



The WSRC Team

Medical Care

Issued January 2007



INTRODUCTION

This Document does not create an expressed or implied contract of employment.

The medical care benefits described in this Summary Plan Description are sponsored by Washington Savannah River Company and Bechtel Savannah River, Incorporated (WSRC/BSRI), and administered by Washington Savannah River Company (WSRC). Persons eligible to participate in the WSRC/BSRI Health Choice Medical Plan include those as described herein who are connected by employment with the WSRC Team. “The WSRC Team” includes Washington Savannah River Company (WSRC), Bechtel Savannah River, Incorporated (BSRI), BWXT Savannah River Company, BNG America Savannah River Corporation and CH2 Savannah River Company.

The WSRC/BSRI Health Choice Medical Plan is a self-insured plan which uses funds from the U.S. government and contributions from Plan participants to pay the cost of claims and administrative expenses. Blue Cross Blue Shield of SC, Blue Cross Blue Shield of GA, and Value Options have been hired to process claims under the Plan and not as an insurer(s).

Under the WSRC/BSRI Health Choice Medical Plan, you have several medical options:

- Prime Choice,
- Standard Choice,
- Basic Choice,
- BlueChoice Health Maintenance Organization (HMO)*,
- No medical coverage.

All of the options are designed to protect you and your family from the high cost of medical treatment. Each option offers a different level of protection. Prime and Standard Choice can lower out-of-pocket expenses when you choose treatment through a network of doctors, hospitals and certain other providers, while offering you the option to use non-Network providers. Basic Choice requires you to pay a relatively high deductible before the plan will pay any benefits. Blue Choice HMO provides the highest level of coverage, but you must use HMO providers to have any non-emergency benefit coverage. You also have the option of electing no medical coverage.

This book provides details regarding your Health Choice Prime, Standard and Basic Choice medical coverage options. **Information on BlueChoice HMO is provided in a separate Summary Plan Description prepared by Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.** Read this book carefully and refer to it whenever you have any questions about your Prime, Standard or Basic Choice medical care benefits. If you find you need additional assistance with the mental health and substance abuse benefits with the Plan, call Value Options Customer Service at 1-800-333-6557. If you find you need additional assistance with the Prime, Standard or Basic Choice options, call the Blue Cross Blue Shield of South Carolina Customer Service Line at 1-800-325-6596 or visit their website at www.bcbssc.com.

* *Blue Choice HMO is available only to full-service active employees.*

CONTENTS

- 1 Participating In Medical**
 - 1 Eligibility**
 - 1 Eligible Dependents*
 - 3 Special Rules for “Dual Couples”*
 - 3 Enrolling for Coverage**
 - 4 Identification Cards*
 - 5 When Coverage Ends**
 - 5 Your Cost for Coverage**

- 6 How the Medical Options Work**
 - 6 Prime Choice**
 - 6 Standard Choice**
 - 7 Basic Choice**
 - 8 How the Options Are Similar**
 - 9 Deductibles*
 - 10 Out-Of-Pocket Maximum*
 - 11 Network Physician Office Visit Co-pay*
 - 11 Allowable Charge*
 - 11 Reasonable & Customary (R&C)*
 - 12 Annual Maximum Benefits*
 - 12 Your Share of Expenses*
 - 12 Summary of Medical Options**

- 14 The Medical Provider Network**
 - 14 Locating Network Providers**
 - 15 Other Important Facts About the Network**
 - 15 When You Visit a Network Doctor’s Office*
 - 15 When You Must Be Hospitalized or Need to See a Specialist*
 - 15 When You Are Away from Home*
 - 16 If Your Child is Away at School*
 - 16 If You Have Questions about Your coverage*

- 17 Pre-Approvals**
 - 17 Prior Authorization and Pre-Admission**
 - 18 What if You Don’t Precertify Your Hospital Stay?*
 - 18 Maternity Hospital Stay Limit*
 - 18 Women’s Health and Cancer Rights Act*
 - 19 Second Surgical Opinions**
 - 19 Individual Case Management**
 - 19 Transplants - Blue Quality Centers of Excellence**

-
- 21 Covered Medical Expenses**
 - 21 Hospital Services and Supplies
 - 22 Outpatient Services and Supplies
 - 23 Doctors' Services
 - 23 Hospital Alternatives
 - 23 *Home Health Care*
 - 24 *Extended Care Facility*
 - 25 *Hospice Care*
 - 25 Private Duty Nursing
 - 26 Prescription Drug Discount Program
 - 28 Preventive Medical Care Benefits
 - 29 *Prime and Standard Pediatric Preventive Care Schedule*
 - 30 *Prime and Standard Adult Preventive Care Schedule*
 - 30 *Early Detection Service (Basic Choice Medical Option Only)*
 - 31 Mental Health and Substance Abuse Services

33 Charges Not Covered by the Options

37 Coordination of Benefits (COB)

- 37 Which Plan Pays First
- 38 Medicare Coordination

41 Claims Processing

- 43 Appealing a Claim Denial/Reduction

45 Coverage Continuation in Special Situations

- 46 COBRA Continuation Coverage
- 47 HIPAA Coverage
- 47 Conversion Privilege

48 General Provisions

- 48 Right of Recovery
- 49 Overpayments
- 49 Network Treatment Disclaimer

50 Glossary of Helpful Terms

55 ERISA Information- Plan Information

- 55 Plan Information

PARTICIPATING IN MEDICAL

Eligibility

If you are a full-service employee of the WSRC Team (including BSRI Option A Craft employees), you are eligible to enroll for coverage in the WSRC/BSRI Health Choice Medical Plan on your first day of employment. BSRI employees participating in collectively bargained benefits are not eligible for this coverage.

Retirees of the WSRC Team (including BSRI Option A Craft retirees) with a least 15 years of eligibility service and one year of credited service, who retire directly from a WSRC Team employer as a full service employee under the Normal, Early, Optional or Incapability provision of the WSRC/BSRI Pension Plan, and eligible survivors, are also eligible for participation in the WSRC/BSRI Health Choice Medical Plan (except for the Blue-Choice HMO option). If you transfer from a WSRC Team company to your parent company or an Affiliate of your parent company, as defined in the WSRC/BSRI Pension Plan, you are not eligible for the WSRC/BSRI Health Choice Medical Plan. Also, as a WSRC Team retiree, if you are reemployed as a full-time employee by an Affiliated entity your WSRC/BSRI Health Choice Medical Plan participation will end and will not be reinstated by a subsequent termination/retirement from the Affiliate. Rights to continuing medical coverage through the WSRC/BSRI Health Choice Medical Plan do not apply to employees who leave the Company with a vested deferred pension.

Retirees of DuPont Savannah River Plant and their dependents are not eligible to participate in the WSRC/BSRI medical options described in this Summary Plan Description. Dependents of DuPont Retirees include those dependents that normally would be eligible for WSRC Team medical coverage due to their status as an active WSRC Team employee or retiree.

WSRC Team employees with less than 15 years of eligibility service, who have been approved for Long-Term Disability benefits under the WSRC/BSRI Disability Plan, are eligible to continue their enrollment in WSRC/BSRI Health Choice Medical Plan (except for the Blue-Choice HMO option) for up to 24 months in lieu of coverage continuation under the Consolidated Omnibus Budget Reconciliation Action (COBRA). See “Coverage Continuation in Special Situations” on Page 45 of this book and COBRA Continuation coverage on page 31 of the Benefits Overview and General Information book.

Eligible Dependents

Your eligible dependents include your lawful spouse (in accordance with state law in your state of residence) and your “children,” including:*

- your own children,
- legally adopted children (from the time they are legally placed with you), or
- your stepchildren who primarily reside with you, and
- children supported solely by you for whom you have been appointed legal guardian.

You will be required to provide proof of legal guardianship or adoption to the WSRC Team People Support Service Center for authorization by the Plan.

If you and your spouse are employees or retirees of the WSRC Team, you cannot be covered both as an employee and also as a dependent.

Note that if you are divorced, your ex-spouse is no longer eligible to be covered as your dependent under the WSRC/BSRI Health Care Plans as of the date of your divorce decree (even if the court orders you to provide health insurance for your ex-spouse).



* In order to be eligible for coverage, your “children” must meet all of the following criteria:

- be unmarried;
- be under age 20 (or be under age 25 if a full-time student at an accredited institution or be disabled/handicapped as noted below);
- primarily reside with you in a regular parent/child relationship (or living at school while a full-time student); and
- you must be able to claim your child as a dependent on your current federal income tax return.

Your “children” also include children covered by a Qualified Medical Support Order (QMCSO) that requires the Company to provide medical coverage for the children. A QMCSO is an order or judgment from a court or administrative body, which directs the plan to cover a child of the employee/retiree enrolled under the health plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a QMCSO. When an order is received, each affected participant and each child (or the child’s representative) covered by the order will be given notice of the receipt of the order and a copy of the plan’s procedure for determining if the order is valid. Coverage under the plan pursuant to a medical child support order will not become effective until the Plan determines that the order is a valid QMCSO. If you have any questions or would like to receive a copy of the written procedure for determining whether a QMCSO is valid, please contact the WSRC People Support Service Center at 803-725-7772 or 800-368-7333.

Coverage for a dependent child may be extended up to age 25 for full-time students at accredited institutions if the child is unmarried and you are able to claim the child as a dependent on your current federal income tax return. **Starting at age 20, you are responsible for providing Blue Cross Blue Shield of South Carolina official documentation every year showing your dependent is a full time student at an accredited educational institution.** Blue Cross Blue Shield of South Carolina is responsible for evaluating student eligibility documentation.

Your unmarried disabled/handicapped dependent child may continue coverage if your child is all of the following:

- incapable of sustaining employment by reason of a disabling mental handicap or physical handicap;
- is solely supported by the employee and claimed as dependent on your current federal income tax return: and
- the disability must have begun before age 20 and your child must have remained continuously disabled beyond the age limit.

You must provide written proof of such dependency and incapability to Blue Cross Blue Shield-SC for evaluation. You will be requested to periodically provide proof of the disability to continue the child’s eligibility under the Health Choice medical options.

The WSRC/BSRI Health Choice Medical 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, including the right to seek reimbursement for claims paid on any ineligible dependent. See Page 5, “When Coverage Ends.”



Consider your Health Choice medical option carefully. Remember, your election must stay in effect for the full calendar year — unless you have a “Qualifying Change in Status” (marriage, new birth, spouse loses coverage, etc.) under Internal Revenue Service rules. Notify WSRC People Support Service Center) of any Qualifying Change in Status in writing within 60 days. To request a change in your level of coverage, you must submit a “Health Care Enrollment/Change Form” (OSR 5-200) to People Support Service Center no later than 60 days from a Qualifying Change in Status Event. The “Benefits Overview and General Information” book (Pages 7-9) has additional information on requests to change elections. A Qualifying Change in Status that is approved by the Plan will be effective as of the “event” date as long as People Support Service Center is notified within 60 days.

Do not call Blue Cross Blue Shield or Value Options with information on a Qualifying Change in Status. Contact People Support Service Center at (803) 725-7772 instead.

Special Rules for “Dual Couples

“Dual couples” are WSRC Team employees (or WSRC Team retirees) who have a spouse who also works for (or is retired from) the WSRC Team. Dual couples cannot be covered both as a dependent and as an employee/retiree under the medical options. In addition, no dependent child may be covered by more than one WSRC Team employee or retiree.

