# INTRODUCTION

Dear Member:

BlueCross BlueShield of South Carolina (Blue Cross) is pleased to provide your Preferred Blue Plan of Benefits. BlueCross BlueShield provides you and your covered family members with cost-effective health care coverage both locally and on a nationwide basis.

Please refer to the benefits outlined in this Plan of Benefits for all your health care coverage.

The BlueCross BlueShield networks offer the best geographic access to physicians and hospitals of any Preferred Provider Organization (PPO) in the nation. This national coverage is available through the BlueCard® Program in which all BlueCross BlueShield Plans participate. For more provider information visit our Web site at www.SouthCarolinaBlues.com.

We welcome you to our family of health care coverage through BlueCross BlueShield of South Carolina and look forward to meeting your health care needs.

## VISIT OUR WEB SITE

When you visit our Web site at www.SouthCarolinaBlues.com, you will find several very helpful options. For example, you will find:

- Access to a **Provider Directory** that is updated nightly;
- Access to a list of **Network Pharmacies** through Caremark;
- The latest in health care information from our **News** section;
- **"My Insurance Manager℠".** "My Insurance Manager" allows a member to view the status of personal claims on line and to check how much has been applied toward individual Benefit Year Deductibles and out-of-pocket expenses. You can check authorization status, access information on other health plans you may have with us, check eligibility requirements and even order ID cards;
- And, if you have questions but cannot find the answers on the Web site, you can use the feature **"Ask Customer Service"** to get a response from a BlueCross BlueShield representative.

## IMPORTANT INFORMATION ABOUT YOUR HEALTH COVERAGE:

The benefits you receive will depend on whether the provider of medical services is a Participating or Non-Participating Provider. You will receive the maximum benefits that can be paid if you use Participating Providers and you get pre-authorization, when required, before getting medical care. The amount you have to pay for services and supplies will increase when you do not use Participating Providers and may further increase if you do not get Pre-Authorization.

BlueCross BlueShield of South Carolina makes every effort to contract with physicians that practice at Participating Hospitals. For various reasons, some physicians may elect not to contract as Participating Providers. Non-Participating Providers will be paid at the Non-Participating Provider level of benefits with no protection from balance billing from the provider.

## HOW TO GET HELP

How to get help with claims or benefit questions:

- From Greenville, SC; dial 297-4665
- From anywhere else in South Carolina, dial 1-800-922-1185
- From outside South Carolina, dial 1-800-845-6067

How to get help on Pre-Authorization:

For MRIs, MRAs, CT Scans, or PET Scans in an Outpatient Facility:

- 1-866-500-7664.

For all other medical care:

- 736-5990 from the Columbia, SC area.
- 1-800-327-3238 from all other South Carolina locations.
- 1-800-334-7287 from outside South Carolina.

Please do not call these numbers for claims inquiries.

Please note that Pre-Authorization is required for the procedures on the Schedule of Benefits that have a "Pre-Authorization" note.

Pre-Authorization for Mental Health Services, Mental Health Conditions and Substance Abuse Services:

Behavioral Health:

- 699-7308 from the Columbia, SC area.
- 1-800-868-1032 from all other areas.

How to get information on Drug coverage:

Drug Coverage is handled by Caremark.

For inquiries regarding the Prescription Drug Benefit please call:

- 1-888-963-7290

For inquiries regarding Specialty Drugs please call CuraScript:

- 1-877-512-5981

For inquiries regarding the status of prior authorization on Specialty Drugs dispensed by CuraScript, please call:

- 1-877-512-5981

You can also access Caremark or CuraScript from our website, **www.SouthCarolinaBlues.com**

For information regarding Prescription Drug Pre-Authorization, QVT Limits or Step Therapy Programs, contact your Human Resources department..

Essential Advocate Questions:
The Corporation provides you and your Dependents with access to 24-Hour Nurse Advisor and Advocacy, a program that includes immediate care with the 24-hour Nurse Advisor plus the unique service of our health advocacy program tailored to bridge the gap between care and Benefits, Provider and patient, and Hospital and home. Members will experience personal support and receive individualized assistance provided by experienced healthcare and Benefit experts. The health advocates assist Members:

- Locating Providers through the BlueCross Doctor & Hospital Finder
- Educating Members on health plan Benefits and how they work
- Researching current treatments
- Resolution of health care claims
- Preparing Members and family members for medical appointments
- Assisting with eldercare issues
- Arranging transportation relating to medical needs
- Navigating the BlueCross website including cost estimator and quality tools
- And much more

Call 1-888-521-2583 to speak with a registered nurse or health advocate.

Health Management questions:
The Corporation will provide you with access to ***Health Management***, a Disease Management Program for Members with any of the following diseases:

- Asthma
- COPD (Chronic Obstructive Pulmonary Disease or chronic lung problems)
- Diabetes
- Heart Failure
- Coronary Artery Disease
- Hypertension (High Blood Pressure)
- Hyperlipidemia (High Cholesterol)
- Migraine

The purpose of this program is to help the Employees understand their risk factors and treatment options, explore healthy lifestyle choices, set and reach realistic health goals and learn to successfully self manage their condition. Members enrolled in this program receive access to a personal health coach, educational resources, and Web tools that help them learn more about their health and how they can better self-manage their condition. Members identified as having any of the above conditions will automatically be enrolled in *Health Management*. Members that **do not** want to participate can opt out. For more information on this program call 1-855-838-5897 option 2.

Men's and Women's Health Questions:
The Corporation provides you with access to ***Men's and Women's Health***, a program that offers education and reminders on preventive screenings based on recommended guidelines. If you have not had a standard routine wellness exam and/or screening, you will receive:

- A letter recommending that you visit your doctor to obtain the appropriate care (i.e., physical examination, mammogram, Pap Smear, etc.).
- A Men's or Women's health brochure
- Reminders about preventive screenings and immunizations through the mail
- A Prevention Now Wallet Guide
- Access to a health coach to ask questions regarding men's or women's health topics

This program is offered in partnership with the Informed Health program.

Maternity Care questions:
The Corporation provides you with access to ***Maternity Care,*** a confidential Maternity Management Program. ***Maternity Care*** will provide individualized feedback to expectant mothers based on your answers to a confidential assessment survey. This unique program will give you access to a maternity nurse who will work with you and your doctor to coordinate your care and provide you with information to help you make the best decisions for you and your baby. Members 18 years of age or older who enroll in this program will receive the following:

- A pregnancy book of your choice
- Newsletters each trimester about prenatal care and healthy habits
- Access to a 24-hour phone line where you can ask a nurse questions about your pregnancy
- Information on breastfeeding, shots for your baby, how to quit smoking, and more!

To participate in this program, call: 1-855-838-5897 option 3.

Complex Care Management questions:
The Corporation provides you with access to ***Complex Care Management***, a unique patient support and education program which provides you with a registered nurse case manager to assist you in making informed decisions about your health care when you're seriously ill or injured. Participation in the program is voluntary and at no cost to Members. For more information call: 1-800-868-2500, extension 42648.

Personal Health Assessment questions:
The Corporation will provide you with access to ***Personal Health Assessment***, an on-line health risk assessment that allows members to evaluate their wellness potential and receive instant feedback with suggestions for healthy lifestyle changes. To access Personal Health Assessment visit www.SouthCarolinaBlues.com .

## HOW TO FILE CLAIMS

Participating Providers have agreed to file claims for health care services they rendered to you. However, in the event a provider does not file a claim for such services, it is your responsibility to file the claim. If you choose to use a Non-Participating Provider, you are responsible for filing your claim.

Once the claim has been processed, you will have quick access to an Explanation of Benefits (EOB) through our website or by contacting customer service. An EOB will also be mailed to you. The EOB explains who provided the care, the kind of service or supply received, the amount billed, the Allowable Charge, the Coinsurance rate and the amount paid. It also shows Benefit Year Deductible information and the reasons for denying or reducing a claim. Please see this Plan of Benefits for more information.

The only time you must pay a Participating Provider is when you have a Benefit Year Deductible, Coinsurance, Copayment or when you have services or supplies that are not Covered Expenses under your Plan of Benefits.

If you need a claim form, you may obtain one from us at the address below or print a copy from the web site. Or, call us at the telephone numbers listed on the previous page and we will send you a form. After filling out the claim form, send it to the address below:

BlueCross BlueShield of South Carolina
Piedmont Service Center
Post Office Box 6000
Greenville, SC 29606-6000

Please refer to Article XI of this Plan of Benefits for more information on filing a claim.

# SCHEDULE OF BENEFITS

Group Contract Number: 15-53266-00 and 03
Employer: Constantia Hueck Foils, LLC
HRA Plan
Plan of Benefits Effective Date: January 1, 2013

This Schedule of Benefits and the Benefits described herein are subject to all terms and conditions of this Plan of Benefits. In the event of a conflict between this Plan of Benefits and this Schedule of Benefits, this Schedule of Benefits shall control. Capitalized terms used in this Schedule of Benefits have the meaning given to such terms in this Plan of Benefits.

To maximize your Benefits, seek medical services from a Participating Provider. Please call 1-800-810-BLUE (2583) or access our website at www.SouthCarolinaBlues.com to find out if your Provider is a Participating Provider.

| **GENERAL PROVISIONS**<br>**When a Benefit is listed below and has a dollar or percentage amount associated with it, the Benefit will be provided to Members subject to the terms of this Plan of Benefits. When a Benefit has a "Non-Covered" notation associated with it, the Benefit is not available to the Member. All Benefits are subject to the dollar or percentage amount limitation associated with each Benefit in this Schedule of Benefits.** | |
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| **Probationary Period:** | Coverage for new Employees hired following the Effective Date of this Plan of Benefits will commence on the first monthly Effective Date following 90 days of employment. |
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| **Pre-Existing Condition Period:** | Each Member who is age 19 or older on the Enrollment Date must serve a twelve-month Pre-Existing Condition Waiting Period, less any Creditable Coverage the Member can provide. Any member who is a Late Enrollee will serve an eighteen month Pre-Existing Condition Waiting Period. See Article II of this Plan of Benefits for information on qualifying for Special Enrollment. |
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| **Dependent Child, in addition to meeting the requirements contained in this Plan of Benefits; the maximum age limitation to qualify as a Dependent Child is:** | A Child under the age of 26. |
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| **Actively at Work:**<br><br>**Minimum hours per week:**<br><br>**Minimum weeks per year:** | <br><br>At least 30 hours per week.<br><br>At least 48 weeks per year. |
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| **Benefit Year Deductible:** | The Benefit Year Deductible for single coverage is $2,000 for Participating Providers.<br><br>The Benefit Year Deductible for single coverage is $4,000 for Non-Participating Providers<br><br>The Benefit Year Deductible is $4,000 per Family and may be met by any combination of one or more Members for Participating Providers<br><br>The Benefit Year Deductible is $8,000 per Family and may be met by any combination of one or more Members for Non-Participating Providers.<br><br>Covered Expenses that are applied to the Benefit Year Deductible shall contribute to both the Participating and Non-Participating Provider Benefit Year Deductibles. |
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| **Annual Out-of-Pocket Maximum:** | The Out-of-Pocket Maximum for single coverage is $2,000 for Participating Providers.<br><br>The Out-of-Pocket Maximum for single coverage is $3,000 for Non-Participating Providers.<br><br>The Out-of-Pocket Maximum is $4,000 per family and may be met by any combination of one or more Members for Participating Providers.<br><br>The Out-of-Pocket Maximum is $6,000 per family and may be met by any combination of one or more Members for Non-Participating Providers.<br><br>Allowable Charges are paid at 100% after the Out-of-Pocket Maximum is met.<br><br>Covered Expenses that are applied to the Out-of-Pocket Maximum shall contribute to both the Participating and Non-Participating Provider Out-of-Pocket Maximums.<br><br>If claim pays secondary, Coinsurance and Benefit Year Deductible amounts will accumulate toward the Out-of-Pocket Maximum. |
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| **Restricted Annual Dollar Limit:** | $2,000,000 per Member. |
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Benefit Year Deductibles and any Copayments must be met before any Covered Expenses can be paid. The Copayment for each Admission is $0 for a Participating Provider and $100 for a Non-Participating Provider.

This Schedule of Benefits applies during the 01/01 through 12/31 Benefit Year. The Anniversary Date is 01/01.

In the event that two or more Members of one family incur charges for Covered Expenses as a result of injuries received in the same accident, only one Benefit Year Deductible will be applied to Covered Expenses that are incurred by all such Members as a result of injuries sustained in that same accident.

**All Admissions require Pre-Authorization**. If Pre-Authorization is not obtained, room and board charges will be denied. Other services may also require Pre-Authorization. Please see the Schedule of Benefits and Plan of Benefits for more information.

Pre-Authorization is required for the following outpatient Benefits:
MRI
MRA
CT Scans
PET Scans
Septoplasty
Any surgical procedure that may be potentially cosmetic: i.e. blepharoplasty, reduction mammoplasty
Hysterectomy
Investigational procedures
Mental Health Services
Mental Health Conditions
Substance Abuse Services
Behavioral Therapy related to Autism Spectrum Disorder

Benefits for Behavioral Therapy related to Autism Spectrum Disorder, MRIs, MRAs, CT Scans, and PET Scans will be denied when Pre-Authorization is not obtained or approved by the Corporation. Benefits for any other outpatient services that require Pre-Authorization will be reduced by 50% of the Allowable Charge when Pre-Authorization is not obtained or approved by the Corporation.

| ADMISSIONS/INPATIENT BENEFITS | | |
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| | **Participating Provider** | **Non-Participating Provider** |
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| Hospital charges for room and board related to Admissions | The Corporation pays 80% of the Allowable Charge<br><br>The Member pays the remaining 20% of the Allowable Charge | The Corporation pays 50% of the Allowable Charge after the Copayment<br><br>The Member must pay the balance of the Provider's charge |
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| All other Benefits in a Hospital during an Admission (including for example, facility charges related to the administration of anesthesia, obstetrical services including labor and delivery rooms, drugs, medicine, lab and x-ray services) | The Corporation pays 80% of the Allowable Charge<br><br>The Member pays the remaining 20% of the Allowable Charge | The Corporation pays 50% of the Allowable Charge after the Copayment<br><br>The Member must pay the balance of the Provider's charge |
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| Inpatient physical rehabilitation services when Pre-Authorized by the Corporation and performed at a Provider designated by the Corporation | The Corporation pays 80% of the Allowable Charge<br><br>The Member pays the remaining 20% of the Allowable Charge | The Corporation pays 50% of the Allowable Charge after the Copayment<br><br>The Member must pay the balance of the Provider's charge |
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| Skilled Nursing Facility Admissions, limited to 60 days per Benefit Year (Pre-Authorization is required) | The Corporation pays 80% of the Allowable Charge<br><br>The Member pays the remaining 20% of the Allowable Charge | The Corporation pays 50% of the Allowable Charge after the Copayment<br><br>The Member must pay the balance of the Provider's charge |
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| Long Term Acute Care Hospital (Pre-Authorization is required) | The Corporation pays 80% of the Allowable Charge<br><br>The Member pays the remaining 20% of the Allowable Charge | The Corporation pays 50% of the Allowable Charge after the Copayment<br><br>The Member must pay the balance of the Provider's charge |
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| OUTPATIENT BENEFITS | | |
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| | **Participating Provider** | **Non-Participating Provider** |
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| Hospital and Ambulatory Surgical Center charges for Benefits provided on an outpatient basis, including: lab, x-ray and other diagnostic services | The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible | The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member must pay the balance of the Provider's charge |
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| True Emergency Room Visits | The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible | The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member must pay the balance of the Provider's charge |
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| Non-True Emergency Room Visits | The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible | The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member must pay the balance of the Provider's charge |
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| All other covered outpatient Benefits | The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible | The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member must pay the balance of the Provider's charge |
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| PHYSICIAN SERVICES | | |
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| | **Participating Provider** | **Non-Participating Provider** |
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| Physician Services in a Hospital | The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible | The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member must pay the balance of the Provider's charge |
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| Surgical Services, when rendered in a Hospital, Ambulatory Surgical Center or Physician's office | The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible | The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member must pay the balance of the Provider's charge |
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| Physician Services for treatment in a Hospital outpatient department or Ambulatory Surgical Center | The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible | The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member must pay the balance of the Provider's charge |
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| Services in the Physician's office, including contraceptives and contraceptive devices (other than Surgical Services, Maternity Care, physical therapy, dialysis treatment and second surgical opinion) | The Corporation pays 100% of the Allowable Charge after the Member pays a $25 Copayment. | The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member must pay the balance of the Provider's charge |
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| Physician Services in the Member's home | The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible | The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member must pay the balance of the Provider's charge |
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| | **Participating Provider** | **Non-Participating Provider** |
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| Second surgical opinion | The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible | The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member must pay the balance of the Provider's charge |
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| All other Physician Services | The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible | The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member must pay the balance of the Provider's charge |
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**MENTAL HEALTH SERVICES, MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE SERVICES**

**Pre-authorization is required for Mental Health Services, Mental Health Conditions and Substance Abuse Services. If Pre-Authorization is not obtained or approved by the Corporation, the following penalties will apply.**

**Inpatient: Denial of room and board**
**Outpatient: 50% of the Allowable Charge**
**Office: 50% of the Allowable Charge**

| | **Participating Provider** | **Non-Participating Provider** |
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| | | |
| Inpatient Hospital charges for Mental Health Services, Mental Health Conditions and Substance Abuse Services | The Corporation pays 80% of the Allowable Charge<br><br>The Member pays the remaining 20% of the Allowable Charge | The Corporation pays 50% of the Allowable Charge<br><br>The Member must pay the balance of the Provider's charge |
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| Outpatient Hospital or clinic charges for Mental Health Services, Mental Health Conditions and Substance Abuse Services | The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible | The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member must pay the balance of the Provider's charge |
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| Inpatient Physician charges for Mental Health Services, Mental Health Conditions and Substance Abuse Services | The Corporation pays 80% of the Allowable Charge<br><br>The Member pays the remaining 20% of the Allowable Charge | The Corporation pays 50% of the Allowable Charge<br><br>The Member must pay the balance of the Provider's charge |
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| Outpatient Physician charges for Mental Health Services, Mental Health Conditions and Substance Abuse Services | The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible | The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member must pay the balance of the Provider's charge |
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| Office Physician charges for Mental Health Services, Mental Health Conditions and Substance Abuse Services | The Corporation pays 100% of the Allowable Charge after the Member pays a $25 Copayment | The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member must pay the balance of the Provider's charge |
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| | **Participating Provider** | **Non-Participating Provider** |
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| Outpatient Hospital or Physician charges for Emergency Room Services for Mental Health Services, Mental Health Conditions and Substance Abuse Services | The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible | The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member must pay the balance of the Provider's charge |
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| OTHER SERVICES | | |
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| | **Participating Provider** | **Non-Participating Provider** |
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| Ambulance service (including air ambulance) | The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible | The Corporation pays 80% of the Allowable Charge after the Participating Provider Benefit Year Deductible<br><br>The Member must pay the balance of the Provider's charge |
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| Durable Medical Equipment, Prosthetics* and Orthopedic Devices (if purchase or rental of Durable Medical Equipment is $500 or more, Pre-Authorization is required)<br><br>*Prosthetics are covered up to a Maximum Payment of $50,000 per Member per Benefit Year. | The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible | Non-Covered |
| | | |
| Medical Supplies | The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible | The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member must pay the balance of the Provider's charge |
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| Home Health Care, including private duty nursing services, limited to 60 visits per Benefit Year (Pre-Authorization is required) | The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible | The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member must pay the balance of the Provider's charge |
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| Hospice Care, limited to 6 months per episode (Pre-Authorization is required) | The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible | The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member must pay the balance of the Provider's charge |
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| | Participating Provider | Non-Participating Provider |
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| Colorectal Cancer Screenings limited to:<br>• One (1) fecal occult blood testing of three (3) consecutive stool samples per Benefit Year<br>• One (1) flexible sigmoidoscopy every five years<br>• One (1) double contrast barium enema every five years<br>• One (1) colonoscopy every ten (10) years | Covered | Covered |
| | | |
| Behavioral Therapy (ABA) related to Autism Spectrum Disorder limited to:<br>• Members diagnosed at age eight (8) or younger<br>• Members under the age of sixteen (16)<br>• $52,100 per Benefit Year<br><br>Pre-Authorization is required. | The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible | Non-Covered |
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| Provider Charges for physical therapy and occupational therapy (Limited to a combined 30 visits per Member per Benefit Year. Please see the "Outpatient Rehabilitation" section in Article III of the Plan of Benefits for further limitations) | The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible | The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member must pay the balance of the Provider's charge |
| | | |
| Speech therapy (Limited to 20 visits per Member per Benefit Year. Please see the "Outpatient Rehabilitation" section in Article III of the Plan of Benefits for limitations) | The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible | The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member must pay the balance of the Provider's charge |
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| | **Participating Provider** | **Non-Participating Provider** |
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| Radiation therapy<br><br>Cancer chemotherapy<br><br>Respiratory therapy<br><br><br>Pre-authorization is required | The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible | The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member must pay the balance of the Provider's charge |
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| Human organ and tissue transplant services (excluding drugs).<br><br>Human organ and tissue transplant services are only covered if provided at a Blue Distinction Center of Excellence or a transplant center approved by the Corporation in writing<br><br>Physician Charges are subject to the Benefit Year Deductible. | The Corporation pays 80% of the Allowable Charge<br><br>The Member pays the remaining 20% of the Allowable Charge | Non-Covered |
| | | |
| Allergy Injections | The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible | The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member must pay the balance of the Provider's charge |
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| Acupuncture | Non-Covered | Non-Covered |
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| Chiropractic Services, including related x-rays, limited to a $1,000 maximum payment per Member per Benefit Year | The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member pays the remaining 50% of the Allowable Charge after meeting the Member's Benefit Year Deductible | The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member must pay the balance of the Provider's charge |
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| Cosmetic Services | Non-Covered | Non-Covered |
| | | |
| Disease Management Program | Covered | Non-Covered |
| | | |
| Eyeglasses/Vision care | Non-Covered | Non-Covered |
| | | |
| Health Questions Hotline | Covered | Non-Covered |
| | | |

| | **Participating Provider** | **Non-Participating Provider** |
|---|---|---|
| | | |
| Hearing Aids | Non-Covered | Non-Covered |
| | | |
| Oxygen (Pre-authorization is required) | Covered | Covered |
| | | |
| Impacted tooth removal | Non-Covered | Non-Covered |
| | | |
| Infertility treatment | Non-Covered | Non-Covered |
| | | |
| Impotence treatment | Non-Covered | Non-Covered |
| | | |
| Online Health Assessment Program | Covered | Non-Covered |
| | | |
| Massage Therapy | Non-Covered | Non-Covered |
| | | |
| Maternity Management Program | Covered | Non-Covered |
| | | |
| Tobacco Cessation Program | Non-Covered | Non-Covered |
| | | |
| Temporomandibular Joint Disorder (TMJ) including treatment | Non-Covered | Non-Covered |
| | | |
| Orthognathic surgery | Non-Covered | Non-Covered |
| | | |
| Weight Control Program | Non-Covered | Non-Covered |
| | | |
| Diabetic Supplies | The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible<br><br>The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible | The Corporation pays 80% of the Allowable Charge after the Participating Provider Benefit Year Deductible<br><br>The Member must pay the balance of the Provider's charge |
| | | |
| Sustained Health services related to an annual physical exam (limited to $250 per Member per Benefit Year)<br><br>This benefit does not include Preventive Benefits offered under PPACA. See the Preventive Benefits section in this Schedule of Benefits for payment of Preventive Benefits under PPACA. | The Corporation pays 100% of the Allowable Charge after the Member pays a $25 Copayment. | Non-Covered |

| PREVENTIVE BENEFITS<br>The Benefit Year Deductible does not apply to these Benefits | | |
|---|---|---|
| | **Participating Provider** | **Non-Participating Provider** |
| | | |
| Preventive Benefits under PPACA (Refer to www.healthcare.gov for guidelines) | Covered | Non-covered |
| | | |
| Pap smear screenings (the report and interpretation only, limited to one (1) per Benefit Year) | The Corporation pays 100% of Allowable Charge | Non-Covered |
| | | |
| Prostate screenings (limited to one (1) per Benefit Year) | The Corporation pays 100% of Allowable Charge | Non-Covered |
| | | |
| **In South Carolina:** | | |
| | | |
| | **SC Mammography Network** | **All Other Providers** |
| | | |
| Mammography screenings (limited to one (1) per Benefit Year for any female Member age 35 or older) | The Corporation pays 100% of Allowable Charge | Non-Covered |
| | | |
| **Outside South Carolina:** | | |
| | | |
| | **Out-of-State Participating Providers** | **All Other Providers** |
| | | |
| Mammography screenings (limited to one (1) per Benefit Year for any female Member age 35 or older) | The Corporation pays 100% of Allowable Charge | Non-Covered |
| | | |

| PRESCRIPTION DRUG BENEFIT | | | |
|---|---|---|---|
| **Prescription Drugs** | **Mail Service Pharmacy** | **Participating Pharmacy** | **All Other Pharmacies** |
| | | | |
| Generic Drugs | $20 Copayment per Member for each Prescription or refill, up to a 90-day supply | $10 Copayment per Member for each Prescription or refill, for each monthly supply, up to a 90-day supply. | The Corporation pays 50% of the Allowable Charge after a $10 Copayment per Member for each Prescription or refill, for each monthly supply, up to a 90-day supply. |
| | | | |
| Preferred Brand Drug | $80 Copayment per Member for each Prescription or refill, up to a 90-day supply | $35 Copayment per Member for each Prescription or refill, up to a 31-day supply | The Corporation pays 50% of the Allowable Charge after a $35 Copayment per Member for each Prescription or refill, up to a 31-day supply |
| | | | |
| Non-Preferred Brand Drug | $140 Copayment per Member for each Prescription or refill, up to a 90-day supply | $55 Copayment per Member for each Prescription or refill, up to a 31-day supply | The Corporation pays 50% of the Allowable Charge after a $55 Copayment per Member for each Prescription or refill, up to a 31-day supply |
| | | | |
| *Contraceptives: Generic oral contraceptives, generic injections, Mirena IUD, Nexplanon implant, Ortho Evra patch, Nuvaring, Ortho Flex, Ortho Coil, Ortho Flat, Wide-seal, Omniflex, Prentif and Femcap-vaginal | Prescription Drugs will be covered at 100%, up to a 90-day supply | Prescription Drugs will be covered at 100%, up to a 31 day-supply | The Member will be responsible for 100% of the Allowable Charge, then will be reimbursed at 50% of the Allowable Charge, up to a 31-day supply |
| | | | |
| **All Other Contraceptives (Prescription Drugs) | Covered | Covered | Covered |
| | | | |
| Prescription Drugs used for tobacco cessation | Non-Covered | Non-Covered | Non-Covered |
| | | | |

***Contraceptives listed above are covered under the participating medical benefits at the same payment levels.**

**** All other contraceptives are paid at the Generic, Preferred Brand and Non-Preferred Brand Drug payment levels.**

| **Prescription Drugs** | **Mail Service Pharmacy** | **Participating Pharmacy** | **All Other Pharmacies** |
|---|---|---|---|
| | | | |
| Prescription Drug Deductible | $0 (No Prescription Drug Deductible) | $0 (No Prescription Drug Deductible) | $0 (No Prescription Drug Deductible) |
| | | | |
| Prescription Drug Out-of-Pocket | $0 (No Prescription Drug Out-of-Pocket) | $0 (No Prescription Drug Out-of-Pocket) | $0 (No Prescription Drug Out-of-Pocket) |
| | | | |
| Maximum Prescription Drug Benefit | $0 (No Maximum Prescription Drug Benefit) | $0 (No Maximum Prescription Drug Benefit) | $0 (No Maximum Prescription Drug Benefit) |
| | | | |
| Prescription Drugs used for obesity/weight control | Non-Covered | Non-Covered | Non-Covered |
| | | | |

| SPECIALTY DRUG BENEFIT | | |
|---|---|---|
| | **Participating Pharmacy** | **All Other Pharmacies** |
| | | |
| Specialty Drugs | $100 Copayment per Member for each prescription or refill, up to a 31-day supply. | Non-Covered |
| | | |

**AMENDMENT**

**Employer Name:** Constantia Hueck Foils, LLC
**Employer Number:** 15-53266-00 and appropriate subgroups
**Effective Date:** 01/01/2013

The Plan of Benefits between the Employer and the Corporation is amended as follows:

The section entitled **ARTICLE I – DEFINITIONS** is amended as follows by the addition of:

**Step Therapy Programs:** programs that require a Member to use lower-cost medications that are used to treat the same condition before obtaining higher-cost medication.

