Nelson Mullins Riley & Scarborough LLP

HDHP SINGLE PLAN

Preferred Provider

January 1, 2026

PREFERRED PROVIDER

PLAN OF BENEFITS

Dear Member:

Blue Cross and Blue Shield of South Carolina (BlueCross) is pleased to provide administrative services for your Group Health Plan as outlined in this Preferred Provider Plan of Benefits. BlueCross provides you and your covered family members with cost-effective health care coverage administration 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 Blue Cross and Blue Shield 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 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 administration needs.

Blue Cross® and Blue Shield® of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association.

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 access your Member ID card digitally or order a replacement? Need to check the status of a claim or submit claim forms? Need to print an Explanation of Benefits (EOB)?***

You also can use such self-help tools as:

View the status of your eligibility, deductible, out-of-pocket and any healthcare account balances.

Shopping for Care 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.

With **Shopping for Care**, you can find health care Providers and services within our vast Provider network, check out cost information (where available) to make sure you're getting the care you need at the best possible price and see reviews from other patients who have rated a Provider you're considering. You can also identify Blue Distinction® Specialty Care facilities and Hospitals.

Our **Shopping for Care** feature also includes cost estimates to help you find the right care at the right price. Estimates help you avoid surprises when the bills come as costs for a medical procedure – like an ultrasound, a checkup, X-rays or joint replacement – can vary by hundreds of dollars. From My Health Toolkit®, under the Providers & Services tab, click Find Care. As you explore the Find Care categories further, you'll see a Cost Estimates tab that's loaded with price information about hundreds of procedures, from mammograms and MRIs to allergy testing, sleep studies, physical therapy and various types of surgery.

The **Personal Health Assessment (PHA)** is a confidential online survey that can help you identify your personal risk factors while guiding you toward healthier lifestyle choices. Best of all, there's no cost to you! Once you've completed the survey, you'll get your PHA wellness score right away. You can use the wellness score as a baseline for evaluating and improving your health. The assessment also gives tips for lowering risk factors. You can print your report or refer back to it online as long as you keep your coverage.

On the go? The My Health Toolkit® mobile app is available in both the App Store and Google Play. With your personal account, you can:

- Check the status of your claims
- View and share your digital ID card
- Confirm your coverage for services
- Find a Provider or Hospital in your network
- View your healthcare spending account balances, if applicable
- View your Summaries of Benefits and Coverage (SBCs)
- Access health and wellness programs available to you through your plan, including mental and behavioral health support.

Scan the below QR code with your smartphone camera for quick access to our Member website.

IMPORTANT INFORMATION ABOUT YOUR HEALTH COVERAGE

Under this Plan of Benefits, 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 may increase when you do not use Participating Providers and if you do not get Preauthorization.

Members of the Blue Cross and Blue Shield Association (BCBSA) 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 may have no protection from balance billing from the Provider, except where prohibited by applicable law.

HOW TO GET HELP

How to get help with claims or Benefit questions:

- Dial 855-270-0509

How to get help on Preauthorization:

- 803-736-5990 from the Columbia, South Carolina area
- 800-327-3238 from all other South Carolina locations
- 800-334-7287 from outside South Carolina

Please do not call these numbers for claims inquiries.

Please note that Preauthorization is required for certain procedures. Please contact your Provider for additional information.

How to get Preauthorization for inpatient Mental Health Services and Substance Use Disorder Services:

- 803-699-7308 from the Columbia, South Carolina area
- 800-868-1032 from all other areas

For assistance outside the United States:

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

Blue CareOnDemand℠ powered by MDLIVE:
Your Employer provides you with access to ***Blue CareOnDemand***, a Telehealth service. Blue CareOnDemand is powered by MDLIVE. MDLIVE is an independent company that provides Telehealth hosting and software services on behalf of BlueCross. Blue CareOnDemand licensed health care professionals can provide services for primary care, urgent care, common health issues and other specialties. We encourage Members to use the convenience of Blue CareOnDemand for treating unexpected, non-Emergency health issues. Members can use Blue CareOnDemand to seek treatment from U.S. licensed health care professionals twenty-four (24) hours per day, seven (7) days per week and three hundred sixty-five (365) days per year through the convenience of video, phone, or asynchronous consultation.

There are two (2) ways for Members to register and create their patient profiles:

1. Download the "My Health Toolkit®" mobile app from App Store or Google Play. Select *Find Care,* then *Video Visit*.

2. Visit www.SouthCarolinaBlues.com and log in to My HealthToolkit®.Select *Providers & Services*, from the top navigation, then select *Telehealth*, then select *Launch a Visit*.

Once registered, Members can log in to the mobile app or website as needed and consult with doctors through video visits.

Connect Your Way:
Occasional communications from your health plan can help you stay healthy, save money and make the most of your Benefits. Just let us know the best way to reach you – through email, text or push notifications. We'll notify you when it's time for your annual checkup, for example, or if there's an update on a prior authorization request. Updating your contact preferences is easy. Simply log in to My Health Toolkit® from your computer, then on the Profile dropdown in the top navigation, select *Contact Preferences* to update your preferred contact method for each category. You can also update your preferences through the app by logging in and visiting the *My Profile* section.

Essential Advocate:
Your Employer provides you and your Dependents with access to ***Essential Advocate***, a program that includes access to a Care Coordinator and Registered Nurse, plus the unique service of our health advocacy program tailored to bridge the gap between care and Benefits, Provider and patient, and Hospital and home. Members will experience personal support and receive individualized assistance provided by experienced healthcare and Benefit experts. The health advocates assist Members with:

- Identifying and coordinating a range of wellness services.
- Using online tools for treatment options and cost estimates.
- Educating Members on health plan Benefits and how they work.
- Assistance in negotiating fees with healthcare Providers to lower the Member's out-of-pocket costs.
- Providing advice or assistance to Members when filing a complaint or grievance.
- Preparing Members and family members for medical appointments.
- Arranging transportation relating to medical needs.
- Navigating the BlueCross website, including cost estimator and quality tools.
- And much more.

Call 855-638-5839 to speak with a Care Coordinator, Registered Nurse or Health Advocate.

Health Coaching – Chronic Condition:
Your Employer provides you with access to ***Health Coaching – Chronic Condition***, a program designed to help Members with the following conditions live healthier lives:

- Anxiety disorder
- 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 healthcare 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 855-838-5897.

My Health Novel:
If you wish to make healthy lifestyle changes and need assistance in managing your health goals, log onto My Health Toolkit to complete a brief one (1) minute assessment. Members will be matched to programs based on their risk factors, interests and preferred method of participation (i.e., in person or on-line).

Personal Health Assessment:
Your Employer provides you with access to ***PHA***, an online health risk assessment that allows Members to evaluate their wellness potential and receive instant feedback with suggestions for healthy lifestyle changes. To access ***PHA***, login to My Health Toolkit.

HOW TO FILE CLAIMS

Participating Providers have agreed to file claims for healthcare 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. 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.

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. You can also 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: 71-53478-25, 26, 35, 36, 41 and 42
Employer: Nelson Mullins Riley & Scarborough LLP
HDHP Single Plan
Plan of Benefits Effective Date: January 1, 2026

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

GENERAL PROVISIONS

When a Benefit is listed below and has a dollar or percentage amount associated with it then 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 the Plan of Benefits will commence on the date of employment if enrolled on or before that date, otherwise on the date enrolled. Employees must enroll within thirty (30) days from date of hire.
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). Coverage remains in effect until the end of the month
Actively at Work: **Minimum hours per week:** **Minimum weeks per year:**	 At least thirty (30) hours per week. No minimum weeks per year requirement.
Benefit Year Deductible:	$2,500 per Member for Participating Providers (includes Non-Participating Providers of air ambulance services, Emergency Services, and non-Emergency Services furnished at certain Participating Provider facilities). $6,000 per Member 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 for Participating Providers (generally includes Non-Participating Providers of air ambulance services, Emergency Services, and non-Emergency Services furnished at certain Participating Provider facilities):	$5,000 per Member. All 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 and Benefit Year Deductibles which apply to the Participating Provider Out-of-Pocket Maximum shall also contribute to the Non-Participating Provider Out-of-Pocket Maximum.
Out-of-Pocket Maximums for Non-Participating Providers:	$10,000 per Member. Expenses paid towards the following do not contribute to the Out-of-Pocket Maximum determination: • Copayments 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 and Benefit Year Deductibles which apply to the Non-Participating Provider Out-of-Pocket Maximum shall only contribute to the Participating Provider Out-of-Pocket Maximum.
Benefit Year Deductibles 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 01/01.	

PREAUTHORIZATION

Any questions about Preauthorization should be directed to either your Provider or to the Claims Administrator at the number on the back of your Identification Card.

Preauthorization is required for the following services:

- All facility Admissions for non-emergent medical and behavioral health services
- Ambulance services (non-emergency)
- Cleft lip and palate
- Dental care for accidental injury (Preauthorization is required for the treatment plan and subsequent visits)
- Rental of Durable Medical Equipment
- Purchase of Durable Medical Equipment over $500
- Home Health Care
- Hospice Care
- Interdisciplinary pain management program
- Orthopedic devices
- Orthotic devices
- Outpatient Services
  - Any surgical procedure that may be potentially cosmetic: i.e., blepharoplasty, reduction mammoplasty
  - Cancer chemotherapy (initial notification)
  - Hysterectomy
  - Investigational procedures
  - Radiation therapy (initial notification)
  - Sclerotherapy
  - Septoplasty
- Oxygen

Please refer to the Claims Administrator's website for a complete list of Prescription Drugs and Specialty Drugs that require Preauthorization.

The penalties for not obtaining preauthorization, when required, are as follows:

Denial of room and board charges:

- All facility Admissions for non-emergent medical and behavioral health services

Denial of all charges:

- DME purchase of $500 or more
- Home Health Care
- Hospice Care (see facility Admissions for inpatient Hospice Care by a Participating Provider)

Reduction of Benefits:

- Outpatient services, reduced by 50% of the Allowable Charge
- Psychological testing performed in the office, reduced by 50% of the Allowable Charge
- rTMS performed in the office, reduced by 50% of the Allowable Charge

ADMISSIONS/INPATIENT BENEFITS The below include services for medical, mental health and substance use disorders			
	Participating Provider	**Non-Participating Provider at a Participating Provider facility** **(unless the Provider satisfies advance patient notice and consent requirements)**	**Non-Participating Provider at a Non-Participating Provider facility** **(or at a Participating Provider facility if advance patient notice and consent requirements are met)**
Inpatient Hospital charges during an Admission (non-emergency)	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible	The Plan pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Hospital Admission resulting from an emergency room visit	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible	The Plan pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	**Non-Participating Provider**
Inpatient physical rehabilitation services when Preauthorized by the Claims Administrator and performed by a Provider designated by the Claims Administrator	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Skilled Nursing Facility Admissions (limited to one hundred (100) days per Member per Benefit Year) and Residential Treatment Center Admissions	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

OUTPATIENT BENEFITS The below include services for medical, mental health and substance use disorders			
	Participating Provider	**Non-Participating Provider at a Participating Provider facility** **(unless the Provider satisfies advance patient notice and consent requirements)**	**Non-Participating Provider at a Non-Participating Provider facility** **(or at a Participating Provider facility if advance patient notice and consent requirements are met)**
Outpatient Hospital services (non-emergency)	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible	The Plan pays 60% 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**
Lab, X-ray and other diagnostic services	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Outpatient emergency room services	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible

	Participating Provider	Non-Participating Provider
Urgent care	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Surgery	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	For certain surgeries performed by a Non-Participating Provider at certain Participating Provider facilities (unless the Provider satisfies advance patient notice and consent requirements): The Plan pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member generally pays the remaining 10% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible For all other surgeries: The Plan pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Maternity	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 60% 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 physical therapy and occupational therapy	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 90% 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
Habilitation and rehabilitation related to speech therapy Habilitative speech therapy (other than approved ABA therapy for Autism Spectrum Disorder) is limited to Members age six (6) and younger	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

PROVIDER SERVICES The below include services for medical, mental health and substance use disorders			
	Participating Provider	**Non-Participating Provider at a Participating Provider facility** **(unless the Provider satisfies advance patient notice and consent requirements)**	**Non-Participating Provider at a Non-Participating Provider facility** **(or at a Participating Provider facility if advance patient notice and consent requirements are met)**
Inpatient Provider Services for an Admission resulting from an emergency room visit	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible	The Plan pays 60% 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**
Inpatient Provider Services (non-emergency)	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	For certain Inpatient Provider Services performed by a Non-Participating Provider at certain Participating Provider facilities (unless the Provider satisfies advance patient notice and consent requirements): The Plan pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member generally pays the remaining 10% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible For all other Inpatient Provider Services: The Plan pays 60% 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
Surgical Services, when rendered in a Hospital, Provider's office or Ambulatory Surgical Center (non-emergency)	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	For certain Surgical Services performed by a Non-Participating Provider at certain Participating Provider facilities (unless the Provider satisfies advance patient notice and consent requirements): The Plan pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member generally pays the remaining 10% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible For all other Surgical Services: The Plan pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Outpatient Provider Services for lab, X-ray and other diagnostic services	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider Services for lab, X-ray and other diagnostic services performed at an independent laboratory facility	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 60% 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
Provider Services for treatment in a Hospital outpatient department or Ambulatory Surgical Center	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	For certain Provider Services performed by a Non-Participating Provider at certain Participating Provider facilities (unless the Provider satisfies advance patient notice and consent requirements): The Plan pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member generally pays the remaining 10% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible For all other Provider Services for treatment in a Hospital outpatient department or Ambulatory Surgical Center: The Plan pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider Services for an outpatient emergency room visit	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible
Provider Services for habilitation and rehabilitation related to physical therapy and occupational therapy	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 90% 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
Provider Services for habilitation and rehabilitation related to speech therapy Habilitative speech therapy (other than approved ABA therapy for Autism Spectrum Disorder) is limited to Members age six (6) and younger	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider's Services in the office, including contraceptives and birth control devices*	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Habilitation and rehabilitation in a Provider's office related to physical therapy and occupational therapy	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Habilitation and rehabilitation in a Provider's office related to speech therapy Habilitative speech therapy (other than approved ABA therapy for Autism Spectrum Disorder) is limited to Members age six (6) and younger	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Blue CareOnDemand general medicine/urgent care	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	Non-Covered

	Participating Provider	Non-Participating Provider
Blue CareOnDemand behavioral health/mental health	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	Non-Covered

*Contraceptives and birth control devices covered under the Affordable Care Act (ACA) will pay at 100% of the Allowable Charge at Participating Providers. No Benefits are payable at Non-Participating Providers.

OTHER SERVICES			
	Blue Distinction® Center or Blue Distinction® Center+	**Participating Provider**	**Non-Participating Provider**
Human organ and tissue transplant services Provider charges are subject to the Benefit Year Deductible	The Plan pays 100% of the Allowable Charge after the Benefit Year Deductible	The Plan pays 100% of the Allowable Charge after the Benefit Year Deductible	Non-Covered

	Participating Provider	**Non-Participating Provider**
Travel and lodging for covered human organ and tissue transplant services for recipients and their family members* Expenses for travel and lodging are not associated with any network. Therefore, any expenses which meet the criteria for coverage will be paid at the payment level provided	The Plan pays 100% of the Allowable Charge	
Air ambulance service	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible
Ground ambulance service	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 90% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Durable Medical Equipment, Prosthetics and Orthopedic Devices	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Wigs	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Hearing aids for children up to age nineteen (19), limited to $4,000 per Member every thirty-six (36) months	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Cochlear implants	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Medical Supplies	Covered	Covered
Home Health Care	The Plan pays 100% of the Allowable Charge after the Benefit Year Deductible	The Plan pays 100% 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
Private Duty Nursing, limited to fifty (50) visits per Member per Benefit Year	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Hospice Care	The Plan pays 100% of the Allowable Charge after the Benefit Year Deductible	The Plan pays 100% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
ABA related to Autism Spectrum Disorder	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	Non-Covered
Chiropractic services, limited to fifty (50) visits per Member per Benefit Year	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Oxygen	Covered	Covered
Temporomandibular Joint Disorder (TMJ) including treatment, limited to fifty (50) visits per Member per Benefit Year	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Clinical Trials	Covered	Covered

	Participating Provider	Non-Participating Provider
Oral surgeons	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Radiation therapy, respiratory therapy, cancer chemotherapy and renal dialysis	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Anesthesia	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 10% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan pays 90% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

*Limited Benefits are available if the services are provided at a Blue Distinction® Center or Blue Distinction® Center+, a participating transplant facility, or in the case of a kidney transplant, at a facility which has an agreement with Blue Cross and Blue Shield of South Carolina. Two (2) family Members are reimbursable when the patient is a Child. Benefits are limited to 100% up to $200 per day for combined lodging and meals. Actual receipts are required.