You and your spouse may not cover each other or both cover the same child. 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 employee only coverage. (If you make this latter choice in this example, you and your spouse may elect to be covered by different medical options.)

With a mid-year “Qualifying Change in Status,” you will only be able to change your level of coverage (the number of dependents you elect to cover). You will not be able to change the option (Prime, Standard, Basic, HMO, no coverage) you elected.

Enrolling for Coverage

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

- Prime Choice, Standard Choice, Basic Choice, Blue Choice HMO or no medical coverage and
- Coverage for yourself only, you and one dependent, or you and two or more dependents.

During new hire orientation, you will be asked to enroll yourself and your eligible dependents in a health plan. You will have two weeks from your date of hire to make your elections and return your request to the People Support Service Center. Your coverage will be effective on your first day of employment as a full-service employee. If you fail to make an election during the first two weeks, you will be placed in Basic Choice coverage for yourself only, and coverage for your eligible dependents cannot begin until January 1 of the following year (that is, if you elect to cover them during the next annual enrollment period) or if you have a Qualifying Change in Status.

The premium contribution for the coverage you select will be based on your applicable pay period. Premium contributions are not pro-rated in accordance with your employment date or Qualifying Change in Status date. Your premium will coincide with the plan you are enrolled in and the level of coverage (employee only, employee +1, or employee +2 or more) that is in effect at the end of your pay period.



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 Qualifying Change in Status, whichever applies. You must name the dependents to be covered, provide their date of birth, and their Social Security numbers if they have been issued by the Social Security Administration.

To add a dependent to your coverage, you must submit a “Health Care Enrollment/Change Form” (OSR 5-200) to People Support Service Center no later than **60 days** from a Qualifying Change in Status Event. 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 addition of the new dependent.

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 it must be done within 60 days if you want to cover them during the balance of the calendar year. The coverage will be retroactive back to the date of birth when the newborn is added to your coverage within 60 days.

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that your written request for enrollment is received within 60 days after your other coverage ends. 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, provided that your written request for enrollment is received within sixty days after the marriage, birth, adoption, or placement for adoption.

If you are enrolled in Blue Choice HMO coverage and either you or your eligible dependent moves to an area not served by a participating HMO, you will be allowed to discontinue your enrollment in Blue Choice HMO and enroll yourself and your dependents in either Prime, Standard or Basic Choice medical coverage.

Identification Cards

Once you make your medical coverage election, you will receive a Blue Cross Blue Shield of South Carolina identification (ID) card. You will automatically receive two ID cards if you’ve elected to enroll dependents. The ID card provides information needed by the hospital, doctor or other health care provider to prepare and submit your claim for processing. If you should need additional cards, or a replacement card, call Blue Cross Blue Shield Customer Service at 1-800-325-6596 (select Option 1) or access www.bcbssc.com, then select My Insurance Manager.

Be sure to add a new baby to your coverage within 60 days after the baby’s birth, even if a Social Security number hasn’t been assigned. Call People Support Service Center at 725-7772 (local) or (800) 368-7333 for details.

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When Coverage Ends

Your coverage ends when you no longer elect to be covered by one of the medical options. Your coverage also ends when you no longer meet eligibility definitions or 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), when they no longer meet the eligibility requirements, a “Qualifying Change in Status” occurs (as a result, you elect to eliminate a dependent from medical coverage), or your coverage ends. You will be required to provide proof of the Qualifying Change in Status to the WSRC People Support Service Center within 60 days of the event.

If you terminate employment for reasons other than retirement and/or receipt of WSRC Team Long Term Disability, coverage for you and your dependents ends on the last day of your applicable pay period. If your premiums for medical coverage cannot be deducted from your payroll, pension or WSRC Team Long Term Disability check and you fail to make timely payments by the due date, your coverage will be terminated as of the due date. Premium contributions are not pro-rated in accordance with your termination date. In other words, you’ll have to pay the full premium contribution for the pay period in which you terminate employment. In certain situations, you and your dependents may be eligible to continue coverage. See “Coverage Continuation in Special Situations,” starting on Page 45 in this book, and COBRA continuation coverage, starting on Page 31, in the Benefits Overview and General Information.

Your Cost for Coverage

You and the WSRC Team share in the cost of Health Choice Medical coverage. The amount of your premium contribution depends on the medical option you elect and whether you elect coverage for yourself only or for you and your dependents. As an active employee, your premium contributions are deducted from your pay before Social Security and federal and state income taxes are computed and withheld. If you are a retiree, survivor or receiving Long-Term Disability (LTD) payment from the WSRC/BSRI Disability Income Plan, your premium contribution is deducted from your after-tax monthly pension and or LTD payment. You will be billed separately on an after-tax basis if you do not have enough in your WSRC Team pay check, pension and or LTD payment to cover your premiums. 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.

It is your responsibility to remove your dependents from the Plan when they no longer meet the Plan eligibility requirements. If 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, you will not be able to receive a refund of any premium contribution overpayments, and the Plan will seek recovery for any claim payments paid past the claimant’s eligibility date. 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 People Support Service Center to remove your dependents from the Plan.

HOW THE MEDICAL OPTIONS WORK

When you enroll in Health Choice, you choose the level of coverage that's right for you — or you can elect no medical coverage.

Prime Choice

This option gives you the choice of receiving medical care from providers selected to be part of the Blue Cross Blue Shield “Preferred Blue” Medical Network or going to a provider who is not part of the Medical Network.

When you go to a Network doctor, you pay a **\$10 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. If you receive certain additional covered services (e.g., surgery performed in the doctor's office), your cost (coinsurance) is 10% of the discounted fee for the additional covered services plus your \$10 copay. (See the guidelines shown on Page 13)

For non-Network services, you must pay a deductible before Prime Choice begins to pay. The individual annual deductible is \$200 per person (\$400 for your entire family). The individual out-of-pocket maximum for covered services is \$1,000 per person (or \$2,000 for your entire family) in a calendar year. Your out-of-pocket maximum includes your deductible and coinsurance, but not your office service copay or charges incurred for non-covered expenses. (Refer to Pages 9-10 for more information on the deductible and out-of-pocket maximum.) Some services are not covered at all unless you use specific providers. For example, scheduled preventive care services are not covered **unless** a Network doctor is utilized.

If you go to either a Network or non-Network provider, most other covered expenses will be reimbursed up to 90% of the Blue Cross Blue Shield of South Carolina Allowable Charge (network discounted amount) for covered services. If you go to a non-Network provider you must pay your deductible first and non-Network providers may “balance bill” you up to the amount of the total charge.

For covered **prescription medications**, you must also pay the individual annual deductible of \$200 per person (\$400 for your entire family) before Prime Choice begins to reimburse your medications at 80%.

Standard Choice

This option is similar to Prime Choice in that it provides a higher level of coverage if you use a Blue Cross Blue Shield Network provider. And, as with Prime Choice, you have the choice to go to a non-Network provider. The difference is that the office service copay, deductible and out-of-pocket maximum are higher under Standard Choice.

When you go to a Network doctor, 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. If you receive certain additional covered services (e.g., surgery performed in the doctor's office), your cost (coinsurance) is 10% of the discounted fee for the additional covered services plus your \$20 copay. (See the guidelines on Page 13.)

Both Prime Choice and Standard Choice offer a choice of Network and non-Network care. Each time you need medical treatment, you have a choice of using a Blue Cross Blue Shield Network provider or using a provider outside the Network.



For non-Network services, you must pay a deductible before Standard Choice begins to pay. The individual annual deductible is \$400 per person (\$800 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. As with Prime Choice, your out-of-pocket maximum includes your deductible and coinsurance, but not your office service copay or charges incurred for non-covered expenses. (Refer to Pages 9-10 for more information on the deductible and out-of-pocket maximum.) Some services are not covered at all unless you use specific providers. For example, scheduled preventive care services are not covered **unless** a Network doctor is utilized.

If you go to either a Network or a non-Network provider, most other covered expenses will be reimbursed up to 90% of the Blue Cross Blue Shield of South Carolina Allowable Charge (network discounted amount) for covered services. If you go to a non-Network provider you must pay your deductible first and Non-Network providers may “balance bill” you up to the amount of the total charge.

Just as with Prime Choice, for covered **prescription medications**, you must also pay the annual deductible of \$400 per person (\$800 for your entire family) before Standard Choice begins to reimburse you at 80%.

Basic Choice

This option does not involve a requirement of utilizing Network providers in order to receive a higher level of benefits. Most charges under Basic Choice are subject to a much higher deductible and reimbursed at 80% of reasonable and customary charges. Some preventive services are also covered (see Page 30 - “Early Detection Services.”)

Under this option, you pay the lowest amount in premiums, but your deductible and coinsurance amounts are relatively high. **The individual deductible (for one person) of \$1,000 is applied before you are reimbursed for covered services. The deductible for your entire family is \$2,000.** After you have paid your deductible, this option then reimburses you for covered expenses at 80% of reasonable and customary charges (70% of R & C 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 \$4,500 for one person and \$9,000 for your entire family in a calendar year. Like Prime Choice and Standard Choice, you pay the full cost of non-covered expenses.

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How the Options Are Similar

In many ways, all three options are alike. They...

- **Cover the same health care expenses overall** (preventive care is one exception — these expenses are much more limited under Basic Choice). Read about the covered expenses beginning on Page 21.
- Each includes the identical **Mental Health and Substance Abuse treatment services**, as described on Pages 31-32.
- **Exclude the same expenses.** Exclusions are listed beginning on Page 33.
- 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, reasonable and customary amounts, allowed amounts and annual maximums. The following chart lists your deductibles, out-of-pocket amounts and annual maximums, which are further explained below.

Plan	Prime Choice	Standard Choice	Basic Choice
Annual Deductible	\$200/person \$400/family	\$400/person \$800/family	\$1,000/person \$2,000/family
Annual Out-of-Pocket Maximum for Covered Services	\$1,000/person \$2,000/family	\$2,000/person \$4,000/family	\$4,500/person \$9,000/family
Annual Maximum Benefits	\$1,000,000 per person	\$1,000,000 per person	\$1,000,000 per person

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Deductibles

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. Under Prime Choice and Standard Choice, the deductible applies to services provided and billed by a non-Network provider, as well as prescription drugs and non-emergency use of the Emergency Room (see chart on Page 13).

The **individual deductible** is the amount that must be paid by one person each calendar year. The **family deductible** is twice the individual deductible. It can be met two ways:

- When two family members each meet their individual deductible amount, or
- When one family member meets his or her individual deductible amount and all other family members combined meet or exceed the second individual deductible amount.

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 non-Network providers, if you are enrolled in Prime Choice or Standard Choice	Copays for Network doctors' office services
All covered expenses, if you are enrolled in Basic Choice	The 10% coinsurance amount you pay for services provided by Network doctors
Prescription drugs	Expenses that are not covered by your medical option
Non-emergency use of the Emergency Room	Penalties incurred for hospital stays that have not been pre-certified
	Expenses above what is considered the reasonable and customary (R&C) allowance and/or above the BCBS of SC Allowable Charge for each covered service
	Expenses for treatment of mental health and substance abuse, as described on Pages 31-32, that are administered by ValueOptions

*For additional information on services, which are subject to the deductible, refer to Page 13.

