

Comparison of Health Plan Benefits Offered for 2008¹

| Plan | SHP Savings Plan | | SHP Standard Plan ³ | | BlueChoice HealthPlan of South Carolina ³ | CIGNA HMO ³ | MUSC Options ³ | | Medicare Supplemental Plan ³ |
|--|--|---|---|---|--|---|--|---|--|
| Availability | Coverage worldwide | | Coverage worldwide | | Available in all South Carolina counties Coverage worldwide | Available in all South Carolina counties, except: Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda | Available only in these South Carolina counties: <i>Berkeley, Charleston, Colleton and Dorchester</i> | | Same as Medicare Available to retirees and covered dependents/survivors who are eligible for Medicare |
| Active Employee Monthly Premiums <i>Employee Only</i> <i>Employee/Spouse</i> <i>Employee/Children</i> <i>Full Family</i> | \$ 9.28 \$ 72.56 \$ 20.28 \$108.56 | | \$ 93.46 \$237.50 \$142.46 \$294.58 | | \$129.60 \$380.50 \$282.14 \$566.48 | \$136.30 \$390.94 \$288.66 \$577.34 | \$194.82 \$508.68 \$345.76 \$644.66 | | Refer to <i>The Insurance Advantage</i> for rates |
| Please note that premiums for optional employer groups, such as local subdivisions, may vary. To verify your rates, contact your benefits office. | | | | | | | | | |
| Annual Deductible <i>Single</i> <i>Family</i> | (no per-occurrence deductibles) \$3,000 \$6,000 | | \$350 \$700 | | \$250 \$500 | NONE | In-network NONE | Out-of-network \$500 \$1,500 | Pays Medicare Part A and Part B deductibles |
| Coinsurance | In-network Plan pays 80% You pay 20% | Out-of-network Plan pays 60% You pay 40% | In-network Plan pays 80% You pay 20% | Out-of-network Plan pays 60% You pay 40% | HMO pays 90% after copays You pay 10% | HMO pays 80% after copays You pay 20% | Plan pays 100% after copays | Plan pays 60% of allowable charge You pay 40% | Pays Part B coinsurance of 20% |
| Coinsurance Maximum <i>Single</i> <i>Family</i> | \$2,000 \$4,000 (excludes deductible) | \$4,000 \$8,000 (excludes deductible) | \$2,000 \$4,000 (excludes deductible) | \$4,000 \$8,000 (excludes deductible) | \$1,500 \$3,000 (excludes deductible) | \$2,000 \$4,000 (includes inpatient, outpatient, copays and coinsurance) | N/A | \$3,000 \$9,000 (excludes deductible) | None |
| Physicians Office Visits | Chiropractic payments limited to \$500 a year, per person | | \$10 per-occurrence deductible, then: | | \$15 PCP copay \$15 OB/GYN well woman exam \$30 specialist copay | \$15 PCP copay \$15 OB/GYN exam \$30 specialist copay | \$25 PCP copay; \$25 OB/GYN well woman exam; \$50 specialist copay | Plan pays 60% of allowable charge after annual deductible You pay 40%. No preventive care benefits out-of-network | Pays Part B coinsurance of 20% |
| | No per-occurrence deductible or copays | | | | | | | | |
| | In-network Plan pays 80% You pay 20% | Out-of-network Plan pays 60% You pay 40% | In-network Plan pays 80% You pay 20% | Out-of-network Plan pays 60% You pay 40% | | | | | |
| Hospitalization/ Emergency Care | No per-occurrence deductibles or copays | | Outpatient hospital: \$75 per-occurrence deductible Emergency care: \$125 per-occurrence deductible | | Inpatient: \$200 copay Outpatient: \$100 copay/ first 3 visits Emergency care: \$125 copay HMO pays 90% after copays You pay 10% Urgent care: \$35 copay, then HMO pays 100% | Inpatient: \$500 copay per admission, then HMO pays 80% Outpatient facility: \$250 copay per admission, then HMO pays 80% Emergency room: \$100 copay, then HMO pays 100% | Inpatient: \$300 copay Outpatient facility: \$100 ² copay Emergency Care: \$150 copay; \$50 urgent care copay | Plan pays 60% of allowable charge after annual deductible You pay 40% Emergency care: \$150 copay | For inpatient hospital stays, the Plan pays: Medicare deductible; coinsurance for days 61-150; 100% beyond 150 days (Medi-Call approval required) For skilled nursing facility care, the Plan pays coinsurance for days 21-100; 100% beyond 100 days, up to \$6,000 per year. |
| Prescription Drugs | Participating pharmacies and mail order only: You pay the State Health Plan's allowable charge until the annual deductible is met. Afterward, the Plan will reimburse 80% of the allowable charge; you pay 20%. When coinsurance maximum is reached, the Plan will reimburse 100% of the allowable charge. | | Participating pharmacies only (up to 31-day supply): \$10 tier 1 (generic—lowest cost), \$25 tier 2 (brand—higher cost), \$40 tier 3 (brand—highest cost) Mail order (up to 90-day supply): \$25 tier 1, \$62 tier 2, \$100 tier 3 Copay max: \$2,500 | | Participating pharmacies only (31-day supply): \$7 generic, \$35 preferred brand, \$55 non-preferred brand, \$100 specialty pharmaceuticals Mail order (Up to 90-day supply): \$14 generic, \$70 preferred brand, \$110 non-preferred brand | Participating pharmacies only (up to 30-day supply): \$7 generic, \$25 preferred brand, \$50 non-preferred brand Mail order (up to 90-day supply): \$14 generic, \$50 preferred brand, \$100 non-preferred brand | Participating pharmacies only (up to 30-day supply): \$100 deductible, then: \$10 tier 1 (generic—lowest cost), \$30 tier 2 (brand—higher cost), \$50 tier 3 (brand—highest cost), \$100 specialty pharmaceuticals Mail order (up to 90-day supply): \$25 tier 1, \$75 tier 2, \$125 tier 3 | Participating pharmacies only (up to 31-day supply): \$10 tier 1 (generic—lowest cost), \$25 tier 2 (brand—higher cost), \$40 tier 3 (brand—highest cost) Mail order (up to 90-day supply): \$25 tier 1, \$62 tier 2, \$100 tier 3 Copay max: \$2,500 | |

¹Premiums for subscribers of experience-rated groups (such as cities, counties and other local subdivisions) may increase, decrease or remain the same, based on the group's rating.

²There will be no copayment for services performed at MUSC outpatient facilities.

³Refer to your 2007 *Insurance Benefits Guide* for information on how this plan coordinates with Medicare.