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

	Participating Provider	Non-Participating Provider
Preventive Benefits under the Affordable Care Act (ACA) (Refer to www.healthcare.gov for guidelines)	Covered	Non-Covered

SUSTAINED HEALTH SERVICES

This Benefit does not include preventive Benefits offered under the Affordable Care Act (ACA). Payment will be made for the ACA preventive Benefits prior to Sustained Health services. See the preventive Benefits section in this Schedule of Benefits for payment of preventive Benefits under the ACA.

	Participating Provider	Non-Participating Provider
Pap smear screenings (the report and interpretation only), limited to one (1) per Member per Benefit Year	The Plan pays 100% of the Allowable Charge	Non-Covered
Physical exam, limited to one (1) per Member per Benefit Year	The Plan pays 100% of the Allowable Charge	Non-Covered
Prostate screenings, limited to one (1) per Member per Benefit Year	The Plan pays 100% of the Allowable Charge	Non-Covered
Well Child Care performed in the Provider's office, including immunizations, for Dependents	The Plan pays 100% of the Allowable Charge	Non-Covered
Immunizations	The Plan pays 100% of the Allowable Charge	Non-Covered
Flu shots, including Flu Mist	The Plan pays 100% of the Allowable Charge	Non-Covered
Routine bone density screenings	The Plan pays 100% of the Allowable Charge	Non-Covered
Routine colonoscopies	The Plan pays 100% of the Allowable Charge	Non-Covered
Gynecological exam, limited to two (2) per Member per Benefit Year	The Plan pays 100% of the Allowable Charge	Non-Covered

	Participating Provider	Non-Participating Provider
Mammography screenings (limited to one (1) baseline for any female Member between age thirty-five (35) and thirty-nine (39) and one (1) per Benefit Year for any female Member age forty (40) or older)	The Plan pays 100% of the Allowable Charge	Non-Covered

PRESCRIPTION DRUG BENEFIT

Prescription Drug coverage is handled by Optum Rx, an independent company that provides pharmacy Benefits on behalf of BlueCross.

Prescription Drugs	**Mail Service/Home Delivery Pharmacy**	**Participating Pharmacy**	**All Other Pharmacies**
Generic Drugs*, including sexual dysfunction Prescription Drugs	The Member pays 10% of the Allowable Charge for each prescription or refill after the medical Benefit Year Deductible, up to a 90 day supply	The Member pays 10% of the Allowable Charge for each prescription or refill after the medical Benefit Year Deductible, up to a 30 day supply	The Member will be responsible for 100% of the Allowable Charge at the pharmacy then will be reimbursed at 60% per Member for each prescription or refill after the medical Benefit Year Deductible, up to a 30 day supply
Brand Name Drugs*, including Specialty Drugs when filled at a Participating Pharmacy and sexual dysfunction Prescription Drugs Members are encouraged to utilize Generic Drugs when available and may be subject to a penalty if not	The Member pays 10% of the Allowable Charge for each prescription or refill after the medical Benefit Year Deductible, up to a 90 day supply	The Member pays 10% of the Allowable Charge for each prescription or refill after the medical Benefit Year Deductible, up to a 30 day supply	The Member will be responsible for 100% of the Allowable Charge at the pharmacy then will be reimbursed at 60% per Member for each prescription or refill after the medical Benefit Year Deductible, up to a 30 day supply

Prescription Drugs	Mail Service/Home Delivery Pharmacy	Participating Pharmacy	All Other Pharmacies
Contraceptives: oral contraceptives, cervical cap, condoms, diaphragms, digital contraception, Emergency contraception, implantable rod, intrauterine device (IUD), patch, shot/injection, spermicide, sponge, vaginal contraceptive ring and approved sterilization procedures for women A complete list of specific Prescription Drugs or supplies covered at 100% is available at www.SouthCarolinaBlues.com The above contraceptives are covered under the participating medical Benefits at the same payment levels. Refill quantities may vary.	Prescription Drugs will be covered at 100%, up to a 90 day supply	Prescription Drugs will be covered at 100%, up to a 30 day supply	The Member will be responsible for 100% of the Allowable Charge at the pharmacy then will be reimbursed at 100%, up to a 30 day supply
All other contraceptives (Prescription Drugs) All other contraceptives are paid at the Generic and Brand Name Drug payment levels	Covered	Covered	Covered
Tobacco cessation Prescription Drugs	Covered	Covered	Covered
Prescription Drug deductible	$0 (No Prescription Drug deductible)	$0 (No Prescription Drug deductible)	$0 (No Prescription Drug deductible)

Prescription Drugs	Mail Service/Home Delivery Pharmacy	Participating Pharmacy	All Other Pharmacies
Prescription Drug Out-of-Pocket Maximum	$0 (No Prescription Drug Out-of-Pocket Maximum)	$0 (No Prescription Drug Out-of-Pocket Maximum)	$0 (No Prescription Drug Out-of-Pocket Maximum)
Diabetic syringes and supplies A separate Prescription Drug Copayment applies for each supply purchase	Covered	Covered	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
*Including preventive drugs.			

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ARTICLE I - DEFINITIONS

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

ACA: the Affordable Care Act of 2010, as amended.

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.

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 layoff. 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.

Administrative Expense Allowance (AEA) Fee: the AEA Fee is a fixed per-claim dollar amount charged by the Host Blue to Claims Administrator for administrative services the Host Blue provides in processing claims for the Employer's Members. The dollar amount is normally based on the type of claim (e.g. institutional, professional, international, etc.) and can also be based on the size of your group enrollment. The amount of the AEA fee is listed on the Schedule A.

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 Group Health 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 Investigational or Experimental 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 Claims Administrator or a licensee of the Blue Cross and Blue Shield Association (BCBSA) agrees to pay a Provider as payment in full for a service, procedure, supply or equipment. Additionally:

1. The Allowable Charge shall not exceed the Maximum Payment, unless otherwise required by applicable law;

2. The Allowable Charge for Emergency Services (including air ambulance services) provided by Non-Participating Providers, as well as non-Emergency Services provided by Non-Participating Providers at Participating Hospitals, Hospital outpatient departments, Critical Access Hospitals, or Ambulatory Surgical Centers, will pay in accordance with applicable federal law; and,

3. 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 Charge, except where prohibited by applicable law .

For covered items and services described in item 2, above, the Allowable Charge will be the Recognized Amount (less any applicable Benefit Year Deductible, Copayment and/or Coinsurance), unless otherwise prescribed under applicable law. If the Provider disputes such Allowable Charge and initiates a 30-day open negotiation and/or independent dispute resolution process in accordance with applicable federal law, the Claims Administrator will administer such processes.

Notwithstanding anything herein to the contrary, the Member's responsibility for Benefit Year Deductibles, Copayments and/or Coinsurance for covered items and services provided by Non-Participating Providers described in item 2, above, will be calculated as if the item or service was furnished by a Participating Provider, and based on the Recognized Amount (which may differ from the Allowable Charge).

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.

An Ambulatory Surgical Center includes any licensed facility described in section 1833(i)(1)(A) of the Social Security Act.

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

Authorized Representative: an individual (including a Provider) whom the Member designates in writing to act on such Member's behalf.

Autism Spectrum Disorder: the diagnoses designated as such in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Behavioral Health Clinician: a Clinician who renders Mental Health Services and/or Substance Use Disorder Services and is licensed to practice independently.

Behavioral Health Services: all Mental Health Services and/or Substance Use Disorder Services performed by a licensed Behavioral Health Clinician.

Benefit Detail Report: the document (in electronic or hardcopy form) maintained by the Claims Administrator which reflects the benefits selected by the Employer and submitted to the Claims Administrator which outlines the Benefits to be offered under the Group Health Plan. The Claims Administrator shall administer the Plan of Benefits in accordance with the terms of the Benefit Detail Report. In the event of any conflict between the Benefit Detail Report and this Plan of Benefits or the Schedule of Benefits, the Benefit Detail Report shall control.

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 Group Health Plan 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 Article III of this Plan of Benefits; and,
4. Not limited or excluded under the terms of this Plan of Benefits.

Billed Charges: the actual charges as billed by a Provider.

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.

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.

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 Group Health Plan. The term “Child” does not include the Spouse or Domestic Partner of an eligible child.

Claims Administrator: Blue Cross and Blue Shield of South Carolina.

Claims Amount: the amount paid (or payable) for Members’ claims (including fees such as Access Fees, AEA Fees and amounts paid as part of a VBP or in settlement of claims or in satisfaction of a judgment).

Clinical Trials: a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and meets any of the following criteria:

1. Approved or funded through the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHRQ), the Centers for Medicare & Medicaid Services (CMS), or a cooperative group or center of:

a. Any of the preceding entities;

b. The Department of Defense (DOD); or,

c. The Department of Veterans Affairs (VA);

2. Approved or funded by the DOD, VA, or Department of Energy (DOE), provided that the study or investigation has been reviewed and approved through a peer review system that the Secretary of the agency determines to be comparable to the peer review system of studies and investigations used by the NIH, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

3. Approved or funded through a qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants; or,

4. Either conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA), or a drug trial that is exempt from having such an investigational new drug application.

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 healthcare coverage to Employees and Dependents of Employees who would otherwise lose coverage.

COBRA Administrator: the Corporation or, if these Services are subcontracted, its designated subcontractor that provides administrative services related to COBRA.

Coinsurance: the sharing of the Allowable Charge between the Member and the Group Health Plan. After the Member's Benefit Year Deductible requirement is met, the Group Health Plan 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 by multiplying the percentage listed on the Schedule of Benefits and the negotiated pharmacy price for that item at the time of the sale.

Common Law Marriage: due to legal variations as to what constitutes Common Law Marriage, coverage under the Plan will extend to any Dependent Spouse living in a common law relationship with the Employee, if the state of residence recognizes such relationship as legal.

Companion Benefit Alternatives (CBA): a separate company that is responsible for managing Behavioral Healthcare Services (including Preauthorization) on behalf of BlueCross.

Concurrent Care Claim: any claim for 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 payment of Participating Provider level of 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 Authorized Representative) regarding an extension of an Admission to determine if an Admission for longer than the time that was originally Preauthorized is Medically Necessary (when required). The Continued Stay Review process is outlined in Article III.

Continuing Care Patient: a Member who, with respect to a Provider or facility, is either:

1. Undergoing a course of treatment for a serious and complex condition from the Provider or facility;

2. Undergoing a course of institutional or inpatient care from the Provider or facility;

3. Scheduled to undergo nonelective surgery from the Provider or facility, including receipt of postoperative care;

4. Pregnant and undergoing a course of treatment for the pregnancy from the Provider or facility; or,

5. Receiving treatment for a terminal illness from the Provider or facility.

For this purpose, a serious and complex condition means a condition that, in the case of an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm, or in the case of a chronic illness or condition, is life-threatening, degenerative, potentially disability, or congenital and requires specialized medical care over a prolonged period of time.

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 Group Health Plan 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 the Plan of Benefits and on the Schedule of Benefits. Covered Expenses will not exceed the Allowable Charge.

Credit(s): rebates and/or other amounts which may be received by the Claims Administrator from drug manufacturers, a Pharmacy Benefit Manager and/or another third party. Credits are not payable to Members and will be retained by the Claims Administrator to help stabilize overall rates and to offset expenses.

Reimbursements to a Participating Pharmacy, or discounted prices charged at pharmacies, are not affected by these Credits. Any Coinsurance or Copayment that a Member must pay for Prescription Drugs or Specialty Drugs does not change due to receipt of any Credit by the Claims Administrator.

Critical Access Hospital: a facility that is designated by the state in which it is located and certified by the United States Department of Health and Human Services as a critical access hospital.

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 and/or 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;

3. An Incapacitated Dependent; or,

4. A Domestic Partner.

These persons are excluded as Dependents:

a. The legally separated or divorced former Spouse of the Employee;

b. Any person who is on active duty in any military service of any country;

c. Any person who is eligible for coverage under the Plan as an Employee; or,

d. The Spouse and Children of an Employee, if and only if, the Spouse and Children reside outside the United States.

If both husband and wife are Employees, their Children will be covered as Dependents of the husband or wife, but not of both.

Domestic Partner: a Dependent who:

1. Has been in an exclusive committed relationship with the Employee for the past six (6) months and intends to remain in the relationship indefinitely;

2. Have shared a common residence with the Employee for the past six (6) months;

3. Is jointly responsible for the common welfare and financial obligations of the household or the Domestic Partner is chiefly dependent upon the Employee for financial support;

4. Is not related by blood or adoption to the Employee to a degree of closeness that would prohibit marriage under applicable law;

5. Is not legally married to another individual nor a partner in another Domestic Partner relationship;

6. Like the Employee, is at least eighteen (18) years of age and mentally competent to consent to a contract; and,

7. Able to provide documentation of eligibility and can provide three (3) of the following documents as such:

    a. Joint mortgage or lease;

    b. Joint title to a motor vehicle;

    c. Joint bank or credit card;

    d. Designation as primary beneficiary in the other partner's will or life insurance policy;

    e. Durable property and healthcare powers of attorney; or,

    f. Other proof as is sufficient to establish eligibility.

A Domestic Partner may not be a:

a. Roomate;

b. Casual, non-committed partner; or,

c. Ex-Spouse.

The Employee and applicant for coverage as a Domestic Partner will be required to sign and provide requested documentation according to the Declaration of Domestic Partnership form in order to apply for Domestic Partner Benefits. The form must be approved by the director of Human Resources. Filing of this declaration does not enroll the Domestic Partner in Benefits.

Durable Medical Equipment (DME): 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; 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.

Emergency Admission Review: the review that must be obtained by a Member (or the Member's Authorized Representative) within twenty-four (24) hours after, or if later, by the end of the first business day after the commencement of an Admission to a Hospital resulting from an Emergency Medical Condition. The Emergency Admission Review process is outlined in Article III.

Emergency Medical Condition: a medical condition, including a mental health condition or Substance Use Disorder, 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 the Member's unborn Child, in serious jeopardy;

2. Serious impairment to bodily functions; or,

3. Serious dysfunction of any bodily organ or part.

Emergency Services: an appropriate medical screening examination, services, supplies and treatment for stabilization, evaluation and/or initial treatment of an Emergency Medical Condition when provided on an outpatient basis at a Hospital emergency room or department or an independent freestanding emergency department, as well as post-stabilization services provided as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services are furnished.

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 Claims Administrator by the Employer.

Employer: the entity providing this Plan of Benefits.

Employer's Effective Date: the date the Claims Administrator begins to provide Services under this Agreement.

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, 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.

Genetic Information: information about genes, gene products (messenger ribonucleic acid (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 purposely to diagnose a genetic characteristic, tests for abuse of drugs and tests for the presence of human immunodeficiency virus.

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.

Grace Period: a period of time as determined by the Employer after the initial due date that allows for the Member to pay any Premium due.

Group Health Plan: the employee welfare benefit plan established, administered and/or sponsored by the Employer to provide health Benefits to Employees and/or their Dependents, directly or through insurance, reimbursement or otherwise.