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Out-of-Pocket Maximum

The out-of-pocket maximum is the most you will pay in deductibles and coinsurance (excluding any office visit copays) for **covered expenses** during any one calendar year. Once the out-of-pocket maximum is reached, your option begins to pay 100% of eligible expenses within either the appropriate Blue Cross Blue Shield –SC Allowable charge or the reasonable and customary allowance up to the Annual Maximum Benefits. Essentially, 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. 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.

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. Check out the chart below for more specifics.

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

YES	NO
Your deductibles — \$200/\$400, \$400/\$800 or \$1,000/\$2,000 — depending on the option you are enrolled in	The \$10 or \$20 copay for Network doctors’ office services under Prime Choice or Standard Choice
Your coinsurance amounts — 10%, 20% or 30% — for most medically necessary services	Medical expenses that are not covered by your medical option
Your coinsurance share for covered early detection preventive care expenses under Basic Choice	Penalties incurred for hospital stays that have not been precertified
	Expenses above BCBS-SC Allowable charge or what is considered the reasonable and customary (R&C) allowance for each covered service
	All mental health and substance abuse services that are administered by ValueOptions(see Pages 31-32)

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Network Physician Office Visit Co-pay

The office service copay under the Prime Choice option and under the Standard Choice option does not go toward the deductible or out-of-pocket maximum.

The following provides you with guidelines on when to pay your copay (\$10 or \$20) or coinsurance (10%) amounts when you go to a Network provider under Prime Choice and Standard Choice options:

Pay your copay:

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

Pay your coinsurance:

- Laboratory work that your Network doctor sends to an outside laboratory or x-rays performed outside the doctor's office.
- Physician hospital services
- Surgery performed in the Network doctor's office
- Allergy or hormone injections when performed by a nurse and billed with no other service from that doctor's office on that date (other injections require a copay)
- Prenatal care that is billed under the surgery code for total obstetrical (OB) care

Allowable Charge

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. Under Prime and Standard Choice options, network and most non-network providers are paid the same amount for equivalent services. However, 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.

Reasonable & Customary (R&C)

Reimbursement for treatment and services received for some non-Network providers when you participate in Prime Choice or Standard Choice (for example, ambulance services and non-network emergency room services for life threatening or urgent care) see the chart on Page 13 – and for all treatment and services under Basic Choice is based on the reasonable and customary, or R&C, charge.

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R&C charges are determined by the Claims Administrator utilizing a nationwide database from the Health Insurance Association of America and by taking into account:

- The normal range of fees charged by providers in your geographic area for similar services, and
- Any unusual circumstances.

If your expenses are considered more than the R&C amounts determined by the Claims Administrator, you will be responsible for paying the additional amount. These charges will not count toward your deductible or out-of-pocket maximum.

Annual Maximum Benefits

Regardless of the option you choose, the maximum benefit payable by the plan is \$1,000,000 per person per year.

Your Share of Expenses

Whether you enroll in Prime Choice, Standard Choice or Basic Choice, there are certain expenses you are responsible for, including:

- The deductible, coinsurance amounts and copays,
- Any non-Network expenses above the BCBS-SC allowable charge or for services above the reasonable and customary level,
- Expenses not covered,
- Charges that exceed the maximum annual benefit amount,
- Charges that exceed the option's limitations on certain services,
- Any charges for procedures that are not considered to be medically necessary, and
- Charges for services of providers who are not licensed in the state in which their services are provided, when state licensure is required for performance of the services provided.

Summary of Medical Options

The chart on the next page indicates how the Health Choice Medical options reimburse you for covered services. For information on the amount of your deductibles and out-of-pocket expenses, refer to the chart on Page 8.

Expenses	PRIME CHOICE		STANDARD CHOICE		BASIC CHOICE
	Network Provider	Non-Network Provider	Network Provider	Non-Network Provider	
Annual Deductible • Individual • Family	\$200 \$400	\$200 \$400	\$400 \$800	\$200 \$400	\$1,000 \$2,000
Physician's Office Visit services (exams, lab tests, x-rays)	\$10 copay	90% BCBS-SC Allowable Charge after deductible	\$20 copay	90% BCBS-SC Allowable Charge after deductible	80% R&C after deductible
Preventive Care Office Visits (based on schedule)	\$10 copay (1) (See Page 28)	Not Covered	\$20 copay(1) (See Page 28)	Not Covered	80% R&C after deductible (2)
Allergy or hormone injections by nurse in physician's office	90% No deductible (\$10 copay if other services also provided)	90% BCBS-SC Allowable Charge after deductible	90% No deductible (\$20 copay if other services also provided)	90% BCBS-SC Allowable Charge after deductible	80% R&C after deductible
Chiropractic treatment Maximum benefit of \$750 per person/year	90% No deductible	80% R&C after deductible	90% No deductible	80% R&C after deductible	80% R&C after deductible
Ambulance Service	90% R&C No deductible	90% R&C No deductible	90% R&C No deductible	90% R&C No deductible	80% R&C after deductible
Diagnostic x-ray and lab tests, when not performed in a physician's office	90% No deductible	90% BCBS-SC Allowable Charge after deductible	90% No deductible	90% BCBS-SC Allowable Charge after deductible	80% R&C after deductible
Hospital, surgical and most other medical services	90% No deductible	90% BCBS-SC Allowable Charge after deductible	90% No deductible	90% BCBS-SC Allowable Charge after deductible	80% R&C after deductible
Home Health Care,* Hospice care,* Durable medical expenses* <i>*Pre-approval required</i>	90% No deductible	90% BCBS-SC Allowable Charge after deductible	90% No deductible	90% BCBS-SC Allowable Charge after deductible	80% R&C after deductible
Physical/occupational therapy*	90% No deductible	90% BCBS-SC Allowable Charge after deductible	90% No deductible	90% BCBS-SC Allowable Charge after deductible	80% R&C after deductible
Emergency room (Services used for life threatening, acute or urgent care)	90% No deductible	90% No deductible	90% No deductible	90% No deductible	80% R&C after deductible
Emergency room use for routine care	70% after the deductible	70% R&C after the deductible	70% after the deductible	70% R&C after the deductible	70% R&C after deductible
Prescription drugs	80% of discounted amount after deductible	80% of retail amount after deductible	80% of discounted amount after deductible	80% of retail amount after deductible	80% R&C after deductible
Annual Out-of-Pocket Maximum (3) • Individual • Family	\$1,000 \$2,000	\$1,000 \$2,000	\$2,000 \$4,000	\$2,000 \$4,000	\$4,500 \$9,000

(1) Limited to \$250 per person/year

(2) Limited early detection services

(3) Your deductibles and coinsurance amounts (10% or 20% for most services) count toward your out-of-pocket maximums. The Prime and Standard Plans' \$10 and \$20 copays, expenses not covered, amounts over R&C and/or the BCBS-SC Allowable Charge, and mental health and substance abuse services by Value Options do not count toward your out-of-pocket maximum.



The Medical Provider – Network

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 Blue Cross Blue Shield when your Blue Cross Blue Shield coverage is primary. In other words, Network doctors, 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, it is a good idea to ask whether the provider is still participating in "Blue Cross Blue Shield's PPO (Preferred Provider Organization) Network" when you make a medical care appointment. You can review providers on-line at the BCBS-SC website at <http://www.bcbssc.com> or at the Blue Cross Blue Shield Association website at <http://www.blue-card.com>. Both websites provide access to providers nationwide as well as worldwide. You can also call Blue Cross Blue Shield of South Carolina to at 1-800-325-6596 to inquire about the network status of providers. 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 at 1-804-673-1177.

For information on accessing mental health and/or substance abuse services available through the Value Options Network, you should contact Value Options by calling 1-800-333-6557 (available 24 hours/day).

Blue Cross Blue Shield's
Medical Network is available
to you nationwide and
in some foreign countries.
You get the maximum
benefit when you use it.

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Other Important Facts About the Network...

Only for Prime Choice and Standard Choice Participants

When You Visit a Network Doctor's Office

When you visit a Network doctor, make sure you show your Blue Cross Blue Shield ID card. Using information on your ID card, the Network provider will file a claim for services rendered to the Blue Cross Blue Shield organization that they contracted for PPO Network Services (providing the WSRC Plan is the Primary payer). For example, if the WSRC Medical plan was the primary payer, a Blue Cross Blue Shield PPO doctor in Los Alamos, NM would file a claim to Blue Cross Blue Shield of New Mexico.

Generally, when seeing a Network doctor, you pay just your \$10 or \$20 copay at the time you receive care (there are some exceptions; for example, minor surgery performed in the office). Most Network doctors will collect the remainder of their fees directly from Blue Cross Blue Shield and then bill you if there is any balance due for any services not covered under the medical option you have chosen.

If you visit a doctor 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 will have to pay a non-Network provider in full at the time of the visit and then file a claim for reimbursement with Blue Cross Blue Shield of South Carolina. If another medical insurance plan (for example, 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 book on Page 37.

When You Must be Hospitalized or Need to See a Specialist

If your doctor is in the Network and he or she refers you to another medical provider, ask your doctor if he or she can refer you to a specialist or hospital in the Network so you always receive maximum benefits. A referral from a Network doctor is no guarantee that the specialist or hospital you are referred to is in the Network. If you are not certain whether a provider is in the Network, call the Blue Cross Blue Shield Customer Service Line at 800-325-6596 (for mental nervous and substance abuse claims call Value Options at 1-800-333-6557) and ask, or call the provider directly. It is up to you to make sure your providers are participants in the Claim Administrator's 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 Blue Cross Blue Shield at the Customer Service number listed on your Blue Cross Blue Shield of SC identification 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., call BlueCard Worldwide Customer Service 1-800-810-Blue (2583) or collect at 1-804-673-1177 to find out if there are Network providers in the country you'll be traveling to. If you need non-emergency inpatient medical care, you must call the BlueCard WorldWide Service Center, who can help you to facilitate hospitalization at a BlueCard Worldwide hospital. It is important that you call the BlueCard Worldwide Service Center in order to obtain cashless 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 and 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.

In an emergency, get the care you need immediately. Then, if you are admitted as a hospital inpatient, call BCBS-SC's 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. Your treatment will be covered at 90% (80% of R&C after the deductible under Basic Choice) if the care provided was related to a life threatening, acute or urgent situation, at either Network or non-Network hospitals.

NOTE: Routine medical care provided by an emergency room will be reimbursed at 70% of R&C after deductible — regardless of the hospital or doctor you use.

If Your Child is Away at School

Most times, children away at school can use the school's infirmary at no cost or schedule procedures when they come home. You can also find out whether a Network provider is available in the vicinity of the school by calling 1-800-325-6596 for providers in South Carolina and the greater Augusta, GA area or 1-800-810-2583 for providers outside this area. You can also go on the internet and check out "BlueCard Hospital and Doctor Finder" to locate network providers nationwide. The web address is www.bluecard.com.

If You Have Questions About Your Coverage

Call the Blue Cross Blue Shield Customer Service Line at 1-800-325-6596. Customer Service representatives are available Monday through Thursday 8:00a.m.- 6:00p.m. and Friday 8:00 a.m. to 4:30 p.m. to:

- Answer questions about your Health Choice benefits,
- Verify which providers are in the Medical Network,
- Provide additional information about Network providers,
- Help you with Network-related problems, and
- Discuss the status of medical claims.

