WELCOME TO BLUE CROSS BLUE SHIELD OF SOUTH CAROLINA

McEntire Produce, Inc.

Preferred Blue®

HDHP

SouthCarolinaBlues.com

February 1, 2016

INTRODUCTION

Dear Member:

Blue Cross and Blue Shield of South Carolina (BlueCross) is pleased to provide your Preferred Blue® Plan of Benefits. BlueCross 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 networks offer the best geographic access to Providers 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 website at www.SouthCarolinaBlues.com.

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

VISIT OUR WEBSITE AND MOBILE SITE

Through our Member website, www.SouthCarolinaBlues.com, you can access My Health Toolkit®, a source for instant, personalized Benefits and health information. As a Member, you can take full advantage of this interactive website to complete a variety of self-service transactions online from wherever you have Internet access. ***Need to order a replacement Member ID card? Need to check the status of a claim or download claim forms? Need to print an Explanation of Benefits (EOB)?***

You also can use such self-help tools as:

View **real-time status** of your eligibility, deductible, out-of-pocket and any health care account balances.

The **Doctor and Hospital Finder** is where you get the most recent information on our network of medical Providers and Hospitals. Search by name, address, gender, specialty and Hospital affiliation. You can also get information about medical schools attended, board certification status, languages spoken, handicap access, maps and driving directions.

Through our **Treatment Cost Estimator**, you can see your estimated out-of-pocket costs for over four hundred (400) treatment cost categories. Treatment cost categories include inpatient and outpatient procedures like Magnetic Resonance Imaging (MRIs) and Surgical Services. Costs are displayed by place of service and you can compare up to three (3) facilities on cost and quality. Your out-of-pocket costs displayed on the website are based on your Plan design and your real-time Benefit Year Deductible and Out-of-Pocket Maximum status. Your estimated costs will include any Copayment, Benefit Year Deductible and Coinsurance you would owe.

Our **Personal Health Record (PHR)** is more than a place to store your health information. Any time a medical or lab claim is processed, the information is fed to your PHR. You can print medication lists, add doctor's appointments and read up-to-date health and wellness articles.

On the go? The My Health Toolkit® mobile website offers Members features designed for smaller smartphone screens. Unlike some mobile tools, as a BlueCross Member, you do not need to download an app. When you want to access the mobile site, simply navigate to www.SouthCarolinaBlues.com on your smartphone.

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 Preauthorization, when required, before getting medical care. The amount you have to pay will increase when you do not use Participating Providers and if you do not get Preauthorization.

BlueCross makes every effort to contract with Providers that practice at participating Hospitals. Members of the Blue Cross and Blue Shield Association (BCBSA) also attempt to contract with Providers that practice at participating Hospitals. For various reasons, some Providers may elect not to contract as Participating Providers. If you use a Non-Participating Provider, you have no protection from balance billing from the Provider.

This Corporation believes this Plan of Benefits is a "grandfathered health plan" under the Patient Protection and Affordable Care Act of 2010 (PPACA). As permitted by the PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Plan of Benefits may not include certain consumer protections of PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in PPACA, for example, the elimination of lifetime limits on Benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator or call the number on the back of your Identification Card. The Member may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

HOW TO GET HELP

How to get help with claims or benefit questions:

- From Columbia, South Carolina; dial 264-0015
- From anywhere else in or out of South Carolina, dial 1-800-760-9290

How to get help on Preauthorization:

For radiation oncology Services, Magnetic Resonance Imaging (MRIs), Magnetic Resonance Angiography (MRAs), Computerized Axial Tomography (CAT) scans or Positron Emission Tomography (PET) scans in an Outpatient Facility:

- 1-866-500-7664

For all other medical care:

- 736-5990 from the Columbia, South Carolina 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 Preauthorization is required for the procedures on the Schedule of Benefits that have a "Preauthorization" note.

Preauthorization for Mental Health Services and Substance Use Disorder Services:

Behavioral Health:

- 699-7308 from the Columbia, South Carolina area
- 1-800-868-1032 from all other areas

How to get information on Drug coverage:

Drug Coverage is handled by Caremark. Caremark is an independent company that provides pharmacy Benefits on behalf of BlueCross.

For inquiries regarding the Prescription Drug Benefit, please call:

- 1-888-963-7290

For prior authorization on Prescription Drugs, please call:

- 1-800-294-5979

For inquiries regarding Specialty Drugs, please call:

- 1-800-237-2767

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

- 1-800-237-2767

You can also access Caremark from My Health Toolkit.

For information regarding Quantity versus Time Limits or Step Therapy Programs, contact your Customer Service Representative.

BlueCard outside the United States:

You may also call 1-800-810-BLUE (2583) when traveling outside the United States for assistance with locating an international Provider, in translating foreign languages and submitting claims.

Essential Advocate Questions:
The Corporation provides you and your Dependents with access to ***Essential Advocate***, 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 health care and Benefit experts. The health advocates assist Members:

- Locating Providers through the BlueCross Doctor & Hospital Finder.
- Using online tools for treatment options and cost estimates.
- 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.
- Understanding 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 Coaching – Chronic Condition Questions:
The Corporation provides you with access to ***Health Coaching – Chronic Condition***, a program designed to help Members with the following conditions live healthier lives:

- Anxiety
- Attention deficit hyperactivity disorder
- Asthma (pediatric and adult)
- Bipolar disorder
- Coronary artery disease
- Chronic heart failure
- Chronic obstructive pulmonary disease
- Depression
- Diabetes (pediatric and adult)
- Hypertension (high blood pressure)
- Hyperlipidemia (high cholesterol)
- Metabolic health
- Migraine
- Recovery support

As a participant in ***Health Coaching – Chronic Condition***, you will receive personalized information and tools to help you learn more about your condition and ways to improve your health. You will also have access to a personal health coach – a health care professional who can help you reach your health goals.

If you are identified as someone with one of the conditions listed above who could benefit from the program, you will be automatically enrolled. If you do not wish to participate, you can disenroll by calling 1-855-838-5897.

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.

Rally Questions:
The Corporation provides you with access to ***Rally***, a program that can help guide you toward positive lifestyle choices. Once you have completed the confidential ***Rally*** Health Survey, you will receive your ***Rally*** age which may be higher or lower than your physical age based on risk factors and healthy behaviors. This program provides missions and challenges that improve overall health and wellbeing. Along the way, you will earn chances to enter prize sweepstakes. Rally is a product of Rally Health Inc. Rally Health Inc. is an independent company that provides the Rally program on behalf of BlueCross. To access the ***Rally*** Health Survey, login to My Health Toolkit.

Proactive Member Messaging Questions:
The Corporation provides you with access to ***Proactive Member Messaging***, a program that offers wellness reminders and program specific promotions. Proactive Member Messaging is offered through Relay®, a text marketing communications channel. Relay Network, LLC is an independent company that provides the ***Proactive Member Messaging*** program on behalf of BlueCross. To participate, call 1-844-206-0623.

Health Coaching – Lifestyle Questions:
The Corporation provides you with access to the ***Health Coaching – Lifestyle*** bundle, a collection of programs designed to help you improve your health and wellness lifestyle such as kicking a habit, exercising more or switching up your diet. You may also receive guidance as you adjust to a major change in your life, such as pregnancy. A health coach will provide support and help you create an action plan to meet your personal goals. The bundle includes the following programs:

- Back care
- Maternity (preconception, maternity and postpartum care)
- Stress management
- Tobacco-free living
- Weight management (adults and Children)

To participate, call 1-855-838-5897.

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 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 website. 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:

Blue Cross and Blue Shield of South Carolina
Claims Service Center
Post Office Box 100300
Columbia, South Carolina 29202

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

SCHEDULE OF BENEFITS

Employer Contract Number: 25-54927-04 through 05, 08, and 11
Employer: McEntire Produce, Inc.
HDHP
Plan of Benefits Effective Date: February 1, 2016

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

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 "Covered" notation associated with it, the Benefit will pay based on the location of the service (e.g., inpatient, outpatient, office). 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.

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 sixty (60) days of employment.
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 twenty-six (26).
Actively at Work:	
Minimum hours per week:	At least 30 hours per week.
Minimum weeks per year:	At least 48 weeks per year.

Benefit Year Deductible:	$9,000 per family with no one Member meeting more than $4,500 for Participating Providers. $12,000 per family with no one Member meeting more than $6,000 for Non-Participating Providers. Covered Expenses that are applied to the Benefit Year Deductible shall contribute to both the Participating and Non-Participating Provider Benefit Year Deductibles.
Out-of-Pocket Maximums:	$9,000 per family with no one Member meeting more than $4,500 for Participating Providers. $24,000 per family with no one Member meeting more than $12,000 for Non-Participating Providers. Coinsurance for chiropractic services do not contribute to the Out-of-Pocket Maximum determination. If claim pays secondary, Coinsurance and Benefit Year Deductible amounts will not accumulate toward the Out-of-Pocket Maximum. Allowable Charges are paid at 100% after the Out-of-Pocket Maximum is met. If Coinsurance does not contribute to the Out-of-Pocket Maximum, the percentage of reimbursement does not change from the amount indicated on the Schedule of Benefits. Coinsurance, Benefit Year Deductibles and Copayments which apply to the Out-of-Pocket Maximum shall contribute to both the Participating and Non-Participating Provider Out-of-Pocket Maximums.

Benefit Year Deductibles and any Copayments must be met before any Covered Expenses can be paid.

