

THE STATE OF SOUTH CAROLINA
In the Supreme Court

APPEAL FROM THE ADMINISTRATIVE LAW COURT
Shirley C. Robinson, Administrative Law Judge

Appellate Case No. 2012-213186

Jeffrey D. Allen, on behalf of Jane Doe

.....Appellant,

v.

South Carolina Public Employee Benefit Authority,
Employee Insurance Program

Respondent.

RECORD ON APPEAL
VOLUME III

John A. Massalon, Esquire
Wills Massalon & Allen LLC
P.O. Box 859
Charleston, South Carolina 29401
SC Bar Number: 010279
(843) 727-1144

Terry E. Richardson, Jr., Esquire
Richardson Patrick Westbrook & Brickman,
LLC
1730 Jackson Street
P.O. Box 1368
Barnwell, SC 29812
SC Bar Number: 04721
(803) 541-7850
Attorneys for Appellant

Theodore D. Willard, Jr.
Montgomery Willard, LLC
P.O. Box 11886
Columbia, SC 29211

Stephen R. Van Camp
SC Public Employee Benefit Authority
1201 Main Street, Suite 300
Columbia, SC 29201
Attorneys for Respondents.

INDEX
RECORD ON APPEAL
VOLUME III

Plaintiff's Memorandum in Opposition to Defendants Motion to Dismiss.....	470
Appeal Letter – Goodman, Sr. Director of BCBS of March 19, 2010.....	615
Letter from Appellate Review Committee BCBS of April 2, 2010	616
Plaintiff's Notice of Motion and Motion for Class Certification	619
Plaintiff's Notice of Motion and Motion to Compel Responses to Plaintiff's First Interrogatories and First Requests to Produce and Motion to Stay Decision on	
Defendant's Motion for Summary Judgment.....	621
Certificate of Service	624

STATE OF SOUTH CAROLINA)
)
COUNTY OF CHARLESTON)

IN THE COURT OF COMMON PLEAS

CASE NO.: 09-CP-10-7404

Jeffrey D. Allen, individually, as Guardian)
for Jane Doe, a minor, and as Representative)
of other similarly situated State of)
South Carolina employees,)

Plaintiff,)

v.)

South Carolina Budget and Control Board)
Employee Insurance Program and Blue)
Cross and Blue Shield of South Carolina,)

Defendants.)

MEMORANDUM IN OPPOSITION TO
DEFENDANTS' MOTIONS TO DISMISS

FILED
2010 FEB 26 AM 11:44
JULIE J. ARISTARQUE
CLERK OF COURT
BY

Plaintiff submits this memorandum in opposition to the Motion to Dismiss filed by both Defendants. Defendants have filed motions to dismiss the Complaint on grounds of subject matter jurisdiction, exhaustion, and for failure to state specific claims. Based on the following, the court should deny the Motion to Dismiss and allow this case to proceed

I. BACKGROUND

The Plaintiff, Jeffrey D. Allen is an employee of a local South Carolina school district and an insured/member of the State Health Plan. His daughter, [REDACTED], a dependant on that plan, was diagnosed with Type I Diabetes in November 2007 at the age of two (2) years old. This case is about the Defendants' failure to comply with a South Carolina statutory mandate for diabetes coverage and whether this case should be certified as a class action. The Complaint alleges that Defendants have unlawfully denied Plaintiff's and other similarly- situated persons' claims for coverage of diabetes-related education on the grounds that "education is not covered

for diabetes." S.C. Code Ann. section 38-71-46 provides:

Diabetes Mellitus coverage in health insurance policies, diabetes education.

(A) On or after January 1, 2000, *every health maintenance organization, individual and group health insurance policy, or contract issued or renewed in this State must provide coverage for the equipment, supplies, Food and Drug Administration-approved medication indicated for the treatment of diabetes, and outpatient self-management training and education for the treatment of people with diabetes mellitus*, if medically necessary, and prescribed by a health care professional who is legally authorized to prescribe such items and who demonstrates adherence to minimum standards of care for diabetes mellitus as adopted and published by the Diabetes Initiative of South Carolina.¹ This subsection does not prohibit a health maintenance organization or an individual or a group health insurance policy from providing coverage for medication according to formulary or using network providers. Coverage must not be denied unless the health care professional demonstrates a persistent pattern of failure to adhere to the minimal standards of care and unless the health maintenance organization or insurer has first provided written notice to the health care professional that coverage will be denied if the health care professional fails to adhere to the minimal standards of care.

(B) Services and payment for diabetes education programs shall conform to regulations of the Health Care Financing Administration, US Department of Health and Human Services, pursuant to Section 4105 of the Balanced Budget Act of 1997. Diabetes outpatient self-management training and education shall be provided by a registered or licensed health care professional with certification in diabetes by the National Certification Board of Diabetes Educators, or other accredited program approved by the Diabetes Initiative of South Carolina, or by the Diabetes Control Program of the SC Department of Health and Environmental Control in order to meet the needs of rural communities wherein certified health care professionals providing this service are not available.

(C) Nothing contained in this section may be construed to affect in any way the ability of a managed care plan to credential or re-credential a provider.

(D) For purposes of this section: "*Health insurance policy*" means a health benefit plan, contract, or evidence of coverage providing health insurance coverage as defined in Section 38-71-670(6) and Section 38-71-840(14).

¹ The Diabetes Initiative of South Carolina has adopted the standards promulgated by the American Diabetes Association (ADA). See Exhibit A (Affidavit of Daniel Lackland, Executive Director of the Diabetes Initiative of South Carolina).

(emphasis added).

The Complaint alleges that the Plaintiff is insured through the State Health Plan, which is a non-ERISA health benefit plan,² and that the State Health Plan is in violation of the diabetes mandate by its failure to provide coverage for diabetes education in accordance with the statutory mandate which has been in effect since 2000. Upon denial of a single claim for diabetes education, Allen attempted to appeal the denial months prior to filing this action, and the details of the status of the pending administrative proceeding are set forth in detail in the Affidavits of Jeffrey Allen and Christy Allen, attached as Exhibits B and C.

The Complaint alleges that over 15,000 State of South Carolina employees have diabetes, and that the exact number of class members affected by the Defendants' unlawful exclusion of coverage for diabetes education is known only to the Defendants and will be ascertained in discovery. Blue Cross is a defendant because Plaintiff has made all claims and/or communicated only with Blue Cross and Blue Shield of South Carolina (hereinafter "Blue Cross"), and has no information regarding the relationship between the State of South Carolina Budget and Control Board Employee Insurance Program (hereinafter "EIP").

The Complaint seeks: (1) class action certification; (2) a declaration that the State of South Carolina benefit plan violates the diabetes mandate; (3) a declaration regarding the future rights of the members of the putative class; (4) reformation of the benefit plan to comply with the mandate; (4) disgorgement and return of all profits and/or monies which should have been paid to putative class, (5) an injunction to stop the Defendants from continuing their unlawful actions

² 29 U.S.C.A. § 1003(b)(1) expressly excludes government plans from the broad sweep of ERISA preemption of state laws. *Silvera v. Mutual Life Ins. Co. of New York*, 884 F.2d 423, 425 (9th Cir. 1989). ERISA expressly defines governmental plan as including a plan established by the government of a State or political subdivision 29 U.S.C.A. § 1002 (32).

in the future, and (6) costs and attorneys fees.

II. LEGAL ANALYSIS

A. THIS COURT HAS SUBJECT MATTER JURISDICTION

Defendants cite to S.C. Code Ann. § 1-23-600(D) as the basis of their 12(b)(1) motion. Section 1-23-600(D) is part the statute setting forth hearing procedures before the S.C. Administrative Law Court, and states that an “administrative law judge also shall preside over all appeals from final decisions of contested cases” pursuant to the APA, Art. I, section 22 of the Constitution, or another law, ... It then goes on to except various appeals from specific agencies -- none of which involved the Defendants or issues in this case. This statute does not appear to remove general subject matter jurisdiction from this court, and the undersigned can only surmise that this reference goes to the general defense of exhaustion of administrative remedies.

In *Capital City Ins. Co. v. BP Staff, Inc.*, 674 S.E.2d 524, 529 (S.C. Ct. App. 2009), the Court of Appeals recently addressed this very issue, and explained that exhaustion is a “rule of policy, convenience and discretion, rather than one of law, and is not jurisdictional.” And, the failure to exhaust administrative remedies goes to the prematurity of a case, not subject matter jurisdiction. *Id.* In the present case, Allen’s declaratory judgment, equitable and injunctive claims are part of the general class of cases which the court of common pleas has jurisdiction to hear. The mere fact that Allen is also engaged in an administrative proceeding regarding a single claim does not divest the circuit court of its power to hear and determine the claims asserted in the Complaint.

Thus, this trial court has subject matter jurisdiction to hear these types of claims, and should not dismiss Allen's complaint pursuant to Rule 12(b)(1), SCRCP.

B. THE COURT SHOULD DENY DEFENDANTS' 12(B)(6) MOTION

Defendants ask this court to dismiss the Complaint pursuant to SCRCP, Rule 12(b)(6) on the grounds of exhaustion and preemption; failure to state a claim for reformation, disgorgement, and injunctive relief; and the failure to state a claim against BCBSSC because it is allegedly not the insurer. A motion pursuant to Rule 12(b)(6) should be denied unless the court finds that, in the light most favorable to the plaintiff, and with every doubt resolved on his behalf, the complaint states no valid claim relief on any theory. *Plyler v. Burns*, 647 S.E.2d 188, 192 (S.C. 2007).

1. *As a Matter of Law, Exhaustion is Not Required*

Defendants often assert in opposition to class action allegations that administrative remedies have not been exhausted arguing that if the remedies were pursued the case might be resolved without the intervention of the court. That argument fails in this case because neither the State Health Plan nor the state statute governing claims within the context of the state benefit plan offer administrative remedies that adequately embrace the issues presented in this putative class action Complaint.

Section 1-11-710(C) of the South Carolina Code provides that "*claims for benefits* under any self-insured plan of insurance offered by the State to state and public school district employees and other eligible individuals must be resolved by procedures established by the board [South Carolina Budget and Control Board], which shall constitute the exclusive remedy

for these claims, subject only to appellate judicial review consistent with the standards provided in Section 1-23-380.” S.C. Code Ann. § 1-11-710(C) (emphasis added). Section 1-23-380 entitled “Judicial review upon exhaustion of administrative remedies” “does not limit utilization of or the scope of judicial review *available under other means of review, redress, relief, or trial de novo* provided by law.” S.C. Code Ann. § 1-23-380 (A) (Supp. 2009).

In South Carolina, generally, “[w]hen an administrative remedy is available *to determine a question of fact*, one must seek the administrative remedy or be precluded from pursuing relief in the courts.” *Stinney v. Sumter School Dist.* 17, 675 S.E.2d 760, 763 (S. C. Ct. App. 2009) (citing *Hyde v. Dept. of Mental Health*, 442 S.E.2d 582, 583 (S.C. 1994)) (emphasis added). “A party is not required to exhaust administrative remedies if the issue is one that cannot be ruled upon by the administrative body.” *Capital City Ins. Co.*, 674 S.E.2d at 529 (quoting *Charleston Trident Home Builders, Inc. v. Town Council of Town of Summerville*, 632 S.E.2d 864, 867 (S.C. 2006) (citing *Ward v. State*, 538 S.E.2d 245 (S.C. 2000); *see also Stinney*, 675 S.E.2d at 763 (recognizing that inadequacy of the administrative appeal is an exception to the general rule requiring exhaustion)).

The claims made in this Complaint are not “claims for benefits” within the meaning of section 1-11-710(C), and continuing with the appeal would not provide Plaintiff with an adequate remedy.³ The only result possible from the administrative proceeding underway would

³ With regard to many, if not most insurance claims, the Defendants’ exhaustion defense would be applicable. However, a review of several of those cases illustrates how this case is different. For example, in *James v. South Carolina State Budget and Control Board*, 640 S.E.2d 474 (S.C. Ct. App. 2007), the appellate court upheld the circuit court’s reversal of the EIP’s denial of a claim for a child’s cranial molding device as not medically necessary. That case was heard by the EIP, appealed through the Administrative Procedures Act to the Circuit Court, and then the Court of Appeals. In *Grier v. South Carolina Budget and Control Board*, 07-ALJ-30-0139 (2008), the ALJ upheld the reversal of the EIP’s denial of a claim for abdominoplasty (“tummy tuck”) as not medically necessary. In

not provide the relief sought by Allen and the potential class members. The issues to be determined are not “questions of fact,” but are questions of law. The denial of the subject claim states “education is not covered for this condition [diabetes mellitus],” and South Carolina Code Section 38-71-46 states that “[o]n or after January 1, 2000, *every health maintenance organization, individual and group health insurance policy, or contract issued or renewed in this State must provide coverage for . . . outpatient self-management training and education for the treatment of people with diabetes mellitus . . .*”

If the denial of the subject claim were reversed, Allen would receive coverage for a single \$560 diabetes education claim. However, neither the Allen benefit plan nor the putative class members’ benefit plans would be reformed to provide the statutorily mandated insurance coverage for diabetes education. Allen prevailing in the administrative process would not require the Defendants to review all denials made in violation of the diabetes mandate since its enactment in 2000. Allen prevailing in the administrative process would not enjoin the Defendants from violating the diabetes mandate in the future, nor force disgorgement of revenues and profits related to the illegal conduct. This is not a case seeking resolution of a claim for benefits.

2. This Court Has The Discretion To Allow This Case To Go Forward At This Time

Whether administrative remedies must, in fact, be exhausted is a matter within the circuit court’s sound discretion, and this decision will not be disturbed on appeal short of an abuse of

Hendley v. South Carolina Budget and Control Board, 481 S.E.2d 159 (S.C. Ct. App. 1996), the court affirmed the lower court’s reversal of a decision made by the EIP to deny coverage for a hair prosthesis (or “wig”) through interpretation of the language of the benefit plan regarding prostheses. All of these cases involved the agency/administrative review of and interpretation of its own policies and contracts, and single claims for benefits.

discretion. *Hyde*, 442 S.E.2d at 582-83. The purpose of the exhaustion requirement, to allow the agency to render a final decision and set forth its reason for denying the diabetes education claim, would not assist the court in this case. The alleged wrong – violation of the statutory mandate—is not one which the administrative process was designed to address.

The doctrine of exhaustion of administrative remedies only comes into play when a litigant attempts to invoke the original jurisdiction of a circuit court to adjudicate a claim based on a statutory violation for which the legislature has provided an administrative remedy. A litigant need not exhaust administrative remedies where there are no administrative remedies for the wrongs it assertedly suffered.

Capital City Ins., 674 S.E.2d at 530 (citations omitted). Courts have recognized an exception to the requirement of exhaustion of administrative remedies exists when a party demonstrates that pursuit of them would be a vain or futile act. *See Moore v. Sumter County Council*, 387 S.E.2d 455, 458 (S.C. 1990).

The present case will require the court to determine if the South Carolina Budget and Control Board⁴ and BlueCross and Blue Shield of South Carolina, as administrator of the State Health Plan, are required to comply with South Carolina laws regulating insurance. Section 1-23-380 [which is expressly incorporated into section 1-11-710(C)] “does not limit utilization of or the scope of judicial review **available under other means of review, redress, relief**, or trial de novo provided by law.” S.C. Code Ann. § 1-23-380 (A) (Supp. 2009). *See Stinney v. Sumter School Dist. 17*, 675 S.E.2d at 764. The Plaintiff’s Complaint seeks relief, not under the benefit plan language, but under the South Carolina Declaratory Judgment Act, Rule 23 of the South Carolina Rules of Civil Procedure, and common law principles of equity.

⁴ The State Budget and Control Board is a statutorily-created entity made up of the Governor, the State Treasurer, the Comptroller General, the chairman of the Senate Finance Committee, and the chairman of the Ways and Means Committee of the House of Representatives. S.C. Code. Ann. § 1-11-10.

3. *Plaintiff Is Excused From Further Administrative Proceedings and That by Their Action, Defendants Have Waived the Assertion of the Defense of Exhaustion*

The State of South Carolina provides all eligible employees a copy of the *Insurance Benefit Guide* as published annually by the S.C. State Budget and Control Board Employee Insurance Program. See Exhibit B (Affidavit of Jeff Allen ¶ 9), Exhibit D (2009 *Insurance Benefit Guide*)⁵. From the *Guide*, one selects from several benefit plan options—one of which is the State Health Plan administered by Blue Cross. No other documentation is provided directly to employees. *Id.* The 2009 *Guide* booklet contains 236 pages, and the only provision related to any appeal process is as follows:

The Employee Insurance Program (EIP) 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 decision.

If all or part of your claim or your request for preauthorization 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 believe the decision was incorrect, you may 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 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 right. **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 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 as provided by S.C. Code Ann. 1-11-710 and 1-23-380.

⁵ Attached as Exhibit D is the entire State Health Plan Health Insurance, cover page – p. 61, portion of the 2009 Insurance Benefits Guide. The undersigned will bring to the hearing and provide the entire Guide to the court upon request.

Exhibit D (*Guide* at p. 61) (emphasis added). The Affidavits of both Jeff Allen and Christy Allen explain in exhausting detail the attempts made to comply with the only procedures and deadlines set forth in the *Insurance Benefit Guide* and the instructions in the “denial” letters. To summarize, the initial request to reconsider the denial was made to BlueCross within the six (6) months after the denial decision, and the most recent submission to Blue Cross of the requested medical records was made within the 225 day time period stated in the instructions at the bottom of the “ADJUSTMENT” denial letter dated April 20, 2009. To this date, neither Defendant has ever explained its decision to deny, nor provided any response to the Allen appeal. See Exhibit C (C. Allen Affidavit ¶¶ 11, 14, 20).

Attached to the Affidavit in support of the Defendants’ Motion to Dismiss was a copy of the alleged *Insurance Plan Document*, a 93-page document. Defendants cite to the detailed claims procedure therein to explain the alleged administrative appeal procedures. However, as set forth in the Affidavits of both Plaintiff and his wife: (1) the Defendants do not provide copies of the *Insurance Plan Document* to employees/insureds; (2) Mrs. Allen attempted twice to retrieve a copy of said *Insurance Plan Document* from Defendant EIP prior to the filing of this lawsuit; and (3) the Defendants repeatedly refused to provide a copy of the documents. See Exhibits B ¶¶ 10-13 and Exhibit C ¶¶ 23-25. On November 25, 2009, Plaintiff’s counsel mailed a formal South Carolina Freedom of Information Act Request for the *Insurance Plan Document* as referenced in the “Insurance Benefits Guide. Defendant and counsel for the Defendant refused, for the third time, to provide a copy of the *Insurance Plan Document*. See Exhibit E (Letters).

In light of the effort of the Plaintiff and unexplainable delays and confusion, the Defendants should be deemed to have waived any further reliance on the defense of exhaustion. The Plaintiff and his wife made numerous efforts to navigate the "claims procedure" prior to discovering the statutory mandate for diabetes education coverage. Finally, Plaintiff should not be forced to await a decision from Blue Cross on his appeal so that he can then submit it to the EIP for further review because of a possible statute of limitations deadline. This court has broad discretion in its supervision over the progression and disposition of a circuit court case in the interests of justice and judicial economy. *See Williams v. Bordon's Inc.*, 262 S.E.2d 881, 883 (S.C. 1980). "A party should not be required to 'roll the dice' on whether a collateral administrative proceeding will conclude prior to the running of an applicable statute of limitations in order to preserve a claim properly within the jurisdiction of the circuit court." *Capital City Ins. Co. v. BP Staff, Inc.*, 674 S.E.2d 524, 531 (S.C. Ct. App. 2009).

██████████ was first diagnosed with Type I diabetes on November 27, 2007 at the age of two, and diabetic education and training was provided during her initial 3-day hospital stay. In reviewing all claims for diabetic education made by Allen, Defendants have denied three other such claims dating back to December 17, 2007. See Exhibit C (C. Allen Aff. ¶ 22). In light of the State of South Carolina board/agency being named as a Defendant, the undersigned made the determination to commence this action within two (2) years of the date of diagnosis, so as not to risk a possible statute of limitation defense related to the two (2) year statute of limitation in the South Carolina Tort Claims Act. Plaintiff should not be prejudiced by a decision to protect himself against all statute of limitations defenses. The court in *Capital City* held that where a party would be harmed by the running of the statute of limitations or otherwise prejudiced if its

claim is dismissed on exhaustion of administrative remedies, and the court has determined that resolution of the administrative proceeding would impact the circuit court case, then the circuit court should properly consider a stay or continuance of the judicial action until the administrative proceedings have concluded. *Id.* at 531.

4. *The Complaint States a Claim for Reformation, Disgorgement, and Injunctive Relief*

Defendants have moved to dismiss the claims for reformation, disgorgement and injunctive relief on the grounds that the Complaint fails to state a claim for relief. An action to reform an insurance policy is an action in equity. *Elias v. Fireman's Ins. Co. of Newark, New Jersey*, 420 S.E.2d 504, 505 (S.C. 1992). The Complaint in this case alleges that the State Health Plan, an insurance policy within the express terms of 38-71-46(D), violates the diabetes mandate. The freedom of parties to contract is not absolute, and insurance coverage required by law may not be omitted because statutory provisions relating to an insurance contract are part of the contract. *See Bovain v. Canal Ins.*, 678 S.E.2d 422, 429 (S.C. 2009) (citing *Jordan v. Aetna Cas. & Sur. Co.*, 214 S.E.2d 818, 820 (S.C. 1975)). The reformation claims should be permitted to forward at this early stage.

The equitable remedies of restitution and disgorgement require payment of the defendant's ill-gotten gain. *Ellett Brothers, Inc. v. USF&G Co.*, 275 F.3d 384, 388 (4th Cir. 2001) (interpreting South Carolina law). The Plaintiff's class action Complaint sufficiently contains allegations of ill-gotten gain by one or both of the Defendants – that of the retention of monies which should have been paid to the Plaintiff and others similarly situated for claims made for diabetes education. For example, with regard to the named Plaintiff alone, the four

claims he made, which were all denied on the grounds that education is not covered for diabetes total over One Thousand & 00/100 US Dollars (\$1,000.00).

The Plaintiff's Complaint seeks an injunction requiring the Defendants stop wrongfully denying diabetes education claims, and provide the statutorily-mandated coverage in the future. Generally, to obtain an injunction, a party must demonstrate irreparable harm, a likelihood of success on the merits, and an inadequate remedy at law. *Roach v. Combined Util. Comm'n*, 351 S.E.2d 168, 170 (S.C. Ct. App. 1986). The allegations of the Plaintiff's Complaint are sufficient to state a claim for injunctive relief. The subject of this Complaint deals with the harm of a large health benefit plan/insurer continuing to deny health benefit claims for diabetes education, which in addition to the financial burden said denials place on the thousands of South Carolinians affected, arguable deters others from seeking those educational services. This is an irreparable harm. The plain and unambiguous language of the diabetes mandate statute is sufficient to support the conclusion that the Plaintiff is likely to be successful on the merits. Lastly, the allegations of the declaratory and equitable claims made in the complaint, as opposed to more typical legal claims, illustrate the inadequacy of a remedy at law. There is no basis on which to dismiss the claim for a permanent injunction as relief in the ultimate outcome of this putative class action at this time, and the Defendants' motion should be denied.

5. *The Complaint States a Claim against Blue Cross Blue Shield of South Carolina*

Lastly, the Defendants' joint motion seeks to dismiss Blue Cross because is it labeled the third party claims administrator to the State Health Plan. A motion pursuant to Rule 12(b)(6) should be denied unless the court finds that, in the light most favorable to the plaintiff, and with

every doubt resolved on his behalf, the complaint states no valid claim relief on any theory. *Plyler v. Burns*, 647 S.E.2d 188, 192 (S.C. 2007). Looking at the four corners of the Plaintiff's Complaint, it alleges that Defendant Blue Cross was responsible for administering all claims for the State Health Plan, including those made by Plaintiff for diabetes education, and that the only explanation provided to date for the denial of those claims by Blue Cross appears contrary to the plain language of the statutory mandate which is the subject of this action.

"A suit for declaratory judgment is neither legal nor equitable, but is determined by the nature of the underlying issue." *Felts v. Richland County*, 400 S.E.2d 781, 782 (S.C. 1991). "To state a cause of action under the Declaratory Judgment Act, a party must demonstrate a justiciable controversy." *Graham v. State Farm Mut. Auto. Ins. Co.*, 459 S.E.2d 844, 845-46 (1995). A justicable controversy exists when a concrete issue is present, there is a definite assertion of legal rights, and a duty denied by the adverse party. *Id.* The facts pled in the Complaint are sufficient to state a claim for the declaratory and equitable relief demanded.

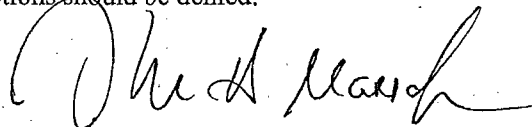
The Affidavit submitted by the Defendant attempts to define the relationship between the two defendants, however, at this early stage of the litigation, the Plaintiff is entitled to discovery on the details of Blue Cross's role, contractual duties, whether the Defendant Blue Cross has a compensation package or financial interest which is contingent on the approval or denial of certain benefit claims, and whether Plaintiff is a third-party beneficiary to the contract between EIP and Blue Cross.

6. *The Motion to Dismiss for Judgment on the Pleadings Pursuant to Rule 12(C) Should Be Denied*

A Rule 12 (c), like Rule 12(b) (6), motion admits the well-pleaded facts in the Complaint; it does not admit the inferences drawn by the plaintiff from such facts, nor does it admit conclusions of law. *Carolina Winds Owners' Association, Inc. v. Joe Harden Builder, Inc.*, 374 S.E.2d 897, 899 (S.C. Ct. App. 1988) (reversed on other grounds). For the reasons stated above with regard to the sufficiency of the Plaintiff's Complaint to state a claim for declaratory judgment and equitable remedies of reformation, disgorgement, and injunction, this motion should be denied. The Motion and Affidavit submitted by the Defendants in lieu of their filing Answers fail to provide this court with any basis on which to dismiss the Plaintiff's Complaint pursuant to Rule 12(c).

III. CONCLUSION

This case is a putative class action which potentially could affect thousands of South Carolinians employed (current and retired) by the State of South Carolina and its local school districts and municipalities, and involves a disease which according to the State of South Carolina affects 9.6% of the population of this State. The allegations in the Plaintiff's Complaint, taken in the light most favorable to the Plaintiff, are sufficient to withstand these Defendants' Rule 12 motions. The motions should be denied.