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 healthcare;

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 provided by an agency that is licensed or certified as a hospice or hospice care agency by the appropriate state regulatory agency.

Hospice Services: services provided in the Member's home or in the home of a family member. Generally, Hospice Services are not available to Members who are inpatients in a Hospital or nursing home facility.

Hospice Services include:

1. Services provided by a registered nurse (RN) or licensed practical nurse (LPN);
2. Physical, speech and occupational therapy;
3. Services provided by a home health aide or medical social worker;
4. Nutritional guidance;
5. Diagnostic services;
6. Administration of Prescription Drugs;
7. Medical and surgical supplies;
8. Oxygen and its use;
9. Durable Medical Equipment;
10. Family counseling concerning the patient's terminal condition.

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 Claims Administrator 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 Total Disability; and,

2. Dependent upon the Employee for at least fifty-one (51) percent of the Child's support and maintenance.

A Child must meet both of these requirements to qualify as an Incapacitated Dependent. 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: surgical or medical procedures, supplies, devices or drugs which, at the time provided or sought to be provided, are, in the judgment of the Claims Administrator, not recognized as conforming to generally accepted medical or behavioral health practice in the United States, or the procedure, drug or device:

1. Has not received required final approval in the United States to market from appropriate government bodies;

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

3. Is not demonstrated in the United States to be superior to established alternatives;

4. Has not been demonstrated in the United States to improve net health outcomes; or,

5. Is one in which the improvement claimed is not demonstrated in the United States to be obtainable outside the Investigational or Experimental setting.

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/Home Delivery Pharmacy: a pharmacy maintained by the Pharmacy Benefit Manager that fills prescriptions and sends Prescription Drugs by mail.

Maximum Payment: the maximum amount the Group Health Plan will pay (as determined by the Claims Administrator) 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 Claims Administrator in its discretion, subject to any different amount that may be required under applicable law:

1. The actual charge submitted to the Claims Administrator for the service, procedure, supply or equipment by a Provider;

2. An amount based upon the reimbursement rates established by the Plan Sponsor in its Benefit Detail Report;

3. An amount that has been agreed upon in writing by a Provider and the Claims Administrator or a licensee of the BCBSA;

4. An amount established by the Claims Administrator, based upon factors including, but not limited to:

    a. Governmental reimbursement rates applicable to the service, procedure, supply or equipment; or,

    b. 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 Claims Administrator allows for the same or similar service, procedure, supply or equipment when provided by a Participating Provider.

In addition, the Maximum Payment for Emergency Services or air ambulance services by a Non-Participating Provider, or non-Emergency Services by a Non-Participating Provider at a Participating Hospital, Hospital outpatient department, Critical Access Hospital, or Ambulatory Surgical Center, will be the Recognized Amount, unless a different Maximum Payment amount is permitted or applicable law.

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 the 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 benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet 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).

Medical Supplies: supplies that are:

1. Medically Necessary;

2. Prescribed by a Provider acting within the scope of such Provider's 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 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.

Medically Necessary/Medical Necessity: using United States standards, health care services and/or Behavioral Health 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 or behavioral health practice;

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

3. Not primarily for the convenience of the patient, patient's caregiver(s) or Provider; and,

4. 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.

All requirements of the above-referenced definition must be met in order for a health care service or Behavioral Health Service to be deemed Medically Necessary. The failure of a health care service or Behavioral Health Service to meet any one of the above referenced requirements means, in the discretion of the Claims Administrator or CBA, the health care service or Behavioral Health Service does not meet the definition of Medically Necessary.

For the purposes of determining Medical Necessity:

1. The Claims Administrator and CBA have the discretion to utilize and rely upon any medical and behavioral health (which includes substance use and mental health) standards, policies, guidelines, criteria, protocols, manuals, publications, studies or literature (herein collectively referred to as “criteria”), whether developed by them or others, which, in their discretion, are determined to be generally accepted standards by the medical and/or behavioral health community;

2. "Generally accepted standards of medical or behavioral health practice" means United States standards that are based on credible scientific evidence published in peer-reviewed medical and/or behavioral health literature generally recognized by the relevant United States medical or behavioral health community, physician or behavioral health specialty society recommendations, and/or any other factors deemed relevant in the discretion of the Claims Administrator or CBA; and,

3. The Claims Administrator and CBA may, in their discretion, use the following materials, including but not limited to, Corporate Administrative Medical (“CAM”) Policies, Technology Evaluation Center (“TEC”) Assessments, Behavioral Health Care Utilization Management Criteria and/or any Care Guidelines or criteria by MCG Health, LLC, its affiliated companies, or other entities generally recognized as providing industry guidance and expertise, which reflect clinically appropriate health care services and Behavioral Health Services and generally accepted standards of medical and behavioral health practice. MCG Health, LLC, its affiliated companies and/or other entities are independent companies that develop evidence based guidelines and criteria for medical, behavioral health and insurance industries to interpret clinical determinations and determine the Medical Necessity and appropriateness of requested services, procedures, devices and supplies.

Member: an Employee or Dependent who has enrolled under the Group Health Plan.

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 Claims Administrator and the Employer for transmitting necessary Member enrollment information from the Employer to the Claims Administrator.

Mental Health Services: treatment (except Substance Use Disorder Services) 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 fifty percent (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.

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.

Non-Medical Leave: personal leave with approval of the Managing Partner.

Non-Participating Provider: any Provider who does not have a current, valid Provider Agreement.

Non-Preferred Drug: a Prescription Drug that does not appear on the list of Preferred Drugs.

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 (listed on the Schedule of Benefits) incurred during a Benefit Year that a Member will be required to pay for Covered Expenses.

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

Participating Pharmacy: a pharmacy that has a contract with the Claims Administrator, Employer 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.

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.

Pharmacy Benefit Manager (PBM): the pharmacy benefit manager with whom the Claims Administrator contracts to perform PBM services.

Plan: any program that provides Benefits or services for medical or dental care or treatment, including:

1. Individual or group coverage, whether insured or self-insured; 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 the Group Health Plan. The Employer is the Plan Administrator of the Group Health Plan.

Plan of Benefits: this document which reflects the Benefits offered under the Group Health Plan based on the Benefit Detail Report. The Plan of Benefits includes the Schedule of Benefits. Employer agrees that the Plan of Benefits will, at a minimum, be incorporated as a part of the Group Health Plan.

Plan of Benefits Effective Date: 12:01 a.m. EST on the date listed on the Schedule of Benefits.

Plan Sponsor: the party sponsoring the Group Health Plan. The Employer is the Plan Sponsor of the Group Health Plan.

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

Preadmission Review: the review that must be obtained by a Member (or the Member's Authorized 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 approval of Benefits based on Medical Necessity prior to the rendering of such Benefits to a Member. The Preauthorization process is outlined in Article III.

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

Premium: the monthly amount paid to the Employer by the Member for coverage under this Plan of Benefits. Payment of Premiums by the Member constitutes acceptance by the Member of the terms of this Plan of Benefits.

Prescription Drug: a drug or medicine that is:

1. Required to be labeled that it has been approved by the 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.

Additionally, to qualify as a Prescription Drug, the drug must be prescribed by a licensed Provider acting within the scope of such Provider's license.

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

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. Members must refer to the Schedule of Benefits to determine if the Benefit Year Deductible applies to the Out-of-Pocket Maximum.

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

Prescription Drug Preauthorization Program: programs that prohibit patients from obtaining medications until approvals have been obtained.

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.

Private Duty Nursing (PDN): hourly or shift skilled nursing care provided in a patient's home. PDN provides more individual and continuous skilled care than can be provided in a skilled nurse visit through a Home Health Agency. The intent of PDN is to assist the patient with complex direct skilled nursing care, to develop caregiver competencies through training and education and to optimize patient health status and outcomes. The frequency and duration of PDN services is intermittent and temporary in nature and is not intended to be provided on a permanent ongoing basis. PDN is not long-term care.

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 the 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; 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; and Behavioral Health Services when performed by a Behavioral Health Clinician, licensed professional counselor, masters level licensed social worker, licensed marriage and family therapist or other licensed Behavioral Health Clinician approved by the Claims Administrator. The term Provider does not include interns, residents, physical trainers, lay midwives or masseuses.

Provider Agreement: an agreement between the Claims Administrator (or another BCBSA licensee) and a Provider under which the Provider has agreed to accept the Claims Administrator's allowance (as set forth in the Provider Agreement) as payment in full for Benefits (subject to the Member liability amounts) and other mutually acceptable terms and conditions.

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.

Provider Services: includes the following services:

A. When performed by a Provider or a Behavioral Health Clinician within the scope of such Provider or Clinician's license, training and specialty and within the scope of generally acceptable medical standards:

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

   2. Basic diagnostic services and machine tests; or,

   3. Behavioral Health Services.

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.

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 (1) of the following:

1. Termination of the Employee's employment (other than for gross misconduct) or reduction of hours worked;

2. Death of the Employee;

3. Divorce or legal separation of the Employee from such Employee's 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.

Recognized Amount: the lesser of the Non-Participating Provider's Billed Charges or the Claims Administrator's median contracted rate for Participating Providers for the same or similar item or service furnished in the same or similar specialty in the same geographic region; provided that, except in connection with air ambulance services, if there is a recognized amount specified for this purpose under an applicable All-Payer Model Agreement under Section 1115A of the Social Security Act, or if not, under applicable state law, then such amount, as applicable, will instead serve as the Recognized Amount.

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. The facility is licensed and/or accredited by the appropriate agency;

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

4. Has a RN, who oversees patient care, present onsite twenty-four (24) hours/day seven (7) days per week OR a RN onsite a minimum of eight (8) hours/day seven (7) days a week and on call twenty-four (24) hours per day/seven (7) days per week. The response time to the facility must be sixty (60) minutes or less when on call. Registered nursing personnel for residential facilities performing detoxification must be on-site twenty-four (24) hours/day seven (7) days per week;

5. Keeps a daily medical record for each patient; and,

6. Is primarily providing a continuous structured therapeutic program specifically designed to treat behavioral health disorders with an awake licensed clinician onsite twenty-four (24) hours/day seven (7) days per week 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.

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, Out-of-Pocket Maximums 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: a licensed and accredited 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 physician available at all times and is responsible for the diagnostic evaluation, provides face-to-face evaluation services with documentation a minimum of once per week and PRN as indicated;

3. Has a physician or RN on full-time duty who is in charge of patient care, along with one (1) or more RNs or LPNs on duty at all times (twenty-four (24) hours a day; seven (7) days a week);

4. Keeps a daily medical record for each patient;

5. Is primarily providing continuous skilled nursing care for sick or injured patients during the recovery stage of their illnesses or injuries and isn't, other than incidentally, a rest home or a home for Custodial Care for the aged; and,

6. Is operating lawfully as a skilled nursing facility in the area where it is located.

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 the Plan of Benefits.

Specialist: a licensed medical doctor who specializes in a particular branch of medicine.

Specialty Drugs: Prescription Drugs, as identified by the Claims Administrator 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).

Spouse: the legally recognized marital partner of an Employee.

Substance Use Disorder: the continued use of, abuse of and/or dependence on 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, including the usual, necessary and related pre-operative and post-operative care when performed by a licensed medical doctor.

Telehealth: the exchange of Member information during which Members can have a telephone or video consultation with a licensed health care professional. For Members utilizing Blue CareOnDemand, Telehealth services may include E-treatment services through which information is communicated to the Provider through a questionnaire.

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 Group Health Plan.

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.

Utilization Management: the use of techniques, such as step therapy, that allow the Claims Administrator to manage the cost of Benefits by assessing their appropriateness using evidence-based criteria or guidelines before they are provided.

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 Agreement and the Plan of Benefits.

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.

Well Baby Care/Well Child Care: care for Dependents. Benefits are payable as specified on the Schedule of Benefits.

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 such Employee's Dependents) for coverage under this Plan of Benefits.

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

   a. Is Actively at Work; and,

   b. Has completed the Probationary Period.

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

4. The Employee must furnish written proof of the requirements for an Incapacitated Dependent, as outlined in Article I, to the Employer 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 provide proof upon request.

5. Probationary Periods and/or contribution levels will not be based on any factor which discriminates in favor of higher wage Employees as required under federal law.

B. ELECTION OF COVERAGE

Any Employee may enroll for coverage under the Group Health Plan 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 Special Enrollment procedure.

The Employee is required to submit a marriage license and file it with the Employer. The Claims Administrator reserves the right to request documentation of such marriage.

The Employee and 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 Claims Administrator.

C. COMMENCEMENT OF COVERAGE

Coverage under the Group Health Plan will commence as follows, provided that coverage will not be effective more than sixty (60) days before the Claims Administrator received 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 the Plan of Benefits Effective Date.

   If the Claims Administrator 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 the Plan of Benefits Effective Date

   Employees and Dependents who become eligible for coverage after the Plan of Benefits Effective Date and have elected coverage will have coverage after they have completed the Probationary Period.

3. Dependents Resulting from Marriage or Domestic Partnership

   Dependents 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 Claims Administrator 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 an 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.

   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 such Employee's own personal tax advisor to determine how these tax implications affect the Employee.

4. Newborn Children

   A newborn Child will have coverage upon the date of the Child's birth provided the Child has been enrolled for coverage and the coverage has been paid for under this Plan of Benefits within thirty-one (31) days after the Child's birth for the Child to have coverage from the date of birth. If a newborn Child is not enrolled within the time frame set forth in the prior sentence, coverage will begin on the date chosen by the Employer and upon the payment of the applicable Premium and administrative charge.

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; or,

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 and administrative charge.

6. Special Enrollment

In addition to enrollment under Article II (C)(2-5), the Claims Administrator 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 Plan at the time the Group Health Plan 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 such other Plan 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 (or other) continuation provision and either the coverage under the provision was exhausted or the employer ceased to offer any Plan (including successor Plans) to any employee;

ii. Was not under a COBRA (or other) 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 or termination of employment), reduction in the number of hours of employment, or the employer ceasing to offer the coverage to the Employee or Dependent or if the employer's contributions toward the coverage were terminated;

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

iv. Under the terms of the Group Health 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), 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.

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

E. MEMBERSHIP APPLICATION

The Claims Administrator will only accept a Membership Application submitted by the Employer on behalf of each Employee. The Claims Administrator 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

The Member agrees that the Claims Administrator may obtain claims information, medical records and other information necessary for the Claims Administrator to consider a request for Preauthorization, a Continued Stay Review, an Emergency Admission Review, a Preadmission Review or to process a claim for Benefits under this Plan of Benefits.

ARTICLE III – BENEFITS

A. PAYMENT

The payment for Benefits is subject to all terms and conditions of this Plan of Benefits. In the event of a conflict between the 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. The Group Health Plan will only pay 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 such Provider's 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 Claims Administrator;

5. That are Medically Necessary;

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

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

8. That comply with the Claims Administrator's corporate medical policy unless otherwise indicated in the Benefit Detail Report.

The amount payable for Benefits is determined as set forth in this Plan of Benefits and on the Schedule of Benefits. Benefits are subject to the limitations and requirements set forth in this Plan of Benefits and on the Schedule of Benefits. Payment for Benefits will not exceed the Allowable Charge.

B. PREAUTHORIZATION

Some Benefits, as set forth on the Schedule of Benefits, require Preauthorization to determine the Medical Necessity. The Group Health Plan reserves the right to add or remove Benefits that are subject to Preauthorization. If Preauthorization is not obtained, Benefits may be reduced or denied. Specific penalties are listed on the Schedule of Benefits. Preauthorization, where required, 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 for additional days is granted or denied 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 Claims Administrator must be called at the numbers given on the Identification Card.

Preauthorization means only that the Claims Administrator 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.

C. SPECIFIC COVERED BENEFITS

In order for the Employer to pay for the Benefits described in Article III(D):

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 (1) or more of the exclusions set forth in Article IV.