This Schedule of Benefits applies during the 01/01 through 12/31 Benefit Year. The Anniversary Date is 02/01.

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

Preauthorization is required for the following outpatient Benefits:
Radiation treatment plans related to oncology
MRI
MRA
CAT scans
PET scans
Sclerotherapy
Septoplasty
Any surgical procedure that may be potentially cosmetic: i.e., blepharoplasty, reduction mammoplasty
Hysterectomy
Investigational procedures
Applied Behavioral Analysis (ABA) related to Autism Spectrum Disorder
Radiation therapy
Cancer chemotherapy

Benefits for ABA related to Autism Spectrum Disorder, radiation treatment plans related to oncology, MRIs, MRAs, CAT scans and PET scans performed in an outpatient facility will be denied when Preauthorization is not obtained or approved by the Corporation. Benefits for any other outpatient services that require Preauthorization will be reduced by 50% of the Allowable Charge when Preauthorization is not obtained or approved by the Corporation. Please see the Mental Health Services and Substance Use Disorder Services section of the Schedule of Benefits for specific Preauthorization penalties related to those services.

ADMISSIONS/INPATIENT BENEFITS		
	Participating Provider	**Non-Participating Provider**
Hospital charges for room and board related to Admissions	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
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 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Inpatient physical rehabilitation services when Preauthorized by the Corporation and performed by a Provider designated by the Corporation	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Skilled Nursing Facility Admissions (Preauthorization is required)	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

OUTPATIENT BENEFITS OTHER THAN MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES		
	Participating Provider	**Non-Participating Provider**
Hospital and Ambulatory Surgical Center charges for Benefits provided on an outpatient basis, including: lab, X-ray and other diagnostic services	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Emergency room	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
All other covered outpatient Benefits	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

PROVIDER SERVICES		
	Participating Provider	**Non-Participating Provider**
Provider Services in a Hospital	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Surgical Services, when rendered in a Hospital, Provider's office or Ambulatory Surgical Center	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider Services for treatment in a Hospital outpatient department or Ambulatory Surgical Center	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Services in the Provider's office, including contraceptives and birth control devices	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider Services in the Member's home	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Second Surgical Opinion	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
All other Provider Services	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES

Preauthorization is required for Mental Health Services and Substance Use Disorder Services. If Preauthorization is not obtained or approved by the Corporation, the following penalties will apply.

Inpatient: Denial of room and board
Outpatient partial hospitalization, repetitive transcranial magnetic stimulation (rTMS), electroconvulsive therapy (ECT), psychological testing and intensive outpatient programs: 50% of the Allowable Charge

	Participating Provider	**Non-Participating Provider**
Inpatient Hospital charges for Mental Health Services and Substance Use Disorder Services	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Residential Treatment Center Admissions for Mental Health Services and Substance Use Disorder Services	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Outpatient Hospital or clinic charges for Mental Health Services and Substance Use Disorder Services	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Inpatient Provider charges for Mental Health Services and Substance Use Disorder Services	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Outpatient or Office Provider charges for Mental Health Services and Substance Use Disorder Services	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Outpatient Hospital emergency room charges for Mental Health Services and Substance Use Disorder Services	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

OTHER SERVICES		
	Participating Provider	**Non-Participating Provider**
Ambulance service (including air ambulance)	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 100% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member must pay the balance of the Provider's charge
Durable Medical Equipment, Prosthetics and Orthopedic Devices (if purchase or rental of Durable Medical Equipment is $500 or more, Preauthorization is required)	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Medical Supplies	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Home Health Care, including private duty nursing services (Preauthorization is required)	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Hospice Care (Preauthorization is required)	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Colorectal cancer screenings limited to: • One (1) fecal occult blood testing of three (3) consecutive stool samples per Benefit Year • One (1) flexible sigmoidoscopy every five (5) years • One (1) double contrast barium enema every five (5) years • One (1) colonoscopy every ten (10) years	Covered	Covered
ABA related to Autism Spectrum Disorder limited to: • Members diagnosed at age eight (8) or younger • Members under the age of sixteen (16) (Preauthorization is required)	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	Non-Covered
Provider charges for habilitation and rehabilitation related to physical therapy and occupational therapy (Please see the "Outpatient Rehabilitation" section in Article III of the Plan of Benefits for further limitations)	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Habilitation and rehabilitation related to speech therapy (Please see the "Outpatient Rehabilitation" section in Article III of the Plan of Benefits for limitations)	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Human organ and tissue transplant services 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 Provider charges are subject to the Benefit Year Deductible	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Allergy injections	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Chiropractic services, including spinal manipulation/subluxation, limited to a $500 maximum payment and/or 20 visits per Member per Benefit Year	The Corporation pays 100% of the Allowable Charge after the Benefit Year Deductible	The Corporation pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Oxygen (Preauthorization is required)	Covered	Covered

PREVENTIVE BENEFITS
The Benefit Year Deductible does not apply to these Benefits

	Participating Provider	**Non-Participating Provider**
Pap smear screenings (the report and interpretation only, limited to one (1) per Benefit Year)	The Corporation pays 100% of the Allowable Charge	Non-Covered
Physical exam (limited to $300 per Member per Benefit Year)	The Corporation pays 100% of the Allowable Charge	Non-Covered
Prostate screenings (limited to one (1) per Benefit Year)	The Corporation pays 100% of the Allowable Charge	Non-Covered
Well child care performed in the Provider's office and immunizations for Dependents up to age 7	The Corporation pays 100% of the Allowable Charge	Non-Covered
Gynecological exam (limited to two (2) per Benefit Year)	The Corporation pays 100% of the 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 forty (40) or older)	The Corporation pays 100% of the 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 forty (40) or older)	The Corporation pays 100% of the Allowable Charge	Non-Covered

PRESCRIPTION DRUG BENEFIT			
Prescription Drugs	**Mail Service Pharmacy**	**Participating Pharmacy**	**All Other Pharmacies**
Generic Drugs	Non-Covered	The Corporation pays 100% of the Allowable Charge for each prescription or refill after the Benefit Year Deductible*, up to a 90 day supply	Non-Covered
Preferred Brand Drug	Non-Covered	The Corporation pays 100% of the Allowable Charge for each prescription or refill after the Benefit Year Deductible*, up to a 90 day supply**	Non-Covered
Non-Preferred Brand Drug	Non-Covered	The Corporation pays 100% of the Allowable Charge for each prescription or refill after the Benefit Year Deductible*, up to a 90 day supply**	Non-Covered
Contraceptives (Prescription Drugs)	Non-Covered	Covered	Non-Covered
Sexual dysfunction Prescription Drugs	Non-Covered	Non-Covered	Non-Covered
Tobacco cessation Prescription Drugs	Non-Covered	Non-Covered	Non-Covered
Obesity/weight control Prescription Drugs	Non-Covered	Non-Covered	Non-Covered
Infertility Prescription Drugs	Non-Covered	Non-Covered	Non-Covered
Cosmetic Prescription Drugs	Non-Covered	Non-Covered	Non-Covered
Prescription Drug deductible	Non-Covered	$0 (No Prescription Drug deductible)	Non-Covered

Prescription Drugs	**Mail Service Pharmacy**	**Participating Pharmacy**	**All Other Pharmacies**
Prescription Drug out-of-pocket	Non-Covered	$0 (No Prescription Drug out-of-pocket)	Non-Covered
Maximum Prescription Drug Benefit	Non-Covered	$0 (No maximum Prescription Drug Benefit)	Non-Covered
Diabetic syringes and supplies	Non-Covered	Covered	Non-Covered
Syringes and related supplies for conditions, such as cancer or burns, test tape, surgical trays and renal dialysis supplies	Non-Covered	Non-Covered	Non-Covered
*Covered Expenses for Prescription Drugs are integrated with the Benefit Year Deductible. **Including Specialty Drugs.			

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 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. An Adverse Benefit Determination includes any cancellation or discontinuance of coverage that has retroactive effect (whether or not there is an adverse effect on any particular benefit), except to the extent attributable to a failure to pay any required Premiums or employee contributions.

Allowable Charge: the amount the Corporation or a member of the Blue Cross and Blue Shield Association (BCBSA) agrees to pay a Participating Provider or Non-Participating Provider as payment in full for a service, procedure, supply or equipment. For a Non-Participating Provider, (i) the Allowable Charge shall not exceed the Maximum Payment and (ii) in addition to the Member's liability for Benefit Year Deductibles, Copayments and/or Coinsurance, the Member may be balance billed by the Non-Participating Provider for any difference between the Allowable Charge and the billed charges.

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 licensed 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 licensed medical doctor or oral surgeon.

Ambulatory Surgical Center includes an endoscopy center.

Applied Behavioral Analysis (ABA): behavioral modification to target cognition, language, and social skills.

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

1. Autistic Disorder;

2. Asperger's Syndrome;

3. Pervasive Developmental Disorder--not otherwise specified

Behavioral Health Provider: a Provider who renders Mental Health Services and/or Substance Use Disorder Services.

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.

Benefit(s): medical services or Medical Supplies that are:

1. Medically Necessary;

2. Preauthorized (when required under this Plan of Benefits or the Schedule of Benefits);

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.

Benefits Checklist: the document completed by the Employer and submitted to BCBSSC which outlines the Benefits to be offered under the Employer's Group Health Plan. BCBSSC shall administer the Group Health Plan in accordance with the terms of the Benefits Checklist.

BlueCard® Program: a program in which all members of the BCBSA 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.