John A. Massalon
Wills, Massalon & Allen, LLC
Post Office Box 859
Charleston, South Carolina 29401
(843) 727-1144

-and-

Terry E. Richardson, Jr.
Matthew D. Hamrick
Richardson, Patrick, Westbrook & Brickman, LLC
1017 Chuck Dawley Blvd.
Mt. Pleasant, South Carolina 29464
(843) 727-6500

ATTORNEYS FOR PLAINTIFF

Charleston, SC

February 26, 2010

09-7404

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on February 26, 2010, a copy of the attached pleading was emailed and placed in an envelope, with first-class postage prepaid, and mailed to:

Theodore D. Willard, Jr.
Montgomery Willard, LLC
Post Office Box 11886
Columbia, South Carolina 29211
(803) 779-3500

Kelly H. Rainsford
State Budget & Control Board
1201 Main Street, Ste. 300
Columbia, South Carolina 29201
(803) 737-0825

ATTORNEYS FOR DEFENDANTS


Wills & Massalon, LLC

FILED
2010 FEB 26 AM 11:44
JULIE J. ANASTROPOUS
CLERK OF COURT
RY

Exhibit “A”
to Plaintiff’s
Memorandum in Opposition
to Defendant’s
Motion to Dismiss

STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON

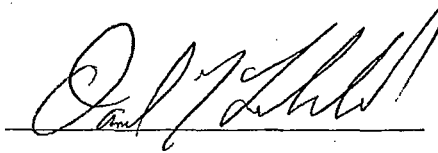
AFFIDAVIT

PERSONALLY appeared before me, Daniel T. Lackland, Dr.PH, who duly sworn,
deposes, and states as follows:

1. I am competent to make this Affidavit.
2. I am 18 years of age or older.
3. That the contents of this Affidavit are true, and are made based on personal knowledge.
4. That I am the current Board Chair of the Diabetes Initiative of South Carolina (DSC).
5. The Diabetes Initiative of South Carolina (DSC) was created by legislative action and signed into law by the Governor of South Carolina in July, 1994. The law established a Board of Directors with members appointed by the top officials of key organizations with an interest in diabetes and its complications.
6. The DSC has adopted and publishes the annual standards promulgated by the American Diabetes Association (ADA) as the minimum standards of care for diabetes mellitus, and those standards explain that diabetes self-management education (DSME) is a critical element of care for all people with diabetes and is necessary in order to improve patient outcomes. DSME "is the ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."

DTL

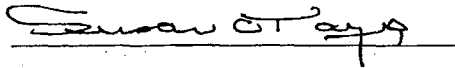
FURTHER THIS AFFIANT SAYETH NOT.



Daniel T. Lackland

SWORN to before me this

22 day of January 2010.



Notary Public for South Carolina

My Commission Expires: 10-7-19

Exhibit “B”
to Plaintiff’s
Memorandum in Opposition
to Defendant’s
Motion to Dismiss

STATE OF SOUTH CAROLINA)
)
COUNTY OF CHARLESTON)

IN THE COURT OF COMMON PLEAS

CASE NO.: 09-CP-10-7404

Jeffrey D. Allen, individually, as Guardian)
for Jane Doe, a minor, and as Representative)
of other similarly situated State of)
South Carolina employees,)

Plaintiff,)

v.)

South Carolina Budget and Control Board)
Employee Insurance Program and Blue)
Cross and Blue Shield of South Carolina,)

Defendants.)

AFFIDAVIT OF JEFFREY D. ALLEN
IN SUPPORT OF PLAINTIFF'S
MEMORANDUM IN OPPOSITION TO
MOTION TO DISMISS

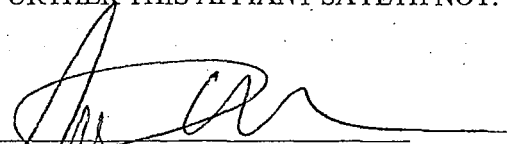
PERSONALLY appeared before me, Jeffrey D. Allen, who duly sworn, deposes, and
states as follows:

1. I am competent to make this Affidavit.
2. I am 18 years of age or older.
3. That the contents of this Affidavit are true, and are made based on my personal knowledge.
4. That I am employed in the district office by the Dorchester County School District No. 2, and am insured through the State Health Plan.
5. That my daughter is a dependant on that insurance plan.
6. That on August 5, 2008, I attended, along with my wife, family caregivers, and two Charleston County School District Nurses who were to be charged with the care of her daughter at school beginning in August 2008, a training session set up by MUSC Pediatric Endocrinology to train her daughter's caregivers, at home and school, how to

operate our daughter's new insulin pump just prescribed by her physician and scheduled to be attached to her body the following week. That training session lasted approximately two hours and was taught by a MUSC diabetic educator.

7. That I first received notice that the claim for the diabetes education services on August 5, 2008 had been denied some time after August 27, 2008 and the denial stated it was based on the grounds that the "benefit plan does not cover education and/or training for this condition."
8. That my wife, Christy Ford Allen, began the appeal process of that denial, but I was not involved in the details of her communications with Blue Cross and MUSC.
9. That I brought home the only insurance documentation I had – the *2009 Insurance Benefits Guide*, attached as Exhibit __ to the Plaintiff's Memorandum in Opposition.
10. That sometime in October 2009, my wife asked me to walk down to the district office benefits administrator and request to see a copy of the *Plan of Benefits Document*.
11. That I did in fact visit the district benefits administrator, but no such document was available.
12. That on October 15, 2009, my wife drafted the attached written request to the Employee Insurance Program for a copy of the *Plan of Benefits Document*.
13. That as of the date of this Affidavit, I had not received any response to my request, and that I first saw a copy of the *Plan of Benefits Document* when Defendants attached it as an attachment to the Defendants' Motion to Dismiss.

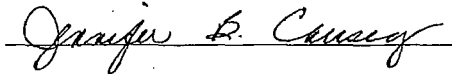
FURTHER THIS AFFIANT SAYETH NOT.



Jeffrey D. Allen

SWORN to before me this

24th day of February 2010.



Jennifer L. Causey

Notary Public for South Carolina

My Commission Expires: 12/19/19

October 15, 2009

Jeffrey D. Allen

████████████████████
Charleston, SC 29414

South Carolina Budget and Control Board
Employee Insurance Program
1201 Main Street, Suite 300
Columbia, South Carolina 29201

To whom it may concern:

This is a request for a copy of the documents referenced in the 2009 Insurance Benefits Guide entitled State Health Plan "*The Plan of Benefits* (available in your benefits office or through EIP)", see Guide at p. 58, and Benefit Contracts. I am insured under the State Insurance Plan administered by BCBSSC. I attempted to review portions to The Plan of Benefits at the office of my benefits administrator, but she reported that she did not have the document, nor has she ever been provided a copy from the EIP. I do not know what the Plan of Benefits includes, but am requesting that you send me a copy of the provisions related to health insurance coverage/exclusions. I presume that you will provide me with a copy as your office is referenced in the Guide as the entity to contact, and because such would appear subject to State FOIA regulation. I will be glad to pay any reasonable copying charge. If the document is available electronically, I would prefer a digital copy by email over a paper copy.

Sincerely,

Jeffrey D. Allen
theallenpad@gmail.com

Exhibit “C”
to Plaintiff’s
Memorandum in Opposition
to Defendant’s
Motion to Dismiss

STATE OF SOUTH CAROLINA)
)
COUNTY OF CHARLESTON)

IN THE COURT OF COMMON PLEAS

CASE NO.: 09-CP-10-7404

Jeffrey D. Allen, individually, as Guardian)
for Jane Doe, a minor, and as Representative)
of other similarly situated State of)
South Carolina employees,)

Plaintiff,)

v.)

South Carolina Budget and Control Board)
Employee Insurance Program and Blue)
Cross and Blue Shield of South Carolina,)

Defendants.)

AFFIDAVIT OF CHRISTY FORD ALLEN
IN SUPPORT OF PLAINTIFF'S
MEMORANDUM IN OPPOSITION TO
MOTION TO DISMISS

PERSONALLY appeared before me, Christy Ford Allen, who duly sworn, deposes, and
states as follows:

1. I am competent to make this Affidavit.
2. I am 18 years of age or older.
3. That the contents of this Affidavit are true, and are made based on my personal knowledge.
4. That I am the wife of the named Plaintiff Jeffrey D. Allen and the mother of [REDACTED] a minor for whom the subject insurance claim was made.
5. That at the time of the filing of this action, I was employed as an attorney at the firm of Wills & Massalon, LLC.
6. I am an approved person to provide and receive HIPA protected information on Jeffrey D. Allen's health insurance account with BlueCross and Blue Shield of SC, and I generally handle the medical and insurance communications for our daughter, who was

diagnosed with Type I diabetes at the age of two (2) in November 2007.

7. That our daughter has been insured through the State of South Carolina employee benefit plan since 2005 as a dependant under my husband's insurance plan.
8. That on August 5, 2008, I attended, along with my husband, family caregivers, and two Charleston County School District nurses who were to be charged with the care of our daughter at school beginning in August 2008, a training session set up by MUSC Pediatric Endocrinology to train our daughter's caregivers, at home and school, how to operate our daughter's new insulin pump prescribed by her physician and scheduled to be attached to her body the following week. That training session lasted approximately two hours and was taught a MUSC diabetic educator.
9. That I first received notice that the claim for the diabetes education services on August 5, 2008 had been denied some time after August 27, 2008 and the denial stated it was based on the grounds that the "benefit plan does not cover education and/or training for this condition." See Exhibit A (First EOB Denial).¹
10. That the EOB dated August 27, 2008, indicated that in order to request reconsideration of your claim "you may request a review in writing to us within six months of this notice."
11. That I mailed the request for reconsideration attached as Exhibit B on February 25, 2009, within the six (6) month deadline contained in the EOB to the address provided therein.
12. That on April 15, 2009, I received a letter from Blue Cross stating that Blue Cross had received the appeal and it had requested additional medical records from the provider,

1. That upon information and belief, the First EOB Denial was not actually received by the undersigned until sometime in December 2008. It appears to have been mailed to our prior home address despite my having previously attempted to change the address through the Blue Cross website.

and that it would review the claim and determine the benefits as soon as it received the requested records. See Exhibit C.

13. Then, I waited for a response to my appeal.

14. That on April 20, 2009, BlueCross issued an "Adjustment" to the August 27, 2008 EOB, which states the following:

TO MAKE A DECISION ON THIS CLAIM, WE HAVE REQUESTED ADDITIONAL MEDICAL INFORMATION FROM YOUR PROVIDER. IF WE RECEIVE THE INFORMATION WITHIN 45 DAYS, WE WILL REVIEW YOUR CLAIM AND DETERMINE BENEFITS WITHIN 15 DAYS OF RECEIVING THE INFORMATION. IF WE DO NOT RECEIVE THIS INFORMATION WITHIN 45 DAYS YOUR CLAIM WILL BE CONSIDERED DENIED. IF WE RECEIVE THE INFORMATION AFTER 45 DAYS, BUT WITHIN 225 DAYS, WE WILL REVIEW YOUR CLAIM AS A FIRST LEVEL APPEAL. PLEASE SEE YOUR PLAN DOCUMENT FOR ADDITIONAL DETAILS REGARDING THE APPEAL PROCESS.
(Emphasis added).²

15. That on August 14, 2009, I telephoned Blue Cross Blue Shield to inquire into the status of the appeal and was informed that Blue Cross had not received the medical records it had requested directly from MUSC. I asked exactly what medical records Blue Cross wanted, but the Blue Cross representative was unable to specify the records. The Blue Cross representative indicated that I should also have the physician send a statement of medical necessity.

16. That I immediately telephoned MUSC and requested the relevant medical records be forwarded to Blue Cross Blue Shield, and sent the email attached as Exhibit D to my daughter's physician.

² The undersigned does not have record of actually receiving this Adjusted EOB dated April 20, 2009, but printed it from the Blue Cross Blue Shield section of the member website in early October 2009.

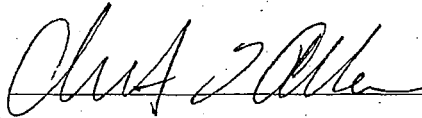
17. That on August 17, 2009, I mailed the letter attached as Exhibit E to MUSC referencing the pending appeal to Blue Cross in response to the attempt by MUSC to collect the unpaid medical claim.
18. That on September 30, 2009, I telephoned Blue Cross again to inquire about the status of the appeal and spoke with "Gina." When I asked Gina for her full name, she responded she was "the only Gina here." Gina indicated that Blue Cross had never received the MUSC records and stated that Blue Cross had requested the records by way of a letter to MUSC dated April 15, 2009. I asked Gina for a copy of the letter Blue Cross sent to MUSC. Gina put me on hold and when she returned said that she was unable to access the actual letter. Gina then indicated that she could not tell me exactly what records Blue Cross needed but that they were needed to determine whether the claim was based on a preexisting condition. When I explained that was not the basis for denial and could not possibly be the reason, Gina said she had "looked back at her computer" and admitted she was mistaken about the preexisting condition, but that Blue Cross needed "ER records." I explained that my daughter was not seen in the ER that day, and she finally was able to explain Blue Cross needed "outpatient" records. I also asked Gina for the direct fax number of the Blue Cross Blue Shield representative handling the appeal, and told her I would get the records myself and send them via fax.
19. Upon hanging up the telephone, I telephoned MUSC to request all medical records for August 5, 2008, and faxed the attached release form to MUSC the same day. See Exhibit F.
20. I received the relevant medical records within days, and on October 5, 2009, on the 168th day after the April 20, 2009 EOB (well within the 225 days referenced), I faxed the letter

attached as Exhibit G with medical records and other documents to the Blue Cross Blue Shield Appeals office.

21. After my extremely time-consuming and frustrating telephone call with "Gina" at BlueCross, I began to do some research into the issue and discovered the diabetes statutory mandate. I then obtained the *Employee Benefit Guide* and reviewed it for language relating to diabetes education; there is none. At that time, I noticed the reference to the *Plan of Benefits Document*, and began searching for that document.
22. On October 5, 2009, I logged into the southcarolinablues.com website and reviewed other claims made on behalf of our daughter and found several other claims, dating back to December 17, 2007, for diabetes education, which were denied on the basis that education is not covered for diabetes under the State Health Plan. See Exhibit H.
23. On October 7, 2009, I telephoned the South Carolina Employee Insurance Plan (EIP) office in Columbia, spoke to a person, and requested a copy of the *Plan of Benefits Document* which is referenced in the 2009 Insurance Benefits Guide, the only document provided to state employees. I was told the *Plan to Benefits Document* was a very large booklet and that my husband needed to go to his benefits administrator, review the one copy they have as employees are not provided copies, make copies, or that he could request a copy from the EIP and would have to pay copying charge.
24. See the Affidavit of Jeffrey D. Allen regarding his unsuccessful efforts at obtaining a copy of said document from his benefits administrator and the written request mailed October 15, 2009 directly to the Employee Insurance Program requesting a copy of "The Plan of Benefits" referenced at page 58 of the Guide, which has yet to be answered.

25. As of the date of this affidavit, I have never received any response to my letters dated February 25, 2009 or October 5, 2009, and therefore believe the appeal is still pending within the BlueCross administrative process.³

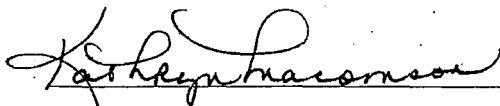
FURTHER THIS AFFIANT SAYETH NOT.



Christy Ford Allen

SWORN to before me this

24th day of Feb. 2010.



Notary Public for South Carolina

My Commission Expires: 12/11/2013

³ On February 3, 2010, the undersigned received a telephone call from Blue Cross offering to enroll [REDACTED] into its "wellness program" for diabetes (the telephone caller first was under the mistaken impression that Eva suffered from asthma). However, after the undersigned disclosed the pendency of this action, the Blue Cross representative called back to disclose that the program was only for persons 5 years or age and older and therefore [REDACTED] would not qualify yet.

EXHIBIT "A"

I-20 @ Alpine Road
Columbia, SC 29219

18807



**BlueCross BlueShield
of South Carolina**
An Independent Licensee of the
Blue Cross and Blue Shield Association

EXPLANATION OF BENEFITS THIS IS NOT A BILL

If you have a question about your
claim, please call Customer Service at
1-800-868-2520 OR LOCALLY AT 736-1576
MON. - FRI. 8:00 A.M. - 6:00 P.M.

STATE HEALTH PLAN

###

August 27, 2008

###

12940772585291
JEFFREY D ALLEN
CHARLESTON SC 29407-7258

SUMMARY INFORMATION

Patient's Name		Relationship to Policyholder		ID No.	Claim No.
[REDACTED]		CHILD		ZCS36961363	8E2631250-00-00
TOTAL CHARGE FOR YOUR CLAIM:	560.00	TOTAL AMOUNT WE PAID:	.00	WHAT YOU OWE PROVIDER:	560.00
The provider can bill you for this amount if you have not yet paid.					
To date, you have satisfied <u>350.00</u> of the <u>350.00</u> deductible for the benefit period that began <u>01/01/2004</u> . This claim contributed <u>00</u> toward your out-of-pocket maximum. You have satisfied <u>3.60</u> of the <u>2,000.00</u> out-of-pocket maximum for this benefit period. We paid a total of <u>14.40</u> for this person this benefit period.					

DETAIL INFORMATION

Provider	MEDICAL UNIVERSITY		
Network Participation	YES		
Dates of Service	08/05/08		
Type of Service	MEDICAL SERVICES		
Charge	560.00		
Amount Not Covered	560.00 01*		
Covered Expenses	.00		
Deductible	.00		
Copay/Spec Deductible	.00		
Allowed Amount	.00		
Coinsurance	.00		
Amount Paid	.00		

* Please refer to the remarks section.

Suspect claims fraud? Please help by calling our hotline at 1-800-763-0703

THANK YOU FOR ALLOWING US TO SERVE YOU!

www.SouthCarolinaBlues.com

Helpful Definitions (Please check your schedule of benefits in your benefits booklet for details)

Amount Approved for Coordination - the amount we will coordinate with your primary health or dental plan's payment.

Benefit Period - the period of time you must pay any deductibles and coinsurance payments that may apply. Benefits begin once you meet the deductible. If you reach the limit, we pay covered expenses in full for the rest of the benefit period. Deductibles and coinsurance start over with each new benefit period.

Coinsurance - the percentage of the allowed amount you pay as your share of the bill. If your plan pays 80%, then 20% would be your coinsurance.

Copayment - a set fee you pay each time you receive a certain service. Some plans do not have copayments.

Deductible - the amount, if any, that you are responsible for paying before we start paying contract benefits. You do not send this amount to us. We subtract this amount from covered expenses on the claims you and healthcare professionals send to us.

Less Benefit Limitation - the amount that is more than your contract allows for this type of service. Your plan covers these services until you have reached the limit of your benefits.

Network Participation - this column shows whether or not the healthcare professional who provided the service participates in our network. If "YES" this is a network participant. If "NO" this is not a network participant. If "N/A", the issue doesn't apply to your coverage, or this particular claim.

Out-of-pocket-maximum - the highest amount of the covered expenses you will have to pay during a benefit period.

Total Benefit Allowed - the amount we would have paid if another insurance carrier was not involved.

APPEAL OR REVIEW

If you have questions about the disposition of this claim, you may call us at the number listed on the front of this statement. Please refer to your insurance benefit guide for more information. If you would like to request a reconsideration of your claim you may request a review by writing to us within six months of this notice at:

STATE HEALTH PLAN
P. O. BOX 100605
COLUMBIA, S.C. 29260-0605

REMARKS SECTION

THE LIFETIME BENEFITS PAID FOR THIS PERSON TO DATE: 3,907.20

WE PROVIDE ADMINISTRATIVE CLAIMS PAYMENT SERVICES ONLY AND DO NOT ASSUME ANY FINANCIAL RISK OR OBLIGATION WITH RESPECT TO CLAIMS.

01 YOUR BENEFIT PLAN DOES NOT COVER EDUCATION AND/OR TRAINING FOR THIS CONDITION.

EXHIBIT "B"

WILLS & MASSALON, LLC

ATTORNEYS AT LAW

Telephone: (843) 727-1144

Facsimile: (843) 727-7696

COPY

Post Office Box 859
Charleston, South Carolina 29402

134 Meeting Street, Suite 100
Charleston, South Carolina 29401

February 25, 2009

Blue Cross Blue Shield of South Carolina
State Health Plan - Appeal
P.O. Box 100605
Columbia, SC 29260-0605

Re: Appeal and Review / SC State Health Plan
Plan No: ZCS36961363
EOB Claim No: 8E2631250-00-00

To whom it may concern:

My husband and daughter are insured under the South Carolina State Insurance Health Plan. My daughter is three (3) years old and was diagnosed with Type I or Juvenile Diabetes in November 2007. According to your denials and EOB "Diabetic Education" is not a covered service. I am writing to formally appeal that position.

In August 2008, my daughter who requires continuous insulin therapy and monitoring received approval to be placed on an insulin pump. As part of that process, the Medical University of South Carolina provides training for care givers on how to properly operate the insulin pump which is mechanically attached to the body at all times. The following persons attended the training session - my husband and I, our parents who also provide childcare for our daughter, and two nurses from our daughter's school who were to be responsible for operating the pump and monitoring her blood sugar levels during the school day.

This letter is intended to serve as an appeal and objection to the denial of the claim for payment made by MUSC. First, I view this training as a necessary part of insulin pump therapy. My daughter is three (3) years old, and as a result of her young age is obviously not able to teach herself how to use the insulin pump. Those persons responsible for her continuous care must be able to competently operate the pump. I have attached to this letter the EOB, which appears to have been mailed to our old address despite my having changed the address through your website (as evidenced by the attached print out showing the current address). I am also attaching a print-out from your website which indicates the current status information.

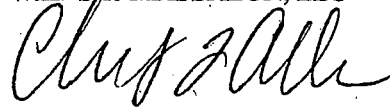
Lastly, I also submit this appeal letter to object to the fact that diabetic education is a item

which you indicated is expressly excluded under the policy. I cannot imagine what possible policy, other than one motivated by profit, would support not providing insurance coverage to the education of Type I diabetics about how to better control and manage an intensive, life-long disease which has no cure. While I see no real distinction, does Blue Cross differentiate between its coverage position on education for Type I and Type II diabetes?

Please accept this letter as my appeal of the denial. I will be glad to provide any additional information requested. Thank you for your consideration of this appeal.

Sincerely,

WILLS & MASSALON, LLC

A handwritten signature in cursive script, appearing to read "Christy Ford Allen".

Christy Ford Allen

Enclosures

cc: Deborah Bowlby, M.D.

18807

I-20 @ Alpine Road
Columbia, SC 29219



**Blue Cross BlueShield
of South Carolina**
An Independent Licensee of the
Blue Cross and Blue Shield Association

EXPLANATION OF BENEFITS THIS IS NOT A BILL

If you have a question about your
claim, please call Customer Service at
1-800-868-2520 OR LOCALLY AT 736-1576
MON. - FRI. 8:00 A.M. - 6:00 P.M.

STATE HEALTH PLAN

###

August 27, 2008

###

!294077258529!
JEFFREY D ALLEN
CHARLESTON SC 29407-7258

SUMMARY INFORMATION

Patient's Name [REDACTED]		Relationship to Policyholder CHILD		ID No. ZCS36961363	Claim No. 8E2631250-00-00
TOTAL CHARGE FOR YOUR CLAIM: 560.00		TOTAL AMOUNT WE PAID: .00		WHAT YOU OWE PROVIDER: 560.00	
				The provider can bill you for this amount if you have not yet paid.	
To date, you have satisfied 350.00 of the 350.00 deductible for the benefit period that began 01/01/2008.					
This claim contributed .00 toward your out-of-pocket maximum. You have satisfied 3.60 of the 2,000.00 out-of-pocket maximum for this benefit period. We paid a total of 14.40 for this person this benefit period.					

DETAIL INFORMATION

Provider	MEDICAL UNIVERSITY			
Network Participation	YES			
Dates of Service	08/05/08			
Type of Service	MEDICAL SERVICES			
Charge	560.00			
Amount Not Covered	560.00 01*			
Covered Expenses	.00			
Deductible	.00			
Copay/Spec Deductible	.00			
Allowed Amount	.00			
Coinsurance	.00			
Amount Paid	.00			

* Please refer to the remarks section.

Suspect claims fraud? Please help by calling our hotline at 1-800-763-0703

THANK YOU FOR ALLOWING US TO SERVE YOU!

www.SouthCarolinaBlues.com

Page 1 of 1

Helpful Definitions (Please check your schedule of benefits in your benefits booklet for details)

Amount Approved for Coordination - the amount we will coordinate with your primary health or dental plan's payment.

Benefit Period - the period of time you must pay any deductibles and coinsurance payments that may apply. Benefits begin once you meet the deductible. If you reach the limit, we pay covered expenses in full for the rest of the benefit period. Deductibles and coinsurance start over with each new benefit period.

Coinsurance - the percentage of the allowed amount you pay as your share of the bill. If your plan pays 80%, then 20% would be your coinsurance.

Copayment - a set fee you pay each time you receive a certain service. Some plans do not have copayments.

Deductible - the amount, if any, that you are responsible for paying before we start paying contract benefits. You do not send this amount to us. We subtract this amount from covered expenses on the claims you and healthcare professionals send to us.

Less Benefit Limitation - the amount that is more than your contract allows for this type of service. Your plan covers these services until you have reached the limit of your benefits.

Network Participation - this column shows whether or not the healthcare professional who provided the service participates in our network. If "YES" this is a network participant. If "NO" this is not a network participant. If "N/A", the issue doesn't apply to your coverage, or this particular claim.

Out-of-pocket-maximum - the highest amount of the covered expenses you will have to pay during a benefit period.

Total Benefit Allowed - the amount we would have paid if another insurance carrier was not involved.

APPEAL OR REVIEW

If you have questions about the disposition of this claim, you may call us at the number listed on the front of this statement. Please refer to your insurance benefit guide for more information. If you would like to request a reconsideration of your claim you may request a review by writing to us within six months of this notice at:

STATE HEALTH PLAN
P. O. BOX 100605
COLUMBIA, S.C. 29260-0605

REMARKS SECTION

THE LIFETIME BENEFITS PAID FOR THIS PERSON TO DATE: 3,907.20

WE PROVIDE ADMINISTRATIVE CLAIMS PAYMENT SERVICES ONLY AND DO NOT
ASSUME ANY FINANCIAL RISK OR OBLIGATION WITH RESPECT TO CLAIMS.

