Medical Plan benefits designed to help protect you and your family from the high cost of medical treatment.

For questions and Pre-Authorization contact:

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

**Hospital Pre-Admission**
In South Carolina (Blue Cross Blue Shield 1-800-327-3238) & Medical Case Management
Outside SC (Blue Cross Blue Shield 1-800-334-7287)

**Mental Health & Substance Abuse Pre-Certification**
1-800-790-5770 (Companion Benefit Alternatives through Blue Cross Blue Shield of South Carolina)

**Employee Assistance Program**
On-site (803) 952-8728
Companion Benefit Alternatives
1-800-790-5770
CompanionBenefitAlternatives.com

**Traveling Outside the U.S:**
BlueCard Worldwide Customer Service 1-800-810-Blue (2583); or 1-804-673-1177; www.bluecard.com

**COBRA Administrator**
Ceridian COBRA Services
PO Box 534099
St. Petersburg, FL 33747-4099
Customer Service: 1-800-877-7994
Website: www.ceridian-benefits.com

**Benefits Solutions Service Center**
803-725-7772 or 800-368-7333;
Service-Center@srs.gov;
“Service Center” SRNS, Benefits Service Center, Building 703-47A, Aiken SC 29808

Savannah River Nuclear Solutions, LLC “SRNS” maintains medical benefits under the Medical Plan (“Plan”) designed to protect you and your family from the high cost of medical treatment. SRNS is also referred to as the “Employer” or “Company” in this Summary Plan Description (“SPD”). This document, together with the administrative policies and procedures of Blue Cross Blue Shield of South Carolina (“the Claims Administrator” or “BCBS”), constitute the Plan Document.

This SPD describes the Plan as of January 1, 2013 with subsequent amendments. Please read this summary carefully. This document explains how the Plan works, how you qualify for and ultimately receive Plan benefits, what benefits are available to you, and what your rights are as a Plan participant. The Employer, however, reserves the right to amend or terminate the Plan, at any time.

The benefits described in this document are sponsored by the Company under a self-insured administrative service contract with Blue Cross Blue Shield of South Carolina (BCBS-SC). The Company, through its Health and Welfare Benefit Committee delegated as its Plan Administrator (the “Plan Administrator”), is responsible for maintaining the enrollment, payroll and other records related to, and administration of, the Plan. You should contact the Company through the SRNS Benefits Solutions Service Center for questions about enrollment and eligibility in the Plan. As a Claims Administrator, BCBS provides claims payment services. You should contact them with general questions about the Plan and specific questions about claim determinations and appeals and payment of your claims. The Plan Administrator and Claims Administrator have discretionary authority to decide all issues of fact. Any decision by the Plan Administrator or Claims Administrator that does not constitute an abuse of discretion must be upheld by the law.
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<td></td>
<td>Network (Out of Pocket)</td>
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<tr>
<td>Annual Deductible</td>
<td></td>
</tr>
<tr>
<td>· Individual</td>
<td>$200</td>
</tr>
<tr>
<td>· Family</td>
<td>$400</td>
</tr>
<tr>
<td>Out-Of-Pocket Maximum</td>
<td></td>
</tr>
<tr>
<td>· Individual</td>
<td>$1,000</td>
</tr>
<tr>
<td>· Family</td>
<td>$2,000</td>
</tr>
<tr>
<td>Preventive Care Office Visits (based on schedule)</td>
<td>$10 Copay ($20 Spec.)</td>
</tr>
<tr>
<td>Prescription Drugs (6)</td>
<td>90% BCBS-SC allowable charge after deductible</td>
</tr>
<tr>
<td>Allergy or hormone injections by nurse in Physician’s office</td>
<td>90% ($10 copay if other services provided)</td>
</tr>
<tr>
<td>Chiropractic Treatment (4)</td>
<td>90% allowable charge, no deductible</td>
</tr>
<tr>
<td>Physical/Occupational Therapy (5)</td>
<td>90% allowable charge, no deductible</td>
</tr>
<tr>
<td>Ambulance Service</td>
<td>90% Maximum Payment no deductible</td>
</tr>
<tr>
<td>Hospital, surgical and most other medical services (3), (5)</td>
<td>90% allowable charge, after deductible</td>
</tr>
<tr>
<td>Emergency Room Services (life threatening acute or urgent care)</td>
<td>90% allowable charge, after deductible</td>
</tr>
<tr>
<td>Emergency Room for routine use</td>
<td>70% allowable charge after deductible</td>
</tr>
<tr>
<td>Diagnostic Services (lab, x-ray and other tests) when not performed in a Physician’s office (7)</td>
<td>90% allowable charge, after deductible</td>
</tr>
<tr>
<td>Home Health Care, Hospice Care, Durable Medical Expenses (5)</td>
<td>90% allowable charge, after deductible</td>
</tr>
<tr>
<td>Prescription Drugs (6)</td>
<td>Allowed % after deductible</td>
</tr>
<tr>
<td>· Generic</td>
<td>90%</td>
</tr>
<tr>
<td>· Preferred</td>
<td>80%</td>
</tr>
<tr>
<td>· Non-Preferred Brand</td>
<td>70%</td>
</tr>
</tbody>
</table>

Annual Maximum Benefit $2,000,000 effective 1/1/2013

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

Effective January 1, 2013
## PREVENTIVE CARE

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Prime Choice and Standard Choice</th>
<th>Basic Choice (High Deductible Health Plan)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network Provider</td>
<td>Out of Network Provider</td>
</tr>
<tr>
<td><strong>Physical Exams (includes Diagnostic Lab Services)</strong> (1)</td>
<td>Paid at 100% of allowable charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>(after plan co-payment).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gynecology Exams</strong></td>
<td>Paid at 100% of allowable charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>(includes Pap Smear Screening)</td>
<td>(after plan co-payment)</td>
<td></td>
</tr>
<tr>
<td><strong>Mammography Screenings (1)</strong></td>
<td>Paid at 90% of allowable charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>One per benefit year, starting at age 40</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prostate Screenings (PSA)</strong></td>
<td>Paid at 90% of allowable charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>One per benefit year</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Colorectal Cancer Screenings</strong></td>
<td>Paid at 90% of allowable charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Sigmoidoscopy - Once every 5 years - age 50 and above. Colorectal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colonoscopy - Once every 10 years - age 50 and above)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Well Child Care (age 0 through age 18)</strong></td>
<td>Paid at 100% of allowable charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>When performed in a Physician's office according to the preventive</td>
<td>(after plan co-payment)</td>
<td></td>
</tr>
<tr>
<td>care schedule listed on the Blue Cross Blue Shield web site (under</td>
<td></td>
<td></td>
</tr>
<tr>
<td>preventative in the Search box)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Adult Immunizations (1)</strong></td>
<td>Paid at 90% of allowable charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>According to the Blue Cross Blue Shield preventive care schedule</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(listed on their website (under preventative in the Search box)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Bone Mineral Density Screenings (1)</strong></td>
<td>Paid at 90% of allowable charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routinely for women starting at age 65 and for those age 60 and younger</td>
<td></td>
<td></td>
</tr>
<tr>
<td>who are at increased risk for osteoporotic fractures</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(1) Routine Mammography, PSA Tests, and Adult Immunizations - If filed with an office visit or routine physical exam, the co-pay will apply. If filed without an office visit, the benefit will be paid at 90% of the allowable charge.

*No Copay under Basic Choice if In-network and out of network Preventive Care is not covered.

Preventive care coverage follows the BCBS Clinical Preventive Care Guidelines, which are based on guidelines from the U.S. Prevention Care Task Force. Following BCBS standards provides more prompt attention to new vaccines and provides benefits for preventive care tests such as:

- **One Annual Wellness/Physical**
  - This is a covered charge, regardless of patient age.
- **Colorectal Cancer Screening**
  - Beginning at age 50, this is a covered charge for a *routine* colonoscopy once every ten years or a sigmoidoscopy once every five years.
- **Bone Mineral Density Screening**
  - Routinely for women starting at age 65 and for those age 60 and younger who are at increased risk for osteoporotic fractures.

You can find more information about the BCBS preventive care schedule for immunizations on their web site at [www.southcarolinablues.com](http://www.southcarolinablues.com) and by typing “preventive guidelines” in the search box. **Benefits for these services are not covered if you use non-Network Providers.**

Always consult with your Physician for specific scheduling recommendations.

Preventive services provided during an office visit by a BCBS PPO Network Physician — such as well-baby care, immunizations, routine physicals and annual gynecological exams — are covered by paying your $10, $20 or $30 office service copay under Prime and Standard Choice option and covered at 100% under the Basic Medical Plan. In addition, associated diagnostic tests that frequently can’t be performed in the Physician’s office — such as outside lab work and x-ray services for mammograms, and sigmoidoscopy — are paid at 90% for Prime and Standard Choice.
and 100% for Basic with no deductible, if you use a BCBS PPO Network free-standing laboratory, radiology facility, or Hospital outpatient department.

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

- **Health Management** – Helps you learn more so you can manage chronic health conditions including Asthma, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), Diabetes, Heart failure, High Blood Pressure, High Cholesterol, and Migraine. For more information on these programs call (855) 838-5897 Option 2.

- **Essential Advocate** – Allows you to call a registered nurse toll-free at (888) 521-2583, 24 hours a day 7 days a week to assess symptoms or get professional advice.

- **Informed Health** is a technology-based clinical risk support tool. It analyzes your health care, laboratory and pharmacy claim data to uncover medical errors, and improve your care.

- **Maternity Care** is designed to give a member better chance at having a healthier pregnancy and giving their babies a great start in life. To participate in this program call (855) 838-5897 Option 3.

- **Men’s and Women’s Health** program targets members 40 and older who have not received a recommended preventive screening by sending them informational materials and reminders.

- **Quit for Life** helps you to quit smoking. Participation is voluntary and confidential. To participate call (866) 784-8454.

- **Weight Management** is a confidential program that provides materials and support to help the member achieve and maintain a healthier weight. To participate call (855) 838-5897 Option 2.

Employee Assistance Program (EAP)
The Employee Assistance Program offers you resources to help with a variety of life’s challenges. The EAP is available in the form of free and confidential counseling. EAP services are provided on-site to all SRNS employees and can also be provided through Companion Benefits Alternative (CBA) for employees and their dependents utilizing off-site providers. Employees that have entered into a Substance Abuse Rehabilitation Agreement with Site Medical must utilize the on-site EAP Coordinator for the required follow-up visits.

EAP services are available through the EAP Coordinator at 2-8728. Off-site EAP services through Companion Benefit Alternatives, a partner of Blue Cross Blue Shield are available through CBA at (800) 790-5770.

The EAP offers short-term counseling for mental health concerns like depression, anxiety, stress, family conflict, addictions, or grief and loss. They are available to help when you come across any situations like these in your life. In addition to the counseling and life management services offered, our website includes e-learning modules and enhanced content including:

- E-Learning Courses – unlimited access to online courses on a wide variety of personal and professional growth topics
- Balanced/Family Life – more than 400 articles; more than 100 interactive tools and videos
- Health and Wellness – more than 2,000 Harvard Medical School-reviewed articles; more than 700 videos; dozens of health assessments
- Legal – more than 1,000 articles; hundreds of state-specific legal forms
- Financial – more than 1,000 articles; 140 calculators; 95 common federal tax forms; thousands of state-specific tax forms
- Mental Health – more than 400 articles; more than 50 videos and quizzes; six mental health assessments
- Stress – more than 4,800 articles and resources; hundreds of videos; multiple calculators and forms

To access this content, simply enter “SRNS” when prompted for your company code.
# PARTICIPATING IN THE MEDICAL PLAN

## Eligibility

<table>
<thead>
<tr>
<th>Employee/Retiree Type</th>
<th>Coverage Eligibility at a Glance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Service Employees (including Craft Option A, but excluding Craft Option B Union workers) (1)</td>
<td>Yes, eligible unless covered under the Savannah River Nuclear Solutions LLC Plan. Also, you can't be covered both as an employee and a dependent under the Plan.</td>
</tr>
<tr>
<td>Terminated Employees and Retirees (2)</td>
<td>No, not eligible. (Eligibility for retirees is described in the SRNS Pre-65 Retiree Health Plan or the Retiree Reimbursement Account SPD)</td>
</tr>
<tr>
<td>DuPont retiree rehires (and their spouses)</td>
<td>No, not eligible</td>
</tr>
</tbody>
</table>

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

(1) If you are a Full Service employee Non-Craft or an Option A Craft Full Service employee, (regularly scheduled to work a minimum of 20 hours per week) you are eligible to enroll for Medical Plan coverage on your first day of active service with the Company, unless otherwise excluded. You are not eligible to participate in this Plan if you:

- are classified by the Employer as an independent contractor (regardless of whether that classification is controlling for federal employment tax purposes or under any other applicable federal, state, or local law and regardless of whether you are classified differently by a court or any federal, state, or local agency),
- perform services under an agreement between the Employer and a leasing organization,
- are a union employee of the Employer and the collective bargaining agreement does not provide for you to participate in this Plan,
- are a high school/post-secondary student participating in School-to-Work programs, or
- are retired from DuPont Savannah River Plant, and were rehired by WSRC or BSRI on 4/1/1989, (therefore you are not eligible for participation in the Medical Plan as an Active employee or as a retiree).

