

GENERAL SYNOD, ARP - HEALTH BENEFITS PLAN

**Medical Plan Summary**

Benefit	Plan A		Plan B	
	Participating Provider	Non-Participating Provider	Participating Provider	Non-Participating Provider
<b>Deductible</b> * indicates deductible waived	\$750 Individual \$1,500 Family	\$750 Individual \$1,500 Family	\$1,250 Individual \$2,500 Family	\$1,250 Individual \$2,500 Family
<b>Coinsurance</b>	80%	60%	80%	60%
<b>Out-of-Pocket Limit</b>	\$3,000 Individual; \$6,000 Family	\$6,000 Individual; \$12,000 Family	\$5,000 Individual \$10,000 Family	\$10,000 Individual \$20,000 Family
<b>Physicians Office Visits</b>				
Primary Care	\$15 Copay	60%	\$20 Copay	60%
Specialty Care	\$30 Copay	60%	\$35 Copay	60%
<b>Preventive Care</b>				
First \$1,000 of covered expenses	100%*	60%	100%*	60%
Amounts over \$1,000	80%	60%	80%	60%
<b>Prescription Drugs</b> (Provided by Caremark)				
Generic/ Preferred/ Non-Preferred (Up to a 31 day supply)	\$10/\$20/\$35 Copays		\$10/\$20/\$30 Copays	
Mail-In (up to a 90 day supply)	\$20/\$40/\$40 Copays		\$20/\$40/\$40 Copays	
<b>Weight Reduction</b>	<b>Voluntary Enrollment Program. Plan will pay for cost of participation.</b>			
<b>Smoking Cessation</b>	<b>Voluntary Enrollment Program. Plan will pay for cost of participation.</b>			
<b>24 Hour Nurse Advisor</b> 888-521-2583	<b>Available 24 hours per day/Seven days per week.</b>			

**Vision Plan Summary**

Benefit	Frequency	Participating Providers	Non-Participating Providers
<b>Eye Examination</b>	12 Months	100% after \$15 co-pay	\$35
<b>Lenses (Standard Plastic)</b> Single Vision/Bifocal/Trifocal	24 Months	100%	\$25/\$40/\$55
<b>Lens Treatment Options</b>	Unlimited	\$15-\$65; 20% off retail on other add-ons and services	N/A
<b>Frames</b> Up to \$110 retail value	24 Months	100%	\$55
<b>Contact Lenses- Therapeutic</b> In lieu of lenses and frames Up to \$110 retail value	24 Months	100% up to \$110; 20% of balance over allowance	\$200
<b>Contact Lenses - Elective</b> In lieu of lenses and frames Up to \$110 retail value	24 Months	100%	\$88
<b>Additional Pairs of Eyeglasses/ Contact Lenses</b>	Unlimited	Vision ONE discount available	N/A

## Dental Plan Summary

Benefit	
<b>Deductible</b> Applies to type II and III services	\$50 Individual \$150 Family
<b>Coinsurance</b>	
Preventive (I) exams/cleanings/x-rays	100%
Basic (II) fillings/extractions	80%
Major (III) crowns/bridges/dentures	50%
<b>Calendar Year Maximum</b> Applies to type I, II & III services	\$1,500
Orthodontic Services (IV)	50%
Lifetime Maximum (IV)	\$1,500

This is an overview of the main features of your benefit plans. Although we've tried to summarize the provisions clearly and accurately, if any information here conflicts with the summary plan description (SPD) the SPD will govern.

10-31-07

## Life Benefit Summary

Term Life Insurance and Accidental Death Benefit	
Eligible Class	Benefit
Erskine Employees	\$10,000
Dependents age 15 days to 6 months	\$200
Dependents age 6 months and older (no Accidental Death)	Spouse \$5,000 Children \$2,500

## LTD Benefit Summary

Long Term Disability Insurance (This is not part of the General Synod Group Plan)	
Waiting period after onset of disability	6 months
Benefit for total disability	60% of earnings
Maximum monthly benefit	\$5,000

### Benefit Contact Information

#### Medical – BCBS of SC [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com)

Claims & Benefits: 800-845-6067

Pre-Authorization:

- General Services: 800-334-7287
- Mental Health & Substance Abuse Services: 800-868-1032

#### Prescription Drugs - Caremark

888-963-7290

[http://www.southcarolinablues.com/bcbs/bcbs\\_img.nsf/\(WebFiles\)/caremark\\_mo\\_form.pdf/\\$FILE/caremark\\_mo\\_form.pdf](http://www.southcarolinablues.com/bcbs/bcbs_img.nsf/(WebFiles)/caremark_mo_form.pdf/$FILE/caremark_mo_form.pdf)

#### 24 Hour Nurse Advisor

888-521-2583

#### Vision – EyeMed/BCBS of SC

<http://www.eyemedvisioncare.com/memweb/ProviderLocator?ClientId=HVAC>

866-723-0513

#### Dental – Kanawha

<http://www.khsonline.com/>

800-822-1274