

Summary Plan Description

# Pre-65 Retiree Health Plan



SAVANNAH RIVER NUCLEAR SOLUTIONS, LLC

AMENDED AND RESTATED EFFECTIVE JANUARY 1, 2026

# Savannah River Nuclear Solutions, LLC Summary Plan Description

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# Overview

**Savannah River Nuclear Solutions, LLC (SRNS) maintains medical and dental benefits under the Pre-65 Retiree Health Plan (the “Plan”), which is 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). The document was amended and restated effective January 1, 2022, noting a new site contractor Savannah River Mission Completion, LLC (SRMC) effective February 27, 2022, at 12:01 am and the end of the Savannah River Remediation, LLC contract. The updates include but are not limited to the “No Surprise Act” information which was enacted to protect members from surprise billing. The document updates include additional information about COVID-19 testing, vaccinations, telehealth services and testing equipment. This document, together with the BlueCross BlueShield of South Carolina (BlueCross, BCBS or BCBSSC) Plan of Benefits document governs any adverse determination and constitutes the Plan Document. This SPD describes the Plan as of January 1, 2026, 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, modify or terminate the Plan, at any time.

The benefits described in this document are sponsored by the Company under a self-funded administrative service contract with BCBSSC. The Company has designated the SRNS Health and Welfare Committee as the Plan Administrator for this Plan. The Plan Administrator is responsible for maintaining the enrollment and other records related to, and administration of, the Plan.

You should contact the Company through the SRNS Service Center at 803.725.7772 or 1.800.368.7333 for questions about enrollment and eligibility in the Plan. As Claims Administrator, BlueCross 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, and discretionary authority to interpret the terms of this SPD.

To the fullest extent permitted by law, the Plan Administrator will have the exclusive discretion to determine all matters relating to the Plan, including but not limited to eligibility, coverage and benefit determinations under the Plan. The Plan Administrator will also have the exclusive discretion to determine all matters relating to interpretation and operation of the Plan. The Plan Administrator may delegate any of its duties and responsibilities to one or more persons or entities. Such delegations of authority must be in writing and must identify the delegate and the scope of the delegated responsibilities. Decisions by the Plan Administrator, or any authorized delegate, will be conclusive and legally binding on all parties.

The plan document will control in instances where inconsistencies might arise between the SPD and the official plan document. Suggested language: “This is a summary of the most important provisions of the Plan. While this summary should answer most of your questions, it does not provide all of the details of the Plan. These can be found in the official Plan document. The official Plan document is always used in cases requiring a legal interpretation of the Plan. If there is any difference between the official Plan document and this summary, your rights will be based on the provisions of the official Plan document (and any legal rules that require changes not yet written into the official Plan document). To request a copy of the official Plan document, please contact the SRNS Service Center. This SPD does not create an express or implied contract of employment. Eligibility for benefits should not be viewed as a guarantee of employment. Also, while SRNS intends to continue providing comprehensive benefits programs, the Company reserves the right to modify or terminate any of the benefit plans at any time. The Company will provide advance notification of any future benefit changes.

## **The COVID-19 Public Health Emergency ended May 11, 2023.**

Effective May 12, 2023 The following changes will be made to the SRNS Medical Plans:

### **COVID-19 Testing**

- At-Home and Over-the-Counter (OTC) Tests. At-Home and Over-the-Counter (OTC) Tests will no longer be covered (reimbursed).
- Polymerase chain reaction (PCR) and Rapid Tests ordered and administered by a health professional. Regular coverage and cost sharing will apply to the test and associated doctor visit according to plan benefits.
- 
- Regular coverage and cost sharing applies, as it did during the Protected Health Emergency according to plan benefits.(cost sharing refers to the members out of pocket cost, deductible, coinsurance, copayments, or similar charges)

### **COVID-19 Antivirals**

- Pharmaceutical treatments (e.g., Paxlovid™) will be covered according to the plan’s terms of coverage and subject to cost sharing requirements.

Effective September 1, 2023 The following changes will be made to the SRNS Medical Plans:

### **COVID-19 Vaccines**

- The COVID-19 vaccine and its administration will be covered without cost-sharing, as long as the vaccine is provided by in-network providers. When furnished by an out-of-network provider, the COVID-19 vaccine along with its administration costs will be processed the same as other vaccines under the terms of the plan, excluded from coverage.

## Contacts for questions and pre-authorizations

### Claims/Customer Service

BlueCross BlueShield of South Carolina  
1.800.325.6596;  
[www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com);  
Monday-Thursday 8 a.m.-6 p.m.;  
Friday 8 a.m.-4:30 p.m. EST;  
Claims Processing Center,  
P.O. Box 100300, Columbia, SC 29202-3300

### Blue CareOnDemand Telehealth Service

Download the Blue CareOnDemand mobile app  
from the App Store or Google Play.  
Visit [www.BlueCareOnDemandSC.com](http://www.BlueCareOnDemandSC.com)

### My Health Toolkit

Download the My Health Toolkit mobile app  
from the App Store or Google Play.  
Digital membership card is available.

### Hospital Preauthorization and Medical Case Management

In South Carolina: BlueCross BlueShield  
of South Carolina 1.800.327.3238  
Outside SC: BlueCross BlueShield 1.800.334.7287

### Imaging Preauthorization

1.800.500.7664 for MRI, MRA, CAT, MSK or PET scans

### Mental Health and Substance Abuse Preauthorization

1.803.699.7308 from Columbia, SC  
1.800.868.1032 from all other areas

### Oncology Case Management

Companion Care Solutions  
1.800.790.5770

### Traveling Outside the U.S.:

BlueCross BlueShield Global Core (formerly BlueCard Worldwide)  
Customer Service  
1.800.810.BLUE (2583)  
[www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)

### COBRA Administrator

HealthEquity® (formerly WageWorks)  
P.O. Box 660212  
Dallas, TX 75266-0212  
Customer Service: 866.924.6937  
<https://mybenefits.wageworks.com>

**SRNS Service Center**

803.725.7772 or 1.800.368.7333

Service-Center@srs.gov

Bldg. 992-2W Savannah River Site

Aiken, SC 29808

**SRNS Workforce Services**

Attn: Plan Administrator

803.952.7273

Bldg. 992-2W Savannah River Site

Aiken, SC 29808

**Pharmacy Benefit Manager**

OptumRx

Prescription Mail Order: P.O. Box 2975, Mission, KS 66201

Phone: 1.855.811.2218

Prescription reimbursement form:

OptumRx Claims Dept., P.O. Box 29044,

Hot Springs, AR 71903

# Participating in the Pre-65 Retiree Health Plan

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

The Effective Date on which the MEPP was closed to New Hires and Rehired Employees was:

- WSRC/BSRI/BNGA/BWXT: December 9, 2008
- With respect to SRNS Employees: August 1, 2008

"Non-Incumbent Employees" means employees who were hired after the MEPP was closed. These Non-Incumbent Employees are not eligible to participate in this Plan at retirement unless previously eligible. For the exact definition of Employees eligible to participate in the MEPP, refer to the definition of "Eligible Employee" contained in the SRNS, LLC Multiple Employer Pension Plan Summary Plan Description.

Membership in the Plan is the responsibility of SRNS Health and Welfare Plan Committee, as Plan Administrator. Questions about eligibility and qualifying changes in status should be directed to the SRNS Service Center at 800.368.7333 or 803.725.7772.

Participant Classification and Eligibility	
Yes	Eligible Participants
✓	Incumbent Retirees and Dependents under the age of 65
✓	Eligible Dependents of an Incumbent Retiree under the age of 65 (even when the Retiree is age 65 or older)
✓	Eligible Dependents, under the age of 65, of a rehired Incumbent Retiree of SRNS or Savannah River Remediation (SRR), Savannah River Mission Completion (SRMC) or Battelle Savannah River Alliance (BSRA) or who is over 65 and who has elected to maintain their Medicare/Post-65 Health Reimbursement Account Status in lieu of joining the Active Health Plan.
✓	Long Term Disability (LTD) Participants (all Non-Incumbent Employees and Incumbent Employees with less than 15 years of eligibility service) under age 65, while still approved for LTD. Maximum of 24 months.
✓	Long Term Disability (LTD) Participants (all Non-Incumbent Employees and Incumbent Employees with less than 15 years of eligibility service) over age 65, still approved for LTD, and with Medicare as Primary. Maximum of 24 months.
No	Ineligible Participants
✗	Incumbent Retirees and Dependents age 65 or older
✗	Active, Full-Service Employees (Non-Craft or Craft) who are not rehired from either SRNS, SRR, SRMC, BSRA, who are regularly scheduled to work a minimum of 20 hours per week.
✗	Former SRNS Employees and Eligible Dependents Enrolled in SRNS Medical and/or Dental Plan through COBRA (Consolidated Omnibus Budget Reconciliation Act)
✗	Terminated Non-incumbent Employees
✗	DuPont Retiree Rehires (and their spouses)

Please refer to the Coverage Continuation in Special Situations Section for:

- SRNS/SRR/BSRA/SRMC incumbents who are retired and then rehired under special rules for retiree rehires; and
- In the event of termination of employment for LTD and/or Leaves of Absences

## Special Rules for "Dual" Couples

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

A dependent child may not be covered by more than one SRNS, SRR, SRMC or BSRA employee or retiree. For example, you may elect to cover your eligible spouse and child, while your spouse elects to waive their 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.)

You must be enrolled in the Plan to add a dependent. If the Plan receives a Medical Support Order that it determines to be valid requiring coverage for your dependent, and you are not enrolled in the Plan, you may be compelled to enroll in the Plan (including payment of required premiums) in order for your dependent to be covered as required under the Medical Support Order.

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

- Are classified by the Employer as an independent contractor (regardless of whether that classification is controlling for federal employment tax purposes or under any other applicable federal, state, or local law and regardless of whether you are classified differently by a court or any federal, state, or local agency),
- Are retired from DuPont Savannah River Plant and were rehired by WSRC or BSRI on or after April 1, 1989, (accordingly, you are not eligible for participation in the Pre-65 Retiree Health Plan as an Active Employee or as a retiree).
- If you are eligible for coverage as an active Employee under the Plan of SRNS, SRR, SRMC or BSRA or and you are also an SRNS, SRR, SRMC or BSRA retiree, you will only be eligible for the active Employee Medical Benefit Plan unless you are over the age of 65 and elect to continue your Post-65 Health Reimbursement Account. You will continue to be ineligible for the SRNS, SRR, SRMC or BSRA Pre-65 Retiree Health Plans until your employment with SRNS or SRR, SRMC or BSRA terminates. After your employment as an active Employee terminates, you will be eligible for the same health benefits as similarly situated retirees.
- You or your dependents elected COBRA medical or dental coverage at the time of retirement.
- Coverage for dependents under the age of 65 will end when the retiree dies, with the exception of dependents who have eligibility rights as Survivors under the MEPP (the definition of "Survivor in the MEPP SPD will be controlling for this purpose).

### **Eligible Dependents**

Your dependents that are eligible for enrollment in this Plan include your lawful spouse and your children. Eligibility for spouses is through either the validation of a state-recognized marriage certificate, including same sex marriage when recognized by state law through a valid marriage license or common law marriage. Common law marriages under South Carolina will be recognized with the same documentation requirements for attestation as any other marriages, along with documentation proving that the common law marriage was established prior to July 24, 2019. You will be required to provide the date of birth, Social Security number and acceptable documentation (list of acceptable documentation is found on page 9 of the SPD) for all covered dependents.

*Note: If you are divorced, your ex-spouse and step-children (unless you have legal guardianship or a Medical Support Order) are no longer eligible to be covered as your dependents under the Plan as of the date of your divorce decree as filed by the court. You have an obligation to notify us within 60 days of the effective date of your divorce and no claims will be eligible for payment from the Plan after the date of the divorce. Coverage continuation for your ex-spouse may be available through COBRA continuation coverage.*

The Plan will comply with all the terms of a qualified medical child support order (QMCSO). A medical child support order is an order or judgment from a court or administrative body that directs the Plan to cover a child of a participant employee under one or more of the participating programs providing group health plan benefits (e.g., Medical Program, Dental Program). Federal law provides that a medical child support order must meet certain form and content requirements in order to be a qualified medical child support order. When an order is received, each affected participant employee and each child (or the child's representative) covered by the order will be given notice of the receipt of the order and a copy of the Plans QMCSO procedures that are used in the determination of the validity and administration of the order.

Coverage under the Plan pursuant to a medical child support order will not become effective until the Plan Administrator determines that the order is a QMCSO. If you have any questions or if you would like to receive a copy of the written procedures for determining whether a medical child support order is valid, please contact the SRNS Service Center.

The coverage under this Plan for your Incapacitated Dependent 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 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 intentional misrepresentation, without reimbursement of premiums paid for the coverage. The Plan may also seek reimbursement for claims paid on behalf of any ineligible dependent including offsetting future claim amounts owed by the Plan on your behalf or on behalf of any other eligible dependents, until any claim amounts paid by the Plan on behalf of an ineligible dependent are recouped. The Claims Administrator also has the right to reprocess the claims, in such a case you will have the responsibility for paying any outstanding amount to the provider.

## Acceptable Documentation for Spouse and Type of Dependent

<p><b>Spouse: Lawful Spouse</b></p>	<p>Copy of page one and two of your most recent 1040 tax return (you may redact wage and social security number information) showing you filed as Married, filing jointly or Married, filing separately. Note: Page two must be signed and can be substituted by a confirmation page if you filed your taxes electronically OR Copy of marriage certificate AND one of the following:</p> <ul style="list-style-type: none"> <li>• A copy of spouse's driver's license (must have the same address as employee/retiree)</li> <li>• A copy of a joint lease or mortgage (current)</li> <li>• Proof of a common ownership of a motor vehicle (current)</li> <li>• Proof of joint bank accounts or credit accounts (current)</li> </ul>
<p><b>Common-Law Spouse</b> <i>(If under South Carolina law, must be established prior to July 24, 2019)</i></p>	<p>Copy of page one and two of your 1040 tax return prior to 2019 (you may redact wage and social security number information) showing you filed as Married, filing jointly or Married, filing separately. Note: Page two must be signed and can be substituted by a confirmation page if you filed your taxes electronically. Copy of the notarized form provided previously for this coverage ** Form OSR-5-379 And one of the following:</p> <ul style="list-style-type: none"> <li>• Joint lease, deed or mortgage agreement;</li> <li>• Joint credit, savings or checking account;</li> <li>• Designation as primary beneficiary in the employee's/retiree's will;</li> <li>• Designation as primary beneficiary in the employee's/retiree's life insurance policy;</li> <li>• Durable property or health care power of attorney granted by either party to the other.</li> <li>• All documentation proving the common law marriage must show that the marriage was established prior to July 24, 2019.</li> </ul>
<p><b>Children</b> <i>(Under age 26)</i></p>	<p>Copy of page one and two of your most recent 1040 tax return (you may cross out wage and social security number information) showing your child as a dependent. Note: Page two must be signed and can be substituted by a confirmation page if you filed your taxes electronically OR one of the following:</p> <ul style="list-style-type: none"> <li>• Copy of birth certificate (Documents must show employee/retiree/dependent relation)</li> <li>• Custodial papers (must be filed with the court)</li> <li>• Court Order (must be filed with the court)</li> <li>• Adoption papers (must be filed with the court)</li> </ul>
<p><b>Stepchild</b> <i>(Under age 26)</i></p>	<p>Copy of birth certificate naming your current, legally married spouse as the parent OR Copy of page one and two of your most recent 1040 tax return (you may cross out wage and social security number information) showing your child as a dependent. Note: Page two must be signed and can be substituted by a confirmation page if you filed your taxes electronically. OR Copy of court-issued Qualified Medical Child Support Order <u>AND</u> Copy of your marriage certificate (naming the child's biological parent as your current legal spouse)</p>
<p><b>Child(ren)</b> <i>(Over age 26)</i></p>	<p>Children must be certified by BCBS as meeting the definition of disabled (as specified below) in order for them to remain on the plan past the end of the year in which they attain age 26. Criteria includes:</p> <ol style="list-style-type: none"> <li>1. Incapable of financial self-sufficiency by reason of mental or physical disability; and</li> <li>2. Dependent upon the employee/retiree for at least 51 percent of his or her support and maintenance.</li> </ol> <p>A child must meet both of the requirements set forth above to qualify as an Incapacitated Dependent. The employee/retiree must provide proof of continuing disability annually or upon BCBS's request. A child who is age 26 or older who does not have a continuing disability will not be covered under the Plan. A disabled dependent may be covered up to age 65 (unless covered under Survivor benefits under the MEPP, in which case coverage may be terminated earlier). Further proof for coverage of children aged 26 and older includes: Copy of page one and two of your most recent 1040 tax return (you may redact wage and social security number information) showing your child as a dependent. Note: Page two must be signed and can be substituted by a confirmation page if you filed your taxes electronically OR one of the following:</p> <ul style="list-style-type: none"> <li>• Copy of birth certificate (Documents must show employee/retiree/dependent relation)</li> <li>• Custodial papers (must be filed with the court)</li> <li>• Court Order (must be filed with the court)</li> <li>• Adoption papers (must be filed with the court)</li> </ul> <p><u>AND</u> a disability form previously submitted to and approved by BCBS.</p>

## Eligibility for SRNS/SRR/SRMC/BSRA Employees Retired and Rehired, and Under Age 65

In general, the following rules apply if both you and your spouse are both under the age of 65: If you are eligible for coverage as a Pre-65 retiree under a Plan of SRNS, SRR, SRMC or BSRA and you are currently an active SRNS FSE ("Full Service Employee") Employee, you will only be eligible for the Active Employee Medical Benefit Plan. You will continue to be ineligible for the SRNS, SRR, SRMC or BSRA retiree Pre-65 Health plan until your employment with SRNS terminates. Your Pre-65 Retiree coverage will be placed in a Waive status. After your employment terminates, you will be eligible for the same Health benefits as similarly situated retirees.

## Eligibility for SRNS/SRR/SRMC/BSRA Employees Retired and Rehired, and Over Age 65

In general, the following rules apply if both you and your spouse are over the age of 65: If, at the time of being hired as an active SRNS Employee, either you or your spouse are over the age of 65 and have an active SRNS/SRR/SRMC or BSRA Health Reimbursement Account, you have the option of continuing your participation in your SRNS/SRR/SRMC or BSRA Health Reimbursement Account or electing coverage as an active SRNS Employee. However, you and your dependents are not eligible to participate in both the SRNS/SRR/SRMC or BSRA Health Reimbursement Account and the SRNS Plan for Active Employees. You should consider your options carefully, as there may be penalties, delayed enrollment, and medical underwriting when rejoining Medicare and/or a Medicare Supplement Plan when your employment ends. You will not be able to select both retiree benefits and active Employee benefits.

## Enrolling for Coverage

**During the annual Open Enrollment process, you will be asked to elect a choice of Medical and Dental plans (or no coverage), as well as a coverage level (e.g., retiree only or retiree plus spouse coverage). The chart at right outlines the medical plan and coverage level choices. The annual Open Enrollment period is usually in October each year. Watch your mailbox or email for information.**

### Initial Enrollment as a New Retiree

At the time of retirement, you will have the opportunity to enroll yourself and your eligible dependents in the Plan. You will not be able to change the plan you are in, but you will be able to add or delete dependents because retirement is a Qualifying Event, as set forth in the next paragraph and applicable law. You can only change the plan you are in during Open Enrollment. You will make any changes at the time you submit your retirement application. Your changes with respect to any dependents covered under the Plan will be effective on the first day of your retirement. Remember that retirement is always effective on the first of a month.

If you do not make an election regarding the plan you are enrolled in at this time, you will not be able to make such changes until the next Open Enrollment period the following calendar year. Open Enrollment changes are not effective until January 1 of the following year unless you have a Qualifying Event, as set forth in the next paragraph and applicable law.

You should allow at least three weeks after your retirement to fill any prescriptions or make doctor's appointments. The Active plans and the Retiree plans have different identifiers and you may have problems at the provider if you do not allow adequate time for SRNS to process the changes. This is especially true as you transition off this Plan and onto Medicare.

When your active employment ends you will be offered COBRA continuation coverage for any medical and/or dental coverage you were enrolled in at the time your employment terminated. If you elect COBRA continuation coverage for your SRNS medical and/or dental coverage, you will not be eligible for coverage under this Plan or the Post-65 Health Reimbursement Account (HRA).

You can elect coverage and add or delete eligible dependents from your coverage during the annual Open Enrollment period for the coverage to be effective at the beginning of the next calendar year. This is the only time you will be able to enroll your dependents without a Qualifying Event, as set forth in the next paragraph and applicable law. You will be required to provide supporting documentation each time you add a dependent.

Qualifying Event for an Employee, Spouse or Dependent	
<b>Change in legal marital status</b>	Marriage, death of a spouse, divorce, legal separation, annulment
<b>Change in number of dependents</b>	Birth, adoption, placement for adoption, death of a dependent child, acquisition of a step-child who will reside in your household as the result of a judgment, decree, or order including a Qualified Medical Child Support Order.
<b>Change in employment status</b>	Termination of employment for employee, spouse, or dependent child; Commencement of Employment for employee, spouse or dependent child
<b>Change in work schedule</b>	Permanent reduction or increase in hours by the employee, spouse or dependent child (including a switch between part-time and full-time); a strike or lock-out; Commencement, or return from, an unpaid leave of absence

<b>Change in which a dependent child satisfies or ceases to satisfy the Plan's eligibility requirements</b>	Attainment of age 26; Any circumstance that qualified or disqualifies the child under the Plan
<b>As related to the Medical Plan</b>	A change due to loss of coverage under a group health plan, Enrollment in Medicare, Medicaid or Tricare, or a special enrollment right due to loss of coverage elsewhere
<b>Newborn</b>	A newborn Child will have coverage upon the date of the Child's birth provided he or she has been enrolled for coverage and the coverage has been paid for under this Plan of Benefits within 60 days after the Child's birth for the Child to have coverage from the date of birth. If a newborn Child is not enrolled within the time frame set forth in the prior sentence, coverage will begin on the date chosen by the Employer and upon the payment of the applicable Premium. You must be enrolled to cover your child.
<b>Dependent children reaching age 26</b>	If SRNS Form OSR 5-200 is not submitted to remove your age 26 dependent, that dependent will automatically be dropped from the Plan at the end of the month in which they turn 26. If this changes your level of coverage, the level will be changed automatically on your behalf.