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, and 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.

COBRA: those provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended, which require certain Employers to offer continuation of health care coverage to Employees and Dependents of Employees who would otherwise lose coverage.

COBRA Administrator: the Corporation or its designated subcontractor (who the Corporation has contracted with to provide administrative Services related to COBRA). For purposes of this Contract, the COBRA Administrator may also provide Retiree Benefits Billing Services as outlined in the Contract and Plan of Benefits if applicable.

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 the 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.

Companion Benefit Alternatives (CBA): a behavioral health care company. CBA is responsible for managing behavioral health care Services, including pre-certifying Mental Health and Substance Use Disorder Benefits for inpatient and outpatient Services.

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

Congenital Disorder/Congenital Disease: a condition documented as existing at birth regardless of cause.

Continuation of Care: the provision of Participating Provider level Benefits for services rendered by certain Non-Participating Providers for a definite period of time in order to ensure continuity of care for covered Members for a Serious Medical Condition.

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 Preauthorized is Medically Necessary. The Continued Stay Review process is outlined in Article III.

Contract: the Master Group Contract between the Corporation and the Employer including the Employer Application, Plan of Benefits and all endorsements, amendments, riders or addenda.

Copayment: the amount, if any, 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) may be received by 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 affected by any Credit.

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.

Dependent(s): an individual who is:

1. An Employee's spouse;

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

3. An Incapacitated Dependent.

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.

Durable Medical Equipment: medical equipment that:

1. Can withstand repeated use;

2. Is Medically Necessary;

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

4. Is appropriate for use in the home;

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

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

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

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

Prosthetic Devices, Orthopedic Devices and Orthotic Devices are considered Durable Medical Equipment when the required Preauthorization is obtained.

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;

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, even if such classification is determined to be erroneous or is retroactively revised.

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

Employer's Effective Date: the date the Corporation begins to provide Services under the Contract.

Enrollment Date: 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, as amended.

Excepted Benefits:

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; or,

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; or,

    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; or,

    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; or,

    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. The Pharmacy Benefit Manager has the discretion to determine if a Prescription Drug is a Generic Drug.

Genetic Information: information about genes, gene products (messenger RNA and transplanted protein) or genetic characteristics derived from an individual or family member of the individual. 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 purposefully 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, as amended.

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 licensed medical doctor, 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 Providers, 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 thirty-one (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. 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;

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

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

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(C)(6)).

Legal Intoxication/Legally Intoxicated: the Member's blood alcohol level was at or in excess of the amount established under applicable state law to create a presumption and/or inference that the Member was under the influence of alcohol, when measured by law enforcement or medical personnel.

Long-Term Acute Care Hospital: 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 charge submitted to the Corporation for the service, procedure, supply or equipment by a Provider;

2. An amount based upon the reimbursement rates in its Benefits Checklist;

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

4. An amount established by the Corporation, based upon factors including, but not limited to, (i) governmental reimbursement rates applicable to the service, procedure, supply or equipment, or (ii) reimbursement for a comparable or similar service, procedure, supply or equipment, taking into consideration the degree of skill, time and complexity involved; geographic location and circumstances giving rise to the need for the service, procedure, supply or equipment; or,

5. The lowest amount of reimbursement the Corporation allows for the same or similar service, procedure, supply or equipment when provided by a Participating Provider.

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.

A Medical Child Support Order must clearly specify:

1. 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;

2. 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;

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

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

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

1. The name of the issuing agency;

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

3. 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: health care services that a Provider, 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;

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 or 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 Providers practicing in relevant clinical areas and any other relevant factors.

Medical Supplies: supplies that are:

1. Medically Necessary;

2. Prescribed by a Provider acting within the scope of his or her license;

3. Are not available on an over-the-counter basis (unless such supplies are provided to a Member in a Provider's office and should not (in the Corporation's 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 Services: treatment (except Substance Use Disorder 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;

2. Have at least 50% bony support;

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 Provider Agreement with the Corporation or another member of the BCBSA.

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.

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 Provider Agreement.

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.

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).

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: the Benefit booklet provided by the Corporation to the Employer which, attached hereto as Exhibit A, reflects the Corporation's understanding of the Benefits offered under the Employer's Group Health Plan based on the Benefits Checklist completed by the Employer and submitted to the Corporation. The Plan of Benefits includes the Schedule of Benefits and all endorsements, amendments, riders or addenda.

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.

PPACA: the Patient Protection and Affordable Care Act of 2010, as amended.

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.

Preauthorized/Preauthorization: the Corporation's approval of Benefits based on Medical Necessity prior to the rendering of such Benefits to a Member. Preauthorization means only that the Corporation has determined that the Benefit is Medically Necessary. Preauthorization is not a guarantee of payment or a verification that Benefits will be paid or are available to the Member. Notwithstanding Preauthorization, payment for Benefits is subject to a Member's eligibility 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 Preauthorization process is outlined in Article III.

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 (FDA); 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 licensed Provider acting within the scope of his or her license as a prescription;

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 Preauthorization 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. The Employer may require an additional orientation period.

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 (PHI) : 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 entitled to practice 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; or,

11. Osteopathy.

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

Provider Agreement: an agreement between the Corporation (or another member of the BCBSA) and a Provider under which the Provider has agreed to accept an allowance as payment in full for Benefits.

Provider Services: includes the following services:

A. When performed by a Provider or a Behavioral Health Provider 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; or,

   2. Basic diagnostic services and machine tests.

B. When performed by a licensed medical doctor, osteopath, podiatrist or oral surgeon, but specifically excluding such services when performed by a chiropractor, optometrist, dentist, physical therapist, speech therapist, occupational therapist or licensed psychologist with a doctoral degree:

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

   2. Benefits rendered in a Member's home;

   3. Surgical Services;

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

   5. Radiological examinations;

   6. Laboratory tests; and,

   7. Maternity services, including consultation, prenatal care, conditions directly related to pregnancy, delivery and postpartum care, and delivery of one (1) or more infants. Provider Services also include maternity services performed by certified nurse midwives when supervised by a licensed medical doctor.

C. Additionally, Provider Services shall include Behavioral Health Services when performed by a Behavioral Health Provider, nurse practitioner, physician assistant, licensed professional counselor, masters level licensed social worker, licensed marriage and family therapist or other licensed Behavioral Health Provider approved by the Corporation.

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; or,

6. A proceeding in bankruptcy under Title 11 of the United States Code with respect to an Employer from whose employment an Employee retired at any time.

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.

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.

Residential Treatment Center (RTC): a licensed institution, other than a Hospital, which meets all six (6) of these requirements:

1. Maintains permanent and full-time facilities for bed care of resident patients;

2. Has the services of a psychiatrist (addictionologist, when applicable) or physician extender available at all times and is responsible for the diagnostic evaluation, provides face-to-face evaluation services with documentation a minimum of once/week and as needed as indicated;

3. Has a registered nurse (RN) present onsite who is in charge of patient care along with one (1) or more RNs or licensed practical nurses (LPNs) onsite at all times twenty-four (24) hours per day and seven (7) days per week;

4. Keeps a daily medical record for each patient;

5. Is primarily providing a continuous structured therapeutic program specifically designed to treat behavioral health disorders and is not a group or boarding home, boarding or therapeutic school, half-way house, sober living residence, wilderness camp or any other facility that provides Custodial Care; and,

6. Is operating lawfully as a RTC in the area where it is located.

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.

Second Surgical Opinion: the medical opinion of a board-certified surgeon regarding an elective surgical procedure. The opinion must be based on the surgeon's examination of the patient. The examination must be performed after another licensed medical doctor has proposed to perform surgery but before the surgery is performed. The second licensed medical doctor must not be associated with the primary licensed medical doctor.

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.

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.

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 licensed medical doctor who 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).

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.

Substance Use Disorder: 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 Use Disorder Services: services or treatment relating to Substance Use Disorder.

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 licensed medical doctor.

Telemedicine: the exchange of Member information from one eligible referring licensed medical doctor (for purposes of Telemedicine outlined herein, the "Referring Physician") site to another eligible consulting licensed medical doctor (for purposes of Telemedicine outlined herein, the "Consulting Physician") site for the purpose of providing medical care to a Member in circumstances in which in person, face-to-face contact with the Consulting Physician is not necessary. The exchange must occur via two-way, real-time, interactive, HIPAA-compliant, electronic audio and video telecommunications systems.

Totally Disabled/Total Disability: 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 licensed medical doctor'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 licensed 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, as amended.

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's Effective Date is eligible to enroll (and to enroll his or her 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 his or her Dependents) beginning on the next day that the Employee:

   a. Is 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. 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.

C. COMMENCEMENT OF COVERAGE

Coverage under this Plan of Benefits will commence as follows, provided that coverage will not be effective more than sixty (60) days before the Corporation receives such Employee's Membership Application:

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's 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's Effective Date, coverage will commence on the date chosen by the Employer.

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.

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 the date of the Child's birth provided he or she has 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 (C) (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;

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;

ii. Was not under a COBRA continuation provision described in Article II (C)(6)(c)(i) 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;

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;

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

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

d. Medicaid or State Children's Health Insurance Program (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 Premium assistance under a Medicaid or SCHIP plan; and,

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

aa. date of termination of Medicaid or SCHIP coverage; or,

bb. determination that the Employee or Dependent is eligible for such assistance.

A Member whose Child becomes eligible to enroll in and receive child health assistance under a SCHIP plan also may disenroll the Child from the Plan of Benefits, pursuant to applicable procedures and deadlines established by the state.

