



Savannah River Remediation  
**PRE-65 RETIREE HEALTH PLAN**

Summary Plan Description  
Effective 01/01/2017

Pre-65 Retiree Health Plan benefits  
designed

# to help protect you and your family

from the high cost of medical treatment.

For questions and Pre-Authorization contact:

**Claims/Customer Service**

Blue Cross Blue Shield of South Carolina 1-800-325-6596;  
[www.southcarolinablues.com](http://www.southcarolinablues.com);  
Monday-Thursday 8:00am-6:00pm; Friday 8:00 am -4:30 pm  
EST; Claims Processing Center, PO Box 100300, Columbia, SC  
29202

**Hospital Pre-Admission**

In South Carolina (Blue Cross Blue Shield 1-800-327-3238)  
& Medical Case Management

Outside SC (Blue Cross Blue Shield 1-800-334-7287)

**Imaging Preauthorization**

MRI,MRA,CAT or PET 1-800-500-7664

**Mental Health & Substance Abuse Pre-Certification**

1-800-790-5770 (Companion Benefit Alternatives through Blue  
Cross Blue Shield of South Carolina)

**Traveling Outside the U.S:**

BlueCard Worldwide Customer Service  
1-800-810-Blue (2583); or 1-804-673-1177;  
[www.bluecardworldwide.com](http://www.bluecardworldwide.com)

**COBRA Administrator**

CONEXIS – a division of Wage Works  
PO Box 660212  
Dallas, TX 75266-0212

Customer Service: 1-888-678-4881 (TTY: 866-599-3140)

**Service Center**

803-725-7772 or 800-368-7333;

[Service-Center@srs.gov](mailto:Service-Center@srs.gov);

“Service Center” SRNS, Benefits Service Center,  
Building 730-1B, Aiken SC 29808

**SRR Human Resources**

**Medical Plan Administrator**

803-208-3978

Building 766-H, RM 1066F, Aiken SC 29808

Savannah River Remediation LLC “SRR” maintains medical and dental benefits under the Pre-65 Retiree Health Plan (“Plan”) designed to protect you and your family members from the high cost of medical treatment. SRR is also referred to as the “Employer” or “Company” in this Summary Plan Description (“SPD”). This document, together with the administrative policies and procedures of Blue Cross Blue Shield of South Carolina (“the Claims Administrator” or “BCBS-SC”) govern any adverse determination and constitute the Plan Document.

This SPD describes the Plan as of January 1, 2017. Please read this summary carefully. This document explains how the Plan works, how you qualify for and ultimately receive Plan benefits, what benefits are available to you, and what your rights are as a Plan participant. The Employer, however, reserves the right to amend or terminate the Plan, at any time.

The benefits described in this document are sponsored by the Company under a self-insured administrative service contract with Blue Cross Blue Shield of South Carolina (BCBS-SC). The Company has designated the SRR Benefits Committee as the Plan Administrator for this Plan. The Plan Administrator is responsible for maintaining the enrollment, and other records related to, and administration of, the Plan. You should contact the Company through the Savannah River Nuclear Solutions, LLC “SRNS” Service Center for questions about enrollment and eligibility in the Plan. SRNS operates the Service Center as a contracted service to the SRR Benefit Plans. However, you can also contact SRR Human Resources with any questions you may have regarding the SRR Plan. As a Claims Administrator, BCBS-SC provides claims payment services. You should contact them with general questions about the Plan and specific questions about claim determinations and appeals and payment of your claims. The Plan Administrator and Claims Administrator have discretionary authority to decide all issues of fact.. This Plan is a stand-alone plan for retirees and is not subject to the Patient Protection and Affordable Care Act, as amended.

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# PARTICIPATING IN THE PRE-65 RETIREE HEALTH PLAN

## Eligibility

Employee/Retiree/Dependent Type	Coverage Eligibility at a Glance
Incumbent Retiree under the age of 65	Yes, eligible if you meet the SRNS, LLC Multiple Employer Pension Plan eligibility and are retired under the Normal, Early, Optional or Incapability Retirement provisions of the Pension Plan,
Eligible Dependents of an Incumbent Retiree under the age of 65 (even when the Retiree is age 65 or older)	Yes, eligible unless noted below
Incumbent Retiree and Dependents age 65 or older	No, not eligible
Actively working Full Service or Limited Service Employees (including Craft Option A, and Craft Option B Union workers)	No, not eligible
Former SRR Employees and Eligible Dependents Enrolled in SRR Medical and/or Dental Plan through COBRA	No, not eligible
SRR Long Term Disability Participants (All Non-incumbent employees and Incumbent employees with less than 15 years of eligibility service)	Yes, Medical only up to a maximum duration of 24 months from the effective start date of Long Term Disability
Terminated Non-incumbent Employees	No, not eligible unless approved for SRR Long Term Disability
DuPont retiree rehires (and their spouses)	No, not eligible

See “Coverage Continuation in Special Situations” at the end of this section for information on when coverage ends in the event of termination of employment for Long Term Disability.

**Incumbent Employees/Retirees** are active employees or current retirees who were eligible for the SRNS, LLC Multiple Employer Pension Plan (MEPP) before the cut-off dates listed below. Incumbent employees who retire under the Normal, Early, Optional, or Incapability provisions of the SRNS LLC MEPP are eligible for this Plan.

**Effective Date on which Plan was closed to New Hires and Rehired Employees:**

**WSRC/BSRI/BNGA/BWXT:** December 9, 2008

**SRR:** July 1, 2009

**Non-Incumbent** employees are those employees who were hired after the SRNS, LLC Multiple Employer Pension Plan was closed. These Non-Incumbent employees are not eligible to participate in this Plan at retirement unless previously eligible. For the exact definition of employees eligible to participate, refer to the definition of “Eligible Employee” contained in the Savannah River Nuclear Solutions, LLC Multiple Employer Pension Plan Summary Plan Description.

You are **not** eligible to participate in this Plan if you:

- are classified by the Employer as an independent contractor (regardless of whether that classification is controlling for federal employment tax purposes or under any other applicable federal, state, or local law and regardless of whether you are classified differently by a court or any federal, state, or local agency),
- are retired from DuPont Savannah River Plant, and were rehired by WSRC or BSRI on or after 4/1/1989, (therefore you are not eligible for participation in the Pre-65 Retiree Health Plan as a retiree).

- If you are eligible for coverage as an active employee under the Medical/Dental Plan of SRR or SRNS, and you are also a SRR or SRNS retiree, you will only be eligible for the active Employee Medical Benefit Plan. You will continue to be ineligible for the SRR or SRNS Pre-65 Retiree Health Plans until your employment with SRR or SRNS terminates. After your employment as an active employee terminates you will be eligible for the same health benefits as similarly situated retirees.
- You or your dependents elected COBRA medical or dental coverage at the time of retirement.

Coverage for dependents under the age of 65 will end when the retirees dies with the exception of dependents who have eligibility rights as a Survivor under the Savannah River Nuclear Solutions, LLC Multiple Employer Pension Plan.

## Eligible Dependents

Your dependents that are eligible for enrollment in the Pre-65 Health Plan include your lawful spouse that is under the age of 65 (and your “children”.) Spouses are eligible to participate in the Plan with validation of a state-recognized marriage certificate, including same sex marriage when recognized by state law through a valid marriage license. South Carolina common law will continue to have documentation requirements for attestation.

**Note If you are divorced, your ex-spouse is no longer eligible to be covered as your dependent under the Pre-65 Health Plan as of the date of your divorce decree and no claims will be eligible for payment from the plan after the date of the divorce. You have an obligation to notify us within 60 days of the effective date of your divorce. Coverage continuation for the ex-spouse may be available through COBRA Continuation Coverage.**

Children include your own children, your legally adopted children (from the time they are legally placed with you), your stepchildren who primarily reside with you and children supported solely by you for whom you have been appointed legal guardian up to the maximum age of 26. Coverage under this plan will be available up to age 26 for dependent children.

You will be required to provide proof to the Service Center for authorization of eligibility by the Plan of legal guardianship, adoption, or Qualified Medical Child Support Order that requires you to provide coverage for the child.

Your child must be under age 26 or satisfy the disabled/handicapped qualifications if over age 26. (see below). Your disabled/handicapped dependent child may continue coverage after attainment of age 26 up to the earlier of age 65 or until your death if your child continues to meet **all** of the following requirements:

- is incapable of sustaining employment by reason of a disabling mental handicap or physical handicap;
- is solely supported by the retiree and claimed as dependent on your current federal income tax return; and
- the disability must have begun before age 26 and your child must remain continuously disabled beyond the age limit.

You must provide written proof of such dependency and incapability to BCBS-SC for evaluation. You will be requested to periodically provide proof of the disability to continue the child’s eligibility under the Plan. The coverage under this Plan for your disabled/handicapped dependent child as well as the coverage for your other dependents will end when your eligibility for benefits under this Plan ends or you die. In the case of your death, your dependents may have eligibility rights under the SRNS, LLC Multiple Employer Pension plan. See the COBRA Continuation Coverage section for more information on extending your coverage.

**The Plan reserves the right to request, at any time, documentation as proof of any dependent’s eligibility, as well as the right to remove any ineligible dependent retroactively from coverage, in the event of fraud or misrepresentation, without reimbursement of premiums and may invoke the right to seek reimbursement for claims paid on any ineligible dependent.**

## Special Rules for “Dual” Couples

If you and your spouse are both employees or retirees of either SRR or SRNS, you cannot be covered as both an employee or retiree and as a dependent under any of the Plans offered by either company.

A dependent child may not be covered by more than one SRR or SRNS employee or retiree. For example, you may elect to cover your eligible spouse and child, while your spouse elects to waive his/her coverage. Alternatively, you may elect coverage for yourself and your child, while your spouse elects coverage for themselves only. (If you elect this latter choice in this example, you and your spouse may elect to be covered by different medical options.)

## Enrolling for Coverage

During the Plan enrollment process, you will be asked to elect:

- Medical Standard Choice or Basic Choice (High Deductible Health Plan), or no medical coverage and
- Dental Prime or Standard or no dental benefits, and
- Coverage for yourself only, you plus one dependent, or you plus two or more dependents.

At the time of retirement, you will be asked to enroll yourself and your eligible dependents in the Plan. You will make your medical and dental elections at the time you submit your retirement application. Your coverage will be effective on your first day of your retirement. If you do not make an election when you submit your retirement application, coverage for you and your eligible dependents then coverage cannot begin until January 1 of the following year (if you elect to cover them during the next annual enrollment period) unless you have a Qualifying Change in Status as described below. When your employment ends, you will be offered COBRA Continuation coverage for any medical and/or dental coverage you were enrolled in at the time your employment terminated. If you elect COBRA Continuation coverage for your SRR medical and/or dental, you will not be eligible for coverage under this Pre-65 Retiree Health Plan.

You can elect coverage, add or delete eligible dependents from your coverage during the annual open enrollment period for the coverage to be effective at the beginning of the next calendar year.

## Requesting Election Changes and Change in Status

Generally, you are permitted to make Medical and/or Dental Plan election changes only during the annual enrollment period, which will be effective beginning January 1 of the following year. Your Plan elections must stay in effect for the full calendar year (also known as the Plan Year). You cannot change your benefit elections during the calendar year unless you have an event that qualifies as a Change in Status for benefit coverage purposes. Certain rules specify the events under which you may change a benefit election during the year, effective with the date of the event through the remaining portion of the calendar year.

If you decline enrollment for yourself or your dependents (including your spouse) because of other group health insurance coverage by another employer and you subsequently lose such coverage, the event may qualify as a "Change in Status" and you may be able to enroll yourself and/or your dependents in this Plan, provided that your written request for enrollment is received by the Service Center within 60 days after your other coverage ends and you are under the age of 65.

If you, your spouse or dependent child experiences an event that qualifies as a Change in Status and you wish to change your benefit elections, you must submit a written request of the benefit election change to the Service Center or SRR Human Resources within 60 days after the event occurs.

To add or remove eligible dependents from your coverage with a Qualified Change in Status, complete OSR Form 5-200 (available by contacting the SRNS Service Center). Submit the form and supporting documentation to Service Center, Bldg. 730-1B, Aiken, SC 29808 within 60 days of the Qualifying Change in Status. Any change you request to make under the Plan must be consistent with your Qualifying Change in Status. You can only change the Medical Plan option (Standard or Basic) and Dental Plan (Prime or Standard) during the Open Enrollment period (to be effective the following January 1).

**If a Qualifying Change in Status occurs during the Plan Year (calendar year), you will only be able to add or delete a dependent and change your level of coverage (individual only, two covered individuals, three or more covered individuals, or waiver) under your medical and dental care elections. You will not be able to change the option that you elected.**

Whenever you are adding new eligible dependents to your coverage, you must name the dependents to be covered, provide their date of birth, and their Social Security number. (If you do not have the Social Security number for your dependent at the time you enroll them in coverage, you should submit the Social Security number to the Service Center as soon as you receive it.)

Whenever you are adding or deleting dependents from coverage, you may be requested to supply a copy of an official document such as a birth certificate, marriage certificate, legal guardianship as signed by a judge, etc. that supports the dependent's eligibility for Plan coverage and the effective date of the coverage change.

Newborns will not be automatically covered under the parent's coverage for the baby's initial hospitalization. Therefore, you should add any new baby to your coverage as soon as possible but no later 60 days of the date of birth then the coverage will be retroactive back to the date of birth. You should submit your request to add your new baby to the SRNS Benefits Service Center even if the Social Security number hasn't been assigned.

If you, your spouse or dependent child experiences an event that qualifies as a Change in Status but you do not need to change your coverage status, you should still immediately notify the Service Center. Accurate records are important to ensure proper coverage for you and your dependents.

The Plan Administrator has the right to request, at any time, documentation as proof of a Qualifying Change in Status and eligibility for benefits and will have the final decision making authority regarding any allowable changes.

**Do not call the BCBS-SC Claims Administrator with information on a Qualifying Change in Status or an address change. Contact the Service Center instead at (803)725-7772 or (800)368-7333.**

The benefit change you want to make must be consistent with the Qualifying Change In Status. That is, the event must result in the retiree, spouse or dependent child gaining or losing eligibility for coverage under either the Pre-65 Retiree Health Plan or the spouse's or dependent child's employer's plan.

The following events may be considered a "Qualifying Change in Status" if they result in a change in eligibility for health care.

- A change in legal marital status – an event that changes an your legal marital status, including marriage, death of spouse, divorce, legal separation or annulment;
- A change in number of dependents – an event that changes your number of dependent children, including birth, adoption, placement for adoption, death of a dependent child, the acquisition of a stepchild or as a result of a judgment, decree, or order including a Qualified Medical Child Support Order;
- A change in employment status – the termination or commencement of employment by the retiree, spouse or dependent child or the commencement of or return from unpaid leave of absence;
- A change in which you, as the retiree, your spouse or dependent child satisfies or ceases to satisfy the Plan's eligibility requirements – an event that causes a retiree or a retiree's dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of maximum age under the Plan or any similar circumstance under the Plan that qualifies or disqualifies the participant for coverage under the Plan;
- A change due to enrollment in Medicare or Medicaid – a retiree, spouse or dependent child becomes entitled to and enrolls in Medicare (Part A or B) or Medicaid;
- A special enrollment right for eligible persons can arise due to a loss of eligibility for coverage under a group health plan, group health insurance, or Medicaid or Medicare subsidy.

**It is your responsibility to remove your dependents from the Plan when they no longer meet the Plan eligibility requirements. If a dependent is eligible for COBRA and your written enrollment change request is not received within 60 days of the event: your covered dependent will not be eligible for COBRA continuation coverage. Enrolling an ineligible dependent or otherwise failing to comply with the Plan's eligibility requirements shall constitute fraud or an intentional misrepresentation and will result in the retroactive rescission of coverage. The Plan may seek recovery for any claim payments paid past the claimant's eligibility date and you may not be able to receive a refund of any premium contribution overpayments. In the event of a divorce, the "60-day clock" begins on the date of the final divorce decree. Submit Form OSR 5-200, "Health Care Enrollment/Change Form" to the Service Center to remove your dependents from the Plan.**

## Identification Cards

Once you make your Health Plan coverage election, you will receive an identification (ID) card from the BCBS-SC Claims Administrator. You will automatically receive two ID cards if you've elected to enroll dependents. The ID card provides information needed by a hospital, physician or other health care provider to prepare and submit your claim for processing. If you should need additional cards, or a replacement card, contact the BCBS-SC Claims Administrator at 1-800-325-6596.

## Coverage Effective Date and Cost

Your coverage begins on your retirement date, unless you waive your coverage. If you waive coverage and are eligible to enroll during the annual open enrollment or upon a Qualifying Change in Status, your coverage is effective as of the beginning of the Plan Year (calendar year), or on the effective date of your Change in Status, whichever applies. . Coverage for your eligible dependents, if you elect to cover them, begins at the same time as your coverage, or on the effective date of your Change in Status, whichever applies.

You and the Company share in the cost of the Pre-65 Health Plan coverage. The amount of your premium contribution depends on the Plan options you elect and whether you elect coverage for yourself only or for you and your dependents. Premium contributions are calculated and paid monthly and are not pro-rated in accordance with your retirement date or Change in Status date. Your premium will be determined by the Plan option you are enrolled in and the level of coverage (one covered person, two covered people, or 2 or more covered people) that is in effect at the end of the month.

As a retiree your premium contributions are deducted from your pension check after any federal and state income taxes are computed and withheld.

The premium contribution that you are required to pay is reviewed and adjusted periodically by the Company. Typically, premiums are adjusted at the beginning of each calendar year. You will be notified of your premium contribution amount at the time of annual open enrollment or prior to any future change.

The Company or employer has reserved the right to change or amend the premium contribution, at any time for any reason.

## When Coverage Ends

Your coverage ends:

- When you no longer elect to be covered by one of the options,
- on the first day of the month in which you turn age 65.,
- When you no longer meet eligibility requirements or
- When you fail to make the required premium contributions by their due date.

Coverage for your dependents ends when:

- you no longer elect to cover them (during annual open enrollment),
- the required premium is not received by the due date,
- they no longer meet the eligibility requirements,
- a Change in Status occurs (and as a result, you elect to remove a dependent from medical coverage). You will be required to provide proof of the Change in Status to the Service Center within 60 days of the event.

Coverage for you and your dependents ends on the day of the qualifying change in status event that changes your eligibility for the Plan. If your premiums for coverage cannot be deducted from your pension check and you fail to make timely payments by the due date, your coverage will be terminated as of the due date and you will not be eligible to enroll you or your dependents until open enrollment if all outstanding amounts owed have been paid. Premium contributions are not pro-rated in accordance with the start and stop date of your coverage during the month. In certain situations, you and your dependents may be eligible to continue coverage. (See *the "COBRA" section*)

## Coverage Continuation in Special Situations

**When you terminate your employment as an active employee,** coverage for you and your dependents will end on the last day of the pay period in which you are a Full Service employee. If eligible, you can enroll yourself and dependents in this Pre-65 Retiree Health Plan. You may also be able to continue your coverage by electing COBRA continuation coverage; however, **if you elect COBRA Medical and/or Dental you and your dependents will waive the right to enroll in this Pre-65 Retiree Health Plan in the future if otherwise eligible.**

**If you die while an active Incumbent employee,** your dependents may be eligible for coverage under the Pre-65 Retiree Health Plan if you had 15 years of Eligibility Service as defined in the Pension Plan.

**If you die as a retiree** under the Savannah River Nuclear Solutions, LLC Multiple Employer Pension Plan and your surviving spouse who is under the age of 65 and your children would be eligible to participate in the Pre-65 Retiree Health Plan in the following order:

If married at the time of your death, your surviving spouse would be eligible for coverage up to the age of 65. Your children and the children of your surviving spouse could be covered under your surviving spouse's coverage up to the age of 26 if they meet the rules for eligible dependents under the surviving spouse.

If you have no surviving spouse, but you have children under the age of 21, your children will be eligible and can elect coverage up to the age of 21.

**If you turn 65, you are no longer eligible for the Pre-65 Retiree Health Plan; however,** your covered dependents can continue to be covered in the Plan as long as they meet the eligibility requirements of the Plan and premium payments are made by their due date.

**If you at any time waived your coverage** because you had other employer group coverage, you are eligible to enroll when your other employer group coverage ends provided your request is received within 60 days and you provide documentation of the type and termination date of the other coverage.

**If you as an active employee SRR employee are approved for Long Term Disability** under the SRR Disability Plan, you and your eligible dependents could be covered up to a maximum of 24 months from the effective start date of your approval for Long Term Disability. This applies to all Non-incumbent employees and Incumbent employees with less than 15 years of eligibility service.