(2) If you are eligible for coverage as a retiree under a Medical Plan of SRR or SRNS, and you are currently an active SRNS employee, you will only be eligible for the Active employee Medical Benefit Plan. You will continue to be ineligible for the SRR or SRNS retiree Medical Plan until your employment with SRNS terminates. After your employment terminates you will be eligible for the same Health benefits as similarly situated retirees.

## Eligible Dependents

Your dependents that are eligible for enrollment in the Medical Plan include your lawful spouse (and your “children”.) Eligibility for spouses will be defined with validation of a state-recognized marriage certificate, including same sex marriage when recognized by state law through a valid marriage license. South Carolina common law will continue to have the same documentation requirements for attestation. Note that same sex marriage does not have the same tax treatment for benefits. The employee will have to pay imputed income tax for the employer contribution portion of the insurance for the domestic partner and/or his or her children.

**Note:** If you are divorced, your ex-spouse is no longer eligible to be covered as your dependent under the Medical Plan as of the date of your divorce decree. You have an obligation to notify us within 60 days of the effective date of the divorce. Coverage continuation for your ex-spouse may be available through COBRA Continuation Coverage.

Children include your own children, your legally adopted children (from the time they are legally placed with you), your stepchildren who primarily reside with you and children supported solely by you for whom you have been appointed legal guardian.
You will be required to provide proof to the Service Center for authorization of eligibility by the Plan of legal guardianship, adoption, or Qualified Medical Child Support Order that requires you to provide coverage for the child. (See Glossary Section of this book for the definition and requirements of Medical Child Support Order)

Your child must be under age 26 or satisfy the disabled/handicapped qualifications if over age 26 (see below) and must not be eligible for other employer coverage except for coverage through their parents. Your disabled/handicapped dependent child may continue coverage after attainment of age 26 if your child meets all of the following requirements:

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

You must provide written proof of such dependency and incapability to BCBS for evaluation. You will be requested to periodically provide proof of the disability to continue the child’s eligibility under the Medical Plan. The coverage under this Plan for your disabled/handicapped dependent child as well as the coverage for your other dependents will end when your eligibility, for benefits under this Plan ends or you die. See the COBRA Continuation Coverage section for more information on extending your coverage.

The 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, in the event of fraud or misrepresentation, without reimbursement of premiums and may invoke the right to seek reimbursement for claims paid on any ineligible dependent.

Special Rules for “Dual” Couples
If you and your spouse are both employees or retirees of SRR or SRNS, you cannot be covered as both an employee or retiree and as a dependent under any Plans offered by either company.

A dependent child may not be covered by more than one SRR or SRNS employee or retiree. For example, you may elect to cover your eligible spouse and child, while your spouse elects to waive his/her coverage. Alternatively, you may elect coverage for yourself and your child, while your spouse elects 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.)

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

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

During new hire orientation, you will be asked to enroll yourself and your eligible dependents in the Plan. You will have two weeks from your date of hire to make any changes to your elections. 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 (if you elect to cover them during the next annual enrollment period) unless you have a Qualifying Change in Status as described below.

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

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

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

Effective January 1, 2013
To add or remove eligible dependents from your coverage with a Qualified Change in Status, complete OSR Form 5-200 (available on In-Site and/or by contacting the Service Center). Submit the form and supporting documentation to SRNS Benefits Solutions Service Center, Bldg. 703-47A, Aiken, SC 29808 within 60 days of the Qualifying Change in Status. Any change you request to make under the Plan must be consistent with your Qualifying Change in Status. You can only change the Plan option (Prime, Standard or Basic) during the Open Enrollment period (to be effective the following January 1).

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

You will only be able to add or delete a dependent and change your level of coverage (employee, employee plus one dependent, employee plus two or more dependents, or waiver) under your medical care elections as a result of a Qualifying Change in Status. You will not be able to change the option (Prime, Standard, or Basic) that you elected.

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

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

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

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

Do not call the BCBS Claims Administrator with information on a Qualifying Change in Status or an address change. Contact the SRNS Benefits Solutions Service Center instead.

The benefit change you want to make must be consistent with the Qualifying Change In Status. That is, the event must result in the employee, spouse or dependent child gaining or losing eligibility for coverage under either the Medical Plan or the spouse’s or dependent child’s employer’s plan.

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

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

- A change in legal marital status – an event that changes an employee’s legal marital status, including marriage, death of spouse, divorce, legal separation or annulment;

- A change in number of dependents – an event that changes an employee’s number of dependent children, including birth, adoption, placement for adoption, death of a dependent child, the acquisition of a stepchild who will reside in your household or as a result of a judgment, decree, or order including a Qualified Medical Child Support Order;

- A change in employment status – the termination or commencement of employment by the employee, spouse or dependent child or the commencement of or return from unpaid leave of absence;

- A change in which a dependent child satisfies or ceases to satisfy the Plan’s eligibility requirements – an event that causes an employee’s dependent child to satisfy or cease to satisfy the requirements for coverage due to attainment of maximum age under the Plan or any similar circumstance under the Plan that qualifies or disqualifies the child for coverage under the Plan;
• A change due to enrollment in Medicare or Medicaid – an employee, spouse or dependent child becomes entitled to and enrolls in Medicare (Part A or B) or Medicaid;

• A special enrollment right for eligible persons can arise due to a loss of eligibility for coverage under a group health plan, health insurance, or Medicaid or Medicare subsidy.

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

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

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

You and the Company share in the cost of the Medical Plan 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. 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 Change in Status date. Your premium will be determined by the Plan option 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.

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. On January 1, 2013, a same sex marriage does not have the same tax treatment for benefits. The employee will have to pay imputed income tax for the partner benefits and/or his or her children. The Plan will comply with federal and state tax laws that are in effect at the time the coverage is in effect. 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.

When Coverage Ends
Your coverage ends:

• When you no longer elect to be covered by one of the medical options,

• When you no longer meet eligibility requirements or

• When you fail to make the required premium contributions by their due date.

Coverage for your dependents ends when:

• you no longer elect to cover them (during annual open enrollment) or

• they no longer meet the eligibility requirements or

• a Change in Status occurs (and as a result, you elect to remove a dependent from medical coverage). You will be required to provide proof of the Change in Status to the Service Center within 60 days of the event or

• your coverage ends.
Coverage under this Plan for you and your dependents ends on the last day of your applicable pay period if you terminate employment unless you are approved for Long Term Disability. If your premiums for medical coverage cannot be deducted from your payroll or 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 the “COBRA” section)

Coverage Continuation in Special Situations
If you are involuntarily laid off and are a full-service employee, you may elect to receive Displaced Worker’s Medical benefits, as may be provided under a workforce restructuring program, in lieu of COBRA Continuation Coverage or you may choose COBRA continuation coverage.

If you terminate your employment, 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.

If you are an “Incumbent” employee under the terms of the Pension Plan and you terminate employment and meet the Pension Plan eligibility for retirement provisions under the Normal, Early, Optional or Incapability Retirement provisions of the Pension Plan, you may be eligible for participation in the Pre-65 Retiree Medical Plan or the Retiree Reimbursement Account as a retiree unless otherwise excluded. See the Pre-65 Retiree Medical Plan SPD or Retiree Reimbursement Account Summary Plan Description for eligibility requirements.

Rights to continuing medical coverage in retirement do not apply to employees with a vested deferred pension from the Pension Plan or to terminated Non-Incumbent Employees who are not eligible to participate in the Pension Plan.

If you are a “Non-Incumbent” employee under the terms of the Pension Plan and you terminate your employment and/or retire, coverage for you and your dependents will end the last day of the pay period in which you are a full service employee. You may be eligible for COBRA continuation coverage.

If you are approved for Long-Term Disability under the Disability Income Plan, you will be eligible to continue coverage under this Medical Plan in lieu of COBRA continuation coverage for up to 24 months from the date your employment ends. At the end of this maximum 24-month period, your medical coverage ends; however, you may then become eligible for Medicare.

If you die, coverage for your dependents will end on the last day of the pay period in which you die. Your dependents may be eligible for coverage under the Retiree Medical Plan if you were an Incumbent employee had 15 years of Eligibility Service as defined in the Pension Plan. Specific information on survivor benefits is described in the Pre-65 Retiree Medical Plan Summary Plan Description. However, if your death is a result of an occupational injury or illness while you are a full-service employee of SRNS or while receiving Special Benefits for Occupational Related Disabilities under the SRNS Disability Income Plan, your eligible dependents may be able to continue coverage for the medical program for two years at rates determined appropriate by the Company, or until eligible for another employer Medical Plan, whichever comes first. Your survivors will be notified of the option(s) available.

If survivor benefits do not apply, your dependents will be eligible to continue their coverage by electing COBRA continuation coverage.

If you are on a Company approved paid leave of absence, your Medical Plan coverage for yourself and your dependents will continue as if you were actively at work.

If you are on a Company approved Unpaid Leave of Absence (LOA) such as a Family and Medical Leave, you will be able to continue your 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, which will be on an after tax basis. When you return from the Unpaid LOA as an active employee, your premium contributions will resume on a pre-tax deduction basis from your paycheck. Before your Unpaid LOA begins, be sure to contact the SRNS Benefits Service Center for additional information and instructions on making the required premium contributions.

If, while on a Company approved Unpaid LOA, you fail to make your premium payments in a timely manner (that is no later than 31 days after the beginning of the month), your Medical Plan 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 Medical Plan coverage that you had just prior
to the Unpaid LOA will resume, with premium contributions deducted on a pre-tax basis from your paycheck. However, you and your dependents will have forfeited 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 SRNS Medical Plan.

**If, you are absent from employment due to military service** - Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), you may have a right to continuation of benefits subject to the conditions described below.

Under USERRA, if you (or your eligible dependents) are covered under the Plan, and if you become absent from work due to military leave, you (or your eligible dependents) may have the right to elect to continue health coverage under the Plan. In order to be eligible for coverage during the period that you are absent from work on military leave, you must give reasonable notice to the Company of your military leave. During military leave, you are required to pay the Company for the entire cost of such coverage, including any elected dependents’ coverage. Be sure to contact the Service Center for additional information and instructions on making the required premium contributions.

You will be entitled to COBRA-like rights with respect to your medical benefits in that you and your dependents can elect to continue coverage under the Plan for up to 24 months from the date the military leave commences or the length of uniformed service, whichever is shorter.

An employee returning from military leave is guaranteed the right to reinstatement in the Medical Plan without any waiting periods. If, while on a military leave of absence, you fail to make your premium payments in a timely manner (no later than 31 days after the beginning of the month), your Medical Plan 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 military leave, the Medical Plan coverage that you had just prior to the military leave will resume, with premium contributions deducted on a pre-tax basis from your paycheck. However, you and your dependents will have forfeited medical coverage during the period of time that you did not pay the required premium contributions. Medical claims incurred by you or your eligible dependents during that uncovered period of time will not be paid by the SRNS Medical Plan.
PLAN CHOICES (see the “Benefits at a Glance” chart)

When you enroll in the Plan, you choose the level of coverage that’s right for you — or you can elect no medical coverage. Prime Choice, Standard Choice, and Basic Choice (High Deductible Health Plan) each offer a choice of Network and non-Network care.