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.

D. DEPENDENT CHILD'S ENROLLMENT

1. 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.

2. Absent the sponsorship of an Employee, Dependents are not eligible to enroll for coverage under this Plan of Benefits.

E. MEMBERSHIP APPLICATION

The Corporation will only accept a Membership Application submitted by the Employer on behalf of each Employee. The Corporation will not accept a Membership Application directly from an Employee or Dependent.

F. MEMBER CONTRIBUTIONS

The Member is solely responsible for making all payments for any Premium.

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 Preauthorization, a Continued Stay Review, an Emergency Admission Review, a 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. In the event of a conflict between this Plan of Benefits and the Schedule of Benefits, the Schedule of Benefits controls. Oral statements cannot alter the terms of the Plan of Benefits or Schedule of Benefits. Covered Expenses will only be paid for Benefits:

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

2. Performed or provided prior to termination of coverage;

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

4. For which the required Preadmission Review, Emergency Admission Review, Preauthorization and/or Continued Stay Review has been requested and Preauthorization was received from the Corporation (the Member should refer to the Schedule of Benefits for services that require Preauthorization);

5. That are Medically Necessary;

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. PREAUTHORIZATION

All Admissions and some Benefits (as indicated herein or on the Schedule of Benefits) require Preauthorization 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 Preauthorization. If Preauthorization is not obtained for an Admission or if an Admission is not Preauthorized and the Member is still admitted, Benefits may be reduced. Specific penalties are listed on the Schedule of Benefits. Preauthorization is obtained through the following procedures:

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

2. For all Admissions that result from an Emergency Medical Condition, Preauthorization 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, Preauthorization is granted or denied for additional days in the course of the Continued Stay Review;

4. For specific Benefits that require Preauthorization, Preauthorization is granted or denied in the course of the Preauthorization process; and,

5. For items requiring Preauthorization, the Corporation must be called at the numbers 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 in Article III (E).

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

2. The Benefit must be listed in 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; and,

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

E. BENEFITS

ABA RELATED TO AUTISM SPECTRUM DISORDER

The Corporation will pay Covered Expenses for ABA related to Autism Spectrum Disorder as set forth on the Schedule of Benefits. Services must be provided by or under direction of an approved Participating Provider. Preauthorization requests and treatment plans must be submitted to CBA.

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;

2. To ensure the potency and efficacy of the antigens, the provision of multiple dose vials is restricted to sufficient antigen for twelve (12) weeks at either once per week or twice per week dosing; 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;

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

    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 Medically Necessary when used:

1. Locally to or from a Hospital providing Medically Necessary services 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, 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 Preauthorized. 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 Covered Expenses will be paid 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 Preauthorization; however, the dentist must submit a plan for any future treatment to the Corporation for review and Preauthorization 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.

DURABLE MEDICAL EQUIPMENT

The Corporation will pay Covered Expenses for standard, non-luxury (as determined by the Corporation) Durable Medical Equipment when the required Preauthorization is obtained. The Corporation will decide (in its 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.

HABILITATION

The Corporation will pay Covered Expenses for habilitation, including assisting a child with achieving developmental skills when impairments have caused delaying or blocking of initial acquisition of the skills. Habilitation can include fine motor, gross motor, or other skills that contribute to mobility communication and performance of activities of daily living. The services will be described in an individual's plan of care.

HOME HEALTH CARE

The Corporation will pay Covered Expenses for Preauthorized 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 Preauthorized 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 semiprivate 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; and,

6. In a Long-Term Acute Care Hospital.

Benefits for Admissions may be 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 Preauthorized 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 as 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 may be 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 licensed medical doctor or Behavioral Health Provider's 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 and Substance Use Disorder Services;

2. In-hospital medical Benefits in a Skilled Nursing Facility will be provided for visits of a Provider, limited to one (1) visit per day, not to exceed the number of visits if set forth on the Schedule of Benefits.

3. Where two (2) or more Providers of the same general specialty render in-Hospital medical visits on the same day, payment for such services will be made only to one (1) Provider.

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; and,

    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 Provider 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 mammography testing regardless of Medical Necessity for 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.

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 (or in the Corporation's determination, should be) provided as part of another Benefit.

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 Preauthorized 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, Preauthorization is required to use certain Providers or facilities, or to reduce out-of-pocket costs.

ORTHOPEDIC DEVICES

The Corporation will pay Covered Expenses for Preauthorized Orthopedic Devices.

ORTHOTIC DEVICES

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

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 Preauthorized 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 a gynecological examination 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 physical examinations for Members that are within the appropriate age guidelines regardless of Medically Necessity.

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 Provider prescribes a Brand Name Drug and an equivalent Generic Drug is available (whether or not the Provider 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 discretion, place quantity limits on Prescription Drugs.

PROSTATE EXAMINATION

The Corporation will pay Covered Expenses for prostate examinations 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.

PROVIDER SERVICES

The Corporation will pay Covered Expenses for Provider Services, provided that when different levels (as determined by the Corporation) of Provider 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 Provider Services.

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;

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 licensed medical doctor;

2. All such treatment may require Preauthorization and must be performed by a Provider and at a location designated by the Corporation;

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.

RESIDENTIAL TREATMENT CENTER

The Corporation will pay Covered Expenses for a Preauthorized Residential Treatment Center as set forth on the Schedule of Benefits.

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 as set forth on the Schedule of Benefits. 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.

SUBSTANCE USE DISORDER SERVICES

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

SURGICAL SERVICES

The Corporation will pay Covered Expenses for Surgical Services performed by a licensed medical doctor or oral surgeon, as applicable, 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. Assistant Surgeon Services, that consists 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.

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.

TELEMEDICINE

The Corporation will pay Covered Expenses for certain Telemedicine services only if the Member’s access to appropriate specialty care is difficult, inaccessible or unavailable or in an urgent situation where access to the specialty care is needed immediately.

Consulting and Referring Physicians must be Participating Providers who have been credentialed as eligible Telemedicine Providers.

Office and outpatient visits that are conducted via Telemedicine are counted towards any applicable Benefit limits for these services. Telemedicine services will be covered by the Corporation when they are Covered Services under the terms of this Plan of Benefits and under the following circumstances:

1. The medical care is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the Member's need; and

2. The medical care can be safely furnished, and there is no equally effective, more conservative and less costly treatment available.

Examples of interactions that are not reimbursable Telemedicine (or telepsychiatry) services and will not be reimbursed are:

1. Telephone conversations;

2. E-mail messages;

3. Video cell phone interactions;

4. Facsimile transmissions;

5. Services provided by allied health professionals that are neither allopathic or osteopathic physicians; and,

6. Internet-based audio-video communication that is not secure and HIPAA-compliant (e.g., Skype) .

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 EXCEPTIONS TO THIS ARE AS FOLLOWS: (1) WHERE SUCH ITEMS ARE SPECIFICALLY INCLUDED (UP TO THE CORRESPONDING DOLLAR AMOUNT AND/OR COVERAGE PERCENTAGE) IN THE SCHEDULE OF BENEFITS OR IN ARTICLE III-BENEFITS, (2) SERVICES RENDERED BY A HEALTH CARE PROVIDER AS PART OF A PHYSICIAN INCENTIVE PROGRAM SUCH AS PATIENT-CENTERED MEDICAL HOME PROGRAM, AN ACCOUNTABLE CARE ORGANIZATION OR EPISODE-BASED ARRANGEMENT OR (3) AS THE LAW REQUIRES SUBJECT TO THE ABOVE-LISTED EXCEPTIONS, THE CORPORATION WILL NOT PAY ANY AMOUNT FOR THE FOLLOWING:

ACUPUNCTURE

Acupuncture treatment or services, except as specified on the Schedule of Benefits.

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 PREAUTHORIZED

If Preauthorization is not received for an otherwise Covered Expense related to an Admission, Benefits may be reduced as set forth on the Schedule of Benefits.

BEHAVIORAL, EDUCATIONAL OR ALTERNATE THERAPY PROGRAMS

Any behavioral, educational or alternative therapy techniques to target cognition, behavior language and social skills modification, including:

1. ABA therapy unless Medically Necessary for the treatment of Autism Spectrum Disorder;
2. Teaching, Expanding, Appreciating, Collaborating and Holistic (TEACCH) programs;
3. Higashi schools/daily life;
4. Facilitated communication;
5. Floor time;
6. Developmental Individual-Difference Relationship-based model (DIR);
7. Relationship Development Intervention (RDI);
8. Holding therapy;
9. Movement therapies;
10. Music therapy; and,
11. Animal assisted therapy.

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. This exclusion includes, but is not limited to, benefits provided by the Veterans Administration for care rendered for a service-related disability, or any state or federal hospital services for which the Member is not legally obligated to pay.

BIO-FEEDBACK SERVICES

Bio-feedback when related to psychological services.

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 or use 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

Devices or Prescription Drugs of any type, even those dispensed by a prescription, for the purpose of contraception, except as specified on the Schedule of Benefits.