## Requesting Election Changes and Qualifying Events

Election changes and Qualifying Events are administered by the SRNS Health and Welfare Committee. Please do not call BCBS regarding these questions. For these questions, call the SRNS Service Center at 803.725.7772 or 1.800.368.7333. These changes must be submitted on the OSR 5-200 form. The OSR 5-200 form is available on the SRS website at [www.srs.gov](http://www.srs.gov).

You will only be able to add or delete a dependent and change your level of coverage (retiree, retiree plus one dependent, retiree plus two or more dependents) under your medical care elections because of a Qualifying Event. You will not be able to change the Plan option (Medical Standard or Basic and Dental Prime or Standard) that you elected during Open Enrollment. You must be enrolled in the Plan to enroll a dependent.

### ***When can I make changes?***

Generally, you are permitted to make Plan election changes only during the annual enrollment period, which will be effective beginning January 1 of the following year. Your Plan elections must stay in effect for the full calendar year (also known as the Plan Year). You cannot change your benefit level of coverage during the calendar year unless you have a qualifying event for benefit coverage purposes. The rules set forth below 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 a Qualifying Event 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. If you are outside of the 60-day window, you will not be permitted to add dependents. You may be able to drop dependents, but you will not be eligible for premium refunds or entitled to COBRA eligibility.

### ***Add or Delete Dependent***

To add or delete dependents from your coverage due to a Qualifying Event, complete SRNS Form OSR 5-200 (available on [www.srs.gov](http://www.srs.gov) and/or by contacting the Service Center). Submit the form and supporting documentation to the SRNS Service Center, Bldg. 992-2W Savannah River Site, Aiken, SC 29808 within 60 days of the Qualifying Event. Any change you request under the Plan must be consistent with your Qualifying Event. Proof of the Qualifying Event will be required. For example, if you get married you may add your new wife and any new step-children, but you cannot delete your own child who is currently covered.

### ***Newborn Children***

Newborns are not automatically covered under the parent's coverage for the baby's initial hospitalization. The new parent should submit an OSR 5-200 with a copy of the birth certificate as soon as possible after the birth. Coverage can begin retroactive to the newborn's birth date, but the request must be submitted within 60 days of the birth date.

You should submit your request to add your newborn to the SRNS Service Center even if the newborn's Social Security number hasn't been assigned. You will be required to submit the Social Security number as soon as it is available.

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 (e.g., a newborn), you should submit the Social Security number to the SRNS Service Center as soon as you receive it.

### ***Legally Required Documentation***

Whenever you are adding or removing dependents from coverage, you will be requested to supply a copy of an official document such as a birth certificate, marriage certificate, adoption 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. The document should be in English. If the document is not in English, a translation, along with a translator's certificate, should also be provided. (A list of Acceptable Documentation is found on page 7 of this SPD.)

If you, your spouse or your dependent child experiences a Qualifying Event, but you do not need to change your coverage level, you must still immediately notify the Service Center for the child to be covered at BCBS. 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 Event and eligibility for benefits under the Plan, and will have the final decision-making authority regarding any allowable changes. Periodic dependent audits will be conducted.

The benefit changes you want to make must be consistent with the Qualifying Change in Status. That is, the event must result in the retiree, spouse or dependent child gaining or losing eligibility for coverage under either the Plan or the spouse's or dependent child's employer's plan. Documentation will be required.

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 be a Qualifying Event and you may be eligible 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 events listed on the next table may be considered Qualifying Events if they result in a change in eligibility for health care. The change must be made as of the effective date (unless added during Annual Open Enrollment).

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 may constitute fraud or an intentional misrepresentation and may result in the retroactive cancellation of coverage. The Plan may seek recovery for any claim payments paid past the claimant's eligibility date, including offsetting of future claims for you and your remaining eligible dependents until the claim amounts made on behalf of the ineligible dependent(s) are recouped, and you will not be able to receive a refund of any premium contribution overpayments. The Claims Administrator also has the right to reprocess the claims, in such a case you will have the responsibility for paying any outstanding amount to the provider. In the event of a divorce, the "60-day clock" begins on the date the final divorce decree is filed by the clerk of court. Submit SRNS Form OSR 5-200, "Health Care Enrollment/Change Form" to the Service Center to remove your dependents from the Plan.

### **Identification Cards**

Once you make your health plan coverage election, you will receive an identification (ID) card(s) from BlueCross. You will automatically receive two ID cards. If you enroll in retiree plus two or more coverage, you will receive four ID cards. 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 BlueCross. You may also request additional cards online at [www.SouthCarolinaBlues.com/myhealthtoolkit](http://www.SouthCarolinaBlues.com/myhealthtoolkit). The ID cards are always in the subscriber's name. Electronic ID cards are available on the mobile app My Health Toolkit.

### **Coverage Effective Date and Cost**

Your coverage begins on the effective date of your retirement (always the first of the month). If you waive coverage and enroll during the annual Open Enrollment or upon a Qualifying Event, your coverage is effective as of the beginning of the Plan Year (calendar year), or on the effective date of your Qualifying Event, whichever applies. Coverage for your eligible dependents, if you elect coverage for them, begins at the same time as your coverage or on the effective date of the Qualifying Event, whichever applies.

You and the Company share in the cost of the coverage provided under the Plan. The amount of your premium contribution depends on the medical option you elect and whether you elect coverage for yourself only or for yourself and your dependents. The premium contribution for the coverage you select will be based on your applicable pay period. Premiums are not prorated for a Qualifying event. Your premium will be determined by the Plan you are enrolled in and the level of coverage (retiree only, retiree +1, or retiree +2 or more) that is in effect at the end of your pay period (or at the time of payroll processing).

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

If your pension check is not enough to cover the cost of premiums, you will be placed in the Benefits billing system. We will send you a courtesy invoice monthly. However, even if you do not receive an invoice, premiums are due on the first of the month. Failure to pay by the end of the month will result in cancellation of your coverage and you will not be allowed to enroll in any SRNS Health Plans or the Health Reimbursement Account (HRA) at any future date.

## **When Coverage Ends**

Your coverage ends when:

- you no longer elect to be covered by one of the Health Plan options (waive) during Open Enrollment or experience a Qualifying Event;
- on the first day of the month in which you turn age 65 and become eligible for Medicare according to the eligibility rules of Medicare when you are retired and participating in the Plan. This will be on the first of the preceding month if your birthday is on the first of the month;
- you no longer meet eligibility requirements (e.g., your death);
- you fail to make the required premium contributions by their due date (this is always the first of the month); or

- the Plan is amended such that you are no longer eligible for coverage, or terminated entirely.

Coverage for your dependents ends when:

- you no longer elect to cover them (during annual Open Enrollment);
- they no longer meet the eligibility requirements (in the case of a dependent child who attains age 26, coverage will terminate at the end of the calendar month in which they turn 26);
- a Qualifying Event occurs (and as a result, you elect to remove a dependent from medical coverage). You will be required to provide proof of the Qualifying Event to the Service Center within 60 days of the event;
- the required premium is not received by the due date;
- your coverage ends; or
- the Plan is amended such that you or your dependents are no longer eligible for coverage, or terminated entirely.

. In certain situations, you and your dependents may be eligible to continue coverage. (See "COBRA Continuation Coverage" section.)

## Coverage Continuation in Special Situations

If you are an "Incumbent" Employee under the terms of the MEPP and you terminate employment and meet the MEPP eligibility for retirement provisions under the Normal, Early, Optional or Incapability Retirement provisions, you may be eligible for participation in this Plan or the Post-65 Retiree Health Reimbursement Account as a retiree unless otherwise excluded. See the Post-65 Retiree Health Reimbursement Account SPD for eligibility requirements.

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

**If you turn 65 and are a retiree**, you are no longer eligible for coverage under this Plan. However, your covered dependents can continue to be covered in the Plan as long as they meet the eligibility requirements of the Plan and premium payments are made by their due date.

**If you at any time waived your coverage** because you had other employer group coverage, you are eligible to enroll when your other employer group coverage ends provided: 1) you have maintained continuous coverage under another employer group health plan(s) and 2) your request is received within 60 days and you provide documentation of the type and termination date of the other coverage.

If you are approved for Long-Term Disability under the Disability Income Plan, you may be eligible to continue coverage under this Plan in lieu of COBRA continuation coverage for as long as you are eligible and/or approved for LTD or up to a maximum of 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. Since your employment ends after being enrolled in LTD, your coverage will be transitioned to this Plan on the date your LTD benefit begins. You will be charged according to the current Plan premium rate schedule during the period you are approved for LTD. You and your eligible dependents will remain in this Plan even if you are or turn 65 anytime during the 24-month coverage period as long as you remain eligible. (See "When Coverage Ends" section) In certain situations, you and your dependents may be eligible to continue coverage. (See "COBRA Continuation Coverage" section.) If an employee dies, the dependent coverage will end at the end of the pay period. If you become eligible for Medicare Part A and/or B, this Plan will be the secondary payer. If your premium payments cannot be deducted from your paycheck or Long Term Disability (LTD) check you will be billed. In the event you fail to pay your premium by the due date your coverage will be terminated retroactively back to the last full month paid.

## Survivor Benefits

If you are an "incumbent" Employee under the terms of the MEPP, and you meet the MEPP eligibility for retirement provisions for Optional, Early, Normal or Incapability Retirement and you die, your dependents may be eligible for participation in this Plan or the Post-65 Health Reimbursement Account. Please see the MEPP Summary Plan Description for a complete description of retirement eligibility.

If you die as an active incumbent Employee, upon your death, coverage for your dependents under the active plan will end on the last day of the month in which you die. If you meet the retirement provision of the MEPP (generally 50 years old and 15 years of eligibility service), your dependents may be eligible for coverage under this Plan.

- **If you are married and your surviving spouse is under the age of 65**, your spouse may be covered under this Plan up until age 65 and your spouse may cover your dependent children (natural/adopted/step) up until the end of the year in which they attain age 26 under this Plan. If your spouse is living and receiving the Survivor benefit under the MEPP, disabled children may be covered up to the age of 65. Coverage for ALL dependent children will end at the end of the month when/if the surviving spouse dies.
- **If you are married, and your surviving spouse is over the age of 65**, your spouse may be eligible for the Post-65 Health Reimbursement Account (HRA). Please see the Summary Plan Description for the Post-65 HRA. Your children could be covered under this Plan up to the end of the year in which they attain age 26 if they meet the rules for eligible dependents under the surviving spouse. Disabled children may be covered up until age 65. If your spouse dies, the coverage for all children (including disabled) will end on the last day of the month in which the surviving spouse dies.
- **If you are unmarried** at the time of your death and you qualified for retirement (generally 50 years and 15 years of service) under the MEPP and your dependent children (including disabled children) will receive a retirement Survivor pension from the MEPP, they may be covered under this Plan up until age 21. This is because the MEPP Survivor benefit ends at age 21. Coverage will end at the end of the month in which the child turns 21.

If you die as an Early, Optional, or Incapability Retiree under the MEPP, your spouse and your children would continue to be eligible to participate in this Plan as follows:

- **If you are married, your surviving spouse is under the age of 65**, your spouse would be eligible for coverage up to the age of 65. Your Children could be covered under your surviving spouse up to the age of 26 if they meet the rules for eligible dependents under the surviving spouse. Disabled children may be covered up until age 65. If your spouse dies, the coverage for all children (including disabled) will end on the last day of the month in which the spouse dies.
- **If you are married, and your surviving spouse is over the age of 65**, your spouse would continue to be eligible for the Post-65 Health Reimbursement Account (HRA). Please see the Summary Plan Description for the Post-65 HRA. Your children could be covered under this Plan up to the age of 26 if they meet the rules for eligible dependents under the surviving spouse. Disabled children may be covered up until age 65. If your spouse dies, the coverage for all children (including disabled) will end on the last day of the month in which the spouse dies.
- **If you are unmarried** at the time of your death and your children (including disabled) receive a retirement Survivor pension under the MEPP, they may be covered under the Pre-65 Plan up until the end of the month in which they turn age 21. This is because the MEPP Survivor benefit ends at age 21.

Your dependents are not eligible for benefits under this Plan if you are

- not eligible for a normal, early, incapability or optional retirement under the MEPP;
- not an Incumbent; or
- are eligible for a Vested Pension Benefit under the MEPP.

# The Medical Plan for Pre-65 Retirees

This section includes important information about the medical portion of the Plan. The “Benefits at a Glance” and “Prescription at a Glance” charts are intended to cover some of the more common services and are not intended to be all-inclusive. For more information, please refer to the BlueCross BlueShield of South Carolina Plan of Benefits available under the BCBSSC My Health Tool Kit or [SRS - Retiree Benefits](#) for Information.

## Medical benefits at a glance

Expenses	Standard		Basic	
	Network	Non-Network (7)	Network	Non-Network (7)
<b>Annual Deductible</b>				
Individual	\$600	\$600	\$2,000 (1)	\$2,000 (1)
Family	\$1,200 (No one family member can exceed the Individual amount)	\$1,200 (No one family member can exceed the Individual amount)	\$4,000 Family (Aggregate: All Family Members Combined)	\$4,000 Family (Aggregate: All Family Members Combined)
<b>Out-Of-Pocket Maximum (2)</b>				
Individual	\$2,000	\$2,000	\$4,500 (1)	\$4,500 (1)
Family	\$4,000 (No one family member can exceed the Individual amount)	\$4,000 (No one family member can exceed the Individual amount)	\$7,150 (Aggregate: All Family Members Combined)	\$7,150 (Aggregate: All Family Members Combined)
<b>Physician Office Visit (3)</b>				
Primary	\$20 Copay	15% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)
Specialist	\$30 Copay			
<b>Preventive Care Office Visits</b> (based on schedule)	\$0	Not covered	\$0	Not covered
<b>Allergy or hormone injections</b> by nurse in physician's office	15% Allowable Charge (after Deductible)	15% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)
<b>Chiropractic Services</b> including spinal manipulation/subluxation, related X-rays, modalities and office visits (4)	15% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)
<b>Physical and Occupational Therapy</b>	15% Allowable Charge (after Deductible)	15% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)
<b>Ambulance Service</b> (including air ambulance)	15% Allowable Charge (after Deductible)	15% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)

<b>Hospital, Surgical and most other medical services (3) (5)</b>	15% Allowable Charge, (after Deductible)	15% Allowable Charge, (after Deductible)	20% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)
<b>Emergency Room Services</b> (life threatening acute or urgent care)	15% Allowable Charge, (after Deductible)	15% Allowable Charge, (after Deductible)	20% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)
<b>Emergency Room Services</b> (for routine use)	30% Allowable Charge (after Deductible)	30% Allowable Charge (after Deductible)	30% Allowable Charge (after Deductible)	30% Allowable Charge (after Deductible)
<b>Diagnostic Services</b> (lab, x-ray and other tests) when not performed in a physician's office (6)	15% Allowable Charge (after Deductible)	15% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)
<b>Home Health Care, Hospice Care, Durable Medical Equipment (5)</b>	15% Allowable Charge (after Deductible)	15% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)
<sup>8</sup> <b>Blue CareOnDemand</b>	\$10 Copay (before Deductible)	N/A	\$64 before Deductible; \$10 Copay after Deductible	N/A
<b>Musculoskeletal Precertification Program</b>	15% Allowable Charge (after Deductible)	15% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)	20% Allowable Charge (after Deductible)

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, Copays and Coinsurance amounts (10%, 15%, 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/benefit year
5. Pre-Authorization required
6. Preauthorization is required for out-patient major diagnostic procedures (MRI, MRA, CT scans, PET scans, etc.)
7. Members are subject to balance billing by the non-network provider. (Refer to the "No Surprise Act" section for protections from Surprise Billing)
8. Cost may vary for behavioral health services

Note: All Admissions, Rehabilitation Services, Behavioral Health Services and some Out-Patient services require Preauthorization. If Preauthorization is not obtained, charges may be denied.

## General information

### Preventive Care Benefits

One of the most important steps you can take for your health is to schedule regular checkups. It is your responsibility to understand the Company's benefit plan and coverage for preventive care. For current information on preventive care, please visit [www.Healthcare.gov](http://www.Healthcare.gov).

As part of the Affordable Care Act (ACA), certain preventive services must be covered at 100% of the Allowable Charge at an in-network provider without charging you a copayment or coinsurance even if you have not met your deductible. This applies to both the Standard and Basic Plans. The Plans will pay 100% provided the claim is filed as routine/preventive care. If your provider charges you a copayment or coinsurance, it is a good indication that they do not plan to file the claim under the preventive care guidelines. Make sure you work with your provider on filing the claim.

Preventive care includes health services like screenings, check-ups, and patient counseling that are used to prevent illnesses, disease and other problems, or to detect illness at an early stage when treatment is likely to work best. Getting recommended preventive series and making healthy lifestyle choices are key steps to good health and well-being. Recommendations may vary, so be sure to discuss screening options with your doctor.

Certain vaccinations are available through your provider's office as a benefit under the Medical portion of the Plan. Certain vaccinations are also available through your pharmacy. Please see the section on seasonal and non-seasonal vaccines.

Remember, these preventive services are only free when delivered by a doctor or other provider in the Plan's network.

## Seasonal and Non-Seasonal Vaccine Network

Covered retirees and their dependents can get vaccines covered under their pharmacy benefit at no charge to Plan participants. To have coverage, members must use a pharmacy in the OptumRx network that offers the vaccines.

Non-seasonal vaccines usually include tetanus, shingles (Zostavax) and hepatitis B.

The flu vaccine does not require a prescription, but some non-seasonal vaccines may require a prescription. Some pharmacies may administer without a prescription, so it is best to call ahead and check the requirements.

A complete list of the participating pharmacies is available under My Health Toolkit on the [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) website.

If you have questions concerning this benefit, contact BlueCross customer service at 1.800.325.6596. Contact BlueCross directly to determine which specific vaccine and delivery method is covered.

You can find the most current and complete information about the BlueCross preventive care schedule for immunizations on their website at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com). Benefits for these services are not covered if you use non-Network Providers.

## Individual Case Management

BlueCross 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.

## Oncology Case Management

### Support for members with cancer

Finding out you have cancer can cause a flood of emotions. You may feel shocked, sad, angry, afraid or powerless. It's normal to have these emotions or to feel nothing at all. Everyone reacts differently, and your feelings may change from one moment to the next. Companion Care Solutions is a program offered at no cost to help you through these difficult times.

### How this program can help

The goal of all Companion Care Solutions programs is to help you have the best quality of life possible. The program will link you with a personal case manager, a registered nurse with experience in cancer care. Your case manager will partner with you to help you reach your health goals, coordinate care, navigate the health care system, and make the most of your health insurance benefits. Coping with cancer can be complicated. You may need intensive treatments and changes to your lifestyle, medications and diet. Our program offers extra help and support to help you navigate these changes.

### Your case manager can:

- Coordinate care among all your providers. This might include a primary care physician, oncologist and others.
- Provide support and education.
- Make sure you get counseling to help improve your quality of life.
- Help you in managing the costs associated with your condition by making the most of your health insurance benefits.

**For more information about the Companion Care Solutions Oncology Case Management program, please call 1.800.790.5770.**

## Proactive Member Messaging

The Plan provides you with access to BlueCross Proactive Member Messaging, a program that offers opportunities to save money, wellness reminders and program specific promotions. Opportunities to save on prescriptions and medical services are offered through Ways to Save® alerts, a product of Change Healthcare. To sign up for Ways to Save® alerts, log into My Health Toolkit. Wellness reminders and program promotions are offered through Relay®, a text marketing communications channel. To participate, call 1.844.206.0623. Relay Network, LLC and Change Healthcare are independent companies that provide the Proactive Member Messaging program on behalf of BlueCross.

## Blue CareOnDemand Telehealth Service

Blue CareOnDemand is a convenient telehealth service from BlueCross BlueShield of South Carolina.

With Blue CareOnDemand, you can consult a U.S. board-certified physician using a smartphone, tablet or computer rather than visiting an office or urgent care facility. All you need is your computer or mobile device to see a doctor any time, day or night. During your video visit, the doctor will ask questions, answer questions, diagnose your symptoms and, if appropriate, call in a prescription to your local pharmacy.

Blue CareOnDemand is not a replacement for your primary care doctor. You should continue scheduling office visits for regular checkups and preventive care. For true emergencies and life-threatening issues, go to the emergency room or call 911.

Blue CareOnDemand doctors treat these types of conditions and more: Cold and flu symptoms, allergies, bronchitis and other respiratory infections, migraines, sinus problems, rashes and other skin irritations, ear infections, urinary tract infections and pinkeye.