D. BENEFITS

ABA RELATED TO AUTISM SPECTRUM DISORDER

Benefits will be paid 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.

AMBULANCE SERVICES

Benefits will be paid for professional ground and air ambulance services to the nearest network Hospital in case of an accident or Emergency Medical Condition. The following requirements apply to all ground and air ambulance services and transports:

1. The transport is Medically Necessary and reasonable under the circumstances;

2. A Member is transported;

3. The destination is local within the United States; and,

4. The facility is medically appropriate to treat the Member's condition.

Benefits will be paid for ground ambulance transport between two Hospitals only when such ground ambulance transport has been Preauthorized and the Claims Administrator confirms that the receiving Hospital is the closest facility that can provide medically appropriate care to treat the Member's condition. Transport from one facility to a new facility for the purpose of the Member obtaining a lower level of care at the new receiving facility must be Preauthorized. Repatriation for Member convenience is excluded and is not a Benefit for which Covered Expenses are payable.

Preauthorization is required for transportation as an inpatient from one Hospital to a second Hospital using an air ambulance. The following requirements must be met:

1. The first Hospital does not have the needed Hospital or skilled nursing care to treat the Member's illness or injury (such as burn care, cardiac care, trauma care, and critical care);

2. The second Hospital is the nearest medically appropriate facility to treat the Member's illness or injury;

3. A ground ambulance transport would endanger the Member's medical condition; and,

4. The transport is not related to a hospitalization outside the United States.

CHIROPRACTIC SERVICES

Benefits will be paid 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. Benefits shall include but not be limited to:

1. Spinal manipulation/subluxation;

2. Related X-rays;

3. Modalities; and,

4. Office visits.

CLEFT LIP OR PALATE

Benefits will be paid for care and treatment of a congenital cleft lip and/or palate 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 obturators, 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.

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 Group Health Plan. 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 Group Health Plan.

CLINICAL TRIALS

Benefits will be paid for routine Member costs for items and services related to Clinical Trials when:

1. The Member has cancer or other life-threatening disease or condition; and,

2. Either:

    a. the referring Provider is a Participating Provider that has concluded that the Member's participation in such trial would be appropriate; or,

    b. the Member provides medical and scientific information establishing that the Member's participation in such trial would be appropriate; and,

3. The services are furnished in connection with an approved Clinical Trial.

Examples of routine Member costs include, but are not limited to, radiological services, laboratory services, intravenous therapy, anesthesia services, Hospital services, Provider services, office visits, room and board, and Medical Supplies that typically would be covered under the Plan of Benefits for a Member who is not enrolled in a Clinical Trial.

COCHLEAR IMPLANTS

Benefits will be paid for unilateral or bilateral cochlear implantation of a U.S. Food and Drug Administration approved cochlear implant as set forth on the Schedule of Benefits.

DENTAL CARE FOR ACCIDENTAL INJURY

Benefits will be paid for dental services to Natural Teeth required because of accidental injury. For purposes of this section, an accidental injury is defined as an injury caused by a traumatic force, such as a car accident or a blow by a moving object. No Benefits will be 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 Claims Administrator for review and Preauthorization before such treatment is rendered if Benefits are to be paid. Benefits are limited to treatment for only twelve (12) months from the date of the accidental injury.

DIABETES EDUCATION

Benefits will be paid 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 is recognized by the American Diabetes Association.

DURABLE MEDICAL EQUIPMENT

Benefits will be paid for Durable Medical Equipment, certain orthotics and supplies. Coverage is provided only for the cost of the item that meets minimum specifications and any amount that exceeds that cost will be the Member's responsibility. The Group Health Plan will decide whether to buy or rent equipment and whether to repair or replace damaged or worn Durable Medical Equipment. The Group Health Plan will not pay Benefits for Durable Medical Equipment that is solely used by a Member in a Hospital or that the Group Health Plan determines is included in any Hospital room charge.

EMERGENCY SERVICES

Benefits will be paid for the treatment of Emergency Medical Conditions. Benefits are only available to treat an Emergency Medical Condition provided on an outpatient basis at a Hospital emergency room or department and only for as long as the condition continues to be considered an Emergency Medical Condition, unless otherwise required by applicable law.

GYNECOLOGICAL EXAMINATION

Benefits will be paid for routine gynecological examinations each Benefit Year for female Members.

HABILITATION

Benefits will be paid 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.

HEARING AIDS

Benefits will be paid for hearing aids as set forth on the Schedule of Benefits.

HOME HEALTH CARE

Benefits will be paid for Home Health Care when rendered to a homebound Member in the Member's current place of residence.

HOSPICE CARE

Benefits will be paid for Hospice Care.

HOSPITAL SERVICES

Benefits will be paid for Admissions as follows:

1. Semiprivate room, board and general nursing care;
2. Private room, at semiprivate rate;
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, 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 by midnight of the same day. The day a Member enters a Hospital 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. Benefits will be paid for certain 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 Group Health Plan. Benefits shall only be paid for the human organ and tissue transplants as set forth on the Schedule of Benefits.

2. 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.

IN-HOSPITAL MEDICAL SERVICE

Benefits will be paid for a licensed medical doctor or Behavioral Health Clinician'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 such attending surgeon's assistant; and,

    b. When the surgical procedure performed is designated by the Group Health Plan 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

Benefits will be paid for mammography testing, regardless of Medical Necessity, as set forth on the Schedule of Benefits. Benefits will be paid for additional mammograms during a Benefit Year based on Medical Necessity.

MASTECTOMIES AND RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES

Benefits will be paid for mastectomies. The Group Health Plan may not restrict Benefits for a Hospital length of stay following a mastectomy to less than forty-eight (48) hours. Nothing in this paragraph prohibits the attending Provider, after consulting with the Member, from discharging the Member earlier than forty-eight (48) hours. In the case of an early release, Benefits will be paid for one (1) home care visit if ordered by the attending Provider.

In the case of a Member who is receiving Benefits in connection with a mastectomy, Benefits will be paid 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 physical complications at all stages of the mastectomy, including lymphedema.

MEDICAL SUPPLIES

Benefits will be paid for Medical Supplies, provided that the Group Health Plan will not pay Benefits separately for Medical Supplies that are or should be provided as part of another Benefit.

MENTAL HEALTH SERVICES

Benefits will be paid for Mental Health Services provided on an inpatient or outpatient basis.

OBSTETRICAL SERVICES

Benefits will be paid for obstetrical services, including 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 Group Health Plan generally may not restrict Benefits 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 the mother's newborn earlier than the specified time frames or from requesting additional time for hospitalization. In any case, the Group Health Plan may not require that a Provider obtain authorization from the Claims Administrator 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.

ORAL SURGEONS

Benefits will be paid for oral surgeons as set forth on the Schedule of Benefits.

ORTHOPEDIC DEVICES

Benefits will be paid for Orthopedic Devices.

ORTHOTIC DEVICES

Benefits will be paid for 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

Benefits will be paid 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

Benefits will be paid, subject to the following paragraph, for physical therapy, occupational therapy and rehabilitation services as set forth on the Schedule of Benefits.

Benefits for outpatient rehabilitation services will be paid only following an acute incident involving disease, trauma or surgery that requires such care to the extent necessary for chronic and pulmonary rehabilitation based on Medical Necessity.

OXYGEN

Benefits will be paid for oxygen. Durable Medical Equipment for oxygen use in a Member's home is covered under the Durable Medical Equipment Benefit.

PAP SMEAR

Benefits will be paid for a Pap smear as part of a gynecological examination regardless of Medical Necessity. Benefits will be paid for additional Pap smears during a Benefit Year based on Medical Necessity.

PHYSICAL EXAMINATION

Benefits will be paid for physical examinations for Members.

PRESCRIPTION DRUGS

1. Unless expressly excluded under Article IV, Benefits will be paid 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 Claims Administrator 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 or Copayment for Prescription Drugs does not change due to receipt of any Credits by the Group Health Plan or the Claims Administrator.

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

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

2. The Group Health Plan may, in its discretion, use Utilization Management programs for Prescription Drugs.

PREVENTIVE SERVICES

Benefits will be paid for preventive health services required under the ACA as follows:

1. Evidence based services that have a rating of A or B in the current United States Preventive Services Task Force (USPSTF) recommendations;

2. Immunizations as recommended by the CDC; and,

3. Preventive care and screenings for children and women as recommended by the Health Resources and Services Administration (HRSA).

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

PRIVATE DUTY NURSING

Benefits will be paid for Private Duty Nursing outside of Home Health Care or a Hospital setting.

PROSTATE EXAMINATION

Benefits will be paid for prostate examinations per Benefit Year regardless of Medical Necessity as set forth on the Schedule of Benefits. Benefits will be paid for additional prostate examinations during a Benefit Year based on Medical Necessity.

PROSTHETIC DEVICES

Benefits will be paid for a Prosthetic Device, other than a dental or cranial prosthetic, which is a replacement for a body part and which meets minimum specifications for the body part it is replacing regardless of the functional activity level. Coverage is provided for only the cost of the item that meets minimum specifications and any amount that exceeds that cost will be the Member's responsibility. Benefits are provided for only the initial temporary prosthesis and one (1) permanent prosthesis.

PROVIDER SERVICES

Benefits will be paid for Provider Services, provided that when different levels of Provider Services are provided on the same day, Benefits will only be paid for the highest level of Provider Services.

REHABILITATION

Benefits will be paid, as specified on the Schedule of Benefits, for participation in a multidisciplinary team rehabilitation program only following severe neurologic or physical impairment if the following criteria are met:

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

2. All such treatment must be performed by a Provider and at a location designated by the Group Health Plan;

3. Preauthorization must be obtained, if required;

4. The documentation that accompanies a request for rehabilitation meets the criteria outlined in the Claims Administrator's medical policy; and,

5. All such rehabilitation Benefits are subject to periodic review by the Group Health Plan.

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 CENTERS

Benefits will be paid for Residential Treatment Centers as set forth on the Schedule of Benefits.

SKILLED NURSING FACILITY SERVICES

Benefits will be paid for Admissions in a Skilled Nursing Facility as follows:

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

2. Private room, at semiprivate rate;

3. Services performed in a Special Care Unit when it is Medically Necessary that such services be performed in such unit;

4. Ancillary services and Medical Supplies;

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 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 Skilled Nursing Facility by midnight of the same day. The day a Member enters a 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.

SPECIALTY DRUGS

Benefits will be paid for Specialty Drugs as set forth on the Schedule of Benefits and may:

1. Require Preauthorization; and/or,

2. Be subject to certain place of service requirements.

Covered Expenses for Specialty Drugs dispensed to a Member shall not exceed the quantity and Benefit maximum set by the Claims Administrator. Certain 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. A list of Specialty Drugs, as well as information about any related requirements and/or restrictions, may be obtained by contacting the Claims Administrator at the number listed on the Identification Card or at www.SouthCarolinaBlues.com.

Any Coinsurance percentage or Copayment for Specialty Drugs does not change due to receipt of any Credits by the Corporation.

SPEECH THERAPY

Benefits will be paid for speech therapy as set forth on the Schedule of Benefits. Speech therapy must be ordered by a Provider and follow either surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person born while covered under the Plan or an injury or a sickness that is other than a learning or mental disorder.

SUBSTANCE USE DISORDER SERVICES

Benefits will be paid for Substance Use Disorder Services as set forth on the Schedule of Benefits.

SURGICAL SERVICES

Benefits will be paid 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 (1/2) of the 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 percent (50%) for the procedure bearing the second and third highest Allowable Charges, twenty-five percent (25%) for the procedures bearing the fourth through the eighth highest Allowable Charges and ten percent (10%) 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 percent (50%) 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 licensed 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) licensed medical doctor or oral surgeon (as applicable) or will be prorated between them by the Group Health Plan when so requested by the licensed medical doctor or oral surgeon in charge of the case.

f. Certain surgical procedures are designated as separate procedures by the Group Health Plan. 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) licensed medical doctor, oral surgeon, physician assistant or nurse practitioner 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 Group Health Plan 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 licensed medical doctor's or oral surgeon's (as applicable) actual charge.

3. Anesthesia services that consist of services rendered by a licensed medical doctor, oral surgeon or a certified registered nurse anesthetist, other than the attending surgeon or such attending surgeon's 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.

SUSTAINED HEALTH BENEFITS

Benefits will be paid for certain routine annual Benefits (known as Sustained Health Benefits) as set forth on the Schedule of Benefits. These Benefits are designed to cover costs associated with routine care and are provided in addition to the Preventive Services covered under the ACA. Because these are additional Benefits, age and monetary limitations may be imposed and cost-sharing may be required by the Member.

TELEHEALTH

Benefits will be paid for Telehealth services which are initiated by either a Member or Provider and are provided by licensed health care professionals who have been credentialed as eligible Telehealth Providers.

TEMPOROMANDIBULAR JOINT (TMJ) DISORDER

Benefits will be paid for the treatment of dysfunctions or derangements of the temporomandibular joint, including orthognathic surgery for the treatment of dysfunctions or derangements of the temporomandibular joint.

TRAVEL AND LODGING

Benefits will be paid for travel and lodging related to a human organ or tissue transplant for recipients as set forth on the Schedule of Benefits.

VARICOSE VEIN AND VENOUS INSUFFICIENCY TREATMENT

Benefits will be paid for services, supplies or treatment for varicose veins and/or venous insufficiency, including but not limited to endovenous ablation, vein stripping or the injection of sclerosing solutions, as outlined in the Claims Administrator's medical policy.

WIGS

Benefits will be paid for wigs when prescribed by a Provider for hair loss as a result of a condition such as, but not limited to, cancer, alopecia, burns or cranial surgery.

ARTICLE IV - EXCLUSIONS AND LIMITATIONS

THE EMPLOYER'S GROUP HEALTH PLAN 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.

ABORTIONS

Charges for elective and non-elective abortions, except for elective abortions for life-threatening pregnancy complications to the mother if she carries the baby to term.

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.

ACUPUNCTURE

Acupuncture treatment or services.

ADJUSTABLE RACKS THAT HOLD MOTORIZED CHAIRS

Adjustable racks that hold motorized chairs.

AMBULANCE

Ambulance services:

1. That do not meet coverage guidelines outlined in the Ambulance Services description in Article III;

2. That are not Medically Necessary and reasonable;

3. For transport to a more distant Hospital solely for the Member's convenience, regardless of the reason, or to allow the Member to use the services of a specific Provider or Specialist. The Group Health Plan will pay the base rate and mileage for a Medically Necessary ambulance transport to the nearest medically appropriate facility. If the transport is to a facility that is not the nearest medically appropriate facility, the Member is responsible for additional cost incurred to go to the Member's preferred facility;

4. If the Member is medically stable and the situation does not involve an emergency, except as specified in Article III; or,

5. For transport from a Hospital in connection with a hospitalization outside the United States.

Any and all travel expenses including, but not limited to, transportation, lodging and repatriation are excluded.

ASSISTED STEERING DEVICES IN CARS

Assisted steering devices in cars.

AUTO ACCIDENTS

This Plan of Benefits does not provide coverage for claims paid or payable under an automobile insurance policy or any other type of liability insurance policy. Automobile insurance policies include, but are not limited to, no fault, personal injury protection, medical payments, liability, uninsured and underinsured policies, umbrella or any other insurance coverage which may be paid or payable for the injury or illness.

BEHAVIORAL, EDUCATIONAL OR ALTERNATE THERAPY PROGRAMS

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

1. Teaching, Expanding, Appreciating, Collaborating and Holistic (TEACCH) programs;
2. Higashi schools/daily life;
3. Facilitated communication;
4. Floor time;
5. Developmental Individual-Difference Relationship-based model (DIR);
6. Relationship Development Intervention (RDI);
7. Group socialization;
8. Primal therapy;
9. Holding therapy;
10. Movement therapy;
11. Art therapy;
12. Dance therapy;
13. Music therapy;
14. Animal assisted therapy;
15. Sexual conversion therapy; and,
16. Cranial electrical stimulation (CES).