COPYING CHARGES

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

COSMETIC AND RECONSTRUCTIVE SERVICES

A. 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 or reconstructive, which are not covered, include, but are not limited to, the following:

   1. Rhinoplasty (nose);

   2. Mentoplasty (chin);

   3. Rhytidoplasty (face lift);

   4. Glabellar rhytidoplasty (forehead lift);

   5. Surgical planing (dermabrasion);

   6. Blepharoplasty (eyelid);

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

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

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

B. A cosmetic or reconstructive service may, under certain circumstances (in the Corporation's discretion), be considered restorative in nature for which Benefits are available, but only if the following requirements are met:

   1. The service is intended to correct, improve or restore a bodily function; or

   2. The service is intended to correct, improve or restore a malappearance or deformity that was caused by physical trauma or accident, congenital anomaly or covered surgical service; and,

   3. The proposed service must be Preauthorized.

CRIME/ILLEGAL ACTS

Any illness or injury received while committing or attempting to commit a crime, felony or misdemeanor or while engaging or attempting to engage in an illegal act or occupation.

CUSTODIAL CARE

Services or supplies related to Custodial Care, except as specified on the Schedule of Benefits.

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 Preauthorized in the 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

Eyeglasses or contact lenses of any type, even those dispensed by a prescription (except after cataract surgery), except as specified on the Schedule of Benefits.

FOOD SUPPLEMENTS

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

FOOT CARE

Routine foot care such as paring, trimming or cutting of nails, calluses or corns, except in conjunction with diabetic foot care.

HEARING AIDS

Hearing aids or examinations for the prescription or fitting of hearing aids, except as specified on the Schedule of Benefits.

HUMAN ORGAN AND TISSUE TRANSPLANTS

Human organ and tissue transplants that are not:

1. Preauthorized;
2. Performed by a Provider as designated by the Corporation;
3. Listed as covered on the Schedule of Benefits; and,
4. Performed at a Blue Distinction Center of Excellence or a transplant center approved by the Corporation in writing.

IMMUNIZATIONS

Immunizations are excluded from coverage under this Plan of Benefits, except as specified on the Schedule of Benefits or if otherwise covered as a Preventive service.

IMPACTED TOOTH REMOVAL

Services or Medical Supplies for the removal of impacted teeth, except as specified on the Schedule of Benefits.

IMPOTENCE

Services, supplies or drugs related to any treatment for impotence, including but not limited to penile implants, except as specified on the Schedule of Benefits.

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

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, except as specified on the Schedule of Benefits.

INPATIENT DIAGNOSTIC AND EVALUATIVE PROCEDURES

Inpatient care and related Provider 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.

INTOXICATION OR DRUG USE

Any service (other than Substance Use Disorder Services), Medical Supplies, charges or losses resulting from a Member being Legally Intoxicated or under the influence of any drug or other substance, or taking some action the purpose of which is to create a euphoric state or alter consciousness. The Member, or Member's representative, must provide any available test results showing blood alcohol and/or drug/substance levels upon request by the Corporation. If the Member refuses to provide these test results, no benefits will be provided.

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, except as specified on the Schedule of Benefits.

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 Use Disorder treatment including: therapeutic schools, wilderness/boot camps, therapeutic boarding homes, half-way houses and therapeutic group homes.

MASSAGE THERAPY

Massage therapy treatment or services, except as specified on the Schedule of Benefits.

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 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. 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, except as specified on the Schedule of Benefits.

2. Also, the treatment or correction of complications from obesity-related treatment are non-covered services, regardless of Medical Necessity, prescription by a Provider or the passage of time from a Member's obesity-related treatment, except as specified on the Schedule of Benefits. This includes the reversal of obesity-related treatments and reconstructive procedures necessitated by weight loss.

3. Membership fees to weight control programs, except as specified on the Schedule of Benefits.

ORTHOGNATHIC SURGERY

Any service related to the treatment of malpositions or deformities of the jaw bone(s), dysfunction of the muscles of mastication, or orthognathic deformities, except as specified on the Schedule of Benefits.

OUTPATIENT SERVICES THAT ARE NOT PREAUTHORIZED

If Preauthorization is not received for an otherwise Covered Expense related to an outpatient service, Benefits may be reduced as set forth on the Schedule of Benefits.

OVER-THE-COUNTER DRUGS

Drugs that are available on an over-the-counter basis or are otherwise available without a prescription, except as specified on the Schedule of Benefits.

PAIN MANAGEMENT PROGRAMS

Chronic pain management programs or multi-disciplinary pain management programs.

PHYSICAL THERAPY ADMISSIONS

All Admissions solely for physical therapy except as provided in Article III.

PREMARITAL AND PRE-EMPLOYMENT EXAMINATIONS

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

PREOPERATIVE ANESTHESIA CONSULTATION

Charges for preoperative anesthesia consultation.

PRESCRIPTION DRUG EXCLUSIONS

- Prescription Drugs that have not been prescribed by a Provider;
- Any vitamins except for prenatal vitamins;
- Prescription Drugs not approved by the FDA;
- Prescription Drugs for non-covered therapies, services, or conditions;
- Prescription Drug refills in excess of the number specified on the Provider's prescription order or Prescription Drug refills dispensed more than one (1) year after the original prescription date;
- More than a thirty-one (31) day supply for Prescription Drugs (ninety (90) day supply for Prescription Drugs obtained through a Mail Service Pharmacy), except as specified on the Schedule of Benefits;
- 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, except as specified on the Schedule of Benefits;

- Prescription Drugs related to any treatment for infertility or impotence, including but not limited to, fertility drugs, except as specified on the Schedule of Benefits;

- Prescription Drugs administered or dispensed in a Provider'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 FDA 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 (1) standard, universally accepted 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 Preauthorization by the Corporation and Preauthorization 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 for obesity or weight control, contraceptives or tobacco cessation, except as specified 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; and,

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

PROVIDER CHARGES

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

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.

RADIOLOGY MANAGEMENT

All charges for radiation oncology services, MRIs, MRAs, CAT scans or PET scans in an office or outpatient facility when the required Preauthorization is not obtained.

RELATIONSHIP COUNSELING

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

SELF-INFLICTED INJURY

Services and supplies received as the result of any intentionally self-inflicted injury that does not result from a medical condition or domestic violence.

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, intellectual disabilities or vocational rehabilitation.

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.

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 him or herself or rendered by a Member's immediate family (parent, Child, spouse, brother, sister, grandparent or in-law).

SEX CHANGE

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

TELEHEALTH

Services which are initiated by either a Member or Provider (including, but not limited to a medical doctor) in which the method of communication is not secure, does not occur in real-time, does not allow for an actual examination or does not utilize both audio and video communication.

TELEMONITORING

Services where a Member transmits, whether by facsimile, e-mail, telephone or any other format, his or her specific health data (e.g. blood pressure, weight, etc.) to a Provider.

TEMPOROMANDIBULAR JOINT (TMJ) DISORDER

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, except as specified on the Schedule of Benefits.

TOBACCO CESSATION TREATMENT

Medical Supplies, services or Prescription Drugs for the treatment of tobacco cessation, except as specified on the Schedule of Benefits.

TRAVEL

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

VISION CARE

Any Medical Supply or service rendered to a Member for vision care, except as specified on the Schedule of Benefits.

WORKERS' COMPENSATION

This Plan 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 waived 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 FOR EMPLOYEE MEMBERS

When a Member's 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 Group Health Plan has rules coordinating its benefits with those of this Plan of Benefits;

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. ADDITIONAL ORDER OF DETERMINATION RULES

This Plan of Benefits coordinates Benefits using the first of the following rules that apply:

1. Dependents.

   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 Plan of the parent whose birthday falls earlier in the year (month and date) is the Primary Plan.

   b. If both parents have the same birthday, the Plan that has covered a parent longer is the Primary 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.

The “birthday rule” does not use the years of the parents’ birth in determining which has the earlier birthday.

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. Fourth, 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 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 Primary Plan except where federal law mandates that this Plan of Benefits is the Secondary 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 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.

   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 Primary Plan 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 OR ON THE DATE DETERMINED BY THE EMPLOYER:

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; or,

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;

    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:

    a. In accordance with applicable state law;

    b. If the Corporation provides notice to the Department of Insurance and to the affected Employer and Members of such discontinuation at least one hundred eighty (180) days prior to the date of the discontinuation of such coverage;

    c. If 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,

    d. If the Corporation will not issue any group health insurance coverage in the market during the five (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 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;

2. A period of three hundred sixty-five (365) days from the date of termination of this coverage,

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 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 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.

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 for 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, legal 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 COBRA Administrator no later than thirty (30) days after the date the Member loses coverage due to a COBRA event. The COBRA Administrator 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 (TAA) created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of a percentage of the Premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer 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 is also available at www.doleta.gov/tradeact/.

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 generally 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 a 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 (60) 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 sixty (60) days of the determination of disability and before the end of the first eighteen (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 legally 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. This does not apply to any Employees or their Dependents if the Employee voluntarily quit work. See Article VII(B)(2)(g)(ii) of this section for coverage for Employees who voluntarily quit.

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 Employer 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 Article VII(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 otherwise 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 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

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

A. SUBROGATION

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.

B. REIMBURSEMENT

In the event Benefits are provided to or on behalf of the Member under the terms of this Plan of Benefits, the Member agrees, as a condition of receiving Benefits, to reimburse the Corporation for Benefits paid relating to an injury caused by an act or omission of a liable third party when the Member receives a settlement, judgment, or other payment relating to the injury from another person, firm, corporation, organization or business entity. However, under no circumstances will the amount of reimbursement exceed the amount of the Member's recovery.

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.

C. GENERAL PROVISIONS

The Corporation's subrogation/reimbursement rights apply to any judgment and/or settlement proceeds received by the Member from or on behalf of the liable third party.