**Quantity versus Time (QVT) Limits:** limits that restrict the quantity of Prescription Drugs that are covered under a Member's Benefit within a certain time frame. The limits established for these drugs are based on FDA approved indication.

The section entitled **ARTICLE IV – EXCLUSIONS AND LIMITATIONS, Prescription Drug Exclusions** is amended as follows by the addition of:

- Prescription Drugs that are not authorized when part of a Step Therapy Program.

THIS IS AN AMENDMENT TO YOUR PRESENT PLAN OF BENEFITS.

# AUTISM SPECTRUM DISORDER AMENDMENT

**Employer Name:** Constantia Hueck Foils, LLC

**Employer Number:** 15-53266-00 and appropriate subgroups

**Effective Date:** 01/01/2013

This Plan of Benefits between the Employer and the Corporation is amended as follows:

**Article I – Definitions is amended by the addition of the following:**

**Autism Spectrum Disorder:** the three following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

A. Autistic Disorder;
B. Asperger's Syndrome;
C. Pervasive Developmental Disorder--Not Otherwise Specified

**Behavioral Therapy:** any behavioral modification using Applied Behavioral Analysis (ABA) techniques to target cognition, language, and social skills.

Behavioral Therapy does not include educational or alternative programs such as, but not limited to:

1. TEACCH,
2. Auditory Integration Therapy,
3. Higashi Schools/Daily Life,
4. Facilitated Communication,
5. Floor Time (DIR, Developmental Individual-difference Relationship-based model),
6. Relationship Development Intervention (RDI), Holding Therapy,
7. Movement Therapies,
8. Music Therapy, and
9. Pet Therapy.

**Article I – Definitions is amended by deleting the definition of Mental Health Conditions and inserting, in lieu thereof, the following:**

**Mental Health Conditions:** certain psychiatric disorders or conditions defined in the most current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association and which is not otherwise excluded by the terms and conditions of this Plan of Benefits. The conditions as mandated by the State of South Carolina are:

1. Bipolar Disorder;

2. Major Depressive Disorder;

3. Obsessive Compulsive Disorder;

4. Paranoid and Other Psychotic Disorder;

5. Schizoaffective Disorder;

6. Schizophrenia;

7. Anxiety Disorder;

8. Post-traumatic Stress Disorder;

9. Depression in childhood and adolescence; and

10. Autism Spectrum Disorder

**Article III – Benefits is amended by the addition of the following:**

**Behavioral Therapy Related to Autism Spectrum Disorder**

Coverage for Behavioral Therapy for Autism Spectrum Disorder is subject to a maximum benefit as shown in the Schedule of Benefits.

**Services must be provided by or under direction of an approved Participating Provider. Pre-Authorization requests and treatment plans must be submitted to Companion Benefit Alternatives. Companion Benefit Alternatives is a separate company that provides utilization management for behavioral health services on behalf of BlueCross BlueShield of South Carolina.**

**AMENDMENT**

**Employer Name:** Constantia Hueck Foils, LLC

**Employer Number:** 15-53266-00 and appropriate subgroups

**Effective Date:** 01/01/2013

The Plan of Benefits between the Employer and the Corporation is amended as follows:

The first paragraph in the section entitled **ARTICLE IV – EXCLUSIONS AND LIMITATIONS** is deleted in its entirety and the following substituted therefore:

REGARDLESS OF LANGUAGE CONTAINED ELSEWHERE IN THIS PLAN OF BENEFITS, THE FOLLOWING ARE NOT BENEFITS UNDER THIS PLAN OF BENEFITS. THE ONLY EXCEPTION TO THIS IS WHERE SUCH ITEMS ARE SPECIFICALLY INCLUDED ON THE SCHEDULE OF BENEFITS OR AS THE LAW REQUIRES (I.E. INTENTIONAL OR UNREASONABLE INJURIES OR ILLNESSES THAT RESULT FROM MEDICAL CONDITIONS OR DOMESTIC VIOLENCE). THE CORPORATION WILL NOT PAY ANY AMOUNT FOR THE FOLLOWING:

THIS IS AN AMENDMENT TO YOUR PRESENT HEALTH PLAN OF BENEFITS.

**AMENDMENT**

**Employer Name:** Constantia Hueck Foils, LLC

**Employer Number:** 15-53266-00 and appropriate subgroups

**Effective Date:** 01/01/2013

The Plan of Benefits between the Employer and the Corporation is amended as follows:

Paragraph E. 6.in **ARTICLE II – ELIGIBILITY FOR COVERAGE** is deleted in its entirety and the following substituted therefore:

6. Special Enrollment.

   In addition to enrollment under Article II (E) (2-5), the Corporation shall permit an Employee or Dependent who is not enrolled to enroll if each of the following is met:

   a. The Employee or Dependent was covered under a Group Health Plan or had Creditable Coverage at the time coverage was previously offered to the Employee or Dependent; and

   b. The Employee stated in writing at the time of enrollment, that the reason for declining enrollment was because the Employee or Dependent was covered under a Group Health Plan or had Creditable Coverage at that time. This requirement shall only apply if the Employer required such a statement at the time the Employee declined coverage and provided the Employee with notice of the requirement and the consequences of the requirement at the time; and

   c. The Employee or Dependent's coverage described above:

      i. Was under a COBRA continuation provision and the coverage under the provision was exhausted; or

      ii. Was not under a COBRA continuation provision described in section 6(c)(i), above, and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment), or reduction in the number of hours of employment, or if the employer's contributions toward the coverage were terminated; or

      iii. Was one of multiple Plans offered by an employer and the Employee elected a different plan during an open enrollment period or when an employer terminates all similarly situated individuals; or

      iv. Was under a HMO that no longer serves the area in which the Employee lives, works or resides; or

      v. Was under a Plan where the Member incurs a claim that would meet or exceed a lifetime limit on all benefits. The Special Enrollment period is continued until at least thirty (30) days after a claim is denied due to the operation of the lifetime limit on all benefits.

vi. Under the terms of the Plan, the Employee requests the enrollment not later than thirty-one (31) days after date of exhaustion described in 6(c)(i) above, or termination of coverage or Employer contribution described in 6(c)(ii) above.

d. Medicaid or SCHIP Coverage

i. The Employee or Dependent was covered under a Medicaid or SCHIP plan and coverage was terminated due to loss of eligibility; or

ii. The Employee or Dependent becomes eligible for assistance under a Medicaid or SCHIP plan; and

iii. The Employee or Dependent requests such enrollment not more than sixty (60) days after either:

(a) date of termination of Medicaid or SCHIP coverage; or
(b) determination that the Employee or Dependent is eligible for such assistance.

The above list is not an all-inclusive list of situations when an Employee or Dependent loses eligibility. For situations other than those listed above see the Employer.

THIS IS AN AMENDMENT TO YOUR PRESENT HEALTH PLAN OF BENEFITS.

# AMENDMENT

**Employer Name:** Constantia Hueck Foils, LLC

**Employer Number:** 15-53266-00 and appropriate subgroups

**Effective Date:** 01/01/2013

The Plan of Benefits between the Employer and the Corporation is amended as follows:

**Article IV- EXCLUSIONS AND LIMITATIONS is amended by deleting the following terms and inserting, in lieu thereof, the following:**

**PSYCHOLOGICAL AND EDUCATIONAL TESTING**

Psychological or educational diagnostic testing to determine job or occupational placement, school placement or for other educational purposes, or to determine if a learning disability exists.

**RELATIONSHIP COUNSELING**

Relationship counseling, including marriage counseling, for the treatment of pre-marital, marital or relationship dysfunction.

**SERVICES FOR CERTAIN DIAGNOSES OR DISORDERS**

Medical Supplies or services or charges for the diagnosis or treatment of sexual and gender identity disorders, personality disorders, learning disorders, dissociative disorders, developmental speech delay, communication disorders, developmental coordination disorders, mental retardation or vocational rehabilitation.

**Article IV- EXCLUSIONS AND LIMITATIONS is amended by the addition of the following:**

**BIO-FEEDBACK SERVICES**

Bio-feedback when related to psychological services.

**SERVICES FOR COUNSELING OR PSYCHOTHERAPY**

**Counseling and psychotherapy services for the following conditions are not covered:**

1. Feeding and eating disorders in early childhood and infancy;
2. Tic disorders except when related to Tourette's disorder;
3. Elimination disorders;
4. Mental disorders due to a general medical condition;
5. Sexual function disorders;
6. Sleep disorders;
7. Medication induced movement disorders; or
8. Nicotine dependence unless specifically listed as a Benefit in Article III of this Plan of Benefits or on the Schedule of Benefits.

THIS IS AN AMENDMENT TO YOUR PRESENT HEALTH PLAN OF BENEFITS.

**PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) AMENDMENT**

**Employer Name:** Constantia Hueck Foils, LLC

**Employer Number:** 15-53266-00 and appropriate subgroups

**Effective Date:** 01/01/2013

**Section 2, Employer Responsibilities, in the Master Group Contract is updated by the addition of the following:**

G. To distribute any Member notices required under the Patient Protection and Affordable Care Act (PPACA).

**Section 6, Termination, in the Master Group Contract is amended by the deletion of paragraph F. in its entirety and the following substituted therefore:**

F. Retroactive Termination/Rescissions. It is the Employer's responsibility to ensure any retroactive Member termination forwarded to the Corporation is in compliance with federal law, specifically, that such termination was due to either:

a. A Member's fraudulent act, practice or omission, or

b. A Member's intentional misrepresentation of material fact, or

c. A Member's failure to timely pay required premiums or contributions towards the cost of coverage.

The Employer is solely responsible for providing to the Member any notice related to retroactive terminations or rescissions that are required by law.

G. Notice of Termination to Members.

(a) Other than as expressly required by law, if this Contract or this Plan of Benefits is terminated for any reason, the Employer is solely responsible for notifying all Members of such termination and coverage of Members will not continue beyond the termination date.

(b) The Employer agrees to indemnify and hold the Corporation harmless for all damages, claims, causes of action, costs and expenses (including a reasonable attorney's fee) arising out of or relating to the Employer's failure to notify Members of termination of this Contract or this Plan of Benefits, or any other notification required to be given to Members by the Employer.

**The Plan of Benefits between the Employer and the Corporation is amended as follows:**

**ARTICLE I - DEFINITIONS** is amended by the deletion of the term **Lifetime Maximum**.

The following definitions in **ARTICLE I – DEFINITIONS** are deleted in their entirety and the following substituted therefore:

**Child**: An Employee's child, whether a natural child, adopted child, foster child, stepchild, or child for whom an Employee has custody or legal guardianship. The term "Child" also includes an Incapacitated Dependent, a Child who is on a Medically Necessary Leave of Absence, a child of a divorced or divorcing Employee who, under a Qualified Medical Child Support Order, has a right to enroll under the Employer's Group Health Plan. The term "Child" does not include the spouse of an eligible child.

Under the Patient Protection and Affordable Care Act and the Health Coverage and the Education Reconciliation Act, a child does not include an individual who is eligible for other employer sponsored coverage if the group health plan is grandfathered plan beginning for plan years before January 1, 2014.

**Dependent**: an individual who is:
1. An Employee's spouse; or
2. A Child under the age set forth on the Schedule of Benefits; or
3. A Child who is on a physician approved, Medically Necessary Leave of Absence; or
4. An Incapacitated Dependent.

**Late Enrollee**: an Employee (or Member 19 or over) who enrolls for coverage under this Plan of Benefits other than during:
1. The first period in which the Employee or Dependent is eligible to enroll if such initial enrollment period is a period of at least thirty (30) days; or
2. A special enrollment period (as set forth in Article II (E)(6)).

**Pre-Existing Condition Waiting Period**: the period (as set forth on the Schedule of Benefits) during which this Plan of Benefits will not provide Benefits to a Member who is age 19 or older for Pre-Existing Conditions, not to exceed twelve (12) months without medical care, treatment or supplies ending after the Member Effective Date of coverage or twelve (12) months after the Enrollment Date, whichever occurs first or eighteen (18) months after the Enrollment Date for a late enrollee.

The following definition is added to **ARTICLE I – DEFINITIONS**:

**Restricted Annual Dollar Limit:** means the total Benefits (under this Group Health Plan) to which a Member is entitled to each Benefit Year for essential health benefits as defined under the (PPACA). The restricted annual dollar limit is for Benefit Years beginning on or after September 23, 2010, but prior to January 1, 2014. Refer to the Schedule of Benefits for the restricted annual dollar limit.

The following is added to paragraph **A. ELIGIBILITY** in **ARTICLE II – ELIGIBILITY FOR COVERAGE**:

4. Probationary Periods and/or contribution levels will not be based on any factor which discriminates in favor of higher wage employees as required under PPACA.

The following is added to paragraph **B. PRE-EXISTING CONDITION WAITING PERIOD** in **ARTICLE II – ELIGIBILITY FOR COVERAGE**:

7. A Member enrolled before the age 19.

**ARTICLE III - BENEFITS** is amended by the deletion of the **ROUTINE ANNUAL BENEFITS** and the following substituted therefore:

**PREVENTIVE SERVICES**
The Corporation will pay for preventive health services required under PPACA as follows:

a. Evidence based services that have a rating of A or B in the current United States Preventive Services Task Force (USPSTF) recommendations;
b. Immunizations as recommended by the Center for Disease Control and Prevention (CDC); and
c. Preventive care and screenings for children and women as recommended by the Health Resources and Services Administration (HRSA).

These Benefits are provided without any cost-sharing by the Member when the services are provided by a Participating Provider. Any other covered preventive screenings will be provided as specified in the Schedule of Benefits.

THIS IS AN AMENDMENT TO YOUR PRESENT PLAN OF BENEFITS.

**AMENDMENT**

**Employer Name:** Constantia Hueck Foils, LLC

**Employer Number:** 15-53266-00 and appropriate subgroups

**Effective Date:** 01/01/2013

**The Plan of Benefits between the Employer and the Corporation is amended as follows:**

**The following definition is added to ARTICLE I – DEFINITIONS:**

**Custodial Care:** non-skilled services that are primarily for the purpose of assisting an individual with daily living activities or personal needs (e.g. bathing, dressing, eating), which is not specific therapy for any illness or injury.

**The following benefits in ARTICLE III - BENEFITS are deleted in their entirety and the following substituted therefore:**

**DENTAL CARE FOR ACCIDENTAL INJURY**

The Corporation will pay Covered Expenses for dental services to Natural Teeth required because of accidental injury. For purposes of this section, an accidental injury is defined as an injury caused by a traumatic force such as a car accident or a blow by a moving object. No Benefits will be made available for injuries that occur while the Member is in the act of chewing or biting. Services for conditions that are not directly related to the accidental injury are not covered. The first visit to a dentist does not require Pre-Authorization; however, the dentist must submit a plan for any future treatment to the Corporation for review and Pre-Authorization before such treatment is rendered if Covered Expenses are to be paid. Benefits are limited to treatment for only six (6) months from the date of the accidental injury.

**ORTHOTIC DEVICES**
The Corporation will pay Covered Expenses for Pre-Authorized Orthotic Devices that are not available on an over-the-counter basis and are not otherwise excluded under this Plan of Benefits.

**PROSTHETIC DEVICES**
Coverage is provided for a Prosthetic Device, other than a dental or cranial prosthetic, which is a replacement for a body part, and which meets minimum specifications for the body part it is replacing regardless of the functional activity level. Coverage is provided for the cost of the standard, non-luxury item only (as determined by the Corporation). Components that are considered deluxe or upgraded over a standard model are not a covered service. Except as provided below, Benefits are provided for only the initial temporary prosthesis and one permanent prosthesis. No Benefits are provided for repair, replacement or duplicates, nor are Benefits provided for services related to the repair or replacement of such prosthetics, except when necessary due to a change in the Member's medical condition, and with prior authorization from the Corporation.

Prosthetic Devices do not include bioelectric, microprocessor or computer programmed prosthetic components

**Article III - BENEFITS is amended by the deletion of paragraph 2, SURGICAL SERVCIES and the following substituted therefore:**

2. Surgical assistant services, that consist of the Medically Necessary service of one (1) medical doctor or oral surgeon who actively assists the operating surgeon when a covered Surgical Service is performed in a Hospital, and when such surgical assistant service is not available by an intern, resident, or in-house Physician. The Corporation will pay charges at the percentage of the Allowable Charge set forth on the Schedule of Benefits for the Surgical Service, not to exceed the medical doctor's or oral surgeon's (as applicable) actual charge.

**The following exclusions are added to Article IV – EXCLUSIONS AND LIMITATIONS:**

**CRANIAL ORTHOTICS**

Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, adjustable cranial orthoses (band or helmet) for positional plagiocephaly or craniosynostoses in the absence of cranial vault remodeling surgery.

**CUSTODIAL CARE**

Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, services or supplies related to Custodial Care.

**GROWTH HORMONE THERAPY**

Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, growth hormone therapy for patients over 18 years of age. Growth hormone therapy for patients 18 years of age or younger is excluded unless for documented growth hormone deficiency.

**HEMOPHILIA SERVICES**

A percentage of the Allowable Charge (as set forth on the Schedule of Benefits) for services, treatment or medications related to the management of all types of blood clotting or coagulation disorders, such as, but not limited to Hemophilia, unless the member has received treatment at least once in a given Benefit year at a Hemophilia Treatment Center (HTC) as designated by the U.S. Centers for Disease Control and Prevention.

**HYPNOTISM**

Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, hypnotism treatment or services.

**PRE-CONCEPTION SERVICES**

Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, pre-conception testing, pre-conception counseling, or pre-conception genetic testing.

**PROSTHETIC DEVICES**

Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, repair or replacement for routine wear and tear is not a covered Benefit.

**PULMONARY REHABILITATION**

Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, pulmonary rehabilitation, except in conjunction with a covered lung transplant.

**SERVICES RENDERED BY AN INDEPENDENT HEALTHCARE PROFESSIONAL**

Charges for services or supplies from an independent healthcare professional whose services are normally included in facility charges.

**VARICOSE VEIN TREATMENT**

Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, services, supplies or treatment for varicose veins, including but not limited to endovenous ablation, vein stripping, or the injection of sclerosing solutions.

**WHEELCHAIRS OR POWER OPERATED VEHICLES**

Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, manual or motorized wheelchairs or power operated vehicles such as scooters for mobility outside of the home setting. Coverage for these devices to assist with mobility in the home setting is subject to the establishment of Medical Necessity by the Corporation.

**The following exclusions in ARTICLE IV – EXCLUSIONS AND LIMITATIONS are deleted in their entirety and the following substituted therefore:**

**DENTAL SERVICES**

Any dental procedures involving tooth structures, excision or extraction of teeth, gingival tissue, alveolar process, dental X-rays, preparation of mouth for dentures, or other procedures of dental origin. However, that such procedures may be Pre-Authorized in the sole discretion of the Corporation if the need for dental services results from an accidental injury to Natural Teeth within six (6) months prior to the date of such services.

**FOOD SUPPLEMENTS**

Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, orthomolecular therapy including infant formula, nutrients, vitamins and food supplements. Enteral feedings when not a sole source of nutrition.

**OBESITY RELATED PROCEDURES**

1. Unless such item has a dollar or percentage amount associated with it on the Schedule of Benefits, services, supplies, treatment or medication for the management of morbid obesity, obesity, weight reduction, weight control or dietary control (collectively referred to as “obesity-related treatment”) including, but not limited to, gastric bypass or stapling, intestinal bypass and related procedures or gastric restrictive procedures.

2. Also, the treatment or correction of complications from obesity-related treatment are non-covered services, regardless of Medical Necessity, prescription by a Physician or the passage of time from a Member’s obesity-related treatment. This includes the reversal of obesity-related treatments, and reconstructive procedures necessitated by weight loss.

3. Membership fees to weight control programs.

**PAIN MANAGEMENT PROGRAMS**

Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, chronic pain management programs or multi-disciplinary pain management programs, including TENS units, unless Medically Necessary.

**SERVICES FOR CERTAIN DIAGNOSES OR DISORDERS**

Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, medical supplies or services or charges for the diagnosis or treatment of learning disabilities, developmental speech delay, perceptual disorders, mental retardation, vocational rehabilitation, animal assisted therapy, rTMS, eye movement desensitization and reprocessing (EMDR), behavioral therapy for solitary maladaptive habits, or rapid opiate detoxification.

**ARTICLE IV – EXCLUSIONS AND LIMITATIONS is amended by the deletion of CUSTODIAL OR LONG-TERM CARE SERVICES and the following substituted therefore:**

**LONG-TERM CARE SERVICES**

Admissions or portions thereof for long-term care, including:

1. Rest care;

2. Long-term acute or chronic psychiatric care;

3. Care to assist a Member in the performance of activities of daily living (including, but not limited to: walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation, and taking medication);

4. Custodial or long-term care; or,

5. Psychiatric or substance abuse residential treatment, including: Residential Treatment Centers; Therapeutic schools; Wilderness/Boot camps; Therapeutic Boarding Homes; Half-way Houses; and Therapeutic Group Homes.

THIS IS AN AMENDMENT TO YOUR PRESENT PLAN OF BENEFITS.

**AMENDMENT**

**Employer Name:** Constantia Hueck Foils, LLC

**Employer Number:** 15-53266-00 and appropriate subgroups

**Effective Date:** 01/01/2013

**The Plan of Benefits between the Employer and the Corporation is amended as follows:**

**Article XI – CLAIMS FILING AND APPEALS PROCEDURES** is deleted in its entirety and the following substituted therefore:

## A. CLAIMS FILING PROCEDURES

1. When a Participating Provider renders services, generally, the Participating Provider should either file the claim on the Member's behalf or provide an electronic means for the Member to file a claim while the Member is in the Participating Provider's office. However, the Member is responsible for ensuring that the claim is filed.

2. Written notice of receipt of services on which a claim is based must be furnished to the Corporation, at its address on the Identification Card, within twenty (20) days of the beginning of services, or as soon thereafter as is reasonably possible. Failure to give notice within the time does not invalidate nor reduce any claim if the Member can show that it was not reasonably possible to give the notice within the required time frame and if notice was given as soon as reasonably possible. Upon receipt of the notice, the Corporation will furnish or cause a claim form to be furnished to the Member. If the claim form is not furnished within fifteen (15) days after the Corporation receives the notice, the Member will be deemed to have complied with the requirements of this Plan of Benefits as to proof of loss. The Member must submit written proof covering the character and extent of the services within the policy time fixed for filing proof of loss.

3. For Benefits not provided by a Participating Provider, the Member is responsible for filing claims with the Corporation. When filing the claims, the Member will need the following:

    a. A claim form for each Member. Members can get claim forms from a member services representative at the telephone number indicated on the Identification Card or via the Corporation's website, www.SouthCarolinaBlues.com.

    b. Itemized bills from the Provider(s). These bills should contain all the following:

        i. Provider's name and address;

        ii. Member's name and date of birth;

        iii. Member's Identification Card number;

        iv. Description and cost of each service;

        v. Date that each service took place; and

        vi. Description of the illness or injury and diagnosis.

c. Members must complete each claim form and attach the itemized bill(s) to it. If a Member has other insurance that already paid on the claim(s), the Member should also attach a copy of the other Plan's explanation of benefits notice.

d. Members should make copies of all claim forms and itemized bills for the Member's records since they will not be returned. Claims should be mailed to the Corporation's address listed on the claim form.

4. The Corporation must receive the claim within ninety (90) days after the beginning of services. Failure to file the claim within the ninety (90) day period, however, will not prevent payment of Covered Expenses if the Member shows that it was not reasonably possible to file the claim timely, provided the claim is filed as soon as is reasonably possible. Except in the absence of legal capacity, claims must be filed no later than fifteen (15) months following the date services were received.

5. Receipt of a claim by the Corporation will be deemed written proof of loss and will serve as written authorization from the Member to the Corporation to obtain any medical or financial records and documents useful to the Corporation (as determined by the Corporation). The Corporation, however, is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at the time the claim was processed. Any party who submits medical or financial reports and documents to the Corporation in support of a Member's claim will be deemed to be acting as the agent of the Member. If the Member desires to appoint an Authorized Representative in connection with such Member's claims, the Member should contact the Corporation for an Authorized Representative form.

6. There are four (4) types of claims: Pre-Service Claims, Urgent Care Claims, Post-Service Claims, and Concurrent Care Claims. The Corporation will make a determination for each type of claim within the following time periods:

   a. Pre-Service Claim.

      i. A determination will be provided in writing or in electronic form within a reasonable period of time, appropriate to the medical circumstances, but no later than fifteen (15) days from receipt of the claim.

      ii. If a Pre-service Claim is improperly filed, or otherwise does not follow applicable procedures, the Member will be sent notification within five (5) days of receipt of the claim.

      iii. An extension of fifteen (15) days is permitted if the Corporation determines that, for reasons beyond the control of the Corporation, an extension is necessary. If an extension is necessary, the Corporation will notify the Member within the initial fifteen (15) day time period that an extension is necessary, the circumstances requiring the extension, and the date the Corporation expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Member will have at least forty-five (45) days to provide the required information. If the Corporation does not receive the required information within the forty-five (45) day time period, the claim will be denied. The Corporation will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If the Corporation receives the requested information after the forty-five (45) days, but within 225 days, the claim will be reviewed as a first level appeal. Reference Article XI B for details regarding the appeals process.

b. Urgent Care Claim.

i. A determination will be sent to the Member in writing or in electronic form as soon as possible taking into account the medical exigencies, but no later than seventy-two (72) hours from receipt of the claim.

ii. If the Member's Urgent Care Claim is determined to be incomplete, the Member will be sent a notice to this effect within twenty-four (24) hours of receipt of the claim. The Member will then have forty-eight (48) hours to provide the additional information. Failure to provide the additional information within forty-eight (48) hours may result in the denial of the claim.

iii. If the Member requests an extension of Urgent Care Benefits beyond an initially determined period and makes the request at least twenty-four (24) hours prior to the expiration of the original determination period, the Member will be notified within twenty-four (24) hours of receipt of the request for an extension.

c. Post-Service Claim.

i. A determination will be sent within a reasonable time period, but no later than thirty (30) days from receipt of the claim.

ii. An extension of fifteen (15) days may be necessary if the Corporation determines that, for reasons beyond the control of the Corporation, an extension is necessary. If an extension is necessary, the Corporation will notify the Member within the initial thirty (30) day time period that an extension is necessary, the circumstances requiring the extension, and the date the Corporation expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Member will have at least forty-five (45) days to provide the required information. If the Corporation does not receive the required information within the forty-five (45) day time period, the claim will be denied. The Corporation will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If the Corporation receives the requested information after the forty-five (45) days, but within 225 days, the claim will be reviewed as a first level appeal. Reference Article XI B for details regarding the appeals process.

d. Concurrent Care Claim.