## MEDICAL BENEFITS AT A GLANCE

Summary of Benefits Expenses	Standard Choice		Basic Choice (High Deductible Health Plan)	
	Network	Non-Network	Network	Non-Network
<b>Annual Deductible</b> · Individual · Family	\$600 \$1,200	\$600 \$1,200	\$1,450 (1) \$2,900 Family All Members Combined	\$1,450 (1) \$2,900 Family All Members Combined
<b>Out-Of-Pocket Maximum (2)</b> · Individual · Family	\$2,000 \$4,000	\$2,000 \$4,000	\$4,500 (1) Family \$7,150 All Members Combined	\$4,500 (1) Family \$7,150 All Members Combined
<b>Physician Office Visit (3)</b> · Primary · Specialist	\$20 Copay \$30 Copay	85% BCBS-SC allowable charge after deductible	80% allowable after deductible	80% allowable after deductible
<b>Preventive Care Office Visits (based on schedule)</b>	100% BCBS-SC allowable charge <u>before</u> deductible	Not covered	100% BCBS-SC allowable charge <u>before</u> Deductible	Not Covered
<b>Allergy or hormone injections by nurse in Physician's office</b>	85% after deductible (\$20 copay if other services provided)	85% BCBS-SC allowable charge after deductible	80% BCBS-SC allowable charge after deductible	80% BCBS-SC allowable charge after deductible
<b>Chiropractic Treatment (4)</b>	85% after deductible	80% BCBS-SC allowable after deductible	80% BCBS-SC allowable charge after deductible	80% BCBS-SC allowable charge after deductible
<b>Physical/Occupational Therapy</b>	85% after deductible	85% BCBS-SC allowable charge after deductible	80% BCBS-SC allowable charge after deductible	80% BCBS-SC allowable charge after deductible
<b>Ambulance Service</b>	85% of Maximum Payment after deductible	85% of Maximum Payment after deductible	80% of Maximum Payment after deductible	80% of Maximum Payment after deductible
<b>Hospital, surgical and most other medical services (3), (5)</b>	85% after deductible	85% BCBS-SC allowable charge, after deductible	80% BCBS-SC allowable charge after deductible	80% BCBS-SC allowable charge after deductible
<b>Emergency Room Services (life threatening acute or urgent care)</b>	85% after deductible	85% BCBS-SC allowable charge after deductible	80% BCBS-SC allowable charge after deductible	80% BCBS-SC allowable charge after deductible
<b>Emergency Room for routine use</b>	70% after deductible	70% BCBS-SC allowable charge after deductible	70% BCBS-SC allowable charge after deductible	70% BCBS-SC allowable charge after deductible
<b>Diagnostic Services (lab, x-ray and other tests) when not performed in a Physician's office (7)</b>	85% after deductible	85% BCBS-SC allowable charge, after deductible	80% BCBS-SC allowable charge after deductible	80% BCBS-SC allowable charge after deductible
<b>Home Health Care, Hospice Care, Durable Medical Expenses (5)</b>	85% after deductible	85% BCBS-SC allowable charge, after deductible	80% BCBS-SC allowable charge after deductible	80% BCBS-SC allowable charge after deductible
<b>Prescription Drugs (6)</b> -Generic -Preferred -Non-Preferred Brand	Allowed % after deductible 90% 80% 70%	Allowed % after deductible 90% 80% 70%	Allowed % after deductible 80% 80% 80%	Allowed % after deductible 80% 80% 80%

- Under Basic Choice Medical Plan – If you cover one or more dependents, the family deductible applies before reimbursement and the family out-of-pocket applies.
  - Your copays, deductibles and coinsurance amounts (10%, 15%, 20% or 30% for most services) count toward your out-of-pocket maximums.
  - Includes eligible mental health and chemical dependency services. All Admissions, Rehabilitation Services and some Out-Patient services require Pre-Authorization.
  - Limited to \$750 total per person/year.
  - Pre-Approval required.
  - See Prescription Drug section for more detailed information.
  - Pre-certification is required for outpatient major diagnostic procedures (e.g. MRI, MRA, CT scans, PET scans, etc.).
- If Pre-Authorization is not obtained, charges may be denied.

## PREVENTIVE CARE

Expenses		Standard Choice	Basic Choice (High Deductible Health Plan)	Standard/Basic Choice
		In-Network Provider	In-Network Provider	Out of Network Provider
Physical Exams (includes Diagnostic Lab Services)	One annual wellness /physical exam every benefit year, starting at age 19.)	Paid at 100% of allowable charge	Paid at 100% of the Allowable Charge*	Not Covered
Gynecology Exams	Age 21-65: Pap test every three years	Paid at 100% of allowable charge	Paid at 100% of the Allowable Charge*	Not Covered
Mammography Screenings	One per benefit year, starting at age 40	Paid at 100% of allowable charge	Paid at 100% of the Allowable Charge*	Not Covered
Prostate Screenings	Age 50 and over, One per benefit year	Paid at 100% of allowable charge	Paid at 100% of the Allowable Charge*	Not Covered
Colorectal Cancer Screenings	Sigmoidoscopy - Once every 5 years - age 50 and above. Colonoscopy - Once every 10 years - age 50 and above)	Paid at 100% of allowable charge	Paid at 100% of the Allowable Charge*	Not Covered
Well Child Care (age 0 through age 18)	When performed in a Physician's office according to the preventive care schedule listed on the Blue Cross Blue Shield web site	Paid at 100% of allowable charge	Paid at 100% of the Allowable Charge*	Not Covered
Adult Immunizations	According to the Blue Cross Blue Shield preventive care schedule listed on their website	Paid at 100% of allowable charge	Paid at 100% of the Allowable Charge*	Not Covered
Bone Mineral Density Screenings	Routinely for women starting at age 65 and for those age 60 and younger who are at increased risk for osteoporotic fractures	Paid at 100% of allowable charge	Paid at 100% of the Allowable Charge*	Not Covered

Preventive Benefits under Standard Choice and Basic Choice medical are covered at 100% with no deductible, copayment or co-insurance when you use a provider that is participating in the BCBS network for your plan. Preventive services provided during an office visit by a BCBS-SC Network Physician — such as well-baby care, immunizations, routine physicals and annual gynecological exams — are covered under Standard Choice and the Basic Medical Plan option at 100%.

In addition, associated diagnostic tests that frequently can't be performed in the Physician's office — such as outside lab work and x-ray services for mammograms, and sigmoidoscopy — are paid at 100% for Standard Choice and Basic Medical Plan at 100% with no deductible, if you use a BCBS-SC Network free-standing laboratory, radiology facility, or Hospital outpatient department.

You can find the most current and complete information about the BCBS-SC preventive care schedule for immunizations on their web site at [www.southcarolinablues.com](http://www.southcarolinablues.com) and by logging into "My Health Toolkit" - "Wellness" - "Preventive Care Guidelines". **Benefits for these services are not covered if you use non-Network Providers.**

### Blue CareOnDemand

Blue CareOnDemand is a convenient new service from BlueCross BlueShield of South Carolina. With Blue CareOnDemand, you can consult with a doctor using a smartphone, tablet or computer rather than visiting an office or urgent care facility. All you need is your computer or mobile device to see a doctor any time, day or night. During your video visit, the doctor will ask questions, answer questions, diagnose your symptoms and, if appropriate, call in a prescription to your local pharmacy. *Blue CareOnDemand is not a replacement for your primary care doctor. You should continue scheduling office visits for regular checkups and preventive care. For true emergencies and life-threatening issues, go to the emergency room or call 911.*

## What types of conditions can doctors treat?

- Cold and flu symptoms
- Bronchitis and other respiratory infections
- Sinus infections
- Pinkeye
- Ear infections
- Allergies
- Migraines
- Rashes and other skin irritations
- Urinary tract infections
- *And more!*

There are two easy ways to use Blue CareOnDemand. Don't wait until you're sick. Create your user account now so it's ready when you need it.

- From your computer, go to [www.BlueCareOnDemandSC.com](http://www.BlueCareOnDemandSC.com)
- From your mobile phone or tablet, download the "Blue CareOnDemand" app for your Apple or Android device.

BlueCareOn Demand	Standard Choice	Basic Choice
	\$10 copay	\$59 prior to meeting the deductible and \$10 copay after the deductible

## Vaccine Network

Covered employees and their dependents can get flu vaccines covered under their pharmacy benefit. To have coverage, members must use a pharmacy in the CVS/caremark Vaccine Network, a network of more than 62,000 pharmacies nationwide. CVS/caremark is a division of CVS Health, an independent company that provides pharmacy benefit services on behalf of our health plans. In addition to the seasonal vaccines, you can now go to your local Vaccine Network Pharmacy to get vaccines such as tetanus, shingles (Zostavax) and hepatitis B at \$0 copay.

The flu vaccines covered under the Seasonal Vaccine program are:

- Injectable Seasonal Influenza Vaccine
- Injectable Seasonal Influenza Vaccine-High Dose (Fluzone)
- Intradermal Influenza Vaccine (Short Needle)

A list of pharmacies that participate in the vaccine network is available and can be viewed by logging into MyHealthToolkit from the [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) website and selecting "Find a Pharmacy" under the Benefits tab. Vaccine network participating pharmacies are those with "Vaccine Network" displayed under Services and Programs. Once you identify a convenient pharmacy, it is recommended that you contact them in advance to ensure there are no additional requirements (such as a prescription from your doctor, age restrictions, etc.) and to make sure they have the vaccine in stock.

If you have any questions concerning the vaccine benefit, you can contact BCBS customer service at 1-800-325-6596.

## My Health Essentials Engagement Suite

Participation in the Medical Plan provides you with access to the BCBS-SC "My Health Essentials Engagement Suite". The Engagement Suite is comprised of a wide variety of health management programs to help you achieve and maintain good health. The Engagement Suite" includes:

Rally: – Personalized digital health experience offering an interactive health survey, daily missions, virtual fitness challenges, ongoing prize sweepstakes, user communities and integration with mobile devices and fitness wearables. Rally is a product of Rally Health Inc., an independent company that offers a health management program on behalf of the SRR health plan.

Health Coaching – Chronic Conditions: One-on-one telephonic coaching to provide condition-specific education and support. (1-855-838-5897)

Health Coaching – Lifestyle: One-on-one telephonic coaching to support overall well-being and prevent more serious conditions. (1-855-838-5897)

Essential Advocate: 24/7/365 access to a registered nurse with the high-touch services of a personal health advocate 888-521-2583

# **MEDICAL PLAN CHOICES** (see the “Benefits at a Glance” chart)

When you enroll in the Plan, you choose the level of coverage that's right for you — or you can elect no medical coverage. Standard Choice, and Basic Choice (High Deductible Health Plan) each offer a choice of Network and non-Network care. You should always use your “My health Toolkit” at [www.southcarolinablues.com](http://www.southcarolinablues.com) or call BCBS-SC customer service at 1-800-325-6596 when searching for Network providers.

## **Standard Choice**

The Standard Choice Medical option gives you the choice of receiving medical care from providers participating in the BCBS-SC “Blue Open Access POS” Medical Network or going to a Provider who is not part of the Medical Network. The Standard Choice Medical Plan generally provides a higher level of coverage if you use a BCBS-SC Network Provider as you will not be balanced billed by the provider for charges above the BCBS-SC Allowable charge. However, Preventative Care is not covered when you use a non-Network provider.

When you go to a Network **primary care Physician**, such as a family doctor, internist, pediatrician, gynecologist, psychiatrist, or psychologist, you pay a **\$20 copay** for the office service, which might consist of one or more of the following: exam, in-office lab work or in-office x-ray. Preventive Care Office visits based on the services in the preventive care schedule are paid at 100% before the deductible when you use a network physician. When you see a **Specialist (e.g. Neurologist, Dermatologist, or Podiatrist, etc.)**, you pay a **\$30 copay**. If you receive certain additional covered services (e.g., surgery performed in the Physician's office), your cost (coinsurance) is 15% of the discounted fee for the additional covered services plus your \$20 or \$30 copay.

For services other than preventive care and doctor visits requiring a copay, you must pay a deductible before the Plan begins to pay. The individual annual deductible is \$600 per person (\$1,200 for your entire family). Your out-of-pocket maximum for covered services is \$2,000 per person (or \$4,000 for your entire family) in a calendar year. The Standard Choice Medical Plan out-of-pocket maximum includes your copays, deductible, and coinsurance, but not your charges incurred for non-covered expenses. Some services are not covered at all unless you use specific Providers. For example, scheduled preventive care services are not covered **unless** a Network Physician is utilized.

If you go to either a Network or a non-Network Provider, most other covered expenses will be reimbursed up to 85% of the BCBS-SC Allowable Charge (Network discounted amount) for covered services after the deductible. If you go to a non-Network Provider, the non-Network Providers may “balance bill” you up to the amount of the total charge.

For covered **Prescription Drugs**, you must pay the annual deductible of \$600 per person (\$1,200 for your entire family) before the Plan begins to reimburse you at 90% for Generic medications, 80% for Preferred medications and 70% for Non-Preferred Brand Name Drugs. See information regarding Mail Order and other pharmacy benefit requirements under the “Prescription Drugs” section.

## **Basic Choice (High Deductible Health Plan)**

The Basic Choice Medical Plan offers lower premiums than the Standard Medical Plan, but requires that you meet a higher deductible before reimbursement for most covered services. Under the Basic Choice (High Deductible Health Plan) option:

- you pay the lowest amount in premiums,
- your deductible and coinsurance amounts are higher,
- preventive care from a network provider is covered at 100% before deductible for services included on the BCBS-SC preventive schedule, and
- you may be eligible to make contributions into a tax advantaged Health Savings Account that helps you pay for current and future unreimbursed medical expenses.

The individual deductible (for single coverage) of \$1,450 is applied before you are reimbursed for most covered services. However, if you are enrolled in employee +1, or family coverage, the entire family deductible of \$2,900 applies before any reimbursement is made for most covered services. After you have paid your deductible, this option then reimburses you for covered expenses at 80% of the Allowable Charge (70% of the Allowable Charge when you use an emergency room for routine, non-emergency care). When combined, the maximum you will pay out of your pocket in deductibles and coinsurance amounts for covered services will be:

Basic Choice Out-of-Pocket Maximum Single Coverage Level	Calendar Year 2017  \$4,500
Employee plus one or more	\$7,150

Also, once you are enrolled in the Basic Choice High Deductible Health Plan, you may be eligible to establish a tax advantaged Health Savings Account (HSA) to pay for eligible health care expenses. To be eligible to contribute to a Health savings Account

- You must be enrolled in the SRR Basic Medical Plan
- You are not enrolled in Medicare
- You are not claimed as a dependent on someone else's tax return
- You do not have other non-HSA compatible coverage such as a general purpose Flexible Spending Account (FSA) or Health Reimbursement Arrangement (HRA)

The Health Savings Account offers you a triple tax advantage - tax deductible contributions, tax-free while you are saving and tax free distributions for eligible expenses.

The company will provide a lump sum contribution for 2017 into a Health Savings Account with HSA Bank in the amount of \$250 for single coverage and \$500 for employee plus one or more covered dependents. The amount of the contribution will be evaluated each year and announced during open enrollment. As an active employee, you may contribute to your HSA through pre-tax payroll deductions that you authorize. The 2017 IRC annual contribution limits into your HSA are as follows and **are reduced by the amount the company contributes**:

	CY2017
Individual with self-only coverage:	\$3,400
Individual with EE+1 or family coverage:	\$6,750

If you are 55 years of age or older, your annual contribution limit is increased by \$1,000. Your unused balance in your HSA rolls over from year to year allowing your account balance to grow tax-free. You are permitted to make contributions at any time throughout the year. You are the owner of your HSA and are responsible for maintaining records of your medical expenses that satisfy IRS requirements. You are no longer eligible to contribute to a HSA once you are enrolled in Medicare.

### Health Savings Account Mid-year Eligibility Changes

You, as the employee, are responsible for managing your Health Savings Account according to the applicable tax laws and regulations. The following are some examples of changes that you may want to consider in the management of your HSA. Individuals who become HSA eligible, lose HSA eligibility, or change High Deductible Health Plan (HDHP) coverage types mid-year are limited in the amount they can contribute to their HSAs unless they make use of the IRS' Full Contribution Rule, sometimes referred to as the last-month-of-the-year rule.

The sum of your contributions into your HSA can vary but the sum of your calendar year contributions cannot exceed the annual contribution limit. If you have any questions about your Health Savings Account contact HSA Bank at (866)471-5946 or review IRS Publication 969.

### How the Options Are Similar

In many ways, the two options are alike. They...

- Cover the same health care expenses overall.
- Exclude the same expenses. Exclusions are listed in a later section.
- Utilize the same BCBS Network of medical providers.
- Are designed so that your share of the cost is limited when the cost of covered treatment exceeds specified amounts (annual out-of-pocket maximum expenses for covered services).
- Provide the same maximum annual benefits for covered services.

Each option has provisions on deductibles, out-of-pocket expenses, allowed amounts and annual maximums. The following chart lists your deductibles, out-of-pocket amounts and annual maximums, which are further explained below.

## Deductibles

Plan	Standard Choice	Basic Choice
2016 Annual Deductible	\$600/person \$1,200/family	\$1,450/individual (applies to single coverage only) \$2,900/family

The amount of the deductibles will be evaluated each year and announced during open enrollment.

Under each option, there is an annual deductible. A deductible is an amount you pay each year before the Plan begins to pay benefits for certain covered medical services. Under Basic Choice, the deductible applies to all services with the exception of preventive care. Under Standard Choice, the deductible applies to all services with the exception of doctor visit copays and preventive care.

The **Individual Deductible** is the amount that must be paid by one person each calendar year. It applies to the Standard Choice options, and to single coverage under the Basic Choice option.

The **Family Deductible** is twice the individual deductible. All covered members deductibles will be totaled to meet the Family deductible.

For the Standard Medical Plan no one family member will exceed the single (per member) deductible. If the family deductible amount is met by other family members – then this member will not have to meet the single deductible amount since their deductible is considered met.

Under the Basic Choice option, the deductibles are aggregated. If you cover one or more dependents, the entire family deductible (\$2,900) must be met before any reimbursement is made by the Medical Plan.

There is no carryover of unsatisfied deductible amounts from one year to the next. Your deductible amount starts over each January.

## Do These Expenses Count Toward Your Deductible?

YES	NO
Covered services rendered by Network and non-Network Providers, if you are enrolled in Standard Choice and Basic Choice Medical Plan.	Copays for Network Physicians' office services
Non-emergency use of the Emergency Room	The 10%, 15%, 20% or 30% coinsurance amounts you pay for services provided by Network Physicians
Prescription drugs (yes, unless otherwise excluded)	Expenses that are not covered by your medical option
	Penalties incurred for hospital stays that have not been pre-certified
	Expenses above what is considered the BCBS-SC Allowable Charge and/or Maximum Payment for each covered service
	Non-covered expenses (including but not limited to the cost of non-covered prescription drugs under the Mandatory Generic, Step Therapy, and Quantity Management programs)

### Wellness Initiatives and Vanishing Deductible

You and your covered spouse will each have the opportunity to earn up to \$250 in wellness credits to be applied to the deductible or added to your Health Savings Account if you are enrolled in the Basic High Deductible Health Plan at the start of the Plan year. Dependent children of any age are not eligible to earn wellness credits. Each completed activity is assigned a monetary value, with a maximum credit of \$250 per eligible participant. Your earned wellness credits will be applied at the start of the following Plan year. Actual incentives may be added or modified from Plan year to Plan year.

### Out-of-Pocket Maximum

Standard Choice Plan	CY2017
Annual Out-of-Pocket Maximum for Covered Services	\$2,000/individual \$4,000/family

The out-of-pocket maximum is the most you will pay in copays, deductibles, and coinsurance for **Covered Expenses** during any one calendar year. Once the out-of-pocket maximum is reached, your medical plan option begins to pay 100% of eligible expenses within either the appropriate BCBS-SC Allowable charge or the BCBS-SC Maximum Payment. The out-of-pocket maximum is designed to protect you against having to pay extraordinary medical bills in a given year.

The family out-of-pocket maximum works the same way as the family deductible.

Under the Standard Choice options, once one family member has reached the maximum for the year, the covered expenses of all other family members can be combined to reach the family out-of-pocket maximum amount. No one family member will exceed the \$2,000 out-of-pocket maximum.

Under the Basic Choice option, the out-of-pocket maximums are aggregated. This means that if you cover one or more dependents, the entire family out-of-pocket maximum must be met before the Medical Plan will begin to pay covered expenses at 100%.

Basic Choice Plan	CY2017
Annual Out-of-Pocket Maximum for Covered Services	\$4,500/individual only coverage \$7,150/employee plus one or more

Some charges are not counted toward the out-of-pocket maximum. You are responsible for those expenses whether or not you've reached your out-of-pocket maximum. Refer to the chart below for more details.

### Do These Expenses Count Toward Your Out-of-Pocket Maximum?

YES	NO
Your deductibles	
Your coinsurance amounts —10%,15%, 20% or 30%— for most Medically Necessary services	Medical expenses that are not covered by your medical option, including but not limited to:
The \$10, \$20, or \$30 copay for Network & Specialist Physicians' office services under the Standard Choice option	Penalties incurred for hospital stays or major out-patient diagnostic procedures (MRI, MRA,CT scans, PET scans, etc.) that have not been pre-certified;  Expenses above the Allowable charge and/or Maximum Payment for each covered service;

The office service copay under the Standard Choice option does not go toward the deductible but is applied towards meeting the out-of-pocket maximum. Preventive Care Office visits based on the services in the preventive care schedule are paid at 100% before the deductible when you use a network physician and do not require a copay.

The following provides you with guidelines on when to pay your copay ( \$20, or \$30) or coinsurance (15%) amounts when you go to a Network Provider under the Standard Choice option:

Pay your copay:

- Physician's office visit or
- Office visit with lab and/or x-ray or
- Lab and/or x-ray only in Network Physician's office.

Pay your coinsurance:

- Laboratory work that your Network Physician sends to an outside laboratory or x-rays performed outside the Physician's office or
- Physician hospital services or
- Surgery performed in the Network Physician's office or
- Allergy or hormone injections when performed by a nurse and billed with no other service from that Physician's office on that date (other injections require a copay) or

- Prenatal care that is billed under the surgery code for total obstetrical (OB) care.

Type of Physician	Standard Choice Option
Primary Care	\$20
Specialist	\$30

The copay for office visits to a primary care Physician (such as a family doctor, internist, pediatrician, gynecologist, psychologist and psychiatrist) will be the lower copay amount. A 15% employee coinsurance amount for physical/occupational therapy, chiropractic treatment (maximum benefit of \$750 per person per year) and allergy or hormone shots by a nurse in a Physician's office will also apply.

### **Allowable Charge and Maximum Payment**

The Allowable Charge is the total payment for eligible services, supplies, or equipment as determined by the Claims Administrator to Providers participating in the Claims Administrator's Network. When you use non-Network Providers you can be billed for the balance over the Allowable Charge and the amount over the Allowable Charge does not count towards your deductibles or out-of-pocket maximums.