Prime Choice
This option gives you the choice of receiving medical care from Providers selected to be part of the BCBS “Preferred Blue” Medical Network or going to a Provider who is not part of the Medical Network.

When you go to a Network primary care Physician, such as a family doctor, internist, pediatrician, gynecologist, psychiatrist or psychologist, you pay a $10 copay for the office visit.  This may consist of one or more of the following: exam, in-office lab work or in-office x-ray. When you see a Specialist, (e.g. Neurologist, Dermatologist, or Podiatrist, etc), you pay a $20 copay. If you receive certain additional covered services (e.g., surgery performed in the Physician’s office), your cost (coinsurance) is 10% of the discounted fee for the additional covered services plus your $10 or $20 copay.

For non-Network services, you must pay a deductible before the Plan 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. Some services are not covered at all unless you use specific Providers. For example, scheduled preventive care services are not covered unless a Network Physician is utilized.

If you go to either a Network or non-Network Provider, most other covered expenses will be reimbursed, up to 90% of the BCBS 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 Drugs, you must pay the individual annual deductible of $200 per person ($400 for your entire family) before the Prime Choice option begins to reimburse your medications at 90% for Generic medications, 80% for Preferred medications and 70% for Non-Preferred Brand Name Drugs. See information regarding Mail Order and other pharmacy benefit program requirements under the “Prescription Drugs” section.

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

When you go to a Network primary care Physician, such as a family doctor, internist, pediatrician, gynecologist, psychiatrist, or psychologist, you pay a $20 copay for the office service, which might consist of one or more of the following: exam, in-office lab work or in-office x-ray. When you see a Specialist (e.g. Neurologist, Dermatologist, or Podiatrist, etc), you pay a $30 copay. If you receive certain additional covered services (e.g., surgery performed in the Physician’s office), your cost (coinsurance) is 10% of the discounted fee for the additional covered services plus your $20 or $30 copay.

For non-Network services, you must pay a deductible before the Plan 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 the Prime Choice option, your out-of-pocket maximum includes your deductible and coinsurance, but not your office service copay or charges incurred for non-covered expenses. Some services are not covered at all unless you use specific Providers. For example, scheduled preventive care services are not covered unless a Network Physician is utilized.

If you go to either a Network or a non-Network Provider, most other covered expenses will be reimbursed up to 90% of the BCBS 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 Drugs, you must pay the annual deductible of $400 per person ($800 for your entire family) before the Plan begins to reimburse you at 90% for Generic medications, 80% for Preferred medications and 70% for...
Non-Preferred Brand Name Drugs. See information regarding Mail Order and other pharmacy benefit requirements under the “Prescription Drugs” section.

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

The Basic Choice Medical Plan offers significantly lower premiums than the Prime and Standard Medical Plans, but requires that you meet a higher deductible before reimbursement for most covered services. Also, once you are enrolled in the Basic Choice High Deductible Health Plan, you are eligible to establish a tax advantaged Health Savings Account (HSA) to pay for eligible health care expenses. The Health Savings Account offers you a triple tax advantage - tax deductible contributions, tax-free while you are saving and tax free distributions for eligible expenses.

Charges under the Basic Choice option are subject to payment after the deductible and are reimbursed at 80% of BCBS Allowed Amount. However, preventive services are covered at 100% before the Deductible if you utilize a BCBS Network Provider. The Basic Plan meets the IRS criteria as a Health Savings Account compatible health Plan. A Health Savings Account or HSA is a tax-advantaged account that you can set aside tax-free dollars to pay eligible health expenses. The company will provide a lump sum contribution for 2013 into a Health Savings Account with HSA Bank in the amount of $250 for single coverage and $500 for employee plus one or more covered dependents. The amount of the contribution will be evaluated each year and announced during open enrollment. As an active employee, you may contribute to your HSA through pre-tax payroll deductions that you authorize. The 2013 IRC annual contribution limits into your HSA are as follows and are reduced by the amount the company contributes:

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>Contribution Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual with self-only</td>
<td>$3,250</td>
</tr>
<tr>
<td>Individual with EE+1 or family</td>
<td>$6,450</td>
</tr>
</tbody>
</table>

If you are 55 years of age or older, your annual contribution limit is increased by $1,000. Your unused balance in your HSA rolls over from year to year allowing your account balance to grow tax-free. You are permitted to make payroll contribution changes at any time throughout the year without a qualifying event. You are the owner of your HSA and are responsible for maintaining records of your medical expenses that satisfy IRS requirements. You are no longer eligible to contribute to a HSA once you are enrolled in Medicare.

**Health Savings Account Mid-year Eligibility Changes**

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

The sum of your contributions into your HSA can vary but the sum of your calendar year contributions cannot exceed the annual contribution limit. The following are examples of three mid-year changes in eligibility and the potential impact to your HSA:

- **An individual who gains eligibility mid-year** is limited to the sum of the monthly contribution limits for the months of eligibility. For example, an individual who becomes HSA eligible May 1st and remains eligible to the end of the year is limited to 8/12ths (May through December) of the annual contribution maximum for his or her applicable coverage.

- **An individual who loses eligibility mid-year** is limited to the sum of the monthly contribution limits for the months prior to losing eligibility. For example, an individual who was eligible at the start of the year and loses eligibility July 31st is limited to 7/12ths (January through July) of the annual maximum for the applicable coverage type.

- **An individual who is HSA eligible but changes HDHP coverage type mid-year** is limited to the sum of the monthly contribution amounts for the months covered by self-only plus the months covered by family HDHP coverage. For example, an individual who was eligible for self-only HDHP coverage at the start of the year and changes to family HDHP coverage on April 1 for the remainder of the year is eligible for the sum of 3 months of self-only contribution (January through March) and 9 months (April through December) of family contribution.

In addition, HSA regulations include a full-contribution rule, giving individuals who are HSA-eligible in December the opportunity to make a contribution for the calendar year that is the greater of the sum of their monthly contribution limits for the months their coverage was actually in place or the annual limit allowed for the coverage type that is in place on December 1st. Individuals who make use of the full contribution rule must remain HSA-eligible from December 1 of the year the contribution is for until December 31 of the following year (13 months).
If not, any contributions in excess of the sum of the monthly maximums are treated as taxable income plus an additional 10 percent tax.

Here’s an example to illustrate use of the full contribution rule:
- John enrolled in family HDHP coverage October 1, 2013 (no HDHP coverage prior) and uses the full-contribution rule
- John’s monthly maximum sum is $1,612.50 ($6,450/12 months X 3 months)
- John makes the full $6,450 contribution
- John’s additional contributions are $4,837.50
- John must remain HSA-eligible until December 31 of the following year
- If not, he is taxed on the additional contributions of $4,837.50

Under the Basic Choice (High Deductible Health Plan) option:
- you pay the lowest amount in premiums,
- your deductible and coinsurance amounts are higher,
- preventive care is covered at 100% before deductible for services included on the BCBS preventative schedule, and
- you are eligible to make pre-tax payroll contribution into a tax advantaged Health Savings Account

The individual deductible (for single coverage) of $1,250 is applied before you are reimbursed for most covered services. However, if you are enrolled in employee +1, or family coverage, the entire family deductible of $2,500 applies before any reimbursement is made for most covered services. After you have paid your deductible, this option then reimburses you for covered expenses at 80% of the Allowable Charge (70% of the Allowable Charge when you use an emergency room for routine, non-emergency care). When combined, the maximum you will pay out of your pocket in deductibles and coinsurance amounts for covered services will be $4,500 in a calendar year if you are enrolled in single coverage or $9,000 if you are enrolled in employee + one or family coverage. As with the Prime Choice and Standard Choice options, you pay the full cost of non-Covered Expenses

**How the Options Are Similar**
In many ways, all three options are alike. They...

• **Cover the same health care expenses overall.**

• **Exclude the same expenses.** Exclusions are listed in a later section.

• Are designed so that your share of the cost is limited when the cost of covered treatment exceeds specified amounts (annual out-of-pocket maximum expenses for covered services).

• Provide the same maximum annual benefits for covered services.

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

**Deductibles**

<table>
<thead>
<tr>
<th>Plan</th>
<th>Prime Choice</th>
<th>Standard Choice</th>
<th>Basic Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013 Annual Deductible</td>
<td>$200/person $400/family</td>
<td>$400/person $800/family</td>
<td>$1,250/individual $2,500/family</td>
</tr>
</tbody>
</table>

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

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

The **Individual Deductible** is the amount that must be paid by one person each calendar year. It applies to the Prime Choice and Standard Choice options, and to single coverage under the Basic Choice option.
The **Family Deductible** is twice the individual deductible. It can be met two ways under the Prime Choice and Standard Choice options:

- 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.

Under the Basic Choice option, the deductibles are aggregated. If you cover one or more dependents, the entire family deductible ($2,500) must be met before any reimbursement is made by the Medical Plan.

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

**Do These Expenses Count Toward Your Deductible?**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered services rendered by non-Network Providers, if you are enrolled in Prime Choice or Standard Choice</td>
<td>Copays for Network Physicians’ office services.</td>
</tr>
<tr>
<td>All covered expenses, if you are enrolled in Basic Choice</td>
<td>The 10% and 20% coinsurance amount you pay for services provided by Network Physicians.</td>
</tr>
<tr>
<td>Prescription drugs (yes unless otherwise excluded)</td>
<td>Expenses that are not covered by your medical option</td>
</tr>
<tr>
<td>Non-emergency use of the Emergency Room</td>
<td>Penalties incurred for hospital stays that have not been pre-certified.</td>
</tr>
<tr>
<td></td>
<td>Expenses above what is considered the BCBS Allowable Charge and/or Maximum Payment for each covered service.</td>
</tr>
<tr>
<td></td>
<td>Non-covered expenses (including but not limited to the cost of non-covered prescription drugs under the Mandatory Generic, Step Therapy, and Quantity Management programs)</td>
</tr>
</tbody>
</table>
Wellness Initiatives and Vanishing Deductible

You and your spouse will each have the opportunity in 2013 to earn up to $250 in wellness credits to be applied to the deductible or added to your Health Savings Account if you are enrolled in the Basic High Deductible Health Plan for the 2014 Plan year. Dependent children of any age are not eligible to earn wellness credits. Each activity equals a $125 of deductible credit, with a maximum credit of $250 per eligible participant. Your action in 2013 to earn wellness credits will save you money in 2014. Actual incentives may be added or modified from Plan year to Plan year.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Who's Eligible</th>
<th>Reward*</th>
<th>Reward Rules*</th>
<th>How To Get It for 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Wellness Exam (physical or GYN exam)</td>
<td>Employee and covered spouse</td>
<td>$125 deductible credit</td>
<td>One per eligible participant per year</td>
<td>Physician files claim directly to BlueCross. Exam must be completed between 11/1/12 and 10/31/13.</td>
</tr>
<tr>
<td>Weight Management Health Coaching Ph. (800) 334-7287 select option 2</td>
<td>Employee and covered spouse</td>
<td>$125 deductible credit</td>
<td>One per eligible participant per year</td>
<td>Complete four coaching sessions with assigned coach between 1/1/13 and 10/31/13.</td>
</tr>
<tr>
<td>Quit for Life Tobacco Health Coaching Ph. (866) 784-8454</td>
<td>Employee and covered spouse</td>
<td>$125 deductible credit</td>
<td>One per eligible participant per year</td>
<td>Complete five contacts with assigned coach between 1/1/13 and 10/31/13.</td>
</tr>
<tr>
<td>Personal Health Assessment (PHA) <a href="http://www.southcarolina">www.southcarolina</a> blues.com</td>
<td>Employee and covered spouse</td>
<td>$125 deductible credit</td>
<td>One per eligible participant per year</td>
<td>Complete online through My Health Toolkit between 1/1/13 and 10/31/13.</td>
</tr>
<tr>
<td>Regular gym attendance</td>
<td>Employee and covered spouse</td>
<td>$125 deductible credit</td>
<td>One per eligible participant per year</td>
<td>Complete 110 workout sessions at a gym between 1/1/13 and 10/31/13. Submit the printout of visits to the Benefits Service Center</td>
</tr>
</tbody>
</table>

*For those in the Basic High Deductible Health Plan, rather than a reduction to your deductible you will receive additional funding into your HSA for completed activities up to the maximum allowed.