01 YOUR BENEFIT PLAN DOES NOT COVER EDUCATION AND/OR TRAINING FOR THIS
CONDITION.

Member Claim Status Summary

Page 1 of 1

Claims Status/Explanation of Benefits

Claim Detail

Claim Status: **FINALIZED/DENIAL**
Member ID: **ZCS36961383**
Member's Name: **JEFFREY D ALLEN**
Patient's Name: **[REDACTED]**
Patient's Date of Birth: **[REDACTED]/2005**
Patient's Gender: **Female**

Here is the information about the claim you chose. Please click on the "Line Item(s)" button to view the claim's summary.

Claim Number: **8E26312500000**
Dates of Service: **08/05/2008 to 08/05/2008**
Charges: **\$560.00**

Was Denied On: **08/25/2008**
Status Explanation: **PATIENT'S MEDICAL RECORDS**
FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE

[View Additional Status Information](#)

View your [Explanation of Benefits \(EOB\)](#) (You will need [Adobe Acrobat Reader](#) to view or print items on this page.)

[Claims List](#) [Previous Claim](#) [Next Claim](#) [Line Item\(s\)](#) [New Search](#) [Ask Customer Service](#)

Modify Your Profile Information

Required fields feature an asterisk (*).

Do we have your most current information?

- If you've added health or dental coverage since you last visited My Insurance Manager, please update this form.
- If you have a spouse or dependents on your health or dental plan and would like to check their claims information online, please add them to your profile.

Please take a minute to complete this form so we can give you access to the information you need.

Please note: This profile is for your Web site My Insurance Manager registration only! Any changes you make here will not carry over to your health plan records. If you need to make changes to your address, phone number or other information that affects your health or dental plan, please [Ask Customer Service](#).

Security

Member ID: ZCS36961363

Change your current password [here](#).

To change your Security Question, please choose a Security Question from the list below, then enter your answer. If you lose your Password, we will ask you this question. If you give the right answer, you will be able to reset your Password.

Security Question:* What is the name of the city where you and your spouse first met?
Security Answer:* CHARLESTON

General Information

First Name:* JEFFREY
Middle Initial: D
Last Name:* ALLEN
Suffix:
Gender: Female ☒ Male ☒
Address:*
Address, continued:
City:* Charleston
State:* SC
ZIP Code:* 29414 (11111)
Daytime Area Code & Phone Number: () - Extension: (555-555-5555)
Fax: () - (555-555-5555)

Our Ask Customer Service feature allows you to send us a question or comment. If you would like us to respond online, then we need your e-mail address.

E-mail Address: callen@wills-massalon.com
Confirm E-mail Address: callen@wills-massalon.com

Coverage

Have you added health or dental coverage since you last accessed My Insurance Manager? Please let us know and we will automatically update your profile so you can access all your claims information.

☒ Yes ☐ No

Dependents

Do you have dependents who are on your insurance plan? Add them to your profile and it will be easy to check their benefits information!

You must list dependents on your dental plan separately from those on your health plan. Just enter the name and birthdate for each person. Choose which plan they belong to — either health or dental — then click on "Add."

EXHIBIT "C"



**BlueCross BlueShield
of South Carolina**
Columbia, S.C. 29219-0001

An Independent licensee of the Blue Cross and Blue Shield Association.

Visit My Insurance Manager at www.SouthCarolinaBlues.com

April 15, 2009

Jeffrey Allen
[REDACTED]

Charleston, SC 29414-6577

RE: Patient: [REDACTED]
Claim Number: 8E26312500001

Dear Mr. Allen:

We received your appeal for the above claim. In order to review this claim accurately, we have asked the health care professional listed below to send additional medical records via our secure fax at (803) 264-4269.

We'll review the claim and determine your benefits as soon as we receive all the medical records we requested.

Please ask your provider whether you need to sign a special form authorizing them to release these records. Thank you for your help.

PROVIDERS: Medical University Hospital

Sincerely,

Rochelle Council
State Business Unit

IKEY: ZCY247451184
MED1 /460/18
EOD

74858

I-20 @ Alpine Road
Columbia, SC 29219



**BlueCross BlueShield
of South Carolina**
An Independent Licensee of the
Blue Cross and Blue Shield Association

EXPLANATION OF BENEFITS

THIS IS NOT A BILL

If you have a question about your
claim, please call Customer Service at

1-800-868-2520 OR

LOCALLY AT 736-1576

MON. - FRI. 8:00 A.M. - 6:00 P.M.

This is an **ADJUSTMENT** to
a claim we processed previously

6385014T

JEFFREY D ALLEN
CHARLESTON SC 29414-6577

April 20, 2009

STATE HEALTH PLAN

SUMMARY INFORMATION

Patient's Name JEFFREY D ALLEN		Relationship to Policyholder CHILD		ID No. ZCS36961363	Claim No. 8E2631250-00-01
TOTAL CHARGE FOR YOUR CLAIM:	AMOUNT PREVIOUSLY PAID:	AMOUNT PAID FOR THIS CLAIM:	TOTAL AMOUNT WE PAID:	WHAT YOU OWE PROVIDER:	00
560.00	00	00	00	The provider can bill you for this amount if you have not yet paid	
To date, you have satisfied 350.00 of the 350.00 deductible for the benefit period that began 01/01/2008.					
This claim contributed 00 toward your out-of-pocket maximum. You have satisfied 1,245.36 of the 2,000.00 out-of-pocket maximum for this benefit period. We paid a total of 5,086.94 for this person this benefit period.					

DETAIL INFORMATION

Provider	MEDICAL UNIVERSITY			
Network Participation	YES			
Dates of Service	08/05/08			
Type of Service	MEDICAL SERVICES			
Charge	560.00			
Amount Not Covered	560.00 01*			
Covered Expenses	.00			
Deductible	.00			
Copay/Spec Deductible	.00			
Allowed Amount	.00			
Coinsurance	.00			
Amount Paid	.00			

* Please refer to the remarks section.

Suspect claims fraud? Please help by calling our hotline at 1-800-763-0703

THANK YOU FOR ALLOWING US TO SERVE YOU!

www.SouthCarolinaBlues.com

Page 1 of 1

Helpful Definitions (Please check your schedule of benefits in your benefits booklet for details)

Amount Approved for Coordination - the amount we will coordinate with your primary health or dental plan's payment.

Benefit Period - the period of time you must pay any deductibles and coinsurance payments that may apply. Benefits begin once you meet the deductible. If you reach the limit, we pay covered expenses in full for the rest of the benefit period. Deductibles and coinsurance start over with each new benefit period.

Coinsurance - the percentage of the allowed amount you pay as your share of the bill. If your plan pays 80%, then 20% would be your coinsurance.

Copayment - a set fee you pay each time you receive a certain service. Some plans do not have copayments.

Deductible - the amount, if any, that you are responsible for paying before we start paying contract benefits. You do not send this amount to us. We subtract this amount from covered expenses on the claims you and healthcare professionals send to us.

Less Benefit Limitation - the amount that is more than your contract allows for this type of service. Your plan covers these services until you have reached the limit of your benefits.

Network Participation - this column shows whether or not the healthcare professional who provided the service participates in our network. If "YES" this is a network participant. If "NO" this is not a network participant. If "N/A", the issue doesn't apply to your coverage, or this particular claim.

Out-of-pocket-maximum - the highest amount of the covered expenses you will have to pay during a benefit period.

Total Benefit Allowed - the amount we would have paid if another insurance carrier was not involved.

APPEAL OR REVIEW

If you have questions about the disposition of this claim, you may call us at the number listed on the front of this statement. Please refer to your insurance benefit guide for more information. If you would like to request a reconsideration of your claim you may request a review by writing to us within six months of this notice at:

STATE HEALTH PLAN
P. O. BOX 100605
COLUMBIA, S.C. 29260-0605

REMARKS SECTION

THE LIFETIME BENEFITS PAID FOR THIS PERSON TO DATE: 10,144.57

WE PROVIDE ADMINISTRATIVE CLAIMS PAYMENT SERVICES ONLY AND DO NOT ASSUME ANY FINANCIAL RISK OR OBLIGATION WITH RESPECT TO CLAIMS.

01 TO MAKE A DECISION ON THIS CLAIM, WE HAVE REQUESTED ADDITIONAL MEDICAL INFORMATION FROM YOUR PROVIDER. IF WE RECEIVE THE INFORMATION WITHIN 45 DAYS, WE WILL REVIEW YOUR CLAIM AND DETERMINE BENEFITS WITHIN 15 DAYS OF RECEIVING THE INFORMATION. IF WE DO NOT RECEIVE THIS INFORMATION WITHIN 45 DAYS YOUR CLAIM WILL BE CONSIDERED DENIED. IF WE RECEIVE THE INFORMATION AFTER 45 DAYS, BUT WITHIN 225 DAYS, WE WILL REVIEW YOUR CLAIM AS A FIRST LEVEL APPEAL. PLEASE SEE YOUR PLAN DOCUMENT FOR ADDITIONAL DETAILS REGARDING THE APPEAL PROCESS.

EXHIBIT "D"

Christy F. Allen

From: Christy F. Allen
Sent: Friday, August 14, 2009 2:42 PM
To: bowlbyd@musc.com
Cc: walshe@musc.com
Subject: FW: Allen, Eva Diabetic Education Insurance Appeal DOS 8/5/08
Attachments: BCBS.pdf

Dr. Bowlby-

In reference to the appeal letter I copied you on below back in February 2009, Blue Cross has just informed me that MUSC has never responded to its request for records on 4/14/09 for the medical records for the date of service of 8/5/08, to include the name and address of the physician who recommended the training, and a statement of medical necessity.

I will call MUSC records directly, but am forwarding this to you as well.

Thank you

Christy Allen

-----Original Message-----

From: Christy Allen [mailto:callen@wills-massalon.com]
Sent: Tuesday, February 24, 2009 8:40 AM
To: bowlbyd@musc.edu
Subject: Allen, [REDACTED] Diabetic Education Insurance Appeal

Dr. Bowlby -

My daughter [REDACTED] is a patient of yours. She is 3 and got a pump last August. She is insured under the State Health Plan for BC/BS, and I decided to appeal a denial I received for the training session you all provided prior to her getting her pump. While it is not really about the money, it seems to be an absurd policy not to cover "diabetic education." I really am not asking that you do anything, as I can only imagine the insurance problems you deal with on a daily basis.

However, I was wondering if you have had any experience with this issue.

I am attached the letter I intend to send for your general information.

Thank you

Christy Allen

--

*Christy Ford Allen
Attorney
Wills & Massalon, LLC
PO Box 859
Charleston, SC 29402
(843) 727-1144 telephone
(843) 727-7696 facsimile
*

EXHIBIT "E"

WILLS & MASSALON, LLC

ATTORNEYS AT LAW

Telephone: (843) 727-1144

Facsimile: (843) 727-7696

Post Office Box 859
Charleston, South Carolina 29402

134 Meeting Street, Suite 100
Charleston, South Carolina 29401

August 17, 2009

MUSC Hospital Patient Accounting
MSC 819
Charleston, SC 29425

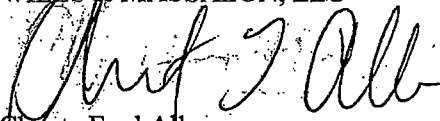
Re: Acct# 241145762
Appeal and Review / SC State Health Plan

To whom it may concern:

Enclosed please find partial payment of the invoice number referenced above. The amount due is currently subject to an appeal to my insurance carrier, which has been delayed due to MUSC's lack of responsiveness to the carrier's requests for information. After my follow up with both the carrier and MUSC last week, I understand the appeal and information is now being reviewed. Attached is the appeal letter dated February 2009. I request that you do not submit this bill to collection as I would prefer to await the decision of my carrier prior to paying it in full.

Sincerely,

WILLS & MASSALON, LLC



Christy Ford Allen

Enclosure

EXHIBIT “F”

*** TX REPORT ***

TRANSMISSION OK

TX/RX NO	0775
RECIPIENT ADDRESS	7927292
DESTINATION ID	
ST. TIME	09/30 10:35
TIME USE	00'26
PAGES SENT	1
RESULT	OK

792-7292



AUTHRELS

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Page 1 of 1

This form must be completed in its entirety in order to be considered valid.

Patient Name: [REDACTED] Date of Birth: [REDACTED] 05
Medical Record Number: [REDACTED] Social Security Number: [REDACTED]
☒ I authorize MUSC Medical Center to disclose/release information to:
☐ I authorize MUSC Medical Center to obtain information from:
Name of Individual / Organization: Christy F. Allen
Street Address: [REDACTED] City: Charleston State: SC Zip Code: 29414
Phone Number: 843-709-0369 Fax Number: 843-727-7696 E-mail Address: callen@wills-massalon.com

The purpose of the disclosure is: ins. denial appeal

The type of information to be disclosed is as follows:

- | | | | |
|--|---|--|--|
| ☐ films / images | ☐ problem list | ☐ medication list | ☒ physician orders |
| ☐ radiology reports | ☐ consultation reports | ☐ physician progress note / visit notes | ☐ immunization records |
| ☐ nurses notes | ☐ history and physical | ☐ discharge summary | ☐ laboratory results |
| ☒ entire record | | | |
| ☐ abstract (history and physical, consult, lab, radiology report, pathology, discharge summary, operative report) | | | |
| ☐ other | | | |

For dates of service:

08/05/08 ("outpatient records")

I understand this information may include reference to psychiatric / psychological care, sexual assault, drug abuse, results of tests for all infectious diseases including HIV / AIDS and / or alcohol abuse.

I authorize the exchange of this information via (check all preferred methods): ☐ mail ☒ fax ☒ e-mail ☐ other

I understand that I have a right to cancel / revoke this authorization at any time. I understand that if I cancel / revoke this authorization I must do so in writing and present my written cancellation / revocation to the Health Information Services Department (Medical Records). I understand that the cancellation / revocation will not apply to information, which has already been released in response to this authorization, as stated in the Notice of Privacy Practice. Unless otherwise canceled / revoked, this authorization will expire / end one year from this date.

I understand that a reasonable, cost-based fee for copies of protected health information and postage fees will be charged.

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment. I understand I may review and / or copy the information to be disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the possibility of

EXHIBIT “G”

WILLS & MASSALON, LLC
ATTORNEYS AT LAW

134 Meeting Street, Suite 100
Charleston, South Carolina 29401

Telephone: (843) 727-1144
Facsimile: (843) 727-7696

FACSIMILE MEMORANDUM

TO: BCBS Appeals/Medical Records

Fax: 1-803-264-4269

FROM: Christy Allen

RE: Appeal - ZCS 36961363

FILE NO.

DATE: October 5, 2009

Pages : 7



Medical University of South Carolina

Charleston, SC

843-792-2123

Practice Partner Note

Patient: [REDACTED]

MRN: 002585257

Attending:

Date: 8/5/08 3:33 PM

Status: INITIAL

Date: 08/05/08 : 03:33pm

Title: EDUCATION DOCUMENTATION - PEDS ENDO

MEDICAL UNIVERSITY OF SOUTH CAROLINA

[REDACTED] ALLEN

3 year female

Learning Needs/Content Taught: Patient's Plan of Care, Medications, Nutrition, Food/Drug Interactions, Health Promotion, Patient Safety, Medical Equipment

Person(s) Taught: Parent, Family Member(grandmothers), school nurse and nursing supervisor, Other,

Readiness to Learn: No barriers

Department: Nursing

Teaching/Learning Method: Written and Verbal, Demonstration

Outcome/Comprehension: Able to state understanding and/or return demonstration

Comments (names of teaching materials used, concerns, etc.): Met with [REDACTED] parent's, grandparent's, and school nurses to instruct them on the Medtronic Paradigm insulin pump. They were instructed on troubleshooting hyper/hypoglycemia on the insulin pump, importance of monitoring, ketone testing, and site rotation.

They were instructed on all mechanics of pump therapy and demonstrated good understanding. They were encouraged to practice with the pump with saline until [REDACTED] is started on the pump next week. [REDACTED]'s school nurse was given a practice pump and NS to review and she will return out pump next week. We discussed school needs and plan.

[REDACTED] will be started on the pump next week. SS

SIGNED BY SHARON SCHWARZ, R.N. (E17) 08/05/2008 03:39PM

524

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.

Printed by: MITCHELL, VERNESSA

Date Printed: 09/30/2009

404

Page1

WILLS & MASSALON, LLC

ATTORNEYS AT LAW

Telephone: (843) 727-1144

Facsimile: (843) 727-7696

Post Office Box 859
Charleston, South Carolina 29402

134 Meeting Street, Suite 100
Charleston, South Carolina 29401

September 30, 2009

Blue Cross Blue Shield of South Carolina
State Health Plan - Appeal
P.O. Box 100605
Columbia, SC 29260-0605

Re: Appeal and Review / SC State Health Plan
Plan No: ZCS36961363
EOB Claim No: 8E2631250-00-00/Pending Appeal

To whom it may concern:

This letter is in regard to the pending appeal of the above referenced claim, which has been pending since February 2009. Due to a lack of contact by you or apparent resolution of the appeal, I called BCBS on August 14, 2009 and was informed that you had not received requested medical records, which your telephone representative was unable to specify, from MUSC. I contacted the records department at MUSC that same day and was informed that it had sent the records once and that it would send the records a second time.

On September 30, 2009, I called BCBS again to inquire about the status of this appeal and was informed that you were still waiting on the requested records from MUSC. I was informed that you needed "outpatient ER records" (despite there being no ER involved in the date of service). I have received no direct request by BC/BS, other than what I initiated through my telephone contacts, for the records or even that I complete a HIPA form.

I have now received the complete set of records from MUSC for the diabetes mellitus insulin pump training session for my daughter who was 3 years old at the time, and enclose these records for your consideration.

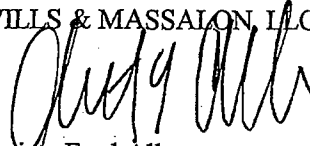
I am also enclosing a copy the South Carolina statute which requires Diabetes Mellitus coverage in health insurance policies. I have highlighted the provision which requires coverage for "outpatient self-management training and education for the treatment of people with diabetes mellitus (or commonly called Type I).

Thank you, and if there is any other information you require in order to resolve this

appeal, please let me know.

Sincerely,

WILLS & MASSALON, LLC

A handwritten signature in black ink, appearing to read "Christy Ford Allen", written over the printed name.

Christy Ford Allen

Enclosures



Medical University of South Carolina
Charleston, SC
843-792-2123

Practice Partner Note

Patient: [REDACTED]
Attending:

MRN: 002585257
Date: 8/5/08 3:41 PM
Status: INITIAL

Record all glucose monitoring and diabetes medications on Pediatric Diabetes Pump Flow Sheet.

6.

Check urine for ketones if blood glucose is greater than 250 mg/dL.

7.

If urine tests positive for ketones, call fellow/attending. Do not use pump to bolus. Change pump access site and give insulin via syringe injection subcutaneously (use high blood glucose insulin amount for pump).

8.

Exercise guidelines: 30 minutes before exercise begins

A. If blood glucose is less than 150 mg/dL prior to exercise, turn insulin pump off and restart after exercise stops.

B. If blood glucose is greater than 150 mg/dL prior to exercise, leave pump on with 50% basal rate reduction and return to ordered basal rate 30 minutes after exercise stops.

C. If blood glucose is greater than 300 mg/dL or if patient is positive for ketones, do not exercise.

Call Pediatric Endocrinology Fellow or Attending if blood glucose is: less than 70 mg/dL two times in a row, less than 50 mg/dL once, or greater than 240 mg/dL two times in a row; or if urine tests positive for ketones.

Weight: 14.3 kg

Patient/Parent may use home glucose meter, meter strips, lancing device, lancets, new unopened vial of insulin, glucose tabs, glucose gel, and glucagon, and may administer insulin.

Medications:

Insulin Pump

1.

Novolog insulin 100 units per ml for pump - use new vial

2.

Set basal rates at 0.1 units per hour

3.

Bolus all meals/snacks one unit insulin for every 30 grams carbohydrate.

4.

For high blood glucose greater than 175 mg/dL before meals or greater than 3 hours after meals from 6 AM to 9 PM, use 1 unit insulin for every 250 mg/dL (sensitivity factor) greater than 175 mg/dL (target).

5.

For high blood glucose greater than 200 mg/dL before meals or greater than 3 hours after meals from 9 PM to 6 AM, use 1 unit insulin for every 280 mg/dL (sensitivity factor) greater than 200 mg/dL (target).

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.



Medical University of South Carolina
Charleston, SC
843-792-2123

Practice Partner Note

Patient:



MRN: 002585257

Attending:

Date: 8/5/08 3:41 PM

Status: INITIAL

6.

If pump has bolus wizard/calculator option, enter blood glucose reading only when reading is greater than 175 mg/dL from 6 AM to 9 PM or greater than 200 mg/dL from 9 PM to 6 AM (Pump will calculate bolus amount to cover hyperglycemia.)

Glucose tablets: 4 or 5 grams per tab--Administer as directed per hypoglycemia protocol.

Glucose gel: 31 gram tube--Administer as directed per hypoglycemia protocol.

Glucagon 0.5 mg IM (0.5 mg for patients less than 20 kg; 1 mg for patients 20 kg or greater)--

Administer for unconscious hypoglycemia.

Hypoglycemia Protocol

1.

Call physician for 2 consecutive blood glucose levels below 70 mg/dL or 1 blood glucose level below 50 mg/dL.

2.

Give three glucose tabs (4 or 5 grams per tab) or 4 ounces unsweetened juice (15 grams carbohydrate). Recheck blood glucose level in 15 minutes and repeat above treatment until blood glucose is greater than 70 mg/dL.

3.

If patient is unable to chew or drink juice, place 15 grams carbohydrate of glucose gel in patient's cheek (use 1/2 of 31 gram weight tube).

Unconscious Hypoglycemia - If patient is unconscious, give glucagon as ordered above.

Discharge Appointment: Please schedule return appointment (876-0444) with Pediatric Endocrine Diabetes Educator for 2-3 weeks after discharge.

Ordering Physician: Deborah Bowlby, MD pager id 14535

SIGNED BY DEBORAH BOWLBY, MD (ATTENDING) (DB1) 08/06/2008
09:35AM

528

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.

Printed by: MITCHELL, VERNESSA

Date Printed: 09/30/2009

38-71-46

TITLE 38 - INSURANCE

CHAPTER 71. ACCIDENT AND HEALTH INSURANCE

38-71-840(14).

38-71-46. Diabetes Mellitus coverage in health insurance policies; diabetes education.

ARTICLE I. GENERAL PROVISIONS

(A) On or after January 1, 2000, every health maintenance organization, individual and group health insurance policy, or contract issued or renewed in this State must provide coverage for the equipment, supplies, Food and Drug Administration-approved medication indicated for the treatment of diabetes, and outpatient self-management training and education for the treatment of people with diabetes mellitus, if medically necessary, and prescribed by a health care professional who is legally authorized to prescribe such items and who demonstrates adherence to minimum standards of care for diabetes mellitus as adopted and published by the Diabetes Initiative of South Carolina. This subsection does not prohibit a health maintenance organization or an individual or a group health insurance policy from providing coverage for medication according to formulary or using network providers. Coverage must not be denied unless the health care professional demonstrates a persistent pattern of failure to adhere to the minimal standards of care and unless the health maintenance organization or insurer has first provided written notice to the health care professional that coverage will be denied if the health care professional fails to adhere to the minimal standards of care.

(B) Services and payment for diabetes education programs shall conform to regulations of the Health Care Financing Administration, US Department of Health and Human Services, pursuant to Section 4105 of the Balanced Budget Act of 1997. Diabetes outpatient self-management training and education shall be provided by a registered or licensed health care professional with certification in diabetes by the National Certification Board of Diabetes Educators, or other accredited program approved by the Diabetes Initiative of South Carolina, or by the Diabetes Control Program of the SC Department of Health and Environmental Control in order to meet the needs of rural communities wherein certified health care professionals providing this service are not available.

(C) Nothing contained in this section may be construed to affect in any way the ability of a managed care plan to credential or re-credential a provider.

(D) For purposes of this section: "Health insurance policy" means a health benefit plan, contract, or evidence of coverage providing health insurance coverage as defined in Section 38-71-670(6) and Section

10/05/2009 09:45 FAX 843 727 7696

Wills & Massalon

0001

*** TX REPORT ***

TRANSMISSION OK

TX/RX NO	0782
RECIPIENT ADDRESS	18032644269
DESTINATION ID	
ST. TIME	10/05 09:43
TIME USE	01'24
PAGES SENT	7
RESULT	OK

Pages : 7

DATE: October 5, 2009

FILE NO.

RE: Appeal - ZCS 36961363

FROM: Christy Allen

EXHIBIT “H”

I-20 @ Alpine Road
Columbia, SC 29219

06119



**BlueCross BlueShield
of South Carolina**
An Independent Licensee of the
Blue Cross and Blue Shield Association

EXPLANATION OF BENEFITS THIS IS NOT A BILL

If you have a question about your
claim, please call Customer Service at
1-800-868-2520 OR LOCALLY AT 736-1576
MON. - FRI. 8:00 A.M. - 6:00 P.M.

###

...

February 25, 2008

###

!294077258529!
JEFFREY D ALLEN
CHARLESTON SC 29407-7258

SUMMARY INFORMATION

Patient's Name ALLEN		Relationship to Policyholder CHILD		ID No. ZCS36961363	Claim No. 8C4534156-00-00
TOTAL CHARGE FOR YOUR CLAIM: 187.00		TOTAL AMOUNT WE PAID: 39.20		WHAT YOU OWE PROVIDER: 147.80	
		Sent to Provider		The provider can bill you for this amount if you have not yet paid.	
To date, you have satisfied 350.00 of the 350.00 deductible for the benefit period that began 01/01/2007					
This claim contributed 9.80 toward your out-of-pocket maximum. You have satisfied 914.00 of the 2,000.00 out-of-pocket maximum for this benefit period. We paid a total of 3,892.80 for this person this benefit period.					

DETAIL INFORMATION

Provider	MEDICAL UNIVERSITY	MEDICAL UNIVERSITY	MEDICAL UNIVERSITY	MEDICAL UNIVERSITY
Network Participation	YES	YES	YES	YES
Dates of Service	12/19/07	12/19/07	12/19/07	12/19/07
Type of Service	OUTPT LAB/PATH	OUTPT LAB/PATH	MEDICAL SERVICES	MEDICAL SERVICES
Charge	60.00	19.00	45.00	63.00
Amount Not Covered	.00	.00	.00	63.00 01*
Covered Expenses	60.00	19.00	45.00	.00
Deductible	.00	.00	.00	.00
Copay/Spec Deductible	60.00	15.00	.00	.00
Allowed Amount	.00	4.00	45.00	.00
Coinsurance	.00	.80	9.00	.00
Amount Paid	.00	3.20	36.00	.00

* Please refer to the remarks section.