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

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

BCBSSC has enhanced their telemedicine program by offering a Behavioral Health Model and a Breast-Feeding Support module. There is no additional cost for these enhancements, and they will be offered at the same Employee co-payments in place now:

## Copayment for Blue CareOnDemand

**Standard:** \$10 copay and may vary.

**Basic:** Blue CareOnDemand cost vary depending on the type of service provided.

## Common Terms Used by Both Plans

For more information on terms, please see the Definitions section.

**Allowable Charge:** The Allowable Charge is the total payment for eligible services, supplies, or equipment as determined by BlueCross that will be paid to Providers participating in the BlueCross 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 Deductible or Out-Of-Pocket maximums.

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

**Coinsurance:** A coinsurance is the percentage you pay after reaching your deductible. If you do not pay a copay, most likely a coinsurance will apply. In most cases you will pay between 15% and 30%. See the "Benefits at a Glance" chart for more information. Any coinsurance amount you pay counts toward your deductible and your out-of-pocket. Coinsurance is required for:

- Laboratory work that your Network physician sends to an outside laboratory or x-rays performed outside the physician's office;
- Physician hospital services;
- Surgery performed in the Network physician's office;
- Allergy injections when performed by a nurse and billed with no other service from that physician's office on that date (other injections may require a copay);
- Prenatal care billed under surgery code for total obstetrical care;
- Prescriptions, for most tiers (see the "Basic Plan" section).

**Copayment (copay):** A copay is a fee you pay for office services or prescription drugs. A copay is required for:

- Physician's office visit under the Standard Plan;
- Blue CareOnDemand under the Standard Plan and after deductible is met on the Basic Plan;
- For generic drugs under the Basic Plan.

**Deductible:** A deductible is an amount you pay each year before the Plan begins to share costs with you. The amount will be evaluated each year and announced during the annual Open Enrollment. There is no carryover of unsatisfied deductible amounts from one year to the next. Your deductible amount starts over each benefit year.

**Medically Necessary:** The service provided is not more or less expensive than the standard of care for the condition as presented.

**Preventive Care Services under the ACA:** Preventive care services are based on the services in the preventive care schedule and are paid at 100% before the deductible when you use a Network physician. They are not covered when you use a non-Network physician. Also, there is a list of ACA-mandated generic drugs that are covered at 100%. Go to [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) to see the list.

**Your Share of Expenses:** You are responsible for certain expenses:

- The deductible, coinsurance amounts and copays;
- Any expenses above the allowable amount at a non-Network provider (pay special attention to ambulance services);
- Expenses not covered;
- Charges that exceed the option's limitations on certain services; and
- Any charges for procedures not considered Medically Necessary

**Out-Of-Pocket Maximum:** Under each option, there is an annual Out-of-Pocket Maximum, which is the most you will pay in copays, deductibles and coinsurance for Covered Expenses during any one benefit year. Once the maximum is reached, your medical plan option begins to pay 100% of the allowable amounts for eligible expenses. The Out-of-Pocket Maximum is designed to protect you against having to pay extraordinary medical bills in each year. The annual Out-of-Pocket amount will be evaluated each year and announced during Open Enrollment. There is no carryover of unsatisfied Out-Of-Pocket amounts from one year to the next. Your Out-Of-Pocket amount starts over each Benefit Year.

## Out-of-Pocket Maximum

Out-of-Pocket Maximum	Standard Plan	Basic Plan
Retiree only	\$2,000 per person	\$4,500
Retiree + One Retiree + Two or More	\$4,000 No one member can exceed \$2,000. All members combined cannot exceed \$4,000.	\$7,150 Aggregate. Must meet this amount for all family members combined.

## Out-of-Pocket Maximum: What counts (and what doesn't)

What counts	What doesn't
Copay and coinsurance amounts from Network Providers	Copayments at Non-Network Providers
Any services that count toward your Deductible also count toward your Out-of-Pocket Maximum	Medical expenses that are not covered by your Medical Plan.
Prescription drugs, unless otherwise excluded (for example, brand name penalties)	Penalties incurred for hospital stays or major out-patient diagnostic procedures (MRI, MRA, CAT scans, PET scans, etc.) that have not been preauthorized
Blue CareOnDemand	Expenses above the allowable charge for each covered service
	Non-covered prescription drugs and penalties under the Mandatory Generic, Step Therapy and Quantity Management Programs and maintenance medication not purchased through the OptumRx Mail Order Pharmacy (Mandatory Mail Order Service Program)
	Preventive Care at Non-Network Provider (not covered)

# Medical Plan Choices

## Standard and Basic Medical Options

When you enroll in the Plan, you choose the coverage option that's right for you, or you can elect no medical coverage. Both the Standard (Preferred Provider Option, PPO) and Basic (High Deductible Health Plan) offer a choice of Network and non-Network care. You should always use "My Health Toolkit" at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) or call BlueCross customer service at 1.800.325.6596 when searching for Network providers.

Both the Basic and the Standard Plan use the same provider Network. For South Carolina providers, it is the PPO Network. For Georgia providers, it is the Blue Open Access Point of Service (POS) Medical Network. Although we use the Georgia POS medical network, the Plan is **NOT** a POS plan.

## How the Standard and Basic Plans Are Similar

Both options are alike in many ways. Each option has provisions on deductibles, Out-of-Pocket Maximums, allowed amounts and annual maximums. In addition, both plans:

- Cover the same health care expenses overall
- Exclude the same expenses (see Appendix B, "Expenses Not Covered")
- Use the same BlueCross Network of medical providers
- Are designed so that your share of the cost is limited when the cost of covered treatment exceeds specified amounts (annual Out-of-Pocket Maximum expenses for covered services);
- Have allowed amounts set by provider contract and do not vary by Plan.

## How the Standard and Basic Plans Are Different

The deductible in the Basic Plan works differently than the Standard Plan deductible. The Individual deductible applies to Individual Only coverage. The deductible is applied before you are reimbursed for most covered services. However, if you are enrolled in the Basic Plan, Retiree + One, or Retiree + Two or more, **the entire family deductible must be met before any reimbursement is made for most covered services.** After you have paid your deductible, you will then pay between 20% and 30% of the allowable charge (30% of the allowable charge when you use an emergency room for routine, non-emergency care). See the "Benefits at a Glance" located at the beginning of the booklet as well as the BlueCross BlueShield Plan of Benefits for specific coinsurance amounts.

## Standard Medical Option

The Standard Medical option gives you the choice of receiving medical care from providers participating in the BlueCross Medical Networks or going to a provider who is not part of the Medical Network. The Standard Plan generally provides a higher level of coverage if you use a BlueCross Network provider as you will not be balanced billed by the provider for charges above the Allowable Amount. Preventive care is not covered when you use a non-Network provider.

## Standard Plan Copayments

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.

### Standard: Copay

**Primary Care:** \$20

**Specialist:** \$30

When you see a specialist (such as a neurologist, dermatologist or podiatrist, etc.), you pay a \$30 copay.

The copayment does not count toward your deductible but will count toward your Out-of-Pocket Maximum.

## Out-of-Pocket Maximum

Your Out-of-Pocket Maximum for covered services is \$2,000 per person (or \$4,000 for your entire family) in a benefit year. The Standard Plan Out-of-Pocket Maximum includes your copays, deductible and coinsurance, but not your charges incurred for non-Covered Expenses. Preventive care services are not covered at all unless you use Network providers and would not count toward your Out-of-Pocket Maximum. Once you reach the Out-of-Pocket Maximum, the plan will pay 100% of the allowed amount of Covered Expenses.

Under the Standard Plan, the individual Out-of-Pocket Maximum is the amount that must be paid by one person each calendar year and applies under both the individual and family options. No one family member will exceed the individual (per member) Out-of-Pocket Maximum. If the family Out-of-Pocket Maximum (\$4,000) is met by other family members, then this member will not have to meet the individual Out-of-Pocket Maximum amount since the family's maximum is met.

Note that if all family members combined meet the family Out-of-Pocket Maximum, no one person must meet the \$2,000 individual Out-of-Pocket Maximum.

## Standard Option Quick Look

*Higher premiums than the Basic Plan*

*Lower deductible than the Basic Plan*

*Lower coinsurance than the Basic Plan*

*Copayments of \$20/\$30 for office visits*

*Lower Out-of-Pocket Maximum than the Basic Plan*

*No one family member can exceed individual deductible*

*Can be used with Healthcare Traditional Spending Account*

Standard Option: Annual Deductible	
Individual Only	\$600 per person
Entire Family	\$1,200 No one member can exceed \$600. All members combined cannot exceed \$1,200.

## Standard Plan Deductibles

Under the Standard Plan, the Individual Only deductible is the amount that must be paid by one person each calendar year and applies under both the Individual and Family options. No one family member will exceed the individual (per member) deductible. If the family deductible is met by other family members, then this member will not have to meet the single deductible amount since the family deductible is met. Note that if all family members combined meet the family deductible, no one person must meet the individual deductible.

For services, other than preventive care and doctor visits requiring a copay, you must pay a deductible before the Plan begins to pay. This includes prescription drugs. The individual annual deductible is \$600 per person (\$1,200 for your entire family). For coverage levels other than Individual Only, no one member can exceed the individual deductible amount.

Under the Standard option, the deductible applies to all services except for doctor visit copays, preventive care, and Blue CareOnDemand. The Service Examples chart below highlights a few major expenses; however, the chart is not intended to be all-inclusive.

## Prescription Drugs

Covered prescription drugs count toward the annual deductible. After the deductible is met, you will pay a coinsurance amount: The copay is 10% for generic medications, 20% for preferred medications, and 30% for non-preferred brand name drugs. See information regarding mail order and other pharmacy benefit requirements under the "Prescription Drugs" section. There are certain ACA preventive medications that are paid for at 100%. Refer to the ACA preventive drug list at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com).

## Other Expenses

If you go to either a Network or a non-Network provider, for most other Covered Expenses you will pay between 15% and 30% of the allowable charge (Network allowed amount) after the deductible. If you go to a non-Network provider, the non-Network providers may "balance bill" you up to the amount above and beyond the BlueCross allowable charge.

If you receive certain additional covered services (e.g., surgery performed in the physician's office), after you meet your deductible, your cost will include a coinsurance (percentage of the allowable charge) for the additional covered services plus your \$20 or \$30 copay.

<b>Standard Option Deductibles: Service Examples</b>	
You will pay 100% of these charges UNTIL you meet your deductible	The Plan pays BEFORE you meet your deductible (and so, does not count toward deductible)
<p style="text-align: center;">Covered services rendered by Network and non-Network providers (other than office visits)</p> <ul style="list-style-type: none"> <li>•</li> <li>Emergency Room</li> <li>•</li> <li>Prescription drugs <i>(unless otherwise excluded; for example: brand name drug penalties, mandatory mail order service program)</i></li> <li>•</li> <li>Chiropractic</li> <li>•</li> <li>Non-Network office visit</li> </ul>	<p style="text-align: center;">Copays for Network physicians office visits (\$20/\$30)</p> <ul style="list-style-type: none"> <li>•</li> <li>Blue CareOnDemand \$10 copayment</li> <li>•</li> <li>Preventive care (100% at Network Provider)</li> <li>•</li> <li>ACA Preventive Drugs</li> </ul>

## Basic Medical Option

The Basic Plan (High Deductible Health Plan) offers lower premiums than the Standard Plan but requires that you meet a higher deductible before reimbursement for most covered services. In addition, a coinsurance is used in most cases as opposed to a copayment.

For example, at the first of the year, you are responsible for paying the entire cost of doctor visits as opposed to the Standard plan which has a \$20/\$30 copayment. There is a copayment with the Generic Tier of the Prescription Drug Plan and with the Blue CareOnDemand after you meet your deductible.

Also, participants in the Basic plan are eligible for a pre-tax Health Savings Account (HSA) to help pay for current and future unreimbursed medical expenses. This is one of the principal advantages of the Basic Plan. See the section on HSA for additional information.

### Office Visit: Coinsurance

When you go to a Network physician, you pay a 100% of the allowable charge for the office visit until you meet the deductible. This visit might consist of one or more of the following: exam, in-office lab work or in-office x-ray. Once you meet the deductible, you will generally pay 20% of the allowable charge. This will count towards your deductible and your Out-Of-Pocket Maximum.

### Out-of-Pocket Maximum

Once you reach the benefit year Out-of-Pocket Maximum, the plan will pay 100% of allowable charge for Covered Expenses. Your Out-of-Pocket Maximum for covered services is \$4,500 for Individual Only coverage or \$7,150 for "Individual +1" or "Individual + 2 or More", in a benefit year. The Basic Plan Out-of-Pocket Maximum includes your copays, deductible and coinsurance, but not your charges incurred for non-Covered Expenses. Preventive care services are not covered at all unless you use Network providers and would not count toward your Out-of-Pocket Maximum. Once you reach the Out-of-Pocket Maximum, the plan will pay 100% of the allowed amount of Covered Expenses.

One major difference between the Standard and Basic Plans is the way the Out-Of-Pocket (and the deductible) are met. Under the Basic Plan, the Individual Only Out-of-Pocket Maximum is the amount that must be paid by the individual in the Basic Plan. However, if you are in the "Individual + One" and "Individual + Two or More" tiers of coverage, you must meet the entire family Out-Of-Pocket before the Plan begins to pay at 100% for covered services. **This is very different from the Standard Plan.** This means you will have to pay \$7,150 before the plan begins to pay at 100%.

## Basic Option Quick Look

*Lower premiums than the Standard Plan*

*Higher deductible than the Standard Plan*

*Higher coinsurance than the Standard Plan*

*Coinsurance for office visits after deductible is met*

*Higher Out-of-Pocket Maximum than the Standard Plan*

*Preventive Maintenance Drug List (plan pays before you meet deductible)*

*Family must meet entire deductible before plan begins to pay*

*Can be used with Healthcare Limited Spending Account*

*Can be used with Health Savings Account*

Basic Option: Out-Of-Pocket Maximum	
Individual Only	\$4,500 per person
Individual + One Individual + Two or More	\$7,150 You must meet the entire family Out-Of-Pocket before the Plan begins to pay at 100% for covered services.

Basic Plan: Annual Deductible	
Individual Only	\$2,000
Individual + One Individual + Two or More	\$4,000 Aggregate Must meet this amount for all family members combined before claims are paid

### Basic Plan: Deductibles

Under the Basic Plan, the deductible applies to all services except for preventive care (you pay for all services until the deductible is met). The amount of the deductible will be evaluated each year and announced during annual Open Enrollment.

The deductible in the Basic Plan works differently than the Standard Plan deductible. The Individual deductible of \$1,600 applies to Individual Only coverage. The deductible of \$1,650 is applied before you are reimbursed for most covered services. However, if you are enrolled in Individual + One, or Individual + Two or more, the entire family deductible of \$3300 must be met before any reimbursement is made for most covered services. After you have paid your deductible, you will then pay between 20% and 30% of the allowable charge (30% of the allowable charge when you use an emergency room for routine, non-emergency care). See the "Benefits at a Glance" page for specific coinsurance amounts.

Most expenses apply toward your deductible. This means you must pay 100% of these expenses before the coinsurance percentage applies. Note that preventive services performed at a non-network provider are not covered at all.

The chart below is not intended to be all inclusive but is intended to highlight a few of the major expenses.

You will pay 100% of these charges UNTIL you meet your deductible	The Plan pays BEFORE you meet your deductible (and so, does not count toward deductible)
<p style="text-align: center;">Covered services rendered by Network and non-Network providers</p> <ul style="list-style-type: none"> <li>•</li> <li>Emergency Room</li> <li>•</li> <li>Prescription drugs <i>(unless otherwise excluded; for example: brand name drug penalties, mandatory mail order service program)</i></li> <li>•</li> <li>Chiropractic</li> <li>•</li> <li>Non-Network office visit</li> <li>•</li> <li>Blue CareOnDemand Varies depending on service utilized</li> </ul>	<p style="text-align: center;">Preventive Care (100% at Network provider)</p> <ul style="list-style-type: none"> <li>•</li> <li>ACA preventive drugs</li> <li>•</li> <li>SRNS Expanded Preventive Drug List <i>(See "Prescription Drugs" section)</i></li> </ul> <p style="text-align: center;">The Expanded Preventive Drug list applies to your deductible</p>
<p><i>Note: Blue CareOnDemand coinsurance varies by service provided.</i></p>	

## Prescription Drugs

Covered prescription drugs count toward annual deductible. You will pay 100% of the allowable cost of the drug under the Basic Plan until you reach the deductible, then you will pay a coinsurance amount for generic, preferred brand, and non-preferred brand name drugs. See information regarding mail order and other pharmacy benefit requirements under the "Prescription Drugs" section. There are certain preventive medications that are paid for at 100% per the ACA. There is a list of these drugs on [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com). In addition, under the Basic Plan, an expanded list of preventive maintenance drugs can be paid for before the deductible is met. See [www.SouthCarolinaBlues.Com](http://www.SouthCarolinaBlues.Com), or [www.srs.gov](http://www.srs.gov) > Careers > Active & Retiree Benefit Information. The maximum coinsurance amount applies to these as well. This is another significant difference between the Standard and Basic Plan. This list is not applicable to the Standard Plan. For more information see the Prescription Drug section of this SPD.

## Other Expenses

If you go to either a Network or a non-Network provider, for most other Covered Expenses you will pay between 20% and 30% of the allowable charge (Network allowed amount) after the deductible. If you go to a non-Network provider, they may "balance bill" you up to the amount above and beyond the BlueCross allowable charge.

# Health Savings Account

In conjunction with the Basic Plan, SRNS offers the opportunity **for the retiree** to participate in a Health Savings Account (HSA). Once you are enrolled in the Basic High Deductible Health Plan, you may be eligible to establish a tax-advantaged HSA to pay for eligible health care expenses.

An HSA is a tax-exempt trust or custodial account set up with a qualified trustee. The qualified trustee for SRNS is HSA Bank. You may access your account directly from HSA Bank. SRNS will provide, with your authorization, HSA Bank with the initial information required to set up the HSA account.

The HSA offers you a triple tax advantage:

- Tax deductible contributions
- Tax-free while you are saving
- Taxes not deducted when used to pay for qualified medical expenses HSAs are complex. This section provides general guidelines, but if your situation is complex, you should refer to the Internal Revenue Service (IRS) publication 969 at [www.irs.gov/pub/irs-pdf/p969.pdf](http://www.irs.gov/pub/irs-pdf/p969.pdf) or you may all call HSA Bank at 866.471.5946 or visit their website at [www.hsabank.com](http://www.hsabank.com). You should also consult with your personal tax advisor to fully understand the tax consequences of contributing to and using the funds in your HSA to help pay for medical expenses.

To be eligible to contribute to an HSA:

- You must be enrolled in the Basic Plan;
- You cannot be enrolled in Medicare (Part A or B);
- You cannot be claimed as a dependent on someone else's tax return;
- You do not have other non-HSA compatible coverage such as a Health Care Traditional FSA or Health Reimbursement Arrangement (HRA);
- You cannot be covered under TRICARE or a former employer's plan, in addition to your coverage at SRNS; and
- You cannot be a veteran who has received medical treatment through the Veterans Health Administration.

The Company may provide a contribution into an HSA with HSA Bank. This amount, if any, will be determined prior to Open Enrollment each year. SRNS company contributions (if provided) will be prorated over the year as long as the retiree remains eligible (1/12 of the eligible funding which will be deposited at the end of each month as long as the employee is eligible).

## When can I open an account?

Only the retiree can open an HSA account during Open Enrollment. If you decline enrolling in an HSA when you first sign up for the Basic Plan, you may be able to open an account during the year. SRNS will send enrollment data to HSA Bank on your behalf. You cannot open an account if a post office box is used as your address.

### **Key Points of the Health Savings Account:**

- 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 the owner of the HSA and are responsible for maintaining records of your medical expenses that satisfy IRS requirements.
- You are no longer eligible to contribute to an HSA once you are enrolled in Medicare (Part A or B). Accordingly, if the retiree dies or attains age 65 and are no longer covered under this Plan, your dependent spouse (or survivor) and/or children will not be eligible to contribute to or receive Employer contributions towards the HSA account (though you may continue using your existing balance to pay for future unreimbursed medical expenses).
- Per IRS regulations, the account is an individual account, not a joint account.

## How to use your HSA

You will receive a debit card from HSA Bank, which you can use like your personal debit card to pay for health care expenses directly. You can also pay bills online or request personal checks. Once you reach age 65, you can use your HSA accounts for other items/expenses. However, the card cannot be used for those purchases. A manual claim must be filed.

If you have questions, contact HSA Bank at 866.471.5946 or [www.hsabank.com](http://www.hsabank.com).

*Note: If there is a discrepancy between what is presented in this section and what is presented by HSA Bank and the IRS, IRS rules will be followed first, then HSA Bank rules.*

Health Savings Account	2025 Annual Contributions*	Over 55 Limit
Retiree Only	\$4,400	\$5,400
Retiree + One or More	\$8,750	\$9,750

## Contributions to the account

As a retiree, you may contribute to your HSA directly through HSA Bank. Deductions from your pension check are not allowed. Contribution limits are updated every year by the IRS. You will be notified of any changes to these limits in the Health Plan annual Open Enrollment period each year.

To determine how much, you may contribute during the year, you should reduce the annual contribution by the amount the company might contribute (see your annual Open Enrollment materials posted on [SRS - Retiree Benefits](#)).

The sum of your contributions into your HSA can vary but the sum of your calendar year contributions cannot exceed the annual contribution limit. It is the retiree's responsibility to ensure they do not exceed the annual contribution limit. There may be tax consequences if you exceed the annual contribution maximum.