Value Options representatives are available 24 hours a day at 1-800-333-6557 for mental health and substance abuse benefit pre-certification.

Important words to keep in mind when you think of "emergency" are life threatening, acute and urgent care. Check the Glossary beginning on Page 50 for a full description.

PRE-APPROVALS

Regardless of the medical option you choose, Health Choice Medical 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 WSRC.

As described in this section, you should call Blue Cross Blue Shield to:

- Have every hospital admission approved,
- Receive prior authorization for certain medical services,
- Access the services of a case manager when a catastrophic or long-term illness occurs.
- You should call ValueOptions for authorization of mental health and substance abuse benefits.

You must follow certain procedures to avoid financial penalties.

Prior Authorization and Pre-Admission Certification — Required for Certain Services

Blue Cross Blue Shield requires that **all** inpatient hospital stays and certain other medical services meet the medical necessity provisions of the options. 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 doctor or facility), **prior authorization or pre-admission certification is required under all three options** (Prime Choice, Standard Choice and Basic Choice) for any of the following services:

- Any inpatient admission
- Any home health services (nursing visits, infusion therapy, physical therapy, occupational therapy or speech therapy provided in the home)
- Any admission to an extended care facility (inpatient rehabilitation, skilled nursing facility)
- Any rental or purchase of durable medical equipment that exceeds \$500.00
- Any transplant
- All hospice care
- Any private duty nursing
- Restorative Speech Therapy (note: developmental Speech therapy is not a covered expense)
- Certain prescription drugs as determined by BCBS-SC (Contact BCBS-SC Customer Service or logon to www.bcbssc.com for more information)

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, it is ultimately your responsibility.



For hospital admissions and prior authorization of certain other services as outlined above, call Blue Cross Blue Shield. If calling from within South Carolina, call 1-800-327-3238 or from outside South Carolina, call 1-800-334-7287. (Call Value Options at 1-800-333-6557 for certification of mental nervous and substance abuse services.) These numbers are on your Blue Cross Blue Shield ID Card.

When you call, a Blue Cross Blue Shield nurse will request the following information:

- Employee's name, Blue Cross Blue Shield 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 prior authorization for another medical service is requested, the details regarding its medical necessity.

A registered nurse or physician consultant will in turn contact your physician to confirm the need for hospitalization or other medical services. Once that contact has been made, you will receive a telephone call or letter from the Claim Administrator notifying you whether your hospital stay or other medical service has been certified or authorized.

What if You Don't Pre-certify Your Hospital Stay?

If you fail to make the pre-certification phone call for a non-Network hospital admission, **you will incur a \$200 penalty which does not count toward your deductible or out-of-pocket maximum.**

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

If you stay in the hospital beyond the days certified by the Claims Administrator...**no hospital benefits will be paid for the extra days.**

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 medical Plan covers the stay for mother and child in a 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).

Women's Health and Cancer Rights Act

The medical plan complies with the provisions of the Women's Health and Cancer Rights Act concerning coverage for reconstructive surgery in connection with mastectomies. Specifically, the Plan covers reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications of all stages of mastectomies, including lymphedemas.

Second Surgical Opinions

If your doctor recommends elective, non-emergency surgery, you might want to get a second doctor's opinion to be sure you really need the operation. It's not required, however. Surveys indicate that some operations are not medically necessary. Other types of treatment, like medication for example, might be just as effective to treat a given problem.

The Health Choice medical options cover services related to a second surgical opinion, or a third surgical opinion in the event your second surgical opinion conflicts with your doctor's original diagnosis or recommendation. You will be responsible for any applicable copay and/or employee coinsurance.

Any surgeon providing a second or third opinion should not be associated 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

Blue Cross Blue Shield 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. Call 1-800-327-3238 from within South Carolina or 1-800-334-7287 from outside South Carolina if you need this service.

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

Blue Cross Blue Shield — using its resources as the nation's largest health care federation — 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.

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If you or your covered dependent is considering any type of transplant, you or your physician should call the Blue Cross Blue Shield of South Carolina toll-free 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 Blue Cross Blue Shield of South Carolina, you will be directed to the Blue Distinction Center best qualified to perform the specific transplant required.

If Blue Cross Blue Shield of South Carolina 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. WSRC/BRSI Health Choice benefits for the Prime, Standard and Basic Choice medical options 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 reimbursed at the existing SRS mileage rate) 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.

Blue Cross Blue Shield 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

The Prime, Standard and Basic Choice medical options cover a portion of most medically necessary services and supplies, both inside and outside of a hospital. Blue Cross Blue Shield will determine if a claim is to be considered **medically necessary** for the diagnosis, care or treatment of an illness, injury or pregnancy. Value Options will determine if a claim is to be considered medically necessary for the diagnosis and treatment of mental health and /or substance abuse.

How much is paid depends on the option you choose and — with Prime Choice and Standard Choice — your Network or non-Network usage.

The chart on Page 14 shows the percentages the options pay for a variety of covered expenses.

Hospital Services and Supplies

The Prime, Standard and Basic Choice medical options cover a semiprivate room and board in a recognized hospital or approved rehabilitative facility.

Other covered hospital expenses include charges billed by a hospital for:

- Nursing care provided by hospital staff,
- Use of operating, delivery, recovery and treatment rooms,
- Use of intensive care and coronary units,
- Inhalation therapy,
- Laboratory and other medical diagnostic tests, such as electrocardiograms,
- Medicines, supplies and dressings,
- Anesthesia supplies,
- Appliances used in the hospital,
- Diagnostic x-rays, Magnetic Resonance Imaging (MRI) and Computerized Axial Tomography (CAT) scans,
- Routine nursery care,
- Blood typing and matching, administration of blood and blood plasma,
- Use of a cystoscopic and other specialized procedure rooms,
- Special diets, and
- Other doctor-prescribed services and tests approved by the Claims Administrator.

Special note: Many facilities offer suitable care outside a hospital setting. See Pages 23-24 for details.

If you stay in a private room because no semiprivate room is available, or because your doctor determines and documents (and Blue Cross Blue Shield agrees) that isolation is necessary, the private room and board rate will be covered.

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Outpatient Services and Supplies

The Prime, Standard and Basic Choice medical options also cover most medical services and supplies that you receive as an outpatient in a hospital, including:

- Hospital facility charges for outpatient surgery (provided the charges are incurred on the day the surgery is performed),
- Fees of surgeons, assisting surgeons (when medically necessary), surgical assistants and anesthesiologists, for outpatient surgery,
- Doctors' fees for outpatient treatment,
- Diagnostic x-ray and laboratory services,
- X-ray therapy, radiation therapy, and chemotherapy
- Emergency room services. (Remember, though, that your payment percentage depends on whether care is of an acute, urgent or life threatening nature, or is routine. Refer to the chart outlining payment on Page 14 and the information below.)

When should you go
to an Emergency Room?

For routine
physical ailments?

No!

For medical crises?

Yes!

Emergency rooms (ERs) are specially designed to give immediate aid in cases of medical crises resulting from accidents or a sudden illness. ERs are staffed with highly-trained doctors and nurses, and outfitted with high-tech equipment. Because of this, emergency room services can be very expensive and should be reserved for **life threatening, acute and urgent care**. When a sudden and severe medical problem occurs, by all means go to an emergency room immediately.

Conversely, for routine physical ailments and non-threatening injuries, call your doctor and make an appointment, if necessary. If you go to an emergency room, you may have to wait several hours for a doctor because the most severe emergencies are treated first. Plus, you'll pay a lot more (70% after the deductible) for routine non-emergency treatment and you may not receive adequate follow-up care.

If you believe that a trip to the Emergency Room was a life-threatening, acute or urgent situation, but your Explanation of Benefits from Blue Cross Blue Shield shows that the claim was processed as a "routine, non-emergency" visit, then call Blue Cross Blue Shield Customer Service (1-800-325-6596) to discuss your particular situation.

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Doctors' Services

The medical options pay a portion of the medically necessary charges for services performed by a doctor or other licensed practitioner (such as a Certified Nurse Practitioner) qualified as being covered under this plan and acting within the scope of his or her license. When office services are provided by a Network doctor, you generally pay a \$10 copay under Prime Choice or a \$20 copay under Standard Choice before Blue Cross Blue Shield pays the balance of the negotiated fee.

Reimbursement for charges is limited to 90% of the Allowable charge after the deductible when services are provided by a non-Network physician under Prime Choice and Standard Choice, and 80% of R&C after the deductible when you participate in Basic Choice. Covered expenses include:

- Doctors' office visits,
- In-hospital consultations,
- Surgery (including medically necessary assisting surgeons' and anesthesiologists' charges), and
- Physical therapy, speech therapy and occupational therapy to restore a skill or ability lost through illness or injury. (Note: developmental therapy is not covered.) (See Page 35.)

Hospital Alternatives

The Prime, Standard and Basic Choice medical options provide coverage for care at home or in certain health care facilities that are not hospitals. In addition to the following hospital alternatives, expenses are covered if you go to a Christian Science facility or a birthing center.

Home Health Care

Through the use of a home health care agency, you may be able to shorten your hospital stay and spend your recovery time in the comfort of your own home. **Prior authorization is required**, as described on Page 17.

Covered home health care expenses include the following services which are prescribed by your doctor:

- Part-time or intermittent nursing care by either a Registered Nurse (RN) or Licensed Practical Nurse (LPN),
- Dressings, medical supplies and prescribed drugs, and
- Laboratory services, to the extent they would have been covered if you had been hospitalized.

Expenses for the following services are not covered:

- Services of a person who resides in your home or is a member of your family,
- Custodial care,

If you do not have a definite need to be in a hospital, receiving medical care in another setting — such as an extended care facility, a hospice, or through a home health care agency — is often less costly, more comfortable, and just as effective.

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- Transportation services, and
 - Any services provided when the individual is not under the continuing care of a doctor.

Extended Care Facility

If you (or a member of your family) are recovering from an illness or injury, benefits for rehabilitative care are payable for certain services and supplies. **Prior authorization is required**, as described on Page 17.

Care at an extended care facility will be considered for coverage by Blue Cross Blue Shield if the stay is recommended by the patient's attending physician and all of the following apply: Confinement begins within 14 days after a hospital stay of at least three consecutive days, the patient remains under the doctor's continuing care, and the initial hospital stay begins while the patient is enrolled in the applicable medical option.

Covered expenses include:

- Room and board, including charges for general nursing care,
- Use of special treatment rooms, x-rays, laboratory examinations, most therapy and other medical services customarily provided to patients, and
- Drugs, solutions, dressings and casts.

The following expenses are not covered:

- Custodial care,
- Treatment of alcoholism, drug abuse or mental illness (see Mental Health and Substance Abuse Services on Page 31), or
- Care for the convenience of someone, such as a family member.

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Hospice Care

Hospice care refers to the medical, psychological and nursing care provided to terminally ill patients with a life expectancy of less than six months. It permits someone with no hope of recovery to leave a hospital for a more comfortable and dignified setting. **Prior authorization is required**, as described on Page 17. The following will be considered by Blue Cross Blue Shield as covered expenses when ordered by the patient's attending physician, and provided and billed by a hospice:

- Semiprivate room and board and special services,
- Nursing and therapy services,
- Outpatient services,
- Psychological and dietary counseling,
- Home care by professional hospice workers (other than household or family members), and
- Pain-relief treatment, including drugs and supplies.