The Member will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction or termination to allow the Member time to appeal the decision before the Benefits are reduced or terminated.

7. Notice of Determination.

a. If the Member's claim is filed properly, and the claim is in part or wholly denied, the Member will receive notice of an Adverse Benefit Determination that will:

i. State the specific reason(s) for the Adverse Benefit Determination;

ii. Reference the specific Plan of Benefits provisions on which the determination is based;

iii. Describe additional material or information, if any, needed to complete the claim and the reasons such material or information is necessary;

iv. Describe the claims review procedures and this Plan of Benefits and the time limits applicable to such procedures, including a statement of the Member's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review;

v. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request); and,

vi. If the reason for denial is based on a lack of Medical Necessity or Investigational or Experimental Services exclusion or similar limitation, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request).

b. The Member will also receive a notice if the claim is approved.

## B. APPEAL PROCEDURES FOR AN ADVERSE BENEFIT DETERMINATION

1. The Member has one hundred eighty (180) days from receipt of an Adverse Benefit Determination to file an appeal. An appeal must meet the following requirements:

   a. An appeal must be in writing; and,

   b. An appeal must be sent (via U.S. mail) to Blue Cross and Blue Shield of South Carolina at the address on the Member's Identification Card; and,

   c. The appeal request must state that a formal appeal is being requested and include all pertinent information regarding the claim in question; and,

   d. An appeal must include the Member's name, address, identification number and any other information, documentation or materials that support the Member's appeal.

2. The Member may submit written comments, documents, or other information in support of the appeal, and will (upon request) have access to all documents relevant to the claim. A person other than the person who made the initial decision will conduct the appeal. No deference will be afforded to the initial determination.

3. If the appealed claim involves an exercise of medical judgment, the Corporation will consult with an appropriately qualified health care practitioner with training and experience in the relevant field of medicine. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on the appeal.

4. The Corporation will make a final decision on the appeal within the time periods specified below:

   a. Pre-Service Claim.

      The Corporation will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than thirty (30) days after receipt of the appeal.

b. Urgent Care Claim.

The Member may request an expedited appeal of an Urgent Care Claim. This expedited appeal request may be made orally, and the Corporation will communicate with the Member by telephone or facsimile. The Corporation will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than seventy-two (72) hours after receipt of the request for an expedited appeal.

c. Post-Service Claim.

The Corporation will decide the appeal within a reasonable period of time, but no later than sixty (60) days after receipt of the appeal.

d. Concurrent Care Claim.

The Corporation will decide the appeal of Concurrent Care Claims within the time frames set forth in Article XI (B)(4)(a-c) depending on whether such claim is also a Pre-Service Claim, an Urgent Care Claim or a Post-Service Claim.

5. Notice of Appeals Determination.

a. If a Member's appeal is denied in whole or in part, the Member will receive notice of an Adverse Benefit Determination that will:

i. State specific reason(s) for the Adverse Benefit Determination;

ii. Reference specific provision(s) of this Plan of Benefits on which the benefit determination is based;

iii. State that the Member is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for Benefits;

iv. Describe any voluntary appeal procedures offered by the Corporation and the Member's right to obtain such information;

v. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information will be provided free of charge upon request);

vi. If the reason for an Adverse Benefit Determination on appeal is based on a lack of Medical Necessity, Investigational or Experimental Services or other limitation or exclusion, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request); and

vii. Include a statement regarding the Member's right to bring an action under section 502(a) of ERISA.

b. The Member will also receive a notice if the claim on appeal is approved.

## C. EXTERNAL REVIEW PROCEDURES

1. After a Member has completed the appeal process, a Member may be entitled to an additional, external review of the Member's claim at the Corporation's expense. An external review may be used to reconsider the Member's claim if the Corporation has denied, either in whole or in part, the Member's claim. In order to qualify for external review, the claim must have been greater than $500.00 and denied, reduced, or terminated because:

    a. It does not meet the requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness; or,

    b. It is an Investigational or Experimental Service and it involves a life-threatening or seriously disabling condition.

2. After a Member has completed the appeal process, (and an Adverse Benefit Determination has been made) such Member will be notified in writing of such Member's right to request an external review. The Member should file a request for external review within sixty (60) days of receiving the notice of the Corporation's decision on the Member's appeal. In order to receive an external review, the Member will be required to authorize the release of such Member's medical records (if needed in the review for the purpose of reaching a decision on Member's claim). If a Member needs assistance during the external review process, the Member may contact the South Carolina Department of Insurance at the following address and telephone number:

    South Carolina Department of Insurance
    P.O. Box 100105
    Columbia, S.C. 29202-3105
    1-800-768-3467

3. Within five (5) business days of a Member's request for an external review, the Corporation will respond by either:

    a. Assigning the Member's request for an external review to an independent review organization and forwarding the Members records to such organization; or,

    b. Notifying the Member in writing that the Member's request does not meet the requirements for an external review and the reasons for the Corporation's decision.

4. The external review organization will take action on the Member's request for an external review within forty-five (45) days after it receives the request for external review from the Corporation.

5. Expedited external reviews are available if the Member's Physician certifies that the Member has a serious medical condition. A serious medical condition, as used in this Article XI (C)(5), means one that requires immediate medical attention to avoid serious impairment to body functions, serious harm to an organ or body part, or that would place the Member's health in serious jeopardy. If the Member may be held financially responsible for the treatment, a Member may request an expedited review of the Corporation's decision if the Corporation's denial of Benefits involves Emergency Medical Care and the Member has not been discharged from the treating Hospital.

**AMENDMENT**

**Employer Name:** Constantia Hueck Foils, LLC
**Employer Number:** 15-53266-00 and appropriate subgroups
**Effective Date:** 01/01/2013

**The Plan of Benefits between the Employer and the Corporation is amended as follows:**

**The following definitions are added to ARTICLE I – DEFINITIONS:**

**Continuation of Care:** means the provision of in-network level Benefits for services rendered by certain out-of-network Providers for a definite period of time in order to ensure continuity of care for covered Members for a serious medical condition.

**Serious Medical Condition:** A health condition or illness that requires medical attention, and for which failure to provide the current course of treatment through the current Provider would place the Member's health in serious jeopardy. This includes cancer, acute myocardial infarction and pregnancy.

**Article XII – GENERAL PROVISIONS is amended by the addition of the following:**

**CONTINUATION OF CARE**

If a Participating Provider's contract ends or is not renewed for any reason other than suspension or revocation of the Provider's license and the Member is receiving treatment for a Serious Medical Condition, the Member may be eligible to continue to receive in-network Benefits for that Provider's services.

In order to receive this Continuation of Care for a Serious Medical Condition, the Member must submit a request to the Corporation on the appropriate form. The treating Provider should include a statement on the form confirming the Serious Medical Condition. Upon receipt of the request, the Corporation will notify the Member and the Provider of the last date the Provider is part of the network and a summary of Continuation of Care requirements. The Corporation will review the request to determine qualification for the Continuation of Care. If additional information is necessary to make a determination, the Corporation may contact the Member or the Provider for such information. If the Corporation approves the request, in-network Benefits for that Provider will be provided for ninety (90) days or until the end of the benefit period, whichever is greater. During this time, the Provider will accept the network allowance as payment in full. Continuation of Care is subject to all other terms and conditions of this Contract, including regular Benefit limits.

THIS IS AN AMENDMENT TO YOUR PRESENT PLAN OF BENEFITS.

**AMENDMENT**

**Employer Name:** Constantia Hueck Foils, LLC
**Employer Number:** 15-53266-00 and appropriate subgroups
**Effective Date:** 01/01/2013

**The Plan of Benefits between the Employer and the Corporation is amended as follows:**

Paragraph A. in **ARTICLE VII – CONVERSION AND CONTINUATION OF COVERAGE** is deleted in its entirety and the following substituted therefore:

**A. CONVERSION FOR DIVORCED SPOUSES**

Upon the entry of a valid order or decree of divorce between an Employee and such Employee's Dependent spouse, the divorced spouse shall be entitled (upon request) to a conversion policy, without evidence of insurability, upon submission of an application of insurance made to the Corporation within sixty (60) days following the divorce decree and upon payment of the appropriate premium. Any Probationary Periods set forth in the conversion policy that had previously been met under this Plan of Benefits shall be considered as being met to the extent that such Probationary Periods were met under this Plan of Benefits.

**AMENDMENT**

**Employer Name:** Constantia Hueck Foils, LLC
**Employer Number:** 15-53266-00 and appropriate subgroups
**Effective Date:** 01/01/2013

**The Plan of Benefits between the Employer and the Corporation is amended as follows:**

The first two paragraphs of the section entitled **IMPORTANT INFORMATION ABOUT YOUR HEALTH COVERAGE** are deleted in their entirety and the following substituted therefore:

**IMPORTANT INFORMATION ABOUT YOUR HEALTH COVERAGE:**

The benefits you receive will depend on whether the provider of medical services is a Participating or Non-Participating Provider. You will receive the maximum benefits that can be paid if you use Participating Providers and you get Pre-authorization, when required, before getting medical care. The amount you have to pay for services and supplies will increase when you do not use Participating Providers and may further increase if you do not get Pre-Authorization.

BlueCross BlueShield of South Carolina makes every effort to contract with physicians that practice at Participating Hospitals. Members of the Blue Cross and Blue Shield Association also attempt to contract with Providers that practice at Participating Hospitals. For various reasons, some physicians may elect not to contract as Participating Providers. Non-Participating Providers will be paid at the Non-Participating Provider level of benefits with no protection from balance billing from the provider.

**ARTICLE XII – GENERAL PROVISIONS** is amended by the deletion of the **BLUECARD PROGRAM** and the following substituted therefore:

Out-of-Area Services.

The Corporation has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever Members access healthcare services outside the geographic area the Corporation serves, the claim for those services may be processed through one of these Inter-Plan Programs and presented to the Corporation for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Members under this Agreement are described generally below.

Typically, Members, when accessing care outside the geographic area the Corporation serves, obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, Members may obtain care from non-participating healthcare providers. The Corporation’s payment practices in both instances are described below.

**A. BlueCard® Program**

(a) Under the BlueCard® Program, when Members access covered healthcare services within the geographic area served by a Host Blue, the Corporation will remain responsible to Employer for fulfilling the Corporation's contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating healthcare providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our action will be consistent with the spirit of this description.

(b) Liability Calculation Method Per Claim.

The calculation of the Member liability on claims for covered healthcare services processed through the BlueCard Program will be based on the lower of the participating healthcare provider's billed covered charges or the negotiated price made available to the Corporation by the Host Blue.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to the Corporation by the Host Blue may represent a payment negotiated by a Host Blue with a healthcare provider that is one of the following:

(i) an actual price. An actual price is a negotiated payment without any other increases or decreases, or

(ii) an estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives, or

(iii) an average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the Member and Employer is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to the Corporation is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

A small number of states require Host Blues either (i) to use a basis for determining Member liability for covered healthcare services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge.

Should the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, the Corporation would then calculate Member liability and Employer liability in accordance with applicable law.

(c) Return of Overpayments.

Under the BlueCard Program, recoveries from a Host Blue or its participating healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by claim or prospective basis.

**B. Non-Participating Providers Outside the Corporation's Service Area**

For information regarding payment of a Non-Participating Provider see the front of the benefit booklet and Article I - DEFINITIONS of the Plan of Benefits.

THIS IS AN AMENDMENT TO YOUR PRESENT PLAN OF BENEFITS.

**AMENDMENT**

**Employer Name:** Constantia Hueck Foils, LLC
**Employer Number:** 15-53266-00 and appropriate subgroups
**Effective Date:** 01/01/2013

The Plan of Benefits between the Employer and the Corporation is amended as follows:

The following benefit in **ARTICLE III - BENEFITS** is deleted in its entirety and the following substituted therefore:

**SPECIALTY DRUGS**

The Corporation will pay Covered Expenses for Specialty Drugs. Covered Expenses for Specialty Drugs dispensed to a Member shall not exceed the quantity and benefit maximum set by the Corporation. Specialty Drugs may be considered medical Benefits. For any Specialty Drugs paid as medical Benefits the Benefit Year Deductible, Out-of-Pocket Maximum and/or Benefit Maximum will apply as set forth on the Schedule of Benefits. The Member may obtain a list of Specialty Drugs by contacting the Corporation at the number listed on the Identification Card or at www.SouthCarolinaBlues.com.

Any Coinsurance percentage for Specialty Drugs is based on the Allowable Charge at the Participating Pharmacy, and does not change due to receipt of any Credits by the Corporation. Copayments likewise do not change due to receipt of any Credits by the Corporation.

THIS IS AN AMENDMENT TO YOUR PRESENT PLAN OF BENEFITS.

# Health Reimbursement Account

# Addendum to

# Plan of Benefits

South Carolina

*BlueCross BlueShield of South Carolina*
*is an independent licensee of the*
*Blue Cross and Blue Shield Association*

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**EMPLOYER: CONSTANTIA HUECK FOILS LLC**

**HRA PLAN EFFECTIVE DATE: JANUARY 1, 2013**

**HRA PLAN YEAR: JANUARY 1, 2013 THROUGH DECEMBER 31, 2013**

## ARTICLE I. INTRODUCTION

### Establishment of HRA Plan

The Employer has established this Employer Health Reimbursement Account Plan (the "HRA Plan") as of the HRA Plan Effective Date. This HRA Plan is designed to provide certain Employees the chance to receive certain health benefits as further described herein.

### Legal Status

**This HRA Plan is intended to qualify as a health plan under Sections 105 and 106 of the Internal Revenue Code of 1986, as amended (the "Code"), and pursuant to IRS Notice 2002-45 addressing health reimbursement arrangements. The Employer has the exclusive authority, power and discretion to determine eligibility for benefits and construe the terms of the HRA Plan.**

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## ARTICLE II. DEFINITIONS AND CONSTRUCTION

### Definitions

Capitalized terms that are used in this Addendum to HRA Plan of Benefits, but that are not defined herein, have the meaning ascribed to such terms in the Plan of Benefits.

**"Claims Administrator"** is Blue Cross and Blue Shield of South Carolina. The Claims Administrator is not an ERISA fiduciary.

**"Closing Period"** means the fifteen month period following the date of service for which a Member may submit requests for reimbursements of Qualified Medical Expenses. After this period of time the HRA Plan will not consider requests for reimbursements of Qualified Medical Expenses.

**"Code"** means the Internal Revenue Code of 1986, as amended.

**"Eligible Employee"** is defined in the first paragraph of Article III.

**"Employee"** means an employee of the Employer, and whom the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include any leased employee (including, but not limited to those individuals defined in Code Section 414(n)), or an individual classified by the Employer as a contract worker, independent contractor, as-needed employee, temporary employee or casual employee, whether or not any such persons are on the Employer's W-2 payroll, or any individual who performs services for the Employer but who is paid by a temporary or other employment agency or is covered by a collective bargaining agreement.

**"Health Reimbursement Account"** means the Employer's account established for each Member and described in Article IV of this HRA Plan.

**"HRA Plan Effective Date"** of this HRA Plan means the HRA Plan Effective Date as listed in the front of this Addendum.

**"HRA Plan"** means this Employer Health Reimbursement Account HRA Plan as amended by the Employer from time to time.

**"HRA Plan Sponsor"** means the Employer.

**"HRA Plan Year"** means the twelve-month period identified in this Addendum.

**"Minimum Reimbursement Amount"** is the minimum dollar amount selected by the Employer to be reimbursed from the HRA Plan in this Addendum.

**"Member"** means a person who participates in this HRA Plan.

**"Qualified Medical Expense"** means an expense incurred by a Member for medical care that is designated by the Employer as a medical expense payable under this Addendum.

## ARTICLE III. PARTICIPATION

### Eligibility to Participate

An Employee who is covered by the Plan of Benefits on the HRA Plan Effective Date is an Eligible Employee on the HRA Plan Effective Date. Individuals who become Employees after the HRA Plan Effective Date are Eligible Employees when the Employee is covered by the Plan of Benefits.

### Participation in HRA Plan

(a) *Employee Participation*. An Employee or Dependent becomes a Member in this HRA Plan on the date such Employee becomes an Eligible Employee.

(b) *Reimbursement for a Qualified Medical Expense*. A Member may request reimbursement for a Qualified Medical Expense incurred by Dependent as permitted by Article V.

### Termination of Participation

An Employee or Dependent will cease to be a Member in this HRA Plan upon the earlier of:

(a) the termination or amendment of this HRA Plan such that the Member is no longer eligible for HRA Plan benefits; or

(b) the date on which an Eligible Employee ceases (because of retirement, termination of employment, layoff, reduction in hours, loss of HRA Plan coverage, death or any other reason) to be an Employee eligible to participate under the terms of Article III, except to the extent provided by Article V.

### COBRA

To the extent required by law, COBRA is available under the HRA Plan as described at Article V.

*[The balance of this page is intentionally blank.]*

## ARTICLE IV. HEALTH REIMBURSEMENT ACCOUNT

### Establishment of Accounts

The Employer will establish and maintain a Health Reimbursement Account with respect to each Employee who participates in the HRA Plan. However, such account is unfunded and no separate fund is maintained and assets are not otherwise segregated for this purpose. Such accounts are established as recordkeeping accounts for the purpose of tracking amounts credited and debited to the Health Reimbursement Account.

### Crediting and Debiting of Accounts

The Employer will credit Member's Health Reimbursement Account, in the amount determined by the Employer, on a weekly basis. The Employer will debit a Member's Health Reimbursement Account in the amount of reimbursed Qualified Medical Expenses. A Member's Health Reimbursement Account may be debited for the Qualified Medical Expenses of a COBRA qualified beneficiary. Refer to Article V for additional reimbursement details.

Account balances may be monitored through the Blue-by-Design section of at the web address listed on the back of your identification card.

### HRA Carryover Rule

Any balance in the HRA Plan at the end of the current HRA Plan Year will be carried over in full to the next HRA Plan Year

### Fees

Fees may be charged for any additional debit cards issued.

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## ARTICLE V. REIMBURSEMENT

**Reimbursement Amount**

(a) *Maximum Reimbursement Amount.* The maximum benefit amount that a Member may elect to receive under this HRA Plan in the form of reimbursement for Qualified Medical Expenses is the balance currently in the Member's accumulated Health Reimbursement Account.

(b) *Limited to Expenses Incurred while an Eligible Employee*. The HRA Plan reimburses Qualified Medical Expenses incurred for medical care of a Member while such individual is covered by the Plan of Benefits, or as otherwise provided this Article V. A Qualified Medical Expense is incurred when medical care or service giving rise to a Qualified Medical Expense is given or dispensed, or, in the case of insurance premiums (including COBRA premiums), at the time payment of the premium is required.

(c) *Rolling Rule*. To the extent a Qualified Medical Expense is not immediately reimbursable because such Expense exceeds the amount in a Member's Health Reimbursement Account, such expense shall be reimbursable as additional amounts are credited to such Member's Health Reimbursement Account. Qualified Medical Expenses incurred during the current HRA Plan Year will not be reimbursed under any other HRA Plan Year.

(d) *Limited to Expenses not Reimbursable Under the HRA Plan*. In most cases Qualified Medical Expenses do not qualify for reimbursement under the HRA Plan if such expenses are reimbursable or have been reimbursed to the Member or any other person through the Plan of Benefits, other insurance, or any other accident or health plan.

(e) *Reimbursement with a Flexible Spending Account.* Qualified Medical Expenses are reimbursable to a Member under a Code Section 125 Flexible Spending Account of the Employer or of any other employer. The Member should verify with the Employer the order of payment when a HRA and Flexible Spending Account both exist.

**Reimbursement Procedure—**

(a) *Timing of Reimbursement*. As soon as is administratively practicable (but no more often than weekly) after the Member submits a claim for reimbursement, the Employer (through its Claims Administrator) will reimburse an individual (as determined by the Employer) for Qualified Medical Expenses or will notify the Member that reimbursement has been denied or that additional information is needed to adjudicate the claim. If the amount of available funds is less than the claim for Qualified Medical Expenses, then the claim will be treated as an ongoing claim for benefits during the HRA Plan Year and shall reimburse such excess as additional amounts are credited to the HRA Plan. Amounts unpaid due to the lack of funds at the end of the HRA Plan Year will not be paid.

(b) *Applying for Reimbursements*. A Member may apply for reimbursement for Qualified Medical Expenses by submitting an application in writing to the Claims Administrator on such form as the Employer may prescribe from time to time, before the end of the Closing Period. The application shall be accompanied by bills, invoices, or other such statements from an independent third party showing the amounts of such Qualified Medical Expenses, together with any additional documentation that the Employer may require. Reimbursements may be applied for by debit card, automatic claims adjudication, or manually. See your Employer for details.

(c) *Minimum Reimbursements*. The Employer will not issue reimbursements when such reimbursements would be less than the Minimum Reimbursement Amount, with the exception of the final reimbursement processed after termination of employment or, if applicable, at the end of the applicable COBRA period or a claims run-out period. If a reimbursement would be less than the Minimum Reimbursement Amount, the Employer will hold such reimbursement until such time as the total reimbursements requested by a Member equal or exceed the Minimum Reimbursement Amount. The Minimum Reimbursement Amount is $20.

**Reimbursements After Termination of Eligible Employee Status**

(a) *General*. Except as otherwise provided in this Article V, when an individual ceases to be a Member, such individual's ability to receive reimbursements from a Health Reimbursement Account maintained by the Employer will terminate.

(b) *COBRA.*

(i) *General.* To the extent required by federal law, Employees and such Employee's Dependents whose Health Reimbursement Account coverage terminates because of a COBRA qualifying event shall be given the opportunity to continue coverage under this HRA Plan for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA).

(ii) *Health Reimbursement Account for COBRA Qualified Beneficiary*. If a qualified beneficiary elects COBRA, the Employer shall maintain a Health Reimbursement Account for such qualified beneficiary. The amount credited to a qualified beneficiary's Health Reimbursement Account is the COBRA premium as allowed under COBRA.

(iii) *Qualified Medical Expenses Reimbursable for COBRA Qualified Beneficiary*. The amount available for reimbursement under COBRA shall never exceed the amount in the COBRA qualified beneficiary's Health Reimbursement Account. In addition, a qualified beneficiary who elects COBRA may deplete such individual's Health Reimbursement Account remaining on the date of the qualifying event less Qualified Medical Expenses previously reimbursed to a qualified beneficiary, the Eligible Employee, or any Member or other person, and regardless of whether incurred before or after the qualifying event. Reimbursement shall be made first from oldest dollars available to a qualified beneficiary.

(iv) *Premium*. A qualified beneficiary will be eligible for reimbursement of Qualified Medical Expenses incurred after a qualifying event only to the extent such qualified beneficiary continues to make timely payment of the COBRA premium.

(c) *Claims Run-Out for Termination of a Member.* If applicable, a former Member may receive reimbursement for Qualified Medical Expenses incurred by such Employee (or by a spouse or Dependent if such spouse or Dependent is covered by the Health Insurance HRA Plan on the date on which the Member terminated participation) after termination of employment to the extent of such former Member's Health Reimbursement Account balance. The claims run-out time period runs concurrently with COBRA, if COBRA is available. If termination of participation is due to the former Employee's death, a Dependent may request reimbursement of Qualified Medical Expenses incurred following death (provided such Dependent was covered by the HRA Plan on the date on which the former Employee's death occurred).

(d) *Termination of HRA Plan*. If the Employer terminates the HRA Plan, no person has any right to reimbursements from the HRA Plan or a Health Reimbursement Account. All reimbursements not yet made are void, and there is no Closing Period or claims run-out.

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## ARTICLE VI. CLAIMS AND APPEALS PROCEDURE

Any claims submitted under the HRA Plan will be treated as Post-Service Claims. The Claims and Appeals Procedure for this HRA Plan is in the Plan of Benefits.

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## ARTICLE VII. RECORDKEEPING AND ADMINISTRATION

### Powers of the Employer

**The Employer shall have such duties and powers as it considers necessary or appropriate to discharge its duties hereunder, including, but not limited to, the following exclusive authority, power and discretion:**

(a) To construe and interpret this HRA Plan and to decide all questions of fact and issues relating to eligibility, participation and benefits;

(b) To prepare and distribute information explaining this HRA Plan and the benefits under this HRA Plan in such manner as the Employer determines to be appropriate;

(c) To request and receive from all Employees such information as the Employer shall from time to time determine to be necessary for the proper administration of this HRA Plan;

(d) To prepare and keep on file such reports and information concerning the benefits covered by this HRA Plan as the Employer determines from time to time to be necessary and proper;

(e) To appoint and employ such individuals or entities to assist in the administration of this HRA Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants.

(f) To sign documents for the purposes of administering this HRA Plan, or to designate an individual or individuals to sign documents for the purposes of administering this HRA Plan; and

(g) To maintain the books of accounts, records, and other data in the manner necessary for proper administration of this HRA Plan and to meet any applicable disclosure and reporting requirements.

### Election Modifications Required by Employer

The Employer may at any time amend the amount credited towards a Health Reimbursement Account if the Employer determines that such action is necessary or advisable in order to:

(a) satisfy the Code's nondiscrimination requirements applicable to this HRA Plan or other cafeteria plan;

(b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized;

(c) maintain the qualified status of benefits received under this HRA Plan; or

(d) satisfy Code nondiscrimination requirements or other limitations applicable to the HRA Plan.

### Forfeiture of Unclaimed Reimbursements

Reimbursements that are unclaimed within ninety (90) days following the end of the Closing Period following the HRA Plan Year in which the Expense was incurred are forfeited and used to offset administrative expenses and future costs.

### HIPAA Compliance

The HIPAA Compliance requirements for this HRA Plan are in the Plan of Benefits.

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## ARTICLE VIII. GENERAL PROVISIONS

### Funding This HRA Plan

All of the amounts payable under this HRA Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer to maintain any fund or to segregate any amount for the benefit of any Member, and no Member or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this HRA Plan may be made. The Employer may, at any time or from time to time, alter the credits or dollars accumulated in a Health Reimbursement Account.

There is no trust or other fund from which benefits are paid. While the Employer has responsibility for the payment of benefits out of its general assets, it has hired the Claims Administrator to serve on its behalf.

### No Contract of Employment

Nothing herein contained is intended to be or shall be construed as constituting a contract of employment or other similar arrangement between any individual and the Employer.

### Amendment and Termination

This HRA Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate this HRA Plan and any such amendment or termination will automatically apply to the Employer, Employees, Employee's Dependents, or any successor beneficiary thereof. Employer is the sole entity or person authorized to amend this HRA Plan or to delegate authority to amend this HRA Plan. Upon such termination no amounts are reimbursable from the HRA Plan, including Article V. The Employer makes no promise, guarantee or contract as to future availability of a Health Reimbursement Account, and may eliminate balances in or amounts credited to a Health Reimbursement Account at any time.

### No Guarantee of Tax Consequences

The Employer makes no commitment or guarantee that any amounts paid to or for the benefit of a Member under this HRA Plan will be excludable from the Member's gross income for federal or state income tax purposes.

### Non-Assignability of Rights

The right of any Member to receive any reimbursement under this HRA Plan shall not be alienable by the Member by assignment or any other method and shall not be subject to being taken by the Member's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

### HRA Plan Fiduciary

The Employer is the sole fiduciary of this HRA Plan.