Suspect claims fraud? Please help by calling our hotline at 1-800-763-0703

THANK YOU FOR ALLOWING US TO SERVE YOU!

www.SouthCarolinaBlues.com

Page 1 of 1

Helpful Definitions (Please check your schedule of benefits in your benefits booklet for details)

Amount Approved for Coordination - the amount we will coordinate with your primary health or dental plan's payment.

Benefit Period - the period of time you must pay any deductibles and coinsurance payments that may apply. Benefits begin once you meet the deductible. If you reach the limit, we pay covered expenses in full for the rest of the benefit period. Deductibles and coinsurance start over with each new benefit period.

Coinsurance - the percentage of the allowed amount you pay as your share of the bill. If your plan pays 80%, then 20% would be your coinsurance.

Copayment - a set fee you pay each time you receive a certain service. Some plans do not have copayments.

Deductible - the amount, if any, that you are responsible for paying before we start paying contract benefits. You do not send this amount to us. We subtract this amount from covered expenses on the claims you and healthcare professionals send to us.

Less Benefit Limitation - the amount that is more than your contract allows for this type of service. Your plan covers these services until you have reached the limit of your benefits.

Network Participation - this column shows whether or not the healthcare professional who provided the service participates in our network. If "YES" this is a network participant. If "NO" this is not a network participant. If "N/A", the issue doesn't apply to your coverage, or this particular claim.

Out-of-pocket-maximum - the highest amount of the covered expenses you will have to pay during a benefit period.

Total Benefit Allowed - the amount we would have paid if another insurance carrier was not involved.

APPEAL OR REVIEW

If you have questions about the disposition of this claim, you may call us at the number listed on the front of this statement. Please refer to your insurance benefit guide for more information. If you would like to request a reconsideration of your claim you may request a review by writing to us within six months of this notice at:

STATE HEALTH PLAN
P. O. BOX 100605
COLUMBIA, S.C. 29260-0605

REMARKS SECTION

THE LIFETIME BENEFITS PAID FOR THIS PERSON TO DATE: 3,892.80

WE DID NOT PAY BENEFITS ON THIS CLAIM BECAUSE YOU HAVE NOT MET YOUR DEDUCTIBLE YET. ONCE YOU MEET YOUR DEDUCTIBLE WITH FUTURE CLAIMS, WE WILL BEGIN PAYING OUR SHARE OF THE COVERED EXPENSES.

WE PROVIDE ADMINISTRATIVE CLAIMS PAYMENT SERVICES ONLY AND DO NOT ASSUME ANY FINANCIAL RISK OR OBLIGATION WITH RESPECT TO CLAIMS.

01 YOUR BENEFIT PLAN DOES NOT COVER EDUCATION AND/OR TRAINING FOR THIS CONDITION.

17247

I-20 @ Alpine Road
Columbia, SC 29219



**BlueCross BlueShield
of South Carolina**

An Independent Licensee of the
Blue Cross and Blue Shield Association

EXPLANATION OF BENEFITS THIS IS NOT A BILL

If you have a question about your
claim, please call Customer Service at
1-800-868-2520 OR LOCALLY AT 736-1576
MON. - FRI. 8:00 A.M. - 6:00 P.M.

STATE HEALTH PLAN

###

April 23, 2008

###

###

1294077258529!
JEFFREY D ALLEN
CHARLESTON SC 29407-7258

SUMMARY INFORMATION

Patient's Name JEFFREY D ALLEN		Relationship to Policyholder CHILD		ID No. ZCS36961363	Claim No. 8D0831845-00-00
TOTAL CHARGE FOR YOUR CLAIM: 160.00		TOTAL AMOUNT WE PAID: 00		WHAT YOU OWE PROVIDER: 160.00	
The provider can bill you for this amount if you have not yet paid.					
To date, you have satisfied 319.00 of the 350.00 deductible for the benefit period that began 01/01/2008					
This claim contributed 00 toward your out-of-pocket maximum. You have satisfied 00 of the 2,000.00 out-of-pocket maximum for this benefit period.					

DETAIL INFORMATION

Provider	MEDICAL UNIVERSITY	MEDICAL UNIVERSITY	MEDICAL UNIVERSITY	MEDICAL UNIVERSITY
Network Participation	YES	YES	YES	YES
Dates of Service	04/09/08	04/09/08	04/09/08	04/09/08
Type of Service	OUTPT LAB/PATH	OUTPT LAB/PATH	MEDICAL SERVICES	MEDICAL SERVICES
Charge	60.00	19.00	45.00	36.00
Amount Not Covered	.00	.00	.00	36.00 01*
Covered Expenses	60.00	19.00	45.00	.00
Deductible	.00	4.00	45.00	.00
Copay/Spec Deductible	60.00	15.00	.00	.00
Allowed Amount	.00	.00	.00	.00
Coinsurance	.00	.00	.00	.00
Amount Paid	.00	.00	.00	.00

* Please refer to the remarks section.

Suspect claims fraud? Please help by calling our hotline at 1-800-763-0703

THANK YOU FOR ALLOWING US TO SERVE YOU!

www.SouthCarolinaBlues.com

Page 1 of 1

Helpful Definitions (Please check your schedule of benefits in your benefits booklet for details)

Amount Approved for Coordination - the amount we will coordinate with your primary health or dental plan's payment.

Benefit Period - the period of time you must pay any deductibles and coinsurance payments that may apply. Benefits begin once you meet the deductible. If you reach the limit, we pay covered expenses in full for the rest of the benefit period. Deductibles and coinsurance start over with each new benefit period.

Coinsurance - the percentage of the allowed amount you pay as your share of the bill. If your plan pays 80%, then 20% would be your coinsurance.

Copayment - a set fee you pay each time you receive a certain service. Some plans do not have copayments.

Deductible - the amount, if any, that you are responsible for paying before we start paying contract benefits. You do not send this amount to us. We subtract this amount from covered expenses on the claims you and healthcare professionals send to us.

Less Benefit Limitation - the amount that is more than your contract allows for this type of service. Your plan covers these services until you have reached the limit of your benefits.

Network Participation - this column shows whether or not the healthcare professional who provided the service participates in our network. If "YES" this is a network participant. If "NO" this is not a network participant. If "N/A", the issue doesn't apply to your coverage, or this particular claim.

Out-of-pocket-maximum - the highest amount of the covered expenses you will have to pay during a benefit period.

Total Benefit Allowed - the amount we would have paid if another insurance carrier was not involved.

APPEAL OR REVIEW

If you have questions about the disposition of this claim, you may call us at the number listed on the front of this statement. Please refer to your insurance benefit guide for more information. If you would like to request a reconsideration of your claim you may request a review by writing to us within six months of this notice at:

STATE HEALTH PLAN
P. O. BOX 100605
COLUMBIA, S.C. 29260-0605

REMARKS SECTION

THE LIFETIME BENEFITS PAID FOR THIS PERSON TO DATE: 3,892.80

WE PROVIDE ADMINISTRATIVE CLAIMS PAYMENT SERVICES ONLY AND DO NOT ASSUME ANY FINANCIAL RISK OR OBLIGATION WITH RESPECT TO CLAIMS.

01 YOUR BENEFIT PLAN DOES NOT COVER EDUCATION AND/OR TRAINING FOR THIS CONDITION.

83436

I-20 @ Alpine Road
Columbia, SC 29219



**BlueCross BlueShield
of South Carolina**
An Independent Licensee of the
Blue Cross and Blue Shield Association

EXPLANATION OF BENEFITS THIS IS NOT A BILL

If you have a question about your
claim, please call Customer Service at
1-800-868-2520 OR LOCALLY AT 736-1576
MON. - FRI. 8:00 A.M. - 6:00 P.M.

STATE HEALTH PLAN

###

August 25, 2008

###

###

!294077258529!
JEFFREY D ALLEN
CHARLESTON SC 29407-7258

SUMMARY INFORMATION

Patient's Name ALLEN		Relationship to Policyholder CHILD		ID No. ZCS36961363	Claim No. 8E3431354-00-00
TOTAL CHARGE FOR YOUR CLAIM: 473.00		TOTAL AMOUNT WE PAID: .00		WHAT YOU OWE PROVIDER: 441.56	
The provider can bill you for this amount if you have not yet paid.					
To date, you have satisfied <u>350.00</u> of the <u>350.00</u> deductible for the benefit period that began <u>01/01/2008</u> .					
This claim contributed <u>.00</u> toward your out-of-pocket maximum. You have satisfied <u>3.60</u> of the <u>2,000.00</u> out-of-pocket maximum for this benefit period. We paid a total of <u>14.40</u> for this person this benefit period.					

DETAIL INFORMATION

Provider	MEDICAL UNIVERSITY	MEDICAL UNIVERSITY	MEDICAL UNIVERSITY
Network Participation	YES	YES	YES
Dates of Service	08/13/08	08/13/08	08/13/08
Type of Service	OUTPT LAB/PATH	OUTPT LAB/PATH	MEDICAL SERVICES
Charge	19.00	34.00	420.00
Amount Not Covered	11.27 01*	20.17 01*	420.00 02*
Covered Expenses	7.73	13.83	.00
Deductible	.00	.00	.00
Copay/Spec Deductible	7.73	13.83	.00
Allowed Amount	.00	.00	.00
Coinsurance	.00	.00	.00
Amount Paid	.00	.00	.00

* Please refer to the remarks section.

Suspect claims fraud? Please help by calling our hotline at 1-800-763-0703

THANK YOU FOR ALLOWING US TO SERVE YOU!

www.SouthCarolinaBlues.com

Page 1 of 1

Helpful Definitions (Please check your schedule of benefits in your benefits booklet for details)

Amount Approved for Coordination - the amount we will coordinate with your primary health or dental plan's payment.

Benefit Period - the period of time you must pay any deductibles and coinsurance payments that may apply. Benefits begin once you meet the deductible. If you reach the limit, we pay covered expenses in full for the rest of the benefit period. Deductibles and coinsurance start over with each new benefit period.

Coinsurance - the percentage of the allowed amount you pay as your share of the bill. If your plan pays 80%, then 20% would be your coinsurance.

Copayment - a set fee you pay each time you receive a certain service. Some plans do not have copayments.

Deductible - the amount, if any, that you are responsible for paying before we start paying contract benefits. You do not send this amount to us. We subtract this amount from covered expenses on the claims you and healthcare professionals send to us.

Less Benefit Limitation - the amount that is more than your contract allows for this type of service. Your plan covers these services until you have reached the limit of your benefits.

Network Participation - this column shows whether or not the healthcare professional who provided the service participates in our network. If "YES" this is a network participant. If "NO" this is not a network participant. If "N/A", the issue doesn't apply to your coverage, or this particular claim.

Out-of-pocket-maximum - the highest amount of the covered expenses you will have to pay during a benefit period.

Total Benefit Allowed - the amount we would have paid if another insurance carrier was not involved.

APPEAL OR REVIEW

If you have questions about the disposition of this claim, you may call us at the number listed on the front of this statement. Please refer to your insurance benefit guide for more information. If you would like to request a reconsideration of your claim you may request a review by writing to us within six months of this notice at:

STATE HEALTH PLAN
P. O. BOX 100605
COLUMBIA, S.C. 29260-0605

REMARKS SECTION

THE LIFETIME BENEFITS PAID FOR THIS PERSON TO DATE: 3,907.20

WE PROVIDE ADMINISTRATIVE CLAIMS PAYMENT SERVICES ONLY AND DO NOT ASSUME ANY FINANCIAL RISK OR OBLIGATION WITH RESPECT TO CLAIMS.

01 THIS AMOUNT IS THE DIFFERENCE BETWEEN WHAT THE PROVIDER CHARGED FOR THIS SERVICE AND OUR ALLOWANCE.

02 YOUR BENEFIT PLAN DOES NOT COVER EDUCATION AND/OR TRAINING FOR THIS CONDITION.

Exhibit “D”
to Plaintiff’s
Memorandum in Opposition
to Defendant’s
Motion to Dismiss

2009

Insurance Benefits Guide

South Carolina Budget and Control Board
Employee Insurance Program
www.eip.sc.gov

Contact Information

APS HEALTHCARE INC.

SHP Mental Health and Substance Abuse

Claims, State of SC
P.O. Box 1307
Rockville, MD 20849
Customer Service: 800-221-8699
Tobacco Treatment: 866-784-8454
Fax: 888-897-8931
www.apshealthcare.com
(password=statesc)

BLUECHOICE HEALTHPLAN OF SOUTH CAROLINA

P.O. Box 6170
AX-435
Columbia, SC 29260-6170
Member Services:
800-868-2528
803-786-8476
www.BlueChoiceSC.com

BLUECROSS BLUESHIELD OF SOUTH CAROLINA (BCBSSC)

SHP Standard Plan, Savings Plan, Medicare Supplemental Plan

P.O. Box 100605
Columbia, SC 29260-0605
Customer Service Center:
800-868-2520
803-736-1576
Fax: 803-264-4204
www.SouthCarolinaBlues.com

Medi-Call

BlueCross BlueShield of SC
AF 330
I-20 Alpine Road
Columbia, SC 29219
800-925-9724
803-699-3337
Fax: 803-264-0183

BlueCard

800-810-BLUE (2583)

State Dental Plan, Dental Plus

BlueCross BlueShield of SC
P.O. Box 100300
Columbia, SC 29202-3300
Customer Service: 888-214-6230
803-264-7323
Fax: 803-264-7739
www.SouthCarolinaBlues.com

CIGNA HEALTHCARE HMO

P.O. Box 5200
Scranton, PA 18505-5200
Member Services: 800-244-6224
www.cigna.com

EMPLOYEE INSURANCE PROGRAM (EIP)

Street Address:
1201 Main Street, Suite 300
Columbia, SC 29201
Mailing Address:
P.O. Box 11661
Columbia, SC 29211-1661
Customer Service:
803-734-0678 (Greater Columbia area)
888-260-9430 (toll-free outside Columbia area)
Retiree Billing: 803-734-1696
Fax: 803-737-0825
www.eip.sc.gov

FRINGE BENEFITS MANAGEMENT COMPANY (FBMC)

MoneyPlus

P.O. Box 1878
Tallahassee, FL 32302-1878
3101 Sessions Road
Tallahassee, FL 32303
Customer Service: 800-342-8017
Automated Information: 800-865-FBMC (3262)
Claims Fax: 888-800-5217
Other Fax: 850-425-6220
www.myFBMC.com

THE HARTFORD

Basic Life, Optional Life, Dependent Life

P.O. Box 2999
Hartford, CT 06104-2999
Medical Evidence of Good Health: 800-331-7234
Status of Death Claims: 888-563-1124
Retiree Enrollment /Claims: 888-803-7346, ext. 33666
Conversion: 877-320-0484
Customer Service: 800-523-2233

(Continued on inside back cover)

Table of Contents

Introduction	2
Confidentiality Policies	3
What's New for 2009?	6

General Information 7

Your Insurance Benefits: Help When You Need It Most	9
Enrolling in a Health or Dental Plan	9
Eligibility	9
Insurance Cards	11
Annual and Open Enrollment	11
Special Eligibility Situations	12
Coverage of Dependent Children Age 19 and Older	15
Enrollment of a Transferring Employee	16
Leave Without Pay	17
When You Become Eligible for Medicare	17
When Your Coverage Ends	18
Death of a Subscriber or a Covered Dependent	19
Workers' Compensation	21
Coordination of Benefits	21
Prevention Partners	21
The Vision Care Discount Program	22
The Internet Provides Easy Access to Your Insurance Information	23
Appeals	24
Checklists: Quick Guides to Your Benefits	25
Retiree Checklist	25
Survivor Checklist	26

Health Insurance 27

The State Health Plan	30
Benefits at a Glance	31
How the Standard Plan Works	32
How the Savings Plan Works	33
Lifetime Maximum	34
Coordination of Benefits	34
Subrogation	35
Using SHP Provider Networks	35
BlueCard® and BlueCard Worldwide®	36
Out-of-Network Benefits for Medical Care	37
Out-of-Network Differential	38
Managing Your Medical Care	39
Medi-Call	39
Maternity Management	40
Health Management Program	41

Wellness Management	41
Medical Case Management	41
Online Health Tools	43
State Health Plan Benefits	44
Preventive Benefits	50
Well Child Care Benefits	51
Natural Blue sm and Other Discount Programs	52
Additional Benefits for Savings Plan Participants	53
Prescription Drug Benefits	53
Prescription Drugs	53
Retail Pharmacy	56
Mail-Order Pharmacy	56
Coordination of Benefits	57
Exclusions	57
Mental Health and Substance Abuse Benefits	57
Exclusions	58
Web Site: www.SouthCarolinaBlues.com	60
Appeals	61
Health Maintenance Organizations	62
What Are My Choices?	62
HMO Service Areas	62
BlueChoice Health Plan	63
Benefits at a Glance	63
Primary Care Physician	64
Network Benefits	64
Covered Services	65
Exclusions and Limitations	70
Other Plan Features	72
Web Site: www.BlueChoiceSC.com	73
Appeals	73
CIGNA HMO	75
Network Benefits	75
Out-of-Network Benefits	76
Exclusions	76
Special Features of the CIGNA Plan	78
Lifestyle Management Programs	78
Claims	78
Web Site: www.myCIGNA.com	78
Appeals	78

Dental Insurance

81

Dental Benefits at a Glance	84
Claim Example (using Class III procedure)	85
State Dental Plan Only	85
State Dental Plan with Dental Plus	85
How to File a Dental Claim	85
Special Provisions of the State Dental Plan	86

Dental Services Not Covered	86
Coordination of Benefits	88
Appeals	90

Life Insurance 91

Basic Life Insurance Program	93
Optional Life Insurance Program	95
Contract Terms	95
Enrolling in Optional Life Insurance	98
Your Life Insurance Benefits	99
Your Benefits and Facility of Payment of Claims	99
Your Accidental Death and Dismemberment Benefits	100
Claims	102
Extension of Benefits	103
When Your Coverage Ends	104
Dependent Life Insurance Program	105
Enrollment and Eligibility	105
Schedule of Benefits	107
Payment of Claims	107
When Dependent Life Insurance Coverage Ends	108
The Beneficiary Assist® Program	109
Travel Assistance	109
Optional Life, Dependent Life/Spouse, Child Monthly Premiums	111

Long Term Disability 113

Basic Long Term Disability	115
BLTD Plan Benefits Summary	117
When Are You Considered Disabled?	117
When BLTD Coverage Ends	118
Appeals	118
Supplemental Long Term Disability	119
SLTD Plan Benefits Summary	122
How Does SLTD Insurance Work?	123
When Are You Considered Disabled?	123
Conversion	124
When SLTD Coverage Ends	125
Appeals	125

Long Term Care 127

Long Term Care Insurance	129
Important Points About the Plan	129
Plan Details	130
Coverage Amounts	131
Base Plan Features	131

Points to Remember	133
Exclusions	133
Appeals.....	134

MoneyPlu\$ 135

MoneyPlu\$ — Your Tax-favored Accounts Program	137
Pretax Group Insurance Premium Feature.....	139
Flexible Spending Accounts.....	139
Deciding How Much to Contribute to Your Flexible Spending Accounts	140
Dependent Care Spending Account.....	141
Medical Spending Account	143
EZ REIMBURSE® MasterCard® Card	147
Access to Information About Your Flexible Spending Account	149
Changing Your Flexible Spending Account Coverage.....	151
How Leaving Your Job Affects Your Flexible Spending Account	151
Appeals.....	152
Health Savings Account.....	152
Contributions	153
How Death Affects Your MoneyPlu\$ Accounts	157

Retirement/Disability Retirement 159

Benefits for Retirees	161
Are You Eligible for Retiree Insurance?	161
Who Pays For Your Insurance?	162
Enroll Within 31 Days Of Your Retirement	163
How to Enroll	164
Your Health Plan Choices as a Retiree.....	165
When Your Coverage as a Retiree Begins.....	165
Returning to Employment After Retirement.....	166
If You or Your Covered Dependents are Eligible for Medicare	166
When Coverage Ends.....	167
When You or Your Dependents Become Eligible for Medicare	168
Your Health Options With Medicare.....	171
The Medicare Supplemental Plan.....	172
Medicare Deductibles and Coinsurance	172
Medicare Supplemental Plan Deductibles and Coinsurance	173
What the Medicare Supplemental Plan Covers.....	173
The Standard Plan	176
How the Standard Plan and Medicare Work Together	176
“Carve-out” Method of Claims Payment	178
Filing Claims As a Retiree	179
HMO Plans	179
If You Are Eligible for Medicare.....	179
How BlueChoice HealthPlan and Medicare Work Together	180
How CIGNA HMO and Medicare Work Together	181
Dental Benefits.....	181

MoneyPlus\$	182
Long Term Care	182
Life Insurance.....	183
\$3,000 Basic Life Insurance.....	183
Optional Life Insurance.....	183
Dependent Life Insurance	184
Long Term Disability	184
Basic Long Term Disability	184
Supplemental Long Term Disability	184
The Vision Care Discount Program	185
Comparison of Health Plans for Retirees and Dependents NOT Eligible for Medicare	186
Comparison of Health Plans for Retirees and Dependents Eligible for Medicare	190

Premiums 195

Comparison of Health Plan Benefits Offered for 2009.....	198
2009 Active Employee and Funded Retiree Health, Dental and Dental Plus Rates	200
2009 Non-funded Retiree and COBRA Health, Dental and Dental Plus Rates	201
2009 Survivor Health, Dental and Dental Plus Rates.....	202
2009 Monthly Insurance Rates for Permanent, Part-time Teachers.....	203
Long Term Care Monthly Premiums	204
Optional Life, Dependent Life/Spouse Monthly Premiums	206
Dependent Life/Child Monthly Premium	209

Appendix 211

Claims Procedures	213
How to File a State Health Plan Claim	213
How to File a Medco Prescription Drug Claim	213
How to File a Dental Claim	214
Notice of Privacy Practices.....	215
How EIP May Use and Disclose Health Information	215
Your Health Information Rights	217
Complaints	218
Changes to This Notice	218
Other Uses of Health Information	218
Part D Creditable Coverage Letter	219
Medicare Part D: Frequently Asked Questions	221
Health Savings Account Custodial Agreement.....	222

Index 229

Introduction

BENEFITS ADMINISTRATORS AND OTHERS CHOSEN BY YOUR EMPLOYER WHO MAY ASSIST WITH INSURANCE ENROLLMENT AND ADJUSTMENTS, RETIREMENT OR TERMINATION AND RELATED ACTIVITIES ARE NOT AGENTS OF THE EMPLOYEE INSURANCE PROGRAM AND ARE NOT AUTHORIZED TO BIND THE EMPLOYEE INSURANCE PROGRAM.

THIS GUIDE CONTAINS AN ABBREVIATED DESCRIPTION OF INSURANCE BENEFITS. THE *PLAN OF BENEFITS* DOCUMENTS AND BENEFITS CONTRACTS CONTAIN COMPLETE DESCRIPTIONS OF THE HEALTH AND DENTAL PLANS AND ALL OTHER INSURANCE BENEFITS. THEIR TERMS AND CONDITIONS GOVERN ALL BENEFITS OFFERED BY THE STATE. IF YOU WOULD LIKE TO REVIEW THESE DOCUMENTS, CONTACT YOUR BENEFITS ADMINISTRATOR OR THE EMPLOYEE INSURANCE PROGRAM.

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS. THE AGENCY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT, IN WHOLE OR IN PART. NO PROMISES OR ASSURANCES, WHETHER WRITTEN OR ORAL, WHICH ARE CONTRARY TO OR INCONSISTENT WITH THE TERMS OF THIS PARAGRAPH CREATE ANY CONTRACT OF EMPLOYMENT.

Introduction

We know that your benefits are important to you and to your family. We also know that you lead busy lives and often don't have a chance to read about your insurance until there is a need to use it. For that reason, we continually try to make the *Insurance Benefits Guide* (IBG) easier to understand and use.

The section "What's New for 2009?" highlights major changes in insurance programs offered through the Employee Insurance Program (EIP). There also are some changes in this book.

New symbols have been added to boxes. A box with a book will tell you where to go for more information about a topic. An apple marks information about how to stay healthy or manage diseases.

As always, this guide includes explanations of benefits, premiums and contact information and an overview of the health plans and other programs offered through EIP.

Terms that may be unfamiliar to you are italicized and defined in the text. However, if you have questions, ask your benefits administrator; the third-party administrator, such as BlueCross BlueShield of South Carolina or FBMC; or EIP. The IBG's index has been expanded. Turn to it for help in finding information about specific topics, including definitions of terms.

Remember, only information concerning those programs for which you are eligible and in which you are enrolled applies to you. The word "you," as used in this book, means anyone insured through EIP, you and/or your covered dependents.

We encourage you to review each chapter that applies to you and to discuss your benefits with your family. Charts are included to help you compare plans. Pay close attention to copayments, deductibles, preauthorization requirements and services that may be limited or not covered.

For a more detailed explanation of your benefits, check the appropriate chapter in the IBG. If you still have questions, call your benefits administrator or EIP.

For information about processing and payment of claims, contact the third-party administrator listed on the inside cover of the IBG.

Every year there are changes in the programs offered by the Employee Insurance Program. To avoid mistakes, please recycle your 2008 *Insurance Benefits Guide* and use this one.

To make the best use of your insurance, please remember:

- You are responsible for understanding your benefits. Ask questions if you do not understand them.
- Coverage and changes are not automatic.
- You may make changes in your coverage within 31 days of a qualifying event, such as birth, adoption, marriage or involuntary loss of other coverage. To do so, contact your benefits administrator.
- Whether you are covered by the State Health Plan or a Health Maintenance Organization (HMO), some services must be approved by your plan before you receive them. Check preauthorization requirements now so you will be familiar with them when you need services.

Confidentiality Policies

The South Carolina Budget and Control Board Employee Insurance Program (EIP) is committed to protecting the privacy of your health information. EIP strives continually to ensure its compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, which mandates security and privacy of health information by setting standards for access and distribution of that information.

EIP provides a Notice of Privacy Practices directly to all persons covered under the state insurance program. This brochure outlines the situations in which EIP uses and discloses health information. It also outlines your rights with regard to the information and disclosure. A copy of EIP's Notice of Privacy Practices is on page 215 and on the EIP Web site, www.eip.sc.gov. In addition, the Web site contains links to forms mentioned in the Notice of Privacy Practices.

If you would like for someone, such as your spouse or your parents, to have access to your protected health information – or if they would like for you to have access to theirs – you, as a subscriber or a covered dependent, must complete an Authorized Representative Form. The form is available on EIP's Web site. Choose your category and then select "Forms." Under "Forms," select "Other Forms" then "HIPAA Information" then "Authorized Representative Form."