If you change coverage levels within the Basic Plan during the year (between Retiree Only and Retiree Plus One or More), you will have to recalculate your annual contribution amount. You should refer to the instructions for IRS Form 8889 on how to calculate this new amount or contact HSA Bank.

# General Provisions that Apply to Both Standard And Basic Plans

## The BlueCross Medical Provider Network

### *In-Network Allowable Amounts: The Advantage*

BlueCross has negotiated rates with the in-network providers. The provider has agreed to accept as payment-in-full the allowed amount (regardless of what is billed). The member's share is based on this allowed amount (which is lower than the billed amount)—this saves them money. Also, you can't be balance billed for this service. Balance billing is when a non-network provider expects you to pay the difference between the allowed and the billed amount.

### *Locating Network Providers*

The providers in the Network may sometimes change. For the most current information on network status, check with your provider or check on-line by logging into your "My Health Toolkit" account on the BCBS South Carolina website at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com). You may also call BlueCross at 1.800.325.6596.

For information on providers located outside of the United States, you should contact BlueCross BlueShield Global Core, formerly BlueCard Worldwide at 1.800.810-Blue (2583) or call collect to 1.804.673.1177 or go to [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com).

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

When you visit a Network physician, make sure you show your ID card. Using information on your ID card, the Network provider will file a claim for services rendered to the BCBS organization that they contracted for Network services (provided the Plan is the primary payer.)

If you visit a physician who is not in the Network, you should still present your ID card, so the receptionist can check your eligibility and coverage. In many cases, you may have to pay a non-Network provider in full at the time of the visit; then, you are responsible for filing 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.

## Mental Health/Substance Abuse Services

For information on accessing mental health and/or substance abuse services available, you should contact Companion Benefit Alternatives (CBA), a BlueCross and BlueShield of South Carolina subsidiary, at 1.800.868.1032. Preauthorization of mental health and substance abuse services is required for in-patient admissions, out-patient facility services and other admissions, such as residential treatment centers. Preauthorization is through CBA, the BCBS-SC Mental Health and Substance Abuse Clinical Care Managers and is available 24 hours a day, seven days a week.

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

If your physician is in the Network and he/she refers you to another medical provider, ask your physician if you can be referred to a specialist or hospital in the Network so you receive maximum benefits. A referral is not required and is not a guarantee that the specialist or hospital you are referred to is in your Network. It is up to you to ensure your providers are participants in the Network and that you have followed preauthorization requirements of the Plan if you want to receive maximum benefits.

## Emergencies and Preauthorization

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

As described in this section, your provider should call BlueCross to:

- Have each hospital admission preauthorized,
- Receive preauthorization 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 CBA.

## Preauthorization: Required for Certain Services

You and your provider must follow certain procedures to avoid financial penalties. Medical policies regarding preauthorization are available for review at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) > Insurance Basics > Understanding Your Coverage

The Employer's Group Health Plan requires that all inpatient hospital stays, and certain other medical services meet the applicable medical necessity requirements.

While Network providers are familiar with pre-admission certification procedures and requirements (which means, there is less likelihood of a conflict in cooperation by a Network physician or facility), the member is responsible for making sure the appropriate preauthorization's have been obtained prior to receiving treatment.

**IMPORTANT:** Preauthorization is the approval of benefits based on medical necessity per the BCBS medical policies prior to the rendering of such benefits to a member. It is not a guarantee of payment. Preauthorization means only that the service is medically necessary per the BCBS medical policies. While preauthorization is not a guarantee of claims payment or verification of benefits, it does establish that the requested procedure(s) meets the criteria outlined in the BlueCross Medical Policy. Notwithstanding preauthorization, payment for benefits is subject to a member's eligibility and all other limitations and exclusions contained in this SPD. A member's entitlement to benefits is not determined until the member's claim is processed.

Investigational and/or experimental procedures are procedures, supplies, devices or drugs which, at the time provided, or sought to be provided, are in the judgement of BlueCross and not recognized as conforming to generally accepted medical or behavioral health practice in the U.S., or the procedure, drug or device:

- Has not received required final approval in the U.S. to market from appropriate government bodies;
- Is one about which the peer-reviewed medical literature in the U.S. does not permit conclusions concerning its effect on health outcomes;
- Is not demonstrated in the U.S. to be superior or as beneficial as established alternatives;
- Has not been demonstrated in the U.S. to improve net health outcomes; or,
- Is one in which the improvement claimed is not demonstrated in the U.S. to be obtainable outside the investigational or experimental setting.
- Always double check with BCBS Customer Service prior to undergoing any type of procedure and ask if it is investigational or experimental.

### **What if You Don't Preauthorize Your Hospital Stay?**

If preauthorization 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 copayment will be applied.

If you follow preauthorization 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 BCBS, 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. Preauthorization is required.

### **Second Surgical Opinions**

If your physician recommends elective, non-emergency surgery, you may want to get a second board-certified surgeon's opinion. The opinion must be based on the surgeon's examination of the patient. The examination must be performed after another licensed medical doctor has proposed to perform surgery, but before the surgery is performed. The second licensed medical doctor must not be associated with the primary licensed medical doctor. Second opinions are not required.

### **Transplants**

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

If BlueCross 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 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.

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

### **BlueCard® Program**

The BlueCard® Program is an inter-plan arrangement with the BlueCross and BlueShield Association. Under this arrangement, when you access covered healthcare services within the geographic area served by a Host Blue, the Host Blue will be responsible for contracting and handling all interactions with its Participating Providers. Please call 1.800.810.2583 when traveling outside the United States for assistance with locating an international provider, in translating foreign languages

and submitting claims. For more details regarding the BlueCard Program, please refer to the BlueCross BlueShield of South Carolina Plan of Benefits location on SRNS InSite and on the [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) website.

If you are traveling outside the U.S. contact BlueCross BlueShield Global Core, formerly 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 BlueCross BlueShield Global Core, formerly 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 BlueCross BlueShield Global Core, formerly BlueCard Worldwide Service Center. Assignments of benefits to foreign providers or facilities will not apply.

### Preauthorization certification

Preauthorization certification by BlueCross is required for any of the following services and apply to both the Standard and Basic Plan.

The following services/procedures require preauthorization.

Preauthorization Certification required	
Services/procedures	Payment/Penalty
<b>In-Patient</b>	
All admissions require preauthorization. If preauthorization is not obtained, room and board charges will be denied for participating providers. A \$200 penalty will apply when preauthorization is not obtained for non-participating providers.	\$200 penalty (does not count toward deductible or out-of-pocket)
<b>Out-Patient</b>	
Radiology management	
MRI: Payment will be denied without preauthorization	Not Allowed
MRA: Payment will be denied without preauthorization	Not Allowed
CAT scans: Payment will be denied without preauthorization	Not Allowed
Musculoskeletal care	
PET scans: Payment will be denied without preauthorization	Not Allowed
Radiation therapy: One time notification	
Cancer chemotherapy: One time notification	
Sclerotherapy: Benefits will be reduced by 50% of the Allowable Amount without preauthorization	50%
Septoplasty: Benefits will be reduced by 50% of the Allowable Amount without preauthorization	50%
Any surgical procedure that may be potentially cosmetic (i.e., blepharoplasty, reduction mammoplasty): Benefits will be reduced by 50% without preauthorization	50%
Hysterectomy	50%
Investigational or experimental procedures	Not Allowed
Mental health services and substance use disorder services	
Applied Behavioral Analysis (ABA) related to Autism Spectrum Disorder (preauthorization requests and treatment plans must be submitted to Companion Benefit Alternatives). Benefits will be reduced by 50% of the Allowable Amount without a preauthorization	50%
Facility-based inpatient services (no room and board; penalty for non-network)	\$200 per occurrence
Facility-based outpatient services (partial hospitalization, electroconvulsive therapy and intensive outpatient programs)	
Psychological testing	50%
Repetitive transcranial magnetic stimulation	50%
Residential treatment centers	Not Allowed

**In addition, the following services/procedures may also require preauthorization.**

- Ambulance
- Durable medical equipment, prosthetics and orthopedic devices, if purchase or rental is \$500 or more
- Home health care, including private duty nursing services
- Hospice care
- Oxygen
- Private duty nursing services
- Certain prescription drugs
- Cleft lip or palate (for service not covered under Dental Plan)
- Dental care for accidental injury
- Human organ and tissue transplants
- Obstetrical services outside the terms of the Newborn and Mother's Health Act of 1996
- Orthopedic devices
- Orthotic devices not available on an over the counter basis and not otherwise excluded.
- Rehabilitation following severe neurologic or physical impairment by a multidisciplinary team
- Clinical trials
- Pharmacy: Refer to [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) for complete information

## **Prescription Drugs**

### **Important Website**

Because of the complexities of the prescription drug provision of this plan, it is important that you refer to the BCBS website for the most current information regarding this coverage.

[www.southcarolinablues.com/](http://www.southcarolinablues.com/)

My Health Toolkit

(Benefits > Pharmacy >

Pharmacy Benefits)

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 BlueCross ID card to ensure that you will receive maximum benefits.

When you present your BlueCross 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 Pharmacy Benefit Manager system and will charge you the lower of the Pharmacy Benefit Manager program negotiated price or the regular retail price. If you use a network pharmacy, your pharmacy claim will be transmitted to BlueCross (Note: Preauthorization from BlueCross is required for some drugs. You will be notified when the medication is dispensed if it requires preauthorization.)

The Pharmacy Benefits Manager for BlueCross is OptumRx, which administers the prescription drug program for this Plan. For questions about pharmacy benefits or mail services, contact OptumRx at 855.811.2218. Optum Specialty Pharmacy is the preferred specialty prescription drug pharmacy and a division of OptumRx. For specialty prescription drug questions, contact Optum Specialty Pharmacy at 877.259.9428.

In addition, the Plan uses three BlueCross drug management programs: Mandatory Generic, Step Therapy and Quantity Management. Drug lists for the three tiers and the drug management programs change periodically and updated information on these programs can be found by logging into My Health Toolkit (Benefits > Pharmacy > Drug Lists and Drug Management Programs). You may also call BlueCross Customer Service at 800.325.6596.

Maintenance Medication must be purchased through the Mail Service Saver Program.

There are two additional categories of prescription drugs:

- The ACA Preventive Drug list is applicable under both the Standard and Basic plans.
- The Maintenance Preventive Drug list is applicable under the Basic Plan. These drugs may be purchased before you meet the deductible.

## Mail Service Saver Program (Mandatory)

### What Is the Mail Service Saver Program?

It's a program that requires you to have prescriptions for drugs which are considered "maintenance drugs" filled through an Optum Mail pharmacy. OptumRx is an independent company that provides pharmacy services on behalf of your health plan.

If you are not already getting your maintenance medications through the mail pharmacy, you will need a new prescription from your doctor written specifically for a 90-day supply.

You can continue to get 30-day prescriptions for any acute (short-term) medications, such as antibiotics or pain medications, at any in-network retail pharmacy. Specialty drugs and controlled substances are not included in this program.

Maintenance drugs are **prescriptions commonly used to treat conditions that are considered chronic or long-term**. These conditions usually require regular, daily use of medicines. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes.

### How Does the Program Work?

If you are not already getting 90-day supply maintenance medications through the mail-in pharmacy, you will be required to fill through the Optum Mail Pharmacy.

#### Grace fills

You can get up to two 30-day prescriptions for each maintenance drug you may be getting at any in-network retail pharmacy before the requirement to fill through the mail-in pharmacy goes into effect.

### What Do I Need To Do?

Talk to your doctor about obtaining 90-day prescriptions for your maintenance medications. You can get started with mail service in several ways:

- Contact OptumRx Mail Service by phone at (855) 811-2218.
- Have your doctor's office call in a 90-day prescription to (800) 791-7658 or have your doctor e-prescribe to OptumRx Mail Service. Then OptumRx will call you to complete the initial mail order pharmacy setup or you can call OptumRx to complete the process.
- You can complete a mail service order form and send it to OptumRx Mail Service with your doctor's prescription (the form is attached).
- Active prescriptions can be electronically transferred to mail order via the My Health Toolkit App.

### Not Covered

If you do not enroll in Mail Service, your maintenance prescriptions will not be covered by your pharmacy benefit once your grace period fills are exhausted.

## Prescription benefits at a glance

Expenses	Standard		Basic	
	Network	Non-Network (1)	Network	Non-Network (1)
<b><sup>2</sup>Prescription Drugs</b>	<b>after Deductible</b>	<b>after Deductible</b>	<b>after Deductible</b>	<b>after Deductible</b>
Generic	10%	10%	\$10	\$10
Preferred	20%	20%	20% (max \$35)	20% (max \$35)
Non-Preferred	30%	30%	30% (max \$50)	30% (max \$50)
<b>Specialty Drugs</b>	30%	Not Covered	30% (max \$50)	Not Covered
<b><sup>2</sup>ACA Covered Prescription Drugs</b>	<b>before Deductible</b>	<b>before Deductible</b>	<b>before Deductible</b>	<b>before Deductible</b>
Generic	0%	0%	0%	0%
<b><sup>2</sup>SRNS Preventive Drug List</b>	Not Applicable	Not Applicable	<b>before Deductible</b>	<b>after Deductible</b>
Generic			\$10	\$10
Preferred			20% (max \$35)	20% (max \$35)
<b><sup>2</sup>Mail Order (90-day supply)</b>	<b>after Deductible</b>	Not Covered	<b>after Deductible</b>	Not Covered
Generic	10%		\$25	
Preferred	20%		20% (max \$ 87.50)	
Non-Preferred Brand	30%		30% (max \$125)	
<b>Mail Order (90-day supply) Specialty Drugs</b>	30%	Not Covered	30% (max \$125)	Not Covered
<b><sup>2</sup>SRNS Preventive Drug List Mail Order (90-day supply)</b>	Not Applicable	Not Applicable	<b>before Deductible</b>	Not Covered
Generic			\$25	
Preferred			20% (max \$87.50)	

1. Prescription drug programs are subject to the BlueCross Mandatory Generic, Step Therapy and Quantity Management Programs.

2. Mail Service Saver Program: OptumRx Mandatory mail order requirement for "maintenance medications."

## Three-Tier Drug Coverage

The SRNS Plan for prescription drugs has a three-tier design plus specialty drugs. The first tier is generic drugs. The second tier is preferred brand name drugs, and the third tier is comprised of non-preferred brand name drugs. The level of benefit paid by the Plan depends on whether the drug is generic, preferred brand (also called “formulary”) or non-preferred brand.

### Three-Tier Standard and Basic Prescription Drug Coverage *(after deductible is met)*

<b>Tier 1: Generic Drugs</b>		
Standard Medical Plan	Basic (High Deductible Health Plan)	Mail Order Basic / In Network (High Deductible Health Plan)
You pay 10%, the company pays 90%	You pay \$10	You pay \$25 for a 90-day supply
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 are 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.		

<b>Tier 2: Preferred Brand Name Drugs</b>		
Standard Medical Plan	Basic (High Deductible Health Plan)	Mail Order Basic / In Network (High Deductible Health Plan)
You pay 20%, when no generic equivalent is available	You pay 20%, maximum \$35	You pay 20%, maximum \$87.50
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 below will be applied.		

<b>Tier 3: Non-preferred Brand Name Drugs</b>		
Standard Medical Plan	Basic (High Deductible Health Plan)	Mail Order Basic / In Network (High Deductible Health Plan)
You pay 30%, when no generic equivalent is available	You pay 30%, maximum \$50	You pay 30%, maximum \$125
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 copayment, the Mandatory Generic Penalty described below will be applied.		

## 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 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 Food and Drug Administration (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 (Benefits > Pharmacy > Drug Lists and Pharmacy Management 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 Prior Authorization department or fax the request. These numbers are available on the BlueCross BlueShield website.

When you go to the pharmacy, the pharmacist will enter your prescription into the computer system. If your prescription is a second-choice medication, the system will check your claims history. If you have filled prescriptions for first-choice medications, the pharmacist will fill your prescription for a second-choice medication. If you are required to try a first-choice medication, you have three options:

1. You or your pharmacist may 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 and Out-of-Pocket Maximum.
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 BlueCross 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 a 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

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

Quantity Management limits are based on FDA 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 [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) website. Log into My Health Toolkit (Benefits > Pharmacy > Drug Lists and Pharmacy Management Programs). You should review the list of medications to determine if quantity limits apply to you.

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

Certain drugs on the list will be annotated to indicate that they are eligible for consideration for a medical necessity override for a larger amount. If you need more of these medications, please have your doctor call the Prior Authorization department for the current Pharmacy Benefit Manager.

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 if 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 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 a 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.

## 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 [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) website. Log into My Health Toolkit (Benefits > Pharmacy > Drug Lists > Drug Management Programs > Prior Authorization). If your doctor prescribes a medication that needs Prior Authorization, have your doctor call the current Pharmacy Benefit Manager's Prior Authorization department.

## 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, 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. Contact Optum Specialty Pharmacy, the current Specialty Drug Benefit Manager, at 877.259.9428.

## Mandatory Generic Prescriptions

The Mandatory Generic program can help you save money on the prescription drugs. When a generic equivalent is available for your brand-name drug, your pharmacist will ask if you want to take the generic instead. If your doctor indicated on the prescription that generic substitution is allowed, and you approve, it, your pharmacist will fill your prescription with the generic medication. You'll pay the copayment (after you meet your deductible) for your prescription.

If you are prescribed a preferred or non-preferred brand name drug when a generic equivalent drug is available, you may pay more out of pocket. You must pay the preferred or non-preferred coinsurance after you meet your deductible, PLUS any difference in cost between the generic and the brand name drug. Even when your doctor requests that a brand drug be "Dispensed as Written," you will still be required to pay the cost difference. The cost difference does not count toward your deductible or out-of-pocket limits. 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.

Under the ACA, if your doctor prescribes a brand name drug when there is a generic available and your claim is denied, your physician may submit a "Generic Program Exception Request." For an exception to be granted, the following criteria must be met:

1. The generic has been ineffective in the treatment of the member's condition;
2. Based on sound clinical evidence, the known relevant physical or mental characteristics of the member and known characteristics of the drug regimen, the generic is likely to be ineffective or adversely affect patient compliance; or
3. The generic has caused or, based on sound clinical evidence is likely to cause an adverse reaction to the member.

The Generic Program Exception Request is available on My Health Toolkit (Benefits > Pharmacy > Drug Lists and Drug Management Programs > Mandatory Generic Programs).

<b>Generic Prescription vs. Preferred Brand</b>	
Cost to Member for a Preferred Brand Drug When Generic is Available: Standard and Basic Plan	
<b>Member Copayment on Preferred Drug (Cost \$80)</b>	<b>20% \$16</b>
<i>Plus</i> , Preferred Brand Drug Cost	\$80
<i>Less</i> : Generic Drug Cost	-\$30
Brand less Generic Drug Cost	\$50
<b>Member pays for preferred brand</b>	<b>\$66</b>
<b>Member generic cost</b>	<b>\$6</b>

## Refills

The 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 BlueCross 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 BlueCross Customer Service at 800.325.6596.

## Manual Claim Filing for Prescriptions

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

- You use a non-network pharmacy or
- You forget to show your BCBSSC 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 BlueCross Customer Service by calling 800.325.6596 or [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com). When completing a prescription drug claim form:

- Use a separate form for each family member
- Completely fill out Part One of the claim form
- Attach a drug receipt that includes:
  - Date the prescription was filled
  - Name/address of the pharmacy
  - Name of drug and strength
  - Quantity
  - How many days' supply
  - National Drug Code
  - Prescription number
  - Amount paid

The prescription drug claim form should be mailed to Pharmacy Benefit Manager at the address listed at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com).

## Mail Order Prescriptions

The Plan covers mail order prescription refills through the Pharmacy Benefit Manager system. 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 BlueCross website.

## Prescription Drug Exclusions: What's not covered

1. Prescription drugs that are specifically listed on the BlueCross website as excluded;
2. Prescription drugs that have not been prescribed by a provider acting within the scope of his or her license;
3. Drugs not approved by the FDA;
4. Prescription drugs for non-covered therapies, services or conditions;
5. Prescription drug refills more than the number specified on the provider's prescription order or refills dispensed more than one year after the original prescription date;
6. More than a 31-day supply for prescription drugs (90-day supply for prescription drugs obtained through a mail service pharmacy), except as specified on the Schedule of Benefits or unless the quantity is limited by a Quantity versus Time program;
7. Any type of service or handling fee (except for 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.
8. Dosages that exceed the recommended daily dosage of any prescription drug as determined by BCBS based on the following guidelines as described in the current:
  - a. United States Pharmacopeia;
  - b. Facts and Comparisons
  - c. Reference; and/or,
  - d. National Formulary
9. Prescription drugs used for or related to cosmetic purposes, including hair growth and skin wrinkles, except as specified on the BlueCross Schedule of Benefits;

10. Prescription drugs related to any treatment for infertility or impotence (except when prescribed for benign prostatic hypertrophy), including, but not limited to, fertility drugs, except as specified on the Schedule of Benefits;
11. Over-the-counter (OTC) drugs and over-the-counter supplies or supplements, except for OTC drugs that are designated by BCBS as prescription drugs and are listed as covered on the Prescription Drug List (PDL) and are prescribed by a Provider;
12. Prescription drugs that are being prescribed for a specific medical condition that are not approved by the FDA for treatment of that condition (except for prescription drugs for a specific medical condition that have at least two formal clinical studies, or prescription drugs for the treatment of a specific type of cancer, provided the drug is recognized for treatment of that specific cancer in at least one 1 standard, universally accepted reference compendia or is found to be safe and effective in formal clinical studies, the results of which have been published in peer reviewed professional medical journals);
13. Prescription drugs that are not consistent with the diagnosis and treatment of a member's illness, injury or condition, or are excessive in terms of the scope, duration, dosage or intensity of drug therapy that is needed to provide safe, adequate and appropriate care or are not provided in compliance with any applicable place of service requirements;
14. Prescription drugs or services administered or dispensed when the required preauthorization is not obtained;
15. Prescription drugs for injury or disease that are paid by worker's compensation benefits (if a worker's compensation claim is settled, it will be considered paid by worker's compensation benefits);
16. Prescription drugs that are not authorized when part of a Step Therapy program;
17. Prescription drugs which are new to the market and which are under clinical review by BlueCross shall be listed on the PDL as excluded until the clinical review has been completed and a final determination has been made as to whether the drug should be covered;
18. Prescription drugs, regardless of therapeutic class, that are determined to offer no clinical or cost-effective advantage over other comparable prescription drugs already covered under the PDL; and,
19. Vitamins, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind, except for prescription prenatal vitamins or prescription vitamin B-12 injections for anemias, neuropathies or dementias secondary to a vitamin B-12 deficiency.
20. Maintenance Medications not purchased through the Mail Service Saver Program.