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 healthcare benefits, including, but not limited to, Medicare, TRICARE and Medicaid, 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.

CHIROPRACTIC SERVICES

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, including unattended electrical stimulation, including Transcutaneous Electrical Nerve Stimulation (TENS) units when performed in the office.

CLINICAL TRIAL

Any of the following:

1. Services that are not covered routine patient care costs or services, including the following:

    a. The investigational drug, device, item or service that is provided solely to satisfy data collection and analysis needs;

    b. An item or service that is not used in the direct clinical management of the Member; and,

    c. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

2. An item or service provided by the research sponsors free of charge for any person enrolled in the Clinical Trial; and,

3. Travel and transportation expenses unless otherwise covered under the Plan of Benefits, including, but not limited to:

    a. Fees for personal vehicle, rental car, taxi, medical van, ambulance, commercial airline or train;

    b. Mileage reimbursement for driving a personal vehicle;

    c. Lodging; and,

    d. Meals.

COMPLICATIONS FROM NON-COVERED SERVICES

Complications arising from a Member’s receipt or use of services, Medical Supplies or other treatment that are not Benefits.

CONTRACEPTIVES

Medical Supplies, services, 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, 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 injury or accident, congenital anomaly or covered Surgical Service; and,
   3. The proposed service is Preauthorized.

CRANIAL ORTHOTICS

Adjustable cranial orthoses (band or helmet) for positional plagiocephaly or craniosynostoses in the absence of cranial vault remodeling surgery.

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 covered if the need for dental services results from an accidental injury within twelve (12) months prior to the date of such services.

FOOD SUPPLEMENTS

Orthomolecular therapy, including infant formula, nutrients, vitamins and food supplements administered by mouth. Enteral feedings administered via a feed tube, including prescription and over-the-counter formulations, when not a sole source of nutrition, except as specified on the Schedule of Benefits.

FOOT CARE

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

GENDER DYSPHORIA AND AFFIRMING SURGICAL SERVICES

Any charges for medical and clinical consultation and services for gender altering or affirming medical or surgical services.

HAIR REPLACEMENTS

Wigs, hairpieces and any other artificial substitute for scalp hair other than when prescribed by a Provider for hair loss as a result of a condition such as, but not limited to, cancer, alopecia, burns or cranial surgery.

HEARING AID EXAMS

Examinations for the prescription or fitting of hearing aids.

HUMAN ORGAN AND TISSUE TRANSPLANTS

Human organ and tissue transplants that are not:

1. Preauthorized, if required, as set forth on the Schedule of Benefits;
2. Performed by a Provider as designated by the Claims Administrator; and,
3. Listed as covered on the Schedule of Benefits.

Medical and surgical expenses for care and treatment of a living human organ transplant donor are not covered.

ILLEGAL ACTS

Any illness or injury received, directly or indirectly, related to and/or contributed to, in whole or in part, while committing or attempting to commit a felony or while engaging or attempting to engage in an illegal act or occupation.

IMPACTED TOOTH REMOVAL

Services or Medical Supplies for the removal of impacted teeth.

IMPOTENCE

Services, supplies or drugs related to any treatment for impotence, including but not limited to penile implants unless the condition is the result of Medically Necessary prostate cancer surgery.

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, unless covered under a prior Plan.

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.

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 directly or indirectly resulting from, related to and/or contributed to, in whole or in part, a Member being Legally Intoxicated or under the influence of alcohol, chemicals, narcotics, drugs and/or other substances, 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, chemical, narcotic, drug and/or substance levels upon request by the Claims Administrator. If the Member refuses to provide these test results, no Benefits will be provided.

INVESTIGATIONAL OR EXPERIMENTAL SERVICES

Services or supplies or drugs that are Investigational or Experimental.

LIFESTYLE IMPROVEMENT SERVICES

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

LONG-TERM CARE SERVICES

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

1. Rest care;

2. 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);

3. Custodial or long-term care; or,

4. Psychiatric or Substance Use Disorder treatment, including, but not limited to, behavioral modification facilities, wilderness programs, boot camps, emotional group academies, military schools, therapeutic boarding schools, halfway houses and group homes.

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 payable to a trainer of any type.

MOTORIZED WHEELCHAIRS OR POWER OPERATED VEHICLES

Motorized wheelchairs or power operated vehicles, such as scooters for mobility outside of the home setting, except as specified on the Schedule of Benefits. Coverage for these devices to assist with mobility in the home setting is subject to the establishment of Medical Necessity.

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, Benefits may be paid in an amount equal to the amount payable had the service been rendered in the least costly setting.

NUTRITIONAL COUNSELING

Nutritional counseling.

OBESITY RELATED SERVICES

1. Services, supplies, treatment or medication for the management of obesity or morbid obesity.

2. Surgical procedures for the treatment of morbid obesity, including services, supplies and charges for the treatment of compications from or reversal of such procedures.

3. Membership fees to weight control programs, except as specified 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 for Over-the-Counter Drugs that are designated as Prescription Drugs by the Claims Administrator, listed as covered on the PDL accordingly and prescribed by a Provider.

PAIN MANAGEMENT

Services, supplies or charges for any kind of pain management, including but not limited to, wellness or alternative treatment programs, acupuncture, massage therapy, Transcutaneous Electrical Nerve Stimulation (TENS) unit therapy and hypnotism. The Claims Administrator may, in its discretion under certain limited circumstances, approve services for an interdisciplinary pain management program, as defined herein. An interdisciplinary pain management program is a program that includes physicians of different specialties and non-physician Providers who specialize in the assessment and management of patients with a range of painful diagnoses and chronic pain, the purpose of which is intended to provide the interventions needed to allow the patients to develop pain coping skills and discontinue analgesic medication. Services, supplies or charges for an interdisciplinary pain management program must be Preauthorized in advance. Preauthorization approval shall be on a case by case basis, in the discretion of the Claims Administrator, and contingent upon such program, and the Providers offering such program, complying with the Claims Administrator's Provider credentialing and medical policy requirements, which may change from time to time based on new evidence-based medical information available to the Claims Administrator. The Member is solely responsible for seeking Preauthorization in advance, regardless of the state of location of the Provider offering the interdisciplinary pain management program.

PARTICIPATING PROVIDER CHARGES NOT PREAUTHORIZED

For any service that requires Preauthorization, the penalty for not obtaining Preauthorization will vary from state to state, depending on the contractual agreements the BCBS Plan has with its local Providers in that state. Generally, this is a penalty to the Provider, but in some cases, the Member may be held liable.

PHYSICAL THERAPY ADMISSIONS

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

PREOPERATIVE ANESTHESIA CONSULTATION

Charges for preoperative anesthesia consultation.

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.

REPATRIATION

Services and supplies received as the result of transporting a Member, regardless of cause, from a foreign country for the convenience of the Member or to the Member's residence in the United States.

RETAIL PRESCRIPTION DRUG EXCLUSIONS

Charges for:

1. Prescription Drugs that are specifically listed on the website as excluded;

2. Prescription Drugs that have not been prescribed by a Provider acting within the scope of such Provider's license;

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

4. 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;

5. Any type of service or handling fee (with the exception of the dispensing fee charged by the pharmacist for filling a prescription) for Prescription Drugs;

6. Dosages that exceed the recommended daily dosage of any Prescription Drug based on the following guidelines as described in the current:

    a. United States Pharmacopeia (USP);

    b. Facts and Comparisons; and/or,

    c. Physicians' Desk Reference.

7. Prescription Drugs used for or related to cosmetic purposes (including hair growth and skin wrinkles), obesity or weight control, travel vaccinations, seasonal vaccinations, non-seasonal vaccinations, infertility or impotence, including but not limited to fertility drugs, except when prescribed for benign prostatic hypertrophy, over-the-counter and prescription birth control devices, except as specified on the Schedule of Benefits;

8. 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:

    a. Prescription Drugs for a specific medical condition that have at least two (2) formal clinical studies; or,

    b. 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.

9. Prescription Drugs that are not consistent with the diagnosis and treatment of a Member's illness, injury or condition, are excessive in terms of the scope, duration, dosage or intensity of drug therapy that is needed to provide safe, adequate and appropriate care or are not provided in compliance with any applicable place of service requirements;

10. Prescription Drugs or services administered or dispensed when the required Preauthorization is not obtained;

11. 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);

12. Prescription Drugs which are part of a Utilization Management program and do not meet the requirements of such program;

13. Prescription Drugs which are new to the market and which are under clinical review by the Claims Administrator 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;

14. Prescription Drugs, as determined by the Claims Administrator, for which the costs and associated services are in any way paid for, through or under a pharmaceutical manufacturer or other discount card or coupon program on behalf of the Member;

15. 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,

16. Non-prescription mineral supplements, non-prescription 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.

SERVICES FOR CERTAIN DIAGNOSES OR DISORDERS

Medical Supplies or services or charges for the diagnosis or treatment of learning disorders, communication disorders, motor skills disorders, intellectual disabilities, vocational rehabilitation, relational problems or rapid opiate detoxification, except as specified 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 themself or rendered by a Member’s immediate family (parent, Child, Spouse, brother, sister, grandparent or in-law).

SERVICES REQUIRING PREAUTHORIZATION FOR WHICH SUCH PREAUTHORIZATION IS NOT OBTAINED

If Preauthorization is required for an otherwise Covered Expense and such Preauthorization is not obtained, Benefits may be reduced or denied as set forth on the Schedule of Benefits.

TRAVEL

Travel, whether or not recommended by a Provider unless directly related to human organ or tissue transplants for recipients when Preauthorized and except as specified on the Schedule of Benefits.

VISION CARE SERVICES

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

WORKERS' COMPENSATION/ON THE JOB INJURIES

This Plan of Benefits does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained or alleged by a Member that arises out of, in connection with, or as the result of, any work for wage or profit when coverage is available under any Workers' Compensation Act or similar federal or state law regarding on the job injuries is required or is otherwise available for the Member. Benefits will not be provided under this Plan of Benefits if coverage under the Workers' Compensation Act or similar law would have been available to the Member but the Member or Employer elected exemption from available workers' compensation coverage, waived entitlement to workers' compensation benefits for which the Member 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 or Workers' Compensation Carrier.

If the Group Health Plan pays Benefits for an injury or illness and the Group Health Plan determines the Member also received a recovery from the Employer or Employer's Workers' Compensation Carrier by means of a settlement, judgment or other payment for the same injury or illness, the Group Health Plan shall have the right of recovery as outlined in Article IX of this Plan of Benefits.

ARTICLE V - COORDINATION OF BENEFITS

A. APPLICABILITY

The coordination of benefits rules are intended to prevent duplicate payments from different Plans that otherwise cover a Member for the same Benefits. The rules determine which is the Primary Plan and which is the Secondary Plan.

Generally, unless a specific rule applies, where a claim is submitted for payment under this Plan of Benefits and one (1) or more other Plans, this Plan of Benefits is the Secondary Plan. Additionally, special rules for the coordination of benefits with Medicare may also apply. The Group Health Plan does not coordinate benefits with individual Plans.

B. COORDINATION OF BENEFITS WITH AUTO INSURANCE

This is a self-funded ERISA Plan which does not provide benefits for claims which are paid or payable under automobile insurance coverage. Automobile insurance coverage shall include, but is not limited to, no-fault, personal injury protection, medical payments, liability, uninsured and underinsured coverage, umbrella or any other insurance coverage which may be paid or payable for the injury or illness.

Although benefits for claims which are paid or payable under automobile insurance coverage are not covered by this Plan of Benefits, the Group Health Plan or Claims Administrator may, in its sole discretion, agree to extend Benefits to a Member for the injury or illness. In this instance, if a Member has automobile no-fault, personal injury protection or medical payments coverage, or if such coverage is extended to the Member through a group or their own automobile insurance carrier, that coverage is primary to the Group Health Plan. The Group Health Plan will always be secondary to automobile no-fault, personal injury protection or medical payments coverage plans and the Group Health Plan will coordinate benefits for claims which are payable under those automobile policies.

If the Member resides in a state where automobile no-fault, personal injury protection or medical payments coverage is mandatory and the Member does not have the state mandated automobile coverage, the Group Health Plan will deny Benefits up to the amount of the state mandated automobile coverage.

This coordination of benefits provision applies whether or not the Member submits a claim under the automobile no-fault, personal injury protection or medical payments coverage.

As a condition of receiving Benefits, the Member must:

1. Immediately notify the Group Health Plan or Claims Administrator of an injury or illness for which automobile insurance coverage may be liable, legally responsible, or otherwise makes a payment in connection with the injuries or illness;

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

3. Deliver to the Group Health Plan or Claims Administrator a copy of your Personal Injury Protection Log, Medical Payments log and/or Medical Authorization within ninety (90) days of being requested to do so;

4. Deliver to the Group Health Plan or Claims Administrator a copy of the police report, incident or accident report, or any other reports issued as a result of the injuries or illness within ninety (90) days of being requested to do so; and,

5. Cooperate fully with the Group Health Plan or Claims Administrator 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 Group Health Plan or Claims Administrator.

Failure to cooperate with the Group Health Plan as required under this section will entitle the Group Health Plan or Claims Administrator to invoke the Auto Accident Exclusion and deny payment for all claims relating to the injury or illness up to the amount of available or state mandated coverage.

C. ORDER OF DETERMINATION RULES FOR EMPLOYEE MEMBERS

When a Member's claim is submitted under the Group Health Plan and another Plan, the Group Health Plan is a Secondary Plan unless:

1. The other Plan has rules coordinating its benefits with those of the Group Health Plan;

2. There is a statutory requirement establishing that the Group Health Plan is the Primary Plan and such statutory requirement is not pre-empted by ERISA; or,

3. Both the other Plan's rules and the Group Health Plan's rules require that Benefits under this Plan of Benefits be determined before those of the other Plan.

D. ADDITIONAL ORDER OF DETERMINATION RULES

The coordination of benefits is determined using the first of the following rules that apply:

1. Dependents

    a. The Plan that covers an individual as an Employee or retiree is the Primary Plan.

2. Dependent Child - Parents not Separated or Divorced

   When the Group Health Plan 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 Claims Administrator 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 parent’s Spouse with the custody of the Child;

   c. Third, the Plan of the parent not having custody of the Child; or,

   d. Fourth, the Plan of the parent’s Spouse 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 healthcare expenses (or health insurance coverage) 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, that Plan is the Primary Plan. If the parent with responsibility for healthcare expenses has no health insurance coverage for the Dependent Child, but that parent’s Spouse does have coverage, the Spouse’s Plan is the Primary 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 healthcare expenses of the Child (or if the order provides that both parents are responsible), the Plans covering the Child shall follow the order of determination rules outlined in Article V(D)(2). Once the Dependent Child reaches the age of eighteen (18) and/or the terms of the court decree are no longer applicable, the Plan which has covered the Dependent for a longer period of time will be primary.

4. Active and Inactive Employees

   The benefits of the Plan that covers a person as an Employee who is neither laid off nor retired or as that Employee's dependent is the Primary Plan. If the Secondary 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

   The Group Health Plan is a Primary Plan except where federal law mandates that the Group Health Plan 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. Continuation Coverage

   In instances where a Member is covered by this Group Health Plan and other employer-sponsored coverage and only one of them is continuation coverage (*e.g.*, COBRA or other continuation coverage), such continuation coverage will be the Secondary Plan.

E. EFFECT ON BENEFITS OF THIS PLAN OF BENEFITS

1. The Group Health Plan as Primary Plan

   When the Group Health Plan is the Primary Plan, the Benefits shall be determined without consideration of the benefits of any other Plan.

2. The Group Health Plan as Secondary Plan

   When the Group Health Plan 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 the Group Health Plan are reduced in this manner, each Benefit is reduced in proportion and then charged against any applicable limit of the Group Health Plan. The benefits payable by the Primary Plan and the Benefits payable by the Group Health Plan will not total more than the Allowable Charge.

3. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered for purposes of determining the appropriate level of coverage available.