If you have any questions about HIPAA, please contact:

Privacy Officer
South Carolina Budget and Control Board
1201 Main Street, Suite 300
Columbia, SC 29201
Phone: 803-734-0678
Fax: 803-737-0825
E-mail: privacyofficer@eip.sc.gov

What's New for 2009?

WHAT'S NEW FOR 2009?

What's New for 2009?

General Information

- Retirees, survivors and COBRA subscribers, as well as active subscribers, can now update their contact information and beneficiaries and print a copy of their benefits statement year-round on MyBenefits, EIP's online enrollment system. During October, they can also make their own enrollment changes.

For details, see page 24 and www.eip.sc.gov.

State Health Plan

- The State Health Plan now covers certain services related to autism spectrum disorders.

For details, see page 45.

Health Maintenance Organizations

- The HMOs offered through the Employee Insurance Program now cover certain services related to autism spectrum disorders.

For details, see page 66 (BlueChoice HealthPlan) and page 76 (CIGNA HMO).

- MUSC Options, a point of service plan offered in the Charleston area, is no longer offered.

Long Term Care

- The Prudential Insurance Company of America has replaced Aetna as the EIP's long term care insurance provider.

For details, see pages 127-134.

MoneyPlu\$

- Eligible Savings Plan subscribers may now open a Health Savings Account online.

For details, see page 153.

Retirement/Disability Retirement

- Employees who began service with an employer participating in the state insurance program on or after May 2, 2008, are covered under new retiree insurance eligibility rules.

For details, see page 163.



General Information

General Information

Table of Contents

Your Insurance Benefits: Help When You Need It Most.....	9
Enrolling in a Health or Dental Plan.....	9
Eligibility.....	9
Insurance Cards.....	11
Annual and Open Enrollment.....	11
Special Eligibility Situations.....	12
Coverage of Dependent Children Age 19 and Older.....	15
Enrollment of a Transferring Employee.....	16
Leave Without Pay.....	17
When You Become Eligible for Medicare.....	17
When Your Coverage Ends.....	18
Death of a Subscriber or a Covered Dependent.....	19
Workers' Compensation.....	21
Coordination of Benefits.....	21
Prevention Partners.....	21
The Vision Care Discount Program.....	22
The Internet Provides Easy Access to Your Insurance Information.....	23
Appeals.....	24
Checklists: Quick Guides to Your Benefits.....	25
Retiree Checklist.....	25
Survivor Checklist.....	26

Your Insurance Benefits: Help When You Need It Most

Your insurance, offered through the Employee Insurance Program, provides a financial safety net when you are ill or injured. Several health plans are available.

Through the **State Health Plan**, you may enroll in the Standard Plan, the Savings Plan or, if you are a retiree and eligible for Medicare, the Medicare Supplemental Plan.

Health Maintenance Organizations are also offered:

- BlueChoice HealthPlan is available statewide.
- CIGNA HMO is available in all counties **except** Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda.

Active employees who enroll in a health plan receive Basic Life Insurance and Basic Long Term Disability Insurance at no charge.

Eligible employees and retirees may also enroll in the State Dental Plan and in Dental Plus. Dental Plus supplements State Dental Plan coverage. It pays a higher amount for the same services covered by the State Dental Plan except orthodontics, which Dental Plus does not cover.

For more information on retiree health insurance options, including options for retirees who are returning to work, refer to the Retirement/Disability Retirement chapter, which begins on page 159.

ENROLLING IN A HEALTH OR DENTAL PLAN

ELIGIBILITY

An eligible active employee:

- Is employed by the state, a school district or a participating *local subdivision* and
- Works in a permanent, full-time position and
- Receives compensation from the state, a school district or a participating local subdivision.

Eligible employees also include clerical and administrative employees of the S.C. General Assembly and judges in the state courts. S.C. General Assembly members and elected members of the councils of participating counties or municipalities, who also participate in the S.C. Retirement Systems (SCRS), and permanent, part-time teachers are considered employees for insurance purposes. Members of other governing boards are not eligible for coverage. If you work for more than one *participating group*, please contact your benefits administrator for further information.

Retiree insurance eligibility is explained on pages 161-163.

A *local subdivision* is any *participating group* other than a state agency, higher education institution or a school district. Examples of local subdivisions include: counties, municipalities, councils on aging, commissions on alcohol and other drug abuse, special purpose districts, community action agencies, disabilities and special needs boards, recreation districts, hospital districts and councils of government. Since 1985, the General Assembly has passed legislation extending voluntary participation in the state insurance benefits program to certain local subdivisions. For a local subdivision to be eligible to participate in the state insurance program, it must fall within one of the categories established by statute (Section 1-11-720 of the 1976 S.C. Code of Laws, as amended).

An eligible dependent spouse is:

- A lawful spouse, or
- A former spouse who is required to be covered by a divorce decree, but not both spouses.

A spouse who is eligible for coverage as an employee of any participating group, including a local subdivision, may not be covered as a dependent in any program. A spouse who is a permanent, part-time teacher may be covered as an employee or as a dependent, but not as both.

An eligible dependent child:

- Must be unmarried and younger than age 19
- Must be principally dependent (more than 50 percent) on the subscriber for maintenance and support
- Must be the natural child, adopted child, stepchild, foster child or child for whom the subscriber has legal custody and
- Must reside in the subscriber's home in a parent-child relationship unless the subscriber has been directed to provide coverage by a court order.

For information about coverage of full-time students ages 19-24 and incapacitated children age 19 and older, see pages 15-16.

Please note: You may cover an eligible dependent child age 19-24 if he is a full-time student. You may cover an eligible incapacitated child age 19 and older.

If you and your spouse are both eligible for coverage, only one of you can cover your children under any one program. However, one parent can cover the children under health, and the other can cover the children under dental.

Initial Enrollment

If you are an eligible employee or retiree of a *participating group* in South Carolina, you can enroll in a health plan and the dental plan within 31 days of the date you are hired or the date you retire. You can also enroll your eligible dependents. A *participating group* is a state agency, school district, county, municipality or other group that is authorized by statute to participate in, and is participating in, the state insurance plan.

To enroll in a health or dental plan, you must complete the required forms, including a *Notice of Election (NOE)* form. An *NOE* is used to: enroll in benefits; add or drop dependents; or change a subscriber's coverage level, beneficiary, name or address. Coverage is not automatic.

To enroll in Dental Plus, you must be enrolled in the State Dental Plan. You must cover the same family members under both plans.

After you enroll, please check your payroll stub to make sure the correct premiums are deducted. Your health and dental coverage will continue from one year to the next as long as you are a full-time, permanent employee or an eligible retiree. Your coverage begins on the first day of the month if you are *actively at work* on the first working day of the month.

An employee is considered *actively at work* on his employer's scheduled workday if he is performing the regular duties of his occupation. He may be working at his usual work place or at another place, if he is required to travel. An employee is considered actively at work on a paid

Your benefits administrator or "BA" helps you enroll in or change your insurance coverage.

Your employer's human resources staff is your BA if you are:

- An active employee of a state agency, higher education institution or school district
- An active employee, retiree, survivor or COBRA subscriber of a local subdivision

The Employee Insurance Program is your BA if you are:

- A retiree, survivor or COBRA subscriber of a state agency, higher education institution or school district

vacation day or on one of his employer's normal holidays only if he was actively at work on the last day before the vacation day or holiday.

If you are not actively at work on the first working day of the month, your coverage starts on the first day of the next month. Your enrolled dependents' coverage begins on the same day your coverage begins.

INSURANCE CARDS

If you enroll in the Standard Plan, Savings Plan or Medicare Supplemental Plan, BlueCross BlueShield of South Carolina will send you insurance cards for you and your covered family members. BlueChoice HealthPlan and CIGNA Healthcare will mail insurance cards to their members. Benefits administrators will provide State Dental Plan subscribers with a card upon which they can write their name and Benefits ID Number. Dental Plus subscribers will receive an insurance card from BlueCross BlueShield of South Carolina.

Insurance cards for all family members are issued in the subscriber's name

Benefits Identification Number

The Employee Insurance Program gives each subscriber an eight-digit Benefits Identification Number (BIN). This unique number is used instead of a Social Security Number (SSN) in e-mails and written communication between you and your dependents and EIP. It is designed to make your personal information more secure. When you contact EIP, you may give your SSN or your BIN, and the Customer Service staff will be able to assist you.

The State Health Plan and BlueChoice HealthPlan put your BIN on your identification card. The BIN is also used on Dental Plus cards. CIGNA gives its members another secure number. If you are not enrolled in a program that uses the BIN, EIP will send you your number.

Keep a record of your BIN in a safe place. All subscribers need it to use MyBenefits, EIP's online enrollment system. However, you can also get your BIN through MyBenefits. For more information, see page 24.

ANNUAL AND OPEN ENROLLMENT

Every October, you may make changes in your **health coverage** without regard to special eligibility situations.

- During *annual enrollment*, eligible employees, retirees, survivors and COBRA subscribers may change health plans only. This includes changing to or from the Medicare Supplemental Plan, if you are retired.
- During *open enrollment*, which occurs in odd-numbered years, eligible subscribers may enroll in or drop their own health coverage and add or drop eligible dependents. You may also change **dental coverage**.

Changing Plans or Coverage

You can change to or from the Savings Plan, the Standard Plan, a health maintenance organization (HMO) or the Medicare Supplemental Plan (if you are retired) only during October enrollment periods. There may be exceptions to this rule. Contact your benefits administrator for details if you are an active employee or if you are a retiree, a survivor or COBRA subscriber of a local subdivision. Retirees, survivors and COBRA subscribers of other employers should contact EIP, which is their benefits administrator.

Please don't use a highlighter on any document or form you send to EIP or to any third-party administrator.

Retirees and survivors and their eligible dependents who are enrolled in a health plan may change to the Medicare Supplemental Plan within 31 days of Medicare eligibility or during annual or open enrollment.

If you are retired and eligible for Medicare, you may not enroll in the Savings Plan. Active employees of any age and retired employees who are not eligible for Medicare may enroll in the Savings Plan.

You can add or drop State Dental Plan and Dental Plus coverage only during open enrollment, which is in October of odd-numbered years, or within 31 days of a special eligibility situation.

Other changes you may make in your insurance coverage are explained in *The Insurance Advantage*, which you receive each September. Changes made during open or annual enrollment become effective the following January 1.

General Information

Pre-Existing Condition Exclusions

Most of the health plans offered through EIP exclude coverage for a *pre-existing condition*. This means that if you have a medical condition before coming to the plan, you may have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. The pre-existing exclusion does not apply to pregnancy nor to a child who is enrolled within 31 days of birth; adoption, if the child is younger than age 18; or placement for adoption, if the child is younger than age 18.

This exclusion may last up to 12 months (18 months if you are a late entrant) from your enrollment date. However, you can reduce the length of this exclusion period by the number of days of your prior creditable coverage. Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a *significant break in coverage*, a period of more than 62 days in which you did not have insurance. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you must present to your benefits administrator a creditable coverage letter or a letter on letterhead from your previous employer or insurance company that includes the dates coverage began and ended, the names of all individuals covered and the types of coverage.

The State Dental Plan and Dental Plus do not have pre-existing condition exclusions.

Late Entrants

If you do not enroll within 31 days of the date you begin employment, retire or experience a special eligibility situation, you cannot enroll yourself or your eligible dependents until the next open enrollment period. Open enrollment is held in October of odd-numbered years, and your coverage will take effect the following January 1. As late entrants, you and your dependents will be subject to an 18-month pre-existing condition exclusion period, which may be reduced by prior creditable coverage.

SPECIAL ELIGIBILITY SITUATIONS

If you decline enrollment for yourself or your eligible dependents (including your spouse), because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents for coverage at a later date if you or your dependents involuntarily lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must complete an NOE within **31 days** of the date your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Changes permitted by a special eligibility situation must be made within 31 days of the qualifying event.

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 eligible dependents in health and/or dental coverage. However, you must complete an NOE within **31 days** of the date of the marriage, birth, adoption or placement for adoption. A salary increase does not create a special eligibility situation.

If you are an active employee and eligible to change your health, dental or Optional Life Insurance coverage due to a special eligibility situation, you also may enroll in or drop the Pretax Group Insurance Premium Feature.

Marriage

If you, as a covered subscriber, wish to add a dependent spouse because you marry, you can do so by completing an NOE within 31 days of the date of your marriage. Coverage becomes effective with the date of marriage. You cannot cover your spouse as a dependent if he is eligible, or becomes eligible, for coverage as an employee or as a retiree of a participating group. If you do not add your spouse within 31 days of the date of marriage, you cannot add him until the next open enrollment period or within 31 days of a special eligibility situation.

Legal Separation

If you and your covered spouse separate, your spouse may remain on your health, dental and Dependent Life/Spouse coverage until the divorce is final.

To drop your spouse when you separate, you must submit a copy of a court order signed by the judge to your benefits administrator. It must state that the divorce is in progress, and it must be attached to an NOE. Your spouse's coverage will end the last day of the month after the date of separation, if you drop your spouse within 31 days of separation. Otherwise coverage will end the first of the month after the date you request it.

If you reconcile with your spouse after you drop health insurance coverage for your spouse, coverage cannot be reinstated until the next open enrollment period or a special eligibility situation. He will then be considered a late entrant. As a late entrant, he will not be eligible for coverage for pre-existing conditions until 18 months after enrollment. If he enrolls due to a special eligibility situation, he will not be eligible for coverage for pre-existing conditions until 12 months after enrollment (which may be reduced by prior creditable coverage). For more information, see page 12.

You may re-enroll your spouse in Dependent Life/Spouse year-round if you submit medical evidence of good health and it is approved by The Hartford. Dental coverage can be reinstated during the next open enrollment period or within 31 days of a special eligibility situation.

Divorce

If you, as a subscriber, divorce, you must drop your spouse from your coverage by completing an NOE and submitting a **complete copy** of the divorce decree within 31 days of the date the divorce decree is signed. Your divorced spouse's coverage ends the last day of the month after the divorce decree is signed. You can continue to cover your eligible dependent children if they live with you and you are financially responsible for them.

You may continue to provide health, dental and Dependent Life coverage for your former spouse only if the Family Court requires that you do so. You must give a complete copy of the Family Court decree or a complete copy of the divorce decree, as well as an NOE, to your benefits administrator, who will send both to EIP. The document must list the programs under which your former spouse must be covered. Retirees of state agencies, higher education institutions and school districts, survivors and COBRA subscribers should notify EIP. Retirees of local subdivisions should notify their benefits administrator.

If you remarry, you can cover your divorced spouse or your current spouse, but you cannot cover both under any EIP program. Dependent spouses who lose coverage due to a qualifying event may be eligible to continue coverage under COBRA. For more information, you must contact your benefits administrator or EIP as soon as possible, but **no later than** within 60 days of the event or from when coverage would have been lost due to the event, whichever is later.

Adding Children

Eligible children may be added by completing an NOE **within 31 days** of the date of birth, gaining legal custody, adoption or placement for adoption. **Children must be listed on your NOE to be covered, even if you already have full family or employee/children coverage. Notification to Medi-Call of the delivery of your baby does not add the baby to your health insurance.**

To add adopted children to your policy, you must submit a copy of the legal adoption documentation from the court, verifying the completed adoption; or a letter of placement from an attorney, adoption agency or the S.C. Department of Social Services (DSS) verifying the adoption is in progress, as well as an NOE. An adopted child will be covered on the date of adoption or when the child has been placed in a subscriber's home, a petition for adoption has been filed and the petitioner has temporary custody of the child.

To verify custody or guardianship of a child, you must submit a copy of the court order or other legal documentation from a placement agency or DSS granting you custody or guardianship of the child or foster child. The documents must verify that you, the subscriber, have guardianship responsibility for the child and not just financial responsibility.

If a court order is issued requiring you to cover your dependent child, you must notify your employer and EIP within 31 days of the date the court order was issued and elect coverage for that child and yourself, if you are not already enrolled.

If you and your spouse are both eligible for coverage, only one of you can cover your children under any one program. However, one parent can cover the children under health, and the other can cover the children under dental. Only one parent can carry Dependent Life coverage for eligible dependent children.

Gaining Other Coverage

If you or your dependents gain other **group** coverage, you have 31 days to cancel your coverage by completing an NOE and returning it to your benefits office with proof of the other coverage. To document that you have gained coverage, you must present a letter on company letterhead that includes dates of coverage, names of all individuals covered and types of coverage gained.

If you fail to cancel coverage within 31 days, you must wait until the next open enrollment period. For more details, contact your benefits administrator or EIP.

Involuntary Loss of Other Coverage

If you or your dependents are covered under another health or dental plan and you lose that coverage involuntarily because it was discontinued or the covered employee left his job, you have 31 days from the last day of coverage to enroll through EIP. To enroll, you must complete an NOE and return it to your benefits office. To document that you have lost coverage, you must attach a creditable coverage letter or a letter on company letterhead that includes dates of coverage, names of all individuals who lost coverage, the types of coverage and the reason for the loss. Dependents must be listed on the NOE to be covered. Only family members who actually lost coverage may enroll. If you fail to enroll within the 31 days, you must wait until the next open enrollment, which occurs in October of odd-numbered years, or within 31 days of a special eligibility situation.

COVERAGE OF DEPENDENT CHILDREN AGE 19 AND OLDER**Full-time Students, Ages 19-24**

You may cover your dependent children, ages 19-24, who are full-time students. They must meet these requirements:

- At the beginning of the semester, a student must be enrolled in and attending an accredited high school, vocational/trade school or college or university **full-time**, as defined by the institution he attends. He must remain a full-time student throughout the semester.
- While summer school is not required for maintaining student status, a dependent who enrolls in summer school full-time may become eligible. However, the student will lose eligibility if he does not re-enroll full-time the next semester/quarter.
- Enrollment in adult education night classes and correspondence courses is not considered full-time attendance. Internet courses from the accredited educational institution the student is attending do count toward the hours needed for him to be considered a full-time student.

If your child is not a full-time student, his coverage ends the last day of the month in which he turns 19, unless he is covered as an incapacitated dependent. Your child's eligibility for coverage also ends if he gets married.

About 90 days before your dependent's 19th birthday, you will receive a Student Certification letter. To continue coverage, complete and return this letter to your benefits administrator within 31 days of the child's 19th birthday. You must also include a statement on letterhead from the educational institution he is attending that confirms he is a full-time student as of the date of his 19th birthday and gives his dates of enrollment. Evidence of pre-registration is not adequate. If the child's 19th birthday occurs during the summer, return the Student Certification letter with the "Pending Student Certification" block marked to your BA. (Retirees of state agencies, higher education institutions and school districts should return the letter to EIP.) You must submit the letter from the institution verifying that your child is a full-time student by September 30.

If the letter is not returned by September 30, the child will lose eligibility for coverage on October 1. You will be able to add the child to your coverage, again:

- At open enrollment
- Within 31 days of the date he first becomes eligible due to a special eligibility situation
- Within 31 days of the date the child first returns to school full-time.

If your dependent, age 19-24, goes back to school full-time, you may put him back on your health coverage. Within 31 days of eligibility, submit an NOE and a statement on letterhead from the educational institution that verifies your dependent is a full-time student and gives his dates of enrollment. In this case, that would be the date he is again a full-time student.

If your 19-year-old is certified as a full-time student **while he is in high school**, you must notify your benefits administrator within 31 days of the date he leaves high school if he will not be returning to school in the fall.

When your child is covered as a full-time student, his coverage ends the last day of the month in which he graduates, is no longer a full-time student, marries or turns age 25, unless he is covered as an incapacitated dependent.

If a child does not remain a full-time student for the entire semester, his coverage ends the last day of the month in which he becomes ineligible. His 60-day COBRA notification period begins the first day of the month after he becomes ineligible.

If a child remains a full-time student through the semester and does not graduate, EIP will assume the child intends to enroll as a full-time student the next semester. If a child is not a full-time student by September 1, for the fall semester (or by February 1 for the spring semester) his 60-day COBRA notification period will begin on this date. You must notify your benefits office that the child is no longer a full-time student and submit an NOE, dropping him from your coverage. If notification is received within 60 days of when coverage would have been lost due to the event, continuation of insurance under COBRA will be offered. Otherwise, it will not be offered.

EIP conducts periodic audits of the eligibility of covered dependents ages 19-24. If your child is found to be ineligible, his coverage will be canceled, and EIP will seek repayment of any benefits paid for him while he was ineligible.

If a dependent whose eligibility is audited is a graduate of a community or technical college, a four-year college or a university and will return to school when the next term begins, you will be asked to provide EIP with a letter from the school he hopes to attend acknowledging his application or a letter of acceptance from the school he will attend.

Incapacitated Children

You can continue to cover your child, who is age 19 or older, if he is incapacitated and you are financially responsible for him. To cover your dependent child who is incapacitated, he must meet these requirements:

- The child must have been continuously covered by health insurance from the time of incapacitation.
- The child must be unmarried and must remain unmarried to continue eligibility.
- The child must be incapable of self-sustaining employment because of mental illness, retardation or physical disability and must remain principally dependent (more than 50 percent) on the covered employee, retiree, survivor or COBRA subscriber for support and maintenance.

Incapacitation must be established no earlier than 90 days before the child's 19th birthday, but no later than 31 days after the date he is no longer covered as an eligible, full-time student. An Incapacitated Child Certification Form must be completed by the subscriber and the child's physician and then sent to EIP for review. EIP will send the form to Standard Insurance Company for review of the medical information and for compliance with the Plan of Benefits. Additional medical documentation from the child's physician may be required by The Standard. The Standard will forward its recommendation to EIP, which makes the final decision.

If the child became incapacitated while enrolled as a full-time student, you must also include a letter from the school he was attending stating that he was a full-time student up to the date of incapacitation and that he is no longer a full-time student.

Also complete and attach an Authorized Representative Form signed by the incapacitated child. If applicable, you may forward a copy of guardianship papers from the probate court for your incapacitated child. Either of these documents gives EIP permission to discuss or disclose the child's protected health information with the child's Authorized Representative.

ENROLLMENT OF A TRANSFERRING EMPLOYEE

As an active employee, you are considered a transfer if you change employment from one participating group to another with no more than a 15 calendar-day break in employment or in insurance coverage.

To avoid a lapse in coverage or delays in processing claims, be sure to tell your benefits administrator that you are transferring to another participating group. **Check with the benefits administrator at your new employer to be sure that your benefits have been transferred.**

As an **academic employee**, you are considered a transfer if you complete a school term and move to another participating academic employer at the beginning of the next school term. Your insurance coverage with the employer you are leaving will remain in effect until you begin work with your new employer, typically September 1. On that date, your new employer will pick up your coverage. If you do not transfer to another participating academic employer, your coverage ends the last day of the month in which you were actively at work.

A transfer is not considered a new hire for insurance purposes. When you transfer, you must remain enrolled in all of the same insurance programs in which you were enrolled at your former employer.

LEAVE WITHOUT PAY

If you are an active employee, you may be eligible to continue your coverage for a limited time if you are on leave without pay, as long as you pay the required premiums. Please contact your benefits administrator about your insurance coverage if you are taking: educational leave, military leave, leave provided under the Family and Medical Leave Act (FMLA), leave because of a disability approved by the Workers' Compensation Benefits Program or disability leave. Leave must be approved by your employer.

WHEN YOU BECOME ELIGIBLE FOR MEDICARE

If You Are an Active Employee When You or Your Spouse Turns 65

If you are actively working and/or covered under a state health plan for active employees when you turn 65, you may delay enrollment in Part B because your insurance as an active employee remains primary. However, if you are planning to retire within three months of age 65, you should contact the Social Security Administration to learn about your Medicare enrollment options.

When you do retire, you should sign up for Part B within 31 days of retirement. Medicare will then be your primary coverage, and you need Part A and Part B for full coverage. It is strongly advised that you enroll in Medicare Part B coverage. **If you are not enrolled in Part B at retirement, you will be required to pay the portion of your healthcare costs that Part B would have paid.**



For more information
about Medicare eligibility,
see page 168.

If you are an active employee when your spouse turns 65, your spouse should enroll in Medicare Part A but may defer enrollment in Part B until you retire or leave covered employment.

Most Medicare recipients covered by health insurance offered through EIP should not sign up for Medicare Part D, the prescription drug program. Your drug expenses will continue to be covered under your health insurance.

Medicare at Age 65 When You Are Retired

The Social Security Administration should notify you or any dependents of Medicare eligibility approximately 90 days before turning 65 if you are receiving a Social Security check. If you are not notified, contact your local Social Security office immediately. If you are already receiving Social Security benefits when you turn 65, Medicare Part A and Part B will start automatically. It is strongly advised that you enroll in Medicare Part B coverage. **If you are not enrolled in Part B, you will be required to pay the portion of your healthcare costs Part B would have paid.** Even if you have not reached the age to qualify for full Social Security benefits, you should sign up for Medicare within three months of your 65th birthday.

If you are not receiving Social Security benefits when you turn 65 and you wish to wait to receive them until you reach full retirement age, you must contact the Social Security Administration to enroll in Medicare Part A. It is strongly advised that you enroll in Medicare Part B coverage. Medicare becomes your primary health insurance at age 65, regardless of whether you are receiving Social Security benefits.

Most Medicare recipients covered by health insurance offered through EIP should not sign up for Medicare Part D, the prescription drug program. Your drug expenses will continue to be covered under your health insurance.

Medicare Before Age 65

If you or your covered dependent becomes eligible for Medicare before age 65 due to disability or end-stage renal disease (ESRD), the Social Security Administration will notify you. **You must notify EIP within 31 days of Medicare eligibility.** When you notify EIP, please submit a copy of your Medicare card.

If Medicare is your primary insurance, it is strongly advised that you **enroll in Medicare Part B**, which helps cover doctors' services and outpatient hospital care. **If you are not enrolled in Part B, you will be required to pay the portion of your healthcare costs Part B would have paid.** Not enrolling in Part B may substantially increase the amount you pay.

WHEN YOUR COVERAGE ENDS

Your coverage will end:

- The last day of the month in which you were actively at work, unless you are transferring to another participating group
- The last day of the month in which you become ineligible for coverage (for example, your working hours are reduced from full-time to part-time)
- The day after your death
- The date the coverage ends for all employees or
- If you do not pay a required premium when it is due. (For example, if you are on leave without pay or on COBRA and are paying the full cost, you must make a monthly payment.)

Dependent coverage will end:

- The date your coverage ends
- The date dependent coverage is no longer offered or
- The last day of the month in which your dependent's eligibility for coverage ends.

If your coverage or your dependent's coverage ends, you may be eligible for continuation of coverage as a retiree, as a survivor or under COBRA. If you are dropping a dependent from your coverage, you must complete a Notice of Election (NOE) form within 31 days of the date the dependent is no longer eligible for coverage.

