room Services (life threatening acute or urgent care)	90% allowable charge, no deductible	90% Maximum Payment no deductible	90% allowable charge, no deductible	90% Maximum Payment, no deductible	80% Maximum Payment after deductible
Emergency Room for routine use	70% allowable after deductible	70% BCBS-SC allowable charge after deductible	70% after deductible	70% BCBS-SC allowable charge after deductible	80% allowable after deductible
Diagnostic Services (lab, x-ray and other tests) when not performed in a physician's office (7)	90% allowable charge, no deductible	90% BCBS-SC allowable charge, after deductible	90% allowable charge, no deductible	90% BCBS-SC allowable charge, after deductible	80% allowable after deductible
Home Health Care, Hospice Care, Durable Medical Expenses (5)	90% no deductible	90% BCBS-SC allowable charge, after deductible	90% no deductible	90% BCBS-SC allowable charge, after deductible	80% allowable after deductible
Prescription Drugs (6)	Allowed % after deductible	Allowed % after deductible	Allowed % after deductible	Allowed % after deductible	Allowed % after deductible
-Generic	90%	90%	90%	90%	80%
-Preferred	80%	80%	80%	80%	80%
-Non-Preferred Brand	70%	70%	70%	70%	80%

Annual Maximum Benefit $2,000,000 effective 1/1/2013

1. Under Basic, if you cover one or more dependents, the family deductible applies before reimbursement and the family out-of-pocket applies.

2. Your deductibles and coinsurance amounts (10%, 20% or 30% for most services) count toward your out-of pocket maximums.

3. Includes eligible mental health and chemical dependency services (Behavioral health office visits require a pre-certification in addition to an office co-pay)

4. Limited to $750 total per person/year

5. Pre-approval required

6. Coverage is after satisfaction of the deductible. See "Pharmacy Benefit Changes" section of this booklet for more detailed information.

7. Pre-certification is required for out-patient major diagnostic procedures (MRI, MRA, CT scans, PET scans, etc.)

All admissions, rehabilitation services, behavioral health services and some out-patient services require pre-authorization. If pre-authorization is not obtained, charges may be denied. A $200 penalty will apply when pre-authorization is not obtained within 48 hours or first day of business after the admission.

Basic Medical Plan and New Health Savings Accounts

New for 2013, if a retiree enrolls in the Basic Medical Plan, they will be given the opportunity to enroll in a Health Savings Account. A Health Savings Account or "HSA" is a tax-advantaged account that you can use to set aside tax-advantaged dollars to pay for eligible health expenses.

As a retiree, your deductions are after-tax, so you would use your tax filings to receive any due credits. (You may want to consult a tax advisor with any questions.)

Advantages of an HSA

Pay for Medical Expenses With Tax-Free Dollars
You can pay for IRS qualified medical expenses with your HSA funds.

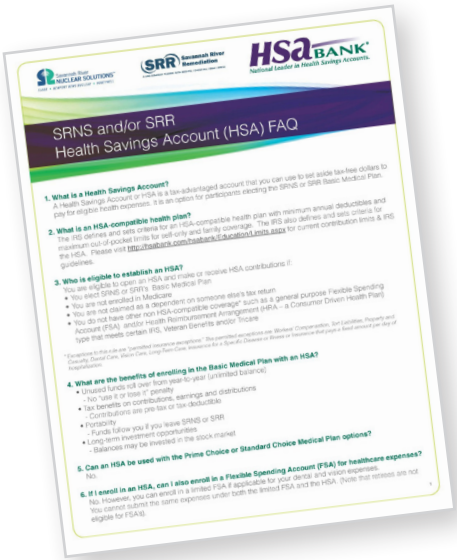
Funds Roll Over From Year to Year
If you have no medical expenses or do not use HSA funds to pay for medical expenses, unused funds roll over and earnings grow tax-free. Even if you decide to waive coverage in your SRNS or SRR health plan in the future, or after you turn age 65, the funds will follow you. You own the funds in your HSA.

Flexibility and Saving
When you combine a lower Medical premium, your tax savings and the 2013 company contribution, you may be able to cut back significantly on your total out-of-pocket health care costs with the HSA Plan.

Funding
For 2013, SRNS and SRR will provide a lump sum contribution of $250 in Single HSA accounts and $500 in Family HSA accounts with HSA Bank, a division of Webster Bank, FDIC.

You can make contributions up to a maximum of $3,250 for Single accounts and $6,450 for Family accounts.

Basic Medical Plan and New Health Savings Accounts *(continued)*



SRNS and/or SRR
Health Savings Account (HSA) FAQ

1. What is a Health Savings Account?
A Health Savings Account or HSA is a tax-advantaged account that you can use to set aside tax-free dollars to pay for eligible health expenses. It is an option for participants electing the SRNS or SRR Basic Medical Plan.