### Plan of Benefits Provisions Controlling

In the event the terms or provisions of any summary or description of this HRA Plan, or of any other instrument, are in any construction interpreted as being ambiguous or in conflict with the provisions of this HRA Plan as herein set forth, (or are not addressed within this HRA Plan) the provisions of this HRA Plan shall be controlling.

### Severability

In the event any provision of the HRA Plan shall be held illegal or invalid for any reason, this illegality or invalidity shall not affect the remaining provisions of this HRA Plan, and such remaining provisions shall be fully

severable and this HRA Plan shall, to the extent practicable, be construed and enforced as if the illegal or invalid provision had never been inserted therein.

**Code Compliance**

**It is intended that this HRA Plan meet all applicable requirements of the Code, ERISA, and of all regulations issued thereunder. This HRA Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this HRA Plan and the Code and/or ERISA, the provisions of the Code and/or ERISA shall be deemed controlling, and any conflicting part, clause or provision of this HRA Plan shall be deemed superseded to the extent of the conflict.**

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# PREFERRED BLUE®
# PLAN OF BENEFITS

South Carolina

*BlueCross BlueShield of South Carolina*
*is an independent licensee of the*
*Blue Cross and Blue Shield Association*

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# ARTICLE I - DEFINITIONS

Capitalized terms that are used in this Plan of Benefits shall have the following defined meanings:

**Actively at Work**: a permanent, full-time employee who works at least the minimum number of hours per week and the minimum number of weeks per year (each as set forth on the Schedule of Benefits) and who is not absent from work during the initial enrollment period because of a leave of absence or temporary lay-off. An absence during the initial enrollment period due to a Health Status-Related Factor will not keep an employee from qualifying for Actively at Work status.

**Admission**: the period of time between a Member's admission as a patient into a Hospital or Skilled Nursing Facility and the time the Member leaves or is discharged.

**Adverse Benefit Determination**: any denial, reduction or termination of, or failure to provide or make (in whole or in part) payment for a claim for Benefits, including any such denial reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or Member's eligibility to participate in a plan, and including, a denial reduction or termination of, or failure to provide or make payment (in whole or in part) for a Benefit which results from the application of any utilization review as well as a failure to cover an item or services for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

**Allowable Charge**: the charge payable by the Corporation. The payment will not exceed the Maximum Payment.

**Alternate Recipient**: any Child who is recognized under a Medical Child Support Order as having a right to enroll in this Plan of Benefits.

**Ambulatory Surgical Center**: a licensed facility that:

1. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;

2. Provides treatment by or under the supervision of medical doctors or oral surgeons and provides nursing services when the Member is in the facility;

3. Does not provide inpatient accommodations; and,

4. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a medical doctor or oral surgeon.

Ambulatory Surgical Center includes an endoscopy center.

**Benefit Year**: the period of time set forth on the Schedule of Benefits. The initial Benefit Year may be more or less than twelve (12) months.

**Benefit Year Deductible**: the amount, if any, listed on the Schedule of Benefits that must be paid by the Member each Benefit Year before the Corporation will pay Covered Expenses. The Benefit Year Deductible is subtracted from the Allowable Charge before Coinsurance is calculated. Members must refer to the Schedule of Benefits to determine if the Benefit Year Deductible applies to the Out-of-Pocket Maximum.

**Benefits**: medical services or Medical Supplies that are:

1. Medically Necessary; and,

2. Pre-Authorized (when required under this Plan of Benefits or the Schedule of Benefits); and,

3. Included in this Plan of Benefits; and,

4. Not limited or excluded under the terms of this Plan of Benefits.

Benefits available under this Plan of Benefits are listed in Article III.

**BlueCard® Program**: a program in which all members of the Blue Cross and Blue Shield Association participate. Details of the BlueCard Program are more fully set forth in Article XII.

**Brand Name Drug**: a Prescription Drug that is manufactured under a registered trade name or trademark.

**Certificate of Creditable Coverage**: a document from a Group Health Plan or insurer that states that a Member had prior Creditable Coverage with that Group Health Plan or insurer.

**Child**: An Employee's unmarried child, whether a natural child, adopted child, foster child, stepchild, or child for whom an Employee has custody or legal guardianship and for whom the Employee provides at least fifty-one (51%) of the child's support. The term "Child" also includes an Incapacitated Dependent, a child of a divorced or divorcing Employee who, under a Qualified Medical Child Support Order, has a right to enroll under the Employer's Group Health Plan. A child who is (or was) married will not be entitled to coverage, notwithstanding the termination of such marriage.

**COBRA**: the Consolidated Omnibus Budget Reconciliation Act of 1985 and any amendments thereto.

**Coinsurance**: the sharing of Covered Expenses between the Member and the Corporation. After the Member's Benefit Year Deductible requirement is met, the Corporation will pay the percentage of Allowable Charges as set forth on the Schedule of Benefits. The Member is responsible for the remaining percentage of the Allowable Charge. Coinsurance is calculated after any applicable Benefit Year Deductible or Copayment is subtracted from the Allowable Charge based upon the network charge or lesser charge of the Provider.

For Prescription Drug Benefits, Coinsurance means the amount payable by the Member calculated as follows:

1. The percentage listed on the Schedule of Benefits; multiplied by,

2. The amount listed in the Participating Provider's schedule of allowance for that item calculated at the time of sale; and,

3. Without regard to any Credit or allowance that may be received by the Corporation.

**Concurrent Care Claim**: an ongoing course of treatment to be provided over a period of time or number of treatments.

**Continued Stay Review**: the review that must be obtained by a Member (or the Member's representative) regarding an extension of an Admission to determine if an Admission for longer than the time that was originally Pre-Authorized as Medically Necessary. The Continued Stay Review process is outlined in Article III.

**Contract**: the Master Group Contract between the Corporation and the Employer.

**Copayment**: the amount specified on the Schedule of Benefits that the Member must pay directly to the Provider each time the Member receives Benefits.

**Corporation**: Blue Cross and Blue Shield of South Carolina.

**Covered Expenses**: the amount payable by the Corporation for Benefits. The amount of Covered Expenses payable for Benefits is determined as set forth in this Plan of Benefits and at the percentages set forth on the Schedule of Benefits. Covered Expenses are subject to the limitations and requirements set forth in this Plan of Benefits and on the Schedule of Benefits. Covered Expenses will not exceed the Allowable Charge.

**Credit(s)**: financial credits (including rebates and/or other amounts) to the Corporation directly from drug manufacturers or other Providers through a Pharmacy Benefit Manager. Credits are used to help stabilize overall rates and to offset expenses and may not be payable to Employer or Members.

Reimbursements to a Participating Pharmacy, or discounted prices charged at Pharmacies, are not affected by these Credits. Any Coinsurance that a Member must pay for Prescription Drugs or Specialty Drugs is based upon the Allowable Charge at the pharmacy, and does not change due to receipt of any Credit by the Corporation. Copayments are not effected by any Credit.

**Creditable Coverage**: benefits or coverage provided under any of the following (each capitalized term as defined under HIPAA unless defined in this Plan of Benefits):

1. A Group Health Plan;

2. Health Insurance coverage;

3. Part A or Part B, Title XVIII of the Social Security Act (Medicare);

4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;

5. Chapter 55 of Title 10, United States Code (Armed Forces, Medical and Dental Care);

6. A medical care program of the Indian Health Service or of a tribal organization;

7. A state health benefit risk pool, including the South Carolina Health Insurance Pool (SCHIP);

8. A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefit Plan);

9. A public health plan, including that of the United States Federal Government as well as that of a foreign country or its political subdivision; or

10. A health benefit plan under Section 5(e) of 22 U.S.C. 2504(e) (Peace Corps Act); or

11. A State Children's Health Insurance Program (SCHIP).

The term "Creditable Coverage" does not include coverage consisting solely of Excepted Benefits (as defined in this Article I).

**Dependent**: an individual who is:

1. An Employee's spouse; or

2. A Child under the age set forth on the Schedule of Benefits; or

3. A Child who is over the age set forth on the Schedule of Benefits, but who has not reached the age of termination of Benefits as set forth on the Schedule of Benefits, and is enrolled in and is attending (with attendance qualifying such Child as a full-time student under the rules of the institution) one of the following:

    a. High school; or

    b. An accredited or licensed school commonly recognized as a vocational, technical or trade school; or

    c. An accredited college or university; or

4. An Incapacitated Dependent.

The time period between graduation from high school and college entry, or between college graduation and graduate school entry, will be covered only if the Child has applied for admission beginning with the next regular semester immediately following graduation.

When requested by the Corporation, the Employee will furnish written proof (in the form of a certificate on the applicable school's letterhead) of items 3(a-c).

**Discount Services**: services (including discounts on services) that are not Benefits, but which may be offered to Members from time to time as a result of being a Member.

**Disease Management Program**: the voluntary disease management program provided by the Corporation. The Disease Management Program offers Members the opportunity to better understand and address their diagnosed conditions as well as other ancillary products or services depending on the nature of the condition.

**Durable Medical Equipment**: medical equipment that:

1. Can stand repeated use; and,

2. Is Medically Necessary; and,

3. Is customarily used for the treatment of a Member's illness, injury, disease or disorder; and,

4. Is appropriate for use in the home; and,

5. Is not useful to a Member in the absence of illness or injury; and,

6. Does not include appliances that are provided solely for the Member's comfort or convenience; and,

7. Is a standard, non-luxury item (as determined by the Corporation); and,

8. Is ordered by a medical doctor, oral surgeon, podiatrist, opthamologists or osteopath.

Prosthetic Devices, Orthopedic Devices and Orthotic Devices are considered Durable Medical Equipment.

**Emergency Admission Review**: the review that must be obtained by a Member (or the Member's representative) within twenty-four (24) hours of or by the end of the first working day after the commencement of an Admission to a Hospital to treat an Emergency Medical Condition. The Emergency Admission Review process is outlined in Article III.

**Emergency Medical Care**: Benefits that are provided in a Hospital emergency facility to evaluate and treat an Emergency Medical Condition.

**Emergency Medical Condition**: a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the Member, or with respect to a pregnant Member, the health of the Member or her unborn child, in serious jeopardy; or,

2. Serious impairment to bodily functions; or,

3. Serious dysfunction of any bodily organ or part.

**Employee**: any employee of the Employer who is eligible for coverage, as provided in Article II of this Plan of Benefits, and who is so designated to the Corporation by the Employer.

**Employer**: the entity identified as the Employer in the Contract.

**Employer's Effective Date:** means the date the Corporation begins to provide services under the Master Group Contract.

**Enrollment Date**: means the date of enrollment in the Group Health Plan or the first day of the Probationary Period for enrollment, whichever is earlier.

**ERISA**: the Employee Retirement Income Security Act of 1974, and any amendments thereto.

**Excepted Benefits**: for purposes of HIPAA, the following insurance coverage that does not constitute Creditable Coverage:

1. Coverage only for accident, or disability income insurance, or any combination thereof;

2. Coverage issued as a supplement to liability insurance;

3. Liability insurance, including general liability insurance and automobile liability insurance;

4. Worker's compensation or similar insurance;

5. Automobile medical payment insurance;

6. Credit-only insurance;

7. Coverage for on-site medical clinics;

8. Other similar insurance coverage specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

9. If offered separately:

    a. Limited scope dental or vision benefits;

    b. Benefits for long-term care, nursing home care, home health care, community- based care, or any combination thereof;

    c. Such other similar, limited benefits as specified in regulations.

10. If offered as independent, non-coordinated benefits:

    a. Coverage only for a specified disease or illness;

    b. Hospital indemnity or other fixed indemnity insurance.

11. If offered as a separate insurance policy:

    a. Medicare supplemental health insurance (as defined under Section 1882(g)(l) of the Social Security Act);

    b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code;

    c. Similar supplemental coverage under a Group Health Plan.

**Generic Drug**: a Prescription Drug that has a chemical structure that is identical to and has the same bio-equivalence as a Brand Name Drug but is not manufactured under a registered brand name or trademark or sold under a brand name. Whether a Prescription Drug is a Generic Drug is determined by the Corporation's Pharmacy Benefit Manager.

**Genetic Information**: information about genes, gene products (messenger RNA and transplanted protein) or genetic characteristics derived from a Member or family member of the Member. Genetic Information includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes. However, Genetic Information shall not include routine physical measurements, chemical, blood, and urine analyses unless conducted to diagnose a genetic characteristic; tests for abuse of drugs; and tests for the presence of human immunodeficiency virus.

**Grace Period**: the thirty-one (31) day period for the payment of any Premium due, except the first Premium, during which time the Covered Expenses are paid by the Corporation, unless the Employer gives the Corporation written notice of intent to discontinue the Contract or this Plan of Benefits prior to the date the next Premium is due in accordance with the terms of the Contract. There is no Grace Period for the payment of the first Premium.

**Group Health Plan**: an employee welfare benefit plan to the extent that such plan provides health benefits to employees or their dependents, as defined under the terms of such Group Health Plan, directly or through insurance, reimbursement, or otherwise. This Plan of Benefits is a Group Health Plan.

**Health Status-Related Factor**: information about a Member's health, including:

1. Health status;
2. Medical conditions (including both physical and mental illnesses);
3. Claims experience;
4. Receipt of health care;
5. Medical history;
6. Genetic Information;
7. Evidence of insurability (including conditions arising out of acts of domestic violence); or,
8. Disability.

**HIPAA**: the Health Insurance Portability and Accountability Act of 1996, and any amendments and regulations thereto.

**Home Health Agency**: an agency or organization licensed by the appropriate state regulatory agency to provide Home Health Care.

**Home Health Care**: part-time or intermittent nursing care, health aide services, or physical, occupational, or speech therapy provided or supervised by a Home Health Agency and provided to a home-bound Member in such Member's private residence.

**Hospice Care**: care for terminally ill patients under the supervision of a Physician, and is provided by an agency that is licensed or certified as a hospice or hospice care agency by the appropriate state regulatory agency.

**Hospital**: a short-term, acute care facility licensed as a hospital by the state in which it operates. A Hospital is primarily engaged in providing medical, surgical, or acute behavioral health diagnosis and treatment of injured or sick persons, by or under the supervision of a staff of licensed Physicians, and continuous twenty-four (24) hour-a-day services by licensed, registered, graduate nurses physically present and on duty. The term Hospital does not include Long-Term Acute Care Hospitals, chronic care institutions or facilities that principally provide custodial, rehabilitative or long-term care, whether or not such institutions or facilities are affiliated with or are part of a Hospital. A Hospital may participate in a teaching program. This means medical students, interns, or residents participating in a teaching program may treat Members.

**Identification Card**: the card issued by the Corporation to a Member that contains the Member's identification number.

**Incapacitated Dependent**: a Child who is:

1. Incapable of financial self-sufficiency by reason of mental or physical disability; and,
2. Dependent upon the Employee for at least fifty-one (51) percent of his or her support and maintenance.

A Child must meet both of these requirements to qualify as an Incapacitated Dependent. The Employee will furnish written proof of items (1) and (2) no later than 31 days after the Child's attainment of the maximum age listed on the Schedule of Benefits. The Employee will update items (1) and (2) each year after the two (2) year period following the maximum age listed on the Schedule of Benefits. A Child who is not incapacitated by the maximum Dependent Child age listed on the Schedule of Benefits will not be covered.

**Investigational or Experimental Services**: surgical procedures or medical procedures, supplies, devices or drugs which, at the time provided, or sought to be provided, are in the judgment of the Corporation not recognized as conforming to generally accepted medical practice, or the procedure, drug or device:

1. Has not received required final approval to market from appropriate government bodies; or,

2. Is one about which the peer-reviewed medical literature does not permit conclusions concerning its effect on health outcomes; or,

3. Is not demonstrated to be as beneficial as established alternatives; or,

4. Has not been demonstrated to improve net health outcomes; or

5. Is one in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting.

**Late Enrollee**: an Employee (or Dependent) who enrolls for coverage under this Plan of Benefits other than during:

1. The first period in which the Employee or Dependent is eligible to enroll if such initial enrollment period is a period of at least thirty (30) days; or

2. A special enrollment period (as set forth in Article II(E)(6)).

**Lifetime Maximum**: means the total Benefits (under this Group Health Plan) to which a Member is entitled during such Member's lifetime.

**Long-Term Acute Care Hospital**: means a long-term, acute care facility licensed as a long-term care hospital by the state in which it operates and which meets the other requirements of this definition. A Long-Term Acute Care Hospital provides highly skilled nursing, therapy and medical treatment to Members (typically over an extended period of time) although such Members may no longer need general acute care typically provided in a Hospital. A Long-Term Acute Care Hospital is primarily engaged in providing diagnostic services and medical treatment to Members with chronic diseases or complex medical conditions. The term Long-Term Acute Care Hospital does not include chronic care institutions or facilities that principally provide custodial, rehabilitative or long-term care, whether or not such institutions or facilities are affiliated with or are part of a Long-Term Acute Care Hospital. A Long-Term Acute Care Hospital may participate in a teaching program. This means medical students, interns, or residents participating in a teaching program may treat Members.

**Mail Service Pharmacy**: a Pharmacy maintained by the Pharmacy Benefit Manager that fills prescriptions and sends Prescription Drugs by mail.

**Maternity Management Program**: the voluntary program offered by the Corporation to Members who are pregnant.

**Maximum Payment**: the maximum amount the Corporation will pay for a particular Benefit. The Maximum Payment will not be affected by any Credit. The Maximum Payment will be one of the following as determined by the Corporation in its discretion:

1. The actual charges made for similar services, supplies or equipment by Providers and filed with the Corporation during the preceding calendar year;

2. The Maximum Payment for the preceding year increased by an index based on national or local economic factors or indices;

3. The lowest rate at which any medical service, supply or equipment is generally available in the local service area when, in the judgment of the Corporation, charges for such service, supply or equipment generally should not vary significantly from one Provider to another, and which rate will be available to Members upon written request;

4. An amount that has been agreed upon by a Provider and the Corporation or a member of the Blue Cross and Blue Shield Association; or,

5. An amount established by the Corporation in its sole discretion. In determining the Maximum Payment under this paragraph 5, the Corporation may, through its medical staff and/or consultants, determine the Maximum Payment based on a number of factors, including, for example, comparable or similar services or procedures.

**Medical Child Support Order**: any judgment, decree or order (including an approved settlement agreement) issued by a court of competent jurisdiction or a national medical support notice issued by the applicable state agency which:

1. Provides child support with respect to a Child or provides for health benefit coverage to a Child, is made pursuant to a state domestic relations law (including a community property law), and relates to this Plan of Benefits; or

2. Enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a Group Health Plan.

3. A Medical Child Support Order must clearly specify:

    a. The name and the last known mailing address (if any) of each participant Employee and the name and mailing address of each Alternate Recipient covered by the order;

    b. A reasonable description of the type of coverage to be provided by the Group Health Plan to each such Alternate Recipient or the manner in which such type of coverage is to be determined;

    c. The period to which such order applies; and,

    d. Each Group Health Plan to which such order applies.

4. If the Medical Child Support Order is a national medical support notice, the order must also include:

    a. The name of the issuing agency;

b. The name and mailing address of an official or agency that has been substituted for the mailing address of any Alternate Recipient; and,

c. The identification of the underlying Medical Child Support Order.

A Medical Child Support Order meets the requirement of this definition only if such order does not require a Group Health Plan to provide any type or form of the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993).

**Medically Necessary/Medical Necessity**: means health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice; and

2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

3. Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

**Medical Supplies**: means supplies that are:

1. Medically Necessary; and

2. Prescribed by a Physician acting within the scope of his or her license (or are provided to a Member in a Physician’s office); and

3. Are not available on an over-the-counter basis (unless such supplies are provided to a Member in a Physician’s office and should not (in the Corporation’s sole discretion) be included as part of the treatment received by the Member); and

4. Are not prescribed in connection with any treatment or Benefit that is excluded under this Plan of Benefits.

**Member**: an Employee or Dependent who has enrolled under this Plan of Benefits.

**Member Effective Date**: the date on which an Employee or Dependent is covered for Benefits under the terms of Article II of this Plan of Benefits.

**Membership Application**: any mechanism agreed upon by the Corporation and the Employer for transmitting necessary Member enrollment information from the Employer to the Corporation.

**Mental Health Conditions:** certain psychiatric disorders or conditions defined in the most current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association and which is not otherwise excluded by the terms and conditions of this Plan of Benefits. The conditions as mandated by the State of South Carolina are:

1. Bipolar Disorder;
2. Major Depressive Disorder;
3. Obsessive Compulsive Disorder;
4. Paranoid and Other Psychotic Disorder;
5. Schizoaffective Disorder;
6. Schizophrenia;
7. Anxiety Disorder;
8. Post-traumatic Stress Disorder; and
9. Depression in childhood and adolescence.

**Mental Health Services**: treatment (except Substance Abuse Services) for a condition that is defined, described or classified as a psychiatric disorder or condition in the most current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association and which is not otherwise excluded by the terms and conditions of this Plan of Benefits.

**Natural Teeth**: teeth that:

1. Are free of active or chronic clinical decay; and
2. Have at least 50% bony support; and
3. Are functional in the arch; and
4. Have not been excessively weakened by multiple dental procedures; or,
5. Teeth that have been treated for one (1) or more of the conditions referenced in 1-4 above, and as a result of such treatment have been restored to normal function.

**Non-Participating Provider:** any Provider who does not have a current, valid Participating Provider Agreement with the Corporation or another member of the Blue Cross and Blue Shield Association.

**Non-Preferred Drug**: a Prescription Drug that bears a recognized brand name of a particular manufacturer but does not appear on the list of Preferred Brand Drugs and has not been chosen by the Corporation or its designated Pharmacy Benefit Manager to be a Preferred Drug, including any Brand Name Drug with an “A” rated Generic Drug available.

**Orthopedic Device**: any ridged or semi-ridged leg, arm, back or neck brace and casting materials that are directly used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.

**Orthotic Device**: any device used to mechanically assist, restrict, or control function of a moving part of the Member's body.

**Out-of-Pocket Maximum**: the maximum amount (if listed on the Schedule of Benefits) of otherwise Covered Expenses incurred during a Benefit Year that a Member will be required to pay. The Out-of-Pocket Maximum is Coinsurance payable by the Member. Copayments and Benefit Year Deductibles may not apply toward the Out-of-Pocket Maximum (as set forth on the Schedule of Benefits).

**Over-the-Counter Drug**: a drug that does not require a prescription.

**Participating Pharmacy**: a pharmacy that has a contract with the Corporation or with the Pharmacy Benefit Manager to provide Prescription Drugs or Specialty Drugs to Members.

**Participating Provider**: a Provider who has a current, valid Participating Provider Agreement.

**Participating Provider Agreement**: an agreement between the Corporation (or another Member of the Blue Cross and Blue Shield Association) and a Provider under which the Provider has agreed to accept an allowance as payment in full for Benefits.

**Pharmacy Benefit Manager**: an entity that has contracted with the Corporation and is responsible for the administration of the Prescription Drug Benefit in accordance with this Plan of Benefits.

**Physician**: a person who is:

1. Not an:
    a. Intern;
    b. Resident; or,
    c. In-house physician; and
2. Duly licensed by the appropriate state regulatory agency as a:
    a. Medical doctor;
    b. Oral surgeon;
    c. Osteopath;
    d. Podiatrist;
    e. Chiropractor;
    f. Optometrist; or,
    g. Psychologist with a doctoral degree in psychology; and
3. Legally entitled to practice within the scope of his or her license; and
4. Customarily bills for his or her services.

**Physician Services:** the following services, performed by a Physician within the scope of his or her license, training and specialty and within the scope of generally acceptable medical standards as determined by the Corporation:

1. Office visits, which are for the purpose of seeking or receiving care for an illness or injury;

2. Basic diagnostic services and machine tests;

3. Physician Services include the following services when performed by a medical doctor, osteopath, podiatrist or oral surgeon, but specifically excluding such services when performed by a chiropractor, optometrist, or licensed psychologist with a doctoral degree:

    a. Benefits rendered to a Member in a Hospital or Skilled Nursing Facility;

    b. Benefits rendered in a Member's home;

    c. Surgical Services;

    d. Anesthesia services, including the administration of general or spinal block anesthesia;

    e. Radiological examinations;

    f. Laboratory tests; and,

    g. Maternity services, including consultation, prenatal care, conditions directly related to pregnancy, delivery and postpartum care, and delivery of one or more infants. Physician Services also include maternity services performed by certified nurse midwives when supervised by a medical doctor.

**Plan**: any program that provides benefits or services for medical or dental care or treatment including:

1. Group coverage, whether insured or self-insured. This includes, but is not limited to, prepayment, group practice or individual practice coverage; and

2. Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

3. Each contract or other arrangement for coverage is a separate Plan for purposes of this Plan of Benefits. If a Plan has two (2) or more parts and the coordination of benefit rules in Article V apply only to one (1) of the parts, each part is considered a separate Plan.

**Plan Administrator**: the entity charged with the administration of this Plan of Benefits. The Employer is the Plan Administrator of this Plan of Benefits.

**Plan of Benefits:** this Preferred Blue Plan of Benefits including the Employer Application, the Membership Application, the Schedule of Benefits, and all endorsements, amendments, riders, or addendums.

**Plan of Benefits Effective Date**: 12:01 AM on the date listed on the Schedule of Benefits.

**Post-Service Claim:** any claim for a Benefit that is not a Pre-Service Claim.

**Preadmission Review:** the review that must be obtained by a Member (or the Member's representative) prior to all Admissions that are not related to an Emergency Medical Condition. The Preadmission Review process is outlined in Article III.

**Pre-Authorized/Pre-Authorization**: the Corporation's approval of Benefits based on Medical Necessity prior to the rendering of such Benefits to a Member. Pre-Authorization means only that the Corporation has determined that the Benefit is Medically Necessary. Pre-Authorization is not a guarantee of payment or a verification that Benefits will be paid or are available to the Member. Payment for Benefits is also subject to a Member's eligibility, Pre-Existing Condition Limitations and all other limitations and exclusions contained in this Plan of Benefits. A Member's entitlement to Benefits is not determined until the Member's claim is processed. The Pre-Authorization process is outlined in Article III.

**Pre-Existing Condition**: a physical or mental condition for which medical advice, diagnosis, care or treatment was received or recommended during the six (6) month period preceding the Enrollment Date, if applicable. Genetic Information may not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to the Genetic Information.

**Pre-Existing Condition Waiting Period**: the period (as set forth on the Schedule of Benefits) during which this Plan of Benefits will not provide Benefits to a Member for Pre-Existing Conditions, not to exceed twelve (12) months without medical care, treatment or supplies ending after the Member Effective Date of coverage or twelve (12) months after the Enrollment Date, whichever occurs first or eighteen (18) months after the Enrollment Date for a late enrollee.

**Preferred Brand Drug**: a Prescription Drug that bears a recognized brand name of a particular manufacturer and appears on the list of Preferred Brand Drugs.

**Preferred Drug**: a Prescription Drug that has been reviewed for cost effectiveness, clinical efficacy and quality that is preferred by the Pharmacy Benefit Manager, for dispensing to Members. Preferred Drugs are subject to periodic review and modification by the Corporation, or its designated Pharmacy Benefit Manager, and include Brand Name Drugs and Generic Drugs.

**Premium**: the amount paid to the Corporation by the Employer on the Members' behalf for coverage under this Plan of Benefits. Payment of Premiums by the Employer constitutes acceptance by the Employer of the terms of this Plan of Benefits and the Contract.