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 Group Health Plan (including through the Claims Administrator) 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 the Group Health Plan. In such a case, the Group Health Plan may pay that amount to the organization that made such payment. That amount will then be treated as though it has been paid under the Group Health Plan. 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 Group Health Plan is more than the Group Health Plan should have paid, the Group Health Plan may recover the excess or overpayment from the Member on whose behalf it has made payments, from a Provider, 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 AN EMPLOYEE'S COVERAGE AND ALL OF SUCH EMPLOYEE'S DEPENDENTS' COVERAGE WILL OCCUR ON THE EARLIEST OF THE FOLLOWING CONDITIONS:

1. The date the Group Health Plan is terminated pursuant to Article VI(B)-(E);

2. The date an Employee retires unless the Group Health Plan 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 twelve (12) months 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 a court order ending the marriage between the Dependent Spouse and the Employee regardless of whether such order 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 the Group Health Plan;

7. In addition to terminating when an Employee's coverage terminates, an Incapacitated Dependent's coverage terminates when that individual no longer meets the definition of an Incapacitated Dependent;

8. Upon the death of the Employee; or,

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. A Declaration to Terminate Domestic Partnership form must be completed by the Employee and submitted to the director of Human Resources for approval.

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

B. TERMINATION FOR FAILURE TO PAY PREMIUMS

1. If a Member fails to pay the Premium during the Grace Period, such Member shall automatically be terminated from participation in the Group Health Plan, without prior notice to such Member.

2. In the event of termination for failure to pay Premiums, Premiums received after termination will not automatically reinstate the Employee in participation under the Group Health Plan absent written agreement by the Employer. If the Employee's participation in the Group Health Plan is not reinstated, the late Premium will be refunded to the Employee.

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. If Premiums are not paid by an Employee, coverage ends as of the due date of that Premium contribution.

Reason You Stopped Active Work	Period Of Time
Sickness or injury	Twelve (12) continuous months
Layoff	None
Non-Medical Leave of absence	Twelve (12) continuous months

D. NOTICE OF TERMINATION TO MEMBERS

Other than as expressly required by law, if the Group Health Plan is terminated for any reason, the Employer is solely responsible for notifying all Members of such termination and that coverage will not continue beyond the termination date.

E. REINSTATEMENT

The Group Health Plan**,** in its discretion (and upon such terms and conditions as any stop-loss carrier or the Employer may determine), may reinstate coverage under the Group Health Plan that has been terminated for any reason. If a Member's coverage (including coverage for the Member's Dependents) for Covered Expenses under the Group Health Plan terminates while the Member is on leave pursuant to the Family and Medical Leave Act because the Member fails to pay such Member's Premium, 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.

F. 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 Group Health Plan. The Member further agrees that notifications received from, or given to, the Employer by the Claims Administrator are notification to the Employees except for any notice required by law to be given to the Members by the Claims Administrator.

ARTICLE VII – CONTINUATION OF COVERAGE

A. CONTINUATION

1. COBRA

   a. Plan Administrator and Sponsor

      The Employer is both the Plan Administrator and Plan Sponsor for the Group Health Plan. The Employer agrees to offer continuation of coverage pursuant to the provisions of COBRA, if required, to eligible Members while the Group Health Plan 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:

      i. is determined to be disabled under Title II or XVI of the Social Security Act,

      ii. 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:

         aa. sixty (60) days of the determination of disability; and,

         bb. before the end of the first eighteen (18) months of COBRA coverage.

      Such Employee or Dependent 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 the Group Health Plan ceases because of the Qualifying Event;

ii. The date the Member is sent notice by the Employer of the right to elect continuation coverage; 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 (TAA).

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.

The 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 Claims Administrator (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 866-628-4282. TTD/TTY callers may call toll free at 866-626-4282. More information about the TAA 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 the Group Health Plan 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 COBRA Administrator 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(A)(1)(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.

2. USERRA

a. In any case in which an Employee or any of such Employee's Dependents has coverage under the 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 the Plan of Benefits as provided in this Article VII(A)(2). 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 the Group Health Plan upon re-employment. Except as otherwise provided in this Article 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 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. The Article VII(A)(2)(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.

B. QUALIFIED MEDICAL CHILD SUPPORT ORDER

The Group Health Plan 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 Group Health Plan:

i. The Employer shall promptly notify the Employee and each Alternate Recipient of the receipt of the Medical Child Support Order and the Employer'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 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 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 the 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 fiduciary for the Group Health Plan 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 the Group Health Plan 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 the Group Health Plan 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 Group Health Plan 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 the Group Health Plan but fails to enroll an Alternate Recipient under the 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 the Group Health Plan, 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. BENEFITS SUBJECT TO THIS PROVISION

This provision shall apply to all Benefits provided under any section of the Plan of Benefits. All Benefits under this Plan of Benefits are being provided by a self-funded ERISA plan.

B. STATEMENT OF PURPOSE

Subrogation and Reimbursement represent significant Group Health Plan assets and are vital to the financial stability of the Group Health Plan. Subrogation and Reimbursement recoveries are used to pay future claims by other Group Health Plan members. Anyone in possession of these assets holds them as a fiduciary and constructive trustee for the benefit of the Group Health Plan. The Group Health Plan has a fiduciary obligation under the Employee Retirement Income Security Act (ERISA) to pursue and recover these Group Health Plan assets to the fullest extent possible.

C. DEFINITIONS

1. Another Party

   Another Party shall mean any individual or entity, other than the Group Health Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Member's injuries or illness.

   Another Party shall include the party or parties who caused the injuries or illness; the liability insurer, guarantor or other indemnifier of the party or parties who caused the injuries or illness; a Member's own insurance coverage, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other insurer; a workers' compensation insurer or governmental entity; or, any other individual, corporation, association or entity that is liable or legally responsible for payment in connection with the injuries or illness.

2. Member

   As it relates to the Subrogation and Reimbursement Provision, a Member shall mean any person, Dependent or representatives, other than the Group Health Plan, who is bound by the terms of the Subrogation and Reimbursement Provision herein. A Member shall include but is not limited to any beneficiary, Dependent, Spouse or person who has or will receive Benefits under the Group Health Plan, and any legal or personal representatives of that person, including parents, guardians, attorneys, trustees, administrators or executors of an estate of a Member, and heirs of the estate.

3. Recovery

   Recovery shall mean any and all monies identified, paid or payable to the Member through or from Another Party by way of judgment, award, settlement, covenant, release or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the injuries or illness. A Recovery exists as soon as any fund is identified as compensation for a Member from Another Party. Any recovery shall be deemed to apply, first, for Reimbursement of the Group Health Plan's lien. The amount owed from the Recovery as Reimbursement of the Group Health Plan's lien is an asset of the Group Health Plan.

4. Reimbursement

   Reimbursement shall mean repayment to the Group Health Plan of recovered medical or other Benefits that it has paid toward care and treatment of the injuries or illness for which there has been a Recovery.

5. Subrogation

   Subrogation shall mean the Group Health Plan's right to pursue the Member's claims for medical or other charges paid by the Group Health Plan against Another Party.

D. WHEN THIS PROVISION APPLIES

This provision applies when a Member incurs medical or other charges related to injuries or illness caused in part or in whole by the act or omission of the Member or another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the injuries or illness; or Another Party may otherwise make a payment without an admission of liability. If so, the Member may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Member agrees, as a condition of receiving Benefits from the Group Health Plan, to transfer to the Group Health Plan all rights to recover damages in full for such Benefits.

E. DUTIES OF THE MEMBER

The Member will execute and deliver all required instruments and papers provided by the Group Health Plan or Claims Administrator, including an accident questionnaire, as well as doing and providing whatever else is needed, to secure the Group Health Plan's rights of Subrogation and Reimbursement, before any medical or other Benefits will be paid by the Group Health Plan for the injuries or illness. The Group Health Plan or Claims Administrator may determine, in its sole discretion, that it is in the Group Health Plan's best interests to pay medical or other Benefits for the injuries or illness before these papers are signed (for example, to obtain a prompt payment discount); however, in that event, the Group Health Plan will remain entitled to Subrogation and Reimbursement. In addition, the Member will do nothing to prejudice the Group Health Plan's right to Subrogation and Reimbursement and acknowledges that the Group Health Plan precludes operation of the made-whole and common-fund doctrines. A Member who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the portion of the Recovery subject to the Group Health Plan's lien to the Group Health Plan under the terms of this provision. A Member who receives any such Recovery and does not immediately tender the Group Health Plan's portion of the Recovery to the Group Health Plan will be deemed to hold the Group Health Plan's portion of the Recovery in constructive trust for the Group Health Plan, because the Member is not the rightful owner of the Group Health Plan's portion of the Recovery and should not be in possession of the Recovery until the Group Health Plan has been fully reimbursed. The portion of the Recovery owed by the Member for the Group Health Plan's lien is an asset of the Group Health Plan.

As a condition of receiving Benefits, the Member must:

1. Immediately notify the Group Health Plan or Claims Administrator of an injury or illness for which Another Party may be liable, legally responsible or otherwise makes a payment in connection with the injuries or illness;

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

3. Deliver to the Group Health Plan or Claims Administrator a copy of the Personal Injury Protection Log, Medical Payments log and/or Medical Authorization within ninety (90) days of being requested to do so;

4. Deliver to the Group Health Plan or Claims Administrator a copy of the police report, incident or accident report, or any other reports issued as a result of the injuries or illness within ninety (90) days of being requested to do so;

5. Authorize the Group Health Plan or Claims Administrator 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 or illness under the Group Health Plan and the expenses incurred by the Group Health Plan or Claims Administrator in collecting this amount, and assign to the Group Health Plan the Member's rights to Recovery when this provision applies;

6. Include the amount paid for Benefits as a part of the damages sought against Another Party. Immediately reimburse the Group Health Plan or Claims Administrator, out of any Recovery made from Another Party, the amount of medical or other Benefits paid for the injuries or illness by the Group Health Plan up to the amount of the Recovery and without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise;

7. Immediately notify the Group Health Plan or Claims Administrator in writing of any proposed settlement and obtain the Group Health Plan or Claims Administrator's written consent before signing any release or agreeing to any settlement; and,

8. Cooperate fully with the Group Health Plan or Claims Administrator 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 Group Health Plan or Claims Administrator.

F. FIRST PRIORITY RIGHT OF SUBROGATION AND/OR REIMBURSEMENT

Any amounts recovered will be subject to Subrogation or Reimbursement. The Member's submission of claims for illnesses or injury caused by Another Party constitutes the Member's agreement to the terms of this provision and the Member's grant to the Group Health Plan of a first priority equitable lien by agreement. The Group Health Plan's right to recover exists regardless of whether it is based on Subrogation or Reimbursement.

The Group Health Plan will be subrogated to all rights the Member may have against that other person or Another Party and will be entitled to first priority Reimbursement out of any Recovery to the extent of the Group Health Plan's payments. In addition, the Group Health Plan shall have a first priority equitable lien against any Recovery to the extent of Benefits paid and to be payable in the future. The Group Health Plan's first priority equitable lien supersedes any right that the Member may have to be "made whole." In other words, the Group Health Plan is entitled to the right of first Reimbursement out of any Recovery the Member procures or may be entitled to procure regardless of whether the Member has received full compensation for any of such Member's damages or expenses, including attorneys' fees or costs and regardless of whether the Recovery is designated as payment for medical expenses or otherwise. Additionally, the Group Health Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative or contributory negligence, limits of collectability or responsibility, characterization of Recovery as pain and suffering or otherwise. As a condition to receiving Benefits under the Group Health Plan and Plan of Benefits, the Member agrees that acceptance of Benefits is constructive notice of this provision.

G. WHEN A MEMBER RETAINS AN ATTORNEY

An attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) for an injury or illness in which the Group Health Plan has paid or will pay Benefits, has an absolute obligation to immediately tender the portion of the Recovery subject to the Group Health Plan's equitable lien to the Group Health Plan under the terms of this provision. As a possessor of a portion of the Recovery, the Member's attorney holds the Recovery as a constructive trustee and fiduciary and is obligated to tender the Group Health Plan's portion of the Recovery immediately over to the Group Health Plan. A Member's attorney who receives any such Recovery and does not immediately tender the Group Health Plan's portion of the Recovery to the Group Health Plan will be deemed to hold the Recovery in constructive trust for the Group Health Plan, because neither the Member nor the attorney is the rightful owner of the portion of the Recovery subject to the Group Health Plan's lien. The portion of the Recovery owed for the Group Health Plan's lien is an asset of the Group Health Plan.

If the Member retains an attorney, the Member's attorney must recognize and consent to the fact that this provision precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine against the Group Health Plan in such attorney's pursuit of Recovery. The Group Health Plan will not pay the Member's attorneys' fees and costs associated with the recovery of funds, nor will it reduce its Reimbursement pro rata for the payment of the Member's attorneys' fees and costs, without the expressed written consent of the Claims Administrator.

H. WHEN THE MEMBER IS A MINOR OR IS DECEASED OR INCAPACITATED

This Subrogation and Reimbursement Provision will apply with equal force to the parents, trustees, guardians, administrators, or other representatives of a minor, incapacitated, or deceased Member and to the heirs or personal and legal representatives, regardless of applicable law. No representative of a Member listed herein may allow proceeds from a Recovery to be allocated in a way that reduces or minimizes the Group Health Plan's claim by arranging for others to receive proceeds of any judgment, award, settlement, covenant, release or other payment or releasing any claim in whole or in part without full compensation therefore or without the prior written consent from the Group Health Plan or Claims Administrator.

I. WHEN A MEMBER DOES NOT COMPLY

When a Member does not comply with the provisions of this section, the Group Health Plan or Claims Administrator shall have the authority, in its sole discretion, to deny payment of any claims for Benefits by the Member and to deny or reduce future Benefits payable (including payment of future Benefits for other injuries or illnesses) under this Plan of Benefits by the amount due as satisfaction for the Reimbursement to the Group Health Plan. The Group Health Plan or Claims Administrator may also, in its sole discretion, deny or reduce future Benefits (including future Benefits for other injuries or illnesses) for the Member under any other group benefits plan maintained by the Employer. The reductions will equal the amount of the required Reimbursement; however, under no circumstances shall the Reimbursement, denial or reduction of Benefits exceed the amount of the Recovery. If the Group Health Plan must bring an action against a Member to enforce the provisions of this section, then the Member agrees to pay the Group Health Plan's attorneys' fees and costs, regardless of the action's outcome.

J. PRIOR RECOVERIES

In certain circumstances, a Member may receive a Recovery that exceeds the amount of the Group Health Plan's payments for past and/or present expenses for treatment of the injuries or illness that is the subject of the Recovery. In other situations, based on the extent of the Member's injuries or illness, the Member may have received a prior Recovery for treatment of the injuries or illness that is the subject of a claim for Benefits under the Group Health Plan. In these situations, the Group Health Plan will not provide Benefits for any expenses related to the injuries or illness for which compensation was provided through a current or previous Recovery. The Member is required to submit full and complete documentation of any such Recovery in order for the Group Health Plan to consider eligible expenses. To the extent a Member's Recovery exceeds the amount of the Group Health Plan's lien, the Group Health Plan is entitled to deny that amount as an offset against any claims for future Benefits relating to the injuries or illness. In those situations, the Member will be solely responsible for payment of medical bills related to the injuries or illness. The Group Health Plan also precludes operation of the made-whole and common-fund doctrines in applying this provision.

The Group Health Plan or Claims Administrator has sole discretion to determine whether expenses are related to the injuries or illness to the extent this provision applies. Acceptance of Benefits under this Plan of Benefits for injuries or illness which the Member has already received a Recovery may be considered fraud, and the Member will be subject to any sanctions determined by the Group Health Plan or Claims Administrator, in their sole discretion, to be appropriate, including denial of present or future Benefits under this Plan of Benefits.