Private Duty Nursing

When a patient's condition requires constant monitoring in a hospital, the hospital is responsible for providing this care. Normally, private duty nursing is required for the management of a patient with extensive monitoring needs in the home. When private duty nursing services are recommended, the following guidelines must be followed:

- **Services must be pre-authorized** and determined to be medically necessary by Blue Cross Blue Shield, as described on Page 17. To be sure the expenses will be covered, call Blue Cross Blue Shield to have your situation reviewed by a case manager before incurring any charges. A doctor's recommendation does not guarantee coverage.
- The provider of skilled services must be an RN or LPN.
- Custodial care services are not covered.
- Services provided by an RN or LPN who is a member of your family or who resides in your home are not covered.

Call the Blue Cross Blue Shield Customer Service Line at 1-800-325-6596 for information on hospice programs participating in the Network.

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Prescription Drug Discount Program

A special prescription drug discount program is provided with the Prime, Standard and Basic Choice medical options. Each option has a benefit of 80% after your annual deductible has been met. If you use pharmacies which participate in the Caremark prescription network, your 80% benefit will be based on a discounted price (or the regular retail price, if it is lower). There is no discount at non-participating pharmacies (so your 80% benefit will be based on the regular retail price at non-participating pharmacies). There are some very important things to remember in order to receive maximum benefits from the prescription drug discount program:

The Plan pays 80% of the covered prescription drug charges after you have met your annual deductible. If you have not yet met your annual deductible, the covered charge will be applied to your deductible. If your WSRC/BSRI medical option is secondary to another medical insurance plan (for example, your spouse's employer's medical plan), you still need to show your Blue Cross Blue Shield ID Card to ensure that you will receive maximum benefits.

When you present your Blue Cross Blue Shield 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 Caremark system, and will charge you the lower of the Caremark program discounted price or the regular retail price. You will pay the pharmacist the discounted price for your prescription at the time you pick it up. If you use a network pharmacy, your pharmacy claim will be transmitted to BCBS-SC. Once you meet the deductible for your coverage option, a reimbursement check will be included with your explanation of benefits. You will be reimbursed for 80% of the covered expense after you have met the deductible. Prior authorization from BCBS-SC is required for some drugs.

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 forget to notify the pharmacist that your claims should be filed first with your WSRC/BSRI Health Choice Medical Plan; or if
- You are filing claims the WSRC/BSRI Medical Plan 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 1) through BCBS-SC Customer Service by calling 1-800-325-6596, or on the BCBS-SC website at www.bcbssc.com. 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

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- 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
 - Days supply
 - Prescription (Rx) Number
 - Amount paid

The Prescription Drug Claim Form should be mailed to:

**Blue Cross Blue Shield of South Carolina
Claims Processing Center
PO Box 100300
Columbia, South Carolina 29202**

The prescription drug discount program covers up to a 90-day supply of medication. Also, 75% of the days supplied on the prescription must have elapsed before you will be allowed to have a re-fill. If you have special needs that require a longer supply, or a re-fill before the 75% rule is satisfied, or if you have other questions concerning the prescription drug discount program, contact Blue Cross Blue Shield Customer Service at 1-800-325-6596 to discuss your individual situation.

Prescription Drug refills beyond one year from the original prescription date will not be covered.

Following these rules will help you and the WSRC Team save money on prescription drugs.

Preventive Medical Care Benefits

One of the best ways to prevent illness is by taking care of yourself. Recognizing the importance of regular check-ups and immunizations, **Prime Choice and Standard Choice** include extensive preventive coverage for well baby, child, adolescent and adult care provided in a network physician's office setting. (Basic Choice provides limited adult preventive care benefits through the Early Detection Program as described on Page 30.)

The charts on Pages 29-30 list the covered pediatric and adult preventive care services, and show, in general, how often and at what ages you and your family members should schedule each type of preventive care service. **Always consult with your physician for specific scheduling recommendations.**

Under Prime Choice and Standard Choice, preventive services provided during an office visit by a **Medical Network** doctor — such as well-baby care, immunizations, routine physicals and annual gynecological exams — are covered by paying your \$10 or \$20 office service copay (depending on the option you choose), with a limited benefit of \$250.00 per person per calendar year for services provided by the Network doctor (including lab work and x-rays performed in the doctor's office).

In addition, associated diagnostic tests — outside lab work and x-ray services for mammograms, and sigmoidoscopy — that frequently can't be performed in the doctor's office are paid at 90% with no deductible, if you use a **Medical Network** free-standing laboratory, radiology facility, or hospital outpatient department.

If you are enrolled in Prime Choice or Standard Choice, you must use Network providers for coverage of preventive care services. Benefits for these services are not covered if you use non-Network providers.

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Prime and Standard Choice Pediatric Preventative Care Schedule

Examinations and Tests	Frequency of Reimbursement for Covered Services
<ul style="list-style-type: none"> Routine Physical Exam, Limited Clinical Screening Tests and Immunizations performed in the doctor's office 	<ul style="list-style-type: none"> Every 2 months Ages 1-18 months Once, Age 19-24 months Annually, Ages 3-4 years Every three years, Ages 5-16 years Once, Age 17-18 years
PPD (Tuberculin Skin Test)	<ul style="list-style-type: none"> Once, Age 9 months, and Once, Age 4-6 years
Pelvic Exam and Pap Smear (Only for females identified as high risk)	Annually, Ages 13-18 years

Immunization Schedule for Children	
<i>DPT: Diphtheria/Pertussis/Tetanus</i>	<i>MMR: Measles/Mumps/Rubella</i>
<i>OPV: Oral Polio</i>	<i>HIB: Haemophilus Influenza B</i>
<i>HBV: Hepatitis B</i>	<i>Td: Tetanus/Diphtheria Booster</i>
<i>VAR: Varicella (Chicken Pox)</i>	
Birth or 2 weeks:	HBV#1
2 months:	HBV#2, DPT#1, OPV#1, HIB#1
4 months:	DPT#2, OPV#2, HIB#2
6 months:	HBV#3, DPT#3, HIB#3
12-15 months:	MMR#1, VAR, HIB#4
18 months:	DPT#4, OPV#3
4-6 years:	DPT#5, MMR#2, OPV#4
12 years:	HBV (series of 3) only if not already immunized VAR ONLY if not already immunized and with no reliable history of chicken pox
14-16 years:	Td

Note: The Immunization Schedule above reflects recommendations of the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP), current as of July 1997. Always seek guidance from your child's health care provider for any individualized changes or updates to the AAP and AAFP recommendations.

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Prime and Standard Choice Adult Preventive Care Schedule

Type of Service	Frequency of Reimbursement for Covered Services
Routine Physical Exam, Limited Clinical Screening Tests and Immunizations performed in the doctor's office (limited to \$250* per person per year)	Once every 2 years, ages 19-39 Annually, beginning at age 40
Pelvic Exam and Pap Smear	Annually, beginning at age 19
Professional Breast Exam and Mammogram	Professional breast check with every physical exam. Screening mammogram, annually, beginning at age 40
Routine Prostate Screening Test (PSA)	Annually, beginning at age 40
Rectal Exam/Sigmoidoscopy	Once at age 50, then once every two years thereafter
Tetanus-Diphtheria Immunization (TD) Booster	Once every 10 years
Influenza Immunization	When appropriate (high risk) per BCBS-SC guidelines, ages 19-49 annually, beginning at age 50
Pneumovax Immunization	Once, age 65 or older
Hepatitis B Immunization	Once, age 19 or older if high risk (non-occupational)

**The \$250 limitation includes a well-care examination, clinical laboratory tests and x-rays performed in the doctor's office in which there is no corresponding diagnosis (routine, well-care only) and the immunizations noted above when they are provided as part of the routine physical examination and meet the frequency requirements noted above.*

Early Detection Services (Basic Choice Medical Option Only)

When you participate in Basic Choice, coverage is available to you and other adult family members for pap smears, mammograms and sigmoidoscopies, without an accompanying diagnosis. These tests have proven to be valuable tools in combating cervical, breast and colon cancers through early detection. The following schedule of preventive services applies only to the Basic Choice Medical option. Under Basic Choice, charges for each of these early detection tests are covered at 80% of R&C after the deductible - whether the test is billed in conjunction with a routine examination or with a diagnosis.

Early Detection Service Schedule

- Pap Smears: One every year beginning at age 19
- Mammograms: One every year beginning at age 40
- Sigmoidoscopies: One at age 50, then one every three years beginning at age 51

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Mental Health and Substance Abuse Services

Regardless of whether you elect Prime Choice, Standard Choice, Basic Choice or Blue Choice HMO, your coverage for mental health and substance abuse services will be managed by ValueOptions. ValueOptions is one of the largest mental health plan administrators in the United States, with a Network of providers throughout the nation.

Often, when someone needs mental health, alcohol or drug treatment, it is difficult and confusing to find the right approach and level of care. ValueOptions will help you and your dependents find and receive appropriate care. The ValueOptions Network is composed of licensed practitioners and facilities who meet strict credentialing requirements.

To contact ValueOptions, call their toll-free number, 1-800-333-6557, 24 hours a day, 7 days a week. A Clinical Care Manager will discuss your problem and assess your needs. Your Clinical Care Manager also will refer you to a qualified provider in your community. The ValueOptions network of providers includes inpatient hospitals, day treatment programs, specialty child and adolescent services, outpatient treatment programs, intensive outpatient alcohol and drug treatment programs, and professionals in private practice. ValueOptions reviews the treatment you receive from providers of these services in an effort to monitor the quality of care being provided by the Network and to determine the appropriateness and **medical necessity** for the continuation of your treatment.

It is important to remember that **without pre-certification and continued certification from ValueOptions, your treatment will not be covered.** (The only exception is limited coverage for non-Network outpatient mental health treatment.) **Ultimately, it is your responsibility to make sure that ValueOptions is pre-notified about any mental health or alcohol or drug treatment to receive benefits. Also, ValueOptions must approve extensions of treatment beyond the initial pre-certification.**

For emergency services, ValueOptions clinicians are available 24 hours a day, 7 days a week. Employees must call ValueOptions at 1-800-333-6557 for a referral for inpatient treatment. If there is risk of you (or your dependent) being a danger to yourself/himself/herself or to another person, ValueOptions will assist the caller in getting help. This may require ValueOptions to authorize admission to non-Network facilities or the Emergency Room. After the patient is stabilized, continued coverage may be contingent on transferring the patient to a ValueOptions Network facility. **Again, all mental health and alcohol and drug admissions and treatment programs must be certified by ValueOptions.**

See Pages 41-42 for information on filing claims to ValueOptions (when you use non-ValueOptions-Network outpatient mental health providers).

**YOU MUST CALL
VALUEOPTIONS
prior to seeking treatment.
Going directly to a provider
known to be in the Network
is not sufficient to receive
Network benefits.
You must be referred
by ValueOptions!**

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Mental Health and Substance Abuse Benefits

Expenses	ValueOptions Provider (with ongoing ValueOptions management)	Non-Network Provider
Inpatient mental health	100% after \$250 annual deductible per person* No limit on days. After discharge, outpatient visit copays apply	Not covered
Outpatient mental health	\$20 copay/visit No limit on visits	50% up to a maximum benefit of \$25/visit Maximum 20 visits/person/year
Chemical dependency: inpatient or outpatient	100% after \$250 annual deductible per person* No limit on days	Not covered

** If a patient requires both inpatient mental health services and inpatient or outpatient chemical dependency treatment services in the same calendar year, only one \$250 deductible will apply.*

CHARGES NOT COVERED BY THE OPTIONS

The following is a list of expenses that the Health Choice medical options do not cover. This list is intended to provide you with only the more common non-covered services. It is not a complete listing. Call the Blue Cross Blue Shield Customer Service Line at 1-800-325-6596 to find out if a particular service or treatment program not mentioned in this book is covered under Health Choice. Call Value Options at 1-800-333-6557 regarding coverage of mental health and substance abuse services.