**Prescription Drug**: a drug or medicine that is:

1. Required to be labeled that it has been approved by the Food and Drug Administration; and,

2. Bears the legend "Caution: Federal Law prohibits dispensing without a prescription" prior to being dispensed or delivered, or labeled in a similar manner; or,

3. Insulin.

Additionally, to qualify as a Prescription Drug, the drug must:

1. Be ordered by a medical doctor or oral surgeon as a prescription; and,

2. Not be entirely consumed at the time and place where the prescription is dispensed; and,

3. Be purchased for use outside a Hospital.

**Prescription Drug Copayment**: the amount payable, if any, set forth on the Schedule of Benefits, by the Member for each Prescription Drug filled or refilled. This amount will not be applied to the Benefit Year Deductible or the Out-of-Pocket Maximum.

**Pre-Service Claim:** any request for a Benefit where Pre-Authorization must be obtained before receiving the medical care, service or supply.

**Primary Plan**: a Plan whose benefits must be determined without taking into consideration the existence of another Plan.

**Probationary Period**: the period of continuous employment (if included on the Schedule of Benefits) with the Employer that an Employee must complete before becoming eligible to enroll in this Plan of Benefits.

**Prosthetic Device**: any device that replaces all or part of a missing body organ or body member, except a wig, hairpiece or any other artificial substitute for scalp hair.

**Protected Health Information**: has the same meaning as the term is defined under HIPAA.

**Provider**: any person or entity licensed by the appropriate state regulatory agency and legally engaged within the scope of such person or entity's license in the practice of any of the following:

1. Medicine
2. Dentistry
3. Optometry
4. Podiatry
5. Chiropractic services
6. Behavioral Health
7. Physical therapy
8. Oral surgery
9. Speech therapy
10. Occupational therapy

The term Provider also includes a Hospital, a Rehabilitation Facility, a Skilled Nursing Facility and nurses practicing in expanded roles (such as pediatric nurse practitioners, family practice nurse practitioners and certified nurse midwives) when supervised by a medical doctor or oral surgeon. The term Provider does not include physical trainers, lay midwives, or masseuses.

**Qualified Medical Child Support Order**: a Medical Child Support Order that:

1. Creates or recognizes the existence of an Alternate Recipient's right to enroll under this Plan of Benefits; or,
2. Assigns to an Alternate Recipient the right to enroll under this Plan of Benefits.

**Qualifying Event**: for continuation of coverage purposes under Article VII, a Qualifying Event is any one of the following:

1. Termination of the Employee's employment (other than for gross misconduct) or reduction of hours worked that renders the Employee no longer Actively at Work and therefore ineligible for coverage under this Plan of Benefits;

2. Death of the Employee;

3. Divorce or legal separation of the Employee from his or her spouse;

4. A Child ceasing to qualify as a Dependent under this Plan of Benefits;

5. Entitlement to Medicare by an Employee, or by a parent of a Child;

6. A proceeding under Title II of COBRA with respect to the Employer from whose employment an Employee retired at any time.

**Rehabilitation Facility**: licensed facility operated for the purpose of assisting Members with neurological or other physical injuries to recover as much restoration of function as possible.

**Schedule of Benefits**: the pages of this Plan of Benefits so titled, which specify the coverage provided and the applicable Copayments, Coinsurance, Benefit Year Deductibles and Benefit limitations.

**Secondary Plan**: a Plan that is not a Primary Plan. When this Plan of Benefits constitutes a Secondary Plan, availability of Benefits are determined after those of the other Plan and may be reduced because of benefits payable under the other Plan.

**Skilled Nursing Facility**: an institution other than a Hospital that is certified and licensed by the appropriate state regulatory agency as a skilled nursing facility.

**Special Care Unit**: a specially equipped unit of a Hospital, set aside as a distinct care area, staffed and equipped to handle seriously ill Members requiring extraordinary care on a concentrated and continuous basis, such as burn, intensive, or coronary care units.

**Special Enrollment**: the time period during which an Employee or eligible Dependent who is not enrolled for coverage under this Plan of Benefits may enroll for coverage due to the involuntary loss of other coverage or under permitted circumstances described in Article II of this Plan of Benefits.

**Specialist:** a Physician that specializes in a particular branch of medicine.

**Specialty Drugs:** Prescription Drugs that treat a complex clinical condition and/or require special handling such as refrigeration. They generally require complex clinical monitoring, training and expertise. Specialty drugs include, but are not limited to infusible specialty drugs for chronic diseases, injectable and self-injectable drugs for acute and chronic diseases, and specialty oral drugs. Specialty drugs are used to treat acute and chronic disease states (e.g. growth deficiencies, Hemophilia, Multiple Sclerosis, Rheumatoid Arthritis, Gaucher's Disease, Hepatitis, cancer, organ transplantation, Alpha 1-Antitrypsin Disease and immune deficiencies).

**Substance Abuse**: the continued use, abuse and/or dependence of legal or illegal substance(s), despite significant consequences or marked problems associated with the use (as defined, described, or classified in the most current version of *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.)

**Substance Abuse Services**: services or treatment relating to Substance Abuse.

**Surgical Services**: an operative or cutting procedure or the treatment of fractures or dislocations. Surgical Services include the usual, necessary and related pre-operative and post-operative care when performed by a medical doctor or oral surgeon.

**Totally Disabled/Total Disability**: means that the Member is able to perform none of the usual and customary duties of such Member's occupation. With respect to a Member who is a Dependent, the terms refer to disability to the extent that such Member can perform none of the usual and customary duties or activities of a person in good health of the same age. The Member must provide a Physician's statement of disability upon periodic request by the Corporation.

**Urgent Care Claim:** any claim for medical care or treatment where making a determination under other than normal time frames could seriously jeopardize the Member's life or health or the Member's ability to regain maximum function; or, in the opinion of a medical doctor or oral surgeon with knowledge of the Member's medical condition, would subject the Member to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.

**USERRA:** The Uniformed Services Employment and Reemployment Rights Act of 1994 including any amendments thereto.

# ARTICLE II – ELIGIBILITY FOR COVERAGE

## A. ELIGIBILITY

1. Every Employee who is Actively at Work and who has completed the Probationary Period on or after the Employer Effective Date is eligible to enroll (and to enroll such Employee's Dependents) for coverage under this Plan of Benefits.

2. If an Employee is not Actively at Work or has not completed the Probationary Period such Employee is eligible to enroll (and to enroll such Employee's Dependents) beginning on the next day that the Employee is

    a. Actively at Work; and

    b. Has completed the Probationary Period.

3. Dependents are not eligible to enroll for coverage under this Plan of Benefits without the sponsorship of an Employee who is enrolled under this Plan of Benefits.

## B. PRE-EXISTING CONDITION WAITING PERIOD

This Plan of Benefits will not pay Covered Expenses during a Member's Pre-Existing Condition Waiting Period. The Pre-Existing Condition Waiting Period is reduced by the aggregate of any periods of Creditable Coverage immediately prior to the Member Effective Date in accordance with section C, below.

The Pre-Existing Condition Waiting Period does not apply to the following:

1. Genetic Information unless there is a diagnosis of a condition related to that Genetic Information;

2. Pregnancy;

3. Newborns who have Creditable Coverage within thirty-one (31) days of birth, so long as there has been no break in coverage of sixty-three (63) days or more;

4. An adopted Child, or a Child placed for adoption before age eighteen (18), if the Child has Creditable Coverage within thirty-one (31) days of the adoption or placement for adoption, so long as there has been no break in coverage of sixty-three (63) days or more; or,

5. The Prescription Drug Benefit if such Benefit is included on the Schedule of Benefits; or,

6. Any gap period between an initial COBRA Qualifying Event and the first day of a special COBRA election period under the Trade Act of 2002.

The Member will be notified if any Pre-Existing Condition Waiting Period applies to the Member and how this determination was made.

## C. CREDITABLE COVERAGE

1. Evidence of Creditable Coverage may reduce the length of the Member's Pre-Existing Condition Waiting Period. If a Member had Creditable Coverage immediately prior to the Member Effective Date, and there was no break in coverage for a period of sixty-three (63) consecutive days or more following prior Creditable Coverage, the Pre-Existing Condition Waiting Period will be reduced by the aggregate number of days of Creditable Coverage. A Probationary Period does not count as a break in Creditable Coverage. Excepted Benefits do not count as Creditable Coverage.

2. To receive credit for Creditable Coverage, the Member must provide the Corporation with a Certificate of Creditable Coverage or other acceptable evidence of Creditable Coverage. A Member has the right to request a Certificate of Creditable Coverage from any prior Group Health Plan or individual health plan. If requested by the Member in writing, the Corporation will request a Certificate of Creditable Coverage for the Member.

3. If the Member does not agree with the Corporation's decision with respect to prior Creditable Coverage, the Member has the right to send the Corporation additional evidence of Creditable Coverage. Decisions regarding Pre-Existing Condition Waiting Periods may be reconsidered by the Corporation.

4. To request a Certificate of Creditable Coverage from the Corporation the Member must call Customer Service at the number listed on the Identification Card.

5. The Corporation will automatically issue Certificates of Creditable Coverage to any Members that terminate under this Plan of Benefits.

## D. ELECTION OF COVERAGE

Any Employee may enroll for coverage under this Plan of Benefits for such Employee and such Employee's Dependents by completing and filing a Membership Application with the Employer. Dependents must be enrolled within thirty-one (31) days of the date on which they first become Dependents. Employees and Dependents may also enroll if eligible under the terms of any late enrollment or special enrollment procedure.

## E. COMMENCEMENT OF COVERAGE

Coverage under this Plan of Benefits will commence as follows:

1. Employees and Dependents Eligible on the Employer's Effective Date

   For Employees (and such Employee's Dependents for whom such Employee has elected coverage) who are Actively at Work prior to and on the Employer Effective Date, coverage will generally commence on this Plan of Benefits Effective Date.

   If the Corporation receives an Employee's Membership Application dated after the Employer Effective Date, coverage will commence on the date chosen by the Employer. Notwithstanding the preceding sentence, coverage will not be effective more than sixty (60) days before the Corporation receives such Employee's Membership Application.

2. Employees and Dependents Eligible After this Plan of Benefits Effective Date

   Employees and Dependents who become eligible for coverage after this Plan of Benefits Effective Date and have elected coverage, will have coverage after they have completed the Probationary Period. Notwithstanding the preceding sentence, coverage will not be effective more than sixty (60) days before the Corporation receives such Employee's Membership Application.

3. Dependents Resulting from Marriage

   Dependent(s) resulting from the marriage of an Employee will have coverage upon enrollment provided they have been enrolled for coverage within thirty-one (31) days after marriage and appropriate Premiums must be paid to the Corporation for such Dependent(s) to have coverage from the date of the marriage.

4. Newborn Children

   A newborn Child will have coverage upon enrollment provided he or she have enrolled for coverage (and the coverage has been paid for) within thirty-one (31) days after the Child's birth.

5. Adopted Children

   For an adopted Child of an Employee, coverage shall commence as follows:

   a. Coverage shall be retroactive to the Child's date of birth when a decree of adoption is entered within thirty-one (31) days after the date of the Child's birth;

   b. Coverage shall be retroactive to the Child's date of birth when adoption proceedings have been instituted by the Employee within thirty-one (31) days after the date of the Child's birth, and if the Employee has obtained temporary custody of the Child;

   c. For an adopted Child other than a newborn, coverage shall begin when temporary custody of the Child begins. However, such coverage shall only continue for one (1) year unless a decree of adoption is entered in which case coverage shall be extended so long as such Child is otherwise eligible for coverage under the terms of this Plan of Benefits.

   If an adopted Child is not enrolled within the time frame set forth in (a)-(c) above, coverage will begin on the date chosen by the Employer and upon the payment of the applicable Premium.

6. Special Enrollment

In addition to enrollment under Article II(E)(2-5), the Corporation shall permit an Employee or Dependent who is not enrolled to enroll if each of the following is met:

a. The Employee or Dependent was covered under a Group Health Plan or had Creditable Coverage at the time coverage was previously offered to the Employee or Dependent; and

b. The Employee stated in writing at the time of enrollment, that the reason for declining enrollment was because the Employee or Dependent was covered under a Group Health Plan or had Creditable Coverage at that time. This requirement shall only apply if the Employer required such a statement at the time the Employee declined coverage and provided the Employee with notice of the requirement and the consequences of the requirement at the time; and

c. The Employee or Dependent's coverage described above:

i. Was under a COBRA continuation provision and the coverage under the provision was exhausted; or

ii. Was not under a COBRA continuation provision described in section 6(c)(i), above, and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment), or reduction in the number of hours of employment, or if the employer's contributions toward the coverage were terminated; or

iii. Was one of multiple Plans offered by an employer and the Employee elected a different plan during an open enrollment period or when an employer terminates all similarly situated individuals; or

iv. Was under a HMO that no longer serves the area in which the Employee lives, works or resides; or

v. Was under a Plan where the Member incurs a claim that would meet or exceed a lifetime limit on all benefits. The Special Enrollment period is continued until at least thirty (30) days after a claim is denied due to the operation of the lifetime limit on all benefits.

vi. Under the terms of the Plan, the Employee requests the enrollment not later than thirty-one (31) days after date of exhaustion described in 6(c)(i) above, or termination of coverage or Employer contribution described in 6(c)(ii) above.

The above list is not an all-inclusive list of situations when an Employee or Dependent loses eligibility. For situations other than those listed above see the Employer.

**F. DEPENDENT CHILD'S ENROLLMENT**

1. A Dependent Child will not be denied enrollment for any of the following reasons:

a. Being born out of wedlock;

b. Not being claimed as a Dependent on the Employee's federal tax return; or,

c. Not residing with the Employee.

2. A Dependent's eligibility for or receipt of Medicaid assistance will not be considered in enrolling that Dependent for coverage under this Plan of Benefits. For a Dependent to be covered under this Plan of Benefits, the required Premium must be paid.

### G. DISCLOSURE OF MEDICAL INFORMATION

By accepting Benefits or payment of Covered Expenses, the Member agrees that the Corporation may obtain claims information, medical records, and other information necessary for the Corporation to consider a request for Pre-Authorization or Continued Stay Review, or Emergency Admission Review, or Preadmission Review or to process a claim for Benefits.

## ARTICLE III – BENEFITS

### A. PAYMENT

The payment of Covered Expenses for Benefits is subject to all terms and conditions of this Plan of Benefits and the Schedule of Benefits. The total amount paid for Benefits shall not exceed the Lifetime Maximum and in the event that a Member reaches the Lifetime Maximum, no further Benefits will be paid under this Plan of Benefits. In the event of a conflict between this Plan of Benefits and the Schedule of Benefits, the Schedule of Benefits controls. Covered Expenses will only be paid for Benefits:

1. Performed or provided on or after the Member Effective Date; and

2. Performed or provided prior to termination of coverage; and

3. Provided by a Provider, within the scope of his or her license; and

4. For which the appropriate Preadmission Review, Emergency Admission Review, Pre-Authorization and/or Continued Stay Review has been requested and Pre-Authorization was received from the Corporation; and

5. That are Medically Necessary; and

6. That are not subject to an exclusion under Article IV of this Plan of Benefits; and

7. After the payment of all required Benefit Year Deductibles, Coinsurance and Copayments.

### B. PRE-AUTHORIZATION

All Admissions and some Benefits (as indicated herein or on the Schedule of Benefits) require Pre-Authorization to determine the Medical Necessity of such Admission or Benefit. The Corporation reserves the right to add or remove items from the list of Benefits that are subject to Pre-Authorization. Each Member is responsible for obtaining Pre-Authorization and the appropriate review. If Pre-Authorization is not obtained for an Admission or if an Admission is not Pre-Authorized, and the Member is still admitted, Benefits will be reduced (up to and including denial of all or a portion of the room and board charges associated with the Admission). Specific penalties for outpatient services, Mental Health Services, Mental Health Conditions and Substance Abuse Services are listed on the Schedule of Benefits. Pre-Authorization is obtained through the following procedures:

1. For all Admissions, that are not the result of an Emergency Medical Condition, Pre-Authorization is granted or denied in the course of the Preadmission Review;

2. For all Admissions, that result from an Emergency Medical Condition, Pre-Authorization is granted or denied in the course of the Emergency Admission Review;

3. For Admissions that are anticipated to require more days than approved through the initial review process, Pre-Authorization is granted or denied for additional days in the course of the Continued Stay Review; and,

4. For specific Benefits that require Pre-Authorization, Pre-Authorization is granted or denied in the course of the Pre-Authorization process.

5. For items requiring Pre-Authorization, the Corporation must be called at the number given on the Identification Card.

## C. ASSIGNMENT OF COVERED EXPENSES

Payment for Covered Expenses may not be assigned to Non-Participating Providers.

## D. SPECIFIC COVERED BENEFITS

If all of the following requirements are met the Corporation will provide the Benefits described and listed under Article III (E).

1. All of the requirements of this Article III must be met.

2. The Benefit must be listed in this Article III.

3. The Benefit must not have a "**Non-Covered**" notation associated with it on the Schedule of Benefits.

4. The Benefit (separately or collectively) must not exceed the dollar or other limitations contained on the Schedule of Benefits.

5. The Benefit must not be subject to one or more of the exclusions set forth in Article IV.

## E. BENEFITS

### ALLERGY INJECTIONS

The Corporation will pay Covered Expenses for allergy injections as set forth below:

1. For patients with demonstrated hypersensitivity that cannot be managed by medications or avoidance; and,

2. To ensure the potency and efficacy of the antigens, the provision of multiple dose vials is restricted to sufficient antigen for the lesser of a twelve (12) week or twenty-four (24) dose; and,

3. When any of the following conditions are met:

    a. The patient has symptoms of allergic rhinitis and/or asthma after natural exposure to the allergen; or,

    b. The patient has a life threatening allergy to insect stings; or,

c. The patient has skin test and/or serologic evidence of a potent extract of the antigen; or,

d. Avoidance or pharmacologic (drug) therapy cannot control allergic symptoms.

**AMBULANCE**

The Corporation will pay Covered Expenses for ambulance transportation (including air ambulance when necessary) when used:

1. Locally to or from a Hospital providing Medically Necessary service in connection with an accidental injury or that is the result of an Emergency Medical Condition; and,

2. To or from a Hospital in connection with an Admission.

**CHIROPRACTIC SERVICES**

If specifically included on the Schedule of Benefits as a Benefit and such item does not have a "Non-Covered" notation, the Corporation will pay Covered Expenses for services and Medical Supplies required in connection with the 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.

**CLEFT LIP OR PALATE**

The Corporation will pay Covered Expenses for the care and treatment of a congenital cleft lip or palate, or both, and any physical condition or illness that is related to or developed as a result of a cleft lip or palate.

Benefits shall include, but not be limited to:

1. Oral and facial Surgical Services, surgical management and follow-up care;

2. Prosthetic Device treatment such as obdurators, speech appliances and feeding appliances;

3. Orthodontic treatment and management;

4. Prosthodontia treatment and management;

5. Otolaryngology treatment and management;

6. Audiological assessment, treatment, and management, including surgically implanted amplification devices; and

7. Physical therapy assessment and treatment.

Benefits for a cleft lip or palate must be Pre-Authorized. If a Member with a cleft lip or palate is covered by a dental policy, then teeth capping, prosthodontics, and orthodontics shall be covered by the dental policy to the limit of coverage provided under such dental policy prior to coverage under this Plan of Benefits. Covered Expenses for any excess medical expenses after coverage under any dental policy is exhausted shall be provided as for any other condition or illness under the terms and conditions of this Plan of Benefits.

**COLORECTAL CANCER SCREENING**

The Corporation will pay Covered Expenses for a colorectal cancer screening as outlined on the Schedule of Benefits.

**DENTAL CARE FOR ACCIDENTAL INJURY**

The Corporation will pay Covered Expenses for dental services to Natural Teeth required because of accidental injury. For purposes of this section, an accidental injury is defined as an injury caused by a traumatic force such as a car accident or a blow by a moving object. No Benefits will be made available for injuries that occur while the Member is in the act of chewing or biting. Services for conditions that are not directly related to the accidental injury are not covered. The first visit to a dentist does not require Pre-Authorization; however, the dentist must submit a plan for any future treatment to the Corporation for review and Pre-Authorization before such treatment is rendered if Covered Expenses are to be paid. Benefits are limited to treatment for only one (1) year from the date of the accidental injury.

**DIABETES EDUCATION**

The Corporation will pay Covered Expenses for outpatient self-management training and education for Members with diabetes mellitus provided that such training and educational Benefits are rendered by a Provider whose program:

1. Is recognized by the American Diabetes Association; or,

2. Is certified by the Diabetes Initiative of South Carolina.

**DISEASE MANAGEMENT PROGRAM**

The Corporation will offer Members who have an appropriate diagnosis the option to participate in the Corporation's Disease Management Program. A Member's participation in the Disease Management Program is voluntary.

**DURABLE MEDICAL EQUIPMENT**

The Corporation will pay Covered Expenses for standard, non-luxury (as determined by the Corporation) Durable Medical Equipment. The Corporation will decide (in its sole discretion) whether to buy or rent equipment and whether to repair or replace damaged or worn Durable Medical Equipment. The Corporation will not pay Covered Expenses for Durable Medical Equipment that is solely used by a Member in a Hospital or that the Corporation determines is included in any Hospital room charge.

**EMERGENCY MEDICAL CARE**

The Corporation will pay Covered Expenses for care that is necessary as a result of an Emergency Medical Condition.

**GYNECOLOGICAL EXAMINATION**

The Corporation will pay Covered Expenses for routine gynecological examinations each Benefit Year for female Members.

**HEALTH QUESTIONS HOTLINE**

The Corporation will provide Members with access to a 24 hour, health care questions hotline.

**HOME HEALTH CARE**

The Corporation will pay Covered Expenses for Pre-Authorized Home Health Care, including private duty nursing, when rendered to a homebound Member in the Member's current place of residence.

**HOSPICE CARE**

The Corporation will pay Covered Expenses for Pre-Authorized Hospice Care.

**HOSPITAL AND SKILLED NURSING FACILITY SERVICES**

The Corporation will pay Covered Expenses for Admissions as follows:

1. Semiprivate room, board, and general nursing care;

2. Private room, at semi-private rate as determined by the Corporation;

3. Services performed in a Special Care Unit when it is Medically Necessary that such services be performed in such unit rather than in another portion of the Hospital;

4. Ancillary services and Medical Supplies including services performed in operating, recovery and delivery rooms;

5. Diagnostic services including interpretation of radiological and laboratory examinations, electrocardiograms, and electroencephalograms;

6. In a Long-Term Acute Care Hospital.

Benefits for Admissions are subject to the requirements for Preadmission Review, Emergency Admission Review, and Continued Stay Review.

The day on which a Member leaves a Hospital or Skilled Nursing Facility, with or without permission, is treated as a day of discharge and will not be counted as a day of Admission, unless such Member returns to the Hospital or Skilled Nursing Facility by midnight of the same day. The day a Member enters a Hospital or Skilled Nursing Facility is treated as a day of Admission. The days during which a Member is not physically present for inpatient care are not counted as Admission days.

**HUMAN ORGAN AND TISSUE TRANSPLANTS**

1. The Corporation will pay Covered Expenses for certain Pre-Authorized human organ and tissue transplants. To be covered, such transplants must be provided from a human donor to a Member, and provided at a transplant center approved by the Corporation. Covered Expenses shall only be provided for the human organ and tissue transplants set forth on the Schedule of Benefits.

2. The payment of Covered Expenses for living donor transplants will be subject to the following conditions:

    a. When both the transplant recipient and the donor are Members, Covered Expenses will be paid for both.

    b. When the transplant recipient is a Member and the donor is not, Covered Expenses will be paid for both the recipient and the donor to the extent that Covered Expenses to the donor are not provided by any other source.

c. When the donor is a Member and the transplant recipient is not, no Covered Expenses will be paid to either the donor or the recipient.

3. Benefits for human organ and tissue transplants are subject to the Benefit Year Deductible amount and will be provided according to the percentage and/or dollar maximum specified on the Schedule of Benefits.

4. Human organ and tissue transplant coverage includes expenses incurred for legal donor organ and tissue procurement and all inpatient and outpatient Hospital and medical expenses for the transplant procedure and related pre-operative and post-operative care, including immunosuppressive drug therapy and air ambulance expenses.

5. Transplants of tissue as set forth below (rather than whole major organs) are Benefits under this Plan of Benefits, subject to all of the provisions of this Plan of Benefits as follows:

   a. Blood transfusions;

   b. Autologous parathyroid transplants;

   c. Corneal transplants;

   d. Bone and cartilage grafting; and

   e. Skin grafting.

**IN-HOSPITAL MEDICAL SERVICE**

The Corporation will pay Covered Expenses for a Physician's visit or visits to a Member during a Medically Necessary Admission for treatment of a condition other than that for which Surgical Service or obstetrical service is required as follows:

1. In-hospital medical Benefits primarily for Mental Health Services, Mental Health Conditions and Substance Abuse Services;

2. In-hospital medical Benefits in a Skilled Nursing Facility will be provided for visits of a Physician, limited to one visit per day, not to exceed the number of visits set forth on the Schedule of Benefits.

3. Where two (2) or more Physicians render in-hospital medical visits on the same day, payment for such services will be made only to one (1) Physician.

4. Concurrent medical and surgical Benefits for in-hospital medical services are only provided:

   a. When the condition for which in-hospital medical services requires medical care not related to Surgical Services or obstetrical service and does not constitute a part of the usual, necessary, and related pre-operative or post-operative care, but requires supplemental skills not possessed by the attending surgeon or his/her assistant;

   b. When the surgical procedure performed is designated by the Corporation as a warranted diagnostic procedure or as a minor surgical procedure.

5. When the same Physician renders different levels of care on the same day, Benefits will only be provided for the highest level of care

**MAMMOGRAPHY TESTING**

The Corporation will pay Covered Expenses for one (1) mammography test per Benefit Year regardless of Medical Necessity for female Members that are within the appropriate age guidelines. The Corporation will pay Covered Expenses for additional mammograms during a Benefit Year based on Medical Necessity.

**MATERNITY MANAGEMENT PROGRAM**

The Corporation will provide Members with access to the Maternity Management Program. The Maternity Management Program is designed to assist a Member in receiving prenatal care through coordination with the Member, the Provider, and the Corporation. The Maternity Management Program is not provided for a Child.

**MEDICAL SUPPLIES**

The Corporation will pay Covered Expenses for Medical Supplies, provided that the Corporation will not pay Covered Expenses separately for Medical Supplies that are provided as part of another Benefit.

**MENTAL HEALTH CONDITIONS**

The Corporation will pay Covered Expenses for Mental Health Conditions.

**MENTAL HEALTH SERVICES**

The Corporation will pay Covered Expenses for the inpatient and outpatient treatment for Mental Health Services.

**OBSTETRICAL SERVICES**

The Corporation will pay Covered Expenses for Pre-Authorized obstetrical services. Notwithstanding the preceding sentence, no maternity or obstetrical services are covered for a Member who is a Child. Midwives licensed and practicing in compliance with the Nurse Practices Act in a Hospital will be covered under this Benefit.

Under the terms of the Newborn and Mother's Health Act of 1996, the Corporation generally may not restrict Covered Expenses for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery (not including the day of delivery), or less than ninety-six (96) hours following a cesarean section (not including the day of surgery). Nothing in this paragraph prohibits the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than the specified time frames or from requesting additional time for hospitalization. In any case, the Corporation may not require that a Provider obtain authorization from the Corporation for prescribing a length of stay not in excess of forty-eight (48) or ninety-six (96) hours as applicable. However, Pre-Authorization is required to use certain Providers or facilities, or to reduce out-of-pocket costs.