ARTICLE IX - WORKERS' COMPENSATION PROVISION

This Plan of Benefits does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained or alleged 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 of Benefits if coverage under the Workers' Compensation Act or similar law would have been available to the Member but the Member or the Employer elected exemption from available workers' compensation coverage; waived entitlement to workers' compensation benefits for which the Member 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 not authorized by the Member's Employer or Workers' Compensation carrier.

Although treatment for work-related or alleged work-related injuries or illness is excluded under this Plan of Benefits, the Group Health Plan or Claims Administrator may, in its sole discretion, agree to extend coverage to a Member for the injury or illness. In this instance, the Member agrees, as a condition of receiving Benefits, to reimburse the Group Health Plan in full from any workers' compensation recovery as described herein. The Member further agrees as a condition of receiving Benefits, to execute and deliver all required instruments and papers provided by the Group Health Plan or Claims Administrator, including an accident questionnaire, as well as doing and providing whatever else is needed, to secure the Group Health Plan's right of recovery, before any medical or other Benefits will be paid by the Group Health Plan for the injuries or illness. The Group Health Plan or Claims Administrator may determine, in its sole discretion, that it is in the Group Health Plan's best interests to pay medical or other Benefits for the injuries or illness before these papers are signed (for example, to obtain a prompt payment discount); however, in that event, the Group Health Plan will remain entitled to reimbursement from any workers' compensation recovery the Member may receive.

As a condition of receiving Benefits, the Member must:

1. Immediately notify the Group Health Plan or Claims Administrator of an injury or illness for which the Member's 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 to the Claims Administrator an accident questionnaire within one hundred eighty (180) days of the accident questionnaire being mailed to the Member;

3. Deliver to the Group Health Plan or Claims Administrator 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 amount paid for Benefits as a part of the damages sought against the Member's Employer and/or Employer's Workers' Compensation carrier. Immediately reimburse the Group Health Plan, out of any recovery made from the Employer and/or Employer's Workers' Compensation carrier, the amount of medical or other Benefits paid for the injuries or illness by the Group Health Plan up to the amount of the recovery and without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise;

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

7. Cooperate fully with the Group Health Plan or Claims Administrator 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 Group Health Plan or Claims Administrator.

The Group Health Plan or Claims Administrator has sole discretion to determine whether claims for Benefits submitted under the Plan of Benefits are related to the injuries or illness to the extent this provision applies. If the Group Health Plan or Claims Administrator pays Benefits for an injury or illness and the Group Health Plan or Claims Administrator 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 Group Health Plan from the recovery for all Benefits paid by the Group Health Plan relating to the injury or illness. However, under no circumstances shall the Member's reimbursement to the Group Health Plan exceed the amount of such recovery.

If the Member receives a recovery from the Employer and/or Employer's Workers' Compensation carrier, the Group Health Plan'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 healthcare is not agreed upon or defined by the Member, Employer or the Workers' Compensation carrier; or the medical or healthcare benefits are specifically excluded from the settlement or compromise.

Failure to reimburse the Group Health Plan from the recovery as required under this section will entitle the Group Health Plan or Claims Administrator to invoke the Workers' Compensation exclusion and deny payment for all claims relating to the injury or illness.

ARTICLE X - ERISA RIGHTS

Each Member in the 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 the Group Health Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Group Health Plan 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 the Group Health Plan, 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 the Group Health Plan's 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 healthcare coverage for themselves and their Dependents if there is a loss of coverage under the Group Health Plan 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 and control its assets are called "fiduciaries," and have a duty to do so prudently and in the interest of the Members. The Employer is the fiduciary of the Group Health Plan.

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 Group Health Plan documents or the latest annual report from the Group Health 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 Group Health 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 Group Health 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 the Group Health Plan, 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.

F. PLAN SPECIFIC INFORMATION

1. Plan Name:	Group Medical Benefits Plan for the Employees of Nelson Mullins Riley & Scarborough LLP
2. Name and Address of the Employer establishing the Plan:	Nelson Mullins Riley & Scarborough LLP Meridian, Suite 1700 1320 Main Street Columbia, South Carolina 29201
3. Employer's ID Number:	57-0215445
4. Plan Year	01/01 – 12/31
5. Plan Number:	509
6. Type of Welfare Plan:	Medical
7. Plan Funding:	Paid by the Employer and/or the Employee
8. Plan Administration:	Contract administration, payment of claims administration
9. Agent and Address for Service of Legal Process:	Plan Administrator and Address of Plan Administrator
10. Plan Administrator Name, Address and Telephone Number:	Blue Cross and Blue Shield of South Carolina I-20 at Alpine Road Columbia, South Carolina 29219
11. Named Fiduciary:	Nelson Mullins Riley & Scarborough LLP
12. Plan Termination:	The right is reserved in the Plan for the Plan Administrator, by action of its Board of Directors, to terminate, suspend, withdraw, amend or modify the Group Health Plan in whole or in part, with respect to any class or classes of Employees, at any time, with proper notification and subject to the terms of the Group Health Plan and any applicable laws.

13. Plan Document:	A full description of the medical Benefits appears in the official Plan document which is the final authority. These papers may be examined in the company office of the Employer within thirty (30) days after your written request is received by the Plan Administrator.

ARTICLE XI - CLAIMS FILING AND APPEAL PROCEDURES

A. CLAIMS FILING PROCEDURES

1. Where a Participating Provider renders services, generally the Participating Provider should either file the claim on a 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. For Benefits not provided by a Participating Provider, the Member is responsible for filing claims with the Claims Administrator. 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 Claims Administrator'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 EOB 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 Claims Administrator's address listed on the claim form.

3. Except in the absence of legal capacity, claims must be filed no later than fifteen (15) months following the date services were received.

4. Receipt of a claim by the Claims Administrator will be deemed written proof of loss and will serve as written authorization from the Member to the Claims Administrator to obtain any medical or financial records and documents useful to the Claims Administrator. The Claims Administrator, 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 Claims Administrator 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 Claims Administrator for an Authorized Representative form.

5. There are four (4) types of claims: Pre-Service Claims, Urgent Care Claims, Post-Service Claims and Concurrent Care Claims. Determinations for each type of claim will be made 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 Claims Administrator (on behalf of the Group Health Plan) determines that, for reasons beyond the control of the Claims Administrator, an extension is necessary. If an extension is necessary the Claims Administrator 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 Claims Administrator 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 Claims Administrator does not receive the required information within the forty-five (45) day time period, the claim will be denied. The Claims Administrator 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 Claims Administrator 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 Claims Administrator (on behalf of the Group Health Plan) determines that, for reasons beyond the control of the Claims Administrator, an extension is necessary. If an extension is necessary, the Claims Administrator 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 Claims Administrator 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 Claims Administrator does not receive the required information within the forty-five (45) day time period, the claim will be denied. The Claims Administrator 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 Claims Administrator 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.

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

viii. If the reason for denial is based on a lack of Medical Necessity, Investigational or Experimental 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; and,

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.

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. 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;

   b. An appeal must be sent (via U.S. mail) to the following address:

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

   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 Employer will consult with an appropriately qualified healthcare practitioner with training and experience in the relevant field of medicine. If a healthcare professional was consulted for the initial determination, a different healthcare professional will be consulted on the appeal.

5. The final decision on the appeal will be made within the time periods specified below:

   a. Pre-Service Claim

      The Claims Administrator (on behalf of the Group Health Plan) 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 Plan will communicate with the Member by telephone or facsimile. The Plan 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 Claims Administrator (on behalf of the Group Health Plan) 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 Plan will decide the appeal of Concurrent Care Claims within the time frames set forth in Article XI(B)(5)(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 Final Internal 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, healthcare 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 the 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 Claims Administrator (on behalf of the Group Health Plan) 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 is available 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 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. Include a statement regarding the Member's right to bring an action under section 502(a) of ERISA;

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

x. 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.

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

g. The Plan has absolute and exclusive discretion, power, and authority to administer and interpret the Group Health Plan, including but not limited to:

i. Construing the Plan of Benefits or any other Group Health Plan documents, including any language in or omitted from the Plan of Benefits;

ii. Deciding coverage for, eligibility for, entitlement to, or the amount of any Benefits under the Group Health Plan; and,

iii. Processing or resolving any claim, appeal, or demand for Benefits under the Group Health Plan. All such acts or omissions by Plan, whether made directly by Plan or through a third party authorized by Plan (for example, the Claims Administrator), shall be subject to the arbitrary and capricious standard of judicial review.

7. The Plan may retain the Claims Administrator to assist the Plan in making the determination on appeal. Regardless of its assistance, the Claims Administrator is only acting in an advisory capacity and is not acting in a fiduciary capacity. The Plan at all times retains the right to make the final determination.

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 no cost to the Member. An external review may be used to reconsider the Member's claim if the Claims Administrator has denied, either in whole or in part, the Member's claim. In order to qualify for external review, the termination or denial or reduction of the claim must be related to:

   a. Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness of a Benefit;

   b. An Investigational or Experimental service that involves a life-threatening or seriously disabling condition; or,

   c. Administration of the Plan of Benefits' provisions related to cost-sharing and surprise billing protections for emergency or air ambulance services by Non-Participating Providers and care provided by Non-Participating Providers at certain Participating Provider facilities.

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 four (4) months of receiving the notice of the Claims Administrator'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).

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

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

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

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 Claims Administrator's decision if the Claims Administrator's denial of Benefits involves Emergency Services and the Member has not been discharged from the treating Hospital. The independent review organization must make its decision within seventy-two (72) hours after it receives the request for expedited review.

ARTICLE XII - GENERAL PROVISIONS

ADMINISTRATIVE SERVICES ONLY

The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. The Group Health Plan is a self-funded health Plan and the Employer assumes all financial risk and obligation with respect to claims.

AMENDMENT

Upon thirty (30) days prior written notice, the Employer may unilaterally amend the Group Health Plan. Increases in the Benefits provided or decreases in the Premium are effective without such prior notice. The Claims Administrator has no responsibility to provide individual notices to each Member when an amendment to the Group Health Plan 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 Claims Administrator or the Provider a specific designation, in a format that is reasonably acceptable to the Group Health Plan 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

I. Out-of-Area Services

Overview

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 ("BCBSA"). Whenever Members access healthcare services outside the geographic area 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 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. Corporation remains responsible for fulfilling its contractual obligations to you. Corporation's payment practices in both instances are described below.

This disclosure describes how claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with Inter-Plan Arrangements. Note that 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 are not processed through Inter-Plan Arrangements.

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.

1. Liability Calculation Method Per Claim – In General

a. Member Liability Calculation

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 Charges or the negotiated price made available to Corporation by the Host Blue.

b. Employer Liability Calculation

The calculation of the Employer's liability on claims for covered healthcare services processed through the BlueCard Program will be based on the negotiated price made available to Corporation by the Host Blue under the contract between the Host Blue and the Provider. Sometimes, this negotiated price may be greater for a given service or services than the Billed Charge in accordance with how the Host Blue has negotiated with its Participating Provider(s) for specific healthcare services. In cases where the negotiated price exceeds the Billed Charge, the Employer may be liable for the excess amount even when the Member's Benefit Year Deductible has not been satisfied. This excess amount reflects an amount that may be necessary to secure (a) the Provider's participation in the network and/or (b) the overall discount negotiated by the Host Blue. In such a case, the entire contracted price is paid to the Provider, even when the contracted price is greater than the Billed Charge.

2. Claims Pricing

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's Provider contracts. The negotiated price made available to 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 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.

The Host Blue determines whether it will use an actual, estimated or average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price the Employer pays on a specific claim and the actual amount the Host Blue pays to the Provider. However, the BlueCard Program requires that 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.

Any positive or negative differences in estimated or average pricing are accounted for through variance accounts maintained by the Host Blue and are incorporated into future claim prices. As a result, the amounts charged to the Employer will be adjusted in a following year, as necessary, to account for over-or underestimation of the past years' prices. The Host Blue will not receive compensation from how the estimated price or average price methods, described above, are calculated. Because all amounts paid are final, neither positive variance account amounts (funds available to be paid in the following year), nor negative variance amounts (the funds needed to be received in the following year), are due to or from the Employer. If the Employer terminates, you will not receive a refund or charge from the variance account.

Variance account balances are small amounts relative to the overall paid claims amounts and will be liquidated over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of claims processed and variance account balance. Variance account balances may earn interest at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

3. BlueCard Program Fees and Compensation

The Employer understands and agrees to reimburse Corporation for certain fees and compensation which Corporation is obligated under the BlueCard Program to pay to the Host Blues, to BCBSA and/or to vendors of BlueCard Program-related services. The specific BlueCard Program fees and compensation that are charged to Corporation are set forth in Schedule A. BlueCard Program Fees and compensation may be revised from time to time.

B. Negotiated Arrangements

With respect to one or more Host Plans, instead of using the BlueCard Program, Corporation may process your Member claims for covered healthcare services through Negotiated Arrangements.

In addition, if Corporation and the Employer have agreed that (a) Host Blue(s) shall make available (a) custom healthcare Provider network(s) in connection with this Agreement, then the terms and conditions set forth in Corporation's Negotiated Arrangement(s) for National Accounts with such Host Blue(s) shall apply. These include the provisions governing the processing and payment of claims when Members access such network(s). In negotiating such arrangement(s), Corporation is not acting on behalf of or as an agent for the Employer, the Employer's Group Health/ Plan or the Employer's Members.

Member Liability Calculation

Member liability calculation will be based on the negotiated price/lower of either Billed Charges or negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) that the Host Blue makes available to Corporation and that allows the Employer Members access to negotiated participation agreement networks of specified Participating Providers outside of Corporation service area.

The amount the Member pays for Covered Services under such arrangement at the point of service, if not a flat dollar Copayment, will be calculated based on the "price" that the Host Blue passed to Corporation and that allows the Employer's Members access to negotiated participation agreement networks of specified Participating Providers outside of Corporation's service area. The "price" may be the:

(i) Negotiated price/lower of either Billed Charges or negotiated price; or

(ii) Lower of either Billed Charges or negotiated price (refer to the description of negotiated price in this BlueCard Program language).

Under certain circumstances, if Corporation pays the Healthcare Provider amounts that are the responsibility of the Member Corporation may collect such amounts from the Member.

In situations where participating agreements allow for bulk settlement reconciliations for Episode-Based Payment/Bundled Payments, Corporation may include a factor for such settlement reconciliations as part of the fees Corporation charges to the Employer.

Where the Employer agrees to use reference-based Benefits, which are service-specific Benefit dollar limits for specific procedures, based on a Host Blue's local market rates, Members will be responsible for the amount that the healthcare Provider bills for a specified procedure above the reference Benefit limit for that procedure. For a Participating Provider, that amount will be the difference between the negotiated price and the reference Benefit limit. For a Non-Participating Provider, that amount will be the difference between the Provider's Billed Charge and the reference Benefit limit. Where a reference Benefit limit exceeds either a negotiated price or a Provider's Billed Charge, the Member will incur no liability, other than any applicable Member cost sharing under this Agreement.

Fees and Compensation

The Employer understands and agrees to reimburse Corporation for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to BCBSA and/or to vendors of Inter-Plan Arrangement-related services. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time. In addition, the participation agreement with the Host Blue may provide that Corporation must pay an administrative and/or a network Access Fee to the Host Blue, and the Employer further agrees to reimburse Corporation for any such applicable administrative and/or network Access Fees. The specific fees and compensation that are charged to the Employer under Negotiated Arrangements are set forth in Schedule A.

C. Special Cases: Value-Based Programs

Value-Based Programs Overview

The Employer's Members may access covered healthcare services from Providers that participate in a Host Blue's VBP. VBPs may be delivered either through the BlueCard Program or a Negotiated Arrangement. These VBPs may include, but are not limited to, Accountable Care Organizations, Global Payment/Total Cost of Care arrangements, Patient Centered Medical Homes and Value-Based Shared Savings arrangements.