COBRA

COBRA is short for Consolidated Omnibus Budget Reconciliation Act. It requires that continuation of **group health and/or dental insurance coverage** be offered to you and/or your covered dependents if you are no longer eligible for coverage due to a qualifying event. Qualifying events include:

- The covered employee's working hours are reduced from full-time to part-time
- The covered employee voluntarily quits work, retires, is laid off or is fired (unless the firing is due to gross misconduct)
- The covered employee is separated or divorced from his spouse
- A covered child no longer qualifies as a dependent.

If you or one of your dependents become eligible for Medicare, notify EIP within 31 days of Medicare eligibility. If you do not notify EIP of your Medicare eligibility and EIP continues to pay benefits as if it were your primary insurance when EIP discovers you are eligible for Medicare, EIP will:

- Immediately begin paying benefits as if you were enrolled in Medicare
- Seek reimbursement for overpaid claims back to the date you or your dependent(s) became eligible for Medicare

For covered dependents to continue coverage under COBRA, the subscriber or a dependent must notify his benefits office **within 60 days of the qualifying event or the date coverage would have been lost due to the qualifying event**, whichever is later. Otherwise, the individual will lose his rights to COBRA coverage. To begin coverage under COBRA, a COBRA NOE and premiums must be submitted.

COBRA Coverage for former full-time students, ages 19-24

If a child does not remain a full-time student for the entire semester, his coverage ends the last day of the month in which he becomes ineligible for coverage. His 60-day COBRA notification period begins the first day of the following month.

If a child remains a full-time student through the semester and does not graduate, EIP will assume the child intends to enroll as a full-time student the next semester. If a child is not a full-time student by September 1 for the fall semester (or by February 1 for the spring semester) his 60-day COBRA notification period will begin on this date.

The premiums must be paid within 45 days of the date coverage was elected. Your first premium payment must include premiums for the month following the date you lost coverage, the month you elected coverage and the first full month of COBRA coverage.

For example: You lost coverage on June 30 and then elected coverage on August 15. You would be required to pay three premiums: one for the month following the date you lost coverage; one for the month in which you elected coverage; and one for the first full month after you elected coverage.

COBRA coverage becomes effective when the first premium is paid and remains in effect only as long as the premiums are kept up-to-date. EIP is the benefits administrator for COBRA subscribers of state agencies, higher education institutions and school districts. COBRA subscribers from local subdivisions keep the same benefits administrator.

How Medicare Affects COBRA Coverage

If you or your eligible dependent is covered by COBRA and become eligible for Medicare Part A, Part B or both, please notify the Employee Insurance Program. Your COBRA coverage will end.

A subscriber or eligible dependent who is covered by Medicare and then becomes eligible for COBRA can enroll in COBRA for secondary coverage. Medicare will be his primary coverage.

If you need more information about COBRA, contact your benefits office or EIP.

When COBRA Benefits Run Out

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) guarantees that persons who have exhausted COBRA benefits and are not eligible for coverage under another group health plan have access to health insurance coverage without being subject to a pre-existing condition exclusion period. However, certain conditions must be met. In South Carolina, the South Carolina Health Insurance Pool provides this guarantee of health insurance coverage. For information, call 803-788-0500, ext. 46401 (Greater Columbia area) or 800-868-2500, ext. 46401 (toll-free outside the Columbia area).

DEATH OF A SUBSCRIBER OR A COVERED DEPENDENT

If an active employee or a retiree of a local subdivision dies, a family member should contact the deceased's employer to report the death, to discontinue the employee's health and dental coverage and start survivor coverage for any covered dependents. If a state agency, higher education or school district retiree dies, a family member should contact EIP.

If one of your dependents dies, please contact your benefits administrator. EIP is the benefits administrator for retirees of state agencies, higher education institutions and school districts. Survivor subscribers of local subdivisions keep the same benefits administrator.

Survivors

Spouses and children who are covered as dependents under the State Health Plan or an HMO are eligible as survivors for a one-year waiver of health insurance premiums when a covered employee dies.

Premiums are also waived for qualified survivors of funded retirees of state agencies, higher education institutions and school districts. Participating local subdivisions may elect to, but are not required to, waive the premiums of survivors of retirees. Retirees of a participating local subdivision should check with their benefits administrator to see whether the waiver applies.

For a list of steps to follow when a loved one dies, see page 26.

Survivors of retirees hired as employees on or after May 2, 2008

When a retiree of a state agency, higher education institution or school district who was covered by a health plan dies, health insurance funding for his covered dependents is determined by the retiree's number of years of earned service credit.

- If the retiree had five years, but fewer than 15 years, of earned service credit, the survivor may continue coverage by paying the subscriber and the employer parts of the premium.
- If the retiree had 15 years, but fewer than 25 years, of earned service credit, the state will pay 50 percent of the full premium for the first 12 months. After that, the survivor pays both the subscriber and employer parts of the premium.
- If the retiree had 25 or more years of earned service credit, the state waives the full premium for the first 12 months. After that, the survivor pays both the subscriber and the employer parts of the premium.

If the retiree worked for a local subdivision, ask his employer for information about premiums.

After the premium has been waived for a year, a survivor must pay the employee and employer share of the premium to continue coverage. If you and your spouse are both covered employees or retirees at the time of death, your surviving spouse is not eligible for the premium waiver.

If you are a covered spouse or dependent child of a covered employee who was **killed in the line of duty** while working for a participating group, your premium will be waived for the first year after the employee's death. You must submit verification of death in the line of duty. After the one-year waiver, if you are a covered surviving spouse of a state agency or a school district employee you may continue coverage, *at the employer-funded rate*, until you remarry or otherwise become ineligible. If you are a covered surviving dependent child, you may continue coverage at the *employer-funded rate* until you are no longer eligible for coverage as a dependent. Participating local subdivisions may elect to, but are not required to, contribute to your insurance premium, but you may continue coverage, at the full rate, for as long as you are eligible.

State Dental Plan and Dental Plus premiums are not waived. However, survivors may continue dental coverage by paying the full premium.

As a surviving spouse, you can continue coverage until you remarry. If you are a dependent child, you can continue coverage until you are no longer eligible as a dependent. If you are no longer eligible for coverage as a survivor, you may be eligible to continue coverage under COBRA. Contact EIP for details.

As long as a survivor remains covered by either health or dental insurance, he can add the other during open enrollment or within 31 days of a special eligibility situation. If he drops both health and dental insurance, he is no longer eligible as a survivor and cannot re-enroll in coverage, even at open enrollment.

If a surviving spouse becomes an active employee of a participating employer, he can switch to active coverage. When he leaves active employment, he can go back to survivor coverage within 31 days, if he has not remarried.

WORKERS' COMPENSATION

Insurance offered through EIP is not meant to replace Workers' Compensation and does not affect any requirement for coverage for Workers' Compensation insurance. It is not intended to provide or duplicate benefits for work-related injuries that are within the Workers' Compensation Act. If you need more information, please contact your benefits office or EIP.

COORDINATION OF BENEFITS

Some families in which one spouse works for a participating employer and the other works for an employer that is not covered through EIP are eligible to enroll in two health plans. While the additional coverage may mean that more of your medical expenses are paid by insurance, you probably pay premiums for both plans. Weigh the advantages and disadvantages carefully before you purchase extra coverage.

Most health plans have a system to determine how claims are handled when a person is covered under more than one insurance plan. This is called "coordination of benefits" (COB). When a subscriber has coverage under more than one plan, he can file a claim for reimbursement from each plan. Third-party administrators, such as BlueCross BlueShield of South Carolina or your HMO, coordinate benefits so that you get the maximum reimbursement allowed. **That amount will never be more than 100 percent of your covered medical, dental or prescription drug expenses.**

There are rules that determine the order in which the plans pay benefits. The plan that pays first is the *primary* plan. The *secondary* plan pays after the primary plan. Here are some examples of how that works:

- The plan that covers a person as an employee is primary to the plan that covers the person as a dependent.
- When both parents cover a dependent child, the plan of the parent whose birthday comes earlier in the year is primary. Other rules may apply in special situations, such as when a child's parents are divorced.
- If you are eligible for Medicare and are covered as an active employee, your State Health Plan or HMO coverage is primary over Medicare. Exceptions may apply in the case of Medicare coverage due to kidney disease. Contact your local Social Security office for details.

For more information about how coordination of benefits works, see the section on your health plan.

PREVENTION PARTNERS

Prevention Partners, a unit of EIP, is designed to help you and your family lead healthier lives. Its activities, programs and services promote good health through disease prevention, early detection of disease and chronic disease education.

A major initiative of Prevention Partners is the Preventive Worksite Screening. This comprehensive health screening measures cholesterol levels, blood pressure, triglyceride levels, kidney function and red and white blood cell counts. These measurements indicate if an employee is at risk for developing hypertension, diabetes and anemia.

This benefit is available to active and retired employees and their covered spouses whose primary insurance coverage is the Standard Plan, the Savings Plan, BlueChoice HealthPlan or CIGNA HMO for just a \$15 copayment. The cost of the Preventive Worksite Screening does not contribute toward a subscriber's annual deductible or out-of-pocket maximum. Individuals are screened at their current or former worksite. To participate, individuals should contact their benefits administrator to find out when their worksite holds its screening.

Chronic Disease Workshops, another major program, give subscribers and their dependents information they need to help them take better care of themselves. Workshops include: Caregivers, Diabetes, Heart Disease, Asthma, Kidney Evaluation, Women's Reproductive Health, Weight Management, Medications, Men's Health, Cholesterol/Lipids and Gastrointestinal Ailments.

Information offered in the programs can be very helpful. For example, 28 people enrolled in a diabetes control program in 2006. The percentage of participants who were controlling their blood pressure increased from 51 percent to 85 percent during the program. The percentage of participants with desirable blood sugar levels increased from 33 percent to 60 percent.

Other Prevention Partners programs include:

- Spring Wellness Walk
- Lifestyle change workshops on weight loss, exercise and lowering risk factors
- Worksite program consultation
- Volunteer Worksite Prevention Partners coordinator network and conferences
- Prevention Partners training workshops

For more information on Prevention Partners, contact your benefits office, your Prevention Partners coordinator or call 888-260-9430. You also can go to the EIP Web site at www.eip.sc.gov. Then click on "Prevention Partners," which is on the left of the home page.

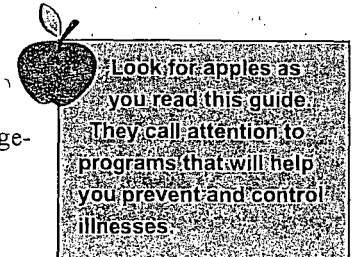
THE VISION CARE DISCOUNT PROGRAM

This program offers you discounted vision care services. Participating ophthalmologists and optometrists throughout the state have agreed to charge no more than \$60¹ for a routine, comprehensive eye examination. If you are fitted for contact lenses, you may pay more because that can require additional services. Participating providers, who include opticians, have agreed to give a 20-percent¹ discount on all eyewear except disposable contact lenses.

¹These amounts can change yearly. Contact your benefits office, provider or EIP for the current amounts.

The eye examination should include at least these tests and services:

- Complete eye and medical history review
- Visual acuity far and near, with and without glasses
- Tonometry
- Screening visual fields
- Refraction
- External motility, biomicroscopic and dilated
- Ophthalmoscopic examinations
- Initiation of diagnostic and treatment programs as necessary, including prescription of lenses, medication and other therapy, arranging for special diagnostics or treatment services, consultations, laboratory procedures or radiological services as may be indicated.



Treatment must be within the scope of the license of the provider. Consult your eye care provider for details on any of these services.

You may participate in this program if you are a full-time or part-time employee, retiree, survivor or COBRA participant. Your dependents also are eligible. You do not have to be enrolled in the State Health Plan or a health maintenance organization. It is your responsibility to show your provider some type of employment-related identification to prove you are eligible for the Vision Care Discount Program. If you do not, you may not receive the discount.

If you are covered by more than one vision care program, you can take advantage of the discounts offered under this program or the benefits offered through your other coverage, but you cannot use both at the same time.

Providers Are Available Statewide

To see the list of participating providers, go to EIP's Web site, www.eip.sc.gov. Click on "Choose Your Category" and then select your category (Active Subscribers, etc.). Next, choose "Online Directories" and then select "Vision Care." You can search for providers by county or by state. This is the most up-to-date list.

If your provider is not listed, you may wish to ask if he gives discounts through the state's Vision Care Discount Program. If your provider would like to be part of the program, he should call EIP. Although EIP lists providers who participate in the program, the state does not recommend any specific eye care provider.

If you do not have access to the Internet, ask your benefits administrator to print a copy of the list for you. You can also request one by writing to EIP at P.O. Box 11661, Columbia, SC 29211, or by calling 803-734-0678 (Greater Columbia area) or 888-260-9430 (toll-free outside the Columbia area).

No Claims to File

The Vision Care Discount Program is a discount program. You do not file claims and will not receive reimbursement for routine eye examinations or eyewear, including contacts. Active employees who have a MoneyPlu\$ Medical Spending Account or a limited-use Medical Spending Account can file a reimbursement claim with MoneyPlu\$ for vision care expenses.

If you have questions about this program, please contact your benefits office or EIP.

THE INTERNET PROVIDES EASY ACCESS TO YOUR INSURANCE INFORMATION

Like many organizations, EIP offers helpful information through the Internet. Two places to find it are *EIP Direct* and the EIP Web site.

EIP Direct is a bimonthly newsletter sent to your benefits administrator, who may send you the information or the newsletter itself. The newsletter gives you information about changes in benefits, answers questions about benefits and tells you about programs that may be of interest to you, such as Prevention Partners chronic disease workshops. *EIP Direct* can be viewed on the EIP Web site, www.eip.sc.gov. Choose "News & Updates" and then "Newsletters."

The Web site is also the place to find other ideas about how to make the best use of your insurance, as well as links to the Web sites of EIP's third-party administrators. When you go to www.eip.sc.gov, you will see a bar across the top of the home page. It has several tabs, including:

- "News and Updates" (includes a tab that takes you to "Newsletters," such as *EIP Direct* and *Avenues*)
- "FAQ" (general information, as well as questions about the Savings Plan and HSAs)
- "Links" (direct access to Web sites of companies that administer EIP programs).

When you select "Choose Your Category," which is on the left, you will see a list of the types of subscribers served by EIP. Most of you are "Active Subscribers," or employees. When you click on your category, you will receive a list of choices. They include "Eligibility," "Forms," "Online Directories" (lists of providers that are part of the plan networks) and "Rates." Click on "Publications" to see a list that includes this guide. You can use the "binoculars" search feature to help you find specific topics in the guide.

"Prevention Partners" is one of the choices listed on the left of our home page. Click on it for ways to improve your health. Under "Education," for example, you will find the Worksite Screening Guide.

"Insurance Managers" provides direct links to the Web sites of the third-party administrators. These sites give you access to your account information, including claim status, verification of authorization for inpatient and outpatient visits and Explanations of Benefits.

If you need assistance or additional information or would like to make a suggestion, click on "Contact Us" to send EIP an e-mail.

MyBenefits — EIP's Online Enrollment System

Access to your benefits information is just a click away with MyBenefits, EIP's online enrollment system. Through MyBenefits, you can update your beneficiaries and contact information and print a copy of your benefits statement anytime you have access to the Internet — 24 hours a day, seven days a week. During the enrollment period each October, you can make your own coverage changes.

The system is convenient and easy to use. To get started with MyBenefits, go to the EIP Web site, www.eip.sc.gov, and select "MyBenefits" on the left side of the screen. If you are a first-time user, you must register. The federal Health Insurance Portability and Accountability Act (HIPAA) requires that insurance programs protect the confidentiality of subscribers' health information. As part of EIP's effort to do so, you need to answer four questions and create a password when you register. After you register, you will be shown a screen listing your password and your answers to the questions. **Print the information, and keep it in a safe place.**

Information about how to use MyBenefits is offered as you work through the program. During enrollment periods, a tutorial will be available, and links to written instructions will accompany each section.

Retirees, survivors and COBRA subscribers, as well as active employees, may update their contact information and make annual and open enrollment changes using MyBenefits. However, COBRA subscribers must pay their initial COBRA premiums before they can register to use MyBenefits.

APPEALS

What If I Disagree With A Decision About Eligibility?

This section contains a summary of the eligibility rules for benefits offered through EIP. Eligibility determinations are subject to the provisions of the Plan of Benefits and state law.

If you are dissatisfied after an eligibility determination has been made, you may ask for a review by writing to EIP within 90 days of notice of the decision. If the decision is upheld by EIP, you have 30 days to seek judicial review as provided by S.C. Code Ann. 1-11-710 and 1-23-380.

CHECKLISTS: QUICK GUIDES TO YOUR BENEFITS

These lists will help you quickly locate information in the *Insurance Benefits Guide* when you find yourself in a new situation.

RETIREE CHECKLIST

Before you retire, review your benefits. You can obtain a copy of your benefits statement from MyBenefits, the online enrollment system. Go to the EIP Web site, www.eip.sc.gov, and click on the "MyBenefits" button. After you log in, click on "Review Benefits."

Eligibility

- Before you set your retirement date, check with your benefits administrator to see if you are eligible to continue your insurance. See page 161.

Funding

- Find out if your employer will pay part of your health insurance premium. See page 162.

Enrollment

- You must complete a Retiree NOE form and an Employment Verification Record within 31 days of your retirement date. See page 164.

Returning to Work

- If you plan to return to work for a participating employer after you retire, see page 166.

Benefits Choices

- **Health**—Your health plan choices as a retiree depend on whether you are eligible for Medicare. To learn what your choices are, see pages 165. For premiums, see pages 200-201.
- Notify your benefits administrator within 31 days of the date you, or a dependent you cover, become eligible for **Medicare. Enroll in Part A and Part B.** In most cases, you should **not** enroll in Part D. For details, see page 168.
- **Dental**—You are eligible for the State Dental Plan and Dental Plus. For benefits information, see page 181. For premiums, see pages 200-201.
- **MoneyPlu\$**—Your eligibility ends at retirement. For details, see page 182.
- **Long Term Care**—You can continue, or may be eligible to enroll in, Long Term Care coverage. For details, see page 182.
- **Life Insurance**—You may continue your **Basic Life, Optional Life** and **Dependent Life** insurance. For details, see page 183.
- **Long Term Disability**—Your **Basic Long Term Disability** insurance ends with retirement. You may continue **Supplemental Long Term Disability** coverage under certain circumstances. For details, see page 184.

Your Benefits Administrator in Retirement

- If you worked for a state agency, a higher education institution or a school district, EIP will become your benefits administrator.
- If you worked for a local subdivision, your benefits administrator will remain the same.

SURVIVOR CHECKLIST

It is never easy when a loved one dies. We hope this list will help you during a difficult time.

Contacts

If the deceased was a retiree of a state agency, higher education institution or school district, or one of their covered dependents:

- Notify EIP.

If the deceased was an active employee, a retiree of a local subdivision or one of their covered dependents:

- Notify the subscriber's employer.

When Coverage Ends for the Deceased

- If the deceased was enrolled in health, dental, Long Term Care and/or Long Term Disability coverage, this coverage ends the day after death.

Health and Dental Insurance

Please read the "Survivors" section, beginning on page 19.

- Spouses or children who were covered as dependents under the State Health Plan or an HMO can continue coverage as survivors. They may also be eligible for a one-year waiver of health insurance premiums.
- Survivors may continue dental coverage, but the premium is not waived.

Life Insurance

A certified, raised-seal death certificate is needed to apply for benefits from The Hartford. See page 102.

- Basic Life insurance, \$3,000, is provided to all full-time, active employees enrolled in a health insurance program. See page 93.
- If the deceased was covered by Optional Life insurance, see page 99.
- If the deceased was covered by Dependent Life insurance, see page 107.
- The Beneficiary Assist® Program is free and available to beneficiaries of Basic, Optional and Dependent Life policies. See page 109.
- If the deceased was retired and his last employer before retirement participates in the Retiree Group Life Insurance program, he may be eligible for a benefit based on his retirement-credited service in the S.C. Retirement Systems (SCRS). Contact SCRS for more information.

Supplemental Long Term Disability Insurance

- If the deceased was receiving Supplemental Long Term Disability benefits provided by The Standard, survivor benefits may be payable to the eligible survivor in a lump-sum payment. See page 125.

Long Term Care Insurance

- If the deceased was enrolled in Long Term Care (LTC), his beneficiary may receive a refund of a portion of the premiums paid based on the deceased's age and decreased by any benefits paid under the plan. For information, contact his LTC insurance provider.

MoneyPlu\$

- If the deceased had a MoneyPlu\$ Health Savings Account, contact NBSC about settling the account. See Article VII of the HSA Custodial Agreement, which is on pages 222-228 and on the EIP Web site under "Publications."
- Medical Spending Accounts (MSAs) and Dependent Care Spending Accounts (DCSAs) end on the date the employee died. See page 157.

Health Insurance

Health Insurance

Table of Contents

The State Health Plan	30
Benefits at a Glance.....	31
How the Standard Plan Works	32
How the Savings Plan Works	33
Lifetime Maximum	34
Coordination of Benefits	34
Subrogation.....	35
Using SHP Provider Networks.....	35
BlueCard® and BlueCard Worldwide®	36
Out-of-Network Benefits for Medical Care	37
Out-of-Network Differential	38
Managing Your Medical Care	39
Medi-Call	39
Maternity Management	40
Health Management Program	41
Wellness Management	41
Medical Case Management	41
Online Health Tools	43
State Health Plan Benefits	44
Preventive Benefits	50
Well Child Care Benefits.....	51
Natural Blue SM and Other Discount Programs	52
Additional Benefits for Savings Plan Participants	53
Prescription Drug Benefits	53
Prescription Drugs	53
Retail Pharmacy	56
Mail-Order Pharmacy.....	56
Coordination of Benefits	57
Exclusions	57
Mental Health and Substance Abuse Benefits	57
Exclusions	58
Web Site: www.SouthCarolinaBlues.com	60
Appeals.....	61
Health Maintenance Organizations.....	62
What Are My Choices?	62
HMO Service Areas.....	62
BlueChoice HealthPlan.....	63
Benefits at a Glance.....	63
Primary Care Physician	64
Network Benefits	64
Covered Services	65
Exclusions and Limitations	70

Other Plan Features	72
Web Site: www.BlueChoiceSC.com	73
Appeals	73
CIGNA HMO	75
Network Benefits	75
Out-of-Network Benefits	76
Exclusions	76
Special Features of the CIGNA Plan	78
Lifestyle Management Programs	78
Claims	78
Web Site: www.myCIGNA.com	78
Appeals	78

Introduction

What Are My Health Plan Choices?

Your health plan choices include the State Health Plan (the Standard Plan, the Savings Plan and, if you are enrolled in Medicare, the Medicare Supplemental Plan) and two Health Maintenance Organizations (BlueChoice® HealthPlan and CIGNA HMO).

All health plans offered through the Employee Insurance Program (EIP) are self-insured. EIP does not pay premiums to an insurance company. Subscribers' monthly premiums and employers' contributions are placed in a trust account maintained by the state. This account is used to pay claims and administrative expenses. Administrative expenses comprise only about 4 percent of the total program spending.

To learn about eligibility, enrollment and other features that are common to all health plans offered through EIP, see the General Information chapter, which begins on page 7.

CaringBridge®: Communication in a Crisis

CaringBridge® offers free, personalized Web sites that 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 and follow the directions. Creating a site does not require any technical expertise. Tell your family and friends about your site so they can keep up-to-date.



If you are an active or a retired employee and the Standard Plan, the Savings Plan or one of the HMOs is your primary coverage, you and your covered spouse may participate yearly in a Prevention Partners worksite screening. For \$15, you will receive a comprehensive health appraisal that includes a blood test and an evaluation of your risk factors. Ask your benefits administrator when a screening is scheduled.

The State Health Plan

The State Health Plan (SHP) offers active employees the **Standard Plan** and the **Savings Plan**. 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 buy prescription drugs for the copayment.

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. Another advantage is that because the Savings Plan is a tax-qualified, high deductible health plan, you may establish a **Health Savings Account (HSA)** if you have *no other health coverage, including Medicare*, unless it is another high deductible health plan, and you cannot be claimed as a dependent on another person's tax return. Funds in an HSA may be used to pay qualified medical expenses now and in the future.

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

BENEFITS AT A GLANCE

This brief overview of your medical plan is for comparison only. The Plan of Benefits 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
Physician Office Visit ³	\$10	None
Coinsurance (after deductible is met):		
Network	20% You Pay 80% Insurance Pays	20% You Pay 80% Insurance Pays
Out-of-network ⁴	40% You Pay 60% Insurance Pays	40% You Pay 60% Insurance 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 Year⁴	No Annual Deductible	Prescription Drugs You must use participating pharmacies. You pay the full allowable charge for prescription drugs, and the cost is applied to your annual deductible. 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. You pay the remaining 20% coinsurance. Drug costs are applied to your plan's in-network coinsurance maximum: \$2,000 – individual; \$4,000 – family. After the coinsurance maximum is met, the plan pays 100% of allowable charges.
Retail Copayments for up to a 31-day supply (Participating pharmacies only)⁴	\$10 Tier 1 (Generic – lowest cost) \$25 Tier 2 (Brand – higher cost) \$40 Tier 3 (Brand – highest cost)	
Mail Order and Retail Maintenance Network Copayments for up to a 90-day supply⁴	\$25 Tier 1 (Generic – lowest cost) \$62 Tier 2 (Brand – higher cost) \$100 Tier 3 (Brand – highest cost)	
Prescription Drug Copayment Maximum⁴	\$2,500 per person (applies to prescription drugs only)	
Tax-favored Medical Accounts	Medical Spending Account	Health Savings Account Limited-use Medical Spending Account

¹Waived if admitted.

²Waived for dialysis, routine mammograms, routine Pap tests, clinic visits, emergency room, oncology, electro-convulsive therapy, and psychiatric medication management.

³Waived for routine Pap smear, routine mammograms and well child care.

⁴Mental health and substance abuse services and prescription drugs are not covered out of network.

How SHP Benefits are Paid

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 Health Solutions, Inc., to process prescription drug claims. Subscribers share the cost of their covered benefits by paying deductibles, coinsurance and copayments for covered services.

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 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' 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. However, if only one person has met the \$350 individual deductible, only he will begin receiving benefits. No 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 family deductible, both 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 Deductibles

A per-occurrence deductible is the amount you must pay before the Standard Plan begins to pay benefits for services in a professional provider's office, emergency room care or outpatient hospital services. You continue to pay per-occurrence deductibles even after you meet your annual deductible and reach your coinsurance maximum. Per-occurrence deductibles do not apply to your annual deductible or to your coinsurance maximum.