The Impact on 2014 Deductible of Wellness Credits Completed in 2013 (Standard Choice example)

<table>
<thead>
<tr>
<th>Employee + Spouse</th>
<th>Completed Credits</th>
<th>Individual Deductible</th>
<th>Family Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>1</td>
<td>$475</td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>0</td>
<td>$600</td>
<td>$1,075</td>
</tr>
<tr>
<td>Employee</td>
<td>2</td>
<td>$350</td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>0</td>
<td>$600</td>
<td>$950</td>
</tr>
<tr>
<td>Employee</td>
<td>2</td>
<td>$350</td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>1</td>
<td>$475</td>
<td>$825</td>
</tr>
<tr>
<td>Employee</td>
<td>2</td>
<td>$350</td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>2</td>
<td>$350</td>
<td>$700</td>
</tr>
</tbody>
</table>
Out-of-Pocket Maximum

<table>
<thead>
<tr>
<th>Plan</th>
<th>Prime Choice</th>
<th>Standard Choice</th>
<th>Basic Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013 Annual Out-of-Pocket Maximum for Covered Services</td>
<td>$1,000/person $2,000/family</td>
<td>$2,000/person $4,000/family</td>
<td>$4,500/individual $9,000/family</td>
</tr>
</tbody>
</table>

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 BCBS Allowable charge or the BCBS Maximum Payment up to the Annual Maximum Benefits. The out-of-pocket maximum is designed to protect you against having to pay extraordinary medical bills in a given year.

The family out-of-pocket maximum works the same way as the family deductible. Under the Prime Choice and Standard Choice options, once one family member has reached the maximum for the year, the covered expenses of all other family members can be combined to reach the family out-of-pocket maximum amount.

Under the Basic Choice option, the out-of-pocket maximums are aggregated. This means that if you cover one or more dependents, the entire family out-of-pocket maximum ($9,000) must be met before the Medical Plan will begin to pay covered expenses at 100%.

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

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

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your deductibles—$200/$400, $400/$800 or $1,250/$2,500—depending on the option you are enrolled in</td>
<td>The $10, $20, or $30 copay for Network &amp; Specialist Physicians' office services under the Prime Choice or Standard Choice options</td>
</tr>
<tr>
<td>Your coinsurance amounts —10%, 20% or 30%—for most Medically Necessary services</td>
<td>Medical expenses that are not covered by your medical option, including but not limited to:</td>
</tr>
<tr>
<td></td>
<td>Penalties incurred for hospital stays or major out-patient diagnostic procedures (MRI, MRA, CT scans, PET scans, etc.) that have not been pre-certified.</td>
</tr>
<tr>
<td></td>
<td>Expenses above the Allowable charge and/or Maximum Payment for each covered service.</td>
</tr>
<tr>
<td></td>
<td>The non-covered prescription drugs under the Mandatory Generic, Step Therapy, and Quantity Management programs.</td>
</tr>
</tbody>
</table>

**Network Physician Office Visit Co-pay**

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

The following provides you with guidelines on when to pay your copay ($10, $20, or $30) or coinsurance (10%) amounts when you go to a Network Provider under the Prime Choice and Standard Choice options:
Pay your copay:
- Physician’s office visit or
- Office visit with lab and/or x-ray or
- Lab and/or x-ray only in Network Physician’s office.

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

<table>
<thead>
<tr>
<th>Type of Physician</th>
<th>Prime Choice Option</th>
<th>Standard Choice Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>$10</td>
<td>$20</td>
</tr>
<tr>
<td>Specialist</td>
<td>$20</td>
<td>$30</td>
</tr>
</tbody>
</table>

The copay for office visits to a primary care Physician (such as a family doctor, internist, pediatrician, gynecologist, psychologist and psychiatrist) will be the lower copay amount. A 10% employee coinsurance amount for physical/occupational therapy, chiropractic treatment (maximum benefit of $750 per person per year) and allergy or hormone shots by a nurse in a Physician’s office will also apply.

**Allowable Charge and Maximum Payment**

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

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

**Your Share of Expenses**

There are certain expenses that you are responsible for, including:
- The deductible, coinsurance amounts and copays,
- Any expenses above the Maximum Payment,
- Expenses not covered,
- Charges that exceed the Annual Maximum Benefit amount (see paragraph below “Annual Maximum Benefit”)
- Charges that exceed the option’s limitations on certain services and
- Any charges for procedures that are not considered to be Medically Necessary.

**Annual Maximum Benefit**

Regardless of the option you choose, the maximum benefit payable by the Plan is $2,000,000 per person per year, effective January 1, 2013.
THE MEDICAL PROVIDER NETWORK

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

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

Locating PPO Network Providers
The PPO Providers in the Network may sometimes change. For the most current information on network status, check with your provider or check on-line at the BCBS South Carolina website at http://www.southcarolinablues.com or at the BCBS Association website at http://www.bluecard.com. Both websites provide access to PPO Providers nationwide as well as worldwide. You can also call BCBS at 1-800-325-6596 or for Providers located nationwide you can contact the Blue Cross Association at 1-800-810-Blue (2583). For information on Providers located outside of the United States, you should contact Blue Card Worldwide Service at 1-800-810-Blue (2583) or call collect to 1-804-673-1177.

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

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

Generally, when using a PPO Network Physician, you pay just your copay at the time you receive care (there are some exceptions, such as minor surgery performed in the office). Most PPO Network Physicians will collect the remainder of their fees directly from BCBS and then bill you if there is any balance due for services not covered under the medical option you have chosen.

If you visit a Physician who is not in the PPO 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 BCBS. If another medical insurance plan (such as your spouse’s employer's plan) provides primary coverage on one or more of your dependents, certain Coordination of Benefits (COB) rules apply. Refer to the COB section in this booklet for more information.

When You Must Be Hospitalized or Need to See a Specialist
If your Physician is in the PPO Network and he/she refers you to another medical Provider, ask your Physician if you can be referred to a specialist or hospital in the PPO Network so you receive maximum benefits. A referral from a PPO Network Physician is no guarantee that the specialist or hospital you are referred to is in the PPO Network. It is up to you to ensure your Providers are participants in the Claim Administrator’s PPO 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 PPO Network coverage goes with you. But, when your treatment is of a non-emergency nature, be sure to call BCBS Customer Service number listed on your BCBS ID card to determine if there is a Network Provider that can meet your needs in the area where you’re staying.

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

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

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

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

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

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

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

Pre-Authorization Requirements

- In-Patient Admissions
  - Hospital
  - Skilled Nursing Facilities
  - Long Term Acute Care (LTAC)
  - In-patient Rehab
  - Mental Health/Substance Abuse Facilities
  - Residential Treatment Facilities
- Durable Medical Equipment (DME) – Purchase price of $500 or greater (note, this applies to both rentals and purchases)
- Home Health Services – Care provided in the home when member is homebound
- Hospice
- Transplants
- Private Duty Nursing – services provided by an RN or LPN (inpatient and home health)
- Out-Patient Services* (see below)
  - Mental Health/Substance Abuse Outpatient Facility Services
  - Potentially experimental/investigation procedures.
  - Chemotherapy and Radiology therapy. We request a one-time notification; no penalty will be applied if not obtained.
- Advanced Imaging Services
  - MRI
  - MRA
  - PET Scan
  - CT Scan
- Bariatric Procedures for the treatment of obesity
• Certain medications have been identified as requiring prior authorization. This list can be viewed online by logging onto My Health Toolkit

• Specialty Drugs

• Out-Patient
  - Sclerotherapy (treatment for varicose veins)
  - Septoplasty (surgical correction to nasal septum)
  - Surgical Procedures that may potentially be cosmetic (such as: Blepharoplasty, Reduction Mammaplasty)
  - Hysterectomy
  - Potentially experimental/investigation procedures
  - Chemotherapy and Radiology therapy. We request a one-time notification; no penalty will be applied if not obtained

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

Medical policies are available for review on the www.southcarolinablues.com provider portal.

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

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

For Hospital admissions and Pre-Authorization of certain other services as outlined above, contact the Claims Administrator (BCBS or for Behavioral Health services Companion Benefit Alternatives). When you call, a nurse will request the following information:
• Employee’s name, BCBS identification number, address and phone number,
• Patient’s name,
• Name, address and phone number of the attending Physician, and
• If a hospital admission, the name and address of the hospital, scheduled admission date, and reason for admission, or if Pre-Authorization for another medical service is requested, the details regarding its medical necessity.

What if You Don’t Pre-certify Your Hospital Stay?
If Pre-Authorization is not obtained, room and board charges will be denied for inpatient hospital stays at an in-network facility. For an in-patient hospital stay at out of network facilities, a $200 penalty will be applied. If Pre-Authorization is not obtained or approved by BCBS for Mental Health and Substance Abuse Services, the following penalties will apply Inpatient - Denial of room and board and Outpatient - $200 penalty.

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

If you stay in the hospital beyond the days certified by the Claims Administrator benefits for the additional days may not be allowed.
These unpaid expenses will be your responsibility and will not count toward your deductible or your annual out-of-pocket maximum.

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

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

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

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

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

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

**Transplants–Blue Distinction Centers for Transplants**
BCBS has contracted with many of the leading transplant care facilities in the nation to provide these services. These institutes have specific expertise in transplant procedures and post-transplant care.

If you or your covered dependent is considering any type of transplant, you or your Physician should contact the BCBS pre-admission review number shown on the front of your ID card to discuss the care required. If the transplant is determined to be Medically Necessary by BCBS, you will be directed to the Blue Distinction Center best qualified to perform the specific transplant required.

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

- The cost of round-trip airline tickets (or personal vehicle travel expenses will be reimbursed at the mileage rate set by the Federal Travel Regulations at the time of the travel.) For the pre-transplant work-up, the actual transplant procedure and post-transplant care, for both the patient and a family member* or companion (airline ticket receipts are required, if flying),

- The actual cost of lodging (with a receipt, excluding any incidentals such as phone calls, etc.) up to $100 per day (combined expenses for the patient and a family member* or companion), and

- The actual cost of meals (with a receipt, excluding any incidentals such as tips, etc.) up to $40 per day per person for your family member* or companion, and up to $40 per day for the patient when the patient is not hospitalized during the trip.

- BCBS can provide you with specific reimbursement guidelines and instructions.

* Travel expenses for two family members are reimbursable when the patient is a dependent child.
COVERED MEDICAL EXPENSES
A portion of most Medically Necessary services and supplies, both inside and outside of a hospital are covered. BCBS will determine if a claim is to be considered Medically Necessary for the diagnosis, care or treatment of an illness, injury or pregnancy.

How much is paid depends on the option you choose and your Network or non-Network usage.

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

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

AMBULANCE
The Plan will pay Covered Expenses for ambulance transportation (including air ambulance when necessary) when used:
- Locally to or from a Hospital providing Medically Necessary services in connection with an accidental injury or that is the result of an Emergency Medical Condition, or
- To or from a Hospital in connection with an Admission, or
- One Hospital to another if the first hospital does not have the services/facilities to treat the patient, or
- Hospital to home or nursing home, or
- Home to Hospital for Medically Necessary inpatient/outpatient treatment.

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

CHIROPRACTIC SERVICES
The Plan will pay Covered Expenses for Services and Medical Supplies required in connection with the detection and correction, by manual or mechanical means, of structural imbalance, distortion, or subluxation in the human body, for purposes of removing nerve interference and the effects of such nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.
CHRISTIAN SCIENCE FACILITIES
The Plan will pay Covered Expenses for Pre-Authorized Christian Science Practitioner/Christian Science Facilities Admissions.

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

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

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

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

Employee Assistance Program (EAP)
The EAP offers free short-term counseling for mental health concerns like depression, anxiety, stress, family conflict, addictions, or grief and loss. In addition to the counseling and life management services offered, there are numerous resources available on the Companion Benefit Alternative website.