- Treatment that is **not medically appropriate or necessary** as determined by Blue Cross Blue Shield of South Carolina (Value Options for mental health and substance abuse Services),
- Routine physical examinations, diagnostic tests and immunizations under Basic Choice, except for certain early detection services as shown on Page 30,
- Routine prenatal care sonograms, unless medically necessary,
- Comfort or convenience items, or personal services,
- Services rendered or supplies provided before coverage begins, i.e., before a member's effective date, or after coverage ends,
- Treatment that is not recommended and approved by a physician,
- Custodial care,
- Travel, except medically necessary transportation by ambulance, motels, apartment rentals or related expenses, except those covered under the Blue Quality Centers for Transplants
- Services you would not be required to pay if you had no medical coverage,
- Any service or supply provided by a member of the patient's family,
- Treatment of injuries due to service in the armed forces of any government,
- Treatment of injuries due to work done for any government — federal, state or local,
- Missed appointments,
- Completion of claim forms or filing of claims,
- Treatment of injuries or diseases covered or compensated for by any Workers' Compensation or similar laws,
- Chiropractic treatment except for manipulation for treatment of musculoskeletal disorders and diagnostic x-rays in connection with such treatment by a licensed provider,
- Massage therapy,
- Inpatient hospitalization for dental care, unless confinement is due to accidental bodily injury, or when a physician, other than a dentist, certifies that inpatient hospitalization is necessary to safeguard the life or health of a patient,
- Routine eye exams, eyeglasses or contact lenses, or examinations for the prescription



or fitting of them (covered under Vision Care Choice),

- Hearing aids or examinations for the prescription or fitting of them,
- Care rendered to a dependent child after his or her marriage;
- Services not reported to the Claims Administrator within **fifteen (15)** months from the date of service,
- Cosmetic surgery, unless it is necessary for prompt repair of a non-occupational injury, or is related to a congenital defect of an eligible newborn child (up to one year in age),
- Treatment resulting from any injury sustained or disease contracted in the performance of an occupation or work outside the WSRC Team for compensation or profit,
- Services or supplies which:
 - are not recommended and approved by a physician,
 - are not necessary for the diagnosis and treatment of an illness or injury (except certain covered preventive care services),
 - are considered personal comfort items such as telephone charges, television rental, barber or homemaker services,
 - exceed the Claims Administrator's allowable charge limitations,
- Services considered **experimental or investigational** by the Claim's Administrator,
- Acupuncture and acupuncture therapy,
- Services incurred for any medical observation or diagnostic study when no disease or injury is revealed unless:
 - the covered person had definite symptoms of illness or injury other than hypochondria,
 - the observation or studies were not part of a routine physical examination,
 - the request for benefit payment is in order in all other respects,
- Items billed separately for services solely benefiting the attending physician rather than for the diagnosis and treatment of the patient, such as pre-surgical routine testing for HIV,
- Physician's charges for medicine, drugs, appliances, supplies, blood and blood derivatives.
- Treatment in connection with the following counseling services: marriage, family, child, career, social adjustment, pastoral or financial,
- Non-medically-necessary orthopedic shoes, orthotic appliances or other supportive

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devices for the feet, solely used for comfort or athletics,

- Radial keratotomy or other methods of refractive eye surgery,
- Medication or treatment for cosmetic purposes,
- Devices, programs or medication to aid in smoking cessation,
- Prescription drug re-fills beyond one year from the original prescription date,
- Any type of service charge, including 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,
- Private duty nursing when not part of an approved Home Health Service or Hospice Care Program,
- Food supplements and non-prescription drugs and medicines which do not bear the legend, "Caution: Federal law prohibits dispensing without a prescription," except for certain medically necessary medications (for example, pre-natal vitamins) approved by Blue Cross Blue Shield,
- Charges made by a clinical pathologist, as related to automated laboratory testing, for supervising a hospital's laboratory,
- All services related to the treatment of sexual dysfunctions, including a penile prosthesis, except following prostate surgery,
- Treatment for, or in connection with speech therapy (except for medically necessary speech therapy when the individual has lost an existing speech function as a direct result of a stroke or injury, or which is related to or developed as a result of cleft lip and palate, and where the treatment has been pre-certified by BCBS-SC clinical review),
- Services, treatment, educational testing or training related to learning disabilities or developmental delays,
- Educational programs or services, such as dietary instructions and weight loss programs, (Note: a diabetic education program may be approved as being medically necessary, by Blue Cross Blue Shield),
- Treatment in connection with primal therapy, rolfing psychodrama, mega vitamin therapy, bioenergetics therapy, carbon dioxide therapy,
- Vision perception training,
- Any service or supply related to the diagnosis or treatment of infertility, including in-vitro fertilization and prescription drugs used for the treatment of infertility,
- Services or supplies related to the reversal of a tubal ligation or vasectomy,
- Services or supplies including medications related to the treatment of obesity, weight

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reduction or dietary control, except for medically necessary gastric bypass surgery or gastric stapling procedures as approved by Blue Cross Blue Shield; also, excluded are procedures to correct complications, reversal, and reconstruction that may arise from such excluded diversionary, or restrictive procedures,

- Charges related to complications of non-covered procedures,
- Services provided by non-licensed lay persons who assist in the delivery of a baby, such as a birthing coach or “doula,”
- Services of providers (persons or facilities) who are not licensed in the state in which their services are provided, when state licensure is required for performance of the services provided,
- Durable Medical Equipment expenses over \$500 for which no pre-approval was obtained from Blue Cross Blue Shield (note the definition of Durable Medical Equipment on Page 51). Non-covered supplies are inclusive of but not limited to band aids, tape, rubber and/or non-sterile gloves, thermometers, heating pads, hot water bottles, home enema equipment, sterile water and bed boards. Other non-covered items include, but not limited to, deluxe equipment such as motor driven chairs or bed, electric stair chairs or elevator chairs, the purchase or rental of exercise cycles, physical fitness equipment, ultraviolet/tanning equipment, water purifiers, hypo-allergenic pillows, mattresses, or waterbeds, whirlpool, spa or swimming pools, exercise and massage equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, residential or place of business structural modification or adjustments made to vehicles, or other items of equipment that the Claims Administrator determines does not meet the criteria.
- Elective abortions, unless the life of the mother is threatened if she should carry the baby to term.

COORDINATION OF BENEFITS (COB)

If you have medical coverage under another group plan in addition to this one —through your spouse or through Medicare, 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, Standard Choice or Basic Choice is coordinated with payments from other group medical plans through which you have coverage.

When your WSRC/BSRI medical option is the secondary plan to another group plan, (for example for coverage on a dependent) your WSRC Team coverage will reimburse covered expenses under the WSRC/BSRI Plan features up to the amount of total covered charges as determined by the Claims Administrator (Blue Cross Blue Shield or Value Options); however, the secondary payment will not exceed the difference between the total covered charges and the primary plan's payment.

Which Plan Pays First?

The plan that pays first is the one that covers you as an employee. 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're 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 (or retirees of) the WSRC Team, under the "Special Rules for Dual Couples" (explained on Page 3), you cannot be covered under the medical options as both an employee and as a dependent of another employee. As a result, you cannot have duplicate coverage under the WSRC/BSRI Health Choice Medical Options.

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 since only one medical plan is involved.

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



Medicare Coordination

When you become eligible for Medicare (Parts A&B), Medicare becomes your primary (first payer) for medical coverage, unless you are receiving the WSRC/BSRI Health Choice Medical Plan benefits as the result of your (or your spouse's) current employment with the WSRC Team.

When Medicare is primary, claims should be submitted and paid by Medicare (Parts A&B) prior to their submission to Blue Cross Blue Shield (BCBS) for reimbursement from the WSRC/BSRI Health Choice Medical Plan. When Medicare (Parts A&B) is primary, BCBS 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 WSRC/BSRI Plan benefit and the Medicare benefit is what Blue Cross Blue Shield would actually pay. The WSRC/BSRI Health Choice Medical Plan should not be confused with what is referred to as a Medicare Supplemental, or Medigap Plan.

With the cave-out provision of the WSRC/BSRI Medical Plan, the Medicare payment is carved-out (or subtracted) from the WSRC payment, rather than the WSRC/BSRI Plan payment being calculated as a supplement to the Medicare payment. Therefore, to calculate the WSRC/BSRI Medical Plan secondary payment, Blue Cross Blue Shield of South Carolina has to:

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

If the result of the WSRC/BSRI Medical Plan primary payment minus the Medicare payable amount is positive, Blue Cross Blue Shield will make a secondary payment under the WSRC/BSRI Health Choice Medical plan (to the lesser of the Medicare Allowable Amount or the WSRC primary payment). However, if the result of the WSRC/BSRI Health Choice Medical Plan primary payment minus Medicare is equal to \$0 or negative amount, there will be no secondary payment from the WSRC Plan.

Keep in mind that when Medicare is Primary, the WSRC/BSRI Health Choice Medical Plan will apply Medicare "Carve-Out" and subtract out of your WSRC/BSRI 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 B coverage. You can help minimize any balance that you may have to pay the provider by enrolling in Medicare Part 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 payor) for prescription drug coverage. **When the WSRC/BSRI Medical Plan option in which you are enrolled is determined to be equal to or better than Medicare Part D, you may not need and or want to enroll in Medicare Part D.**

If you are receiving WSRC Team Benefits as an active WSRC Team employee (or a dependent of a WSRC Team active employee) the WSRC/BSRI Health Choice Medical Plan will still be primary and you will not need to enroll in Medicare Part B, until your employment with WSRC ends.

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Example 1

You incur a \$100 charge for a physician office visit with a BCBS network provider and Blue Cross Blue Shield of South Carolina's Allowed charge for the covered service is \$60. The WSRC/BSRI Medical Plan applies a \$20 charge (e.g. for the Standard 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 WSRC/BSRI Plan was primary) minus the \$0 Medicare payment equals a \$40 WSRC/BSRI Plan payment as the secondary plan.

Example 2

You incur the same \$100 physician's office visit charge with a BCBS network provider as is detailed above for Example 1. The Blue Cross Blue Shield of South Carolina Allowed Charge is \$60 minus the \$20 WSRC/BSRI Medical Plan (Standard option) office visit copay resulting in a normal WSRC/BSRI 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 WSRC/BSRI Medical Plan was primary) minus the \$72 Medicare payment would result in a negative WSRC/BSRI Medical Plan secondary payment. Therefore, the WSRC/BSRI Medical Plan will make \$0 payment as the secondary payment.