The Maximum Payment amount is the maximum amount the Plan will pay (as determined by the Claims Administrator) for a particular Benefit. (See the "Glossary" Section).

### **Your Share of Expenses**

There are certain expenses that you are responsible for, including:

- The deductible, coinsurance amounts and copays,
- Any expenses above the Maximum Payment,
- Expenses not covered,
- Charges that exceed the option's limitations on certain services and
- Any charges for procedures that are not considered to be Medically Necessary.

### **Annual Maximum Benefit**

Regardless of the option you choose, there is no annual maximum benefit payable by the Plan for essential health benefits.

# **THE MEDICAL PROVIDER NETWORK**

The BCBS-SC Medical Network is available to you nationwide and in some foreign countries. You receive the maximum benefit when you use it.

## **In-Network Discounts...the Advantage**

One of the important ways networks can give you an advantage is by saving you money through discounts. Network Providers have agreed not to charge more than what they have agreed to accept in their contract with the Claims Administrator when your Plan coverage is primary. In other words, Network Physicians, Hospitals and other Providers have already agreed to charge pre-negotiated rates. So by using a Network Provider, you're paying a portion of a discounted price.

## **Locating Network Providers**

The Providers in the Network may sometimes change. For the most current information on network status, check with your provider or check on-line by logging into your "My Health Toolkit" account on the BCBS South Carolina website at <http://www.southcarolinablues.com>. You can also call BCBS-SC at 1-800-325-6596 or for Providers located nationwide you can contact the Blue Cross Association at 1-800-810-Blue (2583). For information on Providers located outside of the United States, you should contact Blue Card Worldwide Service at 1-800-810-Blue (2583) or call collect to 1-804-673-1177 or go to [www.bluecardworldwide.com](http://www.bluecardworldwide.com)

For information on accessing mental health and/or substance abuse services available, you should contact Companion Benefit Alternatives (CBA), a BlueCross BlueShield subsidiary, at 1-800-790-5770.

## **When You Visit a Network Physician's Office**

When you visit a Network Physician, make sure you show your BCBS-SC ID card. Using information on your ID card, the Network Provider will file a claim for services rendered to the BCBS organization that they contracted for Network Services (provided the Medical Plan is the Primary payer.) For example, if the Medical Plan was the primary payer, a BCBS Network Physician in Los Alamos, NM would file a claim to BCBS of New Mexico.

If you visit a Physician who is not in the Network, you should still present your ID card so the receptionist can check your eligibility and coverage. In many cases, you may have to pay a non-Network Provider in full at the time of the visit and then file a claim for reimbursement with BCBS. If another medical insurance plan (such as your spouse's employer's plan) provides primary coverage on one or more of your dependents, certain Coordination of Benefits (COB) rules apply. Refer to the COB section in this booklet for more information.

## **When You Must Be Hospitalized or Need to See a Specialist**

If your Physician is in the Blue Open Access POS Network and he/she refers you to another medical Provider, ask your Physician if you can be referred to a specialist or hospital in the Network so you receive maximum benefits. A referral from a Network Physician is no guarantee that the specialist or hospital you are referred to is in your Network. It is up to you to ensure your Providers are participants in the Network and that you have followed pre-certification requirements of the Plan if you want to receive maximum benefits.

## **When You Are Away From Home**

If you are traveling within the U.S. and need care, your Network coverage goes with you. But, when your treatment is of a non-emergency nature, be sure to call BCBS-SC Customer Service number listed on your BCBS-SC ID card to determine if there is a Network Provider that can meet your needs in the area where you're staying.

If you are traveling outside the U.S. contact BlueCard Worldwide Customer Service to find out if there are Network Providers in the country you'll be visiting. If you need non-emergency inpatient medical care, you must call the BlueCard WorldWide Service Center, who can help you access hospitalization at a BlueCard Worldwide hospital. It is important that you call the BlueCard Worldwide Service Center in order to obtain access for inpatient care. You should pay the Provider of service at the time you receive treatment and obtain appropriate documentation of services received including bills, receipts, letters and medical narrative. You should then complete an International Claim Form and send it to the BlueCard Worldwide Service Center. Assignments of benefits to foreign Providers or facilities will not apply.

## BlueCard Program

### Out-of-Area Services

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

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

#### A. BlueCard® Program

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

#### (b) Liability Calculation Method Per Claim.

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

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

- (i) an actual price. An actual price is a negotiated payment without any other increases or decreases, or
- (ii) an estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives, or
- (iii) an average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

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

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

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

(c) Return of Overpayments

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

**B. Negotiated National Account Arrangements**

As an alternative to the BlueCard Program, Members' claims for covered healthcare services may be processed through a negotiated National Account arrangement with a Host Blue.

If BCBS-SC 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 BCBS-SC's negotiated National Account arrangement(s) with such Host Blue(s) shall apply. In negotiating such arrangement(s), BCBS-SC is not acting on behalf of or as an agent for the Employer or for the Members.

**Members Liability Calculation**

Members' liability calculation will be based on the lower of either billed covered charges or negotiated price (Refer to the description of negotiated price under Section A., BlueCard Program) made available to BCBS-SC by the Host Blue that allows Employer's Members access to negotiated participation agreement networks of specified participating healthcare providers outside of BCBS-SC's service area.

**C. Non-Participating Providers Outside BCBS-SC's Service Area**

A Non-Participating Provider is any Provider who does not have a current, valid Participating Provider Agreement with the Corporation or another member of the BCBSA.

# **EMERGENCIES & PRE-APPROVALS**

Regardless of the medical option you choose, the Medical Plan offers several programs designed to help you become a better consumer of health care services and to help keep costs of medical services down for both you and the Company.

As described in this section, you should call BCBS-SC to:

- Have each Hospital admission approved,
- Receive Pre-Authorization for certain medical services (including diagnostic procedures),
- Access the services of a case manager when a catastrophic or long-term illness occurs,
- Receive authorization of mental health and substance abuse out-patient facility services and admissions (including admissions to Residential Treatment Centers) through Companion Benefit Alternatives.

## **Prior Authorization and Pre-Admission Certification - Required for Certain Services**

You must follow certain procedures to avoid financial penalties. BCBS-SC requires that **all** inpatient hospital stays and certain other medical services meet the applicable medical necessity requirements. While Network Providers are familiar with pre-admission certification procedures and requirements (which means there is less likelihood of a conflict in cooperation by a Network Physician or facility), **prior authorization or pre-admission certification by the Claims Administrator is required** for any of the following services:

These requirements are applicable for all plans (Standard and Basic)

### Pre-Authorization Requirements

- In-Patient Admissions
  - Hospital
  - Skilled Nursing Facilities
  - Long Term Acute Care (LTAC)
  - In-patient Rehab
  - Mental Health/Substance Abuse Facilities
  - Residential Treatment Facilities
- Durable Medical Equipment (DME) – Purchase price of \$500 or greater (note, this applies to both rentals and purchases)
- Home Health Services – Care provided in the home when member is homebound
- Hospice
- Participation in an approved Clinical Trial (see “Clinical Trail” in covered services)
- Transplants
- Private Duty Nursing – services provided by an RN or LPN (inpatient and home health)
- Out-Patient Services
  - Mental Health/Substance Abuse Outpatient Facility Services
  - Chemotherapy and Radiology therapy. We request a one-time notification; no penalty will be applied if not obtained.
- Advanced Imaging Services
  - MRI
  - MRA
  - PET Scan
  - CT Scan
- Bariatric Procedures for the treatment of obesity

- For procedures of hysterectomy, sclerotherapy (veins), septoplasty (surgery to straighten the nasal septum), and all cosmetic surgery procedures.
- Certain medications have been identified as requiring prior authorization. This list can be viewed online by logging onto My Health Toolkit
- Specialty Drugs
- Potentially experimental/investigational procedures

The purpose of the pre-certification process is to establish medical necessity for a treatment before the treatment is performed and cost is incurred. While pre-certification is not a guarantee of claims payment, it does establish that the requested procedure(s) meets the criteria outlined in the BlueCross Medical Policy.

Medical policies are available for review on the [www.southcarolinablues.com](http://www.southcarolinablues.com) provider portal.

In an Emergency, get the care you need immediately. Then, if you are admitted as a hospital inpatient, call the BCBS-SC Pre-Admission Review Line (1-800-327-3238 in South Carolina or 1-800-334-7287 outside of South Carolina) within one business day after your emergency admission.

**NOTE:** Routine medical care provided by an emergency room will be reimbursed at a lower level than Emergency Medical Care — regardless of the Hospital or Physician you use. If you believe that a trip to the Emergency Room was for an Emergency Medical Condition, but your Explanation of Benefits from BCBS-SC shows that the claim was processed as a “routine, non-emergency” visit, then contact BCBS-SC to discuss your particular situation. If you are being admitted to a facility, it is your responsibility to obtain pre-certification for all elective admissions at least 48 hours prior to the admission; and in the case of emergency admissions, within one business day of the admission. Network Providers will often assist you with the pre-certification process. However, pre-certification is ultimately your responsibility.

For Hospital admissions and Pre-Authorization of certain other services as outlined above, contact the Claims Administrator (BCBS-SC or for Behavioral Health services Companion Benefit Alternatives). When you call, a nurse will request the following information:

- Employee’s name, BCBS-SC identification number, address and phone number,
- Patient’s name,
- Name, address and phone number of the attending Physician, and
- If a hospital admission, the name and address of the hospital, scheduled admission date, and reason for admission, or if Pre-Authorization for another medical service is requested, the details regarding its medical necessity.

### **What if You Don’t Pre-Certify Your Hospital Stay?**

If Pre-Authorization is not obtained, room and board charges will be denied for inpatient hospital stays at an in-network facility. For an in-patient hospital stay at out of network facilities, a \$200 penalty will be applied. If Pre-Authorization is not obtained or approved by BCBS-SC for Mental Health and Substance Abuse Services, the following penalties will apply: Inpatient - Denial of room and board and Outpatient - \$200 penalty.

If you follow pre-certification procedures but your requested hospitalization is not certified and you go into the hospital anyway...**no benefits will be paid for the duration of your stay.**

If you stay in the hospital beyond the days certified by the Claims Administrator **benefits for the additional days may not be allowed.**

These unpaid expenses will be your responsibility and will not count toward your deductible or your annual out-of-pocket maximum.

## **Maternity Hospital Stay Limit**

The Plan complies with the terms of the Newborns' and Mothers' Health Protection Act of 1996. The Plan covers the stay for mother and child in a covered hospital at the normal benefit level (subject to a coinsurance and/or deductible) for up to 48 hours for a vaginal delivery and up to 96 hours for a cesarean section. Medical complications may require longer stays. Authorization is not required for prescribing a length of stay that does not exceed 48 hours for vaginal delivery or 96 hours for a cesarean section.

## **Second Surgical Opinions**

If your Physician recommends elective, non-emergency surgery, you might want to get a second Physician's opinion to be sure you really need the operation, however second opinions are not required.

You will be responsible for any applicable copay and/or coinsurance for second surgical opinions.

Any surgeon providing a second or third opinion should not be affiliated in any way with the surgeon who gave you the initial recommendation, in order to prevent any possibility of a conflict of interest.

## **Individual Case Management**

BCBS-SC administers an Individual Case Management Program which is available if a catastrophic or long-term illness occurs. A registered nurse case manager assists the patient and family in coordinating the necessary care from various sources. Participation is voluntary.

Depending on the individual situation, the case manager may authorize coverage for a proposed treatment that ordinarily would not be covered. The treatment must be approved by you and your Physician, and must be determined by the case manager to be less costly to the Plan than its alternative covered treatment.

## **Transplants—Blue Distinction Centers for Transplants**

BCBS-SC has contracted with many of the leading transplant care facilities in the nation to provide these services. These institutes have specific expertise in transplant procedures and post-transplant care.

If you or your covered dependent is considering any type of transplant, you or your Physician should contact the BCBS-SC pre-admission review number shown on the front of your ID card to discuss the care required. If the transplant is determined to be Medically Necessary by BCBS-SC, they will recommend a Blue Distinction Center best qualified to perform the specific transplant required. Human organ and tissue transplant services are only covered if provided at a Blue Distinction Center of Excellence or a transplant center approved by BCBS-SC in writing.

If BCBS-SC has pre-approved your transplant care at a Blue Distinction Center of Excellence and you decide to use the specified Blue Distinction Center, all hospital and Physician charges for evaluation, transplant and post-operative care will be paid the same as any other covered Network service. You will also be reimbursed for limited travel and housing accommodation expenses for the transplant patient and one family member or companion.\* There is a \$10,000 limit on reimbursement for travel and housing. The Medical Plan benefits include the following general travel reimbursement guidelines under the Blue Distinction Centers for Transplants:

- The cost of round-trip airline tickets (or personal vehicle travel expenses will be reimbursed at the mileage rate set by the Federal Travel Regulations at the time of the travel.) For the pre-transplant work-up, the actual transplant procedure and post-transplant care, for both the patient and a family member\* or companion (airline ticket receipts are required, if flying),
- The actual cost of lodging (with a receipt, excluding any incidentals such as phone calls, etc.) up to \$100 per day (combined expenses for the patient and a family member\* or companion), and
- The actual cost of meals (with a receipt, excluding any incidentals such as tips, etc.) up to \$40 per day per person for your family member\* or companion, and up to \$40 per day for the patient when the patient is not hospitalized during the trip.
- BCBS-SC can provide you with specific reimbursement guidelines and instructions.

\* Travel expenses for two family members are reimbursable when the patient is a dependent child.

## **COVERED MEDICAL EXPENSES**

A portion of most Medically Necessary services and supplies, both inside and outside of a hospital are covered. BCBS-SC will determine if a claim is to be considered **Medically Necessary** for the diagnosis, care or treatment of an illness, injury or pregnancy.

Covered Expenses will only be paid for Benefits:

- Performed or provided on or after the Effective Date of coverage,
- Performed or provided prior to termination of coverage,
- Provided by a covered Provider within the scope of his or her license,
- For which the required Pre-Admission Review, Emergency Admission Review, Pre-Authorization and/or Continued Stay Review has been requested and Pre-Authorization was received from the Claims Administrator,
- That are Medically Necessary,
- That are not subject to an exclusion under the Charges Not Covered section of this booklet and
- After the payment of all required Deductibles, Coinsurance and Copayments.

## **ALLERGY INJECTIONS**

The Plan will pay Covered Expenses for allergy injections:

- For patients with demonstrated hypersensitivity that cannot be managed by medications or avoidance;
- To ensure the potency and efficacy of the antigens, the provision of multiple dose vials is restricted to sufficient antigen for the lesser of a twelve (12) week or twenty-four (24) week dose, and
- When any of the following conditions are met:
  - The patient has symptoms of allergic rhinitis and/or asthma after natural exposure to the allergen or,
  - The patient has a life threatening allergy to insect stings or food or,
  - The patient has skin test and/or serologic evidence of a potent extract of the antigen or,
  - Avoidance or pharmacological (drug) therapy cannot control allergic symptoms.

## **AMBULANCE**

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

- Locally to or from a Hospital providing Medically Necessary services in connection with an accidental injury or that is the result of an Emergency Medical Condition, or
- To or from a Hospital in connection with an Admission, or
- One Hospital to another if the first hospital does not have the services/facilities to treat the patient, or
- Hospital to home or nursing home, or
- Home to Hospital for Medically Necessary inpatient/outpatient treatment.

## **CHILD BIRTHING FACILITY/CENTER**

The Plan will pay Covered Expenses for a covered Child Birthing Facility/Center at the Inpatient Hospital percentages stated in the Benefits at a Glance Chart. (See the Glossary section for a definition of Child Birthing Facility/Center and Provider.)

## **CHIROPRACTIC SERVICES**

The Plan will pay Covered Expenses for Services and Medical Supplies required in connection with the detection and correction, by manual or mechanical means, of structural imbalance, distortion, or subluxation in the human body, for purposes of removing nerve interference and the effects of such nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column. Limited to a \$750 Maximum Payment per Member per Benefit Year

## **CHRISTIAN SCIENCE FACILITIES**

The Plan will pay Covered Expenses for Pre-Authorized Christian Science Practitioner/Christian Science Facilities Admissions.

## **CIRCUMCISION**

The Plan will pay Covered Expenses for circumcision performed by licensed Physician or a Rabbi certified as a Mohel.

## **CLEFT LIP OR PALATE**

The Plan will pay Covered Expenses for the care and treatment of a congenital cleft lip or palate, or both, and any physical condition or illness that is related to or developed as a result of a cleft lip or palate. Benefits for a cleft lip or palate must be Pre-Authorized. If you are covered by a Dental Plan, then teeth capping, prosthodontics, and orthodontics will be covered by the Dental Plan to the limit of coverage provided under the Dental Plan prior to coverage under this Plan. Covered Expenses for any excess medical expenses after coverage under any dental policy is exhausted will be provided as for any other condition or illness under the terms and conditions of this Plan.

## **CLINICAL TRIALS**

The Plan will pay 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. The referring Provider is a Participating Provider that has concluded that the Member's participation in such a trial would be appropriate; and
3. The Member provides medical and scientific information establishing that the Member's participation in such a trial would be appropriate; and
4. The services are furnished in connection with an Approved Clinical Trial.

An approved Clinical Trial is one that is 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), the Department of Defense (DOD), the Department of Veteran Affairs (VA), a qualified non-governmental research entity identified in the guidelines issued by the NIH or is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA)

## **DENTAL CARE FOR ACCIDENTAL INJURY**

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

## **DIABETES EDUCATION**

The Plan will pay Covered Expenses for outpatient self-management training and education for members with diabetes mellitus provided that such training and education benefits are rendered by a Provider whose program is recognized by the American Diabetes Association.

## **DURABLE MEDICAL EQUIPMENT**

The Plan will pay Covered Expenses for Durable Medical Equipment when the required prior authorization is obtained. BCBS-SC as the Claims Administrator will decide (in its sole discretion) whether to buy or rent equipment and whether to repair or replace damaged or worn Durable Medical Equipment. The Plan will not pay Covered Expenses for Durable Medical Equipment that is used solely in a Hospital or that BCBS-SC determines (in its sole discretion) is included in any Hospital room charge.

## **HOME HEALTH CARE**

The Plan will pay Covered Expenses for Home Health Care when rendered to you in your current place of residence if you are homebound. This service must have been Pre-Authorized by the Claims Administrator.

## **HOSPICE CARE**

The Plan will pay Covered Expenses for Hospice Care provided in an outpatient setting which been Pre-Authorized by the Claims Administrator.

## **HOSPITAL SERVICES**

The Plan will pay Covered Expenses for Admissions as follows:

- Semiprivate room, board, and general nursing care and,
- Private room, if you stay in a private room because no semiprivate room is available, or because your Physician determines and documents (and BCBS-SC approves) that isolation is necessary and,
- 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 and,
- Ancillary services and Medical Supplies including services performed in operating, recovery and delivery rooms and,
- Diagnostic services including interpretation of radiological and laboratory examinations, electrocardiograms, and electroencephalograms and,
- In a Long-Term Acute Care Hospital.

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

The day on which you leave a Hospital, with or without permission, is treated as a day of discharge and will not be counted as a day of Admission, unless you return to the Hospital by midnight of the same day. The day you enter a Hospital is treated as a day of Admission. The days during which you are not physically present for inpatient care are not counted as Admission days.

## **HUMAN ORGAN AND TISSUE TRANSPLANTS**

The Plan will pay Covered Expenses for certain human organ and tissue transplants Pre-Authorized by the Claims Administrator. To be covered, such transplants must be provided from a human donor and provided at a transplant center approved by BCBS-SC. Travel assistance may be available.

## **INPATIENT HOSPITAL MEDICAL SERVICE**

The Plan will pay Covered Expenses for Physician inpatient hospital medical service visits to you during a Medically Necessary Admission for treatment of a condition other than that for which Surgical Service or Obstetrical Service is required as follows:

- Inpatient medical benefits in a Skilled Nursing Facility will be provided for visits of a Physician, limited to one visit per day;
- Where two (2) or more Physicians render inpatient medical visits on the same day, payment for such services will be made only to one (1) Physician,
- Concurrent medical and surgical benefits for inpatient medical services are only provided:
  - When the condition for which inpatient medical services requires medical care not related to Surgical Services or obstetrical service and does not constitute a part of the usual, necessary, and related pre-operative or post-operative care, but requires supplemental skills not possessed by the attending surgeon or his/her assistant; and,
  - When the surgical procedure performed is designated by BCBS-SC as a warranted diagnostic procedure or as a minor surgical procedure,
- When the same Physician renders different levels of care on the same day, benefits will only be provided for the highest level of care.

## **MEDICAL SUPPLIES**

The Plan will pay Covered Expenses for Medical Supplies except the Plan will not pay Covered Expenses separately for Medical Supplies that are (in the Claims Administrator's determination) provided as part of another Benefit.

## **MENTAL HEALTH SERVICES**

The Plan will pay Covered Expenses for Mental Health Services for the inpatient and outpatient treatment. Preauthorization may be required. Contact Companion Benefit Alternative at 1-800-790-5770 for questions about pre-authorization for mental health services.

## **ORTHOGNATHIC SURGERY**

The Plan will pay Covered Expenses for service related to the treatment of malpositions or deformities of the jaw bone(s), dysfunction of the muscles of mastication, or orthognathic deformities.

## **ORTHOPEDIC DEVICES**

The Plan will pay Covered Expenses for Orthopedic Devices Pre-Authorized by the Claims Administrator.

## **ORTHOTIC DEVICES**

The Plan will pay Covered Expenses for Orthotic Devices Pre-Authorized by the Claims Administrator and which are not available on an over-the-counter basis.