# Dental Care Plan

The Dental Care Plan is designed to help you and your family maintain good oral health by assisting you with the cost of dental treatments

## Dental benefits at a glance

Prime	Participating Provider	Non-Participating Provider
<b>Preventative and Diagnostic</b>	The Plan pays 100% of Allowable Charges	The Plan pays 100% of Allowable Charges. Member must pay balance of Provider's charge.
<b>Basic Dental Benefits:</b> <b>Minor Restorative</b> Fillings, oral surgery, simple extractions, root canals, periodontic treatments	The Plan pays 80% of Allowable Charges Member pays remaining 20% of Allowable Charge	The Plan pays 80% of Allowable Charges. Member must pay balance of Provider's charge.
<b>Major Dental Benefits:</b> <b>Major Restorative</b> Crowns, bridges, dentures, implants	The Plan pays 60% of Allowable Charges. Member pays remaining 40% of Allowable Charge.	The Plan pays 60% of Allowable Charges. Member must pay balance of Provider's charge.

Temporomandibular Joint Disorder (TMJ) and Temporomandibular Disorder (TMD) (maximum \$500 per member per lifetime)	The Plan pays 50% of Allowable Charges up to the lifetime maximum Member pays remaining 50% of Allowable Charge	The Plan pays 50% of Allowable Charges up to the lifetime maximum Member must pay balance of Provider's charge.
<b>Orthodontics Benefits</b> (maximum \$2000 per member per lifetime)	The Plan pays 50% of Allowable Charges up to the lifetime maximum (child and adult) Member pays remaining 50% of Allowable Charge	The Plan pays 50% of Allowable Charges up to the lifetime maximum (child and adult) Member must pay balance of Provider's charge.
<b>Annual Deductible</b>	None	None
<b>Maximum Annual Benefit*</b>	\$2,000 per person per benefit year	\$2,000 per person per benefit year

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

## Dental benefits at a glance (continued)

Standard	Participating Provider	Non-Participating Provider
<b>Preventative and Diagnostic</b>	The Plan pays 100% of Allowable Charges	The Plan pays 100% of Allowable Charges. Member must pay balance of Provider's charge.
<b>Basic Dental Benefits: Minor Restorative</b> Fillings, oral surgery, simple extractions, root canals, periodontic treatments	The Plan pays 50% of Allowable Charges after the Benefit Year Deductible  Member pays remaining 50% of Allowable Charge after Benefit Year Deductible	The Plan pays 50% of Allowable Charges after the Benefit Year Deductible  Member must pay balance of Provider's charge after the Benefit Year Deductible
<b>Major Dental Benefits: Major Restorative</b> Crowns, bridges, dentures, implants	The Plan pays 50% of Allowable Charges after the Benefit Year Deductible  Member pays remaining 50% of Allowable Charge after the Benefit Year Deductible	The Plan pays 50% of Allowable Charges after the Benefit Year Deductible  Member must pay balance of Provider's charge after the Benefit Year Deductible
Temporomandibular Joint Disorder (TMJ) and Temporomandibular Disorder (TMD) (maximum \$500 per member per lifetime)	No coverage	No coverage
<b>Orthodontics Benefits</b>	No coverage	No coverage
<b>Annual Deductible</b>	\$50 per family with no one member meeting more than \$25	\$50 per family with no one member meeting more than \$25
<b>Maximum Annual Benefit*</b>	\$1,000 per person per benefit year	\$1,000 per person per benefit year

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

## Dental Plan Choices

### Prime or Standard Options

Prime and Standard Dental options give you the option of using a BCBS PPO Dental Network provider. The level of dental benefit payments from the Plan will be the same from dentist to dentist under the option you choose. However, when you use a network provider you will no longer be subject to being billed for the balance over the BCBS allowed amount.

Dental services are divided into five main categories.

- Preventive and Diagnostic
- Basic Dental Benefits: Minor Restorative
- Major Dental Benefits: Major Restorative
- Temporomandibular Joint Disorder (TMJ)/Temporomandibular Disorder (TMD)
- Orthodontics Prime Dental

## **Prime Dental Care Option**

### **Prime Dental Quick Look**

*Preventive care is covered at 100% of allowable charges*

*Higher premium than Standard Plan*

*Higher Maximum Annual Benefit than Standard Plan  
for Preventive, Basic and Major Services*

*No deductible*

*Pays a higher percentage of Allowable Services*

*Covers TMJ/TMD*

*Covers orthodontics at 50% of allowable charge*

### **Preventive Care**

Prime dental option reimburses 100% of the BCBS allowable charge amount of covered preventive care.

### **Orthodontics (Braces)**

Make sure you understand how this provision works before you make payment arrangements with your orthodontist.

Prime Dental covers both adult and child orthodontics. The benefit level is 50% of the BCBS allowable charge but not more than \$2,000 for each covered person in a lifetime. The lifetime maximum of \$2,000 is applied even if you change coverage from Prime Dental to Standard and then return to the Prime Dental option. To be covered, services must be incurred (rendered by the dentist) during the same year that you are enrolled in the Prime Dental option. A predetermined amount is allowed for the initial banding of the teeth. After that reimbursement is based on the monthly allowable amount. If you arrange for the orthodontist to bill you in six monthly installments, your reimbursement will still be based on a monthly allowable amount. The monthly allowable amount is the same regardless of the number of months you set up for payment. For example, if the monthly allowable amount is \$250, you will be reimbursed at \$125 per month – even if you pay over a shorter period. The maximum is UP TO \$2,000. The maximum annual Benefit amount for orthodontics does not count toward the maximum annual benefit amount for other services.

Covered orthodontia is paid at 50% of the Allowable Charge under Prime, up to a maximum lifetime benefit of \$2,000 per person. Before undergoing treatment for Orthodontics, you must follow the pretreatment estimate procedures described in the General Provisions for Dental section in this book.

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

- Diagnosis, including models and radiographs,
- Active treatment, including necessary appliances, and
- Retention treatment following active treatment, limited to 10 visits in an 18-month period
- Benefits payable per patient are limited to the lifetime maximum of \$2,000 and to services rendered within a period not to exceed 36 consecutive months;
- The initial payment will be equal to no more than 25% of the total liability/coverage limit of the Plan. The following payments will be payable no more frequently than once a month. If for any reason the orthodontic services are terminated before completion of the approved Treatment Plan, the responsibility of the Plan will end with payment through the month of termination; and
- The replacement of any appliances made necessary by reason of loss or theft is not covered.

As noted above, the Plan's payment of orthodontic services is based on the assumption that a portion of the charge is incurred at the time the appliance is installed and that the balance is billed over the period of time the appliance is expected to remain in place. For this reason, the "set-up" fee is paid immediately and the balance of benefits available is paid on a monthly basis after services have been received.

Orthodontic benefits are based on the treatment plan and continue until the maximum benefit has been paid or the individual's coverage ceases, whichever occurs first. If coverage terminates after orthodontic treatment has begun but before treatment is complete, then no further benefits are available when coverage ceases, even though the orthodontic treatment may have begun prior to termination of coverage. You should follow the pre-treatment estimate procedure as described previously before beginning orthodontic treatment.

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

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

Non-surgical treatment(s) for problems specifically related to the treatment of TMDs are limited to:

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

### **Maximum Annual Benefit**

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

## **Standard Dental Care Option**

### Standard Dental Quick Look

*Preventive care is covered at 100% of allowable charges*

*Lower premium than Standard Plan*

*Lower Maximum Annual Benefit than Standard Plan  
for Preventive, Basic and Major Services*

*Deductible applies*

*Pays a lower percentage of Allowable Services*

*Does not cover TMJ/TMD*

*Does not cover orthodontics*

## **Standard Dental**

### ***Deductible***

Standard dental options reimburse 100% of the BCBS allowable charge amount of covered Preventive care. Under Standard Dental, all other covered services are paid at 50% of the BCBS allowable charge level for covered charges after you've met a \$25 individual/\$50 family yearly deductible.

Under Standard Dental the Individual Deductible is the amount that must be paid by one person each calendar year on covered non-preventive services. The Family Deductible is twice the individual deductible with no one member satisfying more than \$25. There is no carryover of unsatisfied deductible amounts from one year to the next. Your deductible amount starts over each January.

### ***Maximum Annual Benefit***

The maximum Plan benefit for preventive and minor and major restorative services combined under the Standard dental is \$1,000 per member per Benefit Year for Preventive and Diagnostic, Basic Dental Benefits, and Major Dental Benefits.

## General Provisions for the Dental Plan

### Your Share of Expenses

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

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

### Pre-Treatment Estimate

A pre-treatment estimate, also called predetermination of benefits, is not mandatory but it is strongly advised. Both dental options pay based on the level of treatment that BCBS determines is “adequate and necessary” according to widely accepted dental practices.

Since dental care can be expensive, it’s a good idea to find out in advance how much will be paid because benefits are limited to the course of treatment which BlueCross BlueShield, upon review, determines is appropriate. By getting a pre-treatment estimate, you’ll know whether the services are covered under BCBS’s dental treatment guidelines. You’ll also know how much of the dentist’s charges BCBS will pay. Therefore, you can avoid misunderstandings about your coverage.

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

### Requesting a Pre-Treatment Estimate

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

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

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

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

### In Case of Conflict

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

### Alternate Course of Treatment

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

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

## Dental Services: What's covered

Dental services are covered and allowable benefits under the Prime Choice and Standard Choice Dental options when the services are based on accepted standards of dental practice; the services are rendered or the supplies furnished by a dentist or dental hygienist acting within the scope of their license and are not otherwise excluded from coverage; the services and supplies are billed by or on behalf of the dentist. Preventive care services are covered at 100% of BCBS allowable charge under both Prime Choice and Standard Choice with no deductible required.

### **Preventive and Diagnostic Dental Benefits**

- Oral examination, including treatment plan if necessary, limited to twice per benefit year;
- Prophylaxis, including cleaning, scaling and polishing, limited to twice per year;
- Space maintainer for prematurely lost deciduous teeth are provided for dependent children under age 20;
- Emergency palliative treatment for the relief of pain;
- Pulp vitality tests;
- Diagnostic casts; and
- Sealants are limited to one (1) per tooth per lifetime for permanent teeth for Members under age twenty (20)

### **Basic Dental Benefits: Minor Restorative Services**

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

### **Major Dental Benefits: Major Restorative**

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

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

8. Dental Implants — placing artificial teeth or supports surgically into the jawbone.

***Cleft Lip and Palate***

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

# Dental Services: What's not covered

You are not covered for the following dental expenses under Prime Choice nor Standard Choice Dental.

1. Any services or charges for services not Medically Necessary;
2. Dental services or supplies that are Investigational or Experimental;
3. Any charges for supplies or dental services rendered to the Member prior to the Member's Effective Date, the Employer's Effective Date or after the Member's coverage terminates;
4. Dental services received from a dental or medical department maintained by or on behalf of the Employer, a mutual benefit association, labor union, trustee or similar person or group;
5. Dental services for which the Member incurs no charge;
6. Any service or charge for service to the extent a Member is entitled to receive payment or benefits relating to such service under any state or federal program that provides healthcare benefits, including Medicare, but only to the extent that benefits are paid or are payable under such programs. This exclusion includes but is not limited to, benefits provided by the Veterans Administration for care rendered for service-related disability, or any state or federal hospital services for which the Member is not legally obligated to pay;
7. Dental services or supplies primarily for cosmetic or aesthetic purposes, including personalization or characterization of dentures;
8. Dental services for which the Member would have no legal obligation to pay in the absence of Dental Coverage;
9. Appliances or restorations necessary to increase vertical dimensions or restore the occlusion, including management of TMJ disorders except as specified on the Schedule of Benefits;
10. Services rendered by a Provider beyond the scope of his or her license;
11. Dental services to the extent that charges for such services exceed the charge that would have been made and actually collected if no coverage hereunder;
12. Charges by a Provider for non-dental services such as broken appointments and completion of claim forms;
13. Charges for visits at home or in the hospital except in connection with emergency care;
14. Dental care or treatment not specifically listed under Dental Covered Expenses or specified on the Schedule of Benefits;
15. Any service or supply rendered by a member of the patient's immediate family or by the patient, including the dispensing of drugs. A member of the patient's family means the spouse, parent, grandparent, brother, sister, child or spouse's parent of the patient;
16. Illness contracted or injury sustained as a result of declared or undeclared war or any act of war, or while in the military service;
17. Services related to teeth missing prior to a Member's Effective Date of coverage under this Plan of Benefits are not eligible for payment of benefits, except as specified on the Schedule of Benefits;
18. Any service for the treatment of dysfunctions or derangements of the TMJ, including orthognathic surgery for the treatment of dysfunctions or derangements of the TMJ, except as specified on the Schedule of Benefits;
19. Any service related to the treatment of malpositions or deformities of the jawbone(s), dysfunction of the muscles of mastication, or orthognathic deformities, except as specified on the Schedule of Benefits;
20. Consultations;
21. Non-IV sedation (nitrous oxide and non-conscious sedation);
22. Replacement Prosthodontics made necessary by loss or theft except as specified in Article III or on the Schedule of Benefits;
23. Temporary crowns and partials;
24. Dental services for diagnosis, treatment or other service for any injury or illness that is sustained or alleged by a Member that arises out of, in connection with, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the Member. Benefits will not be provided under this Plan if coverage under the Workers' Compensation Act or similar law would have been available to the Member but the Member waives entitlement to workers' compensation benefits for which he/she is eligible; failed to timely file a claim for workers' compensation benefits; or the Member sought treatment for the injury or illness from a Provider which is not authorized by the Member's Employer or Workers' Compensation Carrier. If the Plan pays Benefits for an injury or illness and the Plan determines the Member also received a recovery from the Employer or Employer's Workers' Compensation Carrier by means of a settlement, judgment, or other payment for the same injury or illness, the Plan shall have the right of recovery as outlined in Article IX of this Plan of Benefits;
25. Complications arising from a Member's receipt or use of either dental services or supplies or other treatment that are not Benefits, including complications arising from a Member's use of Discount Services;
26. Complications that occur because a Member did not follow the course of treatment prescribed by a Provider;
27. Any illness or injury received while committing or attempting to commit a crime, felony or misdemeanor or while engaging or attempting to engage in an illegal act or occupation;
28. Any dental service, supply or charge for an Incapacitated Dependent that is not enrolled by the maximum Dependent Child age listed on the Schedule of Benefits;

29. Any dental service, supplies, charges or losses resulting from a Member being Legally Intoxicated or under the influence of any drug or other substance, or taking some action the purpose, of which is to create a euphoric state or alter consciousness. The Member, or Member's representative, must provide any available test results showing blood alcohol and/or drug/substance levels upon request by BCBS. If the Member refuses to provide these test results, no benefits will be provided;
30. Charges for a Member's appointment with a Provider that the Member did not attend;
31. Dental services or supplies received as the result of any intentionally self-inflicted injury that does not result from a medical condition or domestic violence;
32. Dental services or supplies or other items not specifically listed as a Benefit in Article III of this Plan of Benefits or on the Schedule of Benefits;
33. Orthodontics: If this Benefit is listed on the Schedule of Benefits as a Covered Expense, the following will apply:
  - a. Benefits for these services will be limited to Members through the age set forth on the Schedule of Benefits, if any;
  - b. Benefits payable per Member are limited to the maximum amount specified on the Schedule of Benefits and to services rendered within a period not to exceed thirty-six (36) consecutive months;
  - c. The initial payment will be equal to no more than twenty-five percent (25%) of the total liability of the Employer, with the following sequential payments payable no more frequently than once a month, and if for any reason the orthodontic services are terminated before completion of the approved Treatment Plan, the responsibility of the Employer will cease with payment through the month of termination; and,
  - d. The replacement of any appliances made necessary by reason of loss or theft is not covered by this Plan of Benefits;
34. Treatment of accidental injury to sound natural teeth within the first 12 consecutive months following the date of the accident, if coverage is provided under the health benefit plan;
35. Payment for dental services shall be limited as follows:
  - a. In all cases involving covered services or supplies in which the Provider and Member selected a more expensive or personalized course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned, payment under this agreement will be based on the charge allowed for the lesser procedure as determined by BCBS;
  - b. In the event a Member transfers from the care of one Provider to that of another Provider during the course of treatment, or if more than one Provider performs services for one dental procedure, the Employer's Group Health Plan shall be liable not more than the amount it would have been liable for had but one Provider performed the service; or
  - c. Any additional treatment that is necessitated by lack of Member cooperation with the Provider or non-compliance with prescribed dental care that results in additional liability will be the responsibility of the Member.

# In this section

*Coordination of Benefits*

*COBRA Continuation Coverage*

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*HIPAA Certification*

*General Provisions*

*ERISA Information*

*Definitions*

## Coordination of Benefits

**Applicability:** The coordination of benefits rules are intended to prevent duplicate payments from different Plans that otherwise cover a Member for the same covered expenses. The rules determine which is the Primary Plan and which is the Secondary Plan. Generally, unless a specific rule applies, where a claim is submitted for payment under the BlueCross Schedule of Benefits and one or more other Plans, this Plan of Benefits is the Secondary Plan. Additionally, special rules for the coordination of benefits with Medicare may also apply.

### Medicare Coordination

**As a retiree, when you or your dependents become eligible for Medicare (Parts A & B), Medicare becomes your primary (first payer) for medical coverage,** unless you are receiving the Plan benefits as the result of your (or your spouse's) current employment with the Company. If you are not eligible for the Plan benefits as an active Employee of the Company, Medicare will be Primary before benefits will be paid by the Company Plan.

**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 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 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 Plan secondary payment, BCBS will:

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

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

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

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

### Example 1

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

### Example 2

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

### **Example 3**

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

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

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

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

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

### **Coordination of Benefits with Auto Insurance**

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

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

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

This coordination of benefits provision applies whether the Member submits a claim under the automobile no-fault, personal injury protection or medical payments coverage.

As a condition of receiving Benefits the Member must:

1. Immediately notify the Plan/BlueCross of an injury or illness for which automobile insurance coverage may be liable, legally responsible, or otherwise makes a payment relating to the injuries or illness;
2. Execute and deliver an accident questionnaire within one hundred eighty (180) days of the accident questionnaire being mailed to the Member;
3. Deliver to the Employer's Plan/BlueCross a copy of your Personal Injury Protection Log, Medical Payments log and/or Medical Authorization within ninety (90) days of being requested to do so; and
4. Deliver to the Plan/BlueCross a copy of the police report, incident or accident report, or any other reports issued as a result of the injuries or illness within ninety (90) days of being requested to do so; and
5. Cooperate fully with the Plan/BlueCross in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan/BlueCross.

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

## Order of Determination Rules for Members

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

1. The other Plan has rules coordinating its benefits with those of this Plan;
2. There is a statutory requirement establishing that this Plan is the Primary Plan and such statutory requirement is not pre-empted by ERISA; or,
3. Both the other Plan's rules and this Plan's rules require that benefits be determined under this Plan before those of the other Plan.

### **Additional Order of Determination Rules**

The Plan coordinates benefits using the first of the following rules that apply.

1. Dependent
  - a. The Plan that covers an individual as an Employee or Retiree is the Primary Plan.
2. Dependent Child – Parents not Separated or Divorced When this Plan and another Plan cover the same Child as a Dependent, then benefits are determined in the following order:
  - a. The Plan of the parent whose birthday falls earlier in the year (month and date) is the Primary Plan.
  - b. If both parents have the same birthday, the Plan that has covered a parent longer is the Primary Plan.
  - c. If the other Plan does not have the rule described in (a) above but instead has a rule based upon the gender of the parent and if, as a result, the Plan and BlueCross do not agree on the order of benefits, the gender rule in the other Plan will apply. The "birthday rule" does not use the years of the parents' birth in determining which has the earlier birthday.
3. Dependent Child – Separated or Divorced Parents: If two (2) or more Plans cover a person as a Dependent Child of divorced, separated or unmarried parents, benefits for the Child are determined in the following order:
  - a. First, the Plan of the parent with custody of the Child;
  - b. Second, the Plan of the parent's Spouse with the custody of the Child;
  - c. Third, the Plan of the parent not having custody of the Child;
  - d. Fourth, the Plan of the parent's Spouse not having custody of the Child.