The per-occurrence 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 Standard Plan allowed \$56 for a physician's visit, you would first pay the \$10 per-occurrence deductible.

- If you *have not* met your annual deductible, the remaining \$46 would apply toward your annual deductible (you owe \$56).
- If you *have* met your annual deductible, the Standard Plan would pay 80 percent of the \$46, or \$36.80, and you would be responsible for the remaining \$9.20, as well as for your \$10 per-occurrence deductible (you owe \$19.20).

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 and psychiatric medication management.

Coinsurance

After your annual deductible has been met, the Standard Plan pays 80 percent of your covered medical, mental health and substance abuse covered 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 of the billed charges 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.

If you use a provider outside the State Health Plan 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. **Prescription drugs and mental health and substance abuse benefits are paid only if you use a network provider.**

A different coinsurance rate applies for infertility treatments and prescription drugs associated with infertility. See pages 46-47.



How are you affected if your provider is not in the network? For information on providers who are not in the network and the out-of-network differential, see page 38.

Coinsurance Maximum (Out-of-pocket Limit)

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 and 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 covered 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 a 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.

If you use non-network providers, the plan pays 60 percent of your covered expenses. You pay the remaining 40 percent as coinsurance, and 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 38 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 pages 46-47.

Coinsurance Maximum (Out-of-pocket Limit)

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 or \$8,000 for family coverage for non-network services. The Savings Plan will then pay 100 percent of the allowable charges. Your payments for non-covered services, annual deductibles and 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 21.

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

On your Notice of Election (NOE) form, you are asked if you are covered by more than one group insurance plan. Your response is recorded and placed in your file. However, the third-party administrator, BlueCross BlueShield of South Carolina (BCBSSC), may ask you this question every year, by sending you a questionnaire. **Please complete this form and return it to BCBSSC promptly, since claims will not be processed or paid until your information is received.** You can also update this information by calling BCBSSC or by visiting www.SouthCarolinaBlues.com.

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 deductible, if it has not been satisfied, and for your coinsurance.
- For a medical claim, you or your provider must file the Explanation of Benefits from your primary plan directly with BCBSSC.
- For mental health and substance abuse benefits, you must file the Explanation 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 payment of any secondary benefits. Prescription drug claim forms are available on the EIP Web site, www.eip.sc.gov. Choose your category, and then click on "Forms." You may also ask your benefits administrator for 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 payment 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 a covered person receives payment for such medical expenses from another who 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)*. As such, it has networks of physicians, hospitals, ambulatory surgical centers and mammography testing centers. There are also networks available to subscribers for durable medical equipment, labs, radiology and X-ray, physical therapy, occupational therapy, speech therapy, skilled nursing facilities, long term acute care facilities, hospices and dialysis centers. They 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 when the services are provided. They will also file your claims.**

If you use an out-of-network medical provider or your physician sends your laboratory tests to an out-of-network provider, your costs will increase. This applies to your medical benefits. 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

Paper copies of the SHP provider directory are no longer distributed. There are two ways to view the online directory. On EIP's Web site, www.eip.sc.gov, choose your category and then select "Online Directories." Click on "State Health Plan Doctor/Hospital Finder." You may also go directly to the BCBSSC Web site, www.SouthCarolinaBlues.com. At the site:

- Under "Find a Doctor Or Other Healthcare Provider," choose "South Carolina."
- Choose "Blue Cross and Blue Shield" as the directory. Check to show whether you want to look for a

- provider by "Location" or by "Name." Then select a "Healthcare Professional Type" from the menu.
- A menu will enable you to select a city or county, a health plan (State Health Plan) and a specialty.

If you do not have access to the Internet, call BCBSSC at 803-736-1576 (Greater Columbia area) or 800-868-2520 (toll-free outside the Columbia area) to request that a list of SHP providers in your area be mailed to you.

BLUECARD® AND 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 Blue Cross Blue Shield provider networks. If you need mental health or substance abuse care outside South Carolina, call APS Healthcare at 800-221-8699.

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 State Health Plan 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 within 48 hours of receiving emergency care.** The toll-free number is on your State Health Plan ID card.
5. When you arrive at the participating doctor's office or hospital, show your identification 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.
6. The provider should file claims with the Blue Cross Blue Shield affiliate in the state where the services were provided.

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 EOB by BCBSSC.

Outside the U.S.

Through the BlueCard Worldwide program, your SHP ID card gives you access to doctors and hospitals in more than 200 countries and territories worldwide and to a broad range of medical services.

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

1. Always carry your 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 SHP benefits and for preauthorization, 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 SHP 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, deductibles, copayments, 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, pay the provider when 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 itemized bill(s) to the BlueCard Worldwide Service Center. The claim form is available online at www.BCBS.com. Type "BlueCard claim form" in the "Search" box. You may also call the BlueCard Worldwide Service Center toll-free at 800-810-2583 or collect at 804-673-1177. 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

Because the State Health Plan 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. Sign in and click on "Locate a pharmacy."
- Mental health and substance abuse providers include: physicians, psychiatrists, health professionals or institutional care providers under agreement to participate in the network administered by APS Healthcare. To see the list, go to the APS Healthcare, Inc., Web site at www.apshealthcare.com. Click on "Information for Members." 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 preauthorization.

For more information on your prescription drug benefits, see page 53. For more information on your mental health and substance abuse benefits, see page 57.

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 APS.

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 preauthorized.

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 allowable charges:

- **Standard Plan and Savings Plan** subscribers must pay a \$4,000 individual coinsurance maximum for out-of-network services and an \$8,000 family coinsurance maximum for out-of-network services.

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

Balance Billing

If you use a provider who is not part of the network, 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 toward meeting your annual deductible or 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 BlueCard network, you will pay 40 percent, instead of the usual 20 percent, in coinsurance. These examples show how it will 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 2009	-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 Standard Plan deductible
		\$2,810	Your out-of-pocket costs 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 2009	- 600	Savings Plan pays
\$1,000	Savings Plan responsibility	400	You pay as coinsurance
x 60%	Savings Plan coinsurance	1,000	Your balance bill from provider
\$ 600	Savings Plan pays	+3,000	Your Savings Plan deductible
		\$4,400	Your out-of-pocket costs for the services of a non-network provider

MANAGING YOUR MEDICAL CARE

MEDI-CALL

Some services provided under the State Health Plan require preauthorization 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 see that the call is made.

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 healthcare options and services required to meet an individual's needs. 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 U.S. or Canada:

- You need **any type** of inpatient care in a hospital¹
- Your preauthorized 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 sclerotherapy performed in an inpatient, outpatient or office setting
- You need an MRA, MRI, PET or CT Scan
- You will receive 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 notify MediCall within the first three months of your pregnancy.**)
- You have an emergency admission during pregnancy²
- Your baby is born²
- 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, GIFT, ZIFT 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 preauthorization request for any procedure that may potentially be considered cosmetic in nature must be received in writing by Medi-Cal seven days before surgery. (Procedures in this category include: blepharoplasty, reduction mammoplasty, augmentation mammoplasty, mastopexy, TMJ or other jaw surgery, panniculectomy, abdominoplasty, rhinoplasty or other nose surgery, etc.) Your physician should include photographs if appropriate.

Whether you are enrolled in the Standard Plan or the Savings Plan, you are required to use Medi-Cal.

¹For mental health or substance abuse services, you must call APS Healthcare at 800-221-8699 for preauthorization before a non-emergency admission or within 24 hours of an emergency admission.

²Contacting Medi-Cal 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-Cal 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 BlueCross BlueShield of South Carolina makes payment. Remember, if you choose a non-network provider, your financial responsibility will be greater.

Are There Penalties for Not Calling?

Yes. If you do not call Medi-Cal when required, you will pay a \$200 penalty for **each** hospital or skilled nursing facility **admission**. In addition, the coinsurance maximum will not apply. You will continue to pay your coinsurance, no matter how much you pay out-of-pocket. If you do not obtain preauthorization 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 keep you and your baby healthy. If you are a mother-to-be, **you must participate in the Maternity Management Program**. Medi-Cal administers EIP's comprehensive maternity management program, "Coming Attractions." The program monitors expectant mothers throughout pregnancy and manages Neonatal Intensive Care Unit (NICU) infants or other babies with special needs until they are 1 year old. **To preauthorize your pregnancy benefits, you must notify Medi-Cal during the first trimester (three months) of your pregnancy.** You do not have to wait until you have seen your physician.

While you can call Medi-Cal, you can also notify Medi-Cal of your pregnancy and enroll in "Coming Attractions" online through the Personal Health Record's maternity screening program. Go to www.SouthCarolinaBlues.com and log into My Health Toolkit. Then select Personal Health Record.

If you do not notify Medi-Cal 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-Cal preauthorization penalty and there will not be a \$2,000 limit on the amount of coinsurance you must pay.

Participating in the Maternity Management Program or contacting Medi-Cal about the birth of your baby does not add your baby to your health insurance. Even if you have Full-Family or Employee/Children coverage, you must add the baby to your policy by completing an NOE within 31 days of his birth.

You are automatically enrolled in "Coming Attractions" when you preauthorize your pregnancy benefit through Medi-Cal. As a participant in the program, you will receive a phone call from a Medi-Cal nurse and a packet of information, including a copy of *Caring for Tomorrow's Children – Having a Healthy Baby*.

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.

If you enroll in the program through the Personal Health Record, you can use the online system to correspond with your case manager and receive articles of interest from recognized medical sources.

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

HEALTH MANAGEMENT PROGRAM

Managing a chronic condition can be difficult. However, studies show you can help control your symptoms by making lifestyle changes and by following your doctor's advice. You can also delay, or even prevent, many of the complications of the disease.

The Health Management Program is designed for Standard Plan and Savings Plan subscribers and their covered family members who have diabetes, heart disease or chronic respiratory conditions. BCBSSC selects participants by reviewing medical, pharmacy and laboratory claims. If you are identified as someone who could benefit from it, you are automatically enrolled. You may, however, opt out of the program.

As a participant, you will receive a welcome letter that includes the name of and contact information for your BlueCross health coach. Your coach will be a registered nurse who will help you learn more about your condition and how to manage it. He or she will also help you work with your physician to develop a plan to take charge of your illness, contacting you by phone or through the online Personal Health Record. You can contact your health coach as often as you like with questions or to ask for advice. For more information, call 803-264-3100 (Greater Columbia area) or 800-334-7287 (toll-free outside the Columbia area).

About Your Privacy

In compliance with federal law, your health information will always be kept confidential. Your employer does not receive the results of any surveys you complete. Enrolling will not affect your health benefits now or in the future.

WELLNESS MANAGEMENT

Weight Management Program

The BlueCross Weight Management program is designed to help you achieve weight-loss goals through small changes you can make while still getting on with your life. Food Awareness Training and realistic goal setting are key parts of this program. 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 at 803-699-3337 (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 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 State Health Plan. 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. They do 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, and all recognize that, ultimately, decisions about your care are between you and your physician. 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. For more information on any of these programs, call 800-925-9724 and ask to be transferred to the case management supervisor.

BlueCross Medi-Call Case Management Program

This case management program is designed for State Health Plan enrollees who have specific catastrophic or chronic disorders, acute illnesses or serious injuries. The program facilitates continuity of care and support of these patients while managing health plan benefits in a way that promotes high-quality, cost-effective outcomes.

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 long-term. Case managers combine standard preauthorization 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. Your Medi-Call nurse case manager may visit you at home, with your permission, or in a treatment facility or your physician's office when the treatment team determines it is appropriate.

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

Alere Complex Care Management Program

Some enrollees are referred to Alere 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 illness or injury, 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 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 transportation and lodging for out-of-town 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 is voluntary. You can leave the program at any time, for any reason. Your benefits will not be affected by your participation.

Here is how the program works: BlueCross BlueShield of South Carolina will refer you to Alere if the program may benefit you. You will receive a letter explaining the program, and an Alere 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.

An Alere team 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 Alere team.) Your local care coordinator nurse will be your main contact. You and your doctor, however, will always make the final decision about your treatment. Complex care management does not replace your doctor's care. Always check with your doctor before following any medical advice.

A Medi-Call nurse will act as a liaison with the Alere nurse. This Medi-Call nurse provides information about benefits and networks and completes authorization for medically necessary services that are covered by the plan.

VillageHealth Disease Management Renal Case Management Program

VillageHealth Disease Management provides renal disease management care for select State Health Plan 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: subscribers with ESRD are referred to VillageHealth by BCBSSC. A South Carolina-based VillageHealth 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 VillageHealth nurse may visit you at 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 be the liaison with the VillageHealth 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.

ONLINE HEALTH TOOLS



Personal Health Record

Your Personal Health Record, which is available on the BCBSSC Web site, is safe and secure. Through it, you have access to your health information, including a list of your claims and the prescription drugs you are taking, 24 hours a day, seven days a week. If you participate in the Health Management Program, your health coach can use it to send you messages, assign tasks and provide you with additional information about your condition. To review your record, go to www.SouthCarolinaBlues.com and log into "My Health Toolkit."

Personal Health Assessment

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

Provider Report Card

BlueCross BlueShield of South Carolina gives you access to a Provider Report Card through its Web site, www.SouthCarolinaBlues.com. With this tool, you can compare hospitals in the same part of the state to determine the number of patients treated, complication rates and how long patients usually stay in the hospital. This information can help you choose a hospital.

Medical Cost Estimator

The cost estimator is available on the BCBSSC Web site, www.SouthCarolinaBlues.com. It can help you determine the cost of a medical service or procedure. This can be useful in budgeting and planning for the cost of certain health conditions. The estimator provides a cost range for an illness, breaks the 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 Medical Spending Account or a Health Savings Account.

STATE HEALTH PLAN BENEFITS

The Standard Plan and the Savings Plan pay benefits for *medically necessary* treatments of illnesses and injuries. This section is a general description of the plan. The *Plan of Benefits* 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 preauthorization by Medi-Call or APS Healthcare. Be sure to read the Medi-Call section beginning on page 39 and the mental health and substance abuse section on page 57 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 provided and
- 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, nonemergency 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.



The Standard Plan has per-occurrence deductibles for some services. See page 32 for details.

Autism Spectrum Disorder Benefits

Effective with the 2009 plan year, Applied Behavior Analysis (ABA) for children diagnosed with an Autism Spectrum Disorder at age 8 or younger will be covered, subject to APS guidelines and preauthorization requirements, for up to a maximum of \$50,000 per plan year. A child must be younger than 16 years of age to receive benefits. All services must be approved by APS Healthcare and performed by an in-network ABA provider.

Chiropractic Care

You are covered for specific office-based services from a chiropractor, including detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference and the effects of such nerve interference, where such interference is the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column. Diagnostic X-rays are covered if medically necessary.

Colonoscopies



Routine colonoscopies are covered once every ten years, starting at age 50, even when no symptoms are apparent. The plan also covers diagnostic colonoscopies. All colonoscopies are subject to the plan's deductibles and coinsurance.

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.

Cranial Remodeling Band or Helmet

The plan covers the use of a cranial remodeling band when preauthorization review determines it to be medically necessary for the correction of a child's moderate to severe positional head deformities associated with premature birth, restrictive intrauterine positioning, cervical abnormalities, birth trauma, torticollis or sleeping positions. Remodeling must be initiated between 4 and 12 months of age, following a failed two-month trial of conservative treatment (e.g., repositioning, neck exercises, etc.).

Diabetic Supplies

Insulin is allowed under the prescription drug program or under the medical plan but not under both. (Insulin 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. Claims for diabetic durable medical equipment should be filed with BCBSSC.

Doctor Visits

Treatments or consultations for an injury or illness are covered, when 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 preauthorized by APS Healthcare. For details on mental health and substance abuse services, see page 57.

Durable Medical Equipment (DME)

Generally, DME must be preauthorized 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 nontherapeutic use or a potentially non-therapeutic 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 State Health Plan 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 immediate 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.

The State Health Plan only recognizes certified nurse midwives as providers for purposes of midwife coverage. A certified nurse midwife (CNM) is an advance-practice registered nurse who is licensed by the State Board of Nursing as a midwife. Lay midwives and certified midwives licensed only by the S.C. Dept. of Health and Environmental Control (DHEC) are not reimbursed.

For more information about Medi-Call, see page 39. You may contact Medi-Call at 803-699-3337 (Greater Columbia area) or 800-925-9724 (South Carolina, nationwide and Canada).

Home Healthcare

Home healthcare includes 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 preauthorized 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 preauthorized by Medi-Call.

Infertility

The plan will pay benefits for the diagnosis and treatment of infertility for enrollees for whom infertility is not a result of a prior tubal ligation or a vasectomy.

The benefits are limited to a lifetime maximum payment of \$15,000 for any covered medical expenses and covered prescription drug expenses incurred by the subscriber or the covered spouse whether covered as a dependent or as an employee. Included in the \$15,000 maximum are diagnostic tests, prescription drugs and up to six cycles of Intrauterine Insemination (IUI) and/or a maximum of three completed cycles of zygote or gamete intrafallopian transfer (ZIFT or GIFT) or in vitro fertilization (IVF) per lifetime. A cycle reflects the cyclic changes of fertility with the cycle beginning with each new insemination or assisted reproductive technology (ART) transfer or implantation attempt. ART procedures not specifically mentioned are not covered, including but not limited to: tubal embryo transfer (TET), pronuclear stage tubal embryo transfer (PROUST) oocyte donation and intracytoplasmic sperm injection (ICSI).

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 preauthorized 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 39).**

Organ Transplants

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

All transplant services must be approved by Medi-Call (see page 39). You must call Medi-Call, even before you or a covered family member is evaluated for a transplant.

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

For more information about the Standard Plan's per-occurrence deductibles, see page 32.

For more information about balance billing, see page 37.

If you are covered under the Standard Plan and you receive your outpatient services at a hospital, you will be charged a \$75 outpatient per-occurrence deductible. You will be charged a \$125 per-occurrence deductible for emergency room services. Per-occurrence deductibles do not apply to your annual deductible or your coinsurance maximum. The per-occurrence deductible for emergency room services is waived if you are admitted to the hospital.

Pregnancy and Pediatric Care

Pregnancy benefits are provided to covered female employees or retirees and to covered 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 40 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 they 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 46 for more information.

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

Reconstructive Surgery After a Medically Necessary 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 postmastectomy cases. All services must be approved by Medi-Call.

Rehabilitation Care

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

- Preauthorization 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 Opinions

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

Speech Therapy

The plan covers short-term speech therapy to restore speech or swallowing function that has been lost as a result of disease, trauma, injury or congenital defect (e.g., cleft lip or cleft palate). Speech therapy must be prescribed by a physician and provided by a licensed speech therapist.

Speech therapy requires preauthorization when provided in an inpatient setting or in a home setting. However, claims for speech therapy that are not preauthorized 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, BlueCross BlueShield of South Carolina 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 (part-time/intermittent)
- 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.

Extended care is covered 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 Prevention Partners programs. 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.

- When you are between the ages 35 and 39, one baseline mammogram (four-view) will be covered.
- If you are age 40 through 74, one routine mammogram (four-view) will be covered every 365 days.

Charges for routine mammograms performed at nonparticipating 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.

A doctor's order is not required for a routine mammogram. However, most centers ask for one, so it is recommended that you get one.

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

For women, age 40 and older, covered as retirees and enrolled in Medicare, Medicare pays for one screening mammogram every 12 months. The State Health Plan 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. This benefit includes payment for an appropriate-level office visit associated with the Pap test.

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 18 are eligible for Well Child Care check-ups.

How Does it Work?

This benefit covers regular doctor visits and timely immunizations. When services are received from a doctor in the State Health Plan Physician Network, benefits will be paid at 100 percent. **Benefits will not be paid for services from non-network providers.** Some services may not be considered part of 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 deductibles and coinsurance, as would any other medical expense.

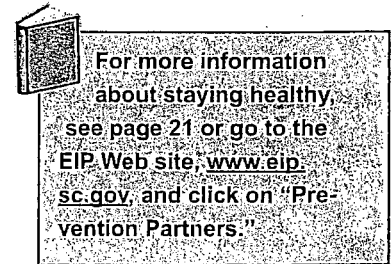
Checkups

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 18 years old — one visit a year.

Immunizations

This schedule shows routine immunizations for which the plan pays 100 percent when a network doctor provides the services. To ensure that the immunization will be covered, the child must have reached the age at which the schedule says the immunization should be given.



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 State Health Plan 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 child has not had it 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 child has not had one 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 child has not already had second dose
Chickenpox	12-18 months 11-12 years if child has not already had disease or vaccine
Influenza	Yearly for children ages 6 months-18 years
Meningococcal	11-12 years
Hepatitis A	12-23 months
Human Papillomavirus (HPV)	11-12 years for females

NATURAL BLUEsm AND OTHER DISCOUNT PROGRAMS

Natural Bluesm is a discount program available to State Health Plan subscribers and offered by BCBSSC. 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 Bluesm also offers discounts on health products, such as vitamins, herbal supplements, books and tapes.

Value Added programs are discounts on products and services that BCBSSC 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.

Members may use their Medical Spending Account (MSA) funds tax free for LASIK, contacts, eyeglasses, hearing aids and many other services. For a complete list of qualified medical expenses for MSAs or Health Savings Accounts, go to www.irs.gov/publications/p502.

For more information on Natural Blue or Value Added, log on to the BCBSSC Web site at www.SouthCarolinaBlues.com. Under "Looking for...", select "Discounts & Added Values."

ADDITIONAL BENEFITS FOR SAVINGS PLAN PARTICIPANTS

As a participant in the Savings Plan, you are taking greater responsibility for your healthcare. 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. Subscribers also have access to Healthline Audiotape Library, which includes more than 400 topics. 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 a self-care handbook, *Health at Home®—Your Complete Guide to Symptoms, Solutions & Self-Care*, and a subscription to the monthly *HealthyLife Wellness Newsletter*.

Physical Exam

Savings Plan participants age 19 and older may receive an annual physical from a network provider 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 lab, 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 drugs associated with infertility treatments have a different coinsurance rate. Please refer to page 46 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 Tier 1 (generic – lowest cost), \$25 for Tier 2 (brand – higher cost) or \$40 for Tier 3 (brand – highest cost) 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 a covered expense in addition to what the insurance plan pays. There are no individual exceptions made to the copayment established for a particular prescription drug.

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 charges for the rest of the year.

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

Savings Plan

With this plan, 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. There is no copayment.

This cost is transmitted electronically to BCBSSC. 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 www.medco.com, log in and select "My Rx Choices." You can search for the medications you take, learn what you will pay for them and find out 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 (Tier 1 – Lowest Cost)

Under both plans, prescription drug choices are divided into three categories: Tier 1 (generic – lowest cost), Tier 2 (brand – higher cost) and Tier 3 (brand – highest cost).

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 an equivalent generic drug is 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 between the allowable charge for the brand name and the generic drug. If the total amount is less than the Tier 2 or Tier 3 (brand-name) 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 Tier 2 or Tier 3 (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 Tier 2 or Tier 3 (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.

Tier 2 (Brand – Higher Cost)

These are medications that Medco's Pharmacy and Therapeutics Committee has determined to be safe, effective and available at a lower cost than Tier 3 brand drugs. This list may be updated throughout the year. It is available online at www.medco.com. You may reach the Medco Web site through the EIP Web site by clicking on "Links."

Tier 3 (Brand – Highest Cost)

These medications carry a higher copayment or higher price. Tier 3 contains medication that may be considered preferred or nonpreferred on the formulary, the list of prescription drugs approved by your plan. There are no individual exceptions made to the copayment established for a particular prescription drug.

Compound Prescriptions

A compound prescription is a medication that requires a pharmacist to mix two or more drugs, based on a doctor's prescription, when such a medication is not available from a manufacturer. It is handled the same way any prescription is handled and must be purchased from a participating pharmacy.

Be sure to select a participating pharmacy that will file your compound prescription claim. If the pharmacy does not file for you, you must pay the entire cost of the prescription and then submit a claim to Medco. Information on how to file a claim to Medco is on page 213. Claims must be accompanied by an itemized list of the ingredients for you to be reimbursed. Ask your pharmacist to provide you with this list when you fill your prescription. Please be sure it includes:

- The name of each ingredient
- The valid National Drug Code (NDC) for each ingredient
- The quantity of each ingredient.

This information allows Medco to process your claim based on the actual ingredients in your medication.

When you file your own claim, your reimbursement may be less than what you paid for the drug because it will be limited to the plan's allowable charge minus the copayment for the actual ingredients in the compound prescription.

Some compound medications may be available through Medco by Mail. Please contact Medco to see if they are available before ordering.

Preauthorization

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 preauthorized, 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 health plan identification card when purchasing medications. The State Health Plan 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 list of network pharmacies 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, choose your category and select "Online Directories." 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. Some controlled substances may not be available by mail. Please call Medco customer service before submitting your prescription.

Please be sure your physician writes your prescription for a 90-day supply. If it is written for a 31-day supply, you will be charged for a 90-day supply but will be sent a 31-day supply. If you have any questions before you order a 90-day supply of a drug, call Medco at 800-771-3450.

Standard Plan

The copayments for up to a 90-day supply are: Tier 1 (generic) – \$25, Tier 2 (brand) – \$62, and Tier 3 (brand) – \$100. There are no individual exceptions made to the copayment established for a particular prescription drug.

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

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 pages 21 and 34 for more information.

EXCLUSIONS

Some prescription drugs are not covered under the plan. See pages 48 and 54 for more information.

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

For Preauthorization – 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 preauthorized by APS Healthcare to be covered.

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

- When you need care inside or outside South Carolina, call APS Healthcare, Inc., the behavioral health manager, at 800-221-8699 to receive preauthorization 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 APS Healthcare.
- If you need inpatient care, you must call APS Healthcare for preauthorization 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 "Information for Members." Then select "State of South Carolina" from the drop down list under "EMPLOYERS." Click on "Online Provider Locator." At the user login, enter the State Health Plan'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 APS customer service.

No Claims to File

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 provider who is not a member of the network. 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 covered 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 free nicotine replacement products (patches, gum or lozenges) if appropriate. Your Quit Coach may also recommend your doctor prescribe a smoking cessation drug, such as bupropion or Chantix, which are available through your prescription drug coverage. 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 1-866-QUIT-4-LIFE (1-866-784-8454). 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. Go to the APS Web site. Follow the instructions above that you use to get to the "Provider Locator," and then click on the "Access APShelpLink" button. Enter the State Health Plan's "Company Code," which is "statesc."