## **OUTPATIENT HOSPITAL AND AMBULATORY SURGICAL CENTER SERVICES**

The Plan will pay Covered Expenses for Surgical Services and Diagnostic Services, including radiological examinations, laboratory tests and machine tests, performed in an Outpatient Hospital setting or an Ambulatory Surgical Center.

## **OUTPATIENT REHABILITATION SERVICES**

The Plan will pay Covered Expenses for physical therapy, occupational therapy, speech therapy and for outpatient rehabilitation services that have been Pre-Authorized by the Claims Administrator only following an acute incident involving disease, trauma or surgery that requires such care.

## **OXYGEN**

The Plan will pay Covered Expenses for Pre-Authorized oxygen. Durable Medical Equipment for oxygen use in your home is covered under the Durable Medical Equipment Benefit.

## **PHYSICIAN SERVICES**

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

## **PRESCRIPTION DRUGS**

- The Plan will pay Covered Expenses for Prescription Drugs that are used to treat a condition for which Benefits are otherwise available and are in accordance with the Mandatory Generics, Step Therapy, and Quantity Management programs. Any Coinsurance percentage for Prescription Drugs is based on the Allowable Charge at the Participating Pharmacy.
- Insulin shall be treated as a Prescription Drug whether injectable or otherwise.
- The Plan may, in its sole discretion, place quantity limits on Prescription Drugs.

## **PREVENTIVE SERVICES**

The Employer's Group Health Plan will pay for preventive health services required under PPACA 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; and,
2. Immunizations as recommended by the Center for Disease Control and Prevention (CDC); and
3. Preventive care and screenings for children and women as recommended by the Health Resources and Services Administration (HRSA).

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

## **PROSTHETIC DEVICES**

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

## **RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES**

If you are receiving Covered Expenses in connection with a mastectomy the Plan will pay Covered Expenses for each of the following:

- Reconstruction of the breast on which the mastectomy has been performed; and
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthetic devices and physical complications at all stages of the mastectomy, including lymphedema.

## **REHABILITATION**

The Plan will pay Covered Expenses for participation in a multidisciplinary team rehabilitation program only following severe neurologic or physical impairment if the following criteria are met:

- All such treatment must be ordered by a medical doctor and
- All such inpatient treatment requires Pre-Authorization by the Claims Administrator.
- The documentation that accompanies a request for rehabilitation benefits must contain a detailed evaluation from a medical doctor that documents to a degree of medical certainty your rehabilitation potential is such that there is an expectation that you will achieve an ability to provide self-care and perform activities of daily living.

All such rehabilitation benefits are subject to periodic review by BCBS-SC.

After the initial rehabilitation period, continuation of rehabilitation benefits will require documentation that shows you are making substantial progress and that there continues to be significant potential for the achievement of the established rehabilitation goals.

## **RESIDENTIAL TREATMENT CENTERS**

The Plan will pay Covered Expenses for Residential Treatment Centers and must be Pre-Authorized by the Claims Administrator.

## **SKILLED NURSING FACILITY SERVICES**

The Plan will pay Covered Expenses for Admissions in a Skilled Nursing Facility as follows:

- Semi-private room, board, and general nursing care; or
- Private room, if you stay in a private room because no semiprivate room is available, or because your Physician determines and documents (and BCBS-SC approves) that isolation is necessary; or
- Services performed in a Special Care Unit when it is Medically Necessary that such services be performed in such unit; or
- Ancillary services and Medical Supplies including services performed in operating, recovery and delivery rooms; or
- Diagnostic services including interpretation of radiological and laboratory examinations, electrocardiograms, and electroencephalograms; or
- In a Long-Term Acute Care Hospital.

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

The day on which you leave 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 you return to the Skilled Nursing Facility by midnight of the same day. The day you enter a Skilled Nursing Facility is treated as a day of Admission. The days during which you are not physically present for inpatient care are not counted as Admission days.

## **SPEECH THERAPY – RESTORATIVE**

The Plan will pay Covered Expenses for restorative speech therapy when it is expected to restore speech to an individual who lost an existing speech function as a direct result from disease (such as stroke) or injury or is related to or developed as a result of a cleft lip and palate.

## **SURGICAL SERVICES**

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

- Surgical Services, subject to the following:
  - 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 procedures will be the Allowable Charge for the major procedure only.
  - 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 having the highest Allowable Charge, plus one-half of Allowable Charge for all other operations or procedures performed.
  - If an operation consists of the excision of multiple skin lesions, the total amount covered will be the Allowable Charge for the procedure having the highest Allowable Charge, fifty (50%) percent for the procedure bearing the second and third highest Allowable Charges, twenty five (25%) percent for the procedures bearing the fourth through the eighth highest Allowable Charges and ten (10%) percent for all other procedures. However, if the operation consists of the excision of multiple malignant lesions, the total amount covered will be the Allowable Charge for the procedure having the highest Allowable Charge and fifty (50%) percent of the charge for each subsequent procedure.
  - 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.
  - If two (2) or more medical doctors or oral surgeons perform operations or procedures in conjunction with one another, other than as an assistant surgeon or anesthesiologist, the Allowable Charge, subject to the above paragraphs, will be coverage for the services of only one (1) medical doctor or oral surgeon (as applicable) or will be prorated between them by BCBS-SC when so requested by the medical doctor or oral surgeon in charge of the case.
  - Certain surgical procedures are designated as separate procedures by BCBS-SC and the Allowable Charge is payable when such procedure is performed as a separate and single entity. However, when a separate procedure is performed as an integral part of another surgical procedure, the total amount covered will be the Allowable Charge for the major procedure only.
- Surgical assistant services that consist of the Medically Necessary service of one (1) medical doctor or oral surgeon who actively assists the operating surgeon when a covered Surgical Service is performed in a hospital when such surgical assistant service is not available by an intern, resident, physician's assistant or in-house physician. The Plan will pay charges at the percentage of the Allowable Charge not to exceed the medical doctor's or oral surgeon's (as applicable) actual charge.
- Anesthesia services that consists of services rendered by a medical doctor, oral surgeon or a certified registered nurse anesthetist, other than the attending surgeon or assistant. This 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.

## **TEMPOROMANDIBULAR JOINT (TMJ) DISORDER**

The Plan will pay Covered Expenses for any service 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.

## **VOLUNTARY STERILIZATION**

Voluntary sterilization services rendered to an adult for a tubal ligation or vasectomy is covered. This Benefit is limited to one time per adult.

# PRESCRIPTION DRUGS

Caremark is the Pharmacy Benefits Manager for BCBS-SC and in that role administers the prescription drug program for this Plan and can be contacted at 888-963-7290. Caremark is also the Specialty Drug Benefit Manager and can be contacted at (800) 237-2767.

The Plan pays a percentage of the covered Prescription Drug charges after you have met your deductible. If you have not met your annual deductible, the covered charge will be applied to your deductible. If this Plan is secondary to another medical insurance plan (for example, your spouse's employer's medical plan), you still need to show your BCBS-SC ID Card to ensure that you will receive maximum benefits.

When you present your BCBS-SC ID Card, your pharmacist will recognize a code on the card and enter information into a computer. The pharmacist will then receive the discounted price electronically from the Claims Administrator Pharmacy Benefit Manager system (Caremark is the BCBS-SC Pharmacy Benefits Manager partner), and will charge you the lower of the Pharmacy Benefit Manager program discounted price or the regular retail price. If you use a network pharmacy, your pharmacy claim will be transmitted to BCBS-SC. (Note: Pre-Authorization from the Claims Administrator is required for some drugs. You will be notified when the medication is dispensed if it requires Pre-Authorization.)

The level of benefit paid by the Plan depends on whether the drug is generic, preferred brand (also called "formulary") or non-preferred brand. Three drug management programs are part of the Plan: Mandatory Generics, Step Therapy, and Quantity Management. Drug lists for these programs change periodically and updated information on these programs can be found by logging into My Health Toolkit. Select Benefits along the top, go to the Prescription Drug section and choose Drug Lists and Programs, or by calling BCBS-SC Customer Service at 1-800-325-6596.

## **Mandatory Generic Prescriptions**

If you request a Preferred or Non-Preferred Brand Name Drug that has a generic equivalent, you will pay the appropriate brand cost share (20% for preferred and 30% for non-preferred) plus the cost difference between the brand and the generic. The cost difference between the Preferred or Non-Preferred Brand Name Drug and the generic equivalent does not count toward satisfaction of your deductible and/or out-of-pocket maximum limits.

Under the mandatory generic drug program, if you are prescribed a preferred or non-preferred brand name drug when a generic drug is available, you will pay more out of pocket. You must pay the brand drug copayment (for preferred or non-preferred, whichever applies) *plus* any difference in cost between the generic and the brand name drug. The example below shows a member's cost when he or she receives a preferred brand drug at a retail pharmacy when a generic is available.

Preferred Brand Drug Cost \$80  
- Generic Drug Cost - \$30  
-----  
**= Brand/Generic Cost Difference \$50**  
+ Member 20% Copayment for Preferred Drug + \$16  
-----  
**= Total Amount Charged to Member \$66**

As shown in the example below, you are not charged more than the cost for a preferred or non-preferred drug. In this example, the coinsurance plus the cost difference equals \$110. This amount exceeds the cost for this drug. As a result, you only are charged \$100. This example shows the member's cost when he or she receives a non-preferred brand drug at a retail pharmacy when a generic is available.

Non-Preferred Brand Drug Cost \$100  
- Generic Drug Cost - \$ 20  
-----  
**= Brand/Generic Cost Difference = \$ 80**  
+ Member 30% Copayment for Non-Preferred Drug +\$30  
-----  
= Copayment plus the cost difference = \$110  
- The amount over original drug cost - \$10  
**= Total Amount Charged to Member = \$100**

This same policy also applies if your doctor indicates that your prescription should be dispensed as written, with no substitutions. In this case, your prescription is filled according to doctor's orders. **However, you still must pay the brand copayment, as well as the difference in cost between the generic and brand name drug.** Speak to your doctor about the possibility of using generics instead of the more expensive brand name drugs.

**An exception may be made to allow you to continue to get the brand name drug and avoid paying the cost difference. This exception will be based on medical necessity. Your provider may request an exception by completing the Mandatory Generic Program Exception Form , and faxing it along with the required supporting medical records, to 803-264-0258. The Mandatory Generic Program Exception form can be obtained at [www.southcarolinablues.com](http://www.southcarolinablues.com) or by calling 1-800-325-6596 option 1.**

## Step Therapy

Step Therapy is a quality and safety program that can help you lower your medication costs. Many medical conditions can be treated using a variety of medications. In some cases, there is a very large difference in cost among the medications, but only a little difference in the way the medications work. Step Therapy requires members to try a cost-effective "First Choice" medication before trying (or "stepping up to") more expensive "Second Choice" medications. Many people find the First Choice medications work just as well for them.

The Step Therapy program is based on FDA and manufacturer dosing guidelines, medical literature, safety, accepted medical practice, appropriate use and benefit design. The program only affects the medications your benefit plan covers. You and your doctor should make the final decision about the medications that are right for you. The list of drugs that require you to try a first choice alternative is updated periodically and can be found by logging into My Health Toolkit. Click Benefits along the top, go to the Prescription Drug section and choose Drug Lists and Programs. If your doctor prescribes a Second Choice medication and the First Choice medications are not right for you, please have your doctor call the Caremark Prior Authorization department at 800-294-5979. Your doctor can also fax requests to 888-836-0730

When you go to the pharmacy, the pharmacist enters your prescription into the computer system. If your prescription is a Second Choice medication, the system will check your claims history. If you have filled prescriptions for First Choice medications, the pharmacist will fill your prescription for a Second Choice medication. If you are required to try a First Choice medication, you have three options:

1. You or your pharmacist can call your doctor to change your prescription to a First Choice medication. You will pay the appropriate coinsurance amount after the deductible. The cost of the prescription will be applied to your deductible
2. You can pay full price for your Second Choice medication prescription and none of the cost goes toward the deductible or the out of pocket maximum.
3. You or your pharmacist can ask your doctor to request a medical necessity exception. If the exception is approved, you will pay the appropriate coinsurance amount after the deductible and the cost of the prescription will be applied to your deductible. If the exception is denied, you will pay the full cost of the second choice prescription and none of the cost goes toward the deductible or the out of pocket maximum.

If the Claims Administrator approves the request, it will cover your prescription. If your request is denied, you can still choose option 1 or 2.

If you submit your prescription to the mail-order pharmacy and do not meet the requirements for a Second Choice medication, the pharmacy will not fill your prescription and will notify you by mail.

## Quantity Management

Quantity Management is a quality and safety program that promotes the safe use of medications. The program limits the amount of some medications that are covered.

The Quantity Management program limits are based on U.S. Food and Drug Administration and manufacturer dosing guidelines, medical literature, safety, accepted medical practice, appropriate use and benefit design. The limits only affect the amount of medication the benefit plan covers. You and your doctor make the final decision about the amount of medication that is right for you.

The most recently updated list of medications is posted on the website. Log into My Health Toolkit. Select Benefits along the top, go to the Prescription Drug section and choose Drug Lists and Programs. You should review the list of medications to determine if quantity limits apply to you.

For most medications on the list, the Plan will only cover a set amount within a set timeframe. The Plan will cover higher amounts of some medications when medically necessary.

Certain drugs on the list will be annotated to indicate that they are eligible for consideration for a medical necessity override for a larger amount. If you need more of these medications, please have your doctor call the Caremark Prior Authorizations department at 800-294-5979. Your doctor can also fax requests to 888-836-0730.

When you go to the pharmacy the pharmacist will enter your prescription information into the computer system. If the drug has a limit on the covered amount, the pharmacist will fill your prescription as long as it does not exceed the limit. If your prescription exceeds the quantity limit, you have three choices.

1. Your pharmacist can reduce your prescription to the quantity your health plan covers.
2. You can pay full price for all of your prescription or for the portion that exceeds the limit.
3. You or your pharmacist can ask your doctor to get a quantity override if one is available.

If the Plan approves the additional quantity, it will pay for it in accordance with drug reimbursement schedule. If the Plan does not approve it or the override is not available, you can still choose option 1 or 2.

If you submit your prescription to the mail-service pharmacy and (1) you do not meet the requirements for an override for an additional quantity or (2) an override exception is not available for your drug, the pharmacy will not fill your prescription. It will return your prescription to you.

The Standard and Basic prescription drug coverage after the deductible has been met is as follows:

**Tier 1: Generic Drugs**

**Standard Medical Plans – you pay 10%, the company pays 90%**

**Basic (High Deductible Health Plan) – you pay 20%, the company pays 80%**

For the lowest out-of-pocket expense, you should always consider Tier 1 Generic drugs if you and your Physician decide they are appropriate for you. Generic drugs can be dispensed at a retail pharmacy, with a maximum 90 day supply. Generic Drugs have a chemical structure that has the same bio-equivalence as a brand name drug but is not manufactured under a registered brand name, trademark or sold under a brand name. The Claims Administrator has the discretion to determine if a prescription drug is a Generic Drug.

**Tier 2: Preferred Brand-Name Drugs**

**Standard Medical Plans – you pay 20%, the company pays 80% when no generic equivalent is available**

**Basic (High Deductible Health Plan) – you pay 20%, the company pays 80%**

Preferred Brand Name Drugs, also known as formulary drugs, are safe, effective brand-name prescription drugs available at a lower cost than some competing brand-name drugs. Consider a Tier 2 drug if no Tier 1 drug is available to treat your condition. Preferred Brand Name Drugs can be dispensed at a retail pharmacy with a maximum 31 day supply. Note: when a generic equivalent is available, but not used, in addition to paying tier 2 co-payment, the Mandatory Generic Penalty described above will be applied.

**Tier 3: Non-Preferred Brand-Name Drugs**

- **Standard Medical Plans – you pay 30%, the company pays 70% when no generic equivalent is available**

- **Basic (High Deductible Health Plan) – you pay 20%, the company pays 80%**

Non-preferred Brand Name Drugs, also known as non-formulary drugs, are brand name drugs that have lower-cost alternatives available. Talk to your Physician about Tier 1 and Tier 2 drugs that may be appropriate for you. Non-preferred drugs can be dispensed at a retail pharmacy with a maximum 31 day supply. Note: when a generic equivalent is available, but not used, in addition to paying tier 3 co-payment, the Mandatory Generic Penalty described above will be applied.

**Prior Authorization –**

Prior Authorization is a quality and safety program that promotes the proper use of certain non-specialty medications. Note: there is a separate list for specialty drugs.. If your doctor prescribes a medication that is included in the Prior Authorization program, you must get prior approval before your plan will cover your medication.

The Prior Authorization program is based on FDA and manufacturing guidelines, medical literature, safety, accepted medical practice, appropriate use and benefit design. This program only affects the medication your benefit plan covers. You and your doctor should make the final decision about the medication that is right for you.

The list of drugs that require Prior Authorization is posted on the website. Log into My Health Toolkit. Select Benefits along the top, go to the Prescription Drug section and choose Drug Lists and Programs. If your doctor prescribes a medication that needs Prior Authorization, have your doctor call the Caremark Prior Authorization department at 800-294-5979. Your doctor can also fax requests to 888-836-0730.

### **Specialty Pharmacy**

Specialty Drugs are prescription medications that are used to treat complex or chronic medical conditions like cancer, rheumatoid arthritis, multiple sclerosis and hepatitis, just to name a few. These drugs are often self-injected and usually require patient-specific dosing and careful clinical monitoring. They may also require special handling and refrigeration. The Specialty Drug prior authorization program is based on FDA and manufacturing guidelines, medical literature, safety, accepted medical practice, appropriate use and benefit design. This program only affects the medication your benefit plan covers. Caremark is the Specialty Drug Benefit Manager and can be contacted at (800) 237-2767 or fax (800)323-2445.

### **Refills**

The Medical Plan covers up to a 90-day supply of medication for Generic Drugs dispensed by retail pharmacies and for Brand Name Drugs dispensed by Mail Order unless otherwise restricted under the Quantity management program. The Plan covers up to a 31 day supply for Brand Name Drugs dispensed at retail. Also, 75% of the days supplied on the prescription must have elapsed before a prescription refill will be considered a covered charge. If you have special needs that require a longer supply, or you need a re-fill before the 75% rule is satisfied, contact BCBS-SC to discuss your individual situation. Prescription Drug refills beyond one year from the original prescription date will not be covered. If you have other questions concerning the Prescription Drug discount program, you should contact BCBS-SC Customer Service at 1-800-325-6596.

### **Mail Order Prescriptions**

The Plan covers mail order prescription refills through BCBS-SC arrangements with a Pharmacy Benefit Manager. Prescription drugs will be delivered by mail directly to your home in plain, tamper-evident packaging. You can get up to a 90 day supply of prescription drugs through mail order. This option can be significantly less costly for many medications. Detailed information on the mail order program can be found on the BCBS-SC web site.

### **Manual Claim Filing for Prescriptions**

**You will need to file your claim using a Claim form if:**

- You use a non-network pharmacy or
- You forget to show your BCBS-SC identification card or
- You are filing claims as the secondary payer (in which case you will also need to include the Explanation of Benefits from the primary payer).

The Prescription Drug Claim form can be obtained through BCBS-SC Customer Service by calling 1-800-325-6596 or on the BCBS-SC website. The following are some things you should remember when completing a Prescription Drug Claim form:

- Use a separate form for each family member
- Completely fill out Part One of the claim form

- For each family member, attach a drug receipt (arranged in date order by family member) that includes:
  - Date the prescription was filled
  - Name and address of the pharmacy
  - NDC number
  - Name of drug and strength
  - Quantity
  - Day's supply
  - Prescription (Rx) Number
  - Amount paid

The Prescription Drug Claim Form should be mailed to BCBS-SC at the address noted at the beginning of this book.

# **CHARGES NOT COVERED**

The following is a list of expenses that the Medical Plan does not cover. This list is intended to provide you with only the more common non-covered services. It is not a complete listing. Contact BCBS-SC to determine if a particular service or treatment program not mentioned in this book is covered.

## **ACUPUNCTURE**

### **ACTS OF WAR**

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

## **ADMISSIONS THAT ARE NOT PREAUTHORIZED**

### **AUTO ACCIDENTS**

This Plan 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. ABA therapy;
2. Teaching, Expanding, Appreciating, Collaborating and Holistic (TEACCH) programs;
3. Higashi schools/daily life;
4. Facilitated communication;
5. Floor time;
6. Developmental Individual-Difference Relationship-based model (DIR);
7. Relationship Development Intervention (RDI);
8. Holding therapy;
9. Movement therapies;
10. Music therapy; and
11. Animal assisted therapy.

### **BENEFITS PROVIDED BY STATE OR FEDERAL PROGRAMS**

Any service or charge for a service to the extent that the Member is entitled to payment or benefits relating to such service under any state or federal program that provides healthcare benefits, including Medicare, but only to the extent that benefits are paid or are payable under such programs. This exclusion includes, but is not limited to, benefits provided by the Veterans Administration for care rendered for a service-related disability or any state or federal hospital services for which the Member is not legally obligated to pay.

### **BIO-FEEDBACK SERVICES**

Bio-feedback when related to psychological services.

### **CLINICAL PATHOLOGIST**

Charges made by a clinical pathologist, as related to automated laboratory testing, for supervising a Hospital's laboratory.

## **COMPLICATIONS FROM FAILURE TO COMPLETE TREATMENT**

## **COMPLICATIONS FROM NON-COVERED SERVICES**

### **CONTRACEPTIVES**

Medical Supplies, services or devices for the purpose of contraception, except as specified on the Schedule of Benefits.