Notwithstanding the foregoing, if the specific terms of a court decree state that one of the parents is responsible for the healthcare expenses (or health insurance coverage) of the Child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, that Plan is the Primary Plan. If the parent with responsibility for healthcare expenses has no health insurance coverage for the Dependent Child, but that parent's Spouse does have coverage, the Spouse's Plan is the Primary Plan. This paragraph does not apply with respect to any claim determination period or plan year during which any Benefits are paid or provided before the Plan has actual knowledge of the existence of an applicable court decree. If the specific terms of a court decree state that the parents shall share joint custody without stating that one of the parents is responsible for the healthcare expenses of the Child (or if the order provides that both parents are responsible), the Plans covering the Child shall follow the order of determination rules outlined in this section under Additional Order of Determination Rules.
4. Active and Inactive Employees: The Plan that covers a person as an Employee who is neither laid off nor retired or as that Employee's dependent is the Primary Plan. If the Secondary Plan does not have this rule, and if, as a result, the Plans do not agree on the order of Covered Expenses, this rule does not apply.
5. Longer or Shorter Length of Coverage: If none of the above rules determines the order of benefits, the Plan that has covered the Member longer is the Primary Plan.
6. COBRA: COBRA allows coverage to begin to continue under certain circumstances if the Member already has or obtains coverage under a Group Health Plan. In these situations, two policies may cover the Member, and the Plan providing COBRA coverage will be the Secondary Plan.

### **Effects on Benefits of This Plan of Benefits**

1. The Plan as Primary Plan: When Plan is the primary plan, the Benefits shall be determined without consideration of the benefits of any other Plan.
2. The Plan as Secondary Plan: When the Plan is a Secondary Plan, the Benefits will be reduced when the sum of the following exceeds the Covered Expenses in a Benefit Year:
  - a. The Covered Expenses in the absence of this coordination of benefits provision; plus
  - b. The expenses that would be payable under the other Plan in the absence of provisions with a purpose like that of this coordination of benefits provision, whether or not a claim is made.

When the sum of these two amounts exceeds the maximum amount payable for Covered Expenses in a Benefit Year, the Covered Expenses will be reduced so that they and the Benefits payable under the Primary Plan do not total more than the Covered Expenses. When the Covered Expenses of the Plan are reduced in this manner, each Benefit is reduced in proportion and then charged against any applicable limit of the Plan.
3. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered for purposes of determining the appropriate level of coverage available.

4. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not a Covered Expense unless the Member's Admission in a private Hospital room is Medically Necessary. When benefits are reduced under a Primary Plan because a Member does not comply with the Primary Plan's requirements, the amount of such reduction in benefits will not be a Covered Expense.

### **Right to Receive and Release Needed Information**

The Plan (including through BlueCross) is entitled to such information as it deems reasonably necessary to apply these coordination of benefit provisions and the Member and the Employer must provide any such information as reasonably requested.

### **Payment**

A payment made under another Plan may include an amount that should have been paid under the Plan. In such a case, the Plan may pay that amount to the organization that made such payment. That amount will then be treated as though it had been paid under the Plan. The term "payment" includes providing Benefits in the form of services, in which case "payment" means the reasonable cash value of the Benefits provided in the form of services.

### **Right of Recovery**

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

## **Appeal Procedures for an Adverse Benefit Determination**

### **Internal BCBS Appeal Procedures**

1. Member has one hundred eighty (180) days from receipt of an Adverse Benefit Determination to file an appeal. An appeal must meet the following requirements:
  - a. An appeal must be in writing;
  - b. An appeal must be sent (via U.S. mail) to the address below:  
BlueCross BlueShield of South Carolina  
Claims Service Center  
P.O. Box 100300  
Columbia, SC 29202
  - c. The appeal request must state that a formal appeal is being requested and include all pertinent information regarding the claim in question; and,
  - d. An appeal must include the Member's name, address, identification number and any other information, documentation or materials that support the Member's appeal.
2. The Member may submit written comments, documents or other information in support of the appeal, and will (upon request) have access to all documents relevant to the claim. A person other than the person who made the initial decision will conduct the appeal. No deference will be afforded to the initial determination.
3. The Member must raise all issues and grounds for appealing an Adverse Benefit Determination at every stage of the appeals process or such issues and grounds will be deemed permanently waived.
4. If the appealed claim involves an exercise of medical judgment, the Employer will consult with an appropriately qualified BCBS healthcare practitioner with training and experience in the relevant field of medicine or vocational expert. If a healthcare professional or vocational expert was consulted for the initial determination, a different healthcare professional or vocational expert will be consulted on the appeal. In addition, the identity of any healthcare professional or vocational expert consulted in connection with the claim will be provided to the participant.
5. The initial decision on an appeal will be made by the Claims Administrator (BlueCross BlueShield of SC) within the time periods specified below:
  - a. Pre-Service Claim: BlueCross (on behalf of the Plan) will decide the appeal within a reasonable period, considering the medical circumstances, but no later than thirty (30) days after receipt of the appeal.
  - b. Urgent Care Claim: The Member may request an expedited appeal of an Urgent Care Claim. This expedited appeal request may be made orally, and BCBS (on behalf of the Plan) will communicate with the Member by telephone or facsimile. BCBS will decide the appeal within a reasonable period, considering the medical circumstances, but no later than seventy-two (72) hours after receipt of the request for an expedited appeal.
  - c. Post-Service Claim: BlueCross (on behalf of the Plan) will decide the appeal within a reasonable period, but no later than sixty (60) days after receipt of the appeal.
  - d. Concurrent Care Claim: BlueCross will decide the appeal (on behalf of the Plan) of Concurrent Care Claims within the time frames set forth in Section 5, a-c, (BlueCross Article XI(B)(5)(a-c)) depending on whether such claim is also a Pre-Service Claim, an Urgent Care Claim or a Post-Service Claim. The final decision on the appeal will be made within the time periods specified below Notice of Final Internal Appeals Determination.
6. Notice of Internal Appeals Determination by the Claims Administrator
  - a. If a Member's appeal is denied in whole or in part, the Member will receive notice of an Adverse Benefit Determination, in a culturally and linguistically appropriate manner, that will:

- i. Include information sufficient to identify the claim involved (including date of service, healthcare Provider, claim amount (if applicable)) and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings;
  - ii. State specific reason(s) for the Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the standard (if any) that was used in denying the claim and a discussion of the decision;
  - iii. Reference specific provision(s) of the Plan of Benefits on which the Benefit determination is based;
  - iv. State that the Member is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits;
  - v. Describe any voluntary appeal procedures offered by BlueCross (on behalf of the Employer's Group Health Plan) and the Member's right to obtain such information;
  - vi. Disclose any internal rule, guideline or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request);
  - vii. If the reason for an Adverse Benefit Determination on appeal is based on a lack of Medical Necessity, Investigational or Experimental services or other limitation or exclusion, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);
  - viii. Provide a description of available internal appeals and external review processes, including information regarding how to initiate such appeals. For claims involving an urgent care claim, a description of the expedited internal and external review processes applicable to such claims;
  - ix. Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under section 2793 of the Public Health Service Act, to assist individuals with the internal claims and appeals and external review processes; and,
  - x. Include a statement regarding the Member's right to bring an action under section 502(a) of ERISA.
- b. The Member will also receive, free of charge, any new or additional evidence considered, relied upon or generated regarding the claim. This evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Benefit Determination is received, to give the Member a reasonable opportunity to respond prior to that date.
  - c. If the Adverse Benefit Determination is based on a new or additional rationale, then the Member will be provided with the rationale, free of charge. The rationale will be provided as soon as possible and sufficiently in advance of the date of the Adverse Benefit Determination to give the Member a reasonable opportunity to respond prior to that date. The Member will be provided, as soon as practicable upon request, the diagnosis and treatment codes and their corresponding meanings, associated with the Adverse Benefit Determination.
  - d. No decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual will be made based upon the likelihood that the individual will support the denial of Benefits.
  - e. A Member's claim and appeals will be decided pursuant to a good faith interpretation of the Plan of Benefits, in the best interest of the Member, without considering either the amount of the Benefits that will be paid to the Member or the financial impact on the Plan.
  - f. The Member will also receive a notice if the claim on appeal is approved.
7. SRNS may retain BlueCross to assist in making the determination on appeal. Regardless of its assistance, BlueCross is only acting in an advisory capacity and is not acting in a fiduciary capacity. SRNS, at all times, retains the right to make the final determination.

## External Review Procedures

1. After a Member has completed the appeal process, a Member may be entitled to an additional, external review of the Member's claim at no cost to the Member. An external review may be used to reconsider the Member's claim if BlueCross has denied, either in whole or in part, the Member's claim. In order to qualify for external review, the claim must have been denied, reduced, or terminated because:
  - a. It does not meet the requirements for Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness; or,
  - b. It is an Investigational or Experimental Service and it involves a life-threatening or seriously disabling condition.
2. After a Member has completed the appeal process, (and an Adverse Benefit Determination has been made) such Member will be notified in writing of such Member's right to request an external review. The Member should file a request for external review within four (4) months of receiving the notice of BlueCross's decision on the Member's appeal. In order to receive an external review, the Member will be required to authorize the release of such Member's medical records (if needed in the review for the purpose of reaching a decision on Member's claim).
3. Within five (5) business days of the date of receipt of a Member's request for an external review, BlueCross will respond by either:
  - a. Assigning the Member's request for an external review to an independent review organization and forwarding the Members records to such organization; or,
  - b. Notifying the Member in writing that the Member's request does not meet the requirements for an external review and the reasons for BlueCross's decision.
4. The external review organization will act on the Member's request for an external review within forty-five (45) days after it receives the request for external review from BlueCross.  
The notice will include:

- a. A general description of the reason for the request for external review, including the date or dates of service, the health care provider and the claim amount (if applicable),
- b. The date the independent review organization (IRO) received the assignment to conduct the external review and the date of the IRO decision,
- c. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching the decision,
- d. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision, and
- e. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either you or the Plan, such as judicial review, and including current contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PHS Act Section 2793.

Upon receipt of a notice of a final external review decision to reverse the adverse benefit determination, the Plan immediately must provide coverage or payment (including immediately authorizing or paying benefits) for the claim.

5. Expedited external reviews are available if the Member's Provider certifies that the Member has a Serious Medical Condition. A Serious Medical Condition, as used in this Section means one that requires immediate medical attention to avoid serious impairment to bodily functions, serious harm to an organ or body part, or that would place the Member's health in serious jeopardy. If the Member may be held financially responsible for the treatment, a Member may request an expedited review of BlueCross's decision if BlueCross's denial of Benefits involves Emergency Services and the Member has not been discharged from the treating Hospital. The independent review organization must make its decision within seventy-two (72) hours after it receives the request for expedited review.

## Final Appeal

The final appeal request available to you is directly to the Plan Administrator. However, the final appeal is only available after you have exhausted all appeal opportunities through the Claims Administrator and completed an external review, if the member meets the requirements for an external review. The final appeal request to the Plan Administrator must be submitted within 30 days from the date of the notice of external review determination. Should the member not meet the requirements for an external review, then the member has 30 days from the date of the notice of determination of the appeal provided by the Claims Administrator to file their final 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 and copy of notice of determinations of the initial appeal provided by the claims administrator and notice of determination from the external review if available to the member and if not a copy of the notice to member stating the external review was not available to the member. 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: Plan Administrator  
Bldg. 992-2W Savannah River Site  
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 Plan Administrator has full discretion and authority to interpret Plan provisions, resolve any ambiguities and evaluate claims. The decision made by Plan Administrator is final and binding. 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 Dental Plan you may be entitled to continue dental coverage for a limited period of time. This is called COBRA continuation coverage.**

On May 4, 2020, in response to the National Emergency concerning the Novel Coronavirus Disease (COVID-19) Outbreak (National Emergency),<sup>5</sup> the Agencies published the Joint Notice, which extended certain timeframes otherwise applicable to group health plans, disability and other welfare plans, pension plans, and their participants and beneficiaries under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code of 1986 (Code). The Joint Notice

extended these timeframes by requiring that plans subject to ERISA or the Code disregard the period for certain action from March 1, 2020, until 60 days after the announced end of the National Emergency or such other date announced by the Agencies in a future notification (the Outbreak Period), subject to a maximum disregarded period of one year.

The American Rescue Plan Act of 2021 (ARP) provides temporary premium assistance for COBRA continuation coverage and, where the employer elects to offer the option, an opportunity to switch to a different health plan option offered by your employer (see below for more information). Premium assistance is available to certain individuals who are eligible for COBRA continuation coverage due to a qualifying event that is a reduction in hours or an involuntary termination of employment. If you qualify for premium assistance, you do not need to pay any of the COBRA premium otherwise due to the plan for the months when you are eligible for premium assistance. This premium assistance is available from April 1, 2021 through September 30, 2021. If you choose to continue your COBRA continuation coverage beyond that date, you may have to pay the full COBRA premium amount due. However, when your premium assistance ends, you may qualify for a special enrollment period to enroll in coverage through the Health Insurance Marketplace.

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

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.

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

#### ***Disabled Members***

1. To be eligible for up to twenty-nine (29) months of continuation of coverage due to disability, an Employee or Dependent:
  - a. Who is determined to be disabled under Title II or XVI of the Social Security Act,
  - b. With a disability onset date either before the COBRA event or within the first sixty (60) days of the COBRA continuation coverage must provide a copy of the notice of the determination of disability to the Employer within:
    - i. Sixty (60) days of the determination of disability; and,
    - ii. Before the end of the first eighteen (18) months of COBRA coverage.

Such Employee or Dependent must also notify the Employer within thirty (30) days of any determination that the Employee or Dependent is no longer disabled.

#### ***Notice of Qualifying Event by the Member***

Each Member is responsible for notifying the Employer within sixty (60) days of such Member's Qualifying Event due to divorce, legal separation or when a Dependent ceases dependency. If the Member does not give such notice, the Member is not entitled to continuation coverage.

#### ***Notice by SRNS to the Member***

SRNS must notify the COBRA Administrator no later than thirty (30) days after the date the Member loses coverage due to a COBRA event. The COBRA Administrator must send a COBRA election Notice to each Member no later than fourteen (14) days after receipt of the notice from the Employer. Notice to the Dependent Spouse is deemed notice to any Dependent of the Spouse.

#### ***Election of Coverage***

Continuation coverage is not automatic. The Member must elect continuation coverage within sixty (60) days of the date the Member is sent notice by the Employer of the right to elect continuation coverage.

#### ***Premium Required***

The Member will be required to pay a Premium for the continuation coverage and shall have the option to make payment in monthly installments. The Member has forty-five (45) days from the date of election to pay the first Premium, which includes the period when coverage commenced, regardless of the date that the first Premium is due.

#### ***Length of COBRA Coverage***

Termination of employment or reduction in hours would not be qualifying events under a Pre-65 retiree plan. A Dependent who is determined to be disabled under Title II or XVI of the Social Security Act before the COBRA event or within the first sixty (60) days of COBRA continuation coverage is entitled to twenty-nine (29) months of continuation coverage, but only if such Dependent has provided notice of the determination of disability within sixty (60) days after determination is issued.

and before the end of eighteen (18) months of coverage. If a second Qualifying Event occurs within this period of continuation coverage, the coverage for any affected Dependent who was a Member under the Employer's Group Health Plan both at the time of the first and the second Qualifying Events may be extended up to thirty-six (36) months from the first Qualifying Event. For all other Qualifying Events, the maximum period of coverage is thirty-six (36) months. Below is a list of circumstances and the period of COBRA coverage for each circumstance.

1. Thirty-six (36) months for Employees' widows or widowers and their Dependent Children
2. Thirty-six (36) months for legally separated or divorced husbands or wives and their Dependent Children.
3. Thirty-six (36) months for Dependent Children who lose coverage because they no longer meet the Plan's definition of a Dependent Child.
4. For Plans providing coverage for retired Employees and their Dependents, a special rule applies for such persons who would lose coverage due to the Employer filing for Title 11 Bankruptcy. (Loss of coverage includes a substantial reduction of coverage within a year before or after the bankruptcy filing.) Upon occurrence of such an event, retired Employees and their eligible Dependents may continue their coverage under the Plan until the date of death of the retiree. If a retiree dies while on this special continued coverage, surviving Dependents may elect to continue coverage for up to thirty-six (36) additional months.

## **How can you elect COBRA continuation 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, WageWorks, 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. It is you or your dependent's responsibility to notify the Service Center within 60 days of the qualifying event.

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

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

In the case of loss of coverage due to an Employee's death, divorce, legal separation, 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.

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

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

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

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

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the COBRA Administrator of a disability or a second qualifying event 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.

### ***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 must have started

at some time before the 60th day of COBRA continuation coverage

and must last at least until the end of the 18-month period of continuation coverage.

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

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

You pay 102% of the full cost of COBRA continuation coverage. You pay 150% of the premium during an 11-month disability extension.

***When and how is payment made for COBRA continuation coverage?***

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 full payment for continuation coverage within 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator with any questions you may have.

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

Grace periods for periodic payments: Although periodic payments are due on the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period if 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. You must make a payment even if you do not receive an invoice. An invoice is a courtesy provided by the COBRA administrator. Your first payment and all periodic payments for continuation coverage should be sent to the COBRA Administrator:

HealthEquity® (formerly WageWorks)  
P.O. Box 660212  
Dallas, TX 75266-0212  
Phone: 888.678.4872

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

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

***For more information***

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

HealthEquity® (formerly WageWorks)  
P.O. Box 660212  
Dallas, TX 75266-0212  
Phone: 888.678.4872

## **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 of Compliance**

Neither the Plan nor any third-party business associate servicing the Plan will disclose Plan Participants' Protected Health Information (PHI) to SRNS or the Plan Administrator unless SRNS 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 relating to 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**

- The Plan and any third-party business associate servicing the 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 Workforce Services, Business Services, Internal Audit and General Counsel Employees may be given access to Plan participants' PHI received from the Plan, health insurance issuer or business associate servicing the Plan. Additionally, as previously stated, SRNS operates the Service Center as a service for the SRNS 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 Plan health insurance issuer or business associate servicing the Plan.

These Employees will have access to Plan participants' PHI only to support or perform the Plan administration functions that the Companies provide for the 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. SRNS will report such breach, violation or noncompliance to the Plan. SRNS will cooperate with the 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

## Administrative Services Only

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

## Amendment

Upon thirty (30) days prior written notice, SRNS or the SRNS Health and Welfare Committee may unilaterally amend, modify, or terminate the Plan. Increases in the benefits provided or decreases in the premium are effective without such prior notice. SRNS or the SRNS Health and Welfare Committee has no responsibility to provide individual notices to each Member when an amendment to the Plan has been made.

## Authorized Representatives

A Provider may be considered a Member's authorized representative without a specific designation by the Member when the Preauthorization request is for Urgent Care Claims. A Provider may be a Member's authorized representative regarding non-Urgent Care Claims only when the Member gives BlueCross or the Provider a specific designation, in a format that is reasonably acceptable to the Plan to act as an authorized representative. If the Member has designated an authorized representative, all information and notifications will be directed to that representative unless the Member gives contrary directions.

## Clerical Error

Clerical errors by BCBS or the Employer will not cause a denial of Benefits that should otherwise have been granted, nor will clerical errors extend Benefits that should otherwise have ended.

## Notice of Nondiscrimination

The SRNS Plan does not discriminate or exclude participants based on race, color, national origin, sex, age, or disability. Any complaints, questions or concerns should be directed to the:

SRNS Plan Administrator  
Bldg. 992-2W Savannah River Site  
Aiken, SC 29808  
803.952.5767

## Disclosure of Personal Health Information to Plan Sponsor

The Employer's Group Health Plan will disclose (or will require BlueCross to disclose) Member's Personal Health Information (PHI) to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions for the Employer's Group Health Plan not inconsistent with the requirements of HIPAA. Any disclosure to and use by the Plan Sponsor will be subject to and consistent with these General Provisions.