Example 3

You incur a \$1000 expense for surgery from a BCBS network provider. The Blue Cross Blue Shield of South Carolina's Allowed charge for the covered service is \$1,000. The WSRC/BSRI 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 $\$900 - \$640 = \$260$, and the result would exceed the Medicare Allowed amount. Therefore the WSRC/BSRI 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 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 WSRC/BSRI 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 Blue Cross Blue Shield of South Carolina Allowed charge,
- Satisfaction of your deductible, copay, coinsurance and out-of-pocket maximums under the WSRC/BSRI Medical Plan,
- Excluded charges under Medicare, and/or the WSRC/BSRI 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 networks. If you use a Blue Cross Blue Shield 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 Blue Cross Blue Shield provider, the Blue Cross Blue Shield reimbursement will be in accordance with the non-network provisions of the Plan.

Claims Processing

When you participate in Prime Choice or Standard Choice and you have a Network medical expense, **the Network doctor, hospital or other provider is required to file the claim for you** in accordance with the provider's Network participation agreement with Blue Cross Blue Shield if the WSRC/BSRI Health Choice Medical Plan is the primary payer.

Regardless of which medical plan you are enrolled in – Prime, Standard, Basic or Blue Choice HMO – mental health and substance abuse treatment providers who are participating in the Value Options Network will file claims to Value Options.

When you go to a provider that does not belong to the Network — or you participate in Basic Choice — you may have to file the claim yourself. If your doctor gives you an itemized bill, you should submit the bill attached to a claim form.

Your claim for benefits should include:

- a description of the service provided including the dates of service provided including the date of service and diagnostic (ICD-9) and treatment (CPT) codes for treatment received in the U.S.
- proof of payment such as an original receipt
- the name and date of birth, of the person receiving services
- the members identification number

For prescription drug benefits, you must file a separate Blue Rx Drug Claim Form.

Medical and Drug Claim Forms may be obtained from the following sources: SRS Benefits Home page via the electronic file server, WSRC People Support Service Center (803-725-7772), or Blue Cross Blue Shield of SC Customer Service (1-800-325-6596).

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 medical expense (that is, **within 15 months from the date of service**), it will not be covered by your Prime, Standard, or Basic Choice Medical option. 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 medical 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.

The Medical Benefits Claim Form is OSR 5-340. A claim form for mental health/substance abuse treatment may be obtained from ValueOptions by calling (800) 333-6557.

Submit the claim forms to the appropriate claims administrator:

Medical Claims	Prescription Drug Claims	Mental Health and Substance Abuse Claims
<p>Blue Cross Blue Shield of SC Claims Processing Center P.O. Box 100300 Columbia, SC 29202</p> <p>Customer Service number (800) 325-6596</p> <p>Pre-Admission Review (800) 327-3238</p>	<p>Blue Cross Blue Shield of SC Claims Processing Center P.O. Box 100300 Columbia, SC 29202</p>	<p>ValueOptions Attn: Claims P.O. Box 1347 Latham, NY 12110-8847</p> <p>Customer Service number (800) 333-6557</p>

After your claim is processed, review your Explanation of Benefits (EOB) statement to make certain you have received the correct benefits.

If your claim is denied, or reduced, you will be notified of the reason for the denial. The Claims Administrator (Blue Cross Blue Shield or Value Options) 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.

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 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, Pre-existing Condition Limitations, and all other Plan limits and exclusions. Actual benefit determination will be made when the Claims Administrator (Blue Cross Blue Shield of South Carolina, or Value Options) processes the post-service claim.

Urgent Care Claims – 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 medical 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.

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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. 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 missing information within 60 days (45 days for Value Options), 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 (24 hours for Value Options), or the Claims Administrator may deny your claim.

Appealing a Claim Denial/Reduction

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 a Blue Cross Blue Shield of SC Customer Service representative for further explanation of the denial. You should call the toll free number listed on your Blue Cross Blue Shield of SC insurance identification card (or Value Options for mental nervous and substance abuse claims) or at the telephone number listed on your EOB denial.

If you wish to file a voluntary written appeal with the Claims Administrator, you must write to the address indicated on your, "Explanation of Benefits." Your letter must state that an appeal has been requested and 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 voluntary 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 voluntary 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.

As Soon As Possible – taking into account medical circumstances that require action, but no later than 72 hours for Urgent Care Claims.

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The final appeal request available to you is directly to the Plan Administrator and 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: The members name, address, identification number, and any other information, documentation, or materials that support the members appeal; also, 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. The WSRC/BSRI Health Choice Medical 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:

Washington Savannah River Company
Attn: Health Care Medical Plan Administrator
Building 703-47A
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 field involved in the medical or dental judgment. (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 WSRC/BSRI Health Choice Medical Plan Administrator has full discretion and authority to interpret Plan provisions, resolve any ambiguities and evaluate claims. The decision made by the WSRC Health Choice Medical 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 WSRC/BSRI Health Choice 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. For more information on your ERISA rights and administration of the Plan, refer to the Benefits Overview and General Information booklet

COVERAGE CONTINUATION IN SPECIAL SITUATIONS

If you are involuntarily laid off from the WSRC Team and are a full-service employee, you may elect to receive Displaced Worker's Medical benefits, as may be provided under the federal contractor workforce restructuring initiatives, in lieu of COBRA Continuation Coverage.

If you terminate your employment with the WSRC Team, coverage for you and your dependents will end on the last day of the pay period in which you are a full-service employee. You may be able to continue your coverage by electing COBRA continuation coverage or by converting to an individual "conversion coverage" policy. See Page 47 and the Benefits Overview and General Information book.

If you die, coverage for your dependents will end on the last day of the pay period in which you die, unless they are eligible to receive survivor benefits under the provisions of the WSRC/BSRI Pension Plan and pay the required monthly contribution. However, to continue receiving medical benefits, survivors must also meet the definition of "Eligible Dependents" on Page 1. For example, parents and stepparents are not eligible for Health Choice survivor coverage. Also, if your surviving spouse remarries, the new spouse and his/her children cannot be added to your survivor's Health Choice coverage. (Note that a dependent child will no longer be covered by the WSRC/BSRI Health Choice Medical Plan options upon reaching age 20, unless he/she is a full-time student at an accredited institution in which case medical coverage can be continued until age 25 if the dependent child is covered as a dependent on the surviving spouse's coverage. If the dependent child is receiving medical coverage through the child's survivor pension benefit the coverage will end when the pension benefit ceases at age 21.)

If survivor benefits do not apply, your dependents will be eligible to continue their coverage by electing COBRA continuation coverage or by converting to an individual "conversion coverage" policy (see Page 47). However, if your death is a result of an occupational injury or illness while you are a full-service employee of the WSRC Team or while receiving Special Benefits for Occupational Related Disabilities under the WSRC/BSRI Disability Income Plan, medical coverage may be continued for your survivors as outlined above. Your survivors will be notified of the option(s) available.

If you retire, with at least 15 years of eligibility service and one year of credited service, directly from a WSRC Team employer as a full service employee (including BSRI Option A Craft employees) under the Normal, Early, Optional, or Incapability provisions of the WSRC/BSRI Pension Plan, you and your eligible dependents are eligible for participation in the WSRC/BSRI Health Choice Medical Plan. If you transfer from a WSRC Team company to an Affiliate, as defined in the WSRC/BSRI Pension Plan, you are not eligible for the WSRC/BSRI Health Choice Medical Plan. Also, as a WSRC Team retiree, if you are re-employed as a full time employee by an your parent company or Affiliated entity of your parent company, your WSRC/BSRI Health Choice Medical Plan participation will end and will not be reinstated by a subsequent termination and or retirement from the Affiliate.

Rights to continuing WSRC/BSRI Health Choice Medical Plan benefits into retirement do not apply to employees who leave the WSRC Team with a deferred vested pension.

If you are approved for Long-Term Disability under the WSRC/BSRI Disability Income Plan, you will be eligible to continue coverage under the WSRC/BSRI Health Choice



Medical Plan for up to 24 months from the date your employment ends in lieu of COBRA continuation coverage. At the end of this maximum 24-month period, your medical coverage ends; however, you may then become eligible for Medicare.

If you are on a paid leave of absence, your WSRC/BSRI Health Choice Medical Plan coverage for yourself and your dependents will continue as if you were actively at work.

If you are on an approved Unpaid Leave of Absence (Unpaid LOA) such as a Family and Medical Leave, you will be able to continue your WSRC/BSRI Health Choice Medical Plan coverage for yourself and your dependents, if you elected to cover them, as long as you pay the required monthly premium contribution in advance. When you return from the Unpaid LOA as an active employee, your premium contributions will resume on a pre-tax deduction basis from your WSRC Team paycheck. Before your Unpaid LOA begins, be sure to contact People Support Service Center for additional information and instructions on making the required premium contributions.

If, while on an Unpaid LOA, you fail to make your premium payments in a timely manner (that is, by no later than 31 days after the beginning of the month), your Health Choice medical coverage for you and your dependents will be terminated retroactively to the beginning of the month for which the premium contribution was not made. When you return as an active employee from the Unpaid LOA, the Health Choice medical coverage that you had just prior to the Unpaid LOA will resume, with premium contributions deducted on a pre-tax basis from your WSRC Team paycheck. However, you and your dependents would have forfeited Health Choice medical coverage during the period of time that you did not pay the required premium contributions. Medical claims incurred by you or your dependents during that uncovered period of time will not be paid by the WSRC Team.

See page 37 of the Benefits Overview and General Information booklet for more information on coverage continuation when you are absent from employment due to military service under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

COBRA Continuation Coverage

Under federal law — the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA) — you and your eligible dependents may be entitled to continue your medical coverage for up to 18, 29, or 36 months depending on the reason for loss of coverage. A Subsequent Qualifying Change in Status also will determine the length of COBRA coverage. In order to be eligible for COBRA continuation coverage, you or your eligible dependents must have lost coverage under certain circumstances (such as termination of employment, divorce or death). In a divorce situation or your dependent's loss of eligibility, you must notify People Support Service Center within 60 days of the date of the Qualifying Change in Status (for example, the date of the final divorce decree) or COBRA continuation coverage cannot be offered to your dependent(s).

If you have a Qualifying Change in Status that could cause you or your dependent(s) to lose coverage, the length of your COBRA continuation period is reduced by the period of con-

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tinuation of coverage, if any, by any applicable WSRC/BSRI plans. An 18-month extension of coverage will be available to Spouses and dependent children who elect continuation coverage if a second Qualifying Change in Status occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second Qualifying Change in Status occurs is 36 months. Such second Qualifying Change in Status may include the death of a covered employee, divorce or separation from the covered Employee, the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second Qualifying Change in Status only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first Qualifying Change in Status had not occurred. You must notify Blue Cross Blue Shield of SC COBRA Administration Unit within 60 days after a second Qualifying Change in Status occurs.

See the Benefits Overview and General Information booklet for more information on COBRA.

HIPAA Certification

The WSRC/BSRI Health Choice medical options do not deny coverage to participants because of preexisting 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 a certificate (automatically provided to you by WSRC in with the COBRA information sent to you by the Plan) that will show evidence of your prior health coverage under the WSRC/BSRI Health Choice Medical Options, including the beginning and ending dates of your medical, dental and vision coverage. You should provide this certificate to your new employer.

If you buy health insurance other than through an employer group plan, the WSRC certificate of prior coverage may help you obtain coverage without a preexisting condition clause.