### **COPYING CHARGES**

## **COSMETIC AND RECONSTRUCTIVE SERVICES**

- A. This Plan of Benefits excludes cosmetic or reconstructive procedures, and any related services or Medical Supplies, which alter appearance but do not restore or improve impaired physical function. Examples of services that are cosmetic or reconstructive, which are not covered include, but are not limited to, the following:
1. Rhinoplasty (nose);
  2. Mentoplasty (chin);
  3. Rhytidoplasty (face lift);
  4. Glabellar rhytidoplasty (forehead lift);
  5. Surgical planing (dermabrasion);
  6. Blepharoplasty (eyelid);
  7. Mammoplasty (reduction, suspension or augmentation of the breast);
  8. Superficial chemosurgery (chemical peel of the face); and,
  9. Rhytidectomy (abdomen, legs, hips, buttocks or elsewhere including lipectomy or adipectomy).
- B. A cosmetic or reconstructive service may, under certain circumstances (in BCBS-SC's discretion), be considered restorative in nature for which Benefits are available, but only if the following requirements are met:
1. The service is intended to correct, improve or restore a bodily function; or,
  2. The service is intended to correct, improve or restore a malappearance or deformity that was caused by physical trauma or accident, congenital anomaly or covered surgical service; and,
  3. The proposed service must be Preauthorized.

### **CRIME/ILLEGAL ACTS**

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

### **CUSTODIAL CARE**

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

### **DENTAL SERVICES**

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

### **DISCOUNT SERVICES**

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

**EYEGASSES**

Eyeglasses or Contact Lenses of any type, even those dispensed by a prescription (except after cataract surgery).

**FOOD SUPPLEMENTS**

Food supplements unless such food supplements are available by prescription only and are prescribed by a Provider and are not used for weight control or loss.

**FOOT CARE**

Routine foot care such as paring, trimming or cutting of nails, calluses or corns, except in conjunction with diabetic foot care. Services and supplies related to non-surgical treatment of the feet, including non-Medically Necessary orthopedic shoes, orthotic appliances or other supportive devices for the feet, solely used for comfort or athletics, except as specified on the Schedule of Benefits.

**HEARING AIDS**

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

**HUMAN ORGAN AND TISSUE TRANSPLANTS**

Human organ and tissue transplants that are not:

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

**IMPACTED TOOTH REMOVAL****IMPOTENCE**

Services, supplies or drugs related to any treatment for impotence, including but not limited to penile implants, drugs, laboratory and X-ray tests, counseling, transsexual procedures or penile prostheses necessary due to any medical condition or organic disease. A penile prosthesis will be considered for payment only after medically necessary prostate surgery or surgery to treat Peyronie's Disease.

**INCAPACITATED DEPENDENTS**

Any service, supply or charge for an Incapacitated Dependent that is not enrolled by the maximum Dependent Child age listed on the Schedule of Benefits.

**INFERTILITY**

Services, supplies or drugs related to any treatment for infertility, including, but not limited to, fertility drugs, gynecological or urological procedures the purpose of which is primarily to treat infertility, artificial insemination, in-vitro fertilization, reversal of sterilization procedures and surrogate parenting.

**INPATIENT DIAGNOSTIC AND EVALUATIVE PROCEDURES**

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

**INTOXICATION OR DRUG USE**

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

**INVESTIGATIONAL OR EXPERIMENTAL SERVICES**

Services or supplies or drugs that are Investigational or Experimental.

### **LIFESTYLE IMPROVEMENT SERVICES**

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

### **LONG-TERM CARE SERVICES**

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

1. Rest care;
2. Long-term acute or chronic psychiatric care;
3. Care to assist a Member in the performance of activities of daily living (including, but not limited to: walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation and taking medication);
4. Custodial or long-term care; or,
5. Psychiatric or Substance Use Disorder treatment including: therapeutic schools, wilderness/boot camps, therapeutic boarding homes, half-way houses and therapeutic group homes.

### **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.

### **MISSED PROVIDER APPOINTMENTS**

### **NO LEGAL OBLIGATION TO PAY**

### **NOT MEDICALLY NECESSARY SERVICES OR SUPPLIES**

### **OBESITY RELATED PROCEDURES**

1. Services, supplies, treatment or medication for the management of morbid obesity, obesity, weight reduction, weight control or dietary control (collectively referred to as "obesity-related treatment"), including, but not limited to, gastric bypass or stapling, intestinal bypass and related procedures or gastric restrictive procedures, except as specified on the Schedule of Benefits.
2. Also, the treatment or correction of complications from obesity-related treatment are non-covered services, regardless of Medical Necessity, prescription by a Provider or the passage of time from a Member's obesity-related treatment, except as specified on the Schedule of Benefits. This includes the reversal of obesity-related treatments and reconstructive procedures necessitated by weight loss.
3. Membership fees to weight control programs, except as specified on the Schedule of Benefits.

### **ORTHOGNATHIC SURGERY**

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

### **OUTPATIENT SERVICES THAT ARE NOT PREAUTHORIZED**

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

### **OVER-THE-COUNTER DRUGS**

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

### **PAIN MANAGEMENT PROGRAMS**

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

## **PHYSICAL THERAPY ADMISSIONS**

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

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

## **PRE-OPERATIVE ANESTHESIA CONSULTATION CHARGES**

## **PRESCRIPTION DRUG EXCLUSIONS**

Charges for:

1. Prescription Drugs that are specifically listed on the PDL as excluded;
2. Prescription Drugs that have not been prescribed by a Provider acting within the scope of his or her license;
3. Drugs not approved by the Food and Drug Administration (FDA);
4. Prescription Drugs for non-covered therapies, services or conditions;
5. 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;
6. More than a thirty-one (31) day supply for Prescription Drugs (ninety (90) day supply for Prescription Drugs obtained through a Mail Service Pharmacy), except as specified on the Schedule of Benefits or unless the quantity is limited by a Quantity versus Time (QVT) program;
7. 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, including fees for the administration or injection of a Prescription Drug, except for hormone and allergy injections by a Physician's office which does not provide the serum or medication;
8. Dosages that exceed the recommended daily dosage of any Prescription Drug as determined by the Corporation based on the following guidelines as described in the current:
  - a. United States Pharmacopeia (USP);
  - b. Facts and Comparisons;
  - c. Physicians' Desk Reference; and/or,
  - d. National Formulary.
9. Prescription Drugs used for or related to cosmetic purposes, including hair growth and skin wrinkles, except as specified on the Schedule of Benefits;
10. Prescription Drugs related to any treatment for infertility or impotence (except when prescribed for benign prostatic hypertrophy), including, but not limited to, fertility drugs, except as specified on the Schedule of Benefits;
11. Prescription Drugs administered or dispensed in a Provider's office, Skilled Nursing Facility, Hospital or any other place that is not a pharmacy licensed to dispense Prescription Drugs in the state where it is operated;
12. Over-the-Counter Drugs and over-the-counter supplies or supplements, except for Over-the-Counter Drugs that are designated by the Corporation as Prescription Drugs and are listed as covered on the PDL and are prescribed by a Provider;

13. Prescription Drugs that are being prescribed for a specific medical condition that are not approved by the FDA for treatment of that condition (except for (i) Prescription Drugs for a specific medical condition that have at least two (2) formal clinical studies or (ii) Prescription Drugs for the treatment of a specific type of cancer, provided the drug is recognized for treatment of that specific cancer in at least one (1) standard, universally accepted reference compendia or is found to be safe and effective in formal clinical studies, the results of which have been published in peer reviewed professional medical journals);
14. Prescription Drugs that are not consistent with the diagnosis and treatment of a Member's illness, injury or condition, or are excessive in terms of the scope, duration, dosage or intensity of drug therapy that is needed to provide safe, adequate and appropriate care;
15. Prescription Drugs or services that require Preauthorization by the Corporation and Preauthorization is not obtained;
16. 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);
17. Prescription Drugs for obesity or weight control;
18. Prescription Drugs that are not authorized when part of a Step Therapy Program;
19. Prescription Drugs which are new to the market and which are under clinical review by the Corporation shall be listed on the PDL as excluded until the clinical review has been completed and a final determination has been made as to whether the drug should be covered;
20. 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,
21. 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.

#### **PROVIDER CHARGES**

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

#### **PSYCHOLOGICAL AND EDUCATIONAL TESTING**

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

#### **RADIOLOGY MANAGEMENT**

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

#### **RELATIONSHIP COUNSELING**

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

#### **SELF-INFLICTED INJURY**

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

#### **SERVICES FOR COUNSELING OR PSYCHOTHERAPY**

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

1. Feeding and eating disorders in early childhood and infancy;
2. Tic disorders, except when related to Tourette's disorder;
3. Elimination disorders;

4. Mental disorders due to a general medical condition;
5. Sexual function disorders;
6. Sleep disorders;
7. Medication induced movement disorders; or
8. Nicotine dependence, unless specifically listed as a Benefit in Article III of this Plan of Benefits or on the Schedule of Benefits.

#### **SERVICES NOT LISTED AS COVERED BENEFITS**

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

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

#### **SERVICES RENDERED BY FAMILY**

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

#### **TEMPOROMANDIBULAR JOINT (TMJ) DISORDER**

Any service for the treatment of dysfunctions or derangements of the temporomandibular joint, this exclusion also applies to orthognathic surgery for the treatment of dysfunctions or derangements of the temporomandibular joint, except as specified on the Schedule of Benefits.

#### **TRAVEL**

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

#### **VARICOSE VEIN TREATMENT**

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, except as specified on the Schedule of Benefits.

#### **VISION CARE SERVICES**

Any Medical Supply or service rendered to a Member for Vision Care and vision perception training.

#### **WORKERS' COMPENSATION**

This Plan 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 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 he/she is eligible, failed to timely file a claim for workers' compensation benefits or the Member sought treatment for the injury or illness from a Provider which is not authorized by the Member's Employer or Workers' Compensation Carrier.

If the Plan pays Benefits for an injury or illness and the 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 Plan shall have the right of recovery as outlined in Article IX of this Plan of Benefits.

## **COORDINATION OF BENEFITS (COB)**

If you have medical coverage under another group plan (through your spouse for example) or through Medicare, in addition to this one — the total benefits you are eligible to receive could be greater than your actual expenses. To help eliminate duplicate payments, your coverage is coordinated with payments from other group medical plans through which you have coverage and through Medicare.

When your medical option is the secondary plan to another group plan, (for example, for coverage on a dependent) your coverage will reimburse Covered Expenses under the Plan up to the amount of total covered charges as determined by the Claims Administrator. However, the secondary payment will not exceed the difference between the total covered charges and the primary plan's payment. See below for a description of how this Plan coordinates with Medicare.

**If you and your spouse (through another employer) both cover your children, the plan of the parent whose birthday falls first in the calendar year will pay first.**

### **Which Plan Pays First?**

If you are an employee of the Company this Plan will pay first. If your child is covered by more than one plan, the plan which covers the parent whose birthday falls first in the year (month and day) pays for the dependent child before the plan covering the other parent. However, if you are separated or divorced, the plan of the parent who has custody of the child (provided that the parent hasn't remarried) will pay before the plan of the parent who doesn't have custody. If you're divorced, but have remarried and have custody of your child, your plan will pay before the child's stepparent's plan, and the stepparent's plan will pay before the plan of the child's non-custodial parent.

If a court gives financial responsibility for the child's health care expenses to one parent, then that parent's medical plan will pay before any other plan. When none of these situations apply, the plan under which you have been covered the longest will pay first.

Other plans include any medical coverage available from:

- Group, fraternal, blanket or franchise insurance,
- Prepayment coverage,
- Coverage under labor-management trustee plans, union welfare plans, employer organization plans or employee benefits organization plans, and/or
- Government programs, except Medicare.

Keep in mind that if both you and your spouse are employed by the Company or covered as a retiree under the Pre-65 Retiree Health Plan, under the "Special Rules for Dual Couples" section above, you cannot be covered under this Plan as both an employee and as a dependent of another employee. As a result, you cannot have duplicate coverage under the Medical Plan. Each retiree is covered only as an retiree or as a dependent. A child is regarded as a dependent of only one employee, not both. No coordination of benefits is applicable since only one medical plan is involved.

If the amount of the payments made by the Employer's Group Health Plan is more than the Employer's Group Health Plan should have paid under this Coordination of Benefits section, the Employer's Group Health Plan may recover the excess or overpayment from the Member on whose behalf it has made payments, from a Provider, from any group insurer, Plan, or any other person or organization contractually obligated to such Member with respect to such overpayments.

# **CLAIMS PROCESSING**

## **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. Written notice of receipt of services on which a claim is based must be furnished to the BCBS-SC, at the following address:

BlueCross BlueShield of South Carolina  
Claims Service Center  
Post Office Box 100300  
Columbia, SC 29202

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

3. For services not provided by a Participating Provider, the Member is responsible for filing claims with BCBS-SC. When filing the claims, the Member will need the following:
  - a. A claim form for each Member. Members can get claim forms from the Benefits Homepage on InSite, a member services representative at BCBS-SC Customer Service at 1-800-352-6596 as indicated on the Identification Card or via the Corporation's website, [www.SouthCarolinaBlues.com](http://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 BCBS-SC address listed on the claim form.

4. BCBS-SC must receive the claim within ninety (90) days after the beginning of services. Failure to file the claim within the ninety (90) day period, however, will not prevent payment of Covered Expenses if the Member shows that it was not reasonably possible to file the claim timely, provided the claim is filed as soon as is reasonably possible. Except in the absence of legal capacity, claims must be filed no later than fifteen (15) months following the date services were received.
5. Receipt of a claim by the BCBS-SC will be deemed written proof of loss and will serve as written authorization from the Member to the BCBS-SC to obtain any medical or financial records and documents useful to the BCBS-SC. BCBS-SC, 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 BCBS-SC 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 BCBS-SC for an Authorized Representative form.
6. There are four (4) types of claims: Pre-Service Claims, Urgent Care Claims, Post-Service Claims, and Concurrent Care Claims. The SRR Health Plan will make a determination for each type of claim within the following time periods:
  - a. Pre-Service Claim
    - i. A determination will be provided in writing or in electronic form within a reasonable period of time, appropriate to the medical circumstances, but no later than fifteen (15) days from receipt of the claim.
    - ii. If a Pre-service Claim is improperly filed, or otherwise does not follow applicable procedures, the Member will be sent notification within five (5) days of receipt of the claim.
    - iii. An extension of fifteen (15) days is permitted if BCBS-SC (on behalf of the SRR Group Health Plan) determines that, for reasons beyond the control of BCBS-SC, an extension is necessary. If an extension is necessary the BCBS-SC 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 BCBS-SC 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 BCBS-SC does not receive the required information within the forty-five (45) day time period, the claim will be denied. BCBS-SC will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If BCBS-SC 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.
  - 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 BCBS-SC (on behalf of the SRR Group Health Plan) determines that, for reasons beyond the control of BCBS-SC, an extension is necessary. If an extension is necessary, BCBS-SC 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 BCBS-SC 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 BCBS-SC does not receive the required information within the forty-five (45) day time period, the claim will be denied. BCBS-SC will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If BCBS-SC receives the requested information after the forty-five (45) days, but within two hundred twenty-five (225) days, the claim will be reviewed as a first level appeal. Reference Article XI (B) for details regarding the appeals process.

d. Concurrent Care Claim

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

7. Notice of Determination

- a. If the Member's claim is filed properly, and the claim is in part or wholly denied, the Member will receive notice of an Adverse Benefit Determination which will:
  - i. State the specific reason(s) for the Adverse Benefit Determination;
  - ii. Reference the specific Plan of Benefits provisions on which the determination is based;
  - iii. Describe additional material or information, if any, needed to complete the claim and the reasons such material or information is necessary;
  - iv. Describe the claims review procedures and 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;
  - v. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request); and,
  - vi. If the reason for denial is based on a lack of Medical Necessity or Investigational or Experimental Services exclusion or similar limitation, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request).
- b. The Member will also receive a notice if the claim is approved.

## **B. APPEAL PROCESS 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; and,
  - b. An appeal must be sent (via U.S. mail) at the address below:  
BlueCross BlueShield of South Carolina  
Claims Service Center  
Post Office Box 100300  
Columbia, SC 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. If the appealed claim involves an exercise of medical judgment, the Plan will consult with an appropriately qualified health care practitioner with training and experience in the relevant field of medicine. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on the appeal.
4. The final decision on the appeal will be made within the time periods specified below:
  - a. Pre-Service Claim  
The BCBS-SC (on behalf of SRR's 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 verbally, and the SRR Medical Plan Administrator will communicate with the Member by telephone or facsimile. The Plan Administrator 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 BCBS-SC (on behalf of SRR's 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 Employer will decide the appeal of Concurrent Care Claims within the time frames of a Pre-Service Claim, an Urgent Care Claim or a Post-Service Claim.

5. Notice of Final Appeals Determination

Your final appeal to the Plan should be sent to:  
Savannah River Remediation  
Attn: SRR Medical Plan Administrator  
Building 766-H, RM. 1066F  
Aiken, SC 29808

- a. If a Member's appeal is denied in whole or in part, the Member will receive notice of an Adverse Benefit Determination.
    - i. State specific reason(s) for the Adverse Benefit Determination;
    - ii. Reference specific provision(s) of the Plan of Benefits on which the Benefit determination is based;
    - iii. State that the Member is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for Benefits;
    - iv. Disclose and provide any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination;
    - v. If the reason for an Adverse Benefit Determination on appeal is based on a lack of Medical Necessity, Investigational or Experimental Services or other limitation or exclusion, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);
    - vi. Include a statement regarding the Member's right to bring an action under section 502(a) of ERISA.
  - b. The Member will also receive a notice if the claim on appeal is approved.
6. The SRR Medical Plan may retain BCBS-SC to assist the Medical Plan in making the determination on appeal. Regardless of its assistance, the BCBS-SC is only acting in an advisory capacity and is not acting in a fiduciary capacity. The SRR Medical Plan at all times retains the right to make the final determination.

As a participant in the Medical Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 as amended (ERISA). The official documents that govern the Plan dictate the actual operation of the Plan and the payment of benefit

## Medicare Coordination

**Under this Plan, when you become eligible for Medicare (Parts A&B), Medicare becomes your primary (first payer) for medical coverage.** If you are covered under this SRR Pre-65 Retiree Health Plan Medical benefits, Medicare will be Primary before any benefits will be paid by the SRR Pre-65 Retiree Health Plan. The one exception to this would be if you are recognized by Medicare as having End-Stage Renal Disease (ESRD). The Medicare Secondary Payer (MSP) provisions of the Social Security Act require Group Health Plans (GHPs) to make payments before Medicare for End-Stage Renal Disease on the date you first become entitled to enroll in Medicare because of ESRD. If you are scheduled for Dialysis you should contact BCBS-SC Customer Service and the Social Security Administration to assure claims will be processed and paid correctly.

**It is your responsibility to notify BCBS-SC and the SRR Medical Plan Administer when you become eligible for Medicare.**

**When Medicare is primary**, claims should be submitted and paid by Medicare (Parts A&B) prior to their submission to BCBS-SC for reimbursement from the Medical Plan. When Medicare (Parts A&B) is primary, BCBS-SC calculates the normal benefit payable for a covered expense and then “carves out,” (or subtracts), what Medicare would pay for the expense. The difference between the normal Plan benefit and the Medicare benefit is what BCBS-SC would actually pay.

With the carve-out provision of the Medical Plan, the Medicare payment is carved-out (or subtracted) from the payment, rather than the Plan payment being calculated as a supplement to the Medicare payment. Therefore, to calculate the Medical Plan secondary payment, BCBS-SC will:

- 1) determine what would normally be payable if the Medical Plan were primary, then
- 2) subtract the amount payable under Medicare.

If the result of the Medical Plan primary payment minus the Medicare payable amount is positive, BCBS-SC will make a secondary payment under the Medical Plan (to the lesser of the Medicare Allowable Amount or the primary payment). However, if the result of the Medical Plan primary payment minus Medicare is equal to \$0 or negative amount, there will be no secondary payment from the Plan.

**Keep in mind that when Medicare is Primary, the Medical Plan will apply Medicare “Carve-Out” and subtract out of your Medical Plan coverage what Medicare Part B would have paid if you had enrolled in Medicare Part B, even if you have not elected Medicare Part A and B coverage. You can help minimize any balance that you may have to pay the Provider by enrolling in Medicare Part A and B once Medicare becomes Primary.**

You may also wish to note that if you are eligible for and elect **Medicare Part D (for prescription drug coverage under Medicare)**, Medicare will then become your primary (first payer) for prescription drug coverage. **When the Medical Plan option in which you are enrolled is determined to be equal to or better than Medicare Part D (also called “creditable coverage”), you may not need and or want to enroll in Medicare Part D.**

### Example 1

You incur a \$100 charge for a Physician’s office visit with a BCBS-SC Network Provider and the BCBS-SC Allowed charge for the covered service is \$60. The Medical Plan applies a \$20 charge (e.g. for the Standard Choice option) for the office visit copay and the resulting payment would normally be \$40 (that is \$60 minus \$20). If the Medicare Allowed amount is \$90 but Medicare makes \$0 payment (since Medicare is applying the \$90 toward your Medicare Part B deductible), the carve-out calculations results in a \$40 payment (normal payment if the Plan was primary) minus the \$0 Medicare payment equals a \$40 Plan payment as the secondary plan.

### Example 2

You incur the same \$100 Physician’s office visit charge with a BCBS-SC Network Provider as is detailed above in Example 1. The BCBS-SC Allowed Charge is \$60 minus the \$20 Medical Plan (Standard Choice option) office visit copay resulting in a normal Medical Plan primary payment of \$40. However, you have now met your Medicare Part B deductible, and Medicare pays 80% of their \$90 Medicare Allowed amount resulting in a Medicare payment of \$72. The carve-out calculation of the \$40 payment (normal payment if the Medical Plan was primary) minus the \$72 Medicare payment would result in a negative Medical Plan secondary payment. Therefore, the Medical Plan will make \$0 payment as the secondary payment.