2. What is an HSA-compatible health plan?
The IRS defines and sets criteria for an HSA-compatible health plan with minimum annual deductibles and maximum out-of-pocket limits for well-only and family coverage. The IRS also defines and sets criteria for the HSA. Please visit http://hsabank.com/hsabank/Education/Limits.aspx for current contribution limits & IRS guidelines.

3. Who is eligible to establish an HSA?
You are eligible to open an HSA and make or receive HSA contributions if:
- You elect SRNS or SRR's Basic Medical Plan
- You are not enrolled in Medicare
- You are not claimed as a dependent on someone else's tax return
- You are not claimed as a dependent on someone else's medical plan
- You do not have other non HSA-compatible coverage* such as a general purpose Flexible Spending Account (FSA) and/or Health Reimbursement Arrangement (HRA – a Consumer Driven Health Plan) type that meets certain IRS, Veteran Benefits and/or Tricare

*Exceptions to this rule are "permitted insurance exceptions". The permitted exceptions are Workers' Compensation, Tort Liabilities, Property and Casualty, Dental Care, Vision Care, Long-Term Care, Insurance for a Specific Disease or Illness or Insurance that pays a fixed amount per day of hospitalization.

4. What are the benefits of enrolling in the Basic Medical Plan with an HSA?
- Unused funds roll over from year-to-year (unlimited balance)
  - No "use it or lose it" penalty
- Tax benefits on contributions, earnings and distributions
  - Contributions are pre-tax or tax deductible
- Portability
  - Funds follow you if you leave SRNS or SRR
- Long-term investment opportunities
  - Balances may be invested in the stock market

5. Can an HSA be used with the Prime Choice or Standard Choice Medical Plan options?
No.

6. If I enroll in an HSA, can I also enroll in a Flexible Spending Account (FSA) for healthcare expenses?
No. However, you can enroll in a limited FSA if applicable for your dental and vision expenses. You cannot submit the same expenses under both the limited FSA and the HSA. (Note that retirees are not eligible for FSAs).

Please see the enclosed "Health Savings Account: Q&As" publication for more details.

Who Is Eligible For the HSA?

You are eligible to open an HSA and make or receive HSA contributions if you:

- Elect SRNS or SRR's Basic Medical Plan
- Are not enrolled in Medicare, Veteran's Affairs benefits or Tricare
- Are not a dependent on someone else's medical plan
- Are not claimed as a dependent on someone else's tax return
- Do not have other non-HSA compatible coverage, such as a Health Reimbursement Arrangement (An HRA is a Consumer Driven Health Plan type that meets certain IRS, Veterans' benefits and/or Tricare guidelines.)

Enrolling in Basic Coverage and Establishing an HSA

Select the Basic Medical Plan option and determine your HSA contribution through the annual Open Enrollment process. A welcome kit from HSA Bank will be mailed to your home in late December that will contain your HSA Bank account number, instructions to access your account online, and details about your investment options. In a separate mailing, you will receive your HSA Bank debit card. (As this is a bank account, there are specific banking regulatory requirements for establishing the account.)

Using the HSA to Pay Bills

There are two ways to pay your medical claims with your HSA Bank funds using the BCBS-SC website. To sign up, simply go to www.SouthCarolinaBlues.com, log in to the Member section and My Health Toolkit, and click "Pay Claims with HSA Bank" on the left side of the page. You can choose either Automatic Payments or select payment on a Claim-By-Claim basis.

There are several options for accessing your HSA funds that include a Debit card, on-line banking and using checks. There is a monthly maintenance fee of $2.25 for each HSA account. (This fee is waived if you keep a balance of $3,000 or greater in your HSA account.)

Pharmacy Benefit Changes

Several changes are taking place Jan. 1, 2013, regarding Pharmacy benefits under the Health Choice Medical Plan. The changes will include the following:

Mandatory Generics

Under the mandatory generic drug program, if you purchase a preferred or non-preferred brand name drug when a generic is available, you will pay more out of pocket. You will pay the brand drug co-insurance (for preferred or non-preferred, whichever applies) plus any difference in cost between the generic and the brand name drug. This same policy also applies if your doctor indicates that your prescription should be dispensed as written, with no substitutions. In this case, your prescription is filled according to your doctor's orders. However, you still must pay the brand co-insurance, as well as the difference in cost between the generic and brand name drug. You may want to speak to your doctor about using generics instead of the more expensive brand name drugs. (Note that any difference in cost between generic and brand name that was paid out-of-pocket will not count toward your deductible or out-of-pocket maximum, as this is **not** a covered expense under the Plan.)

Quantity Management

This is a quality and safety program that promotes the safe use of medications. The program limits the amount of reimbursable expenses for some medications covered by the Plan. This is based on FDA and manufacturer dosing guidelines, medical literature, safety, accepted medical practice, appropriate use and benefit design. Quantity management means that the Plan will cover a set dosage amount within a set timeframe. The Plan will cover higher amounts of some medications when medically necessary.