1. Restrictions on Plan Sponsor's Use and Disclosure of PHI.
  - a. The Plan Sponsor will neither use nor further disclose Member's PHI, except as permitted or required by the Plan Documents, as amended, or required by law.
  - b. The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides Member PHI agrees to the restrictions and conditions of the Plan of Benefits, with respect to Member's PHI.
  - c. The Plan Sponsor will not use or disclose Member PHI for employment-related actions or decisions or relating to any other benefit or Employee Benefit Plan of the Plan Sponsor.
  - d. The Plan Sponsor will report to Employer's Group Health Plan any use or disclosure of Member PHI that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.
  - e. The Plan Sponsor will make PHI available to the Member who is the subject of the information in accordance with HIPAA.
  - f. The Plan Sponsor will make Member PHI available for amendment, and will on notice amend Member PHI, in accordance with HIPAA.
  - g. The Plan Sponsor will make Member PHI available for amendment, and will on notice amend Member PHI, in accordance with HIPAA.
  - h. The Plan Sponsor will make its internal practices, books and records, relating to its use and disclosure of Member PHI, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with HIPAA.
  - i. The Plan Sponsor will, if feasible, return or destroy all Member PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control), received from the Employer's Group Health Plan, including all copies of and any data or compilations derived from and allowing identification of any Member who is the subject of the PHI, when the Member's PHI is no longer needed for the Plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Member PHI, the Plan Sponsor will limit the use or disclosure of any Member PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

- j. The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that Plan Sponsor creates, receives, maintains or transmits on behalf of the Employer's Group Health Plan.
  - k. The Plan Sponsor will ensure that any agent, including a subcontractor, to whom Plan Sponsor provides ePHI (that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Employer's Group Health Plan), agrees to implement reasonable and appropriate security measures to protect this information.
  - l. Plan Sponsor shall report any security incident of which it becomes aware to the Employer's Group Health Plan as provided below:
    - a. In determining how and how often Plan Sponsor shall report security incidents to Employer's Group Health Plan, both Plan Sponsor and Employer's Group Health Plan agree that unsuccessful attempts at unauthorized access or system interference occur frequently and that there is no significant benefit for data security from requiring the documentation and reporting of such unsuccessful intrusion attempts. In addition, both parties agree that the cost of documenting and reporting such unsuccessful attempts as they occur outweigh any potential benefit gained from reporting them. Consequently, both Plan Sponsor and Employer's Group Health Plan agree that this Agreement shall constitute the documentation, notice and written report of any such unsuccessful attempts at unauthorized access or system interference as required above and by 45 C.F.R. Part 164, Subpart C and that no further notice or report of such attempts will be required. By way of example (and not limitation in any way), the Parties consider the following to be illustrative (but not exhaustive) of unsuccessful security incidents when they do not result in unauthorized access, use, disclosure, modification, or destruction of ePHI or interference with an information system:
      - i. Pings on a Party's firewall;
      - ii. Port scans;
      - iii. Attempts to log on to a system or enter a database with an invalid password or username;
      - iv. Denial-of-service attacks that do not result in a server being taken offline; and,
      - v. Malware (e.g., worms, viruses).
    - b. Plan Sponsor shall, however, separately report to Employer's Group Health Plan (i) any successful unauthorized access, use, disclosure, modification or destruction of the Group Health Plan's ePHI of which Plan Sponsor becomes aware if such security incident either (a) results in a breach of confidentiality; (b) results in a breach of integrity but only if such breach results in a significant, unauthorized alteration or destruction of Group Health Plan's ePHI; or (c) results in a breach of availability of Group Health Plan's ePHI, but only if said breach results in a significant interruption to normal business operations. Such reports will be provided in writing within ten (10) business days after Plan Sponsor becomes aware of the impact of such security incident upon Group Health Plan's ePHI.
2. Adequate Separation between the Plan Sponsor and the Employer's Group Health Plan.
- a. Only Employees or other workforce members under the control of the Plan Sponsor ("Employees") who, in the normal course of their duties, assist in the administration of Employee Benefits or the Employer's Group Health Plan or the Employer's Group Health Plan finances or other classes of Employees as designated in writing by the Plan Sponsor may be given access to Member PHI received from the Employer's Group Health Plan or business associate servicing the Employer's Group Health Plan.
  - b. These Employees will have access to Member PHI only to perform the Plan administration functions that the Plan Sponsor provides for the Employer's Group Health Plan.
  - c. These Employees will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of Member PHI in breach or violation of or noncompliance with the provisions of this section to the Plan of Benefits. Plan Sponsor will promptly report such breach, violation or noncompliance to the Employer's Group Health Plan, and will cooperate with the Employer's Group Health Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each Employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Member, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance.
  - d. The Plan Sponsor will ensure that the separation required by the above provisions will be supported by reasonable and appropriate security measures.
  - e. Plan Sponsor certifies that the Plan of Benefits contains and that the Plan Sponsor agrees to the provisions outlined above.

## Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of privacy practices (this "Notice") applies to the health plans and programs (the "Group Health Plan") sponsored by Savannah River Nuclear Solutions, LLC (the "Company"). The Group Health Plan includes the following Company-sponsored plans and benefits that are subject to the administrative simplification section of the Health Insurance Portability and Accountability Act and its implementing regulations: the Active Medical Plan the Pre-65 Retiree Medical Plan, the Active Dental Plan, the Pre-65 Retiree Dental Plan, the Active Vision Plan, the Employee Assistance Program, and Flexible Spending Accounts (Traditional and Limited). This Notice of Privacy Practices summarizes the Group Health Plan's responsibilities and your rights concerning protected health information, which is information that identifies you and relates to your physical or mental health, treatment, and payment for health care services. The Group Health Plan is required to abide by the terms of this Notice, which is currently in effect.

**1. Uses and Disclosures of Information that the Group Health Plan May Make Without Written Authorization.** The Group Health Plan may use or disclose protected health information for the following purposes without your written authorization as long as the legal requirements are met. The examples provided are not meant to be exhaustive.

**Treatment.** The Group Health Plan may use or disclose protected health information so that health care providers may provide treatment to you. For example, the Group Health Plan may disclose medical information about you to doctors, nurses, technicians, or other hospital or medical facility personnel who are involved in taking care of you.

**Payment.** The Group Health Plan may use or disclose protected health information to determine or fulfill its responsibility for coverage and the provision of benefits under the Group Health Plan. Examples of payment activities include but are not limited to: determining eligibility or coverage for Group Health Plan benefits, facilitating payment for the treatment or services you receive from health care providers, coordinating benefits under the Group Health Plan and facilitating the adjudication or subrogation of health care claims. The Group Health Plan also may use or disclose protected health information to review health care services for medical necessity, appropriateness of care and justification of charges and to facilitate utilization review activities, including precertification and preauthorization of services concurrent and retrospective review.

**Health Care Operations.** The Group Health Plan may use or disclose protected health information for certain operations that are necessary to run the Group Health Plan. Examples of Group Health Plan operations include but are not limited to: conducting quality assessment and improvement activities; underwriting or premium rating for purposes of creation, renewal, or replacement of Group Health Plan benefits; coordinating or managing care; and conducting or arranging for medical review. The Group Health Plan is prohibited from using or disclosing protected health information that is genetic information of an individual for underwriting purposes.

**Plan Sponsor.** In accordance with the terms of the Group Health Plan, the Group Health Plan may disclose protected health information to designated employees of the Company, which is the sponsor of the Group Health Plan, solely for purposes of administering the Group Health Plan.

**Required By Law.** The Group Health Plan may use or disclose protected health information as required by law. Public Health Activities. The Group Health Plan may use or disclose protected health information for certain public health activities, including to report information to the appropriate authority to prevent or control disease, injury or disability.

**Abuse or Neglect.** The Group Health Plan may disclose protected health information to an appropriate government agency if it believes it is related to child abuse or neglect or in certain circumstances if it believes it is related to a victim of abuse, neglect or domestic violence. Health Oversight Activities. The Group Health Plan may disclose protected health information to governmental health oversight agencies for activities authorized by law, such as audits, investigations, and inspections. "Health oversight activity" does not include an investigation or other activity relating to you.

**Judicial and Administrative Proceedings.** The Group Health Plan may disclose protected health information in response to an order of a court or administrative tribunal, a subpoena, discovery request or other lawful process as provided by law.

**Law Enforcement.** The Group Health Plan may disclose protected health information, subject to specific limitations, see Benefits Orientation Guide for New Full-Time Employees for certain law enforcement purposes, including in response to legal process or as otherwise required by law; to identify or locate a suspect, fugitive, material witness or missing person; to provide requested information about the victim of a crime; to alert law enforcement that a person may have died as a result of a crime; to report a crime that has occurred on a hospital's premises.

**Coroners, Medical Examiners and Funeral Directors.** The Group Health Plan may disclose protected health information to coroners, medical examiners, or funeral directors as necessary for them to carry out their duties.

**Organ Donation.** The Group Health Plan may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes or tissue.

**Research.** The Group Health Plan may use or disclose protected health information for limited research purposes. Usually, an authorization is required to use and disclose protected health information for research.

**Threat to Health or Safety.** The Group Health Plan may use or disclose protected health information to avert or lessen a serious threat to your health or safety or the health and safety of others.

**Military.** If you are in the military or are a veteran, then the Group Health Plan may disclose protected health information as required for military or veteran purposes.

**National Security.** The Group Health Plan may disclose protected health information to authorized federal officials for national security activities and for the provision of protective services to the President and other authorized officials.

**Persons in Custody.** The Group Health Plan may disclose protected health information about an inmate or person in lawful custody of law enforcement in certain circumstances.

**Workers' Compensation.** The Group Health Plan may disclose protected health information as authorized by and to comply with workers' compensation laws and other similar legally established programs that provide benefits for work-related injuries or illness.

**Business Associates.** The Group Health Plan may disclose protected health information to third party "business associates" who perform various activities involving protected health information (e.g., claims payment or case management services) for the Group Health Plan. The Group Health Plan will require its business associates to agree to appropriately safeguard protected health information and to limit their use or disclosure of protected health information.

**2. Uses and Disclosures of Information that the Group Health Plan May Make Unless You Object.** The Group Health Plan may use and disclose protected health information in the following instances without your written authorization, unless you object.

**Persons Involved in Your Health Care/Payment for Health Care.** Unless you object, the Group Health Plan may disclose protected health information to a member of your family, relative, close friend, or other person identified by you who is involved in your health care or the payment for your health care. The Group Health Plan will limit the disclosure to the protected health information relevant to that person's involvement in your health care or payment.

**Notification.** Unless you object, the Group Health Plan may use or disclose protected health information to notify or assist in notifying a family member, personal representative or other person responsible for your care of your location, general condition or death. Among other things, the Group Health Plan may disclose protected health information to a disaster relief agency to assist in notifying family members.

**3. Uses and Disclosures of Information that We May Make With Your Written Authorization.** Other uses and disclosures of protected health information about you will be made only with your written authorization unless otherwise required by law. The Group Health Plan must obtain authorizations to use and disclose protected health information for marketing, sale of protected health information and that involve psychotherapy notes. You may revoke your authorization at any time by submitting a written revocation to the Privacy Contact identified below, except to the extent that the Group Health Plan has taken action in reliance on your authorization.

**4. Your Rights Concerning Protected Health Information.** Right to Request Additional Restrictions. You have the right to request additional restrictions on the use or disclosure of protected health information for treatment, payment or health care operations. You must submit your request for additional restrictions in writing to the Privacy Contact identified below. In most cases, the Group Health Plan is not required to agree to a requested restriction. If the Page 6 • Benefits Orientation Guide for New Full-Time Employees Group Health Plan agrees to a restriction in writing, then it will comply with the restriction unless an emergency or the law prevents the Group Health Plan from complying with the restriction, or until the restriction is terminated. Except as otherwise required by law, the Group Health Plan will comply if you request that protected health information not be disclosed to a health plan for purposes of payment or health care operations (but not treatment) if the information pertains solely to a health care item or service for which you have paid for out of pocket, in full.

**Right to Receive Communications by Alternative Means.** You have the right to request that the Group Health Plan use alternative means or alternative locations for communications involving protected health information. You must submit your request in writing to the Privacy Contact identified below. The Group Health Plan will accommodate reasonable requests if you clearly state that the disclosure of all or part of the information to which the request pertains could endanger you. The Group Health Plan may condition the accommodation on information as to how payment will be handled or specification of an alternative address or other method of contact.

**Right to Inspect and Copy Records.** You have the right to inspect and obtain a copy of protected health information that is used to make decisions about you. You may access protected health information by submitting a written request to the Privacy Contact identified below. The Group Health Plan may charge you a reasonable cost based fee for providing the records to you. The Group Health Plan may deny your request in writing in certain circumstances. In most cases, if access is denied, then you will have the right to have the denial reviewed.

**Right to Request Amendment to Record.** You have a right to request that incomplete or inaccurate protected health information be amended. You may request the amendment by submitting a request in writing to the Privacy Contact identified below. The Group Health Plan may deny your request in writing in certain circumstances. If the Group Health Plan denies your request, then you have a right to submit a statement of disagreement and to have the statement attached to the record. The Group Health Plan then has the right to add a rebuttal statement.

**Right to an Accounting of Certain Disclosures.** You have the right to request and receive an accounting of disclosures the Group Health Plan has made of protected health information about you for certain purposes within the last six years. An accounting will not include disclosures: made to you; for treatment, payment, or health care operations; to family members or others involved in your health care or payment; for notification purposes; for incidental disclosures; for national security or intelligence purposes; for certain correctional institution or law enforcement purposes; for information that is part of a limited data set; or pursuant to an authorization. You have a right to receive the first accounting within a 12-month period free of charge. The Group Health Plan may charge a reasonable cost-based fee for all requests made after your first request during that 12-month period. You may request an accounting by submitting a written request to the Privacy Contact identified below.

**Right to a Copy of the Notice.** You have the right to obtain a paper copy of this notice upon request. You have this right even if you have agreed to receive the notice electronically.

**Actions on Your Behalf.** You have the right to have a personal representative exercise your rights and take other actions on your behalf.

**5. Group Health Plan Duties.** The Group Health Plan is required by law to maintain the privacy of protected health information, to provide individuals with notice of its legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information.

**6. Changes to This Notice.** The Group Health Plan reserves the right to change the terms of this Notice at any time, and to make the new notice of privacy practices effective for all protected health information that the Group Health Plan maintains, including protected health information created or received prior to making changes to the Notice. The new notice will be posted on the Group Health Plan's website.

**7. Complaints.** You may complain to the Group Health Plan or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by the Group Health Plan. You may file a complaint with the Group Health Plan by notifying the Privacy Contact identified below. The Group Health Plan will not retaliate against you for filing a complaint.

- **Additional Information.** If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at the below address. There will be no retaliation for filing a complaint.  
Office for Civil Rights  
Department of HHS  
Jacob Javits Federal Building  
26 Federal Plaza - Suite 3312  
New York, NY 10278  
Voice Phone (212) 264-3313  
FAX (212) 264-3039  
TDD (212) 264-2355

**8. Privacy Contact.** If you have any questions about this Notice, wish to exercise any of your rights or you believe that your privacy rights have been violated, then you may contact the Privacy Official for the Group Health Plan.

- **For Further Information.** If you have questions, need further assistance regarding or would like to submit a request pursuant to this Notice, you may contact the SRNS Privacy Officer by phone at (803) 952-8749 or at the following address: 992-2W Savannah River Site; Aiken, SC 29808. This Notice of Privacy Practices is also available on our SRNS web page at [https://www.srs.gov/general/jobs/benefits/index\\_e.htm](https://www.srs.gov/general/jobs/benefits/index_e.htm).

#### **Governing Law**

The Employer's Group Health Plan (including the Schedule of Benefits) is governed by and subject to applicable federal law. If and to the extent that federal law does not apply, the Employer's Group Health Plan is governed by and subject to the laws of the State of South Carolina. If federal law conflicts with any state law, then such federal law shall govern. If any provision of the Employer's Group Health Plan conflicts with such law, the Employer's Group Health Plan shall automatically be amended solely as required to comply with such state or federal law.

#### **Grandfathered Health Plan**

As of January 1, 2014, the SRNS Plan is not considered 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. Questions regarding health plan status can be directed to the Plan Administrator at 803.952.5749. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1.866.444.3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

#### **Identification Card**

A Member must present his or her Identification Card prior to receiving Benefits. Identification Cards are for identification only. Having an Identification Card creates no right to Benefits or other services. To be entitled to Benefits, the cardholder must be a Member whose Premium has been paid. Any person receiving Covered Expenses to which the person is not entitled will be responsible for the charges.

#### **Information and Records**

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

#### **Legal Actions**

No Member may bring an action at law or in equity to recover on the Employer's Group Health Plan until such Member has exhausted the appeal process as set forth in Section 7 (BlueCross Article XI). Any and all claims brought under this Plan are subject to a two-year limitations period from the date the cause of action accrued.

#### **Membership Application**

BlueCross will only accept a Membership Application submitted by the SRNS on behalf of its Employees. BlueCross will not accept Membership Applications directly from Employees or Dependents.

#### **Negligence or Malpractice**

BlueCross and SRNS do not practice medicine. Any medical treatment, service or Medical Supplies rendered to or supplied to any Member by a Provider is rendered or supplied by such Provider and not by BCBS or the Employer. BCBS and Employer are not liable for any improper or negligent act, inaction or act of malfeasance of any Provider in rendering such medical treatment, service, Medical Supply or medication.

#### **Notices**

Except as otherwise provided in the Plan, any notice under the Plan may be given by United States registered or certified mail, postage paid, return receipt requested or nationally recognized carrier and addressed to BlueCross:

BlueCross BlueShield of South Carolina  
P.O. Box 100300  
Columbia, SC 29202

To a Member: To the last known name and address listed for the Employee related to such Member on the Membership Application. Members are responsible for notifying BCBS of any name or address changes within thirty-one (31) days of the change.

To the Employer: To the name and address last given to BlueCross. The Employer is responsible for notifying BlueCross and Members of any name or address change within thirty-one (31) days of the change.

#### ***No Waiver of Rights***

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

#### ***Other Insurance***

Each Member must provide the Plan (and its designee, including BCBS) and Employer with information regarding all other health insurance coverage to which such Member is entitled.

#### ***Payment of Claims***

A Member is expressly prohibited from assigning any right to payment of Covered Expenses or any payment related to Benefits. The Plan may pay all Covered Expenses directly to the Member upon receipt of due proof of loss when a Non-Participating Provider renders services. When payment is made directly to the Member, the Member is responsible for any payment to the Provider. Where a Member has received Benefits from a Participating Provider, the Employer's Group Health Plan will pay Covered Expenses directly to such Participating Provider.

#### ***Physical Examination***

The Plan has the right to have examined, at their own expense, a Member whose injury or sickness is the basis of a claim (whether pre-service, post-service, concurrent or urgent care). Such physical examination may be made as often as the Plan (through its designee, including BlueCross) may reasonably require while such claim for Benefits or request for Preauthorization is pending.

#### ***Replacement Coverage***

If the Plan replaced the Employer's prior Plan, all eligible persons who were validly covered under that Plan on its termination date will be covered on the Plan of Benefits Effective Date of the Plan, provided such persons are enrolled for coverage as stated in Section 2.

#### ***Right of Recovery***

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

## **Subrogation and Reimbursement Benefits Subject to This Provision**

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

### **Statement of Purpose**

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

### **Definitions**

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

Another Party shall include the party or parties who caused the injuries or illness; the liability insurer, guarantor or other indemnifier of the party or parties who caused the injuries or illness; a Member's own insurance coverage, such as uninsured, underinsured, medical payments, no fault, homeowner's, renter's or any other insurer; a

workers' compensation insurer or governmental entity; or, any other individual, corporation, association or entity that is liable or legally responsible for payment in connection with the injuries or illness.

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

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

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

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

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

**Duties of the Member:** The Member will execute and deliver all required instruments and papers provided by the Plan/BlueCross, including an accident questionnaire, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other Benefits will be paid by the Plan for the injuries or illness. The Plan/BlueCross may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other Benefits for the injuries or illness before these papers are signed (for example, to obtain a prompt payment discount); however, in that event, the Plan will remain entitled to Subrogation and Reimbursement. In addition, the Member will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made whole and common fund doctrines. A Member who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the portion of the Recovery subject to the Plan's lien to the Plan under the terms of this provision.

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

As a condition of receiving Benefits, the Member must:

- Immediately notify the Plan/BlueCross of an injury or illness for which Another Party may be liable, legally responsible, or otherwise makes a payment in connection with the injuries or illness;
- Execute and deliver an Accident Questionnaire within one hundred eighty (180) days of the Accident Questionnaire being mailed to the Member;
- Deliver to the Plan/BlueCross a copy of the Personal Injury Protection Log, Medical Payments log and/or Medical Authorization within ninety (90) days of being requested to do so;
- Deliver to the Plan/BlueCross a copy of the police report, incident or accident report, or any other reports issued as a result of the injuries or illness within ninety (90) days of being requested to do so;
- Authorize the Plan to sue, compromise and settle in the Member's name to the extent of the amount of medical or other Benefits paid for the injuries or illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the Member's rights to Recovery when this provision applies;
- Include the Benefits paid by the Plan as a part of the damages sought against Another Party. Immediately reimburse the Plan, out of any Recovery made from Another Party, the amount of medical or other Benefits paid for the injuries or illness by the Plan up to the amount of the Recovery and without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise;
- Immediately notify the Plan/BlueCross in writing of any proposed settlement and obtain the Plan/BlueCross written consent before signing any release or agreeing to any settlement; and,
- Cooperate fully with the Plan/BlueCross in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan/BlueCross

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

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

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

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

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

**Prior Recoveries:** In certain circumstances, a Member may receive a Recovery that exceeds the amount of the Plan's payments for past and/or present expenses for treatment of the injuries or illness that is the subject of the Recovery. In other situations, based on the extent of the Member's injuries or illness, the Member may have received a prior Recovery for treatment of the injuries or illness that is the subject of a claim for Benefits under the Plan. In these situations, the Plan will not provide Benefits for any expenses related to the injuries or illness for which compensation was provided through a current or previous Recovery. The Member is required to submit full and complete documentation of any such Recovery in order for the Plan to consider eligible expenses.

To the extent a Member's Recovery exceeds the amount of the Plan's lien, the Plan is entitled to deny that amount as an offset against any claims for future Benefits relating to the injuries or illness. In those situations, the Member will be solely responsible for payment of medical bills related to the injuries or illness. The Plan also precludes operation of the made-whole and common-fund doctrines in applying this provision.

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

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

If, however, the beneficiary receives a settlement, judgment, or other payment relating to an injury or illness from another person, firm, corporation, organization or business entity for the injury or illness, the beneficiary agrees to reimburse the Plan in full, and in first priority, for benefits paid by the Plan relating to the injury or illness. The Plan's right of recovery is on a first dollar recovery basis and applies regardless of whether the recovery, or a portion thereof, is specifically designated as

payment for, but not limited to, medical benefits, pain and suffering, lost wages, other specified damages, or whether the Beneficiary has been made whole or fully compensated for his/her injuries.

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

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

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

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

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

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

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

# Legal Notices

## No Surprise Act

### Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected by federal law from surprise billing or balance billing.