### **Example 3**

You incur a \$1,000 expense for surgery from a BCBS-SC Network Provider. The BCBS-SC Allowed charge for the covered service is \$1,000. The Medical Plan applies a 10% coinsurance for covered surgical charges and the resulting payment would normally be \$900 or 90% of \$1,000. If the Medicare Allowed amount is \$800 and Medicare actually pays \$640 (that is, 80% of \$800), the resulting carve-out calculation would be  $\$900 - \$640 = \$260$ . The result would exceed the Medicare Allowed amount, therefore, the Plan will make a payment of \$160 (up to the Medicare Allowed Amount of  $\$640 + \$160 = \$800$ ).

**Note: Providers do not have to accept the maximum Allowable Charge amounts from non-primary plans. When Medicare is primary, Providers that accept Medicare may “balance bill” you up to the Medicare allowable amount (which may be more or less than the BCBS-SC allowable amount). Providers that do not accept Medicare can “balance bill” you up to their total charged amount.**

There are several factors that impact the amount that is paid by the Medical Plan, and any amount that you may still owe the Provider. For example:

- Satisfaction of the participant's Medicare deductible and co-pay,
- The Medicare discount and resulting Medicare allowed amount,
- The BCBS-SC Allowable Charge,
- Satisfaction of your Deductible, Copay, Coinsurance and Out-of-Pocket Maximum amounts under the Medical Plan,
- Excluded charges under Medicare, and/or the Medical Plan,
- Medicare Part B enrollment and
- The Provider's acceptance of the Medicare allowed amount.

**You can help minimize any balance that you may have to pay the Provider by enrolling in Medicare Part B, and by using Providers that “accept Medicare” and participate in the BCBS-SC Networks.** If you use a BCBS-SC Network Provider who does not accept Medicare, your reimbursement from the Plan will be calculated as if the Medicare benefit was paid and accepted by the Provider. Additionally, if you use a non-Network BCBS-SC Provider, the BCBS-SC reimbursement will be in accordance with the non-Network provisions of the Plan.

# **MEDICAL CLAIMS PROCESSING**

## **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. Written notice of receipt of services on which a claim is based must be furnished to the BCBS-SC, at the following address

BlueCross BlueShield of South Carolina  
Claims Service Center  
Post Office Box 100300  
Columbia, SC 29202

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

3. For services not provided by a Participating Provider, the Member is responsible for filing claims with BCBS-SC. When filing the claims, the Member will need the following:
  - a. A claim form for each Member. Members can get claim forms from the Benefits Homepage on InSite, a member services representative at BCBS-SC Customer Service at 1-800-352-6596 as indicated on the Identification Card or via the Corporation's website, [www.SouthCarolinaBlues.com](http://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.
  - a. 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 BCBS-SC address listed on the claim form.

4. BCBS-SC must receive the claim within ninety (90) days after the beginning of services. Failure to file the claim within the ninety (90) day period, however, will not prevent payment of Covered Expenses if the Member shows that it was not reasonably possible to file the claim timely, provided the claim is filed as soon as is reasonably possible. Except in the absence of legal capacity, claims must be filed no later than fifteen (15) months following the date services were received.
5. Receipt of a claim by the BCBS-SC will be deemed written proof of loss and will serve as written authorization from the Member to the BCBS-SC to obtain any medical or financial records and documents useful to the BCBS-SC. BCBS-SC, 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 BCBS-SC 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 BCBS-SC for an Authorized Representative form.
6. There are four (4) types of claims: Pre-Service Claims, Urgent Care Claims, Post-Service Claims, and Concurrent Care Claims. The SRR Health Plan will make a determination for each type of claim within the following time periods:
  - a. Pre-Service Claim
    - i. A determination will be provided in writing or in electronic form within a reasonable period of time, appropriate to the medical circumstances, but no later than fifteen (15) days from receipt of the claim.
    - ii. If a Pre-service Claim is improperly filed, or otherwise does not follow applicable procedures, the Member will be sent notification within five (5) days of receipt of the claim.
    - iii. An extension of fifteen (15) days is permitted if BCBS-SC (on behalf of the SRR Group Health Plan) determines that, for reasons beyond the control of BCBS-SC, an extension is necessary. If an extension is necessary the BCBS-SC 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 BCBS-SC 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 BCBS-SC does not receive the required information within the forty-five (45) day time period, the claim will be denied. BCBS-SC will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If BCBS-SC 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.
  - 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 BCBS-SC (on behalf of the SRR Group Health Plan) determines that, for reasons beyond the control of BCBS-SC, an extension is necessary. If an extension is necessary, BCBS-SC 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 BCBS-SC 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 BCBS-SC does not receive the required information within the forty-five (45) day time period, the claim will be denied. BCBS-SC will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If BCBS-SC receives the requested information after the forty-five (45) days, but within two hundred twenty-five (225) days, the claim will be reviewed as a first level appeal. Reference Article XI(B) for details regarding the appeals process.

d. Concurrent Care Claim

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

7. Notice of Determination

- a. If the Member's claim is filed properly, and the claim is in part or wholly denied, the Member will receive notice of an Adverse Benefit Determination which will:
  - i. State the specific reason(s) for the Adverse Benefit Determination;
  - ii. Reference the specific Plan of Benefits provisions on which the determination is based;
  - iii. Describe additional material or information, if any, needed to complete the claim and the reasons such material or information is necessary;
  - iv. Describe the claims review procedures and 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;
  - v. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request); and,
  - vi. If the reason for denial is based on a lack of Medical Necessity or Investigational or Experimental Services exclusion or similar limitation, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request).
- b. The Member will also receive a notice if the claim is approved.

**B. APPEAL PROCEDURES FOR AN ADVERSE BENEFIT DETERMINATION**

1. Member has one hundred eighty (180) days from receipt of an Adverse Benefit Determination to file an appeal. An appeal must meet the following requirements:
  - a. An appeal must be in writing; and,

- b. An appeal must be sent (via U.S. mail) at the address below:

BlueCross BlueShield of South Carolina  
Claims Service Center  
Post Office Box 100300  
Columbia, SC 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. If the appealed claim involves an exercise of medical judgment, the Plan will consult with an appropriately qualified health care practitioner with training and experience in the relevant field of medicine. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on the appeal.
  - 4. The final decision on the appeal will be made within the time periods specified below:
    - e. Pre-Service Claim  
The BCBS-SC (on behalf of SRR's 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.
    - f. Urgent Care Claim  
The Member may request an expedited appeal of an Urgent Care Claim. This expedited appeal request may be made verbally, and the SRR Medical Plan Administrator will communicate with the Member by telephone or facsimile. The Plan Administrator 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.
    - g. Post-Service Claim  
  
The BCBS-SC (on behalf of SRR's 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.
    - h. Concurrent Care Claim  
The Employer will decide the appeal of Concurrent Care Claims within the time frames of a Pre-Service Claim, an Urgent Care Claim or a Post-Service Claim.

4. Notice of Final Internal Appeals Determination  
Your final appeal to the Plan should be sent to:  
Savannah River Remediation  
Attn: SRR Medical Plan Administrator  
Building 766-H, RM. 1066F  
Aiken, SC 29808
- a. If a Member's appeal is denied in whole or in part, the Member will receive notice of an Adverse Benefit Determination.
  - i. State specific reason(s) for the Adverse Benefit Determination;
  - ii. Reference specific provision(s) of the Plan of Benefits on which the Benefit determination is based;
  - iii. State that the Member is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for Benefits;
  - iv. Disclose and provide any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination;
  - v. If the reason for an Adverse Benefit Determination on appeal is based on a lack of Medical Necessity, Investigational or Experimental Services or other limitation or exclusion, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);
  - vi. Include a statement regarding the Member's right to bring an action under section 502(a) of ERISA.
- b. The Member will also receive a notice if the claim on appeal is approved.
6. The SRR Medical Plan may retain BCBS-SC to assist the Medical Plan in making the determination on appeal. Regardless of its assistance, the BCBS-SC is only acting in an advisory capacity and is not acting in a fiduciary capacity. The SRR Medical Plan at all times retains the right to make the final determination.

As a participant in the Medical Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 as amended (ERISA). The official documents that govern the Plan dictate the actual operation of the Plan and the payment of benefits.

## II. Dental Benefit Coverage

Savannah River Remediation LLC (SRR) maintains dental benefits under the Pre-65 Retiree Health Plan designed to help you, and your family, keep a healthy mouth by assisting you with the cost of dental treatments. Oral health can provide clues to your overall health and routine dental examinations are a component of maintaining good health.

### DENTAL BENEFITS AT A GLANCE

The Prime Choice and Standard Choice both provide you with the option of using a network of preferred dental providers called a Participating Provider. The level of dental payments from the dental plan will be the same from dentist to dentist however, Participating Providers cannot balance bill you for covered charges over the BCBS-SC allowable amount. The Benefit Year runs from January 1 through December 31.

<u>Prime Choice Dental</u>	<u>Participating Provider</u>	<u>Non-Participating Provider</u>
<b>Preventive and Diagnostic</b>	The Plan pays 100% of Allowable Charges	The Plan pays 100% of Allowable Charges  The Member must pay the balance of the Provider's charge.
<b>Basic Dental Benefits:</b>  <b>Minor Restorative</b>  Filings, Oral Surgery, Simple Extractions, Root Canals, and Periodontic treatments	The Plan pays 80% of Allowable Charges  The Member pays the remaining 20% of the Allowable Charge	The Plan pays 80% of Allowable Charges  The Member must pay the balance of the Provider's charge.
<b>Major Dental Benefits</b>  <b>Major Restorative</b> Crowns, Bridges, Dentures, and Implants	The Plan pays 60% of Allowable Charges  The Member pays the remaining 40% of the Allowable Charge	The Plan pays 60% of Allowable Charges  The Member must pay the balance of the Provider's charge.
<b>Major Dental Benefits (continued)</b> Temporomandibular Joint Disorder (TMJ)/Temporomandibular Disorder (TMD) (subject to a maximum \$500 per member per lifetime)	The Plan pays 50% of Allowable Charges up to the lifetime maximum  The Member pays the remaining 50% of the Allowable Charge	The Plan pays 50% of Allowable Charges up to the lifetime maximum  The Member must pay the balance of the Provider's charge.
<b>Orthodontics Benefits</b> (subject to a maximum \$1,500 per member per lifetime. Effective 01/01/2017 the lifetime maximum will be \$2,000 per member per lifetime)	The Plan pays 50% of Allowable Charges up to the lifetime maximum (child and adult)  The Member pays the remaining 50% of the Allowable Charge	The Plan pays 50% of Allowable Charges up to the lifetime maximum (child and adult)  The Member must pay the balance of the Provider's charge.
<b>Annual Deductible</b>	None	None
<b>Maximum Annual Benefit*</b>	\$2,000 per person per benefit year	\$2,000 per person per benefit year

\*Preventive and Diagnostic, Basic Dental Benefits, and Major Dental Benefits are subject to a combined maximum of \$2,000 per member per Benefit Year. This limit—the maximum annual benefit—is available each year. Payments for TMJ/TMD and orthodontics do not count toward the maximum annual benefit amount under the Prime Choice Dental option. However, there is a maximum lifetime benefit as indicated in the table above for TMJ/TMD and orthodontics.

## DENTAL BENEFITS AT A GLANCE (continued)

<b><u>Standard Choice Dental</u></b>	<b><u>Participating Provider</u></b>	<b><u>Non-Participating Provider</u></b>
<b>Preventive and Diagnostic</b>	The Plan pays 100% of Allowable Charges	The Plan pays 100% of Allowable Charges  The Member must pay the balance of the Provider's charge.
<b>Basic Dental Benefits:</b> <b>Minor Restorative</b>  Filings, Oral Surgery, Simple Extractions, Root Canals, and Periodontic treatments	The Plan pays 50% of Allowable Charges after the Benefit Year Deductible  The Member pays the remaining 50% of the Allowable Charge after the Benefit Year Deductible	The Plan pays 50% of Allowable Charges after the Benefit Year Deductible  The Member must pay the balance of the Provider's charge after the Benefit Year Deductible
<b>Major Dental Benefits</b> <b>Major Restorative</b> Crowns, Bridges, Dentures, and Implants	The Plan pays 50% of Allowable Charges after the Benefit Year Deductible  The Member pays the remaining 50% of the Allowable Charge after the Benefit Year Deductible	The Plan pays 50% of Allowable Charges after the Benefit Year Deductible  The Member must pay the balance of the Provider's charge after the Benefit Year Deductible
<b>Orthodontics Benefits</b>	No Coverage	No Coverage
<b>Temporomandibular Joint (TMJ) Disorder</b>	No Coverage	No Coverage
<b>Annual Deductible</b>	\$50 per family with no one member meeting more than \$25	\$50 per family with no one member meeting more than \$25
<b>Maximum Annual Benefit*</b>	\$1,000 per person per benefit year	\$1,000 per person per benefit year

Preventive and Diagnostic, Basic Dental Benefits, and Major Dental Benefits are subject to a combined maximum of \$1,000 per member per Benefit Year.

# PLAN CHOICES

- Prime Choice and Standard Choice give you the option of using a BCBS PPO Dental Network provider. The level of dental benefit payments from the Plan will be the same from dentist to dentist under the option you choose. However, when you utilize a network provider you will no longer be subject to being billed for the balance over the BCBS allowed amount.
- Preventive care is covered at 100% of allowable charges under both options.
- Prime Choice Dental offers higher coverage on restorative services; TMJ treatment and orthodontics are covered at 50% of allowable with no annual deductible.
- Standard Choice Dental offers a lower coverage level on restorative services; no coverage for TMJ treatment or orthodontics; an annual deductible applies to non-preventive care services.
- As of 1/1/2011, implants are covered under Major Restorative Services for both the Prime Choice and Standard Choice Dental Options.

## **Temporomandibular Joint (TMJ) and Other Temporomandibular Disorders (TMD)**

Under Prime Choice dental, benefits for treatment of TMJ and other Temporomandibular Disorders (TMD) are paid at 50% of the BCBS allowable charge up to a maximum lifetime benefit of \$500 for each covered person. Temporomandibular Disorders are diseases or conditions that result in pain and dysfunction of the jaws.. Prime Choice Dental provides coverage for non-surgical treatment for problems specifically related to the treatment of the Temporomandibular Disorders and is limited to: Dental splints to prevent clenching and/or grinding of the teeth, removal of occlusal appliances, bio-feedback therapy, and physical therapy based on BlueCross BlueShield TMD Treatment Guidelines.

## **Orthodontics**

Prime Choice dental covers both adult and child orthodontics. The benefit level is 50% of the BCBS allowable charge but not more than \$1,500 for each covered person in a lifetime. The lifetime maximum of \$1,500 is applied even if you change coverage from Prime Choice dental to Standard Choice and then return to the Prime Choice dental option. To be covered, services must be incurred (actually rendered by the dentist) during the same year that you are enrolled in the Prime dental option.

## **Deductible - Standard Choice Dental**

Both Prime Choice and Standard Choice dental options reimburse 100% of the BCBS allowable charge amount of covered Preventive care. Under Standard Dental, all other covered services are paid at 50% of the BCBS allowable charge level for covered charges after you've met a \$25.00 individual/\$50.00 family yearly deductible.

Under the Standard Choice Dental Plan the **Individual Deductible** is the amount that must be paid by one person each calendar year on covered non-preventive services. The **Family Deductible** is twice the individual deductible with no one member satisfying more than \$25

There is no carryover of unsatisfied deductible amounts from one year to the next. Your deductible amount starts over each January.

## **Maximum Annual Benefit**

- **Prime Choice:** The maximum Plan benefit (the most the option will pay) in any calendar year for each person covered under the Prime Choice dental option is \$2,000 per member per Benefit Year for Preventive and Diagnostic, Basic Dental Benefits, and Major Dental Benefits combined. However, payments that were made by the Plan for TMD/TMJ and orthodontics do not count toward the maximum annual Benefit amount.
- **Standard Choice:** The maximum Plan benefit for preventive and minor and major restorative services combined under the Standard Choice dental is \$1,000 per member per Benefit Year for Preventive and Diagnostic, Basic Dental Benefits, and Major Dental Benefits.

## **Your Share of Expenses**

Regardless of which dental option you elect, there are certain expenses that you are responsible for:

- The deductible (for non-preventive services under the Standard Choice Dental option only) and coinsurance (for non-preventive services under both the Prime Choice and Standard Choice Dental options),
- Any expenses above the BCBS allowable charge when using a Non-network provider,
- Expenses not covered by the option you elect,
- Charges that exceed the maximum annual benefit,
- Charges that exceed the lifetime maximum benefit (TMJ/TMD and orthodontics), and
- Any charges for procedures that exceed or differ from widely accepted dental practice (refer to “Alternate Course Of Treatment”).

## **Pre-Treatment Estimate**

A pre-treatment estimate, also called predetermination of benefits, is not mandatory but it is strongly advised. Both dental options pay based on the level of treatment that BCBS determines is “adequate and necessary” according to widely accepted dental practices. Since dental care can be expensive, it’s a good idea to find out in advance how much will be paid because benefits are limited to the course of treatment which Blue Cross Blue Shield, upon review, determines is appropriate. By getting a pre-treatment estimate, you’ll know whether the services are covered under BCBS’s dental treatment guidelines. You’ll also know how much of the dentist’s charges BCBS will pay. Therefore, you can avoid misunderstandings about your coverage.

If your dentist recommends a procedure that differs from widely accepted dental practice, then you will be required to pay the difference between your dentist’s bill and the amount covered by Prime Choice or Standard Choice.

## **When and How to Request a Pre-Treatment Estimate**

Except in an emergency, you should discuss fees with your Dentist before treatment begins. If you or a covered member of your family need dental treatment that the Dentist estimates will cost \$300 or more, you should ask that predetermination of Benefits be filed with BCBS-SC. By doing this, both you and the Dentist will know in advance how much your dental Plan will pay for the course of treatment recommended. Here is how predetermination works.

Your Dentist should list on a claim form, the treatment planned and charges for that treatment and forward the form to the Dental Claims Processing Unit at BlueCross BlueShield. After determining the amount eligible for payment, the Dental Claims Processing Unit will let you and your Dentist know the amount of money that can be paid under your coverage for the recommended treatment.

If treatment costs \$300 or more and your Dentist does not ask for predetermination of Benefits, your claim will be paid according to the information contained on the claim form.

Predetermination of Benefits is not necessary for treatment that costs less than \$300 or for emergency care, routine oral examinations, x-rays, fluoride treatments, cleaning, scaling or polishing teeth.

## **In Case of Conflict**

While you can go ahead with any course of treatment, even a more expensive one, recognize that the benefit payment will be based on what BCBS considers to be “necessary, appropriate and adequate” according to widely accepted standards of dental practice for your condition. Some examples of the types of dental treatment where reimbursement may be denied totally or in part, include the unnecessary removal of impacted wisdom teeth and the installation of crowns, inlays and onlays, when a less expensive alternative treatment would be as effective. Refer to “Alternate Course of Treatment” below for more information.

## **Alternate Course of Treatment**

An alternate course of treatment applies when more than one dental service or supply can treat the same dental problem. Sometimes, for example, either a crown or a filling could work adequately well. All services must meet widely accepted dental practice standards.

If alternate services and supplies can be used that will equally treat your dental problems, both dental options will always pay benefits based on the less expensive alternate services or supplies. The standards developed by BCBS are based on the services and supplies that are customarily used by dentists throughout the United States, taking into account the current condition of the patient.

# **COVERED DENTAL SERVICES**

Dental services are covered and allowable benefits under the Prime Choice and Standard Choice Dental options when:

- the services are based on accepted standards of dental practice,
- the services are rendered or the supplies furnished by a Dentist or dental hygienist acting within the scope of their license and are not otherwise excluded from coverage
- the services and supplies are billed by or on behalf of the Dentist.

Preventive care services are covered at 100% of BCBS allowable charge under both Prime Choice and Standard Choice with no deductible required.

## **Covered Dental Services Include the Following:**

### **1) Preventive And Diagnostic Dental Benefits**

- Oral Examination, including Treatment Plan if necessary, limited to twice per benefit year;
- Dental x-rays:
  - full mouth (panoramic) x-ray: once every 3 years,
  - bite-wing x-rays: two (2) times in a calendar year,
  - any dental x-ray required to diagnose a specific condition.
- Topical fluoride applications of stannous fluoride or acid fluoride phosphate, limited to two (2) applications per benefit year.
- Prophylaxis, including cleaning, scaling and polishing, limited to twice per year;
- Space maintainer for prematurely lost deciduous teeth are provided for dependent children under age 20;
- Emergency palliative treatment for the relief of pain;
- Pulp vitality tests;
- Diagnostic casts; and
- Application of sealants on teeth without any fillings: For dependent children under age 20 once per tooth every 60 months.

### **2) Basic Dental Benefits**

#### **Minor Restorative Services**

- Oral Surgery (but not periodontal surgery) including the following:
  - Surgical extractions,
  - Alveoplasty,
  - Surgical excision of lesions and tumors,
  - Removal of cysts and neoplasms,
  - Excision of bone tissue,
  - Biopsies of oral tissue,
  - Treatment of oral fistula,
  - Excision of hyperplastic tissue and
  - Frenulectomy
- Fillings, consisting of amalgam and tooth-colored synthetic materials – Only the anterior teeth (the front 6 top teeth and front 6 bottom teeth) are covered for composite or tooth colored fillings. Amalgam fillings are covered elsewhere in the mouth;
- Simple extractions;
- Endodontics, consisting of pulpotomy, pulp capping and root canal treatment;
- Thirty (30) minutes of IV sedation and general anesthesia if Medically Necessary and rendered in connection with covered oral or dental surgery except as specified on the Schedule of Benefits;
- Apicoectomy (amputation of apex of a tooth root);
- Hemi-section;
- Periodontics: diagnosis and treatment of diseases of the tooth-supporting tissues, as follows:
  - Surgical periodontic examination,
  - Gingival curettage,
  - Gingivectomy and gingivoplasty,
  - Osseous surgery, including flap entry and closure,
  - Management of acute infection and oral lesions;
  - Periodontal cleanings (payable twice per year after the initial periodontal treatment is documented);
  - Repair of removable dentures.