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

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

HOSPITAL SERVICES
The Plan will pay Covered Expenses for Admissions as follows:

- Semiprivate room, board, and general nursing care and,
- Private room, if you stay in a private room because no semiprivate room is available, or because your Physician determines and documents (and BCBS approves) that isolation is necessary and,
- Services performed in a Special Care Unit when it is Medically Necessary that such services be performed in such unit rather than in another portion of the Hospital and,
- Ancillary services and Medical Supplies including services performed in operating, recovery and delivery rooms and,
- Diagnostic services including interpretation of radiological and laboratory examinations, electrocardiograms, and electroencephalograms and,
- In a Long-Term Acute Care Hospital.
Benefits for Admissions are subject to the requirements for Pre-Admission Review, Emergency Admission Review, and Continued Stay Review.

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

**HUMAN ORGAN AND TISSUE TRANSPLANTS**

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

**INPATIENT HOSPITAL MEDICAL SERVICE**

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

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

**MEDICAL SUPPLIES**

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

**MENTAL HEALTH SERVICES**

The Plan will pay Covered Expenses for Mental Health Services including, but not limited to the following (see the Preauthorization Section for additional requirements):

- Bipolar Disorder;
- Major Depressive Disorder;
- Obsessive Compulsive Disorder;
- Paranoid and Other Psychotic Disorder;
- Schizoaffective Disorder;
- Schizophrenia;
- Anxiety Disorder;
- Post-traumatic Stress Disorder
- Depression in childhood and adolescence
- Dissociative Disorders
- Pervasive Development Disorders,
- Sexual and Gender Identity Disorders,
- Personality Disorders.

**ORTHOGNATHIC SURGERY**

The Plan will pay Covered Expenses for service related to the treatment of malpositions or deformities of the jaw bone(s), dysfunction of the muscles of mastication, or orthognathic deformities.
ORTHOPEDIC DEVICES
The Plan will pay Covered Expenses for Orthopedic Devices Pre-Authorized by the Claims Administrator.

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

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

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

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

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

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

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

RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES
If you are receiving Covered Expenses in connection with a mastectomy the Plan will pay Covered Expenses for each of the following:
  - Reconstruction of the breast on which the mastectomy has been performed; and
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - Prosthetic devices and physical complications at all stages of the mastectomy, including lymphedema.

REHABILITATION
The Plan will pay Covered Expenses for participation in a multidisciplinary team rehabilitation program only following severe neurologic or physical impairment if the following criteria are met:
  - All such treatment must be ordered by a medical doctor and
  - All such inpatient treatment requires Pre-Authorization by the Claims Administrator.
  - The documentation that accompanies a request for rehabilitation benefits must contain a detailed evaluation from a medical doctor that documents to a degree of medical certainty your rehabilitation potential is such that there is an expectation that you will achieve an ability to provide self-care and perform activities of daily living.

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

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

**SKILLED NURSING FACILITY SERVICES**
The Plan will pay Covered Expenses for Admissions in a Skilled Nursing Facility as follows:

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

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

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

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

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

- Surgical Services, subject to the following:
  - If two (2) or more operations or procedures are performed at the same time, through the same surgical opening or by the same surgical approach, the total amount covered for such procedures will be the Allowable Charge for the major procedure only.
  - If two (2) or more operations or procedures are performed at the same time, through different surgical openings or by different surgical approaches, the total amount covered will be the Allowable Charge for the operation or procedure having the highest Allowable Charge, plus one-half of Allowable Charge for all other operations or procedures performed.
  - If an operation consists of the excision of multiple skin lesions, the total amount covered will be the Allowable Charge for the procedure having the highest Allowable Charge, fifty (50%) percent for the procedure bearing the second and third highest Allowable Charges, twenty five (25%) percent for the procedures bearing the fourth through the eighth highest Allowable Charges and ten (10%) percent for all other procedures. However, if the operation consists of the excision of multiple malignant lesions, the total amount covered will be the Allowable Charge for the procedure having the highest Allowable Charge and fifty (50%) percent of the charge for each subsequent procedure.
If an operation or procedure is performed in two (2) or more steps or stages, coverage for the entire operation or procedure will be limited to the Allowable Charge set forth for such operation or procedure.

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

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

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

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

**TEMPOROMANDIBULAR JOINT (TMJ) DISORDER**

The Plan will pay Covered Expenses for any service for the treatment of dysfunctions or derangements of the temporomandibular joint, including orthognathic surgery for the treatment of dysfunctions or derangements of the temporomandibular joint.

**VOLUNTARY STERILIZATION**

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

Caremark is the Pharmacy Benefits Manager for BCBS and in that role administers the prescription drug program for this Plan.

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

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

The level of benefit paid by the Plan depends on whether the drug is generic, preferred brand (also called “formulary”) or non-preferred brand. Effective January 1, 2013, three drug management programs are being added to the Plan: Mandatory Generics, Step Therapy, and Quantity Management. Drug lists for these programs change periodically and updated information on these programs can be found by logging into My Health Toolkit. Select Benefits along the top, go to the Prescription Drug section and choose Drug Lists and Programs, or by calling BCBSSC Customer Service at 1-800-325-6596.

Mandatory Generic Prescriptions

Effective January 1, 2013, if you request a Preferred or Non-Preferred Brand Name Drug that has a generic equivalent, you will pay the appropriate brand cost share (20% for preferred and 30% for non-preferred) plus the cost difference between the brand and the generic. The cost difference between the Preferred or Non-Preferred Brand Name Drug and the generic equivalent does not count toward satisfaction of your deductible and/or out-of-pocket maximum limits.

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

Preferred Brand Drug Cost $80
- Generic Drug Cost - $30

= Brand/Generic Cost Difference $50
+ Member 20% Copayment for Preferred Drug + $16

= Total Amount Charged to Member $66

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

Non-Preferred Brand Drug Cost $100
- Generic Drug Cost - $20

= Brand/Generic Cost Difference = $ 80
+ Member 30% Copayment for Non-Preferred Drug +$30

= Copayment plus the cost difference = $110
- The amount over original drug cost - $10
= Total Amount Charged to Member = $100
This same policy also applies if your doctor indicates that your prescription should be dispensed as written, with no substitutions. In this case, your prescription is filled according to doctor’s orders. **However, you still must pay the brand copayment, as well as the difference in cost between the generic and brand name drug.** Speak to your doctor about the possibility of using generics instead of the more expensive brand name drugs.

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

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

When you go to the pharmacy, the pharmacist enters your prescription into the computer system. If your prescription is a Second Choice medication, the system will check your claims history. If you have filled prescriptions for First Choice medications, the pharmacist will fill your prescription for a Second Choice medication. In some cases, the system will also check for other medications you are using that may be unsafe to take with a First Choice medication. If one is found, the pharmacist will fill your prescription. If you are required to try a First Choice medication, you have three options:

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

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

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

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

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

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

For most medications on the list, the Plan will only cover a set amount within a set timeframe. The Plan will cover higher amounts of some medications when medically necessary.
Effective January 1, 2013

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

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

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

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

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

The Prime, Standard and Basic prescription drug coverage is as follows:

**Tier 1:** Generic Drugs (you pay 10%, the company pays 90%)
- Prime and Standard Medical Plans – you pay 10%, the company pays 90%
- Basic (High Deductible Health Plan) – you pay 20%, the company pays 80%

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

**Tier 2:** Preferred Brand-Name Drugs
- Prime and Standard Medical Plans – you pay 20%, the company pays 80% when no generic equivalent is available
- Basic (High Deductible Health Plan) – you pay 20%, the company pays 80%

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

**Tier 3:** Non-Preferred Brand-Name Drugs
- Prime and Standard Medical Plans – you pay 30%, the company pays 70% when no generic equivalent is available
- Basic (High Deductible Health Plan) – you pay 20%, the company pays 80%

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

**Prior Authorization**

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

The Prior Authorization program is based on FDA and manufacturing guidelines, medical literature, safety, accepted medical practice, appropriate use and benefit design. This program only affects the medication your benefit plan covers. You and your doctor should make the final decision about the medication that is right for you.
The list of drugs that require Prior Authorization is posted on the website. Log into My Health Toolkit. Select Benefits along the top, go to the Prescription Drug section and choose Drug Lists and Programs. If your doctor prescribes a medication that needs Prior Authorization, have your doctor call the Caremark Prior Authorization department at 1-800-294-5979. Your doctor can also fax requests to 888-836-0730.

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

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

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

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 identification card or
- You are filing claims as the secondary payer (in which case you will also need to include the Explanation of Benefits from the primary payer).

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

- Use a separate form for each family member
- Completely fill out Part One of the claim form
- For each family member, attach a drug receipt (arranged in date order by family member) that includes:
  - Date the prescription was filled
  - Name and address of the pharmacy
  - NDC number
  - Name of drug and strength
  - Quantity
  - Days supply
  - Prescription (Rx) Number
  - Amount paid

The Prescription Drug Claim Form should be mailed to BCBS at the address noted at the beginning of this book.
CHARGES NOT COVERED

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

ACUPUNCTURE
Acupuncture treatment or services.

ACTS OF WAR
Illness contracted or injury sustained as a result of participation as a combatant in a declared or undeclared war, or any act of war, or while in military service.

ADMISSIONS AND BEHAVIORAL HEALTH SERVICES THAT ARE NOT PRE-AUTHORIZED
If Pre-Authorization is not received for an otherwise Covered Expense related to an Admission or Behavioral Health Services, penalties will be applied (up to and including denial of the Covered Expenses) as specified in this booklet.

BENEFITS PROVIDED BY STATE OR FEDERAL PROGRAMS
Any service or charge for a service to the extent that you are entitled to payment or benefits relating to such service under any state or federal program that provides health care benefits, including Medicare, to the extent that benefits are paid or are payable under such programs.

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

CLINICAL PATHOLOGIST
Charges made by a clinical pathologist, as related to automated laboratory testing, for supervising a hospital’s laboratory.

COMPLICATIONS FROM FAILURE TO COMPLETE TREATMENT
Complications that occur because you did not follow the course of treatment prescribed by a Provider, including complications that occur because you left a hospital against medical advice.

COMPLICATIONS FROM NON-COVERED SERVICES
Charges related to complications of non-covered procedures including complications arising from the use of Discount Services.

CONVENIENCE ITEMS
Comfort or convenience items, or personal services.

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

COSMETIC SERVICES
- This Plan excludes cosmetic or reconstructive procedures and any related services or Medical Supplies, which alter appearance but do not restore or improve impaired physical function. Examples of services that are cosmetic and are not covered are:
  - Rhinoplasty (nose);
  - Mentoplasty (chin);
  - Rhytidoplasty (face lift);
  - Glabellar rhytidoplasty (forehead lift);
  - Surgical planning (dermabrasion);
o Blepharoplasty (eyelid);
  o Mammaryplasty (reduction, suspension or augmentation of the breast);
  o Superficial chemosurgery (chemical peel of the face) and,
  o Rhytidectomy (abdomen, legs, hips, buttocks, or elsewhere including lipectomy or adipectomy).

- A cosmetic service may, under certain circumstances, be considered restorative in nature. In order for Benefits to be available for such restorative surgery, the surgery must be Medically Necessary for prompt repair of a non-occupational injury or be related to a congenital defect of an eligible newborn child (up to one year in age) and the following requirements must be met:
  o The service must be necessary to correct a loss of physical function or alleviate significant pain or,
  o The service must be necessary due to a malappearance or deformity that was caused by physical trauma, surgery or congenital anomaly and,
  o The proposed surgery or treatment must be Pre-Authorized by BCBS.

CUSTODIAL OR LONG-TERM CARE SERVICES
Admissions or portions thereof for custodial care or long-term care, including:
- Rest care;
- Long-term acute or chronic psychiatric care;
- Care to assist in the performance of activities of daily living (including, but not limited to: walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation, and taking medication);
- Care in a sanitarium;
- Custodial or long-term care or,
- Psychiatric or substance abuse residential treatment, including: Therapeutic schools; Wilderness/Boot camps; Therapeutic Boarding Homes; Half-way Houses; and Therapeutic Group Homes.