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* (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, except for those specifically listed under the Preventive Benefits section
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 Benefits according to guidelines), services, surgery (including cosmetic surgery) or supplies that are not medically necessary. (Please note: The Savings Plan covers an annual physical by a network physician for each participant age 19 and older)
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. Dental services, except for removing impacted teeth or treatment within one year of a condition resulting from an accident
11. TMJ splints, braces, guards, etc. (Medically necessary surgery for TMJ is covered if preauthorized by Medi-Call.) TMJ, temporo mandibular joint syndrome, is often characterized by headache, facial pain and jaw tenderness caused by irregularities in the way joints, ligaments and muscles in the jaws work together
12. Custodial care, including sitters and companions or homemakers/caretakers
13. Over-the-counter medicine and contraceptive devices
14. Services related to a vasectomy or tubal ligation performed within one year of enrollment
15. Surgery to reverse a vasectomy or tubal ligation
16. Treatment for infertility resulting from a previous tubal ligation or vasectomy
17. Assisted reproductive technologies (fertility treatment) except as noted on page 46 of this chapter
18. Diet treatments 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
19. Equipment that has a nontherapeutic 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 or prescribed by a physician
20. Air quality or mold tests
21. Supplies used for participation in athletics (that are not necessary for activities of daily living), including but not limited to, splints or braces
22. Physician charges for medicine, drugs, appliances, supplies, blood and blood derivatives, unless approved by Medi-Call
23. Medical care by a doctor on the same 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
24. Physician's charges for clinical pathology, defined as services for reading any machine-generated reports or mechanical laboratory tests. Interpretation of these tests is included in the allowance for the lab service
25. Fees for medical records and claims filing
26. Food supplements, including but not limited to formula, enteral nutrition, Boost/Ensure or related supplements
27. Services performed by members of the insured's immediate family
28. Acupuncture
29. Chronic pain management programs
30. Transcutaneous (through the skin) electrical nerve stimulation (TENS), whose primary purpose is the treatment of pain
31. Complications arising from the receipt of noncovered services



32. Psychological tests to determine job, occupational or school placement or for educational purposes; milieu therapy; or to determine learning disability
33. Services or supplies payable by Workers' Compensation, the Veterans Administration or any other governmental or private program (including Employee Assistance Program services)
34. Charges 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)
35. Intentionally self-inflicted injury that does not result from a medical condition or domestic violence
36. Cosmetic goods, procedures or surgery or complications resulting from such procedures or services
37. Nicotine patches 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
38. Vocational rehabilitation, 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 49 and Speech Therapy on page 49)
39. Sclerotherapy (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 performed within three years and documentation submitted to Medi-Call with a preauthorization request establishes that some varicosities (twisted veins) remained after the procedure
40. Services performed by service or therapy animals or their handlers.
41. Abortions, except for an abortion performed in accordance with federal Medicaid guidelines
42. Pregnancy of a covered dependent child
43. Speech therapy for the treatment of a language/communication or developmental delay (See page 49)
44. Storage of blood or blood plasma
45. Experimental 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:

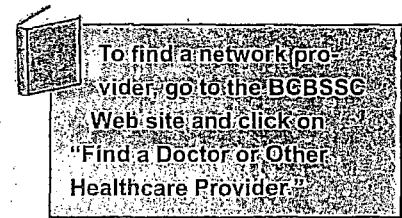
- Chiropractic benefits, under the Savings Plan only, are limited to \$500 per covered person after the annual deductible is met.
- Nonsedating antihistamines and drugs for treating erectile dysfunction are not covered under the Savings Plan.

WEB SITE: WWW.SOUTHCAROLINABLUES.COM

The BlueCross BlueShield of South Carolina (BCBSSC) Web site offers a quick, easy way to manage your benefits and learn more about staying healthy. Go directly to the site, www.SouthCarolinaBlues.com, or go to the EIP Web site, www.eip.sc.gov, and click on "Links." Under "State Health Plan," choose "Medical."

After you log in, with *My Insurance Manager* you can:

- See how much of your deductible and out-of-pocket limit you have satisfied
- Print an Explanation of Benefits
- Request an ID card
- Ask a question.



With *My Health Toolkit*, you can:

- Create a Personal Health Record
- Take a Personal Health Assessment
- Find estimates of the cost of treatment.

APPEALS

WHAT IF MY CLAIM OR REQUEST FOR PREAUTHORIZATION IS DENIED?

The Employee Insurance Program (EIP) 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.

If all or part of your claim or your request for preauthorization 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 believe the decision was incorrect, you may 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 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 as provided by S.C. Code Ann. 1-11-710 and 1-23-380.

Exhibit “E”
to Plaintiff’s
Memorandum in Opposition
to Defendant’s
Motion to Dismiss

WILLS & MASSALON, LLC

ATTORNEYS AT LAW

Telephone: (843) 727-1144

Facsimile: (843) 727-7696

Post Office Box 859
Charleston, South Carolina 29402

134 Meeting Street, Suite 100
Charleston, South Carolina 29401

December 28, 2009

South Carolina Budget and Control Board
Employee Insurance Program
1201 Main Street, Suite 300
Columbia, South Carolina 29201

RE: Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees v. SC Budget & Control Board

Case No.: 09-CP-10-7404

File No.: 595-1

Dear Sir or Madame:

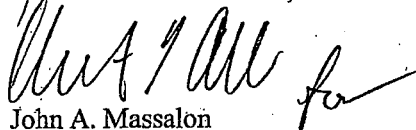
Please allow this letter to serve as a Freedom of Information Act request pursuant to S.C. Code Ann. § 30-4-10 et al. for the following information:

1. A complete copy of the State Health Plan "Plan of Benefits" referenced in the 2009 State Insurance Plan Benefit Guide on page 58.
2. The contract(s) between South Carolina EIP and Blue Cross Blue Shield of South Carolina to administer and/or provide insurance to the State for the State Health Plan effective from January 1, 2000 to present, and any amendments thereto.

With kind regards, I am

Sincerely,

WILLS & MASSALON, LLC



John A. Massalon

cc: Terry E. Richardson, Jr., Esquire
Matthew D. Hamrick, Esquire

595-1

MONTGOMERY WILLARD, LLC
ATTORNEYS AND COUNSELORS AT LAW
1002 CALHOUN STREET
COLUMBIA, SOUTH CAROLINA 29201

(803) 779-3500

POST OFFICE BOX 11886

COLUMBIA, SOUTH CAROLINA 29211-1886

FACSIMILE (803)-799-2755

WORLD WIDE WEB: HTTP://WWW.MONTGOMERYWILLARD.COM

December 31, 2009

John A. Massalon, Esquire
Wills & Massalon, LLC
PO Box 859
Charleston, SC 29402

Re: Freedom of Information Act Request

Jeffrey Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina Employees v. South Carolina Budget & Control Board Employee Insurance Program and BlueCross BlueShield of South Carolina

Case No. 2009-CP-10-7404

Dear Mr. Massalon:

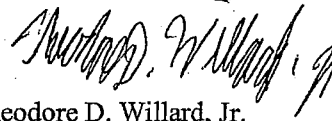
It is my understanding that you served a request for documents related to the above litigation on the South Carolina Budget and Control Board, Employee Insurance Program pursuant to the South Carolina Freedom of Information Act (FOIA), S.C. Code Ann. § 30-410 et seq. This litigation is currently pending in the South Carolina Court of Common Pleas in the Ninth Judicial Circuit.

FOIA protects from disclosure documents that would not otherwise be discoverable in litigation with the agency. Any discovery sought in ongoing litigation should be pursued through the South Carolina Rules of Civil Procedure. Documents which are not privileged or otherwise exempt from disclosure are available through discovery requests addressed to the attorneys of record in the above case. The attached order from a prior case involving a FOIA request during litigation against the State of South Carolina details the governing law on the matter. As explained in the attached order, "FOIA is not intended as a substitute for discovery and was not enacted to provide procedures for obtaining information during litigation or to benefit private litigants."

If you have any questions, please do not hesitate to contact me.

Sincerely,

Montgomery Willard, LLC



Theodore D. Willard, Jr.

Enclosure

cc: Edwin Evans, Esquire
Kelly Rainsford, Esquire
Lucy Grey McIver, Esquire
Matthew D. Hamrick, Esquire
Terry E. Richardson Jr., Esquire

03/13/2010

610

JL

STATE OF SOUTH CAROLINA)
COUNTY OF LEXINGTON)

Robert E. Lominsack,)
Plaintiff.)

-vs-)

Donald V. Myers, Solicitor,
Eleventh Judicial Circuit,)

Defendant.)

IN THE COURT OF COMMON PLEAS

2002-CP-32-1890

ORDER

ORIGINAL FILED
2002 OCT 30 A 9 38
THOMAS H. CONERFORD
CLERK OF COURT
LEXINGTON SC

This matter came before the Court following the Plaintiff's filing of a complaint seeking declaratory and injunctive relief pursuant to the South Carolina Freedom of Information Act ("FOIA"). Prior to the filing of the complaint, the Plaintiff had sent a letter to the Defendant Donald Myers, Solicitor, Eleventh Judicial Circuit, requesting, pursuant to the FOIA, all materials in the possession of the Solicitor's Office relating to a criminal case where the Plaintiff is representing the Defendant in a post conviction relief action against the Defendant's prior legal counsel. By letter dated May 23, 2002, Defendant Myers denied Plaintiff's FOIA request, indicating that Section 17-27-150(B) provides the procedure for discovery in a capital post-conviction relief case, and that the Plaintiff should use that process rather than trying to circumvent the statute by filing a request for these documents under the FOIA. The Plaintiff then filed this Complaint. The issue before the Court is whether to compel compliance with Plaintiff's FOIA request.

I find that Section 17-27-150 of the South Carolina Code details the method of discovery in post-conviction relief proceedings. Further, it is well settled case law that the FOIA is not intended as a substitute for discovery and was not enacted to provide procedures for obtaining information during litigation or to benefit private litigants. U.S. v. Murdock, 544F.2d 599 (5th Cir. 1976);

Frushauf Corp v. Thornton, 507 F.2d 1253 (6th Cir. 1974); N.L.R.B. v. Sears, Roebuck & Co., 421 U.S. 132 (1975).

Therefore, the information sought in this case cannot be obtained under the State Freedom of Information Act and can only be obtained by utilizing the discovery procedure set out by Statute. Plaintiff's request for declaratory and injunctive relief is denied.

AND IT IS SO ORDERED.

MHW
#2


Marc H. Westbrook
Resident Judge
Eleventh Judicial Circuit

October 2nd, 2002.

595-7

STATE OF SOUTH CAROLINA
State Budget and Control Board
EMPLOYEE INSURANCE PROGRAM

MARK SANFORD, CHAIRMAN
GOVERNOR

CONVERSE A. CHELLIS III, CPA
STATE TREASURER

RICHARD ECKSTROM, CPA
COMPTROLLER GENERAL



1201 MAIN STREET, SUITE 300
COLUMBIA, SOUTH CAROLINA 29201
(803) 734-0678
FAX: (803) 737-0557

HUGH K. LEATHERMAN, SR.
CHAIRMAN, SENATE FINANCE COMMITTEE

DANIEL T. COOPER
CHAIRMAN, WAYS AND MEANS COMMITTEE

FRANK W. FUSCO
EXECUTIVE DIRECTOR

January 4, 2010

John A. Massalon, Esquire
Wills & Massalon, LLC
PO Box 859
Charleston, SC 29402

Re: Freedom of Information Act Request
Jeffrey Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina Employees v. South Carolina Budget & Control Board Employee Insurance Program and BlueCross BlueShield of South Carolina
Case No. 2009-CP-10-7404

Dear Mr. Massalon:

The South Carolina Budget and Control Board is in receipt of your request pursuant to the South Carolina Freedom of Information Act (FOIA), S.C. Code Ann. § 30-410 et seq., for documents related to the above-referenced matter, which is pending in the South Carolina Court of Common Pleas in the Ninth Judicial Circuit.

The Act protects from disclosure documents that would not otherwise be discoverable in litigation with the agency. Any discovery sought in ongoing litigation should be pursued through the South Carolina Rules of Civil Procedure. Documents which are not privileged or otherwise exempt from disclosure are available through discovery requests addressed to the attorneys of record in the above case.

If you have any questions, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Robin E. Tester".

Robin E. Tester
Director of Employee Insurance Program

RET/ctqc

cc: Edwin Evans, Esquire
Kelly Rainsford, Esquire
Theodore D. Willard, Jr., Esquire
Lucy Grey McIver, Esquire
Matthew D. Hamrick, Esquire
Terry E. Richardson Jr., Esquire



South Carolina

BlueCross BlueShield of South Carolina
I-20 at Alpine Road
Columbia, SC 29219-0001
803.788.0222

SouthCarolinaBlues.com

March 19, 2010

Jeffrey Allen
[REDACTED]

Charleston, South Carolina 29414-6577

RE: Patient: [REDACTED]
ID#: ZCS: 36961363
Date(s) of Service: August 5, 2008

Dear Mr. Allen:

We received an appeal of the date of service for [REDACTED] Allen listed above, which was updated by a fax received from Christy Allen, which included requested medical records. Our medical director has reviewed the appeal documents including the medical records and upheld the denial on the grounds that (1) the services referenced in the appeal are specifically excluded in the Plan of Benefits, Article 9, paragraph O; in addition Article 9, paragraph BB applies as there is no mention of this service in the Benefits section of the Plan; and (2) the statute referenced in the appeal documents does not apply to the State Health Plan.

Because the medical director has upheld the denial of the above referenced service, the appeal file will now be sent to the Appeals Review Committee. When we have completed this review, we will notify you in writing.

If you have questions about this matter, please call me at (803) 264-2886.

Sincerely,

Brooks Goodman, Senior Director
State Operations, AX-B10
Phone: 803-264-2886
Fax: 803-870-8483
Brooks.goodman@bcbssc.com

cc: John A. Massalon, Esq. ✓
Wills & Massalon, LLC
P.O. Box 859
Charleston, SC 29402

RECEIVED

MAR 23 2010

Wills & Massalon



South Carolina

April 2, 2010

BlueCross BlueShield of South Carolina
1-20 at Alpine Road
Columbia, SC 29219-0001
803.788.0222

SouthCarolinaBlues.com

Jeffrey D. Allen

██████████
Charleston, South Carolina 29414

395-1
PED

RE: Patient: ██████████
Insured: Jeffrey Allen
ID#: 36961363
Appeal: Claim #8E2631250
Group Plan: State Health Plan

Dear Mr. Allen:

The Appeals Review Committee (Committee) of BlueCross BlueShield of South Carolina (BCBSSC) met on March 25, 2010 to review your appeal of the above referenced claim. This is to notify you of our decision.

In reviewing your appeal, the following information was considered:

- A. Letters of appeal dated September 30, 2009 and February 25, 2009 (including a copy of the South Carolina statute, S.C. Code §38-71-46) from Christy F. Allen; and web inquiry dated February 18, 2009;
- B. Office notes dated August 5, 2008 from MUSC Health relating to the care and treatment of ██████████ and pre-authorization request from Medtronic MiniMed dated July 9, 2008 for the Insulin Infusion Pump (including the certificate of medical necessity dated July 7, 2008);
- C. Copy of the claim dated August 5, 2008 from Medical University Hospital and the related explanations of benefits (EOBs) dated August 27, 2008 and April 20, 2009;
- D. Opinion of Ashby Jordan, M.D., Medical Director, BCBSSC dated March 15, 2010;
- E. The Group Health Benefits Plan of the Employees of the State of South Carolina, the Public School Districts, and Participating Entities (the "Plan"), Article 9, Sections O and BB; and Article 7.

RECEIVED

APR 06 2010

Wills & Massalon

F. Letter from Brooks Goodman, BCBSSC, to Mr. Allen dated March 19, 2010; and

G. South Carolina Code §38-71-46.

The Committee considered the following relevant provisions of the Plan:

ARTICLE 9. EXCLUSIONS AND LIMITATIONS

No benefits will be provided under any Article of this Plan for any service, supply or charges for the following:

O. Any medical social services (except for those provided under the Hospice program and Home Health Care Program upon recommendation of the Utilization Review Agency), or vocational, visual, recreational, educational, or milieu therapy. (Emphasis added).

BB. Benefits will not be provided for services or supplies not specifically listed in Article 7, Schedule of Benefits, inclusive.

Based upon our review of the documents identified above, we regret to inform you that no benefits are payable for equipment training or diabetic educational services for the above referenced claim.

According to the Plan, Article 9, Section O, educational services are excluded, and are not covered benefits. Additionally, under Article 9, Section BB, education and training services are excluded because they are not specifically listed as a covered service under Article 7, Covered Medical Expenses. Article 7 does not specifically include diabetes education and training as a covered benefit.

Mr. Goodman's letter dated March 19, 2010, states that the South Carolina statute mandating coverage for diabetes education does not apply to the self-funded State Plan. The Committee agrees with Mr. Goodman, and finds that the statute does not apply to the Plan, and therefore does not apply to this appeal.

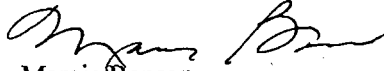
We regret that our decision was not favorable. We are sympathetic to ~~each individual's~~ individual situation; however, we are obligated to review claims consistent with the plain and ordinary meaning of the Plan. In doing so, we are fulfilling our duty as claims administrator to interpret the Plan.

Nothing in this letter should be construed as a waiver of any rights or defenses under the Plan. This determination has been made in good faith and without prejudice under the terms and conditions of the Plan, whether or not specifically mentioned herein.

Your appeal options to BCBSSC are now exhausted. If you wish to further pursue your appeal, you must appeal to the Employee Insurance Program in writing within 90 days of the date of this letter at the following address:

Appeals Coordinator
Employee Insurance Program
Post Office Box 11661
Columbia, South Carolina 29211

Sincerely,



Margie Benson
Appeals Review Committee Coordinator

cc:
Appeals Coordinator
Employee Insurance Program

John A. Massalon, Esq.
Wills & Massalon, LLC
P.O. Box 859
Charleston, SC 29402

STATE OF SOUTH CAROLINA)

COUNTY OF CHARLESTON)

Jeffrey D. Allen, individually, as Guardian)
For Jane Doe, a minor, and as Representative)
Of other similarly situated State of)
South Carolina employees,)

Plaintiff,)

v.)

South Carolina Budget and Control Board)
Employee Insurance Program and Blue)
Cross and Blue Shield of South Carolina,)

Defendants.)

IN THE COURT OF COMMON PLEAS

CASE NO.: 09-CP-10-7404

**Plaintiff's Notice of Motion and
Motion for Class Certification**

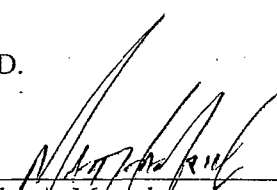
TO: Theodore D. Willard, Jr., Esq. and Kelly H. Rainsford, Esq., counsel for
Defendants.

PLEASE TAKE NOTICE that Plaintiff, by and through his undersigned attorneys, will
move the Court for an order, on the date set by the Court for the hearing of this matter, certifying
a plaintiffs' class in the above-captioned lawsuit.

Plaintiff hereby moves for an order certifying a plaintiffs' class in the above-captioned
lawsuit on the grounds that: (1) the class is so numerous that joinder of all members is
impracticable, (2) there are questions of law or fact common to the class, (3) the claims of the
representative parties are typical of the claims of the class, (4) the representative party will fairly
and adequately protect the interests of the class, and (5) to the extent non-injunctive or non-
declaratory relief is requested with respect to the class as a whole, the amount in controversy
exceeds one hundred dollars for each member of the class.

This motion will be supported with the responses to discovery requests, depositions,
affidavits, and memoranda of law on file with the Court as of the date of the hearing on this
motion.

PLEASE BE PRESENT TO DEFEND IF SO MINDED.



John A. Massalon
Wills Massalon & Allen, LLC
Post Office Box 85

RECEIVED

JUN 04 2010

Charleston, SC 29402
(843) 727-1144

-and-

Terry E. Richardson, Jr.
Matthew D. Hamrick
Richardson, Patrick, Westbrook &
Brickman, LLC
1017 Chuck Dawley Blvd.
Mt. Pleasant, SC 29464
(843) 727-6500

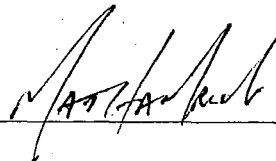
ATTORNEYS FOR PLAINTIFF

CERTIFICATE OF SERVICE

I hereby certify that I have this 3rd day of June, 2010 served the foregoing pleading or paper by depositing a copy of it in the US Mail, first class, postage pre-paid, addressed as follows:

Theodore D. Willard, Jr., Esq.
MONTGOMERY WILLARD, LLC
1002 Calhoun Street
Post Office Box 11886
Columbia, SC 29211

Kelly H. Rainsford, Esq.
State Budget & Control Board
1201 Main Street, Ste. 300
Columbia, SC 29211



Matthew D. Hamrick
Richardson, Patrick, Westbrook &
Brickman, LLC
1017 Chuck Dawley Blvd.
Mt. Pleasant, SC 29464
(843) 727-6500

STATE OF SOUTH CAROLINA)

COUNTY OF CHARLESTON)

Jeffrey D. Allen, individually, as Guardian)
For Jane Doe, a minor, and as Representative)
Of other similarly situated State of)
South Carolina employees,)

Plaintiff,)

v.)

South Carolina Budget and Control Board)
Employee Insurance Program and Blue)
Cross and Blue Shield of South Carolina,)

Defendants.)

IN THE COURT OF COMMON PLEAS

CASE NO.: 09-CP-10-7404

Plaintiff's Notice of Motion and
Motion to Compel Responses to
Plaintiff's First Interrogatories
and First Requests for Production
and Motion to Stay Decision on
Defendant's Motion for Summary
Judgment

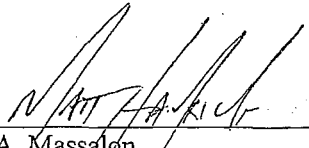
TO: Theodore D. Willard, Jr., Esq. and Kelly H. Rainsford, Esq., counsel for
Defendants.

PLEASE TAKE NOTICE that Plaintiff, by and through his undersigned attorneys, will
move the Court for an order, on the date set by the Court for the hearing of this matter, upon
Plaintiff's motion herein, compelling the Defendants to answer Plaintiff's First Interrogatories
and First Requests for Production (served May 6, 2010, and attached hereto as Exhibits "A,"
"B," "C," and "D") in the above-captioned lawsuit.

Also, as Defendants have moved for (1) a protective order to allow Defendants not to
answer Plaintiff's First Interrogatories and Requests for Production, and (2) summary judgment
prior to any discovery, Plaintiff hereby moves for a stay of decision on Defendants' Motion for
Summary Judgment until after the Court has determined whether Defendants should be required
to respond to Plaintiff's First Interrogatories and Requests for Production.

Counsel for Plaintiff and counsel for Defendants have consulted orally in a good faith
attempt to resolve the matter contained in the foregoing motions.

PLEASE BE PRESENT TO DEFEND IF SO MINDED.


John A. Massalon
Wills Massalon & Allen, LLC
Post Office Box 859
Charleston, SC 29402

RECEIVED

JUN 21 2010

Wills & Massalon

(843) 727-1144

-and-

Terry E. Richardson, Jr.

Matthew D. Hamrick

Richardson, Patrick, Westbrook &
Brickman, LLC

1017 Chuck Dawley Blvd.

Mt. Pleasant, SC 29464

(843) 727-6500

ATTORNEYS FOR PLAINTIFF

CERTIFICATE OF SERVICE

I hereby certify that I have this 17 day of June, 2010 served the foregoing pleading or paper by depositing a copy of it in the US Mail, first class, postage pre-paid, addressed as follows:

Theodore D. Willard, Jr., Esq.
MONTGOMERY WILLARD, LLC
1002 Calhoun Street
Post Office Box 11886
Columbia, SC 29211

Kelly H. Rainsford, Esq.
State Budget & Control Board
1201 Main Street, Ste. 300
Columbia, SC 29211

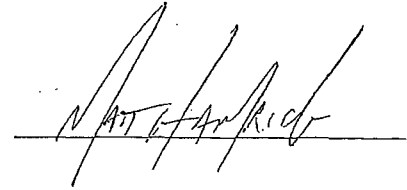
A handwritten signature in black ink, appearing to read "Matthew D. Hamrick", is written over a horizontal line.

EXHIBIT A

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

DOCKET NO. 10-ALJ-30-0710-AP

Jeffrey D. Allen, on behalf of [REDACTED] Appellant,

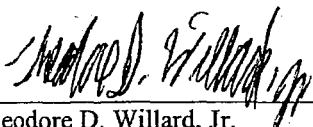
vs.

South Carolina Budget and Control Board,
Employee Insurance Program Respondent.

CERTIFICATE OF SERVICE

I certify that I have served the Supplemental Record on Appeal on Jeffrey D. Allen by depositing one copy of it in the United States Mail, postage prepaid on January 4, 2011, addressed to his attorney of record, Matthew D. Hamrick, 1017 Chuck Dawley Blvd., Post Office Box 1007, Mt. Pleasant, South Carolina 29465.

January 4, 2011



Theodore D. Willard, Jr.
MONTGOMERY WILLARD, LLC
1002 Calhoun Street
Post Office Box 11886
Columbia, South Carolina 29211-1886
Telephone: (803) 779-3500
ATTORNEY FOR THE RESPONDENT

THE STATE OF SOUTH CAROLINA
In the Supreme Court

APPEAL FROM THE ADMINISTRATIVE LAW COURT
Shirley C. Robinson, Administrative Law Judge

Appellate Case No. 2012-213186

Jeffrey D. Allen, on behalf of Jane Doe

.....Appellant,

v.

South Carolina Public Employee Benefit Authority,
Employee Insurance Program

.....Respondent.

CERTIFICATE OF COUNSEL

The undersigned certifies that Record on Appeal: Volumes I-III, complies with Rule 210(g), SCACR, and that the forgoing contains all material proposed to be included by any of the parties, and not any other materials.

January 15, 2013



John A. Massalon, Esquire
Wills Massalon & Allen LLC
P.O. Box 859
Charleston, South Carolina 29401
SC Bar Number: 010279
(843) 727-1144

Terry E. Richardson, Jr., Esquire
Richardson Patrick Westbrook & Brickman, LLC
1730 Jackson Street
Barnwell, SC 29812
SC Bar Number: 04721
(803) 541-7850

Attorneys for Appellant

Other Counsel of Record:

Theodore D. Willard, Jr.
Montgomery Willard, LLC
P.O. Box 11886
Columbia, SC, 29211

Steven Van Camp
South Carolina Public Employee Benefit
Employee Insurance Program
1201 Main Street, Suite 300
Columbia, SC 29201
Attorneys for Respondents.