### 3) Major Dental Benefits –

**Restorative Services** –The restoration and maintenance of oral function by the replacement of missing teeth and structures by artificial appliances as follows:

- Inlays (not part of a bridge);
- Permanent Crowns (not part of a bridge);
- Onlays (not part of a bridge);
- Removable dentures (complete and partial) and bridges (fixed and removable). Benefits for replacement will not be provided for (a) any denture replacement inlay, crown or onlays made less than five (5) years after a placement or replacement which was covered under this Plan or (b) any replacement made necessary by reason of loss or theft;
- Fixed bridge repairs;
- Relining or rebasing of removable dentures more than six months after the installation of an initial or replacement denture, then once every three (3) years;
- Crowns and/or bridges placed over implants.
- Dental Implants — placing artificial teeth or supports surgically into the jawbone.

### 4) Temporomandibular Joint Disorder (TMJ) and Other Temporomandibular Disorders (TMD) — Prime Choice Only

Covered TMJ/TBD Services are paid at 50% of the Allowable Charge under Prime Choice, up to a maximum lifetime benefit of \$ 500 per person. Before undergoing treatment for TMJ/TMD, you must follow the pretreatment estimate procedures described earlier in this book.

Non-surgical treatment for problems specifically related to the treatment of the Temporomandibular Disorders are limited to:

- dental splints to prevent clenching and/or grinding of teeth,
- removable occlusal appliances,
- biofeedback therapy, and
- physical therapy based on BCBS's TMD Treatment Guidelines.

### 5) Orthodontics (Braces) — Prime Choice Only

Covered orthodontia is paid at 50% of the Allowable Charge under Prime Choice, up to a maximum lifetime benefit of \$1,500 per person. Before undergoing treatment for Orthodontics, you must follow the pretreatment estimate procedures described earlier in this book.

The prevention or correction of irregularities in the alignment of the teeth and the prevention or the correction of dysfunctional malocclusion consisting of the following:

- Diagnosis, including models and radiographs,
- Active treatment, including necessary appliances, and
- Retention treatment following active treatment, limited to 10 visits in an 18-month period.
- Benefits payable per patient are limited to the lifetime maximum of \$1,500 and to services rendered within a period not to exceed 36 consecutive months;
- The initial payment will be equal to no more than 25% of the total liability/coverage limit of the Plan. The following payments will be payable no more frequently than once a month. If for any reason the orthodontic services are terminated before completion of the approved Treatment Plan, the responsibility of the Plan will end with payment through the month of termination; and
- The replacement of any appliances made necessary by reason of loss or theft is not covered.

As noted above, the Dental Plan's payment of orthodontic services is based on the assumption that a portion of the charge is incurred at the time the appliance is installed and that the balance is billed over the period of time the appliance is expected to remain in place. For this reason, the "set-up" fee is paid immediately and the balance of benefits available is paid on a monthly basis after services have been received. Orthodontic benefits are based on the treatment plan and continue until the maximum benefit has been paid or the individual's coverage ceases, whichever occurs first. If coverage terminates after orthodontic treatment has begun but before treatment is complete, then no further benefits are available when coverage ceases, even though the orthodontic treatment may have begun prior to termination of coverage. You should follow the pre-treatment estimate procedure as described previously before beginning orthodontic treatment.

## 6) Cleft Lip and Palate

Covered Expenses are available for teeth capping, prosthodontics and orthodontics necessary for the care and treatment of congenital cleft lip and palate. The same Benefit Year Deductible and Coinsurance apply to these services as apply to other procedures covered by Plan. Benefits under this Plan related to these services are primary to any Benefits available for the patient under any individual or group accident Plan.

## Expenses Not Covered Under Either Option

You are not covered for the following dental expenses under Prime Choice or Standard Choice dental:

1. Any services or charges for services not Medically Necessary;
2. Dental services or supplies that are Investigational or Experimental;
3. Any charges for supplies or dental services rendered to the Member prior to the Member's Effective Date, the Employer's Effective Date or after the Member's coverage terminates
4. Dental services received from a dental or medical department maintained by or on behalf of the Employer, a mutual benefit association, labor union, trustee or similar person or group;
5. Dental services for which the Member incurs no charge;
6. Any service or charge for service to the extent a Member is entitled to receive payment or benefits relating to such service under any state or federal program that provides health care benefits, including Medicare, but only to the extent that benefits are paid or are payable under such programs. This exclusion includes but is not limited to, benefits provided by the Veterans Administration for care rendered for service-related disability, or any state or federal hospital services for which the Member is not legally obligated to pay;
7. Dental services or supplies primarily for cosmetic or aesthetic purposes, including personalization or characterization of dentures;
8. Dental services for which the Member would have no legal obligation to pay in the absence of Dental Coverage;
9. Appliances or restorations necessary to increase vertical dimensions or restore the occlusion, including management of TMJ disorders except as specified on the Schedule of Benefits;
10. Services rendered by a Provider beyond the scope of his or her license;
11. Dental services to the extent that charges for such services exceed the charge that would have been made and actually collected if no coverage hereunder;
12. Charges by a Provider for non-dental services such as broken appointments and completion of claim forms;
13. Charges for visits at home or in the hospital except in connection with emergency care;
14. Dental care or treatment not specifically listed under Dental Covered Expenses or specified on the Schedule of Benefits;
15. Any service or supply rendered by a member of the patient's immediate family or by the patient, including the dispensing of drugs. A member of the patient's family means the Spouse, parent, grandparent, brother, sister, Child or Spouse's parent of the patient;
16. Illness contracted or injury sustained as a result of declared or undeclared war or any act of war, or while in the military service;
17. Services related to teeth missing prior to a Member's Effective Date of coverage under this Plan of Benefits are not eligible for payment of benefits, except as specified on the Schedule of Benefits;
18. Any service for the treatment of dysfunctions or derangements of the TMJ, including orthognathic surgery for the treatment of dysfunctions or derangements of the TMJ, except as specified on the Schedule of Benefits;
19. Any service related to the treatment of malpositions or deformities of the jaw bone(s), dysfunction of the muscles of mastication, or orthognathic deformities, except as specified on the Schedule of Benefits;
20. Consultations;
21. Non-IV sedation (nitrous oxide and non-conscious-IV sedation);
22. Replacement Prosthodontics made necessary by loss or theft except as specified in Article III or on the Schedule of Benefits;
23. Temporary crowns and partials;

24. Dental services 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 if coverage under the Workers' Compensation Act or similar law would have been available to the Member but the Member waives entitlement to workers' compensation benefits for which he/she is eligible; failed to timely file a claim for workers' compensation benefits; or, the Member sought treatment for the injury or illness from a Provider which is not authorized by the Member's Employer or Workers' Compensation Carrier. If the Plan pays Benefits for an injury or illness and the 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 Plan shall have the right of recovery as outlined in Article IX of this Plan of Benefits;
25. Complications arising from a Member's receipt or use of either dental services or supplies or other treatment that are not Benefits, including complications arising from a Member's use of Discount Services;
26. Complications that occur because a Member did not follow the course of treatment prescribed by a Provider;
27. Any illness or injury received while committing or attempting to commit a crime, felony or misdemeanor or while engaging or attempting to engage in an illegal act or occupation;
28. Any dental service, supply or charge for an Incapacitated Dependent that is not enrolled by the maximum Dependent Child age listed on the Schedule of Benefits;
29. Any dental service, supplies, charges or losses resulting from a Member being Legally Intoxicated or under the influence of any drug or other substance, or taking some action the purpose of which is to create a euphoric state or alter consciousness. The Member, or Member's representative, must provide any available test results showing blood alcohol and/or drug/substance levels upon request by the Corporation. If the Member refuses to provide these test results, no benefits will be provided;
30. Charges for a Member's appointment with a Provider that the Member did not attend;
31. Dental services or supplies received as the result of any intentionally self-inflicted injury that does not result from a medical condition or domestic violence;
32. Dental services or supplies or other items not specifically listed as a Benefit in Article III of this Plan of Benefits or on the Schedule of Benefits;
33. Orthodontics  
If this Benefit is listed on the Schedule of Benefits as a Covered Expense, the following will apply:
  - a. Benefits for these services will be limited to Members through the age set forth on the Schedule of Benefits, if any;
  - b. Benefits payable per Member are limited to the maximum amount specified on the Schedule of Benefits and to services rendered within a period not to exceed thirty-six (36) consecutive months;
  - c. The initial payment will be equal to no more than twenty-five percent (25%) of the total liability of the Employer, with the following sequential payments payable no more frequently than once a month, and if for any reason the orthodontic services are terminated before completion of the approved Treatment Plan, the responsibility of the Employer will cease with payment through the month of termination; and,
  - d. The replacement of any appliances made necessary by reason of loss or theft is not covered by this Plan of Benefits.
34. Treatment of accidental injury to sound natural teeth within the first twelve (12) consecutive months following the date of the accident, if coverage is provided under the health benefit plan;
35. Payment for dental services shall be limited as follows:
  - a. In all cases involving covered services or supplies in which the Provider and Member selected a more expensive or personalized course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned, payment under this agreement will be based on the charge allowed for the lesser procedure as determined by the Corporation;
  - b. In the event a Member transfers from the care of one Provider to that of another Provider during the course of treatment, or if more than one Provider performs services for one dental procedure, the Employer's Group Health Plan shall be liable not more than the amount it would have been liable for had but one Provider performed the service; or,
  - c. Any additional treatment that is necessitated by lack of Member cooperation with the Provider or non-compliance with prescribed dental care that results in additional liability will be the responsibility of the Member.

## **COORDINATION OF BENEFITS (COB)**

If you have dental coverage under another employer's group dental plan in addition to this one — through your spouse for example — the total benefits you are eligible to receive could be greater than your actual expenses. To help eliminate duplicate payments, your coverage under Prime Choice or Standard Choice is coordinated with payments from other group dental plans through which you have coverage. When the Health Choice Dental Plan is the secondary plan, it will pay up to the amount of Total Covered Charges as determined by BCBS, but the BCBS payment will not exceed the difference between the Total Covered Charges and the primary plan's payment. At no time will the Dental Plan, operating as a secondary plan, pay more than it would have if it had been the primary plan.

The SRR Dental Plan will always be secondary payor to automobile no-fault, personal injury protection, or medical payment coverage plans and the Plan will coordinate benefits for claims which are payable under those automobile policies.

Please note that "other insurance" information must be updated on an annual basis with BCBS.

**If you and your spouse (through another employer) both cover your children, the plan of the parent whose calendar birthday is first in the year will pay first.**

### **Which Plan Pays First**

If you are an employee of SRR, this plan will pay first.

If your child is covered by more than one plan, the plan which covers the parent whose birthday falls first in the year (month and day) pays for the dependent child before the plan covering the other parent. However, if you are separated or divorced, the plan of the parent who has custody of the child (provided that the parent hasn't remarried) will pay before the plan of the parent who doesn't have custody. If you're divorced, but have remarried and have custody of your child, your plan will pay before the child's stepparent's plan, and the stepparent's plan will pay before the plan of the children's non-custodial parent. If a court gives financial responsibility for the child's dental care expenses to one parent, then that parent's dental plan will pay before any other plan. When none of these situations apply, the plan under which you're covered the longest will pay first.

Other plans include any dental coverage available from:

- Group, fraternal, blanket or franchise insurance,
- Prepayment coverage,
- Coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefits organization plans, and
- Government programs, except Medicare.

Each employee is covered only as an employee or as a dependent. A child is regarded as a dependent of only one employee, not both. No coordination of benefits is applicable when only one dental plan is involved.

# **CLAIMS PROCESSING**

**All in-network (and most out-of-network) dental providers will electronically send your claims to BCBS.**

If for some reason, your out-of-network dental provider did not electronically send your claim to BCBS, a Dental Services Claim Form may be obtained from the following sources: SRS Benefits Home page (OSR 5-342), Service Center (803-725-7772), or BCBS of SC Customer Service (1-800-325-6596).

**If you believe your claim wasn't paid correctly, call BCBS Customer Service at 1-800-325-6596.**

Complete your portion of the claim form and take it to your dentist. Your dentist may offer to file claims for you when you provide the necessary insurance information.

Your dentist may give you an itemized bill. BCBS can accept an itemized bill without a completed claim form as long as the following information appears clearly on the bill:

- Employee's name and Social Security number,
- Patient's name and date of birth,
- Date of service,
- Diagnosis or reason for treatment,
- Type of treatment or name of each procedure performed,
- Charge for each service, and
- In the case of an accidental injury, description of the injury and the date of occurrence.

Always get a pre-treatment estimate whenever you are planning to have dental work that is expected to cost more than \$300.

**File claims promptly** so you don't lose track of expenses. Remember, if you do not file a claim within the specified time limit after you incurred a dental expense (that is, **within 15 months from the date of service**), it will not be covered and paid/reimbursed. You should "cluster" the bills for each individual family member onto a separate claim form, and then put the bills in order by type of service and date. If you are coordinating benefits with another plan that is primary (such as your spouse's employer's insurance plan that pays first), attach a copy of the other plan's Explanation of Benefits statement to the claim form. Keep a copy for your records — the claim form and all attachments — of the documents you send.

If your claim is denied or reduced, you will be notified of the reason for the denial. The Claims Administrator will send you notification called, an "Explanation of Benefits" (EOB) regarding the determination of your claim submission. The Claim Administrator's determinations will be in writing or in electronic form, within the following time periods from the claim receipt.

**Urgent Care Claims** – Initial benefit determination will be provided as soon as possible (taking into account the medical circumstances), but no later than seventy-two (72) hours for pre-service urgent care claims. Urgent care claims include claims for health care that if processed under normal pre-service claim review timeframes could seriously jeopardize the claimant's life or health or jeopardize the claimant's ability to regain maximum function, or in the opinion of the Physician, (with knowledge of the claimant's current medical condition) subject the claimant to severe pain which cannot be managed without the care that is the subject of the claim. A Provider may be considered your authorized representative without your specific designation as such when the claim approval request is for urgent care claims.

**Pre-Service Claims within 15 days** – Pre-service claims include any claim for a benefit that, with respect to the terms of the Plan, conditions receipt of the benefit in whole, or in part, on approval of the benefit in advance of obtaining care. An approval means only that a service is Medically Necessary for treatment of a claimant's condition, but is not a guarantee or verification of benefits. Payment is subject to claimant's eligibility and all other Plan limits and exclusions. Actual benefit determination will be made when the Claims Administrator processes the post-service claim.

**Post-Service Claims within 30 days** – Most claims are considered post-service claims since they are usually filed after your health care Provider has already rendered services.

**Pre-service and Post-service Claims** – The Claims Administrator may use a 15 calendar day extension, if it is necessary for reasons beyond the control of the Plan to complete a benefits determination. If an extension is required, the Claims Administrator will notify you within the initial notification periods noted above.

If you are required to submit additional information for the Claims Administrator to make a determination, the initial notification deadlines noted above will be suspended from the time you are contacted for such additional information until you return the requested information. For Post-Service Claims and Pre-Service Claims, you must respond with the requested information within 60 days or the Claims Administrator may deny your claim. For an Urgent Care Claim, you should respond as soon as possible, no later than 48 hours, or the Claims Administrator may deny your claim.

## **Appeals Process**

If you need further explanation regarding the decision to deny or reduce the amount of your claim, or you have additional information that may change that decision, you should first contact BCBS for further explanation of the denial.

If you wish to file an appeal with the Claims Administrator you must send a letter to the Claims Administrator stating that an appeal has been requested. All pertinent information regarding the claim in question must also be included in your letter. The Claims Administrator will respond to you within the following time frames listed below, from the date when your appeal request is received. All of your appeal levels must be made within 180 days of the initial claim denial from the Claim Administrator (that they provided to you as an EOB in writing, or electronic form).

**30 Days for Post-Service Claims** – You can submit a second appeal to the Claims Administrator within 90 days after receiving the decision on your first appeal. The Claims Administrator will complete the second level appeal process within 30 calendar days after receiving your second appeal request.

**15 days for Pre-Service Claims First Level Appeal** – If you file a second appeal of a Pre-Service Claim, the Claims Administrator will complete the second level appeal process within 15 calendar days after receiving your second appeal request.

**Urgent Care Claims** – The Claims Administrator will respond as soon as possible taking into account medical circumstances that require action, but no later than 72 hours for Urgent Care Claims.

**The final appeal request available to you is directly to the Plan Administrator. It must be submitted within 180 days from the initial claim determination made by the Claims Administrator (that they provided to you as an EOB in writing, or electronic form) to file an appeal.** Your appeal to the Plan Administrator must be in writing and include your name, the claimant's name, your address, identification number, and any other information, documentation, or materials that supports the appeal. In addition, all documents, records, questions or comments necessary for a complete review, including reference to the specific Plan provisions that you feel were misinterpreted, or inaccurately applied should be submitted. The Plan Administrator will decide the appeal within a reasonable period of time, but no later than 60 days after receipt of the appeal. You will be notified if there are special circumstances that cause the review to take longer.

Your appeal to the Plan should be sent to:  
**Savannah River Remediation  
Dental Plan Administrator  
Attn: SRR Human Resources,  
Building 766-H  
Aiken, SC 29808**

In deciding an appeal regarding an adverse benefit determination that is based in whole, or in part, on a medical or dental judgment, (including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate), the Plan will obtain an opinion from a health care professional who has the appropriate training and experience in the appropriate field. (The Plan Administrator may use the opinion obtained by the Claim Administrator from an independent peer review organization as part of any voluntary second level appeal you filed with the Claim's Administrator.) The Plan Administrator has full discretion and authority to interpret Plan provisions, resolve any ambiguities and evaluate claims. The decision made by Plan Administrator is final and binding.

**You have 180 days from the initial claim determination** (Explanation of Benefits) made by the Claims Administrator to file a voluntary appeal to the Claims Administrator and/or to the Plan through the Plan Administrator. If you fail to appeal an adverse benefit determination within the time frames set forth above, you will have waived your right to an appeal.

The exhaustion of the claim and appeal procedure is mandatory for resolving any claim arising under this Plan. Applicable law requires you to pursue all claim and appeal rights on a timely basis before seeking any other legal recourse regarding claims for benefits.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 as amended (ERISA). The official documents that govern the Plan dictate the actual operation of the Plan and the payment of benefits.

# **COBRA CONTINUATION COVERAGE**

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), if you or an eligible dependent loses coverage under the Pre-65 Retiree Health Plan you may be entitled to continue coverage for a limited period of time. This is called COBRA continuation coverage.

When you become eligible for COBRA, you may also become eligible for other options that may cost less than COBRA continuation coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

## **What is COBRA continuation coverage?**

Federal law requires that most group health plans (including this Plan) give Retirees/employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired Employee) covered under the group health plan, the covered Retiree's spouse, and the dependent children of the covered Retiree.

COBRA continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights.

## **How can you elect COBRA continuation coverage?**

COBRA continuation coverage is available in the event you and/or your dependent's coverage terminates due to certain qualifying events described below. The Company will provide you and/or your dependents with COBRA information for these qualifying events:

- Termination of your employment for any reason, including retirement, voluntary termination, etc., other than for gross misconduct,
- Your death.

It is your or your dependent's responsibility to notify the SRNS Benefits Service Center within 60 days of the following qualifying events:

- Your dependent child no longer meets the eligibility requirements for coverage,
- Your divorce or legal separation,
- You or your dependent become entitled to Medicare benefits.

If you desire to exercise your right to continuation of coverage under COBRA, you must do so within 60 days following the date of the event that terminated your coverage. To remove a Dependent from your coverage you should complete an OSR 5-200 Health Care Enrollment Change form and submit it to the Service Center no later than 60 days from the date of the qualifying event or loss of coverage. You may be required to provide official documentation supporting your request such as a copy of your divorce decree.

The Plan's COBRA Administrator will send you an election form in the mail to your address of record. To elect continuation coverage, complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the Retiree's spouse may elect continuation coverage even if the retiree does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children.

## **Things to consider when electing COBRA**

### **Impacts to eligibility for SRR retiree health plans and COBRA**

You will be provided an opportunity to elect COBRA Continuation coverage for the Medical and/or Dental plans that you were enrolled in when your employment with SRR ended. If you or your dependents elect COBRA medical or dental the electing individual – you and/or your dependents – will have waived the right to enroll in the SRR Retiree Plans (Pre-65 Retiree Health Plan and Retiree Reimbursement Account). Also, if you, as the employee, elect COBRA, you will be waiving you and your dependents right to enroll in SRR Retiree Health plan. If you or your dependents wish to have SRR retiree medical coverage, now or in the future, do not elect either COBRA medical or dental coverage. However, you or your dependent may elect COBRA vision and still participate in the SRR retiree medical plans. Conversely, if you elect to enroll in the SRR Pre-65 Retiree Health Plan, you cannot elect COBRA continuation coverage. You will not be offered COBRA Continuation coverage when either you or your dependents are no longer eligible for coverage under the Pre-65 Retiree Health Plan unless: 1) you lose eligibility due to a divorce or legal separation, 2) As a dependent you no longer meet the eligibility requirements, or 3) The sponsoring retiree dies.

### **Impacts to eligibility for other group or individual medical plans**

In considering whether to elect COBRA continuation coverage, you should also take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 62-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law.

### **How long will COBRA continuation coverage last?**

In the case of a loss of coverage due to termination of employment, coverage generally may be continued only for up to a total of 18 months.

In the case of loss of coverage due to a Retiree's death, divorce, legal separation, the Retiree's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months.

When the qualifying event is the termination of employment, and the retiree became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the retiree can continue up to 36 months after the date of Medicare entitlement.

### **Continuation coverage will be terminated before the end of the maximum period if:**

- any required premium is not paid on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of participant or beneficiary not receiving continuation coverage (such as fraud).