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

DEVELOPMENTAL SPEECH THERAPY
Treatment for, or in connection with, developmental speech therapy. (Note: Restorative speech therapy is covered when it is expected to restore speech to an individual who has lost an existing speech function as a direct result from disease (such as a stroke) or injury or is related to or developed as a result of a cleft lip and palate, and the required Pre-Authorization is obtained from BCBS.)

DISCOUNT SERVICES
Any charges that result from the use of Discount Services including charges related to any injury or illness that results from your use of Discount Services. Discount Services are not covered under the Plan of Benefits and you must pay for Discounted Services.

DURABLE MEDICAL EQUIPMENT
Durable Medical Equipment expenses over $500 for which no Pre-Authorization was obtained from the Claims Administrator. Non-covered Medical Supplies include but are 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 BCBS determines does not meet the criteria.
EDUCATIONAL PROGRAMS
Educational programs or services, such as dietary instructions and weight loss programs (Note: A diabetic education program deemed to be a medical necessity by BCBS or educational programs included in My Health Essentials may be approved by BCBS).

ELECTIVE ABORTIONS
Elective abortions unless the life of the mother is threatened if she should carry the baby to term.

EYEGLASSES
Routine eye exams, eyeglasses or contact lenses of any type, even though dispensed by a prescription (except after cataract surgery) or examinations for the prescription or fitting of them. Radial keratotomy or other methods of refractive eye surgery.

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

FOOT CARE
Routine foot care such as paring of nails, calluses, or corns. Services and supplies related to nonsurgical treatment of the feet, including non-Medically Necessary orthopedic shoes, orthotic appliances or other supportive devices for the feet, solely used for comfort or athletics.

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

HUMAN ORGAN AND TISSUE TRANSPLANTS
Human organ and tissue transplants that are not:
- Pre-Authorized or,
- Performed by a Provider as designated by BCBS.

IMPACTED TOOTH REMOVAL
Services or Medical Supplies for the removal of impacted teeth.

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

INCAPACITATED DEPENDENTS
Any Service, Supply or Charge for an Incapacitated Dependent that is not enrolled before the maximum dependent child age of 26.

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

INJURY OR ILLNESS RESULTING FROM CRIMINAL ACTIVITY
Illness contracted or injury sustained as a result of participating in a riot or insurrection or while engaged in the commission of a felony or an illegal activity.

INPATIENT DIAGNOSTIC AND EVALUATIVE PROCEDURES
Inpatient care and related Physician Services rendered in conjunction with an Admission, which is principally for diagnostic studies or evaluative procedures that could have been performed on an outpatient basis are not covered unless your medical condition alone required Admission.
INVESTIGATIONAL OR EXPERIMENTAL SERVICES
Services or supplies or drugs that are considered Investigational or Experimental by the Claims Administrator.

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

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

MISSED PROVIDER APPOINTMENTS
Charges for an appointment with a Provider that you did not attend.

NO LEGAL OBLIGATION TO PAY
Any service, supply or charge you are not legally obligated to pay.

NOT MEDICALLY NECESSARY SERVICES OR SUPPLIES
Any service or supply that is not Medically Necessary as determined by the Claims Administrator. However, if a service
is determined to be not Medically Necessary by the Claims Administrator because it was not rendered in the least costly
setting, Covered Expenses will be paid in an amount equal to the amount payable had the service been rendered in the
least costly setting.

OBESITY RELATED PROCEDURES
  • Any Medical Supply or Service provided to you for the treatment of obesity or for the purpose of weight
reduction. This includes all procedures designed to restrict the Member’s ability to assimilate food, such as:
  gastric by-pass, the insertion of gastric bubbles, the wiring shut of the mouth, and any other procedure the
  purpose of which is to restrict your ability to take in food, digest food or assimilate nutrients, except when
  Medically Necessary as pre-approved by the Claims Administrator.

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

  • Membership fees to weight control programs.

OVER-THE-COUNTER DRUGS
Drugs that are available on an over-the-counter basis or otherwise available without a prescription. Over the counter
drugs are covered when required by the Step Therapy program and are obtained using a prescription from a physician.

PAIN MANAGEMENT PROGRAMS
Chronic pain management programs or multi-disciplinary pain management programs unless Medically Necessary as
approved by the Claims Administrator

PHYSICAL THERAPY ADMISSIONS
All Admissions solely for physical therapy, except for rehabilitation benefits as preapproved by the Claims Administrator.

PHYSICIAN CHARGES
Charges by a Physician for blood and blood derivatives and for charges for Prescription Drugs that are not consumed at
the Physician’s office.

PRE-MARITAL AND PRE-EMPLOYMENT EXAMINATIONS
Charges for services, supplies or fees for pre-marital or pre-employment examinations.

PRE-OPERATIVE ANESTHESIA CONSULTATION
Charges for pre-operative anesthesia consultation.
PRESCRIPTION DRUG EXCLUSIONS

Charges for:

- Prescription Drugs that have not been prescribed by a Physician;
- Any vitamins except for prenatal vitamins;
- Prescription Drugs not approved by the Food and Drug Administration;
- Prescription Drugs for non-covered therapies, services, or conditions;
- Prescription Drug refills in excess of the number specified on the Physician’s prescription order or Prescription Drug refills dispensed more than one (1) year after the original prescription date;
- More than a thirty one (31) day supply for Prescription Drugs (ninety (90) day supply for Prescription Drugs obtained through a Mail Service Pharmacy and or Generics obtained at retail);
- Any type of service or handling fee (with the exception of the dispensing fee charged by the pharmacist for filling a prescription) for Prescription Drugs, including fees for the administration or injection of a Prescription Drug, except for hormone and allergy injections by a Physician’s office which does not provide the serum or medication;
- Dosages that exceed the recommended daily dosage of any Prescription Drug as described in the current Physician’s Desk Reference or as recommended under the guidelines of the Pharmacy Benefit Manager, whichever is lower;
- Prescription Drugs used for or related to cosmetic purposes, including hair growth;
- Prescription Drugs related to any treatment for infertility or impotence, including but not limited to, fertility drugs;
- Prescription Drugs administered or dispensed in a Physician’s office, Skilled Nursing Facility, hospital or any other place that is not a Pharmacy licensed to dispense Prescription Drugs in the state where it is operated;
- Prescription Drugs for which there is an over-the-counter equivalent and over-the-counter supplies or supplements unless covered under the Step Therapy program;
- Prescription Drugs that are being prescribed for a specific medical condition that are not approved by the Food and Drug Administration for treatment of that condition (except for Prescription Drugs for a specific medical condition that has at least two (2) formal clinical studies or Prescription Drugs for the treatment of a specific type of cancer, provided the drug is recognized for treatment of that specific cancer in at least one standard, universally accepted reference compendia or is found to be safe and effective in formal clinical studies, the results of which have been published in peer reviewed professional medical journals);
- Prescription Drugs that are not consistent with the diagnosis and treatment of your illness, injury or condition, or are excessive in terms of the scope, duration, dosage or intensity of drug therapy that is needed to provide safe, adequate and appropriate care;
- Prescription Drugs or services that require Pre-Authorization by the Claims Administrator and Pre- Authorization is not obtained;
- Prescription Drugs for injury or illness that are paid by worker’s compensation benefits. (If a worker’s compensation claim is settled, it will be considered paid by worker’s compensation benefits);
- Prescription Drugs that are considered not Medically Necessary by the Claims Administrator;
- Prescription Drugs for obesity or weight control;
- Prescription Drugs that are not authorized when part of a Step Therapy Program;
- Prescription Drugs used for cosmetic purposes.
PRIVATE DUTY NURSING
Private Duty Nursing when not a part of a Home Health service or a Hospice Care program approved by the Claims Administrator.

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

RELATIONSHIP COUNSELING
Marriage, family or child counseling for the treatment of pre-marital, marital or family or child relationship dysfunctions or counseling related to career, social adjustment, financial or religious matters that are requested outside of the Employee Assistance Program.

SERVICES FOR CERTAIN DIAGNOSES OR DISORDERS
Medical supplies or services or charges for learning disabilities, developmental speech delay, perceptual disorders, mental retardation or vocational rehabilitation.

SERVICES FOR CERTAIN THERAPIES
Treatment in connection with primal therapy, rolfing psychodrama, mega vitamin therapy, bioenergetics therapy and carbon dioxide therapy.

SERVICES FOR NON-LICENSED LAY PERSONS
Services provided by non-licensed lay persons, including but not limited to lay persons who assist in the delivery of a baby, such as a birthing coach or “doula”. (See the “Glossary of Helpful Terms” section for definition of a Provider.)

SERVICES PRIOR TO THE COVERAGE EFFECTIVE DATE
Services rendered or supplies provided before coverage begins, i.e., before a member’s effective date or after coverage ends.

SERVICES RELATED TO NON-SURGICAL TREATMENT OF THE FEET
Services and supplies related to non-surgical treatment of the feet, including non-Medically Necessary orthopedic shoes, orthotic appliances or other supportive devices for the feet, solely used for comfort or athletics.

SERVICES RENDERED BY FAMILY
Any Medical Supplies or services that you provide to yourself or rendered by a member of the patient’s immediate family (parent, child, spouse, brother, sister, grandparent or in-law).

SERVICES SOLELY BENEFITING ATTENDING PHYSICIAN
Items billed separately for services solely benefiting the attending Physician rather than for the diagnosis and treatment of the patient, such as pre-surgical routing testing for HIV.

SEX CHANGE
Any Medical Supplies or services or charges incurred for consultation, therapy, surgery or any procedures related to changing sex.

SMOKING CESSATION TREATMENT
Medical Supplies, services or Prescription Drugs for treatment for smoking cessation unless enrolled in a BCBS “Quit for Life” smoking cessation program.

SPEECH THERAPY- DEVELOPMENTAL
Treatment for, or in connection with, developmental speech therapy. (Note: Restorative speech therapy is covered when it is expected to restore speech to an individual who has lost an existing speech function as a direct result from disease (such as a stroke) or injury or is related to or developed as a result of a cleft lip and palate, and the required Pre-Authorization is obtained from BCBS.)

SONOGRAMS
Routine prenatal care sonograms, unless Medically Necessary.
TRAVEL
Travel, whether or not recommended by a Physician unless directly related to human organ or tissue transplants when Pre-Authorized by the Claims Administrator, (except Medically Necessary transportation by ambulance), motels, apartment rentals or related expenses except those covered under the Blue Quality Centers of Excellence program for transplants.

TREATMENT DUE TO OTHER EMPLOYMENT
Treatment resulting from any injury sustained or disease contracted in the performance of an occupation for work outside the Company for compensation or profit.

UNTIMELY CLAIMS FILING
Services not reported to the Claims Administrator within fifteen (15) months from the date of service.

VIRTUAL OFFICE VISITS
Charges incurred as a result of virtual office visits on the Internet, including Prescription Drugs. A virtual office visit on the Internet occurs when the claimant was not physically seen or physically examined by an approved Participating Provider.

VISION CARE SERVICES
Any Medical Supply or service rendered for vision care and vision perception training.

WORKERS’ COMPENSATION
The Plan does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained by someone that arises out of, in connection with, or as the result of, any work for wage or profit when coverage under any Workers’ Compensation Act or similar law is required or is otherwise available for the person. Benefits will not be provided under this Plan if coverage under the Workers’ Compensation Act or similar law would have been available but the individual elects exemption from available Workers’ Compensation coverage; waives entitlement to Workers’ Compensation benefits for which he/she is eligible; failed to timely file a claim for Workers’ Compensation benefits; or the individual sought treatment for the injury or illness from a Provider which is not authorized by the individuals employer. If the Plan pays benefits for an injury or illness and the Plan determines the individual also received Workers’ Compensation benefits by means of a settlement, judgment, or other payment for the same injury or illness, the Plan shall have the right of recovery.
**COORDINATION OF BENEFITS (COB)**

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

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

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

**Which Plan Pays First?**

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

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

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

Keep in mind that if both you and your spouse are employed by (or retirees of) the Company, under the “Special Rules for Dual Couples” section above, you cannot be covered under this Plan as both an employee and as a dependent of another employee. As a result, you cannot have duplicate coverage under the Medical Plan. Each 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.