The Corporation's subrogation/reimbursement interest extends to all Benefits paid or payable 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.

As a condition of receiving Benefits, the Member must:

1. Immediately notify the Corporation of an injury for which another party may be liable, legally responsible, or otherwise makes a payment in connection with the injuries;

2. Execute and deliver an accident questionnaire within one hundred eighty (180) days of the accident questionnaire being mailed to the Member;

3. Deliver to the Corporation a copy of the police report, incident or accident report, or any other reports issued as a result of the injuries within ninety (90) days of being requested to do so;

4. Authorize the Corporation to sue, compromise and settle in the Member's name to the extent of the amount of medical or other Benefits paid for the injuries under the Plan and the expenses incurred by the Corporation in collecting this amount, and assign to the Corporation the Member's rights to recovery when this provision applies;

5. Include the Benefits paid by the Corporation as a part of the damages sought against a liable third party and/or liability insurance company. Immediately reimburse the Corporation, out of any recovery made from a liable third party, the amount of medical Benefits paid for the injuries by the Corporation up to the amount of the recovery;

6. Immediately notify the Corporation in writing of any proposed settlement and obtain the Corporation's written consent before signing any release or agreeing to any settlement; and,

7. Cooperate fully with the Corporation in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Corporation.

The Corporation will pay reasonable attorney's fees and costs from the amount recovered.

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.

ARTICLE IX - WORKERS' COMPENSATION PROVISION

This Plan 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 waived 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.

Although treatment for work-related or alleged work-related injuries or illness is excluded under this Plan of Benefits, the Corporation may, in its discretion, agree to extend Benefits to a Member for the injury or illness. In this instance, the Member agrees, as a condition of receiving Benefits, to reimburse the Corporation in full from any workers' compensation recovery as described herein.

As a condition of receiving Benefits, the Member must:

1. Immediately notify the Corporation of an injury or illness for which his/her Employer and/or Employers' Workers' Compensation carrier may be liable, legally responsible, or otherwise makes a payment in connection with the injuries or illness;

2. Execute and deliver an accident questionnaire within one hundred eighty (180) days of the accident questionnaire being mailed to the Member;

3. Deliver to the Corporation a copy of the police report, incident or accident report, or any other reports issued as a result of the injury or illness within ninety (90) days of being requested to do so;

4. Assert a claim or lawsuit against the Employer and/or Employer's Workers' Compensation carrier or any other insurance coverage to which the Member may be entitled;

5. Include the Benefits paid by the Corporation as a part of the damages sought against his/her Employer and/or Employer's Workers' Compensation carrier;

6. Immediately notify the Corporation in writing of any proposed settlement and obtain the Corporation's written consent before signing any release or agreeing to any settlement; and,

7. Cooperate fully with the Corporation in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Corporation.

The Corporation has discretion to determine whether claims for Benefits submitted to the Corporation are related to the injuries or illness to the extent this provision applies. If the Corporation pays Benefits for an injury or illness and the Corporation determines the Member also received a recovery from the Employer and/or Employer's Workers' Compensation carrier by means of a settlement, judgment, or other payment for the same injury or illness, the Member shall reimburse the Corporation from the recovery for all Benefits paid by the Corporation relating to the injury or illness. However, under no circumstances shall the Member's reimbursement to the Corporation exceed the amount of such recovery.

If the Member receives a recovery from the Employer and/or Employer's Workers' Compensation carrier, the Corporation's right of reimbursement from the recovery will be applied even if: liability is denied, disputed, or is 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, Employer or the Workers' Compensation carrier; or, the medical or health care benefits are specifically excluded from the settlement or compromise.

ARTICLE X – ERISA RIGHTS

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

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.

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. No one, including the Employer, may fire or otherwise discriminate against a Member in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA.

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 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 two hundred twenty-five (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 two hundred twenty-five (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, in a culturally and linguistically appropriate manner, that will:

      i. Include information sufficient to identify the claim involved (including date of service, health care Provider, claim amount (if applicable) and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings;

      ii. State the specific reason(s) for the Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the standard (if any) that was used in denying the claim;

      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 Member's claim;

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

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

      vi. 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;

      vii. 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);

      viii. 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);

      ix. 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);

      x. Provide a description of available internal appeals and external review processes, including information regarding how to initiate such appeals;

      xi. Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under section 2793 of the Public Health Service Act, to assist individuals with the internal claims and appeals and external review processes; and,

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

   b. The Member will be provided, as soon as practicable upon request, the diagnosis and treatment codes and their corresponding meanings, associated with the Adverse Benefit Determination.

c. No decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual will be made based upon the likelihood that the individual will support the denial of Benefits.

d. 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. The Member must raise all issues and grounds for appealing an Adverse Benefit Determination at every stage of the appeals process, or such issues and grounds will be deemed permanently waived.

4. 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.

5. 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.

6. 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, in a culturally and linguistically appropriate manner, that will:

i. Include information sufficient to identify the claim involved (including date of service, health care Provider, claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings;

ii. State specific reason(s) for the Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the standard (if any) that was used in denying the claim and a discussion of the decision;

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

iv. 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;

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

vi. 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);

vii. 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);

viii. Provide a description of available internal appeals and external review processes, including information regarding how to initiate such appeals;

ix. Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under section 2793 of the Public Health Service Act, to assist individuals with the internal claims and appeals and external review processes; and,

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

b. The Member will also receive, free of charge, any new or additional evidence considered, relied upon, or generated in connection with the claim. This evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Benefit Determination is received, to give the Member a reasonable opportunity to respond prior to that date.

c. If the Adverse Benefit Determination is based on a new or additional rationale, then the Member will be provided with the rationale, free of charge. The rationale will be provided as soon as possible and sufficiently in advance of the date of the Adverse Benefit Determination to give the Member a reasonable opportunity to respond prior to that date.

d. The Member will be provided, as soon as practicable upon request, the diagnosis and treatment codes and their corresponding meanings, associated with the Adverse Benefit Determination.

e. No decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual will be made based upon the likelihood that the individual will support the denial of Benefits.

f. A Member's claim and appeals will be decided pursuant to a good faith interpretation of the Plan of Benefits, in the best interest of the Member, without taking into account either the amount of the Benefits that will be paid to the Member or the financial impact on the Plan.

g. 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 (DOI) 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:

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

   ii. 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 Provider 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. The independent review organization will notify the Member and the Corporation immediately upon making the decision.

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 Preauthorization 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

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.

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.

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.

DISCLOSURE TO EMPLOYER

The Employer's Group Health Plan will disclose (or will require BlueCross to disclose) Member's PHI 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 A and B of this section.

A. Restrictions on Employer's Use and Disclosure of PHI.

1. The Employer will neither use nor further disclose Member's PHI, except as permitted or required by the Plan Documents, as amended, or required by law.

2. The Employer will ensure that any agent, including any subcontractor, to whom it provides Member PHI agrees to the restrictions and conditions of this Plan of Benefits, with respect to Member's PHI.

3. The Employer will not use or disclose Member PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer.

4. The Employer will report Employer's Group Health Plan any use or disclosure of Member PHI that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.

5. The Employer will make PHI available to the Member who is the subject of the information in accordance with HIPAA.

6. The Employer will make Member PHI available for amendment, and will on notice amend Member PHI, in accordance with HIPAA.

7. The Employer will track disclosures it may make of Member PHI 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.

8. The Employer will make its internal practices, books, and records, relating to its use and disclosure of Member PHI, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with HIPAA.

9. The Employer will, if feasible, return or destroy all Member PHI, 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 PHI, when the Member's PHI 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 PHI, the Employer will limit the use or disclosure of any Member PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

10. The Employer will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that Employer creates, receives, maintains, or transmits on behalf of the Employer's Group Health Plan.

11. The Employer will ensure that any agent, including a subcontractor, to whom Employer provides ePHI (that Employer creates, receives, maintains, or transmits on behalf of the Employer's Group Health Plan), agrees to implement reasonable and appropriate security measures to protect this information.

12. The Employer shall report any security incident of which it becomes aware to the Employer's Group Health Plan as provided below.

    a. In determining how and how often Employer shall report security incidents to Employer's Group Health Plan, both the Employer and the Employer's Group Health Plan agree that unsuccessful attempts at unauthorized access or system interference occur frequently and that there is no significant benefit for data security from requiring the documentation and reporting of such unsuccessful intrusion attempts. In addition, both parties agree that the cost of documenting and reporting such unsuccessful attempts as they occur outweigh any potential benefit gained from reporting them. Consequently, both the Employer and the Employer's Group Health Plan agree that this Contract shall constitute the documentation, notice and written report of any such unsuccessful attempts at unauthorized access or system interference as required above and by 45 C.F.R. Part 164, Subpart C and that no further notice or report of such attempts will be required. By way of example (and not limitation in any way), the Parties consider the following to be illustrative (but not exhaustive) of unsuccessful security incidents when they do not result in unauthorized access, use, disclosure, modification, or destruction of ePHI or interference with an information system:

        i. Pings on a Party's firewall,

        ii. Port scans,

        iii. Attempts to log on to a system or enter a database with an invalid password or username,

        iv. Denial-of-service attacks that do not result in a server being taken off-line, and,

        v. Malware (e.g., worms, viruses)

    b. The Employer shall, however, separately report to the Employer's Group Health Plan any successful unauthorized access, use, disclosure, modification, or destruction of the Employer's Group Health Plan's ePHI of which the Employer becomes aware if such security incident either (a) results in a breach of confidentiality; (b) results in a breach of integrity but only if such breach results in a significant, unauthorized alteration or destruction of the Employer's Group Health Plan's ePHI; or (c) results in a breach of availability of the Employer's Group Health Plan's ePHI, but only if said breach results in a significant interruption to normal business operations. Such reports will be provided in writing within ten (10) business days after the Employer becomes aware of the impact of such security incident upon the Employer's Group Health Plan's ePHI.