### **How can you extend the length of COBRA continuation coverage?**

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the COBRA Services Administrator of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

### **Second Qualifying Event under COBRA**

An 18-month extension of coverage is available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered retiree, divorce or separation from the covered retiree, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan.

These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the COBRA Services Administrator within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

## **Disability under COBRA**

An 11-month extension of coverage may be available if any of the qualified beneficiaries are determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

You must notify the COBRA Services Administrator of your disability status within 60 days of the SSA determination and prior to the end of the 18 month period of continuation coverage. You will be required to submit a copy of the letter from the SSA notifying you of your disability status. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if they qualify. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the the COBRA Services Administrator of the change within 30 days after SSA's determination.

## **How much does COBRA continuation coverage cost?**

You pay 102% of the full cost of the insurance Plan coverage for COBRA continuation coverage. The premium includes actuarially calculated Plan costs, in addition to the 2% cost for administering COBRA.

## **When and how must payment for COBRA continuation coverage be made?**

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage no later than 45 days after the date of your election. (This is the date the Election Notice is post-marked.) If you do not make your first payment for continuation coverage in full within 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Services Administrator with any questions you may have.

**Periodic payments for continuation coverage:** After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is provided to you during enrollment. Under the Plan, each of these periodic payments for continuation coverage is due on the first day of the month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break.

**Grace periods for periodic payments:** Although periodic payments are due on the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

**If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.** Your first payment and all periodic payments for continuation coverage should be sent to the COBRA Services Administrator:

CONEXIS – a division of Wage Works  
PO Box 660212  
Dallas, TX 75266-0212  
Phone: 888-678-4881(TTY: 866-599-3140)

## **Are there other coverage options besides COBRA Continuation Coverage?**

Yes, Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many options at [www.healthcare.gov](http://www.healthcare.gov).

**For more information**

You should keep the COBRA Services Administrator informed of any changes in your address and the addresses of family members. If you have any questions concerning the information or your rights to coverage, you should contact:

**CONEXIS – a division of Wage Works**  
**PO Box 660212**  
**Dallas, TX 75266-0212**  
**Phone: 888-678-4881(TTY: 866-599-3140)**

# **HIPAA CERTIFICATION**

The options under this Plan do not deny coverage to participants because of pre-existing conditions. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires employers to provide certification showing evidence of your health coverage. You are entitled to receive a certificate (automatically provided to you after termination of coverage) that will show evidence of your prior health coverage under the Plan, including the beginning and ending dates of your dental coverage. You should provide this certificate to your new employer. If you buy health insurance other than through an employer group plan, the certificate of prior coverage may help you obtain coverage without a pre-existing condition clause.

## **Privacy of Protected Health Information Certification or Compliance**

Neither the Plan nor any third party business associate servicing the Plan will disclose Plan participants' Protected Health Information (PHI) to the Company unless the Company certifies that the Plan Document has been amended to comply with the privacy rules under HIPAA, and as set forth below and agrees to abide by the Privacy Rules.

- SRR will neither use nor further disclose PHI received from the Plan, except as permitted or required by the Plan documents, as amended, or required by law.
- SRR will ensure that any agent, including any subcontractor, to whom it provides PHI obtained from the Plan, agrees to the restrictions and conditions of the Plan documents, including this section.
- SRR will not use or disclose a participants' PHI obtained from the Plan for employment-related actions or decisions or in connection with any other non-group health benefit or employee benefit plan of SRR.
- SRR will report to the Plan any use or disclosure of PHI obtained from the Plan that is inconsistent with the uses and disclosures allowed under this section upon learning of such inconsistent use or disclosure.
- SRR will make PHI obtained from the Plan available to the Plan participant.
- SRR will track disclosures it may make of PHI obtained from the Plan so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with applicable law or regulation.
- SRR will make its internal practices, Summary Plan Descriptions, and records, relating to its use and disclosure of PHI obtained from the Plan to the Plan and to the Secretary of Health and Human Services for audit purposes.

SRR will, if feasible, return or destroy all PHI received from the Plan that SRR maintains in whatever form and including copies of any such information, when the plan participant's PHI is no longer needed for the plan administration functions for which the disclosure was made.

## **Purpose or Disclosure to SRR and SRNS**

- The Plan and any third party business associate servicing Plan will disclose PHI obtained from the Plan to SRR only to permit SRR to carry out the administration functions for the Plan not inconsistent with the requirements of the HIPAA. Any disclosure to and use by SRNS of PHI obtained from the Plan will be subject to and consistent with the provisions of this section.
- Neither the Plan nor any third party business associate servicing the Plan will disclose PHI obtained from the Plan to SRR unless the disclosures are explained in the Notice of Privacy Practices distributed to the plan participants.

## **Adequate Separation Between The Company and The Plan**

SRR's Human Resources, Business Services, Internal Audit and General Counsel employees may be given access to Plan participants' PHI received from the Plan, health plan Claims Administrator or business associate servicing the Pre-65 Retiree Health Plan. Additionally, as previously stated, SRNS operates the Benefits Solution Service Center as a contracted service for the SRR Pre-65 Retiree Health Plans, and SRNS employees in the SRNS Benefits Accounting, Benefits Administration, Service Center, Payroll, Internal Audit, and General Counsel organizations may be given access to Plan participants' PHI received from the Pre-65 Retiree Health Plan health insurance issuer or business associate servicing the Plan.

- These employees will have access to Plan participants' PHI only to support or perform the Plan administration functions that the Companies provide for the Pre-65 Retiree Health Plan.

- These SRR employees will be subject to disciplinary action, for any use or disclosure of Plan participants' PHI in breach or violation of or noncompliance with the provisions of this section to the Pre-65 Retiree Health Plan documents. SRR will report such breach, violation or noncompliance to the Plan. SRR will cooperate with the Pre-65 Retiree Health Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action on each employee causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any participant, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance. SRNS applies these same standards to any of its employees who have access to SRR Plan participants PHI and has agreed to report any such breach, violation or noncompliance to SRR and the Plan.

# **GENERAL PROVISIONS**

## **Notice of Nondiscrimination**

The SRR Medical Plan does not discriminate or exclude participants on the basis of race, color, national origin, sex, age, or disability. Any complaints, questions or concerns should be directed to the SRR Medical Plan Administrator, Bldg. 766-H, rm. 1066F, Aiken, SC 29808 or by phone; (803)208-3978,

## **“Cadillac Plans” under Health Care Reform**

Effective in 2020, under the Patient Protection and Affordable Care Act, a 40% excise tax will be imposed on “rich” health plans that cost more than \$10,200 for individual plans and \$27,500 for family plans. Although the new law will not have a tax impact until 2020, current accounting practices require employers to state their intentions regarding this tax now.

## **Retiree Health Plan**

The Company believes the Plan is a Retiree Health plan and is exempt from the Patient Protection and Affordable Care Act (“Act”).

## **Right of Recovery**

If the amount of the payments made by the SRR Health Plan is more than the Plan should have paid under this Coordination of Benefits section, the Plan may recover the excess or overpayment from the Member on whose behalf it has made payments, from a Provider, from any group insurer, Plan, or any other person or organization contractually obligated to such Member with respect to such overpayments.

## **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 are being provided by a self-funded ERISA plan.

## **STATEMENT OF PURPOSE**

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

## **Definitions**

### **Another Party:**

Another Party shall mean any individual or entity, other than this 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, Employer’s Group Health Plan, association or entity that is liable or legally responsible for payment in connection with the injuries or illness.

### **Member:**

As it relates to the Subrogation and Reimbursement Provision, a Member shall mean any person, Dependent or representative, other than the Plan, who is bound by the terms of the Subrogation and Reimbursement Provision. A Member shall include but is not limited to any beneficiary, Dependent, spouse or person who has or will receive Benefits under the 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.

**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 Plan's lien. The amount owed from the Recovery as Reimbursement of the Plan's lien is an asset of the Plan.

**Reimbursement:**

Reimbursement shall mean repayment to the 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.

**Subrogation:**

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

**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 Plan, to transfer to the Plan all rights to recover damages in full for such Benefits.

**Duties of the Member**

The Member will execute and deliver all required instruments and papers provided by the Plan Administrator/SRR Health Plan, including an accident questionnaire, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other Benefits will be paid by the Plan for the injuries or illness. The Plan Administrator/SRR Group Health Plan may determine, in its sole discretion, that it is in the 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 Plan will remain entitled to Subrogation and Reimbursement. In addition, the Member will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the 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 Plan's lien to the Plan under the terms of this provision.

A Member who receives any such Recovery and does not immediately tender the Plan's portion of the Recovery to the Plan will be deemed to hold the Plan's portion of the Recovery in constructive trust for the Plan, because the Member is not the rightful owner of the Plan's portion of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed. The portion of the Recovery owed by the Member for the Plan's lien is an asset of the Plan.

As a condition of receiving Benefits, the Member must:

- Immediately notify the Plan Administrator/SRR Group Health Plan 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;
- Execute and deliver an Accident Questionnaire within one hundred eighty (180) days of the Accident Questionnaire being mailed to the Member;
- Deliver to the Plan Administrator/SRR Health Plan 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;
- Deliver to the Plan Administrator/SRR Health Plan 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;
- Authorize the Plan 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 Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the Member's rights to Recovery when this provision applies;

- Include the Benefits paid by the Plan as a part of the damages sought against Another Party. Immediately reimburse the Plan, out of any Recovery made from Another Party, the amount of medical or other Benefits paid for the injuries or illness by the Plan up to the amount of the Recovery and without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise;
- Immediately notify the Plan Administrator/SRR Health Plan in writing of any proposed settlement and obtain the Plan Administrator/SRR Health Plan's written consent before signing any release or agreeing to any settlement; and,
- Cooperate fully with the Plan Administrator/SRR Health Plan 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 Plan Administrator/Employer's Group Health Plan.

**First Priority Right of Subrogation and/or Reimbursement**

Any amounts recovered will be subject to Subrogation or Reimbursement. The 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 Plan's payments. In addition, the 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 Plan's first priority equitable lien supersedes any right that the Member may have to be "made whole." In other words, the 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 his or her 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 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 Plan, the Member agrees that acceptance of Benefits is constructive notice of this provision.

**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 Plan has paid or will pay Benefits, has an absolute obligation to immediately tender the portion of the Recovery subject to the Plan's equitable lien to the 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 Plan's portion of the Recovery immediately over to the Plan. A Member's attorney who receives any such Recovery and does not immediately tender the Plan's portion of the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because neither the Member nor the attorney is the rightful owner of the portion of the Recovery subject to the Plan's lien. The portion of the Recovery owed for the Plan's lien is an asset of the 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 Plan in his or her pursuit of Recovery. The 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 Plan Administrator.

**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 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 Plan Administrator/SRR Health Plan.

### **When a Member Does Not Comply**

When a Member does not comply with the provisions of this section, the Plan Administrator/SRR Health Plan 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 the Plan by the amount due as satisfaction for the Reimbursement to the Plan. The Plan Administrator/SRR Health Plan 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 Plan must bring an action against a Member to enforce the provisions of this section, then the Member agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

### **Prior Recoveries**

In certain circumstances, a Member may receive a Recovery that exceeds the amount of the 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 Plan. In these situations, the 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 Plan to consider eligible expenses.

To the extent a Member's Recovery exceeds the amount of the Plan's lien, the 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 Plan also precludes operation of the made-whole and common-fund doctrines in applying this provision.

The Plan Administrator/SRR Health Plan has sole discretion to determine whether expenses are related to the injuries or illness to the extent this provision applies. Acceptance of Benefits under the Plan 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 Plan Administrator/SRR Health Plan, in their sole discretion, to be appropriate, including denial of present or future Benefits under the Plan.

In the event benefits are provided to or on behalf of a beneficiary under the terms of this Plan, the beneficiary agrees, as a condition of receiving benefits under the Plan, to transfer to the Plan all rights to recover damages in full for such benefits when the injury or illness occurs through the act or omission of another person, firm, corporation, or organization. The Plan shall be subrogated, at its expense, to the rights of recovery of such Beneficiary against any such liable third party.

If, however, the beneficiary receives a settlement, judgment, or other payment relating to an injury or illness from another person, firm, corporation, organization or business entity for the injury or illness, the beneficiary agrees to reimburse the Plan in full, and in first priority, for benefits paid by the Plan relating to the injury or illness. The Plan's right of recovery is on a first dollar recovery basis and applies regardless of whether the recovery, or a portion thereof, is specifically designated as payment for, but not limited to, medical benefits, pain and suffering, lost wages, other specified damages, or whether the Beneficiary has been made whole or fully compensated for his/her injuries.

The Plan's right of full recovery may be from a third party, any liability or other insurance covering the third party, the insured's own uninsured and/or underinsured motorist insurance, any medical payments, no fault, personal injury protection, malpractice, or any other insurance coverage which are paid or payable.

The Plan will not pay attorney's fees, costs, or other expenses associated with a claim or lawsuit without the expressed written authorization the Plan Administrator.

The Beneficiary shall not do anything to hinder the Plan's right of subrogation and/or reimbursement. The Beneficiary shall cooperate with the Plan, execute all documents, and do all things necessary to protect and secure the Plan's right of subrogation and/or reimbursement, including assert a claim or lawsuit against the third party, or any insurance coverage to which the beneficiary may be entitled. Failure to cooperate with the Plan will entitle the Plan to withhold benefits due the beneficiary under the Plan. Failure to reimburse the Plan as required will entitle the Plan to deny future benefit payments for all beneficiaries under this policy until the subrogation/reimbursement amount has been paid in full.

## Overpayments

If, for any reason, an overpayment is erroneously made under the Plan, you will be responsible for refunding the amount to the Plan. The repayment shall be made by the method established by the Plan Administrator. The methods of repayment may include, but are not limited to, repayment in a lump sum, installment payments, or by deductions taken through payroll. The Plan reserves the right to offset overpayments against future benefit payments until reimbursement is received. The Plan has the right to recover overpayments from your estate and to take any appropriate collection activity available to collect overpaid amounts.

If a benefit payment is issued, either to you or to your Provider, that exceeds the benefit amount you were entitled to under the Plan, the Claims Administrator and/or the Plan has the right to collect the overpayment from you or your Provider. The process the Claims Administrator will follow in collecting overpayments includes:

- Sending written request to you or the provider or
- Reducing the amount of the overpayment from future benefit payments.

**Note:** If an overpayment occurs because you conceal, misrepresent or give misleading information (for example regarding your employment, earnings, medical condition or receipt of Social Security Disability Award) your benefit may be terminated and you must repay the amount of the overpayment.

## Network Treatment Disclaimer

Neither BCBS-SC nor the Company is responsible in any way for treatment received from the Providers who participate in their respective Networks. While BCBS-SC administers their Network and makes every attempt to evaluate the Physicians and other health care Providers against credentialing standards, no guarantees are made as to the competency of the Providers or the quality of the treatment and services. This also applies to non-network Providers. Any malpractice issues on the part of the patient or family must be solely directed at the specific Provider(s) of the treatment or service.

## Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 requires that you be specifically informed that you are covered by the Medical Plan for certain medical services following a mastectomy. The Medical options provide coverage for the following services subsequent to a mastectomy:

- Elective reconstructive surgery of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas. Such coverage is subject to normal plan rules (such as coinsurance provisions). Questions concerning breast reconstruction following a mastectomy should be directed to BCBS-SC.

## HIPPA Late Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within "60 days" after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Service Center at (803)725-7772.

## Wellness Program Disclosure

If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at (803)208-3978 and we will work with you to develop another way to qualify for the reward.

## **Newborn Act Disclosure**

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## **Genetic Information Non-Discrimination Act (GINA)**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and certain other entities from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to a request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

## **Children's Health Insurance Program Notice**

### **Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage to Children and Families**

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **[www.insurekidsnow.gov](http://www.insurekidsnow.gov)** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance. Based upon the State in which you reside, you may be eligible for assistance paying your employer health plan premiums. You should contact your State for further information on eligibility.**

# **ERISA INFORMATION**

The information contained in this section provides important legal and administrative information about how the Medical Plan is administered, your rights to benefits from this Plan and the process of attempting to resolve a problem you might have with any of this Plan. The information in this section explains:

Your rights under Employee Retirement Income Security Act of 1974, as amended (ERISA);

How to contact the Plan Administrator; and

Additional information on rights that you may have as a plan participant.

This Summary Plan Description does not constitute an implied or expressed contract or a guarantee of future benefits. You should read this material carefully and keep it for future reference.

## **Plan Sponsor**

All ERISA-covered benefit plans referred to in this Summary Plan Description (SPD) are sponsored by Savannah River Remediation LLC (referred to in this document as “SRR”, the “Company” or the Employer).

## **Plan Administrator**

The Plan Administrator is responsible for maintaining the records related to and administration of the Health Plan. The Plan Administrator also has the sole discretion to decide all issues of fact or law. The Plan Administrator reserves the right to request, at any time, documents to determine eligibility for benefits and to resolve appeals. The Plan Administrator(s) is designated by the SRR Benefits Committee. The Plan Administrator of this plan is the SRR Benefits Committee. This Committee has delegated day-to-day responsibility for administration of this Plan to an individual who has been designated as the “Plan Administrator” and is referred to in this document as the “Plan Administrator”. Correspondence to the Plan Administrator should be sent to the address noted for the Plan Administrator in the Plan Information section.

## **Plan Numbers**

A Plan Number has been assigned to the Plan for identification purposes. The Plan Number is listed in the Plan Directory located at the end of this Summary Plan Description, along with the formal name of the Plan. You should use the formal name of the Plan and the Plan Number in all correspondence relating to the Plan.

## **Plan Documents**

This Summary Plan Description summarizes the provisions of the Plan. The policies and procedures of BCBS-SC, along with this Summary Plan Description shall constitute the Plan document. If any question should arise which is not covered by the Summary Plan Description, the text of the policies and procedures of BCBS-SC will control how the question will be resolved. Copies of Plan documents, together with Plan annual reports and descriptions are available for review by any Plan participant. If you would like to review a copy of these documents contact your Plan Administrator.

## **Plan Financing and Administration**

The Pre-65 Retiree Health Plan is self-insured and funded through Company contributions and participant premium contributions and is administered under a contract with Blue Cross and Blue Shield of South Carolina.

## **Future of the Plans**

While the Company expects to continue this Plan for an indefinite period of time, the Company, by action of its Board of Managers and/or the Company Benefits Committee, reserves the right at any time and from time to time to modify, amend or terminate in whole or in part, any or all of the provisions of the Plan.

If the Health Plan is changed or terminated, any claim for benefits incurred by you, your eligible dependents or beneficiaries prior to the date of change or termination will be considered liabilities of the Plan. If this Plan is terminated, you will have no further rights to benefits (other than payment of covered expenses incurred during the time you were covered). You are not vested in the Plan’s benefits.

## **ERISA Rights**

Although ERISA does not require that an employer provide benefits, it does set standards on how a plan is run, and requires that you be kept informed of your rights and benefits. As a participant or beneficiary in the Plan, you are entitled to certain rights and protection under ERISA. Federal regulations require that all Summary Plan Descriptions include the following statement:

### **ERISA provides that you may:**

Examine, without charge, at the Plan Administrator's office and at other specified locations such as the benefits Service Center, all Plan documents, including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, Employee Benefits Security Administration (formerly Pension and Welfare Benefits Administration), such as detailed annual reports and plan descriptions. You may obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may charge a reasonable amount for the copies.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefits Plans. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. The fiduciaries are given specific authority under the plan. The determination of matters under their authority will be final and binding.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your application for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your application.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request Plan documents from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have an application for benefits which you believe was improperly denied or ignored, in whole or in part, you may file suit in a state or federal court.

If it should happen that the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration), or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and/or fees. If you lose, the court may order you to pay these costs and/or fees (for example, if it finds your claim frivolous or without reasonable cause).

The addresses for the insurance companies, claims administrators and/or trustees can be found in the Plan Information section at the end of this booklet. The Plan Administrator's address is also shown in the Plan Information section. For legal action, the name and address for the agent for service of process on the Plan Administrator is:

**CT Corporation  
2 Office Park Court, Suite 103  
Columbia, SC 29223  
Phone: 800-528-8790  
803-699-6130**

You may also contact 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, or the nearest office of the Employee Benefits Security Administration:

**U.S. Department of Labor  
Employee Benefits Security Administration  
61 Forsyth Street, SW  
Atlanta, GA 30323**

# **PLAN INFORMATION**

**Plan Year:** January 1 - December 31

**Type of Plan:** A self-insured welfare plan that provides Medical & Dental benefits

**Plan Name:** Savannah River Remediation LLC Pre-65 Retiree Health Plan

**Plan Number:** 509

**Plan Sponsor:** Savannah River Remediation LLC

**Plan Sponsor Employer Identification Number:** 35-6987237

**Plan Administrator:** SRR Benefits Committee Plan Administrator  
Savannah River Remediation LLC  
SRR Human Resources  
Savannah River Site, Bldg. 766-H, rm. 1066F  
Aiken, South Carolina 29808  
Phone (803) 208-3978

**Plan Administrator Employer Identification Number:** 57-0982643

**Claims Administrator:** Blue Cross and Blue Shield of South Carolina  
I-20 at Alpine Road  
Columbia, South Carolina 29219

**Agent for Legal Process:** **CT Corporation**  
**2 Office Park Court, Suite 103**  
**Columbia, SC 29223**  
**Phone: 800-528-8790**  
**803-699-6130**

Eligibility for benefits should not be viewed as a guarantee of continuation of this Plan. While the Company intends to continue providing a comprehensive Pre-65 retiree health plan, the Company reserves the right to modify or terminate this Plan or any parts of this Plan at any time.

**This Summary Plan Description does not create an express or implied contract between the company and retirees.**



Medical Plan  
Summary Plan Description  
Effective 1/01/2012