**Medicare Coordination**

If you are receiving benefits as an Active Employee (or a dependent of an Active Employee) the Medical Plan will still be primary and you may want to delay in enrolling in Medicare Part B, if eligible, until your employment ends. The only exception would be if you are recognized by Medicare as having End-Stage Renal Disease (ESRD) and it has been at least 30 months since you became entitled to Medicare.

When Medicare is primary, claims should be submitted and paid by Medicare (Parts A&B) prior to their submission to BCBS for reimbursement from the 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 Plan benefit and the Medicare benefit is what BCBS would actually pay.

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

1) determine what would normally be payable if the Medical Plan were primary, then

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

**CLAIMS PROCESSING**

When you participate in the Prime Choice, Standard Choice, or Basic Choice options and you have a PPO Network medical expense, the PPO Network Physician, Hospital or other Provider is required to file the claim for you in accordance with the Provider’s Network participation agreement with BCBS if the Medical Plan is the primary payer.

When you go to a Provider that does not belong to the PPO Network — you may have to file the claim yourself. If your Physician 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 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, and
- the member’s identification number

For Prescription Drug benefits, you must file a separate Blue Prescription Drug Claim Form.

**The Medical Plan Benefits Claim Form is OSR 5-340**

Medical Plan and Prescription Drug Claim Forms may be obtained from the following sources: SRS Benefits Home page, Service Center (803-725-7772), or BCBS 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 and paid/reimbursed. You should “cluster” the bills for each individual family member onto a separate claim form, and then put the bills in order by type of service and date. If you are coordinating benefits with another plan that is primary (such as your spouse’s employer’s 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.

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

**Urgent Care Claims** – The Claims Administrator will respond 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 authorization as such when the claim approval request is for urgent care claims.

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

**Post-Service Claims within 30 days** – Most claims are considered post-service claims since they are usually filed after your health care Provider has already rendered services.
Pre-service and Post-service Claims - The Claims Administrator may use a 15 calendar day extension, if it is necessary for reasons beyond the control of the Plan. If an extension is required, the Claims Administrator will notify you within the initial notification periods noted above.

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

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 BCBS for further explanation of the denial. If you wish to file an appeal with the Claims Administrator you must send a letter to the Claims Administrator stating that an appeal has been requested 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). Your appeal to the Claims Administrator must be in writing and sent via U.S. mail to:

Blue Cross BlueShield of South Carolina
Attn: SRNS/SRR Appeals
Post Office Box 100300
Columbia, SC 29202

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

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

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

The final appeal request available to you is directly to the Plan Administrator 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 your name, the claimant’s name, your address, identification number, and any other information, documentation, or materials that supports the appeal. In addition, your appeal must include 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 Plan Administrator will decide the appeal within a reasonable period of time, but no later than 60 days after receipt of the appeal. You will be notified if there are special circumstances that cause the review to take longer. Your appeal to the Plan should be sent to:

Savannah River Nuclear Solutions
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 Medical Plan Administrator has full discretion and authority to interpret Plan provisions, resolve any ambiguities and evaluate claims. The decision made by Medical Plan Administrator is final and binding.
You have **180 days from the initial claim determination** EOB 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. Federal 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 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.
**COBRA CONTINUATION COVERAGE**

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

**What is COBRA continuation coverage?**

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

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

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

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

- Termination of your employment for any reason, including retirement, voluntary termination, etc., other than for gross misconduct,
- A reduction in your work hours of work causing ineligibility for coverage, and
- Your death.

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

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

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

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

**Things to consider when electing COBRA**

**Impacts to eligibility for SRNS retiree medical plans and COBRA**

If you or your dependents elect COBRA medical or dental coverage the electing individual – you or your dependents – will have waived the right to enroll in the SRNS Retiree Plans (Medical, Dental, and Retiree Reimbursement Account). Also, if you, as the employee, elect COBRA, you will be waiving your and your dependents right to enroll in SRNS retiree medical plans. If you or your dependents wish to have SRNS retiree medical coverage, now or in the future, do not elect either COBRA medical or dental coverage. However, you or your dependent(s) may elect COBRA vision and still participate in the SRNS retiree medical plans. Conversely, if you elect to enroll in the SRNS Retiree Medical and Dental Plan, you cannot elect COBRA continuation coverage.
Impacts to eligibility for other group or individual medical plans
In considering whether to elect COBRA continuation coverage, you should also take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 62-day gap in health care coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law.

How long will COBRA continuation coverage last?
In the case of a loss of coverage due to termination of employment coverage generally may be continued only for up to a total of 18 months.

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

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

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

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

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

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

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

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

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

You must notify Ceridian COBRA Services of your disability status within 60 days of the SSA determination and prior to the end of the 18 month period of continuation coverage. You will be required to submit a copy of the letter from the SSA notifying you of your disability status. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if they qualify. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Ceridian COBRA Services of the change within 30 days after SSA’s determination.
How much does COBRA continuation coverage cost?
You pay 102% of the full cost of COBRA continuation coverage. The premium includes actuarially calculated Plan costs, in addition to the cost of administering COBRA.

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

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

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

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

Ceridian COBRA Services
PO Box 534099
St. Petersburg, FL 33747-4099

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

Ceridian COBRA Services
PO Box 534099
St. Petersburg, FL 33747-4099
Website: www.ceridian-benefits.com
Customer Service Telephone: (800) 877-7994
HIPAA CERTIFICATION

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

Privacy of Protected Health Information Certification or Compliance

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

• SRNS will neither use nor further disclose PHI received from the Plan, except as permitted or required by the Plan documents, as amended, or required by law.

• SRNS will ensure that any agent, including any subcontractor, to whom it provides PHI obtained from the Plan, agrees to the restrictions and conditions of the Plan documents, including this section.

• SRNS will not use or disclose a participants’ PHI obtained from the Plan for employment-related actions or decisions or in connection with any other non-group health benefit or employee benefit plan of SRNS.

• SRNS will report to the Plan any use or disclosure of PHI obtained from the Plan that is inconsistent with the uses and disclosures allowed under this section upon learning of such inconsistent use or disclosure.

• SRNS will make PHI obtained from the Plan available to the Plan participant.

• SRNS will track disclosures it may make of PHI obtained from the Plan so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with applicable law or regulation.

• SRNS will make its internal practices, Summary Plan Descriptions, and records, relating to its use and disclosure of PHI obtained from the Plan to the Plan and to the Secretary of Health and Human Services for audit purposes.

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

Purpose or Disclosure to SRNS and SRR

• The Plan and any third party business associate servicing Plan will disclose PHI obtained from the Plan to SRNS only to permit SRNS to carry out the administrative functions for the Plan not inconsistent with the requirements of the HIPAA. Any disclosure to and use by SRNS of PHI obtained from the Plan will be subject to and consistent with the provisions of this section.

• Neither the Plan nor any third party business associate servicing the Plan will disclose PHI obtained from the Plan to SRNS unless the disclosures are explained in the Notice of Privacy Practices distributed to the plan participants.

Adequate Separation Between The Company and The Plan

SRNS’s Human Resources, Business Services, Internal Audit and General Counsel employees may be given access to Plan participants’ PHI received from the Medical Plan, health insurance issuer or business associate servicing the Medical Plan. Additionally, as previously stated, SRNS operates the Benefits Solution Service Center as a service for the SRNS Medical Plans, and SRNS employees in the SRNS Benefits Accounting, Benefits Administration, Service Center, and Payroll organizations may be given access to Plan participants’ PHI received from the Medical Plan health insurance issuer or business associate servicing the Medical Plan.

• These employees will have access to Plan participants’ PHI only to support or perform the Plan administration functions that the Companies provide for the Medical Plan.
• These SRNS employees will be subject to disciplinary action, for any use or disclosure of Plan participants’ PHI in breach or violation of or noncompliance with the provisions of this section to Medical Plan documents. SRNS will report such breach, violation or noncompliance to the Plan. SRNS will cooperate with the Medical Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action on each employee causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any participant, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance. SRNS applies these same standards to any of its employees who have access to SRNS Plan participants PHI and has agreed to report any such breach, violation or noncompliance to SRNS and the Plan.
GENERAL PROVISIONS

“Cadillac Plans” under Health Care Reform
Effective in 2018, under the Patient Protection and Affordable Care Act, a 40% excise tax will be imposed on “rich” health plans that cost more than $10,200 for individual plans and $27,500 for family plans. Although the new law will not have a tax impact until 2018, current accounting practices require employers to state their intentions regarding this tax now. SRNS intends to offer plans that will not incur the excise tax. In the event any taxes are imposed, they will be the participant’s responsibility.

Grandfathered Health Plan
The Company believes the Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (“Act”). As permitted by the Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Health Care Reform Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at (803) 725-7772 or (800) 368-7333. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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 is on a first dollar recovery basis and applies regardless of whether the recovery, or a portion thereof, is specifically designated as payment for, but not limited to, medical benefits, pain and suffering, lost wages, other specified damages, or whether the Beneficiary has been made whole or fully compensated for his/her injuries.

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

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

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

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

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

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

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

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

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

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

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

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

**Wellness Program Disclosure**
If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at (803)725-7772 and we will work with you to develop another way to qualify for the reward.

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

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

Children’s Health Insurance Program Notice

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

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

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

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

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

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

How to contact the Plan Administrator; and

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

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

Plan Sponsor

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

Plan Administrator

The Plan Administrator is responsible for maintaining the records related to and administration of the medical Plan. The Plan Administrator also has the sole discretion to decide all issues of fact or law. The Plan Administrator reserves the right to request, at any time, documents to determine eligibility for benefits and to resolve appeals. The Plan Administrator(s) is designated by the SRNS Benefits Committee. Correspondence to the Plan Administrator should be sent to the address noted for the Plan Administrator in the Plan Information section below.

Plan Numbers

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

Plan Documents

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

Plan Financing and Administration

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

Future of the Plans

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

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

ERISA Rights

Although ERISA does not require that an employer provide benefits, it does set standards on how a plan is run, and requires that you be kept informed of your rights and benefits. As a participant or beneficiary in the Plan, you are entitled to certain rights and protection under ERISA. Federal regulations require that all Summary Plan Descriptions include the following statement:
ERISA provides that you may:
Examine, without charge, at the Plan Administrator’s office and at other specified locations such as your personnel office, all Plan documents, including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, Employee Benefits Security Administration (formerly Pension and Welfare Benefits Administration), such as detailed annual reports and plan descriptions. You may obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may charge a reasonable amount for the copies.

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

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

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

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

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

Corporate Service Company
1301 Gervais Street
Columbia, SC 29201
Phone: (800) 927-9800

You may also contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210, or the nearest office of the Employee Benefits Security Administration:

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

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<td>Savannah River Nuclear Solutions, LLC</td>
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<td>Plan Sponsor Employer Identification Number:</td>
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<td>Plan Administrator:</td>
<td>Health and Welfare Benefit Committee Plan Administrator Savannah River Nuclear Solutions, LLC Savannah River Site, Bldg. 703-47A Aiken, South Carolina 29808 Phone: (803) 725-7772 (800) 368-7333</td>
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<td>Plan Administrator Employer Identification Number:</td>
<td>27-0584392</td>
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<tr>
<td>Claims Administrator:</td>
<td>Blue Cross and Blue Shield of South Carolina I-20 at Alpine Road Columbia, South Carolina 29219</td>
</tr>
<tr>
<td>Agent for Legal Process:</td>
<td>Corporate Service Company 1301 Gervais Street Columbia, SC 29201 Phone: (800) 927-9800</td>
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Eligibility for benefits should not be viewed as a guarantee of employment. While the Company intends to continue providing a comprehensive benefits program, the Company reserves the right to modify or terminate any of the benefit plans at any time.

**This Summary Plan Description does not create an express or implied contract of employment.**
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. Here is a handy reference list:

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

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

**Ambulatory Surgical Center**: A licensed facility that:
1. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;
2. Provides treatment by or under the supervision of medical doctors or oral surgeons and provides nursing services when the patient is in the facility;
3. Does not provide inpatient accommodations and,
4. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a medical doctor or oral surgeon. Ambulatory Surgical Center includes an endoscopy center.