B. Adequate Separation Between the Employer and the Employer's Group Health Plan.

    1. Only Employees or other workforce members under the control of Employer ("Employees") who, in the normal course of their duties, assist in the administration of the Employer's Employee Benefits or the Employer's Group Health Plan or the Employer's Group Health Plan finances, or other classes of Employees as designated in writing by the Employer may be given access to Member PHI received from the Employer's Group Health Plan or third party servicing the Employer's Group Health Plan.

    2. These Employees will have access to Member PHI only to perform the plan administration functions that the Employer provides for the Employer's Group Health Plan or to assist Members.

3. 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 PHI 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 PHI may have been compromised by the breach, violation or noncompliance.

4. The Employer will ensure that the separation required by the above provisions will be supported by reasonable and appropriate security measures.

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 applicable federal law. If and to the extent that 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 Provider'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 registered or certified mail, postage paid, return receipt requested or nationally recognized overnight carrier 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 Member upon receipt of due proof of loss when a Non-Participating Provider renders services. When payment is made directly to the Member, the Member is responsible for any payment to the Provider. 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 Preauthorization 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.

AMENDMENT

Employer Name: McEntire Produce, Inc.
Employer Number: 25-54927-00 and appropriate subgroups
Effective Date: February 1, 2016
Amendment Number: 1

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

The following definition in **ARTICLE I - DEFINITIONS** is deleted in its entirety and the following substituted therefore:

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 prescribed by a licensed Provider acting within the scope of his or her license;

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

3. Be purchased for use outside a Hospital.

Certain Over-the-Counter Drugs may be designated as Prescription Drugs, at the discretion of the Corporation. Such designated Over-the-Counter Drugs will be listed on the PDL.

ARTICLE I - DEFINITIONS is amended by the addition of the following:

Prescription Drug List (PDL): a listing of drugs approved for a specified level of Benefits by the Corporation, under the Plan of Benefits. This list shall be developed and subject to periodic review and modification by the Corporation. The most up-to-date version of the PDL is available on the Corporation's website.

ARTICLE III – BENEFITS, SECTION E. BENEFITS is amended by the deletion and substitution of the following:

PRESCRIPTION DRUGS

1. Unless expressly excluded under Article IV, the Corporation will pay Covered Expenses for Prescription Drugs (as specified on the Schedule of Benefits) that are listed as covered on the PDL and are used to treat a condition for which Benefits are otherwise available. This may include certain Over-the-Counter Drugs designated by the Corporation as Prescription Drugs and listed as covered on the PDL. If so designated, these Over-the-Counter Drugs must be prescribed by a Provider. Any Coinsurance percentage for Prescription Drugs is based on the Allowable Charge 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.

   For more information about Prescription Drugs, please refer to the PDL which can be found on the Corporation's website. A list of drugs that are not covered by the Corporation is also on the PDL.

   In certain instances, the Corporation provides for an exception process that allows a Member or his or her designee (or the prescribing Provider) to request and obtain access, on an expedited basis, to clinically appropriate drugs that otherwise are not covered on the PDL. For more information about this exception process, please contact the Corporation at the number provided on your Identification Card.

2. If a Provider prescribes a Brand Name Drug and an equivalent Generic Drug or Over-the-Counter Drug is available and listed as covered on the PDL (whether or not the Provider indicates in the prescription that the substitution of a Generic Drug or Over-the-Counter Drug is not allowed), and the Member still requests the Brand Name Drug, then any difference between the cost of the covered Generic Drug or Over-the-Counter Drug and the higher cost of the Brand Name Drug shall be the responsibility of the Member. This will be in addition to any Copayment or Coinsurance appropriate to the Brand Name Drug being purchased. In no instance will the Member be charged more than the actual retail price of the drug.

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

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

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

OVER-THE-COUNTER DRUGS

Drugs that are available on an over-the-counter basis or are otherwise available without a prescription, except for Over-the-Counter Drugs that are designated as Prescription Drugs by the Corporation, listed as covered on the PDL accordingly and are prescribed by a Provider.

PRESCRIPTION DRUG EXCLUSIONS

- Prescription Drugs that are specifically listed on the PDL as excluded;

- Prescription Drugs that have not been prescribed by a Provider acting within the scope of his or her license;

- Drugs not approved by the FDA;

- Prescription Drugs for non-covered therapies, services, or conditions;

- Prescription Drug refills in excess of the number specified on the Provider's prescription order or Prescription Drug refills dispensed more than one (1) year after the original prescription date;

- More than a thirty-one (31) day supply for Prescription Drugs (ninety (90) day supply for Prescription Drugs obtained through a Mail Service Pharmacy), except as specified on the Schedule of Benefits;

- 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 determined by the Corporation based on the following guidelines as described in the current:

    1. United States Pharmacopeia (USP);
    2. Facts and Comparisons;
    3. Physicians' Desk Reference; and/or,
    4. National Formulary.

- Prescription Drugs used for or related to cosmetic purposes, including hair growth, and skin wrinkles, except as specified on the Schedule of Benefits;

- Prescription Drugs related to any treatment for infertility or impotence (except when prescribed for benign prostatic hypertrophy), including but not limited to, fertility drugs, except as specified on the Schedule of Benefits;

- Prescription Drugs administered or dispensed in a Provider'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;

- Over-the-Counter Drugs and over-the-counter supplies or supplements, except for Over-the-Counter Drugs that are designated by the Corporation as Prescription Drugs and are listed as covered on the PDL and are prescribed by a Provider;

- Prescription Drugs that are being prescribed for a specific medical condition that are not approved by the FDA for treatment of that condition (except for (i) Prescription Drugs for a specific medical condition that have at least two (2) formal clinical studies or (ii) 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 (1) standard, universally accepted 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 Preauthorization by the Corporation and Preauthorization 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 for obesity or weight control, contraceptives or tobacco cessation, except as specified on the Schedule of Benefits with respect to such Prescription Drugs;

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

- Prescription Drugs which are new to the market and which are under clinical review by the Corporation shall be listed on the PDL as excluded until the clinical review has been completed and a final determination has been made as to whether the drug should be covered;

- Prescription Drugs, regardless of therapeutic class, that are determined to offer no clinical or cost effective advantage over other comparable Prescription Drugs already covered under the PDL; and,

- Vitamins, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind, except for prescription prenatal vitamins or prescription vitamin B-12 injections for anemias, neuropathies or dementias secondary to a vitamin B-12 deficiency.

THIS IS AN AMENDMENT TO YOUR PRESENT PLAN OF BENEFITS.

AMENDMENT

Employer Name: McEntire Produce, Inc.
Employer Number: 25-54927-00 and appropriate subgroups
Effective Date: February 1, 2016
Amendment Number: 2

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

ARTICLE I - DEFINITIONS is amended by the deletion of **Dependent** and the following substituted therefore:

Dependent(s): an individual who is:

1. An Employee's Spouse;

2. A Domestic Partner; or,

3. A Child under the age set forth on the Schedule of Benefits.

ARTICLE I - DEFINITIONS is amended by the addition of the following:

Domestic Partner: a Dependent who:

1. Is unmarried, at least eighteen (18) years of age, mentally competent, resides with the other partner and intends to reside with the other partner for an indefinite amount of time;

2. Is not related to the other partner by adoption or blood;

3. Is the sole Domestic Partner of the other partner, with whom he/she has a close committed and personal relationship, and has been a member of this domestic partnership for the last twelve (12) months;

4. Agrees to be jointly responsible for the basic living expenses and welfare of the other partner; and;

5. Is financially interdependent. Financial interdependence is demonstrated by submission of three (3) or more of the following documents:

    a. a joint mortgage or lease;

    b. a designation of one (1) of the partners as beneficiary in the other partner's Will or life insurance policy;

    c. a durable property and health care powers of attorney;

    d. a joint title to an automobile;

    e. a joint bank account or credit account; or;

    f. such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case.

The Employee and applicant for coverage as a Domestic Partner will be required to sign an Affidavit of Domestic Partnership. The Corporation reserves the right to request documentation of any of the foregoing prior to commencing coverage of the Domestic Partner.

ARTICLE II - ELIGIBILITY FOR COVERAGE, Section B. is amended by the addition of the following:

The Employee and his/her Domestic Partner are required to complete an Affidavit of Domestic Partnership and file it with the Employer. The Employer and/or Employee will submit the affidavit with the Membership Application to the Corporation.

ARTICLE II - ELIGIBILITY FOR COVERAGE is amended by the deletion **of SECTION C. 3.** and the following substituted therefore:

3. Dependents Resulting from Marriage or Domestic Partnership

   Dependent(s) resulting from the marriage of an Employee or the creation of a domestic partnership must apply for coverage within thirty-one (31) days after marriage or domestic partnership and appropriate Premiums must be paid to the Corporation for such Dependent(s) to have coverage from the date of the marriage or domestic partnership. If a Dependent resulting from a marriage or domestic partnership is not enrolled within thirty-one (31) days after the marriage or domestic partnership, coverage will begin on the date chosen by the Employer and after the payment of the applicable Premium.