**ONLINE HEALTH ASSESSMENT PROGRAM**

If specifically included on the Schedule of Benefits as a Benefit and such item does not have a "Non-Covered" notation the Corporation will provide Members with access to an online, internet based 24 hour, health care assessment service program.

**ORTHOPEDIC DEVICES**

The Corporation will pay Covered Expenses for Pre-Authorized Orthopedic Devices.

**ORTHOTIC DEVICES**

The Corporation will pay Covered Expenses for Pre-Authorized Orthotic Devices that are not available on an over-the-counter basis.

**OUTPATIENT HOSPITAL AND AMBULATORY SURGICAL CENTER SERVICES**

The Corporation will pay Covered Expenses for Surgical Services and diagnostic services, including radiological examinations, laboratory tests, and machine tests, performed in an outpatient Hospital setting or an Ambulatory Surgical Center.

**OUTPATIENT REHABILITATION SERVICES**

The Corporation will pay Covered Expenses, subject to the following paragraph, for physical therapy, occupational therapy, speech therapy and rehabilitation services as set forth on the Schedule of Benefits.

Covered Expenses for outpatient rehabilitation services will be paid only following an acute incident involving disease, trauma or surgery that requires such care.

**OXYGEN**

The Corporation will pay Covered Expenses for Pre-Authorized oxygen. Durable Medical Equipment for oxygen use in a Member's home is covered under the Durable Medical Equipment Benefit.

**PAP SMEAR**

The Corporation will pay Covered Expenses for a pap smear as part of the annual gynecological examination Benefit regardless of Medical Necessity. The Corporation will pay Covered Expenses for additional pap smears during a Benefit Year based on Medical Necessity.

**PHYSICAL EXAMINATION**

The Corporation will pay Covered Expenses for an annual physical examination each Benefit Year for Members that are within the appropriate age guidelines regardless of Medically Necessity.

**PHYSICIAN SERVICES**

The Corporation will pay Covered Expenses for Physician Services, provided that when different levels (as determined by the Corporation) of Physician Services are provided on the same day, Covered Expenses for such Benefits will only be paid for the highest level (as determined by the Corporation) of Physician Services.

**PRESCRIPTION DRUGS**

1. The Corporation will pay Covered Expenses for Prescription Drugs (as specified on the Schedule of Benefits) that are used to treat a condition for which Benefits are otherwise available. Any Coinsurance percentage for Prescription Drugs is based on the Allowable Charge at the Participating Pharmacy, and does not change due to receipt of any Credits by the Corporation. Copayments likewise do not change due to receipt of any Credits by the Corporation.

2. If a Physician prescribes a Brand Name Drug and an equivalent Generic Drug is available (whether or not the Physician indicates in the prescription that the substitution of a Generic Drug is not allowed), any difference between the cost of a Generic Drug and the higher cost of a Brand Name Drug shall be the responsibility of the Member.

3. Insulin shall be treated as a Prescription Drug whether injectable or otherwise.

4. The Corporation may, in its sole discretion, place quantity limits on Prescription Drugs.

**PROSTATE EXAMINATION**

The Corporation will pay Covered Expenses for one (1) prostate examination per Benefit Year regardless of Medical Necessity as set forth in the Schedule of Benefits for Members that are within the appropriate age guidelines. The Corporation will pay Covered Expenses for additional prostate examinations during a Benefit Year based on Medical Necessity.

**PROSTHETIC DEVICES**

The Corporation will only pay Covered Expenses for Prosthetic Devices when prescribed for the alleviation or correction of conditions caused by physical injury, trauma, disease or birth defects and is an original replacement for a body part. Covered Expenses will only be paid for standard, non-luxury items (as determined by the Corporation) as a replacement of a Prosthetic Device when such Prosthetic Device cannot be repaired for less than the cost of replacement, or when a change in the Member's condition warrants replacement.

**RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES**

In the case of a Member who is receiving Covered Expenses in connection with a mastectomy; the Corporation will pay Covered Expenses for each of the following (if requested by such Member):

1. Reconstruction of the breast on which the mastectomy has been performed; and

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prosthetic devices and treatment of physical complications at all stages of the mastectomy, including lymphedema.

**REHABILITATION**

The Corporation will pay Covered Expenses for participation in a multidisciplinary team rehabilitation program only following severe neurologic or physical impairment as specified on the Schedule of Benefits if the following criteria are met:

1. All such treatment must be ordered by a medical doctor; and

2. All such treatment requires Pre-Authorization and must be performed by a Provider and at a location designated by the Corporation; and

3. The documentation that accompanies a request for rehabilitation Benefits must contain a detailed Member evaluation from a medical doctor that documents that to a degree of medical certainty the Member has rehabilitation potential such that there is an expectation that the Member will achieve an ability to provide self care and perform activities of daily living; and

4. All such rehabilitation Benefits are subject to periodic review by the Corporation.

After the initial rehabilitation period, continuation of rehabilitation Benefits will require documentation that the Member is making substantial progress and that there continues to be significant potential for the achievement of the established rehabilitation goals.

**ROUTINE ANNUAL BENEFITS**

The Corporation may offer certain routine annual Benefits (typically preventive care) as set forth on the Schedule of Benefits.

**SPECIALTY DRUGS**

The Corporation will pay Covered Expenses for Specialty Drugs. Covered Expenses for Specialty Drugs dispensed to a Member shall not exceed the quantity and benefit maximum set by the Corporation. Specialty Drugs are medical Benefits. Any medical Benefit Year Deductible, Out-of-Pocket Maximum and/or Benefit Maximum will apply as set forth on the Schedule of Benefits. The Member may obtain a list of Specialty Drugs by contacting the Corporation at the number listed on the Identification Card or at www.SouthCarolinaBlues.com.

Any Coinsurance percentage for Specialty Drugs is based on the Allowable Charge at the Participating Pharmacy, and does not change due to receipt of any Credits by the Corporation. Copayments likewise do not change due to receipt of any Credits by the Corporation.

**SUBSTANCE ABUSE SERVICES**

The Corporation will pay Covered Expenses for Substance Abuse Services as set forth on the Schedule of Benefits.

**SURGICAL SERVICES**

The Corporation will pay Covered Expenses for Surgical Services performed by a medical doctor or oral surgeon for treatment and diagnosis of disease or injury or for obstetrical services, as follows:

1. Surgical Services, subject to the following:

    a. If two (2) or more operations or procedures are performed at the same time, through the same surgical opening or by the same surgical approach, the total amount covered for such operations or procedures will be the Allowable Charge for the major procedure only.

    b. If two (2) or more operations or procedures are performed at the same time, through different surgical openings or by different surgical approaches, the total amount covered will be the Allowable Charge for the operation or procedure bearing the highest Allowable Charge, plus one-half of Allowable Charge for all other operations or procedures performed.

    c. If an operation consists of the excision of multiple skin lesions, the total amount covered will be the Allowable Charge for the procedure bearing the highest Allowable Charge, fifty (50%) percent for the procedure bearing the second and third highest Allowable Charges, twenty-five (25%) percent for the procedures bearing the fourth through the eighth highest Allowable Charges, and, ten (10%) percent for all other procedures. Provided, however, if the operation consists of the excision of multiple malignant lesions, the total amount covered will be the Allowable Charge for the procedure bearing the highest Allowable Charge, and fifty (50%) percent of the charge for each subsequent procedure.

    d. If an operation or procedure is performed in two (2) or more steps or stages, coverage for the entire operation or procedure will be limited to the Allowable Charge set forth for such operation or procedure.

e. If two (2) or more medical doctors or oral surgeons perform operations or procedures in conjunction with one another, other than as an assistant surgeon or anesthesiologist, the Allowable Charge, subject to the above paragraphs, will be coverage for the services of only one (1) medical doctor or oral surgeon (as applicable) or will be prorated between them by the Corporation when so requested by the medical doctor or oral surgeon in charge of the case.

f. Certain surgical procedures are designated as separate procedures by the Corporation, and the Allowable Charge is payable when such procedure is performed as a separate and single entity; however, when a separate procedure is performed as an integral part of another surgical procedure, the total amount covered will be the Allowable Charge for the major procedure only.

2. Surgical assistant services, that consist of the Medically Necessary service of one (1) medical doctor or oral surgeon who actively assists the operating surgeon when a covered Surgical Service is performed in a Hospital, and when such surgical assistant service is not available by an intern, resident, Physician's assistant or in-house Physician. The Corporation will pay charges at the percentage of the Allowable Charge set forth on the Schedule of Benefits for the Surgical Service, not to exceed the medical doctor's or oral surgeon's (as applicable) actual charge.

3. Anesthesia services, that consists of services rendered by a medical doctor, oral surgeon or a certified registered nurse anesthetist, other than the attending surgeon or his or her assistant, and includes the administration of spinal or rectal anesthesia, or a drug or other anesthetic agent by injection or inhalation, except by local infiltration, the purpose and effect of which administration is the obtaining of muscular relaxation, loss of sensation, or loss of consciousness. Additional Benefits will not be provided for pre-operative anesthesia consultation.

## ARTICLE IV - EXCLUSIONS AND LIMITATIONS

REGARDLESS OF LANGUAGE CONTAINED ELSEWHERE IN THIS PLAN OF BENEFITS, THE FOLLOWING ARE NOT BENEFITS UNDER THIS PLAN OF BENEFITS. THE ONLY EXCEPTION TO THIS IS WHERE SUCH ITEMS ARE SPECIFICALLY INCLUDED ON THE SCHEDULE OF BENEFITS OR AS THE LAW REQUIRES. THE CORPORATION WILL NOT PAY ANY AMOUNT FOR THE FOLLOWING:

**ACUPUNCTURE**

Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, acupuncture treatment or services.

**ACTS OF WAR**

Illness contracted or injury sustained as a result of a Member's participation as a combatant in a declared or undeclared war, or any act of war, or while in military service.

**ADMISSIONS THAT ARE NOT PRE-AUTHORIZED**

If Pre-Authorization is not received for an otherwise Covered Expense related to an Admission, penalties will be applied (up to and including denial of the Covered Expenses) as set forth on the Schedule of Benefits.

**BENEFITS PROVIDED UNDER ANY LAW**

Any service or charge for a service to the extent a Member is entitled to receive payment or benefits (whether or not any such payment or benefits have been applied for or paid) pursuant to any law (now existing or as may be amended) of the United States, or any state or political subdivision thereof. This exclusion includes, but is not limited to, benefits provided by the Veterans Administration for care rendered for service-related disability, or any state or federal hospital services for which the Member is not legally obligated to pay.

**BENEFITS PROVIDED BY STATE OR FEDERAL PROGRAMS**

Any service or charge for a service to the extent that the Member is entitled to payment or benefits relating to such service under any state or federal program that provides health care benefits, including Medicare, but only to the extent that benefits are paid or are payable under such programs.

**COMPLICATIONS FROM FAILURE TO COMPLETE TREATMENT**

Complications that occur because a Member did not follow the course of treatment prescribed by a Provider, including complications that occur because a Member left a Hospital against medical advice.

**COMPLICATIONS FROM NON-COVERED SERVICES**

Complications arising from a Member's receipt of either services or Medical Supplies or other treatment that are not Benefits, including complications arising from a Member's use of Discount Services.

**CONTRACEPTIVES**

Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, devices or Prescription Drugs of any type, even though dispensed by a prescription, for the purpose of contraception.

**COPYING CHARGES**

Fees for copying or production of medical records and/or claims filing.

**COSMETIC SERVICES**

1. Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, this Plan of Benefits excludes cosmetic or reconstructive procedures, and any related services or Medical Supplies, which alter appearance but do not restore or improve impaired physical function. Examples of services that are cosmetic and are not covered are:

    a. Rhinoplasty (nose);

    b. Mentoplasty (chin);

    c. Rhytidoplasty (face lift);

    d. Glabellar rhytidoplasty (forehead lift);

    e. Surgical planing (dermabrasion);

    f. Blepharoplasty (eyelid);

    g. Mammoplasty (reduction, suspension or augmentation of the breast);

h. Superficial chemosurgery (chemical peel of the face); and,

i. Rhytidectomy (abdomen, legs, hips, buttocks, or elsewhere including lipectomy or adipectomy).

2. A cosmetic service may, under certain circumstances (in the Corporation's discretion), be considered restorative in nature. In order for Benefits to be available for such restorative surgery or treatment, the restorative surgery or treatment must be:

   a. Necessary to correct or alleviate a malappearance or deformity that causes a loss of physical function or causes significant pain; or,

   b. Necessary to correct or alleviate a malappearance or deformity that was caused by physical trauma, surgery or congenital anomaly; and,

   c. The proposed cosmetic services, surgery or treatment must have been Pre-Authorized.

**CUSTODIAL OR LONG-TERM CARE SERVICES**

Admissions or portions thereof for custodial care or long-term care, including:

1. Rest care;

2. Long-term acute or chronic psychiatric care;

3. Care to assist a Member in the performance of activities of daily living (including, but not limited to: walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation, and taking medication);

4. Care in a sanitarium;

5. Custodial or long-term care; or,

6. Psychiatric or substance abuse residential treatment, including: Residential Treatment Centers; Therapeutic schools; Wilderness/Boot camps; Therapeutic Boarding Homes; Half-way Houses; and Therapeutic Group Homes.

**DENTAL SERVICES**

Any dental procedures involving tooth structures, excision or extraction of teeth, gingival tissue, alveolar process, dental X-rays, preparation of mouth for dentures, or other procedures of dental origin. However, that such procedures may be Pre-Authorized in the sole discretion of the Corporation if the need for dental services results from an accidental injury to Natural Teeth within one (1) year prior to the date of such services.

**DISCOUNT SERVICES**

Any charges that result from the use of Discount Services including charges related to any injury or illness that results from a Member's use of Discount Services. Discount Services are not covered under this Plan of Benefits and Members must pay for Discount Services.

**EYEGLASSES**

Unless such item has a dollar or percentage amount associated with it on the Schedule of Benefits, eyeglasses or contact lenses of any type, even though dispensed by a prescription (except after cataract surgery).

**FOOD SUPPLEMENTS**

Food supplements unless such food supplements are available by prescription only and are prescribed by a Physician.

**FOOT CARE**

Routine foot care such as paring of nails, calluses, or corns.

**HEARING AIDS**

Hearing aids or examinations for the prescription or fitting of hearing aids.

**HUMAN ORGAN AND TISSUE TRANSPLANTS**

Human organ and tissue transplants that are not:

1. Pre-Authorized; or,

2. Performed by a Provider as designated by the Corporation; or,

3. Listed as a covered transplant on the Schedule of Benefits.

**IMMUNIZATIONS**

Unless such item has a dollar or percentage amount associated with it on the Schedule of Benefits, immunizations are excluded from coverage under this Plan of Benefits.

**IMPACTED TOOTH REMOVAL**

Unless such item has a dollar or percentage amount associated with it on the Schedule of Benefits, services or Medical Supplies for the removal of impacted teeth.

**IMPOTENCE**

Unless such item has a dollar or percentage amount associated with it on the Schedule of Benefits, services, supplies or drugs related to any treatment for impotence, including but not limited to penile implants.

**INCAPACITATED DEPENDENTS**

Any Service, Supply or Charge for an Incapacitated Dependent that is not enrolled by the maximum Dependent Child age listed on the Schedule of Benefits.

**INFERTILITY**

Unless such item has a dollar or percentage amount associated with it on the Schedule of Benefits, services, supplies or drugs related to any treatment for infertility including but not limited to: fertility drugs; gynecological or urological procedures the purpose of which is primarily to treat infertility; artificial insemination; in-vitro fertilization; reversal of sterilization procedures and surrogate parenting.

**INPATIENT DIAGNOSTIC AND EVALUATIVE PROCEDURES**

Inpatient care and related Physician Services rendered in conjunction with an Admission, which is principally for diagnostic studies or evaluative procedures that could have been performed on an outpatient basis are not covered unless the Member's medical condition alone required Admission.

**INJURY OR ILLNESS RESULTING FROM CRIMINAL ACTIVITY**

Illness contracted or injury sustained as a result of participating in a riot or insurrection, or while engaged in the commission of a felony or an illegal occupation.

**INVESTIGATIONAL OR EXPERIMENTAL SERVICES**

Services, supplies or drugs that are Investigational or Experimental.

**LIFESTYLE IMPROVEMENT SERVICES**

Services or supplies relating to lifestyle improvements including, but not limited to, nutrition counseling or physical fitness programs.

**MASSAGE THERAPY**

Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, massage therapy treatment or services.

**MEMBERSHIP DUES AND OTHER FEES**

Amounts payable (whether in the form of initiation fees, annual dues or otherwise) for membership or use of any gym, workout center, fitness center, club, golf course, wellness center, health club, weight control organization or other similar entity or amounts payable to a trainer of any type.

**MISSED PROVIDER APPOINTMENTS**

Charges for a Member's appointment with a Provider that the Member did not attend.

**NO LEGAL OBLIGATION TO PAY**

Any service, supply or charge the Member is not legally obligated to pay.

**NOT MEDICALLY NECESSARY SERVICES OR SUPPLIES**

Any service or supply that is not Medically Necessary. However, if a service is determined to be not Medically Necessary because it was not rendered in the least costly setting, Covered Expenses will be paid in an amount equal to the amount payable had the service been rendered in the least costly setting.

**OBESITY RELATED PROCEDURES**

1. Unless such item has a dollar or percentage amount associated with it on the Schedule of Benefits, any Medical Supply or service rendered to a Member for the treatment of obesity or for the purpose of weight reduction. This includes all procedures designed to restrict the Member's ability to assimilate food, such as: gastric by-pass, the insertion of gastric bubbles, the wiring shut of the mouth, and any other procedure the purpose of which is to restrict the ability of a Member to take in food, digest food or assimilate nutrients.

2. Services, supplies or charges for the treatment or correction of complications arising from weight control procedures, services, supplies or charges, such as procedures to reverse these restrictive or diversionary procedures and such reconstructive procedures as may be necessitated by the weight loss produced by these non-covered restrictive or diversionary procedures. Examples of such reconstructive procedures include, but are not limited to, abdominal panniculectomy and removal of excessive skin from arms, legs or other areas of the body.

3. Membership fees to weight control programs.

**ORTHOGNATHIC SURGERY**

Unless such item has a dollar or percentage amount associated with it on the Schedule of Benefits, any service related to the treatment of malpositions or deformities of the jaw bone(s), dysfunction of the muscles of mastication, or orthognathic deformities.

**OUTPATIENT SERVICES THAT ARE NOT PRE-AUTHORIZED**

If Pre-Authorization is not received, for an otherwise Covered Expense related to an outpatient service, Benefits will be reduced (up to and including denial) of the Allowable Charge. Outpatient Services requiring Pre-Authorization are listed on the Schedule of Benefits.

**OVER-THE-COUNTER DRUGS**

Drugs that are available on an over-the-counter basis or otherwise available without a prescription.

**PAIN MANAGEMENT PROGRAMS**

Chronic pain management programs or multi-disciplinary pain management programs unless Medically Necessary.

**PHYSICAL THERAPY ADMISSIONS**

All Admissions for physical therapy, except as provided in Article III for rehabilitation Benefits.

**PHYSICIAN CHARGES**

Charges by a Physician for blood and blood derivatives and for charges for Prescription Drugs or Specialty Drugs that are not consumed at the Physician's office.

**PRE-EXISTING CONDITIONS**

Charges for services or supplies relating to the treatment of a Pre-Existing Condition during the Pre-Existing Condition Waiting Period.

**PRE-MARITAL AND PRE-EMPLOYMENT EXAMINATIONS**

Charges for services, supplies or fees for pre-marital or pre-employment examinations.

**PRE-OPERATIVE ANESTHESIA CONSULTATION**

Charges for pre-operative anesthesia consultation.

**PRESCRIPTION DRUG EXCLUSIONS**

- Prescription Drugs that have not been prescribed by a Physician.
- Any vitamins except for prenatal vitamins.
- Prescription Drugs not approved by the Food and Drug Administration.
- Prescription Drugs for non-covered therapies, services, or conditions.
- Prescription Drug refills in excess of the number specified on the Physician's prescription order or Prescription Drug refills dispensed more than one (1) year after the original prescription date;
- Unless different time frames are specifically listed on the Schedule of Benefits, more than a thirty-one (31) day supply for Prescription Drugs (ninety (90) day supply for Prescription Drugs obtained through a Mail Service Pharmacy);
- Any type of service or handling fee for Prescription Drugs, including fees for the administration or injection of a Prescription Drug;
- Dosages that exceed the recommended daily dosage of any Prescription Drug as described in the current Physician's Desk Reference or as recommended under the guidelines of the Pharmacy Benefit Manager, whichever is lower;
- Prescription Drugs used for or related to cosmetic purposes, including hair growth, unless otherwise specified on the Schedule of Benefits;
- Prescription Drugs related to any treatment for infertility or impotence including but not limited to, fertility drugs;
- Prescription Drugs administered or dispensed in a Physician's office, Skilled Nursing Facility, Hospital or any other place that is not a Pharmacy licensed to dispense Prescription Drugs in the state where it is operated;
- Prescription Drugs for which there is an over-the-counter equivalent and over-the-counter supplies or supplements;
- Prescription Drugs that are being prescribed for a specific medical condition that are not approved by the Food and Drug Administration for treatment of that condition (except for Prescription Drugs for a specific medical condition that has at least two (2) formal clinical studies or Prescription Drugs for the treatment of a specific type of cancer, provided the drug is recognized for treatment of that specific cancer in at least one standard reference compendia or is found to be safe and effective in formal clinical studies, the results of which have been published in peer reviewed professional medical journals);

- Prescription Drugs that are not consistent with the diagnosis and treatment of a Member's illness, injury or condition, or are excessive in terms of the scope, duration, dosage or intensity of drug therapy that is needed to provide safe, adequate and appropriate care;

- Prescription Drugs or services that require Pre-Authorization by the Corporation and Pre-Authorization is not obtained;

- Prescription Drugs for injury or disease that are paid by worker's compensation benefits (if a worker's compensation claim is settled, it will be considered paid by worker's compensation benefits);

- Prescription Drugs that are not Medically Necessary;

- Prescription Drugs for obesity or weight control, contraceptives or smoking cessation, unless a dollar or percentage amount is included on the Schedule of Benefits with respect to such Prescription Drugs;

- Prescription Drugs used for cosmetic purposes;

- Prescription Drugs that are Specialty Drugs, except as specified on the Schedule of Benefits.

**PSYCHOLOGICAL AND EDUCATIONAL TESTING**

Psychological or educational diagnostic testing to determine job or occupational placement, school placement or for other educational purposes, or to determine if a learning disability exists.

**RELATIONSHIP COUNSELING**

Marriage or family counseling for the treatment of pre-marital, marital or family relationship dysfunction.

**SERVICES FOR CERTAIN DIAGNOSES OR DISORDERS**

Medical Supplies or services or charges for the diagnosis or treatment of learning disabilities, developmental speech delay, perceptual disorders, mental retardation or vocational rehabilitation.

**SERVICES NOT LISTED AS COVERED BENEFITS**

Medical Supplies or services or other items not specifically listed as a Benefit in Article III of this Plan of Benefits or on the Schedule of Benefits.

**SERVICES PRIOR TO MEMBER EFFECTIVE DATE OR PLAN OF BENEFITS EFFECTIVE DATE**

Any charges for Medical Supplies or services rendered to the Member prior to the Member's Effective Date, the Employer's Effective Date, or after the Member's coverage terminates, except as provided in Articles VI and X.

**SERVICES RENDERED BY FAMILY**

Any Medical Supplies or services rendered by a Member to himself or herself or rendered by a Member's immediate family (parent, child, spouse, brother, sister, grandparent or in-law).

**SERVICES RESULTING FROM INTOXICATION OR DRUG USE**

Any service (other than Substance Abuse Services), Medical Supplies, charges or losses resulting from a Member being intoxicated or under the influence of any drug or other substance; or, abusing alcohol, drugs, or other substance; or, taking some action the purpose of which is to create a euphoric state or alter consciousness unless taken on the advice of a Physician.

**SEX CHANGE**

Any Medical Supplies or services or charges incurred for consultation, therapy, surgery or any procedures related to changing a Member's sex.

**SMOKING CESSATION TREATMENT**

Unless such item has a dollar or percentage amount associated with it on the Schedule of Benefits, Medical Supplies, services or Prescription Drugs for smoking cessation.

**TEMPOROMANDIBULAR JOINT (TMJ) DISORDER**

Unless such item has a dollar or percentage amount associated with it on the Schedule of Benefits, any service for the treatment of dysfunctions or derangements of the temporomandibular joint, this exclusion also applies to orthognathic surgery for the treatment of dysfunctions or derangements of the temporomandibular joint.

**TRAVEL**

Travel, whether or not recommended by a Physician, unless directly related to human organ or tissue transplants specified in Article III and Pre-Authorized by the Corporation.

**VIRTUAL OFFICE VISITS**

Unless such item has a dollar or percentage amount associated with it on the Schedule of Benefits, charges incurred as a result of virtual office visits on the Internet, including charges for Prescription Drugs or Specialty Drugs. A virtual office visit on the Internet occurs when a Member was not physically seen or physically examined by an approved Internet Participating Provider.

**VISION CARE**

Unless such item has a dollar or percentage amount associated with it on the Schedule of Benefits, any Medical Supply or service rendered to a Member for vision care.

**WORKERS' COMPENSATION**

This policy does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained by a Member that arises out of, in connection with, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the Member. Benefits will not be provided under this Plan if coverage under the Workers' Compensation Act or similar law would have been available to the Member but the Member elects exemption from available Workers' Compensation coverage; waives entitlement to Workers' Compensation benefits for which he/she is eligible; failed to timely file a claim for Workers' Compensation benefits; or, the Member sought treatment for the injury or illness from a provider which is not authorized by the Member's employer.

If the Corporation pays benefits for an injury or illness and the Corporation determines the Member also received Workers' Compensation benefits by means of a settlement, judgment, or other payment for the same injury or illness, the Corporation shall have the right of recovery as outlined in Article IX of this Plan of Benefits.

# ARTICLE V - COORDINATION OF BENEFITS

## A. APPLICABILITY

Coordination of benefits is a limitation of Benefits designed to avoid the duplication of payments for Covered Expenses. Coordination of benefits under this Article V applies when a Member has health care coverage under one or more Plans that contain a coordination of benefits provision (or are required by law to contain a coordination of benefits provision). Additionally, special rules for the Coordination of Benefits with Medicare may also apply.

## B. COORDINATION OF BENEFITS WITH AUTO INSURANCE

If the Member resides in a state where automobile no-fault, personal injury protection, or medical payments coverage is mandatory, or if the Member is involved in an accident in a state where such coverage is mandatory and the Member's automobile insurance carrier provides the state mandated coverage, the Member's automobile coverage is primary and the Plan takes a secondary status.

## C. ORDER OF DETERMINATION RULES

When a claim is submitted under both this Plan of Benefits and another Plan, this Plan of Benefits is a Secondary Plan and the availability of Benefits is determined after benefits are determined under the other Plan unless:

1. The other Plan has rules coordinating its benefits with those of this Plan of Benefits; or,

2. There is a statutory requirement relating to the determination of benefits that is not pre-empted by ERISA; or,

3. Both the other Plan's rules and this Plan of Benefits' rules require that Benefits be determined before those of the other Plan.

## D. RULES

This Plan of Benefits coordinates Benefits using the first of the following rules that apply:

1. Dependent Members.

   The Plan that covers an individual as an employee or retiree is the Primary Plan.