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

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

**Child Birthing Facility/Center**: Any facility, either hospital-based or free-standing, in which births for a low-risk pregnant woman occur. Low-risk means normal, uncomplicated pregnancy. The Child Birthing Facility/Center must have the Medically Necessary equipment for low-risk maternity care. Its staff must have the expertise to handle emergency medical procedures in case of life-threatening events to mother and baby. The facility/center must have a written agreement with an acute care Hospital, capable of providing obstetrical and neonatal services, to transfer patients there in case of an emergency. A qualified, licensed nurse, mid-wife and/or an obstetrician must be present at the child birthing facility/center, during all births and during the immediate postpartum period.

**Claims Administrator**: The provider responsible for processing claims under the Medical Plan. Blue Cross Blue Shield of South Carolina is the Claims Administrator.

**COBRA**: The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

**Coinsurance**: The percentage you pay for covered services (not including a copayment for Network Physician’s office visits). Your coinsurance amounts for most medical services are 10%, 20% or 30%, depending on the medical option you choose, the services or supplies provided and the Provider you use.

Coinsurance is calculated after any applicable Deductible or Copayment is subtracted from the Allowable Charge based upon the network charge or lesser charge of the Provider. For Prescription Drug Benefits, Coinsurance is calculated without regard to any Credit or allowance that may be received by the Medical Plan.

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

**Continued Stay Review**: The review that must be obtained by an individual (or the individual’s representative) regarding an extension of an Admission to determine whether it is Medically Necessary (when required).

**Copay**: The flat dollar amount ($10, $20 or $30) that you pay — under Prime Choice or Standard Choice, when you receive treatment in a Medical PPO Network Physician’s office.

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

**Credit(s)**: Financial credits (including rebates and/or other amounts) from drug manufacturers or other Providers through a Pharmacy Benefit Manager. Reimbursements to a Participating Pharmacy or discounted prices charged at Pharmacies are not affected by these Credits. Any Coinsurance that you must pay for Prescription Drugs is based upon...
the Allowable Charge at the pharmacy, and does not change due to receipt of any Credit. Copayments are not affected by any Credit.

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

**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. The Deductible is subtracted from the Allowable Charge before Coinsurance is calculated. The Deductible applies to the Out-of-Pocket Maximum.

**Discount Services**: Services (including discounts on services) that are not benefits, but which may be offered to you from time to time as a result of being a covered under the Plan.

**Durable Medical Equipment**: Medical equipment that:
- Can stand repeated use and,
- Is Medically Necessary and,
- Is customarily used for the treatment of illness, injury, disease or disorder and,
- Is appropriate for use in the home and,
- Is not useful in the absence of illness or injury and
- Does not include appliances that are provided solely for comfort or convenience and,
- Is a standard, non-luxury item (as determined by the Claims Administrator), and
- Is ordered by a medical doctor, oral surgeon, podiatrist, or osteopath.

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

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.

**Emergency Admission Review**: You or your representative must obtain a review within twenty-four (24) hours of or by the end of the first working day after an Admission to a Hospital to treat an Emergency Medical Condition.

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

**Emergency Medical Condition**: A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:
- Placing the health of the individual, or if you are pregnant to the health of your unborn child, in serious jeopardy or,
- Serious impairment to bodily functions or,
- Serious dysfunction of any bodily organ or part.

**Experimental/Investigational**: Surgical or medical procedures, supplies, devices, or drugs, which at the time provided, or sought to be provided are in the judgment of the Claims Administrator not recognized as conforming to accepted, medical practice, or the procedure, drug, or device or either:
- has not received required final approval to market from appropriate government bodies;
- is one about which the peer-reviewed medical literature does not permit conclusions concerning its effect on health outcomes;
- is not demonstrated to be beneficial as established alternatives;
- has not been demonstrated to improve the net health outcomes; or
• 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.

Generic Drug: A Prescription Drug that has a chemical structure that has the same bio-equivalence as a Brand Name Drug but is not manufactured under a registered brand name or trademark or sold under a brand name. The Pharmacy Benefit Manager has the discretion to determine if a Prescription Drug is a Generic Drug.


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

Home Health Care: Part-time or intermittent nursing care, health aide services, or physical, occupational, or speech therapy provided or supervised by a Home Health Agency and provided to a home-bound person in their private residence.

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

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

Inpatient Services: Are provided as a bed patient in a hospital, a rehabilitation hospital, an extended care 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.

Long-Term Acute Care Hospital: Means a long-term, acute care facility licensed as a long term care hospital by the state in which it operates and which meets the other requirements of this definition. A Long-Term Acute Care Hospital provides highly skilled nursing, therapy and medical treatment (typically over an extended period of time) although patients may no longer need general acute care typically provided in a Hospital. A Long-Term Acute Care Hospital is primarily engaged in providing diagnostic services and medical treatment patients with chronic diseases or complex medical conditions. The term Long-Term Acute Care Hospital does not include, chronic care institutions or facilities that principally provide custodial, rehabilitative or long-term care, whether or not such institutions or facilities are affiliated with or are part of a Long-Term Acute Care Hospital. A Long-Term Acute Care Hospital may participate in a teaching program. This means medical students, interns, or residents participating in a teaching program may treat patients.
**Maximum Payment:** The maximum amount the Plan will pay (as determined by the Claims Administrator) for a particular Benefit. The Maximum Payment will not be affected by any Credit. The Maximum Payment will be one of the following as determined by the Claims Administrator in its discretion:

- The actual charges made for similar services, supplies or equipment by Providers and filed with the Claims Administrator during the preceding calendar year;
- The Maximum Payment for the preceding year increased by an index based on national or local economic factors or indices, or
- The lowest rate at which any medical service, supply or equipment is generally available in the local service area when, in the judgment of the Claims Administrator, charges for such service, supply or equipment generally should not vary significantly from one Provider to another, or
- An amount that has been agreed upon by a Provider and the Claims Administrator or a member of the Blue Cross and Blue Shield Association, or
- An amount established by the Claims Administrator in its sole discretion. In determining the Maximum Payment the Claims Administrator may, through its medical staff and/or consultants, determine the Maximum Payment based on a number of factors, including, for example, comparable or similar services or procedures.

**Medical Child Support Order:** Any judgment, decree or order (including an approved settlement agreement) issued by a court of competent jurisdiction or a national Medical Support Notice issued by the applicable state agency that mandates benefit coverage for a child.

**Medically Necessary/Medical Necessity:** Is a health care service that a Physician exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms and the service, supply or equipment must, in the judgment of the Claims Administrator be:

- In accordance with generally accepted standards of medical practice; and
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, Physician, or other health care Provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

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

**Medical Supplies:** Means supplies that are:

- Medically Necessary and,
- Prescribed by a Physician acting within the scope of his or her license (or are provided in a Physician's office) and,
- Are not available on an over-the-counter basis (unless such supplies are provided in a Physician's office and should not (in the Claims Administrator's discretion) be included as part of the treatment received by the individual) and
- Are not prescribed in connection with any treatment or benefit that is excluded under this Plan.

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

**Network:** A group of Physicians and other health care Providers who contractually agree to undergo an extensive screening process and provide care at pre-negotiated discounted rates. BCBS administers the Medical Network. You can view BCBS Network Providers online at www.bluecard.com.

**Non-Participating Provider:** Any Provider who does not have a current, valid Participating Provider Agreement with the Claims Administrator or another member of the Blue Cross and Blue Shield Association.
Non-Preferred Drug: A Prescription Drug that bears a recognized brand name of a particular manufacturer but does not appear on the list of Preferred Brand Drugs and has not been chosen by the Claims Administrator or its designated Pharmacy Benefit Manager to be a Preferred Drug, including any Brand Name Drug with an “A” rated Generic Drug available.

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, $20 or $30), costs that exceed the Claims Administrator’s Allowed Charge and/or Maximum Payment and pre-admission certification penalties — do not count toward the out-of-pocket maximum.

Outpatient Services: Services provided outside a Hospital-confined setting. This includes services provided in the outpatient department of a Hospital, a clinic, or a Physician’s office.

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

Participating Pharmacy: A pharmacy that has a contract with the Claims Administrator or with the Pharmacy Benefit Manager to provide Prescription Drugs.

Participating Provider: A Provider who has a current, valid Participating Provider Agreement with the Claims Administrator.

Participating Provider Agreement: An agreement between the Claims Administrator (or another member of the Blue Cross and Blue Shield Association) and a Provider under which the Provider has agreed to accept an allowance (as set forth in the Provider Agreement) as payment in full for benefits and other mutually acceptable terms and conditions.

PHI: Protected Health Information as that term is defined under HIPAA.

Physician: A person who is:
- Not an:
  - Intern or,
  - Resident or,
  - In-house physician and,
- Duly licensed by the appropriate state regulatory agency as a:
  - Medical doctor (including psychiatrists); or,
  - Oral surgeon or,
  - Osteopath or,
  - Podiatrist or,
  - Chiropractor or,
  - Optometrist or,
  - Psychologist with a doctoral degree in psychology and,
- Legally entitled to practice within the scope of his or her license and
- Customarily bills for his or her services.

Physician Services: The following services, performed by a Physician within the scope of his or her license, training and specialty and within the scope of generally acceptable medical standards as determined by the Claims Administrator:
- Office visits, which are for the purpose of seeking or receiving care for an illness or injury or,
- Basic diagnostic services and machine tests;
- Physician Services includes the following services when performed by a medical doctor, osteopath, podiatrist or oral surgeon, but specifically excluding such services when performed by a chiropractor, optometrist, or licensed psychologist with a doctoral degree:
  - Benefits rendered in a Hospital or Skilled Nursing Facility or,
  - Benefits rendered in the patient’s home or,
Surgical Services or,
- Anesthesia services, including the administration of general or spinal block anesthesia or,
- Radiological examinations or,
- Laboratory tests or,
- Maternity services, including consultation, prenatal care, conditions directly related to pregnancy, delivery and postpartum care, and delivery of one or more infants. Physician Services also include maternity services performed by certified nurse midwives.

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-Admission Review: The review that you must obtain (or be obtained by your representative) prior to all admissions that are not related to an Emergency Medical Condition.

Pre-Authorized/Pre-Authorization: The approval of benefits based on Medical Necessity prior to the rendering of such benefit. Pre-Authorization means only that the benefit is Medically Necessary. Pre-Authorization is not a guarantee of payment or a verification that benefits will be paid or are available to you. Notwithstanding Pre-Authorization, payment for benefits is subject to the Eligibility and all other limitations and exclusions contained in this Plan. Your entitlement to benefits is not determined until the claim is processed.

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

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

Prescription Drug: A drug or medicine that is:
- Required to be labeled that it has been approved by the Food and Drug Administration, and
- Bears the legend “Caution: Federal Law prohibits dispensing without a prescription” prior to being dispensed or delivered, or labeled in a similar manner, or
- Insulin.

Additionally, to qualify as a Prescription Drug, the drug must:
- Be ordered by a medical doctor or oral surgeon as a prescription and
- Not be entirely consumed at the time and place where the prescription is dispensed, and
- Be purchased for use outside a Hospital.

Premium Contributions: The amount you pay to purchase medical coverage from the company.

Prescription Drug Pre-Authorization Program: Programs that prohibit patients from obtaining medications until approvals have been obtained.

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.

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

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

Provider: Any person or entity licensed by the appropriate state regulatory agency and legally engaged within the scope of such person or entity’s license in the practice of any of the following:
- Medicine
- Dentistry
- Optometry
- Podiatry
- Chiropractic services
- Behavioral Health
- Physical therapy
- Oral surgery
- Speech therapy
- Occupational therapy

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

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

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

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

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

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

**Step Therapy Program:** Programs that require you to use lower-cost medications that are used to treat the same condition before obtaining higher-cost medications.

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

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

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

**Treatment Center for Chemical Dependency:** A facility that is approved by BCBS and is staffed and equipped to provide specialized treatment of alcoholism and narcotics addiction.
Medical Plan
Summary Plan Description
Effective 1/01/2013