If you go to the pharmacy with a prescription over the covered amount, the pharmacist can reduce your prescription to the quantity the Plan covers or you can pay full price for the portion of your prescription that exceeds the limit. Your doctor can ask for a quantity override, if one is available. (Depending on the amount of the override, this may or may not be approved by the Plan.)

Step Therapy

This is a program that can help you lower your medication costs. Many medical conditions can be treated using a variety of medications. In some cases, there is a large difference in cost among the medications, but only a small difference in the way the medications work. Step Therapy requires members to try cost-effective "first choice" medications before trying (or "stepping up" to) more expensive "second choice" medications. The program is also based on FDA and manufacturer dosing guidelines, medical literature, safety, accepted medical practice, appropriate use, and benefit design.

If you go to the pharmacy with a prescription for a second choice medication, your claims history will be checked. If you have filled prescriptions for first choice medications before, the pharmacist will fill your prescription for the second choice medication. If you have not had prescriptions filled for first choice medications prior, you or your pharmacist can call your doctor to change your prescription to a first choice medication or you can pay full price for the second choice prescription. If your doctor feels you need the second choice medication, a medical necessity request can be made.

For more information on any of these programs, and to see a list of affected drugs, please see the BCBS-SC website for the most up-to-date information at http://www.southcarolinablues.com/members/prescriptiondruginformation/druglists/drugmanagement.aspx.

Dental Options for 2013

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.

Implants are covered under Major Restorative Services for both the Prime and Standard Options.

New for 2013

- Sealants will now be available to dependent children under age 20, one per 60 months.
- Fluoride treatments will now have no age limits for high risk adults.

Dental Option Features	Prime Choice Dental	Standard Choice Dental
Class I: Preventive and Diagnostic	100% of Allowable Charges	100% of Allowable Charges
Class II: Minor Restorative (Basic Dental, Oral Surgery and Periodontic Benefits)	80% of Allowable Charges	50% of Allowable Charges
Class III: Major Restorative (Prosthodontic Benefits)	60% of Allowable Charges	50% of Allowable Charges
TMJ and TMD	50% of Allowable Charges, $500 lifetime maximum	None
Class IV: Orthodontics	50% of Allowable Charges, $1,500 lifetime maximum (child and adult)	None
Annual Deductible	None	$25 per person/ $50 per family on covered non-preventative 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. Payments for TMJ/TMD and orthodontics do not count toward the maximum annual benefit amount under the Prime Choice Dental option. However, there is a maximum lifetime benefit as indicated in the table above for TMJ/TMD and orthodontics.*

Mid-year Changes

Your elections are effective Jan. 1, 2013. 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

Please refer to the Medical and Dental summary plan descriptions for complete details about mid-year changes.

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 Jan. 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 may not be refunded any premium contributions, and
3) any claims paid after the dependent became ineligible may be recovered by the Claims Administrator and/or the company.

For a complete list of qualifying life event changes, please refer to the applicable Summary Plan Description located on the company external website at www.srs.gov.

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 may, according to the rules of the Plan, 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 (803) 725-7772 or e-mailing at service-center@srs.gov.

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 your benefit coverage level and cost for 2013 is accurate and complete, and your dependent information is accurate and complete.

Making your changes

New for 2013: Retirees will have the ability to make on-line changes to their health coverage for 2013. You can choose to complete the paper enrollment or access Self Service on-line to make your open enrollment changes. If you'd like to make online changes, see the additional enclosure document providing a user ID and password for your initial login. If you'd like to make your open enrollment changes on paper, follow the directions on the form.

Be sure to complete your enrollment by Nov. 11, 2012. All employees who retired prior to 1998 will need to make an election. If no election is made, you will be defaulted into the Standard Medical and Standard Dental plans. You will receive a confirmation of your 2013 benefits coverage in December.

Annual Notices

Women and Cancer

The SRNS and SRR Medical Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy, including lymphedema.

HIPPA Late Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the SRNS Benefits Service Center.

Genetic Information Non-Discrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Contact Information

SRNS Benefits Solutions Service Center
Service-Center@srs.gov
Local:
803-725-7772
Toll Free:
800-368-7333

Blue Cross Blue Shield of South Carolina
Customer Service:
800-325-6596
www.southcarolinablues.com

HSA Bank
Customer Service:
800-357-6246
www.hsabank.com

While SRNS and SRR intend to continue providing comprehensive benefits programs, the companies reserves the right to modify or terminate any of the benefit plans at any time. SRNS and SRR will provide advance notification of any future substantial and material benefit changes.

This open enrollment communication is also intended to summarize and notify you of any material modifications to the Plan ("Summary of Material Modifications").

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