Conversion Privilege

If you do not wish to continue Health Choice medical coverage under COBRA, you may apply for an individual "conversion coverage" policy without medical examination. Application for an individual policy must be made to Blue Cross Blue Shield within 30 days after the termination of your WSRC/BSRI Health Choice medical coverage. Contact Blue Cross Blue Shield of South Carolina at 800-868-2500 extension 46401 for a conversion application.

If you elect COBRA continuation coverage, you may request conversion to an individual "conversion coverage" policy within 30 days of the expiration of your COBRA continuation coverage period.

GENERAL PROVISIONS

Right of Recovery

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 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 (Med-Pay), no fault, personal injury protection (PIP), 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 of the Plan.

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 Document. 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 a benefit payment is issued, either to you or to your provider, that exceeds the benefit amount you were entitled to, 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 be refunded, or
- Reducing the amount of the overpayment from future benefit payments.

Network Treatment Disclaimer

Neither Blue Cross Blue Shield, ValueOptions nor the WSRC Team is responsible in any way for treatment received from the providers who participate in their respective Networks. While Blue Cross Blue Shield and ValueOptions administer their Networks and make every attempt to evaluate the doctors 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.

GLOSSARY OF HELPFUL TERMS

Understanding what your medical benefits are and how they work is an important part of becoming an informed health care consumer. This book contains many medical terms... some will be familiar to you, others may not. Here is a handy reference list:

Acute

A rapid, sudden and unexpected onset of a change in a person's physical or mental condition, necessitating immediate medical attention.

Allowable Charge

The allowance mutually agreed upon by a network provider and the Claims Administrator and set forth in an agreement between the network provider and the Claims Administrator. In the event the "Allowable Charge" does not apply for a specific service, supply or provider, the allowance for claims administered by Blue Cross Blue Shield of South Carolina will be the lesser of the actual charge as submitted or the least of the following:

- the actual charges made for similar services, supplies or equipment by providers and filed with Blue Cross Blue Shield of South Carolina,
- the "Allowable Charge" for the preceding year increased by an index based on national or local economic factor indices;
- the lowest charge level at which any medical services, supply or equipment is generally available in the locality when in the judgment of Blue Cross Blue Shield of South Carolina a charge for such services, supply or equipment generally should not vary significantly in quality from one provider to another,
- a sets of allowances that has been mutually agreed upon by Blue Cross Blue Shield of South Carolina and providers contracting with Blue Cross Blue Shield of South Carolina,
- a set of allowances established by Blue Cross Blue Shield of South Carolina,
- is not affected by formulary credits.

Review of the "Allowable Charge" for claims administered by Blue Cross Blue Shield of South Carolina will occur following each calendar year. In the absence of actual or similar charges, as referred to above, Blue Cross Blue Shield of South Carolina may, through its medical staff and consultants, determine the "Allowable Charge" based on comparable or similar services or procedures. The Allowable Charge may be subject to a deductible, co-payment and/or coinsurance.

Coinsurance

The percentage you pay for covered services (except Network doctors' office visits with co-pays of \$10 or \$20 under Prime Choice and Standard Choice). Your coinsurance amounts for most medical services are 10%, 20% or 30%, depending on the Health Choice medical option you choose, the services or supplies provided and the provider you use.

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Copay

The flat dollar amount (\$10 or \$20) that you pay — under Prime Choice or Standard Choice — when you receive treatment in a Medical Network doctor's office. The medical options pay the balance of the cost of the office visit for most services. Also, the copay applies to office services, such as a laboratory test with or without a physical examination by the physician.

Deductible

The initial amount of medical expenses you are responsible for each year before Prime Choice or Standard Choice pays benefits for non-Network services and prescription drugs and before Basic Choice pays for almost all services. You must pay a new deductible each year... there is no carryover from one year to the next. A separate \$250.00 annual deductible is required for inpatient mental health services and/or inpatient or outpatient chemical dependency treatment services.

Durable Medical Equipment

Means a durable (able to withstand prolonged use) device or appliance whose use is essentially medical in nature to enhance the recovery of, or to assist a patient in, the achievement of physical independence. Such devices or equipment must be ordered by a Physician. They must be medically necessary to meet specific medical need. Such devices must be medical in nature, that is, wheelchairs, splints, respirators, etc. Devices such as air conditioners, whirlpool baths, spas, vacuum cleaners or air filters would not qualify as they are not devices that have exclusive medical uses. To qualify as Durable Medical Equipment, the item must have use that is limited to the patient for whom it is ordered, that is, the device or equipment would not be used by others.

Emergency Care

An injury or illness so severe or acute that it could cause death or permanent damage. It is an unforeseen condition of such acute nature that failure to receive immediate care or treatment could result in deterioration to the point of placing the person's life in jeopardy or causing significant impairment to bodily functions. (Some examples: a severed artery; an asthma attack.)

Experimental/Investigational

Experimental or investigational services are surgical or medical procedures, supplies, devices, (or drugs which at the time provided, or sought to be provided) that are in the judgment of the Claims Administrator not recognized as conforming to accepted, medical practice, or the procedure, drug, or device or either:

1. has not received required final approval to market from appropriate government bodies;
2. is one about which the peer-reviewed medical literature does not permit conclusions concerning its effect on health outcomes;
3. is not demonstrated to be beneficial as established alternatives;



4. has not been demonstrated to improve the net health outcomes; or
5. is one in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting.

A drug, device, procedure or treatment will be determined to be experimental or investigational if in the judgment of the Claims Administrator:

- There are insufficient outcome data available from controlled clinical trials published in peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved;
- Its approval has not been granted from the FDA for marketing for such treatment;
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes; or
- The written protocols or informed consent used by the treating facility or another facility substantially studying the same drug, device, procedure or treatment, states that it is experimental, investigational or for research purposes.

Extended Care Facility

A facility which provides 24-hour-a-day nursing care by RNs and/or LPNs and is accredited by the Joint Commission on Accreditation of Health Care Organizations or is recognized (certified) by Medicare.

Home Health Care Agency

An organization that is specially licensed to provide certain nursing and other health care services to individuals who require in-home care.

Hospital

An acute care facility where patients with serious illnesses or injuries can receive extensive diagnostic and treatment services on an inpatient or outpatient basis. Not a convalescent facility, nursing home, or facility for the aged.

Inpatient Services

Services that are provided as a bed patient in a hospital, a rehabilitation hospital, an extended care facility (skilled nursing facility), or a substance abuse treatment facility.

Life-Threatening

Any condition, illness or injury that if left untreated would result in:

- Loss of life or limb;
- Significant impairment to bodily function; or
- Permanent dysfunction of a body part.

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Medical Necessity

Means the service, supply or equipment received is required to identify or treat the illness or injury which a Physician has diagnosed or reasonably suspects. The service, supply or equipment must, in the judgment of the Claims Administrator (1) be consistent with the diagnosis and treatment of the patient's condition, (2) be in accordance with standards of good medical practice, as determined by a Physician's peers in the same profession (3) be required for reasons other than the convenience of the Patient or his Physician and (4) be performed in the least costly setting required by the patient's condition. The fact that a service, supply or equipment is prescribed by a Physician does not necessarily mean such service is Medically Necessary.

Requires that services or medical supplies must be considered appropriate, in the opinion of Claims Administrator, to diagnose or treat a covered person's illness or injury. To be appropriate, the service or supply must, in the opinion of the Claims Administrator:

- Be care or treatment likely to produce a significant positive outcome, and no more likely to produce a negative outcome than any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; or
- Be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- As to diagnosis, care and treatment, be no more costly (taking into account all health care expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

Network

A group of doctors and other health care providers who contractually agree to undergo an extensive screening process and provide care at pre-negotiated discounted rates. Blue Cross Blue Shield administers the medical Network; ValueOptions administers the mental health and substance abuse treatment Network. You can view Blue Cross Blue Shield network providers online at www.bluecard.com. The Network administered by ValueOptions is unpublished. You need to contact ValueOptions Customer Service at 1-800-333-6557 for referral to a network provider and for certification of all mental nervous and substance abuse treatment.

Out-of-Pocket Maximum

The most you will pay in deductibles and coinsurance for covered expenses during any one calendar year before your Health Choice Medical option begins to pay 100% of eligible covered expenses. Certain expenses — such as the copay (\$10 or \$20), costs that exceed the Claims' Administrator's Allowed Charge and/or R&C, and pre-admission certification penalties — do not count toward the out-of-pocket maximum. Refer to the lists on Pages 9-10.

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Outpatient Services

Services provided outside a hospital-confined setting. This includes services provided in the outpatient department of a hospital, a clinic, or a doctor's office.

Post-Service Claims

Most claims are considered post-service claims since they are usually filed after your health care provider has already rendered services.

Pre-Service Claims

Any claim for a benefit which, 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 the claimant's eligibility, pre-existing conditions limitations and all other Plan limits and exclusions. Actual benefit determination will be made when the Claims Administrator processes the post-service claim.

Premium Contributions

The amount you pay to purchase medical coverage from the WSRC/BSRI Team (not what you pay when you use the coverage.)

Reasonable & Customary (R&C)

R&C charges are determined by taking into account:

- The normal range of fees charged by providers in your geographic area for similar services, and
- Any unusual circumstances.

Routine Care

An injury or illness that can be treated or managed adequately at home until you can arrange to see your family doctor (for example, a cold). Routine care also encompasses most preventive care.

Treatment Center for Chemical Dependency

A facility that is approved by ValueOptions, and is staffed and equipped to provide specialized treatment of alcoholism and narcotics addiction.

Urgent Care Claims

Claims for treatment for an acute injury or illness that if processed under the normal pre-service claim review timeframes could seriously jeopardize the claimant's life or health, 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 that cannot be managed without the care or treatment that is the subject of the claim. A Provider may be the claimant's authorized representative, without the claimant specific designation as such when a claim is considered an Urgent Care Claim.

ERISA INFORMATION

As a participant in the WSRC/BSRI Health Choice Medical Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 as amended (ERISA). The official documents which govern the medical options dictate the actual operation of the Plan and the payment of benefits. For more information on your ERISA rights and administration of the Plan, refer to the Benefits Overview and General Information book.

Plan Information

Type of Plan: A self-insured welfare plan that provides health benefits
Plan Name: Health Choice Medical Plan (Prime Choice, Standard Choice and Basic Choice)
Plan Sponsor: Washington Savannah River Company and Bechtel Savannah River, Incorporated (WSRC/BSRI)

Employer Identification Numbers of The WSRC Team:

The identification numbers assigned by the Internal Revenue Service are:

Washington Savannah River Company LLC (WSRC):	82-0510443
Bechtel Savannah River, Inc. (BSRI):	94-3077224
BWXT Savannah River Company:	54-1804131
BNG America, Savannah River Corporation:	54-1813446
CH2 Savannah River Company:	02-0693747

Plan Number: 501
Plan Year: January 1 - December 31
Plan Administrator: Medical Plan Administrator
Washington Savannah River Company
Savannah River Site
Aiken, South Carolina 29808

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

ValueOptions
5001 S. Miami Blvd., Suite 200
Durham, NC 27709

Agent for Legal Process: Corporate Service Company
1301 Gervais Street
Columbia, SC 29201
Phone: 800-927-9800



Eligibility for benefits should not be viewed as a guarantee of employment. While the WSRC Team intends to continue providing a comprehensive benefits program, the WSRC Team reserves the right to modify or terminate any of the benefit plans at any time. For more information on the procedures to modify or terminate benefit plans, refer to the “General Information” book

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