2. Dependent Child - Parents not Separated or Divorced.

   When this Plan of Benefits and another Plan cover the same Child as a Dependent then Benefits are determined in the following order:

   a. The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year.

b. If both parents have the same birthday, the benefits of the Plan that has covered a parent longer are determined before those of the other Plan.

c. If the other Plan does not have the rule described in (a) above, but instead has a rule based upon the gender of the parent; and if, as a result, the Plan and the Corporation do not agree on the order of benefits, the gender rule in the other Plan will apply.

3. Dependent Child - Separated or Divorced Parents.

If two (2) or more Plans cover a person as a Dependent Child of divorced, separated, or unmarried parents, benefits for the Child are determined in the following order:

a. First, the Plan of the parent with custody of the Child;

b. Second, the Plan of the spouse of the parent with the custody of the Child;

c. Third, the Plan of the parent not having custody of the Child.

d. If sections a-c above do not apply, the Plan of the spouse of the parent not having custody of the Child.

Notwithstanding the foregoing, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the Child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the Plan has actual knowledge of the existence of an applicable court decree.

If the specific terms of a court decree state that the parents shall share joint custody without stating that one of the parents is responsible for the health care expenses of the Child, the Plans covering the Child shall follow the order of determination rules outlined in section V (D) (2).

4. Active and Inactive Employees.

The benefits of a Plan that covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, are determined before those of a Plan that covers that person as a laid off or retired employee, or as that employee's dependent. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of Covered Expenses, this rule does not apply.

5. Medicare.

This Plan of Benefits is a Secondary Plan with respect to Medicare benefits except where federal law mandates that this Plan of Benefits be the Primary Plan. Any claims where Medicare is primary must be filed by the Member after Medicare payment is made.

6. Longer and Shorter Length of Coverage.

If none of the above rules determines the order of benefits, the Plan that has covered the Member longer is the Primary Plan.

7. COBRA.

   COBRA allows coverage to begin or continue under certain circumstances if the Member already has or obtains coverage under a Group Health Plan. In these instances, two policies may cover the Member, and the Plan providing COBRA coverage will be the Secondary Plan.

## E. EFFECT ON BENEFITS OF THIS PLAN OF BENEFITS

1. This Plan of Benefits as Primary Plan

   When this Plan of Benefits is the Primary Plan, the Benefits shall be determined without consideration of the benefits of any other Plan.

2. This Plan of Benefits as Secondary Plan

   When this Plan of Benefits is a Secondary Plan, the Benefits will be reduced when the sum of the following exceeds the Covered Expenses in a Benefit Year:

   a. The Covered Expenses in the absence of this coordination of benefits provision; plus

   b. The Covered Expenses that would be payable under the other Plan, in the absence of provisions with a purpose like that of this coordination of benefits provision, whether or not a claim is made.

   c. When the sum of these two (2) amounts exceeds the maximum amount payable for Covered Expenses in a Benefit Year, the Covered Expenses will be reduced so that they and the benefits payable under the other Plans do not total more than the Covered Expenses. When the Covered Expenses of this Plan of Benefits are reduced in this manner, each Benefit is reduced in proportion and then charged against any applicable limit of this Plan of Benefits.

3. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be a Covered Expense.

4. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not a Covered Expense unless the Member's Admission in a private Hospital room is Medically Necessary. When benefits are reduced under a Primary Plan because a Member does not comply with the Primary Plan's requirements, the amount of such reduction in benefits will not be a Covered Expense.

## F. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

The Corporation is entitled to such information as it deems reasonably necessary to apply these coordination of benefit provisions and the Member and the Employer must provide any such information as reasonably requested.

## G. PAYMENT

A payment made under another Plan may include an amount that should have been paid under this Plan of Benefits. In such a case, the Corporation may pay that amount to the organization that made such payment. That amount will then be treated as though it had been paid under this Plan of Benefits. The term "payment " includes providing benefits in the form of services, in which case "payment " means the reasonable cash value of the benefits provided in the form of services.

### H. RIGHT OF RECOVERY

If the amount of the payments made by the Corporation is more than the Corporation should have paid under this coordination of benefits section, the Corporation may recover the excess or overpayment from the Member on whose behalf it has made payments, from a Provider, from any group insurer, Plan, or any other person or organization contractually obligated to such Member with respect to such overpayments.

## ARTICLE VI – TERMINATION OF THIS PLAN OF BENEFITS

### A. GENERALLY

TERMINATION OF EMPLOYEE'S COVERAGE AND ALL OF SUCH EMPLOYEE'S DEPENDENTS' COVERAGE WILL OCCUR ON THE EARLIEST OF THE FOLLOWING CONDITIONS:

1. The date this Plan of Benefits is terminated pursuant to Article VI(B)-(I).

2. The date an Employee retires unless this Plan of Benefits covers such individual as a retiree.

3. The date an Employee ceases to be eligible for coverage as set forth in Article II.

4. The date an Employee is no longer Actively at Work, except that an Employee may be considered Actively at Work during a disability leave of absence for a period not to exceed ninety (90) days from the date the Employee is no longer Actively at Work or, for a qualified Employee (as qualified under the Family and Medical Leave Act of 1993), during any leave taken pursuant to the Family and Medical Leave Act of 1993.

5. In addition to terminating when an Employee's coverage terminates, a Dependent spouse's coverage terminates on the date of entry of an order or decree ending the marriage between the Dependent spouse and the Employee regardless of whether such order or decree is subject to appeal.

6. In addition to terminating when an Employee's coverage terminates, a Child's coverage terminates when that individual no longer meets the definition of a Child under this Plan of Benefits.

7. In addition to terminating when an Employee's coverage terminates, an Incapacitated Dependent's coverage terminates when that individual no longer meets the definition of an Incapacitated Dependent.

8. Death of the Employee.

### B. TERMINATION FOR FAILURE TO PAY PREMIUMS

1. If the Premium remains unpaid after the Grace Period, this Plan of Benefits shall automatically terminate, without prior notice to the Employer, or to any Member, immediately after the last day of the Grace Period.

2. If a subgroup fails to pay the Premium after the Grace Period, this Plan of Benefits for that subgroup shall automatically terminate, without any prior notice to the Employer or Members, for nonpayment of Premium immediately after the last day of the Grace Period. Additionally, the Corporation retains the right to terminate this Plan of Benefits for the entire group in the event a subgroup fails to pay their portion of the Premium.

3. During the Grace Period the Corporation will pay Covered Expenses for Benefits (including Prescription Drugs) obtained by Members during the Grace Period.

4. In the event of termination for failure to pay Premiums, Premiums received by the Corporation after the Grace Period will not automatically reinstate this Plan of Benefits absent written agreement by the Corporation. The Corporation will refund the amount of any late Premium paid if this Plan of Benefits is not reinstated, except that portion relating to coverage provided prior to or during the Grace Period.

## C. TERMINATION WHILE ON LEAVE

During an Employee's leave of absence that is taken pursuant to the Family and Medical Leave Act, the Employer must maintain the same health benefits as provided to Employees not on leave. The Employee must continue to pay his or her portion of the Premium and the Employer will continue to pay the same Premium the Employer would have paid had the Employee been Actively at Work. If Premiums are not paid by an Employee within thirty-one (31) days of the Premium due date, coverage ends as of the due date of that Premium contribution.

## D. TERMINATION FOR LACK OF MEMBERSHIP

If there is no longer any Member who lives, resides or works in South Carolina or in an area for which the Corporation is authorized to do business, the Corporation may terminate this Plan of Benefits and coverage will terminate on the date given by the Corporation in written notice to the Employer.

## E. UNIFORM TERMINATION OF COVERAGE

1. The Corporation may terminate coverage under this Plan of Benefits if:

   a. The Corporation ceases to offer coverage of the type of group health insurance coverage provided by this Plan of Benefits and provides notice to the Employer and Members at least ninety (90) days prior to the date of the discontinuation of such coverage; and

   b. The Corporation offers to each Employer provided coverage of this type in such market the option to purchase any other group health insurance currently being offered by the Corporation to a Group Health Plan in such market; and

   c. The Corporation acts uniformly without regard to the claims experience of the Employer or any Health Status-Related Factor relating to any Members or Employees or Dependents who may become eligible for such coverage.

2. If the Corporation elects to discontinue offering all group health insurance coverage in South Carolina, coverage under this Plan of Benefits may be discontinued by the Corporation only in accordance with applicable state law; and

3. The Corporation provides notice to the Department of Insurance and to affected Employer and Members of such discontinuation at least one hundred eighty (180) days prior to the date of the discontinuation of such coverage; and

4. All group health insurance coverage issued or delivered for issuance in South Carolina is discontinued and coverage under such health benefit coverage in such market is not renewed; and

5. In the case of a discontinuation in a market, the Corporation will not issue any group health insurance coverage in the market during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

## F. NOTICE OF TERMINATION TO MEMBERS

Other than as expressly required by law, if this Plan of Benefits is terminated for any reason, the Employer is solely responsible for notifying all Members of such termination and notifying Members that coverage of Members under this Plan of Benefits will not continue beyond the termination date. The Employer agrees to indemnify and hold the Corporation harmless for all damages, claims, causes of action, penalties, fines, charges, costs and expenses (including a reasonable attorney's fee) arising out of or relating to the Employer's failure to notify Members of termination of this Plan of Benefits.

## G. REINSTATEMENT

The Corporation in its sole discretion (and upon such terms and conditions as the Corporation may determine) may reinstate coverage under this Plan of Benefits that has been terminated for any reason. If a Member's coverage (and including coverage for the Member's Dependents) for Covered Expenses under this Plan of Benefits terminates while the Member is on leave pursuant to the Family and Medical Leave Act because the Member fails to pay such Member's portion of the Premium within the Grace Period, the Member's coverage will be reinstated without new Probationary Periods if the Member returns to work immediately after the leave period, re-enrolls, and within thirty-one (31) days following such return pays all such Employee's portion of the past due amount and then current Premium.

## H. EXTENSION OF BENEFITS FOLLOWING TERMINATION

If this Plan of Benefits is terminated under this Article VI(H), or a Member participating in this Plan of Benefits is terminated, all rights to receive Covered Expenses for Benefits provided on or after the date of termination will automatically cease, except that a Member admitted to a Hospital or Skilled Nursing Facility or totally disabled on the date of such termination will be entitled to Covered Expenses for each day of that Admission or total disability, but will be limited to Benefits (including Prescription Drugs) directly related to the illness or injury causing the confinement or the total disability and will continue until the earlier of:

1. The date of recovery of the Member from the total disability; or,

2. A period of three hundred sixty five (365) days from the date of termination of this coverage, or,

3. The date on which the Covered Expenses to which the Member is entitled are exhausted; or,

4. The date the Member has full coverage for the disabling condition under another Group Health Plan with benefits that are similar to the Benefits and such Group Health Plan makes a reasonable provision for continuity of care for the disabling condition.

## I. EMPLOYER IS AGENT OF MEMBERS

By accepting Benefits, a Member agrees that the Employer is the Member's agent for all purposes of notification of any notice under this Plan of Benefits. The Member further agrees that notifications received from, or given to, the Employer by the Corporation are notification to the Employees except for any notice required by state or federal law to be given to the Members by the Corporation.

# ARTICLE VII – CONVERSION AND CONTINUATION OF COVERAGE

## A. CONVERSION

1. Employees

   a. An employee who was covered under this Plan of Benefits for at least six (6) months and whose employment with the Employer is terminated while this Plan of Benefits is in effect will be entitled to a conversion policy (upon request), like that generally issued on behalf of the Corporation, without evidence of insurability and after exhaustion of any continuation coverage otherwise available to the employee.

   b. Such employee must submit an application for insurance coverage and pay the appropriate premium for such coverage. The application for conversion insurance coverage must be submitted within sixty (60) days following the termination of coverage under this Plan of Benefits.

   c. If the application for conversion insurance coverage is submitted timely and the appropriate premium is paid within thirty-one (31) days, conversion coverage will be effective under the conversion policy as of the date of termination of employment.

   d. If the application for conversion insurance coverage is submitted timely but the premium is paid after the thirty-first (31st) day but before the sixty (60) day election period expires, conversion coverage will be effective on the date the application for conversion insurance coverage is submitted, provided, that in such instance, there will be no conversion coverage for expenses incurred before the date the application for conversion insurance coverage was submitted.

   e. Any Probationary Periods set forth in the conversion policy that had previously been met under this Plan of Benefits shall be considered as being met to the extent that such Probationary Periods were met under this Plan of Benefits.

2. Dependents

   a. If a Dependent's coverage under this Plan of Benefits terminates or in the event of the death of the Employee, such Dependent will be entitled to a conversion policy, upon request, like that generally issued on behalf of the Corporation, without evidence of insurability and after exhaustion of any continuation group insurance coverage for which such Dependent may be eligible by applying for such a policy form the Corporation or such other insurance carrier as the Corporation may designate.

   b. Such application for conversion insurance coverage must be submitted within sixty (60) days after coverage under this Plan of Benefits terminates. If the application for conversion insurance coverage is submitted timely and the appropriate Premium is paid within thirty-one (31) days, conversion coverage will be effective under the conversion policy as of the date of termination of the Employee's employment or death.

   c. If the application for conversion insurance coverage is submitted timely but the premium is paid after the thirty-first (31st) day but before the sixty (60) day election period expires, coverage will be effective on the date the Membership Application is submitted, provided, that in such instance, there will be no conversion coverage for medical expenses incurred before the date the Membership Application was submitted.

d. Any Probationary Periods set forth in the conversion policy that had previously been met under this Plan of Benefits shall be considered as being met to the extent that such Probationary Periods were met under this Plan of Benefits.

3. Divorced Spouse

Upon the entry of a valid order or decree of divorce between an Employee and such Employee's Dependent spouse, the divorced spouse shall be entitled (upon request) to a conversion policy, without evidence of insurability, upon submission of an application of insurance made to the Corporation within sixty (60) days following the divorce decree and upon payment of the appropriate premium. Any Probationary Periods set forth in the conversion policy that had previously been met under this Plan of Benefits shall be considered as being met to the extent that such Probationary Periods were met under this Plan of Benefits.

4. No Conversion Rights if Other Coverage Exists

Except as stated in Section VII. A. 3. above, the Corporation has no obligation to issue a conversion policy to a Member if that Member is covered by or is eligible for coverage under a similar health insurance policy or plan.

**B. CONTINUATION**

1. State Law

In addition to any extension of Benefits or conversion rights a Member may have, each Member has the right, upon request, to continue such Member's coverage under this Plan of Benefits for that portion of the month remaining at termination plus six (6) additional months. The Member must make payment of the appropriate premium (including any Employer portion) to the Employer in advance for such coverage. To be eligible for such coverage, the Member must have been continuously covered under the Employer's Group Health Plan for at least six (6) months and have been terminated for a reason other than non-payment of premium. If a Member is entitled to coverage under COBRA for a greater period of time, to Medicare benefits, or for other group health coverage, such Member is not entitled to continuation coverage under this section. This Plan of Benefits or a successor Plan must remain in force and the Member must pay the applicable premium in advance for the Member to receive this continuation coverage.

2. COBRA

a. Plan Administrator and Sponsor.

The Employer is both the Plan Administrator and Employer of this Plan of Benefits. The Employer agrees to offer continuation of coverage pursuant to the provisions of COBRA, if required, to eligible Members while this Plan of Benefits is in force. COBRA requires the Employer to allow eligible individuals to continue their health coverage for eighteen (18), twenty-nine (29), or thirty-six (36) months, depending on the Qualifying Event.

b. Disabled Members.

To be eligible for up to twenty-nine (29) months of continuation of coverage due to disability, an Employee or Dependent who is determined to be disabled under Title II or XVI of the Social Security Act with a disability onset date either before the COBRA event or within the first sixty (60) days of the COBRA continuation coverage must provide a copy of the notice of the determination of disability to the Employer within sixty (60) days of the determination of disability and before the end of the first eighteen (18) months of COBRA coverage and must also notify the Employer within thirty (30) days of any determination that the Employee or Dependent is no longer disabled.

c. Notice of Qualifying Event by the Member.

Each Member is responsible for notifying the Employer within sixty (60) days of such Member's Qualifying Event due to divorce, separation, or when a Dependent ceases dependency. If the Member does not give such notice, the Member is not entitled to continuation coverage.

d. Notice by the Employer to the Member

The Employer must notify the Corporation no later than thirty (30) days after the date the Member loses coverage due to a COBRA event. The Corporation must send a COBRA Election Notice to each Member no later than fourteen (14) days after receipt of the notice from the Employer. Notice to the Dependent spouse is deemed notice to any Dependent of the spouse.

e. Election of Coverage.

Continuation coverage is not automatic. The Member must elect continuation coverage within sixty (60) days of the later of:

i. The date the Member's coverage under this Plan of Benefits ceases because of the Qualifying Event;

ii. The date the Member is sent notice of the right to elect continuation coverage by the Employer; or

iii. The date the Member becomes an "eligible individual" (as that term is used in the Trade Act of 2002) provided that such election is made not later than six (6) months after the Qualifying Event that gives rise to eligibility under the Trade Act of 2002.

f. Premium Required.

The Member will be required to pay a premium for the continuation coverage and shall have the option to make payment in monthly installments. The Member has forty-five (45) days from the date of election to pay the first premium, which includes the period when coverage commenced, regardless of the date that the first premium is due. Subsequent premiums are subject to a Grace Period.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance ("eligible individuals" as more fully defined in the Trade Act of 2002). Under the new tax provision, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance (as defined in the Trade Act of 2002), including continuation coverage. If a Member has questions about these new tax provisions, the Member may call the Health Care Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act of 2002 is also available at www.doleta.gov/tradeact/2002act_index.asp.

g. Length of COBRA Coverage.

The maximum period for continuation coverage for a Qualifying Event involving termination of employment or a reduction in hours is eighteen (18) months. An Employee or Dependent who is determined to be disabled under Title II or XVI of the Social Security Act before the COBRA event or within the first sixty (60) days of COBRA continuation coverage is entitled to twenty-nine (29) months of continuation coverage, but only if such Employee or Dependent has provided notice of the determination of disability within sixty (60) days after determination is issued and before the end of eighteen (18) months of coverage. If a second Qualifying Event occurs within this period of continuation coverage, the coverage for any affected Dependent who was a Member under this Plan of Benefits both at the time of the first and the second Qualifying Events may be extended up to thirty-six (36) months from the first Qualifying Event. For all other Qualifying Events, the maximum period of coverage is thirty-six (36) months. Below is a list of circumstances and the period of COBRA coverage for each circumstance.

i. Eighteen (18) months for Employees whose working hours are reduced--from full-time to part-time, for instance, and any Dependents who also lose coverage for this reason.

ii. Eighteen (18) months for Employees who voluntarily quit work, and any Dependents who also lose coverage for this reason.

iii. Eighteen (18) months for Employees who are part of an economic layoff, and any Dependents who also lose coverage for this reason.

iv. Eighteen (18) months for Employees who are fired, unless the firing is due to gross misconduct, and any Dependents who also lose coverage for this reason.

v. Twenty-nine (29) months for Employees and all covered Dependents who are determined to be disabled under the Social Security Act during the first sixty days after termination of employment or reduction of hours of employment. Notice of the Social Security Disability determination must be given to the Purchaser within 60 days of the determination of disability and before the end of the first 18 months of continuation of coverage.

vi. Thirty-six (36) months for Employees' widows or widowers and their Dependent Children.

vii. Thirty-six (36) months for separated or divorced husbands or wives and their Dependent Children.

viii. Thirty-six (36) months for Dependent Children who lose coverage because they no longer meet the Plan's definition of a Dependent Child.

ix. Thirty-six (36) months for Dependents who are not eligible for Medicare when the Employee is eligible for Medicare and no longer has coverage with the Employer.

x. For Plans providing coverage for retired Employees and their dependents, a special rule applies for such persons who would lose coverage due to the Purchaser filing for Title 11 Bankruptcy. (Loss of coverage includes a substantial reduction of coverage within a year before or after the bankruptcy filing.) Upon occurrence of such an event, retired Employees and their eligible Dependents may continue their coverage under the Plan until the date of death of the retiree. If a retiree dies while on this special continued coverage, surviving Dependents may elect to continue coverage for up to thirty-six (36) additional months.

3. USERRA

a. In any case in which an Employee or any of such Employee's Dependents has coverage under this Plan of Benefits, and such Employee is not Actively at Work by reason of active duty service in the uniformed services, the Employee may elect to continue coverage under this Plan of Benefits as provided in this ArticleVII(B)(3). The maximum period of coverage of the Employee and such Employee's Dependents under such an election shall be the lesser of:

i. The twenty-four (24) month period beginning on the date on which the Employee's absence from being Actively at Work by reason of active duty service in the uniformed services begins; or

ii. The day after the date on which the Employee fails to apply for or return to a position of employment, as determined under USERRA.

The continuation of coverage period under USERRA will be counted toward any continuation of coverage period available under COBRA.

b. An Employee who elects to continue coverage under this section of this Plan of Benefits must pay one hundred and two percent (102%) such Employee's normal Premium. Except that, in the case of an Employee who performs service in the uniformed services for less than thirty-one (31) days, such employee will pay the normal contribution for the thirty-one (31) days.

c. An employee who is qualified for re-employment under the provisions of USERRA will be eligible for reinstatement of coverage under this Plan of Benefits upon re-employment. Except as provided in Article VII(B)(3)(d), upon re-employment and reinstatement of coverage no new exclusion or Probationary Period will be imposed in connection with the reinstatement of such coverage if an exclusion or waiting period would normally have been imposed. This Article VII(B)(3)(c) applies to the Employee who is re-employed and to a Dependent who is eligible for coverage under this Plan of Benefits by reason of the reinstatement of the coverage of such employee.

d. Article VII(B)(3)(c) shall not apply to the coverage of any illness or injury determined by the Secretary of Veteran's Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

## C. QUALIFIED MEDICAL CHILD SUPPORT ORDER

If this Plan of Benefits is an integral part of a Plan governed by ERISA, then this Plan of Benefits shall pay Covered Expenses in accordance with the applicable requirements of any Qualified Medical Child Support Order.

1. Procedural Requirements.

   a. Timely Notifications and Determinations.

      In the case of any Medical Child Support Order received by the Corporation:

      i. The Employer as the Plan Administrator shall promptly notify the Employee and each Alternate Recipient of the receipt of the Medical Child Support Order and the Corporation's procedures for determining whether Medical Child Support Orders are Qualified Medical Child Support Orders; and,

      ii. Within a reasonable period after receipt of such Qualified Medical Child Support Order, the Employer shall determine whether such order is a Qualified Medical Child Support Order and notify the Employee and each Alternate Recipient of such determination.

   b. Establishment of Procedures for Determining Qualified Status of Orders.

      The Employer as the Plan Administrator shall establish reasonable procedures to determine whether Medical Child Support Orders are Qualified Medical Child Support Orders and to administer the provision of Covered Expenses under of such qualified orders. The Employer's procedures:

      i. Shall be in writing;

      ii. Shall provide for the notification of each person specified in a Medical Child Support Order as eligible to receive Benefits under this Plan of Benefits (at the address included in the Medical Child Support Order) of the Employer's procedures promptly upon receipt by the Plan Administrator of the Medical Child Support Order; and,

      iii. Shall permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

   c. Actions Taken by Fiduciaries.

      If a Plan fiduciary for this Plan of Benefits acts in accordance with these procedural requirements in treating a Medical Child Support Order as being (or not being) a Qualified Medical Child Support Order, then this Plan of Benefits obligation to the Member and each Alternate Recipient shall be discharged to the extent of any payment made pursuant to such act of the fiduciary.

2. Treatment of Alternate Recipients.

   a. Under ERISA.

      A person who is an Alternate Recipient under any Medical Child Support Order shall be considered a beneficiary under this Plan of Benefits for purposes of any provisions of ERISA, as amended, and shall be treated as a participant under the reporting and disclosure requirements of ERISA.

b. Direct Provision of Benefits Provided to Alternate Recipients.

Any payment for Covered Expenses made by the Corporation pursuant to a Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

c. Plan Enrollment and Payroll Deductions.

If an Employee remains covered under this Plan of Benefits but fails to enroll an Alternate Recipient under this Plan of Benefits after receiving notice of the Qualified Medical Child Support Order from the Employer, the Employer shall enroll the Alternate Recipient and deduct the additional premium from the Employee's paycheck.

d. Termination of Coverage.

Except for any coverage continuation rights otherwise available under this Plan of Benefits, the coverage for the Alternate Recipient shall end on the earliest of:

i. The date the Employee's coverage ends;

ii. The date the Qualified Medical Child Support Order is no longer in effect;

iii. The date the Employee obtains other comparable health coverage through another insurer or Plan to cover the Alternate Recipient; or

iv. The date the Employer eliminates family health coverage for all of its Employees.

## ARTICLE VIII – SUBROGATION AND REIMBURSEMENT

In the event benefits are provided to or on behalf of a Member under the terms of this Plan of Benefits, the Member agrees, as a condition of receiving benefits, to transfer to the Corporation all rights to recover damages in full for such benefits when the injury occurs through the act or omission of another person, firm, corporation, organization or business entity. The Corporation shall be subrogated, at its expense, to the rights of recovery of such Member against any third party who is liable, responsible, or otherwise makes a payment for the injury.

If, however, the Member has an injury that occurred by an act or omission of a liable third party, and the Member receives a settlement, judgment, or other payment relating to the injury from another person, firm, corporation, organization or business entity, the Member agrees to reimburse the Corporation for benefits paid by the Corporation relating to the injury.

For purposes of this Article, a liable third party and/or liable insurance coverage include parties and coverages that are responsible or otherwise make a payment for the Member's injury even though liability or other culpability may be denied.

The Corporation's subrogation/reimbursement rights apply to any judgment and/or settlement proceeds received by the insured from or on behalf of the liable third party.

The Corporation's subrogation / reimbursement interest extends to all benefits relating to the injury even if claims for those benefits were not submitted to the Corporation for payment at the time the Member received the settlement, judgment or payment.

The Corporation's right of recovery may be from the liable third party, any liability or other insurance covering the liable third party, malpractice insurance, the Member's own uninsured motorist insurance and/or underinsured motorist insurance.

If the Director of Insurance, or his designee, upon being petitioned by the Member, determines that the exercise of subrogation and/or reimbursement by the Corporation is inequitable and commits an injustice to the Member, subrogation and/or reimbursement will not be allowed. This determination by the director or his designee may be appealed to the Administrative Law Judge Division as provided by law.

The Corporation will pay reasonable attorney's fees and costs from the amount recovered.

The Member shall not do anything to hinder the Corporation's right of subrogation and/or reimbursement. The Member shall cooperate with the Corporation, execute all documents, and do all things necessary to protect and secure the Corporation's right of subrogation and/or reimbursement.

## ARTICLE IX - WORKERS' COMPENSATION PROVISION

This policy does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained by a Member that arises out of, in connection with, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the Member. Benefits will not be provided under this Plan if coverage under the Workers' Compensation Act or similar law would have been available to the Member but the Member elects exemption from available Workers' Compensation coverage; waives entitlement to Workers' Compensation benefits for which he/she is eligible; failed to timely file a claim for Workers' Compensation benefits; or, the Member sought treatment for the injury or illness from a provider which is not authorized by the Member's employer.

If the Corporation pays benefits for an injury or illness and the Corporation determines the Member also received Workers' Compensation benefits by means of a settlement, judgment, or other payment for the same injury or illness, Member shall reimburse the Corporation in full all benefits paid by the Corporation relating to the injury or illness.