   A Domestic Partner's child, who has not been legally adopted by the Employee, must be living with the Employee and Employee's Domestic Partner on a full-time basis in a permanent parent-child relationship. In addition the child must meet the qualifications of Dependent and Child as described in the Plan of Benefits.

   The Employee and/or Employee's Domestic Partner may be required to furnish written proof of a child's eligibility for coverage as a Domestic Partner's child.

   Domestic Partners are not considered to be tax-qualified dependents by the Internal Revenue Service (IRS) unless they satisfy specific statutory requirements and the Employee declares the Domestic Partner or their children on the Employee's tax return. Therefore if the Employee elects Domestic Partner coverage, the IRS may tax the Employee for the value of Benefits provided. The Employee should consult his or her own personal tax advisor to determine how these tax implications affect the Employee.

ARTICLE VI – TERMINATION OF THIS PLAN OF BENEFITS, SECTION A. is amended by the addition of the following:

9. In addition to terminating when an Employee's coverage terminates, a Domestic Partner and the children of the Domestic Partner's coverage terminates when the domestic partnership is dissolved. An Affidavit of Termination of Partnership must be completed by the Employee and submitted to the Employer and/or the Corporation within thirty (30) days of dissolution, and the Employer must send a Membership Application to cancel this person from coverage.

   All other Plan termination of coverage provisions apply to a Domestic Partner and the children of the Domestic Partner.

THIS IS AN AMENDMENT TO YOUR PRESENT PLAN OF BENEFITS.

AMENDMENT

Employer Name: McEntire Produce, Inc.
Employer Number: 25-54927-00 and appropriate subgroups
Effective Date: February 1, 2016
Amendment Number: 3

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

ARTICLE I - DEFINITIONS is amended by the deletion of **Dependent** and the following substituted therefore**:**

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. An Incapacitated Dependent.

ARTICLE I - DEFINITIONS is amended by the addition of the following:

Spouse: Any individual who is lawfully married under any state law, including individuals married to a person of the same sex who is legally married in a state that recognizes such marriages, but who are domiciled in a state that does not recognize such marriages.

ARTICLE II - ELIGIBILITY FOR COVERAGE, paragraph D. is amended by the addition of the following:

The Employee and his/her Spouse are required to submit a marriage license and file it with the Employer. The Corporation reserves the right to request documentation of such marriage.

THIS IS AN AMENDMENT TO YOUR PRESENT PLAN OF BENEFITS.

AMENDMENT

Employer Name: McEntire Produce, Inc.
Employer Number: 25-54927-00 and appropriate subgroups
Effective Date: February 1, 2016
Amendment Number: 4

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

ARTICLE I – DEFINITIONS is amended by the addition of the following:

Accountable Care Organization (ACO): a group of healthcare Providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their Member populations.

Care Coordination: organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.

Care Coordinator: an individual within a Provider organization who facilitates Care Coordination for patients.

Care Coordinator Fee: a fixed amount paid by a Blue Cross and/or Blue Shield Licensee to Providers periodically for Care Coordination under a VBP.

Global Payment/Total Cost of Care: a payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient such as outpatient, physician, ancillary, hospital services and Prescription Drugs.

Negotiated Arrangement/Negotiated National Account Arrangement: an agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard Program.

Patient-Centered Medical Home (PCMH): a model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified physicians.

Provider Incentive: an additional amount of compensation paid to a healthcare Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.

Value-Based Shared Savings: a payment mechanism in which the Provider and payer share cost savings achieved against a target cost budget based upon agreed upon terms and may include downside risk.

Value-Based Program (VBP): a healthcare delivery model such as a patient-centered medical home (“PCMH”), accountable care organization (“ACO”), capitation arrangements or episode-based arrangements aimed at improving patient health quality and outcomes with respect to certain diseases and/or conditions. These services are facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment. The VBP is described further in this Contract and the Plan of Benefits.

ARTICLE IV – EXCLUSIONS AND LIMITATIONS is amended by the deletion first paragraph and following substituted therefore:

THE CORPORATION WILL NOT PAY ANY AMOUNT FOR THE SERVICES AND PRODUCTS LISTED IN THIS ARTICLE IV EXCEPT: (1) SERVICES ARE RENDERED BY A HEALTH CARE PROVIDER AS PART OF A VALUE-BASED PROGRAM OR (2) IF REQUIRED BY LAW.

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

I. Out-of-Area Services

Overview

The Corporation has a variety of relationships with other Blue Cross and/or Blue Shield Licensees, referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). 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 Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the geographic area the Corporation serves, Members obtain care from healthcare Providers that have a contractual agreement ("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 healthcare Providers in the Host Blue geographic area that do not have a contractual agreement ("Non-Participating Providers") with the Host Blue. The Corporation will remain responsible for fulfilling our contractual obligations to you. The Corporation's payment practices in both instances are described below.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits except when paid as medical claims/Benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party.

A. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Members access covered healthcare services within the geographic area served by a Host Blue, the Host Blue will be responsible for contracting and handling all interactions with its Participating Providers. The financial terms of the BlueCard Program are described generally below.

Liability Calculation Method Per Claim

Unless subject to a fixed dollar Copayment, the calculation of the Member liability on claims for covered healthcare services will be based on the lower of the Participating Provider's billed covered charges or the negotiated price made available to the Corporation by the Host Blue.

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's healthcare Provider contracts. The negotiated price made available to the Corporation by the Host Blue may be represented by one of the following:

(i) An actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases; or

(ii) An estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, 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 in effect at the time a claim is processed 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 determine whether or not they will use an actual, estimated or average price. Host Blues using either an estimated price or an average price may 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 or anticipated to be paid to Providers or refunds received or anticipated to be received from Providers). However, the BlueCard Program requires that the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by the Corporation in determining your Premiums.

C. Special Cases: Value-Based Programs

BlueCard Program

The Corporation has included a factor for bulk distributions from Host Blues in the Employer's Premium for Value-Based Programs when applicable under this contract.

If the Member receives covered healthcare services under a Value-Based Program inside a Host Blue's service area, the Member will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to the Corporation through average pricing or fee schedule adjustments.

D. Return of Overpayments

Recoveries of overpayments/from a Host Blue or its Participating and Non-Participating Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits/healthcare Provider/hospital bill audits, credit balance audits, utilization review refunds and unsolicited refunds. Recoveries will be applied/ so that corrections will be made, in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to the Corporation, they will be credited to the Employer account. 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 charged to the Employer as a percentage of the recovery.

E. Inter-Plan Programs: Taxes/Surcharges/Fees

In some instances laws or regulations may impose a surcharge, tax or other fee that applies to insured accounts. If applicable, the Corporation will include any such surcharge, tax or other fee in determining the Employer's Premium.

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

1. Member Liability Calculation

When covered healthcare services are provided outside of the Corporation's service area by Non-Participating Providers, the amount(s) a Member pays for such services will generally be based on either the Host Blue's Non-Participating Provider local payment or the pricing arrangements required by applicable law. In these situations, the Member may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment the Corporation will make for the covered services as set forth in this paragraph. Payments for out-of-network emergency services are governed by applicable law.

2. Exceptions

In some exception cases, the Corporation may pay claims from Non-Participating Providers outside of the Corporation's service area based on the Provider's billed charge. This may occur in situations where a Member did not have reasonable access to a Participating Provider, as determined by the Corporation in the Corporation's sole and absolute discretion or by applicable law. In other exception cases, the Corporation may pay such claims based on the payment the Corporation would make if the Corporation were paying a Non-Participating Provider inside of the Corporation's service area. This may occur where the Host Blue's corresponding payment would be more than the Corporation's in-service area Non-Participating Provider payment. The Corporation may choose to negotiate a payment with such a Provider on an exception basis.

Unless otherwise stated, in any of these exception situations, the Member may be responsible for the difference between the amount that the Non-Participating Provider bills and payment the Corporation will make for the covered services as set forth in this paragraph.

G. BlueCard Worldwide® Program

- **General Information**

If Members are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard service area"), they may be able to take advantage of the BlueCard Worldwide Program when accessing covered healthcare services. The BlueCard Worldwide Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the BlueCard Worldwide Program assists Members with accessing a network of inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when Members receive care from Providers outside the BlueCard service area, the Members will typically have to pay the Providers and submit the claims themselves to obtain reimbursement for these services.

- **Inpatient Services**

In most cases, if Members contact the BlueCard Worldwide Service Center for assistance, hospitals will not require Members to pay for covered inpatient services, except for their cost-share amounts/Benefit Year Deductibles, Coinsurance, etc. In such cases, the hospital will submit Member claims to the BlueCard Worldwide Service Center to initiate claims processing. However, if the Member paid in full at the time of service, the Member must submit a claim to obtain reimbursement for covered healthcare services.

- **Outpatient Services**

Physicians, urgent care centers and other outpatient Providers located outside the BlueCard service area will typically require Members to pay in full at the time of service. Members must submit a claim to obtain reimbursement for covered healthcare services.

- **Submitting a BlueCard Worldwide Claim**

When Members pay for covered healthcare services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Members should complete a BlueCard Worldwide International claim form and send the claim form with the Provider's itemized bill(s) to the BlueCard Worldwide Service Center address on the form to initiate claims processing. The claim form is available from the Corporation, the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com. If Members need assistance with their claim submissions, they should call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

THIS IS AN AMENDMENT TO YOUR PRESENT PLAN OF BENEFITS.

South Carolina