Value-Based Programs under the BlueCard Program

Value-Based Programs Administration

Under VBPs, a Host Blue may pay Providers for reaching agreed-upon cost/quality goals in the following ways:

The Host Blue may pass these Provider payments to Corporation, which Corporation will pass directly on to the Employer as either an amount included in the price of the claim or an amount charged separately in addition to the claim.

When such amounts are included in the price of the claim, the claim may be billed using one of the following pricing methods, as determined by the Host Blue:

(i) Actual Pricing: The charge to accounts for VBP incentives/Value-Based Shared Savings settlements is part of the claim. These charges are passed to the Employer via an enhanced Provider fee schedule.

(ii) Supplemental Factor: The charge to accounts for VBPs incentives/Shared Savings settlements is a supplemental amount that is included in the claim as an amount based on a specified supplemental factor (e.g., a small percentage increase in the claim amount). The supplemental factor may be adjusted from time to time.

When such amounts are billed separately from the price of the claim, they may be billed as follows:

- Where Host Blues pass on the costs of VBPs to Corporation as PMPM amounts not attached to specific claims, Corporation may elect to pass these amounts to the Employer.

The amounts used to calculate either the supplemental factors for estimated pricing or PMPM billings are fixed amounts that are estimated to be necessary to finance the cost of a particular VBP. Because amounts are estimates, there may be positive or negative differences based on actual experience, and such differences will be accounted for in a variance account maintained by the Host Blue (in the same manner as described in the BlueCard claim pricing section above) until the end of the applicable VBP payment and/or reconciliation measurement period. The amounts needed to fund a VBP may be changed before the end of the measurement period if it is determined that amounts being collected are projected to exceed the amount necessary to fund the program or if they are projected to be insufficient to fund the program.

At the end of the VBP payment and/or reconciliation measurement period for these arrangements, Host Blues will take one of the following actions:

- Use any surplus in funds in the variance account to fund VBP payments or reconciliation amounts in the next measurement period.
- Address any deficit in funds in the variance account through an adjustment to the PMPM billing amount or the reconciliation billing amount for the next measurement period.

The Host Blue will not receive compensation resulting from how estimated, average or PMPM price methods, described above, are calculated. If the Employer terminates, you will not receive a refund or charge from the variance account. This is because any resulting surpluses or deficits would be eventually exhausted through prospective adjustment to the settlement billings in the case of VBPs. The measurement period for determining these surpluses or deficits may differ from the term of this Agreement.

Variance account balances are small amounts relative to the overall paid claims amounts and will be liquidated over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of claims processed and variance account balance. Variance account balances may earn interest, and interest is earned at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

Members will not bear any portion of the cost of VBPs except when a Host Blue uses either average pricing or actual pricing to pay Providers under VBPs.

Care Coordinator Fees

Host Blues may also bill Corporation for Care Coordinator Fees for Provider services which we will pass on to the Employer as follows:

1. PMPM billings; or

2. Individual claim billings through applicable Care Coordination codes from the most current editions of either Current Procedural Terminology (CPT) published by the American Medical Association (AMA) or Healthcare Common Procedure Coding System (HCPCS) published by the U.S. Centers for Medicare and Medicaid Services (CMS).

As part of this Agreement, Corporation and the Employer will not impose Member cost sharing for Care Coordinator Fees.

Value-Based Programs under Negotiated Arrangements

If Corporation has entered into a Negotiated National Account Arrangement with a Host Blue to provide VBPs to the Employer's Members, Corporation will follow the same procedures for VBPs administration and Care Coordination Fees as noted in the BlueCard Program section.

For negotiated arrangements, when Control/Home Licensees have negotiated with accounts to waive Member cost sharing for Care Coordinator Fees, the following provision will apply: As part of this Agreement, Corporation and the Employer may agree to waive Member cost sharing for Care Coordinator Fees.

D. Return of Overpayments

Recoveries of overpayments 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 Corporation they will be credited to the Employer's 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.

Voluntary Amendment Language Unless otherwise agreed to by the Host Blue, for retroactive cancellations of membership, Corporation will request the Host Blue to provide full refunds from Participating Providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original claim. For Care Coordinator Fees associated with VBPs, Corporation will request such refunds for a period of only up to ninety (90) days from the termination notice transaction on the payment innovations delivery platform. In some cases, recovery of claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery (a) conflicts with the Host Blue's state law or healthcare Provider contracts, (b) would result from Value-Based Shared Savings and/or Provider Incentive arrangements or (c) would jeopardize the Host Blue's relationship with its Participating Providers, notwithstanding to the contrary any other provision of this Agreement.

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

In some instances laws or regulations may impose a surcharge, tax or other fee that applies to self-funded accounts. If applicable, Corporation will disclose any such surcharge, tax or other fee to the Employer, which will be the Employer's liability.

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

1. Member Liability Calculation

a. In General

When covered healthcare services are provided outside of Corporation's service area by Non-Participating Providers, the amount(s) a/ Member pays for such services will 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 Corporation will make for the covered services as set forth in this paragraph. Payments for out-of-network emergency services will be governed by applicable law.

b. Exceptions

In some exception cases, at the Employer's direction Corporation may pay claims from Non-Participating Providers outside of 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 Corporation or by applicable law. In other exception cases, at the Employer's direction Corporation may pay such claims based on the payment Corporation would make if Corporation were paying a Non-Participating Provider inside of Corporation service area. This may occur where the Host Blue's corresponding payment would be more than Corporation in-service area Non-Participating Provider payment. 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 the payment Corporation will make for the covered services as set forth in this paragraph.

2. Fees and Compensation

The Employer understands and agrees to reimburse Corporation for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to BCBSA and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to the Employer are set forth in Schedule A. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time.

G. Blue Cross Blue Shield Global® Core Program

1. 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 Blue Cross Blue Shield Global Core Program when accessing covered healthcare services. The Blue Cross Blue Shield Global Core Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core 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 Blue Cross Blue Shield Global Core 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 Blue Cross Blue Shield Global Core 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/Covered 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 Blue Cross Blue Shield Global Core 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 Blue Cross Blue Shield Global Core International claim form and send the claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center address on the form to initiate claims processing. The claim form is available from Corporation, the Blue Cross Blue Shield Global Core Service Center, or online at www.bluecardworldwide.com. If Members need assistance with their claim submissions, they should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

2. Blue Cross Blue Shield Global Core Program-Related Fees

The Employer understands and agrees to reimburse Corporation for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to BCBSA and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to the Employer under the Blue Cross Blue Shield Global Core Program are set forth in Schedule A. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time.

CLERICAL ERRORS

Clerical errors by the Claims Administrator or the Employer 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 fraud or a failure to meet applicable quality standards and the Member is a Continuing Care Patient, the Member may be eligible to continue to receive in-network Benefits from that Provider with respect to the course of treatment relating to the Member's status as a Continuing Care Patient.

In order to receive this Continuation of Care, the Member must submit a request to the Claims Administrator on the appropriate form. Upon receipt of the request, the Claims Administrator 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 Claims Administrator will review the request to determine qualification for the Continuation of Care. If additional information is necessary to make a determination, the Claims Administrator may contact the Member or the Provider for such information. If the Claims Administrator approves the request, in-network Benefits for that Provider will be provided, with respect to the course of treatment relating to the Member's status as a Continuing Care Patient, for ninety (90) days or until the date the Member is no longer a Continuing Care Patient for the Provider. 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 OF PHI TO PLAN SPONSOR

The Group Health Plan will disclose (or will require the Corporation to disclose) Member's PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions for the Group Health Plan not inconsistent with the requirements of HIPAA. Any disclosure to and use by the Plan Sponsor will be subject to and consistent with the provisions of paragraphs A and B of this section. The Group Health Plan will also not permit a health insurance issuer with respect to the Group Health Plan to disclose PHI to the Plan Sponsor except as permitted by this paragraph. In addition, the Group Health Plan may not: (a) disclose and may not permit a health insurer to disclose PHI to Plan Sponsor as otherwise permitted by this paragraph unless a statement required by 45 C.F.R. §164.520(b)(1)(iii)(C); and (b) disclose PHI to Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

A. Restrictions on the Plan Sponsor's Use and Disclosure of PHI.

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

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

3. The Plan Sponsor 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 Plan Sponsor.

4. The Plan Sponsor will report to the 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 Plan Sponsor will make PHI available to the Member who is the subject of the information in accordance with HIPAA.

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

7. The Plan Sponsor will track disclosures it may make of Member PHI so that it can make available the information required for the Group Health Plan to provide an accounting of disclosures in accordance with HIPAA.

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

9. The Plan Sponsor will, if feasible, return or destroy all Member PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control), received from the 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 Group Health Plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Member PHI, the Plan Sponsor 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 Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that the Plan Sponsor creates, receives, maintains or transmits on behalf of the Group Health Plan.

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

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

    i. In determining how and how often the Plan Sponsor shall report security incidents to the Group Health Plan, both the Plan Sponsor and the 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 Plan Sponsor and the Group Health Plan agree that this Agreement 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:

        aa. Pings on a party's firewall;

        bb. Port scans;

        cc. Attempts to log on to a system or enter a database with an invalid password or username;

        dd. Denial-of-service attacks that do not result in a server being taken offline; and,

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

ii. The Plan Sponsor shall, however, separately report to the Group Health Plan any successful unauthorized access, use, disclosure, modification or destruction of the Group Health Plan's ePHI of which the Plan Sponsor 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 Group Health Plan's ePHI; or (c) results in a breach of availability of the 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 Plan Sponsor becomes aware of the impact of such security incident upon the Group Health Plan's ePHI.

B. Adequate Separation between the Plan Sponsor and the Group Health Plan.

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

2. These Employees will have access to Member PHI only to perform the Group Health Plan administration functions that the Plan Sponsor provides for the Group Health Plan.

3. These Employees will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of Member PHI in breach or violation of or noncompliance with the provisions of this section. The Plan Sponsor will promptly report such breach, violation or noncompliance to the Group Health Plan and will cooperate with the 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 Plan Sponsor will ensure that the separation required by the above provisions will be supported by reasonable and appropriate security measures.

The Plan Sponsor certifies that the Group Health Plan contains and that the Plan Sponsor agrees to the provisions outlined above.

GOVERNING LAW

The Group Health Plan and Plan of Benefits (including the Schedule of Benefits) are governed by and subject to applicable federal law. If and to the extent that federal law does not apply, the Group Health Plan and Plan of Benefits are 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 the Group Health Plan or Plan of Benefits conflicts with such law, the Group Health Plan and Plan of Benefits shall automatically be amended solely as required to comply with such state or federal law.

IDENTIFICATION CARD

A Member must present the Member's 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.

INFORMATION AND RECORDS

The Claims Administrator and the Employer are entitled to obtain such medical and Hospital records as may reasonably be required from any Provider incident to the treatment, payment and healthcare operations for the administration of the Benefits hereunder and the attending Provider's certification as to the Medical Necessity for care or treatment.

LEGAL ACTIONS

No Member may bring an action at law or in equity to recover under the Group Health Plan until such Member has exhausted the appeal process as set forth in Article XI of the Plan of Benefits. No such action may be brought after the one (1) year anniversary of the pertinent final decision on appeal, or external review as applicable, under the Group Health Plan.

MEMBERSHIP APPLICATION

The Claims Administrator will only accept a Membership Application submitted by the Employer on behalf of its Employees. The Claims Administrator will not accept Membership Applications directly from Employees or Dependents.

NEGLIGENCE OR MALPRACTICE

The Claims Administrator and Employer do 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 Claims Administrator or the Employer. The Claims Administrator and Employer are 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 carrier and addressed:

1. To the Corporation:

   Blue Cross and Blue Shield of South Carolina
   P.O. 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 and Members of any name or address change within thirty-one (31) days of the change.

NO WAIVER OF RIGHTS

On occasion, the Claims Administrator (on behalf of the Group Health Plan) or the Employer may, at their discretion, choose not to enforce all of the terms and conditions of the Group Health Plan or Plan of Benefits. Such a decision does not mean the Group Health Plan or Employer waives or gives up any rights under the Group Health Plan or Plan of Benefits in the future.

OTHER INSURANCE

Each Member must provide the Group Health Plan (and its designee, including the Claims Administrator) and Employer 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 or related to Benefits. The Group Health Plan may pay all Benefits 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 Group Health Plan will pay Benefits directly to such Participating Provider.

PHYSICAL EXAMINATION

The Group Health Plan has the right to have examined, at their own expense, a Member whose injury or sickness is the basis of a claim (whether a Pre-Service Claim, Post-Service Claim, Concurrent Care Claim or Urgent Care Claim). Such physical examination may be made as often as the Group Health Plan (through its designee, including the Claims Administrator) may reasonably require while such claim for Benefits or request for Preauthorization is pending.

REPLACEMENT COVERAGE

If the Group Health Plan 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 the Group Health Plan, provided such persons are enrolled for coverage as stated in Article II.

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हिंदी : ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-844-641-2894 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें। (Hindi)

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አማርኛ ማሳሰቢያ፡- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-844-465-1592 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ። (Amharic)

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বাংলা

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తెలుగు

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Lus Hmoob

LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 1-844-465-1717 (TTY: 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob. (Hmong)

ਪੰਜਾਬੀ

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੇਂ ਪੂਰਕ ਸਹਾਇਕ ਸਾਧਨ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫ਼ਤ ਵਿੱਚ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। 1-844-465-1723 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ। (Punjabi)

ភាសាខ្មែរសូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយ *ភាសាខ្មែរ* សេវាកម្មជំនួយភាសាឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការចាំបាច់សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយឥតគិតថ្លៃផងដែរ។ ហៅទូរស័ព្ទទៅ 1-844-465-1721 (TTY: 711) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។ (Khmer)

فارسي

توجه: اگر فارسی صحبت می‌کنید، خدمات رایگان پشتیبانی زبان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات جانبی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 1-844-398-6233 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید. (Farsi)

اردو

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے مفت لسانی اعانت کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 1-844-465-1725 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔ (Urdu)

אידיש

אכטונג: אויב איר רעדט אידיש, אומזיסטע שפּראַך הילף סערוויסעס זענען אַוועילעבל פאַר אייך. פאַסיגע אוקזילירי הילף און סערוויסעס צוצושטעלן אינפאָרמאַציע אין צוטריטליכע פאָרמאַטן זענען אויך אַוועילעבל פריי פון אָפּצאָל. רופן (TTY: 711) 1-833-584-1829 אָדער רעדט מיט אייער פּראָוויידער. (Yiddish)

Deitsch

WICHDICH: Wann du Deitsch schwetzscht, kenne mer dich Schprooch-Hilf griege. Mir kenne dich aa differnti Sadde Hilf griege, wasewwer as brauchscht fer Information griege, unni as es dich ennich eppes koschde zellt. Call 1-833-584-1829 (TTY: 711) uff odder schwetz mit dei Provider. (Pennsylvania Dutch)

Ελληνικά

ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το 1-844-465-1714 (TTY: 711) ή απευθυνθείτε στον πάροχό σας. (Greek)

Oromoo

Afaan Oromoo HUBACHIISA: Yoo Afaan Oromoo dubbattan ta'e, tajaajilloota gargaarsa afaanii bilisaan isiniif ni kennama. Gargaarsoonni fi tajaajilloonni sirrii ta'an namoota dhagahuufi arguun isaan rakkisuuf odeeffannoo dhangii dhaqqabamaa ta'een kennuunis bilisaan niargamu. Gara 1-800-832-9686 (TTY: 711) tti bilbilaa yookiin qopheessaa keessan haasofsiisaa. (Oromo)

Gagana Samoa

FAAALIGA: Afai e te tautala i le Gagana Samoa, o loo maua fua auaunaga lagolago mo gagana. O le a maua fua fo'i mea faalogo, isi faiga tau fesoasoani ma auaunaga talafeagai e tuuina mai ai faamatalaga i auala faigofie ona maua. Vili le 1-800-832-9686 (TTY: 711) pe talanoa i lau fai auaunaga. (Samoan)

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