The Corporation's right of recovery will be applied even if: the Workers' Compensation benefits are in dispute or are made by means of a compromised, doubtful and disputed, clincher or other settlement; no final determination is made that the injury or illness was sustained in the course of or resulted from the Member's employment; the amount of Workers' Compensation benefits due to medical or health care is not agreed upon or defined by the Member or the Workers' Compensation carrier; or, the medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

As a condition of receiving benefits under this Plan of Benefits, the Member agrees to notify the Corporation of any Workers' Compensation claim he/she may make and agrees to reimburse the Corporation as described herein. The Member shall not do anything to hinder the Corporation's right of recovery. The Member shall cooperate with the Corporation, execute all documents, and do all things necessary to protect and secure the Corporation's right of recovery, including assert a claim or lawsuit against the Workers' Compensation carrier or any other insurance coverages to which the Member may be entitled. Failure to cooperate with the Corporation will entitle the Corporation to withhold benefits due the Member under this Plan of Benefits. Failure to reimburse the Corporation as required under this Article will entitle the Corporation to invoke the Workers' Compensation Exclusion and deny payment for all claims relating to the injury or illness and/or deny future benefit payments for any such Member until the reimbursement amount has been paid in full.

# ARTICLE X – ERISA RIGHTS

If this Plan of Benefits is covered by ERISA, each Member in this Plan of Benefits is entitled to certain rights and protections under ERISA. ERISA provides that all Members shall be entitled to:

## A. RECEIVE INFORMATION ABOUT THE PLAN OF BENEFITS

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing this Plan of Benefits, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by this Plan of Benefits with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of this Plan of Benefits, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may assess a reasonable charge for the copies.

3. Receive, upon request, a summary of this Plan of Benefits' annual financial report. The Plan Administrator is required by law to furnish each Member with a copy of this summary annual report.

## B. CONTINUATION COVERAGE

1. Members are entitled to continue health care coverage for themselves and their Dependents if there is a loss of coverage under this Plan of Benefits as a result of a Qualifying Event. The Member or Dependents may have to pay for such continuation coverage. Employee Members should review the documents governing COBRA continuation coverage rights.

2. Members may be entitled to a reduction or elimination of Pre-Existing Condition Waiting Periods if the Member has Creditable Coverage from another Group Health Plan. Members should be provided a certificate of Creditable Coverage, free of charge, from the Member's prior Group Health Plan or health insurance issuer when:

    a. The Member loses coverage under such Group Health Plan; or,

    b. When the Member becomes entitled to elect COBRA continuation coverage; or,

    c. When the Member's COBRA continuation coverage ceases.

3. A Member is entitled to a certificate of Creditable Coverage if such Member requests it before losing coverage, or if the Member requests it up to twenty-four (24) months after losing coverage. Without evidence of Creditable Coverage, the Member may be subject to a Pre-Existing Condition Waiting Period for twelve (12) months (eighteen (18) months for Late Enrollees) after the Member's enrollment date.

## C. PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Members, ERISA imposes duties upon the people who are responsible for the operation of an employee welfare benefit plan. The people who administer an employee welfare benefit plan are called "fiduciaries," and have a duty to do so prudently and in the interest of the Members. The Employer is a fiduciary of this Plan of Benefits.

## D. ENFORCEMENT OF EMPLOYEE RIGHTS

1. If a Member's claim for a Benefit is denied or ignored, in whole or in part, such Member has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

2. Under ERISA, there are steps a Member can take to enforce the rights described above. For instance, if a Member requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within thirty (30) days, such Member may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay such Member up to $110 a day until such Member receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If a Member has a claim for Benefits that is denied or ignored, in whole or in part, such Member may file suit in a state or federal court. In addition, if a Member disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, such Member may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Member is discriminated against for asserting such Member's rights, such Member may seek assistance from the U.S. Department of Labor, or such Member may file suit in a federal court. The court will decide who should pay court costs and legal fees. If a Member is successful the court may order the person the Member has sued to pay these costs and fees. If the Member loses, the court may order such Member to pay these costs and fees, for example, if it finds such Member's claim is frivolous.

3. No one, including the Employer, the Members' union, or any other person, may fire an Employee or otherwise discriminate against an Employee in any way to prevent an Employee from obtaining a Benefit or exercising the Employee's rights under ERISA.

## E. ASSISTANCE WITH QUESTIONS

If a Member has any questions about this Plan of Benefits, the Member should contact the Plan Administrator. If a Member has any questions about this statement or about a Member's rights under ERISA, or if a Member needs assistance in obtaining documents from the Plan Administrator, the Member should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. A Member may also obtain certain publications about the Member's rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

# ARTICLE XI - CLAIMS FILING AND APPEAL PROCEDURES

## A. CLAIMS FILING PROCEDURES

1. When a Participating Provider renders services, generally, the Participating Provider should either file the claim on the Member's behalf or provide an electronic means for the Member to file a claim while the Member is in the Participating Provider's office. However, the Member is responsible for ensuring that the claim is filed.

2. Written notice of receipt of services on which a claim is based must be furnished to the Corporation, at its address on the Identification Card, within twenty (20) days of the beginning of services, or as soon thereafter as is reasonably possible. Failure to give notice within the time does not invalidate nor reduce any claim if the Member can show that it was not reasonably possible to give the notice within the required time frame and if notice was given as soon as reasonably possible. Upon receipt of the notice, the Corporation will furnish or cause a claim form to be furnished to the Member. If the claim form is not furnished within fifteen (15) days after the Corporation receives the notice, the Member will be deemed to have complied with the requirements of this Plan of Benefits as to proof of loss. The Member must submit written proof covering the character and extent of the services within the policy time fixed for filing proof of loss.

3. For Benefits not provided by a Participating Provider, the Member is responsible for filing claims with the Corporation. When filing the claims, the Member will need the following:

   a. A claim form for each Member. Members can get claim forms from a member services representative at the telephone number indicated on the Identification Card or via the Corporation's website, www.SouthCarolinaBlues.com.

   b. Itemized bills from the Provider(s). These bills should contain all the following:

      i. Provider's name and address;

      ii. Member's name and date of birth;

      iii. Member's Identification Card number;

      iv. Description and cost of each service;

      v. Date that each service took place; and

      vi. Description of the illness or injury and diagnosis.

   c. Members must complete each claim form and attach the itemized bill(s) to it. If a Member has other insurance that already paid on the claim(s), the Member should also attach a copy of the other Plan's explanation of benefits notice.

   d. Members should make copies of all claim forms and itemized bills for the Member's records since they will not be returned. Claims should be mailed to the Corporation's address listed on the claim form.

4. The Corporation must receive the claim within ninety (90) days after the beginning of services. Failure to file the claim within the ninety (90) day period, however, will not prevent payment of Covered Expenses if the Member shows that it was not reasonably possible to file the claim timely, provided the claim is filed as soon as is reasonably possible. Except in the absence of legal capacity, claims must be filed no later than fifteen (15) months following the date services were received.

5. Receipt of a claim by the Corporation will be deemed written proof of loss and will serve as written authorization from the Member to the Corporation to obtain any medical or financial records and documents useful to the Corporation (as determined by the Corporation). The Corporation, however, is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at the time the claim was processed. Any party who submits medical or financial reports and documents to the Corporation in support of a Member's claim will be deemed to be acting as the agent of the Member. If the Member desires to appoint an Authorized Representative in connection with such Member's claims, the Member should contact the Corporation for an Authorized Representative form.

6. There are four (4) types of claims: Pre-Service Claims, Urgent Care Claims, Post-Service Claims, and Concurrent Care Claims. The Corporation will make a determination for each type of claim within the following time periods:

    a. Pre-Service Claim.

        i. A determination will be provided in writing or in electronic form within a reasonable period of time, appropriate to the medical circumstances, but no later than fifteen (15) days from receipt of the claim.

        ii. If a Pre-service Claim is improperly filed, or otherwise does not follow applicable procedures, the Member will be sent notification within five (5) days of receipt of the claim.

        iii. An extension of fifteen (15) days is permitted if the Corporation determines that, for reasons beyond the control of the Corporation, an extension is necessary. If an extension is necessary, the Corporation will notify the Member within the initial fifteen (15) day time period that an extension is necessary, the circumstances requiring the extension, and the date the Corporation expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Member will have at least forty-five (45) days to provide the required information. If the Corporation does not receive the required information within the forty-five (45) day time period, the claim will be denied. The Corporation will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If the Corporation receives the requested information after the forty-five (45) days, but within 225 days, the claim will be reviewed as a first level appeal. Reference Article XI B for details regarding the appeals process.

b. Urgent Care Claim.

i. A determination will be sent to the Member in writing or in electronic form as soon as possible taking into account the medical exigencies, but no later than seventy-two (72) hours from receipt of the claim.

ii. If the Member's Urgent Care Claim is determined to be incomplete, the Member will be sent a notice to this effect within twenty-four (24) hours of receipt of the claim. The Member will then have forty-eight (48) hours to provide the additional information. Failure to provide the additional information within forty-eight (48) hours may result in the denial of the claim.

iii. If the Member requests an extension of Urgent Care Benefits beyond an initially determined period and makes the request at least twenty-four (24) hours prior to the expiration of the original determination period, the Member will be notified within twenty-four (24) hours of receipt of the request for an extension.

c. Post-Service Claim.

i. A determination will be sent within a reasonable time period, but no later than thirty (30) days from receipt of the claim.

ii. An extension of fifteen (15) days may be necessary if the Corporation determines that, for reasons beyond the control of the Corporation, an extension is necessary. If an extension is necessary, the Corporation will notify the Member within the initial thirty (30) day time period that an extension is necessary, the circumstances requiring the extension, and the date the Corporation expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Member will have at least forty-five (45) days to provide the required information. If the Corporation does not receive the required information within the forty-five (45) day time period, the claim will be denied. The Corporation will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If the Corporation receives the requested information after the forty-five (45) days, but within 225 days, the claim will be reviewed as a first level appeal. Reference Article XI B for details regarding the appeals process.

d. Concurrent Care Claim.

The Member will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction or termination to allow the Member time to appeal the decision before the Benefits are reduced or terminated.

7. Notice of Determination.

a. If the Member's claim is filed properly, and the claim is in part or wholly denied, the Member will receive notice of an Adverse Benefit Determination that will:

i. State the specific reason(s) for the Adverse Benefit Determination;

ii. Reference the specific Plan of Benefits provisions on which the determination is based;

iii. Describe additional material or information, if any, needed to complete the claim and the reasons such material or information is necessary;

iv. Describe the claims review procedures and this Plan of Benefits and the time limits applicable to such procedures, including a statement of the Member's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review;

v. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request); and,

vi. If the reason for denial is based on a lack of Medical Necessity or Investigational or Experimental Services exclusion or similar limitation, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request).

b. The Member will also receive a notice if the claim is approved.

## B. APPEAL PROCEDURES FOR AN ADVERSE BENEFIT DETERMINATION

1. The Member has one hundred eighty (180) days from receipt of an Adverse Benefit Determination to file an appeal. An appeal must meet the following requirements:

   a. An appeal must be in writing; and,

   b. An appeal must be sent (via U.S. mail) to Blue Cross and Blue Shield of South Carolina at the address on the Member's Identification Card; and,

   c. The appeal request must state that a formal appeal is being requested and include all pertinent information regarding the claim in question; and,

   d. An appeal must include the Member's name, address, social security number and any other information, documentation or materials that support the Member's appeal.

2. The Member may submit written comments, documents, or other information in support of the appeal, and will (upon request) have access to all documents relevant to the claim. A person other than the person who made the initial decision will conduct the appeal. No deference will be afforded to the initial determination.

3. If the appealed claim involves an exercise of medical judgment, the Corporation will consult with an appropriately qualified health care practitioner with training and experience in the relevant field of medicine. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on the appeal.

4. The Corporation will make a final decision on the appeal within the time periods specified below:

   a. Pre-Service Claim.

      The Corporation will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than fifteen (15) days after receipt of the appeal. If the Member disagrees with the Corporation's decision, the Member can submit a second appeal within ninety (90) days after receipt of the final decision of the first appeal. The Corporation will decide the second appeal within a reasonable period of time, taking into account the medical circumstances, but no later than fifteen (15) days after receipt of the second appeal.

b. Urgent Care Claim.

The Member may request an expedited appeal of an Urgent Care Claim. This expedited appeal request may be made orally, and the Corporation will communicate with the Member by telephone or facsimile. The Corporation will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than seventy-two (72) hours after receipt of the Request for an expedited appeal.

c. Post-Service Claim.

The Corporation will decide the appeal within a reasonable period of time, but no later than thirty (30) days after receipt of the appeal. If the Member disagrees with the Corporation's decision, the Member can submit a second appeal within ninety (90) days after receipt of the final decision of the first appeal. The Corporation will decide the second appeal within a reasonable period of time, but no later than thirty (30) days after receipt of the second appeal.

d. Concurrent Care Claim.

The Corporation will decide the appeal of Concurrent Care Claims within the time frames set forth in Article XI (B)(4)(a-c) depending on whether such claim is also a Pre-Service Claim, an Urgent Care Claim or a Post-Service Claim.

5. Notice of Appeals Determination.

a. If a Member's appeal is denied in whole or in part, the Member will receive notice of an Adverse Benefit Determination that will:

i. State specific reason(s) for the Adverse Benefit Determination;

ii. Reference specific provision(s) of this Plan of Benefits on which the benefit determination is based;

iii. State that the Member is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for Benefits;

iv. Describe any voluntary appeal procedures offered by the Corporation and the Member's right to obtain such information;

v. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information will be provided free of charge upon request);

vi. If the reason for an Adverse Benefit Determination on appeal is based on a lack of Medical Necessity, Investigational or Experimental Services or other limitation or exclusion, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request); and

vii. Include a statement regarding the Member's right to bring an action under section 502(a) of ERISA.

b. The Member will also receive a notice if the claim on appeal is approved.

## C. EXTERNAL REVIEW PROCEDURES

1. After a Member has completed the appeal process, a Member may be entitled to an additional, external review of the Member's claim at the Corporation's expense. An external review may be used to reconsider the Member's claim if the Corporation has denied, either in whole or in part, the Member's claim. In order to qualify for external review, the claim must have been greater than $500.00 and denied, reduced, or terminated because:

    a. It does not meet the requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness; or,

    b. It is an Investigational or Experimental Service and it involves a life-threatening or seriously disabling condition.

2. After a Member has completed the appeal process, (and an Adverse Benefit Determination has been made) such Member will be notified in writing of such Member's right to request an external review. The Member should file a request for external review within sixty (60) days of receiving the notice of the Corporation's decision on the Member's appeal. In order to receive an external review, the Member will be required to authorize the release of such Member's medical records (if needed in the review for the purpose of reaching a decision on Member's claim). If a Member needs assistance during the external review process, the Member may contact the South Carolina Department of Insurance at the following address and telephone number:

    South Carolina Department of Insurance
    P.O. Box 100105
    Columbia, S.C. 29202-3105
    1-800-768-3467

3. Within five (5) business days of a Member's request for an external review, the Corporation will respond by either:

    a. Assigning the Member's request for an external review to an independent review organization and forwarding the Members records to such organization; or,

    b. Notifying the Member in writing that the Member's request does not meet the requirements for an external review and the reasons for the Corporation's decision.

4. The external review organization will take action on the Member's request for an external review within forty-five (45) day after it receives the request for external review from the Corporation.

5. Expedited external reviews are available if the Member's Physician certifies that the Member has a serious medical condition. A serious medical condition, as used in this Article XI (C)(5), means one that requires immediate medical attention to avoid serious impairment to body functions, serious harm to an organ or body part, or that would place the Member's health in serious jeopardy. If the Member may be held financially responsible for the treatment, a Member may request an expedited review of the Corporation's decision if the Corporation's denial of Benefits involves Emergency Medical Care and the Member has not been discharged from the treating Hospital.

# ARTICLE XII - GENERAL PROVISIONS

## AMENDMENT

Upon thirty (30) days prior written notice, the Corporation may unilaterally amend this Plan of Benefits when required by Federal or State law. Increases in the Benefits provided or decreases in the Premium are effective without such prior notice. Notice of an amendment will be effective when addressed to the Employer. The Corporation has no responsibility to provide individual notices to each Member when an amendment to this Plan of Benefits has been made.

## AUTHORIZED REPRESENTATIVES

A Provider may be considered a Member's authorized representative without a specific designation by the Member when the Pre-Authorization request is for Urgent Care Claims. A Provider may be a Member's authorized representative with regard to non-Urgent Care Claims only when the Member gives the Corporation or the Provider a specific designation, in a format that is reasonably acceptable to the Corporation to act as an authorized representative. If the Member has designated an authorized representative, all information and notifications will be directed to that representative unless the Member gives contrary directions.

## BLUECARD PROGRAM

1. The Corporation, participates in the BlueCard Program. Whenever a Member accesses health care services outside the geographic area the Corporation serves, the Member's claims for those services may be processed through the BlueCard Program and presented to the Corporation for payment in conformity with network access rules of the BlueCard Program policies then in effect. Under the BlueCard Program, when a Member receives covered health care services within the geographic area served by a host Blue Cross and/or Blue Shield licensee (a Blue Cross and/or Blue Shield licensee other than the Corporation), the Corporation will remain responsible to the Employer for fulfilling its contract obligations. However, the host Blue Cross and/or Blue Shield licensee will only be responsible, in accordance with applicable BlueCard Program policies, if any, for providing such services as contracting with its participating providers and handling all interaction with its participating providers. The financial terms of the BlueCard Program are described generally below.

2. Liability Calculation Method Per Claim:

    a. The calculation of Member liability on claims for covered health care services incurred outside the geographic area the Corporation serves and processed through the BlueCard Program will be based on the lower of the provider's billed charges or the negotiated price the Corporation pays the host Blue Cross and/or Blue Shield licensee.

    b. The methods employed by a host Blue Cross and/or Blue Shield licensee to determine a negotiated price will vary among host Blue Cross and/or Blue Shield licensees based on the terms of each host Blue Cross and/or Blue Shield licensee's provider contracts. The negotiated price paid to a host Blue Cross and/or Blue Shield licensee by the Corporation on a claim for health care services processed through the BlueCard Program may represent:

        i. the actual price paid on the claim by the host Blue Cross and/or Blue Shield licensee to the health care provider; or,

ii. an estimated price, determined by the host Blue Cross and/or Blue Shield licensee in accordance with the BlueCard Program policies, based on the actual price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the host Blue Cross and/or Blue Shield licensee's health care providers or one or more particular providers; or,

iii. an average price, determined by the host Blue Cross and/or Blue Shield licensee in accordance with the BlueCard Program policies, based on a billed charges discount representing the host Blue Cross and/or Blue Shield licensee's average savings expected after settlements, withholds, any other contingent payment arrangements and non-claims transactions for all of its providers or for a specified group of providers. The average price under this section may result in greater variation to the Member and the Employer from the actual price under section (i), above, than would an estimated price under section (ii), above.

c. Host Blue Cross and/or Blue Shield licensees using either the estimated price under section (b)(ii), above, or the average price under section (b)(iii), above, will, in accordance with the BlueCard Program policies, prospectively increase or reduce such estimated price or average price to correct for over- or underestimation of past prices. However, the amount paid by the Member is a final price and will not be affected by such prospective adjustment.

d. Statutes in a small number of states may require a host Blue Cross and/or Blue Shield licensee either: (1) to use a basis for calculating Member liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim; or, (2) to add a surcharge. Should any state statutes mandate liability calculation methods that differ from the negotiated price method or require a surcharge, the Corporation would then calculate Member liability for any covered health care services in accordance with the applicable state statute in effect at the time the Member received those services.

3. Recoveries under the Blue Card Program.

Under the BlueCard Program, recoveries from a host Blue Cross and/or Blue Shield licensee or from participating providers of a host Blue Cross and/or Blue Shield licensee can arise in several ways, including, but not limited to, anti-fraud and abuse audits, provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the host Blue Cross and/or Blue Shield licensee will engage third parties to assist in discovery or collection of recovery amounts. The fees of such third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard Program policies, which generally require correction on a claim-by-claim or prospective basis.

**CLERICAL ERRORS**

Clerical errors by the Corporation will not cause a denial of Benefits that should otherwise have been granted, nor will clerical errors extend Benefits that should otherwise have ended.

**DISCLOSURE TO PLAN SPONSOR**

The Employer's Group Health Plan will disclose (or will require Blue Cross to disclose) Member's Protected Health Information to the Employer only to permit the Employer to carry out plan administration functions for the Employer's Group Health Plan not inconsistent with the requirements of the HIPAA. Any disclosure to and use by the Employer will be subject to and consistent with the provisions of paragraphs 1 and 2 of this section.

1. Restrictions on Employer's Use and Disclosure of Protected Health Information.

    a. The Employer will neither use nor further disclose Member's Protected Health Information, except as permitted or required by the Plan Documents, as amended, or required by law.

    b. The Employer will ensure that any agent, including any subcontractor, to whom it provides Member Protected Health Information agrees to the restrictions and conditions of this Plan of Benefits, with respect to Member's Protected Health Information.

    c. The Employer will not use or disclose Member Protected Health Information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer.

    d. The Employer will report Employer's Group Health Plan any use or disclosure of Member Protected Health Information that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.

    e. The Employer will make Protected Health Information available to the Member who is the subject of the information in accordance with HIPAA.

    f. The Employer will make Member Protected Health Information available for amendment, and will on notice amend Member Protected Health Information, in accordance with HIPAA.

    g. The Employer will track disclosures it may make of Member Protected Health Information so that it can make available the information required for the Employer's Group Health Plan to provide an accounting of disclosures in accordance with HIPAA.

    h. The Employer will make its internal practices, books, and records, relating to its use and disclosure of Member Protected Health Information, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with HIPAA.

    i. The Employer will, if feasible, return or destroy all Member Protected Health Information, in whatever form or medium (including in any electronic medium under the Employer's custody or control), received from the Employer's Group Health Plan, including all copies of and any data or compilations derived from and allowing identification of any Member who is the subject of the Protected Health Information, when the Member's Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Member Protected Health Information, the Employer will limit the use or disclosure of any Member Protected Health Information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

2. Adequate Separation Between the Employer and the Employer's Group Health Plan.

   a. Certain classes of employees or other workforce members under the control of the Employer may be given access to Member Protected Health Information received from the Employer's Group Health Plan or third party servicing the Employer's Group Health Plan.

   b. These employees will have access to Member Protected Health Information only to perform the plan administration functions that the Employer provides for the Employer's Group Health Plan or to assist Members.

   c. These employees will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Employer, for any use or disclosure of Member Protected Health Information in breach or violation of or noncompliance with the provisions of this section to this Plan of Benefits. Employer will promptly report such breach, violation or noncompliance to the Employer's Group Health Plan, and will cooperate with the Employer's Group Health Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Member, the privacy of whose Protected Health Information may have been compromised by the breach, violation or noncompliance.

   Employer certifies that this Plan of Benefits contains the provisions outlined above.

**GOVERNING LAW**

This Plan of Benefits (including the Schedule of Benefits) is governed by and subject to ERISA and any other applicable federal law. If ERISA or another federal law does not apply, this Plan of Benefits is governed by and subject to the laws of the State of South Carolina. If federal law conflicts with any state law, then such federal law shall govern. If any provision of this Plan of Benefits conflicts with such law, this Plan of Benefits shall automatically be amended solely as required to comply with such state or federal law, and the Corporation shall be entitled to adjust the Premium upon thirty-one (31) days written notice.

**IDENTIFICATION CARD**

A Member must present their Identification Card prior to receiving Benefits.

Identification Cards are for identification only. Having an Identification Card creates no right to Benefits or other services. To be entitled to Benefits, the cardholder must be a Member whose Premium has been paid. Any person receiving Covered Expenses to which the person is not entitled will be responsible for the charges.

**INCONTESTABILITY**

The validity of the Plan of Benefits may not be contested after it has been in force for two (2) years from its date of issue. No statement relating to insurability, except fraudulent misstatements, made by any Member may be used in contesting the validity of the coverage with respect to which the statement was made after the coverage has been in force for a period of two (2) years unless it is contained in a written instrument signed by the person making the statement. The provision does not preclude assertion at any time of defenses based upon the person's ineligibility for coverage under the Plan of Benefits or upon other provision in the Plan of Benefits.

## INFORMATION AND RECORDS

The Corporation is entitled to obtain records and other information as it may reasonably require from any Member or Provider incident to the treatment, payment and health care operations for the administration of the Benefits hereunder. This includes medical and Hospital records, the attending Physician's certification as to the Medical Necessity for care or treatment, and/or any other requested documentation or information. Payment for benefits may be denied until the requested records, documentation or information is received.

## LEGAL ACTIONS

No Member may bring an action at law or in equity to recover on this Plan of Benefits until such Member has exhausted the appeal process as set forth in Article XI. No such action may be brought any later than six (6) years after the time written proof of loss is required to be furnished.

## MEMBERSHIP APPLICATION

The Corporation will only accept a Membership Application submitted by the Employer on behalf of its Employees. The Corporation will not accept Membership Applications directly from Employees or Dependents.

## NEGLIGENCE OR MALPRACTICE

The Corporation does not practice medicine. Any medical treatment, service or Medical Supplies rendered to or supplied to any Member by a Provider is rendered or supplied by such Provider and not by the Corporation. The Corporation is not liable for any improper or negligent act, inaction or act of malfeasance of any Provider in rendering such medical treatment, service, Medical Supply or medication.

## NOTICES

Except as otherwise provided in this Plan of Benefits, any notice under this Plan of Benefits may be given by United States mail, postage paid and addressed:

1. To the Corporation:

   Blue Cross and Blue Shield of South Carolina
   Post Office Box 100300
   Columbia, South Carolina 29202

2. To a Member: To the last known name and address listed for the Employee related to such Member on the Membership Application. Members are responsible for notifying the Corporation of any name or address changes within thirty-one (31) days of the change.

3. To the Employer: To the name and address last given to the Corporation. The Employer is responsible for notifying the Corporation of any name or address change within thirty-one (31) days of the change.

## NO WAIVER OF THE CORPORATION'S RIGHTS

On occasion, the Corporation may, at its option, choose not to enforce all of the terms and conditions of this Plan of Benefits. Such a decision does not mean the Corporation waives or gives up any rights under this Plan of Benefits in the future.

**OTHER INSURANCE**

Each Member must provide the Corporation with information regarding all other health insurance coverage to which such Member is entitled.

**PAYMENT OF CLAIMS**

A Member is expressly prohibited from assigning any right to payment of Covered Expenses or any payment related to Benefits. The Corporation may pay all Covered Expenses directly to the Employee upon receipt of due proof of loss. Where a Member has received Benefits from a Participating Provider, the Corporation will pay Covered Expenses directly to such Participating Provider.

**PHYSICAL EXAMINATION**

The Corporation has the right to have examined, at its own expense, a Member whose injury or sickness is the basis of a claim (whether Pre-Service, Post-Service, Concurrent or Urgent Care). Such physical examination may be made as often as the Corporation may reasonably require while such claim for Benefits or request for Pre-Authorization is pending.

**REPLACEMENT COVERAGE**

If this Plan of Benefits replaced the Employer's prior Plan, all eligible persons who were validly covered under that Plan on its termination date will be covered on the Plan of Benefits Effective Date of this Plan of Benefits, provided such persons are enrolled for coverage as stated in Article II.

# INDEX

This index contains instances of the use of defined terms in this Plan of Benefits. This index does not include Benefits or excluded items.


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