#### What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

“Out-of-network” describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

#### You are protected from balance billing for:

##### Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as deductibles, copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

##### Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

**You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.**

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

**If you believe you've been wrongly billed**, you may contact the Department of Labor or BCBS of South Carolina 800.325.6596.

Individuals interested in obtaining information from the DOL concerning employment-based health coverage laws may call the Employee Benefits Security Administration (EBSA) Toll-Free Hotline at 1.866.444.EBSA (3272) or visit the DOL's website ([www.dol.gov/ebsa](http://www.dol.gov/ebsa)).

## 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 because 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**

The SRNS Wellness Program is a voluntary program available to all active Employees and pre-65 retirees and their spouses who are enrolled in the health Plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve Employee/Retiree health or prevent disease, including the Americans with Disabilities Act of 1990. The Genetic Information Non-discrimination Act (GINA) of 2008 and the Health Insurance Portability and Accountability Act (HIPPA), as applicable, among others. If you choose to participate in the wellness program, you may have an option to complete a voluntary risk assessment called "My Life Check" for the American Heart Association that ask a series of questions about your health-relation activities and behaviors. As part of this survey, you may be asked some biometric questions. You are not required to complete the American Heart Association Survey or to participate in a blood test of other medical examination.

If you decided to complete the Rally health survey, this information from your responses may be used by BlueCross to provide you with information to help you understand your current health and potential risks. You are also encouraged to share your results or concerns with your own doctor. No individual information is shared with SRNS.

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 803.952.5824 and we will work with you to develop another way to qualify for the reward.

If you decide to complete the American Heart Association survey, no individual information is shared with SRNS.

## **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**

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.

## **Women's Health and Cancer Rights Act Notices**

Did you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema)? Call your Plan Administrator 803.952.5749 for more information.

## **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)**

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit [www.healthcare.gov](http://www.healthcare.gov). If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, 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, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer sponsored plan. If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of

being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or call 1-866-444-EBSA (3272). If you live in one of the states listed on the next page, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. You should contact your state for more information on eligibility.

## Medicaid/CHIP Premium Assistance Program

State	Website	Phone
ALABAMA	<a href="http://myalhipp.com/">http://myalhipp.com/</a>	1-855-692-5447
ALASKA	<a href="http://myakhipp.com/">http://myakhipp.com/</a> Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a>	1-866-251-4861
ARKANSAS	<a href="http://myarhipp.com/">http://myarhipp.com/</a>	1-855-MyARHIPP (855-692-7447)
CALIFORNIA	Health Insurance Premium Payment (HIPP) Program: <a href="http://dhcs.ca.gov/hipp">http://dhcs.ca.gov/hipp</a> Email: <a href="mailto:hipp@dhcs.ca.gov">hipp@dhcs.ca.gov</a>	916-445-8322 Fax: 916-440-5676
COLORADO	Health First Colorado: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a>  CHP+: <a href="https://hcpf.colorado.gov/child-health-plan-plus">https://hcpf.colorado.gov/child-health-plan-plus</a>  Health Insurance Buy-In Program (HIBI): <a href="https://www.mycohibi.com">https://www.mycohibi.com</a>	Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711  CHP+ Customer Service: 1-800-359-1991/ State Relay 711  HIBI Customer Service: 1-855-692-6442
FLORIDA	<a href="https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html">https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html</a>	1-877-357-3268
GEORGIA	<a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a>  GA CHIPRA Website: <a href="https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra">https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra</a>	678-564-1162 Press 1  Phone: (678) 564-1162, Press 2
INDIANA	Health Insurance Premium Payment Program  All other Medicaid Website: <a href="https://www.in.gov/medicaid/">https://www.in.gov/medicaid/</a> <a href="http://www.in.gov/fssa/dfr/">http://www.in.gov/fssa/dfr/</a>	Family and Social Services Administration Phone: 1-800-403-0864  Member Services Phone: 1-800-457-4584
IOWA	IOWA: <a href="https://hhs.iowa.gov/programs/welcome-iowa-medicaid">https://hhs.iowa.gov/programs/welcome-iowa-medicaid</a>  Hawki: <a href="https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki">https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki</a>  HIPP: <a href="https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp">https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp</a>	1-800-338-8366  Hawki: 1-800-257-8563  HIPP: 1-888-346-9562
KANSAS	<a href="https://www.kancare.ks.gov">https://www.kancare.ks.gov</a>	1-800-792-4884  HIPP: 1-800-967-4660

State	Website	Phone
KENTUCKY	<a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a> Email: <a href="mailto:KIHIPPROGRAM@ky.gov">KIHIPPROGRAM@ky.gov</a> KCHIP: <a href="https://kynect.ky.gov">https://kynect.ky.gov</a> Kentucky Medicaid: <a href="https://chfs.ky.gov/agencies/dms">https://chfs.ky.gov/agencies/dms</a>	1-855-459-6328  CHIP: 1-877-524-4718
LOUISIANA	<a href="http://www.medicaid.la.gov">www.medicaid.la.gov</a>  <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a>	1-888-342-6207  LaHIPP: 1-855-618-5488
MAINE	<a href="https://www.mymaineconnection.gov/benefits/s/?language=en_US">https://www.mymaineconnection.gov/benefits/s/?language=en_US</a>  Private Health Insurance Premium: <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a>	1-800-442-6003  TTY: Maine relay 711  Private Health Insurance Premium: 800-977-6740  TTY: Maine relay 711
MASSACHUSETTS	<a href="https://www.mass.gov/masshealth/pa">https://www.mass.gov/masshealth/pa</a> Email: <a href="mailto:masspremassistance@accenture.com">masspremassistance@accenture.com</a>	1-800-862-4840  TTY: 711
MINNESOTA	<a href="https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp">https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp</a>	1-800-657-3739
MISSOURI	<a href="https://www.dss.mo.gov/mhd/participants/pages/hipp.htm">https://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a>	573-751-2005
MONTANA	<a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a> Email: <a href="mailto:HSHIPPProgram@mt.gov">HSHIPPProgram@mt.gov</a>	1-800-694-3084
NEBRASKA	<a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a>	(855) 632-7633  Lincoln: (402) 473-7000  Omaha: (402) 595-1178
NEVADA	<a href="http://dhcnp.nv.gov">http://dhcnp.nv.gov</a>	1-800-992-0900
NEW HAMPSHIRE	<a href="https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program">https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program</a> Email: <a href="mailto:DHHS.ThirdPartyLiabi@dhhs.nh.gov">DHHS.ThirdPartyLiabi@dhhs.nh.gov</a>	603-271-5218  Toll free number for the HIPP program: 1-800-852-3345, ext 15218
NEW JERSEY	Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a>  CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a>	Medicaid: 1-800-356-1561  CHIP Premium Assistance Phone: 609-631-2392  CHIP: 1-800-701-0710 (TTY: 711)
NEW YORK	<a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a>	1-800-541-2831
NORTH CAROLINA	<a href="https://medicaid.ncdhhs.gov/">https://medicaid.ncdhhs.gov/</a>	919-855-4100
NORTH DAKOTA	<a href="https://www.hhs.nd.gov/healthcare">https://www.hhs.nd.gov/healthcare</a>	1-844-854-4825
OKLAHOMA	<a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a>	1-888-365-3742

State	Website	Phone
OREGON	<a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a> <a href="http://www.oregonhealthcare.gov/index-es.html">http://www.oregonhealthcare.gov/index-es.html</a>	1-800-699-9075
PENNSYLVANIA	<a href="https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html">https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html</a> CHIP Website: <a href="https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx">https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx</a>	1-800-692-7462 CHIP: 1-800-986-KIDS (5437)
RHODE ISLAND	<a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a>	855-697-4347, or 401-462-0311 (Direct Rite Share Line)
SOUTH CAROLINA	<a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a>	1-888-549-0820
SOUTH DAKOTA	<a href="http://dss.sd.gov">http://dss.sd.gov</a>	1-888-828-0059
TEXAS	<a href="https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program">https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program</a>	1-800-440-0493
UTAH	Utah's Premium Partnership for Health Insurance (UPP) Website: <a href="https://medicaid.utah.gov/upp/">https://medicaid.utah.gov/upp/</a> Email: <a href="mailto:upp@utah.gov">upp@utah.gov</a> Adult Expansion Website: <a href="https://medicaid.utah.gov/expansion/">https://medicaid.utah.gov/expansion/</a> Utah Medicaid Buyout Program Website: <a href="https://medicaid.utah.gov/buyout-program/">https://medicaid.utah.gov/buyout-program/</a> CHIP Website: <a href="https://chip.utah.gov/">https://chip.utah.gov/</a>	1-888-222-2542
VERMONT	<a href="https://dvha.vermont.gov/members/medicaid/hipp-program">https://dvha.vermont.gov/members/medicaid/hipp-program</a>	1-800-250-8427
VIRGINIA	<a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select">https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select</a> <a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs">https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs</a>	Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON	<a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a>	1-800-562-3022
WEST VIRGINIA	<a href="https://www.mywhipp.com/">https://www.mywhipp.com/</a> <a href="https://dhhr.wv.gov/bms/">https://dhhr.wv.gov/bms/</a>	Toll-free phone: 1-855-MyWHIPP (1-855-699-8447) Medicaid: 304-558-1700
WISCONSIN	<a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a>	1-800-362-3002
WYOMING	<a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility">https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility</a>	1-800-251-1269

To see if any more states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact:

U.S. Department of Labor  
Employee Benefits Security Administration  
[www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa)  
866-444-EBSA (3272)

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services

[www.cms.hhs.gov](http://www.cms.hhs.gov)  
(877) 267 2323

Menu Option 4, Ext. 61565

## 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.

### A. 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,” the “Company” or “Plan Sponsor”).

### B. 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.

### C. 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.

### D. Plan Documents

**This Summary Plan Description summarizes the provisions of the Plan. The policies and procedures of BlueCross BlueShield of South Carolina, 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 BlueCross BlueShield of South Carolina 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.**

## E. 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 BlueCross BlueShield of South Carolina.

## F. 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. The Company's rights include the right to obtain coverage and/or administrative services from additional or different insurance carriers, parties, HMOs, third party administrators, etc. at any time, and the right to revise the amount of employee contributions. Employees will be notified of any material modifications to 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.

The benefit(s) described in this summary plan description is also governed by the terms of the SRNS Welfare Benefit Plan, referred to as a Wrap Plan.

## 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 claim 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 claim for benefits.

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:

Corporation Service Company  
1703 Laurel Street  
Columbia, SC 29201

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 NW, Washington, DC 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

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.

Plan Year	January 1 - December 31
Type of Plan	A self-funded welfare plan that provides Medical benefits
Plan Name	The Savannah River Nuclear Solutions, LLC Pre-65 Retiree Health Plan
Plan Number	509
Plan Sponsor	Employer Identification Number 26-0240191
Plan Administrator	SRNS Health and Welfare Committee, Attn: Plan Administrator Savannah River Nuclear Solutions, LLC SRNS Workforce Services Bldg. 992-2W Savannah River Site Aiken, SC 29808 Phone 803.952.5767
Plan Administrator	SRNS Plan Administrator Identification Number 27-0584392
Claims Administrator	BlueCross BlueShield of South Carolina I-20 at Alpine Road, Columbia, SC 29219
Agent for Legal Process	Corporation Service Company 1703 Laurel Street, Columbia, SC 29201
Plan Sponsor	Savannah River Nuclear Solutions, LLC

## Definitions

As used in this SPD, the following capitalized terms shall have the meanings indicated below:

### ACA

The Affordable Care Act of 2010, as amended. Also known as the Patient Protection and Affordable Care Act of 2010.

### Admission

The period of time between a Member's admission as a patient into a Hospital or skilled nursing facility and the time the Member leaves or is discharged.

### Adverse Benefit Determination

Any denial, reduction or termination of, or failure to provide or make (in whole or in part) payment for a claim for Benefits, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in a Plan, and including, a denial, reduction or termination of, or failure to provide or make payment (in whole or in part), for a Benefit which results from the application of any utilization review as well as a failure to cover an item or services for which Benefits are otherwise provided because it is determined to be Investigational or Experimental or not Medically

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

### **Allowable Charge**

The amount the Corporation or licensee of the Blue Cross Blue Shield Association (BCBSA) agrees to pay a Provider as payment in full for a service, procedure, supply or equipment. Additionally:

1. The Allowable Charge shall not exceed the Maximum Payment; and,
2. In addition to the Member's liability for Benefit Year Deductibles, Copayments and/or Coinsurance, the Member may be balance billed by the Non-Participating Provider for any difference between the Allowable Charge and the Billed Charge.

### **Authorized Representative**

An individual (including a Provider) whom the Member designates in writing to act on his or her behalf.

### **Benefit Year**

January 1 - December 31, as set forth on the Schedule of Benefits. The Initial Benefit Year may be more or less than twelve (12) months.

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

1. Medically Necessary;
2. Preauthorized (when required under this Plan of Benefits or the Schedule of Benefits); and,
3. Not limited or exclude under the terms of this Plan of Benefits.

### **BlueCard Program**

A program in which all members of the BCBSA participate. Details of the BlueCard Program are more fully set forth in Part One of the Summary Plan Description.

### **Clinical Trial**

An approved clinical trial is one that is approved or funded through the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHRQ), the Centers for Medicare & Medicaid Services (CMS) the Department of Defense (DOD), the Department of Veterans Affairs (BA), a qualified non-governmental research entity identified in the guidelines issued by the NIH or is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA).

### **COBRA**

The provision of the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended, which require certain Employers to offer continuation of healthcare coverage to Employees and Dependents of Employees who would otherwise lose coverage.

### **COBRA Administrator**

BCBSSC or its designated subcontractor that provides administrative services related to COBRA. Currently the subcontractor providing COBRA services is WageWorks.

### **Coinsurance**

The sharing of the Allowable Charge between the Member and the Group Health Plan. After the Member's Benefit Year Deductible requirement is met, the Group Health Plan will pay a percentage of Allowable Charges as set forth on the Schedule of Benefits. The Member is responsible for the remaining percentage of the Allowable Charge. Coinsurance is calculated after any applicable Benefit Year Deductible or Copayment is subtracted from the Allowable Charge based upon the network charge or the lesser charge of the Provider.

For Prescription Drug Benefits, Coinsurance means the amount payable by the Member calculated as follows:

1. The percentage listed on the Schedule of Benefits; multiplied by,
2. The amount listed in the Participating Provider's schedule of allowance for that item calculated at the time of sale;
3. Without regard to any credit or allowance that may be received by BlueCross.

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

### **Concurrent Care**

An ongoing course of treatment to be provided over a period of time or number of treatments.

### **Copayment**

The amount if any, specified on the Schedule of Benefits that the Member must pay directly to the Provider each time the Member receives Benefits.

### **Covered Expenses**

The amount payable by the Plan for Benefits. The amount of Covered Expenses payable for Benefits is determined as set forth in this Summary Plan Description and at the percentages set forth on the Schedule of Benefits. Covered Expenses are subject to the limitations and requirements set forth in the Summary Plan Description and on the Schedule of Benefits. Covered Expenses will not exceed the Allowable Charge.

### **Discount Services**

From time to time Benefits in the form of discounts for certain Provider services or products will be provided to Members by networks of complementary healthcare Providers with which BlueCross has an agreement for various programs. The discount applies to services the Plan does not cover. BlueCross will not be responsible

for any costs associated with these programs. The services available may include, but are not limited to chiropractors, massage therapists, acupuncturists, fitness clubs and hearing aids.

## **Employer**

Savannah River Nuclear Solutions (SRNS), the entity providing this Summary Plan Description.

## **ERISA**

The Employee Retirement Income Security Act of 1974, as amended.

Excepted Benefits:

1. Coverage only for accident, disability income insurance or any combination thereof;
2. Coverage issued as a supplement to liability insurance;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Worker's compensation or similar insurance;
5. Automobile medical payment insurance;
6. Credit-Only insurance;
7. Coverage for on-site medical clinics; or,
8. Other similar insurance coverage specified in regulations, under which benefits for medical care are secondary incidental to other insurance benefits;
9. If offered separately:
  - a. Limited scope dental or vision benefits;
  - b. Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof; or,
  - c. Such other similar, limited benefits as specified in regulations.
10. If offered as independent, non-coordinated benefits:
  - a. Coverage only for a specified disease or illness; or
  - b. Hospital indemnity or other fixed indemnity insurance.
11. If offered as a separate insurance policy:
  - a. Medicare supplemental health insurance (as defined under Section 1882(g)(1) of the Social Security Act.
  - b. Coverage supplement)l to the coverage provided under Chapter 55 of Title 10 of the United States Code; or,
  - c. Similar supplemental coverage under Group Health Plan

## **HIPAA**

The Health Insurance Portability and Accountability Act of 1996, as amended.

## **Hospital**

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

## **Identification Card**

The card issued by BlueCross to a Member that contains the Member's identification number.

## **Incapacitated**

A child who is:

1. Incapable of financial self-sufficiency by reason of Total Disability; and,
2. Dependent upon the Employee for at least fifty-one (51) percent of his or her support and maintenance.

A child must meet both requirements to qualify as an Incapacitated dependent. A child who is not incapacitated by the maximum dependent child age listed on the Schedule of Benefits will not be covered.

## **Investigational or Experimental**

Surgical or medical procedures, supplies, devices or drugs which, at the time provided or sought to be provided, are, in the judgment of the Corporation, not recognized as conforming to generally accepted medical or behavioral health practice in the United States, or the procedure, drug or device:

1. Has not received required final approval in the United States to market from appropriate government bodies;
2. Is one about which the peer-reviewed medical literature in the United States does not permit conclusions concerning its effect on health outcomes;
3. Is not demonstrated in the United States to be superior to established alternatives;
4. Has not been demonstrated in the United States to improve net health outcomes; or,
5. Is one in which the improvement claimed is not demonstrated in the United States to be obtainable outside the Investigational or Experimental setting.

Provided, however, that routine costs incurred in connection to a Member's participation in a Clinical Trial shall not be considered to be Investigational or Experimental.

#### Maintenance Medication

Maintenance drugs are **prescriptions commonly used to treat conditions that are considered chronic or long-term**. These conditions usually require regular, daily use of medicines. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes.

### Medical Child Support Order

Any judgment, decree or order (including an approved settlement agreement) issued by a court of competent jurisdiction or a national medical support notice issued by the applicable state agency which:

1. Provides Child support with respect to a Child or provides for health benefit coverage to a Child, is made pursuant to a state domestic relations law (including a community property law) and relates to the Plan of Benefits; or
2. Enforces a law relating to medical Child support described in Section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a Group Health Plan.

A Medical Child Support Order must clearly specify:

1. The name and the last known mailing address (if any) of each participant Employee and the name and mailing address of each Alternate Recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by the Group Health Plan to each such Alternate Recipient or the way such type of coverage is to be determined;
3. The period to which such order applies; and,
4. Each Group Health Plan to which such order applies.

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

1. The name of the issuing agency;
2. The name and mailing address of an official or agency that has been substituted for the mailing address of any Alternate Recipient; and,
3. The Identification of the underlying Medical Child Support Order.

A Medical Child Support Order meets the requirement of this definition only if such order does not require a Group Health Plan to provide any type or form of the requirements of a law relating to medical Child support described in Section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993).

### Medical Supplies

Supplies that are:

1. Medically Necessary;
2. Prescribed by a Provider acting within the scope of his or her license;
3. Are not available on an over-the-counter basis (unless such supplies are provided to a Member in a Provider's office and should not (in BCBS's discretion) be included as part of the treatment received by the Member); and,
4. Are not prescribed in connection with any treatment or Benefit that is excluded under this Benefit Plan.

### Medically Necessary, Medical Necessity

Using United States standards, health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical or behavioral health practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease;
3. Not primarily for the convenience of the patient, patient's caregiver(s) or Provider; and,
4. Not costlier than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

All requirements of the above-referenced definition must be met in order for a health care service to be deemed Medically Necessary. The failure of a health care service to meet any one of the above referenced requirements means, in the discretion of BlueCross or Companion Benefit Alternatives (CBA), the health care service does not meet the definition of Medically Necessary.

For the purposes of determining Medical Necessity:

1. BlueCross and CBA have the discretion to utilize and rely upon any medical and behavioral health (which includes substance use and mental health) standards, policies, guidelines, criteria, protocols, manuals, publications, studies or literature (herein collectively referred to as "criteria"), whether developed by them or others, which, in their discretion, are determined to be generally accepted by the medical and/or behavioral health community;
2. BlueCross and CBA have the discretion to utilize and rely upon any medical and behavioral health (which includes substance use and mental health) standards, policies, guidelines, criteria, protocols, manuals, publications, studies or literature (herein collectively referred to as "criteria"), whether developed by them or others, which, in their discretion, are determined to be generally accepted by the medical and/or behavioral health community;
3. BlueCross and CBA may use the following materials, including but not limited to, Corporate Administrative Medical ("CAM") Policies, Technology Evaluation Center ("TEC") Assessments, Behavioral Health Care Utilization Management Criteria and/or any Care Guidelines or criteria by Augusta University Health, LLC or affiliated companies which reflect clinically appropriate health care services and generally accepted standards of medical and behavioral health

practice. Augusta University Health, LLC and/or its affiliated companies are independent companies that develop evidence based guidelines and criteria for medical, behavioral health and insurance industries to interpret clinical determinations and determine the Medical Necessity and appropriateness of that requested.

**Member**

An Employee or Dependent who has enrolled under this Group Health Plan.

**Member Effective Date**

The date on which an Employee or Dependent is covered for Benefits under the terms of this Plan.

**Membership Application**

Any mechanism agreed upon by the BlueCross and SRNS for transmitting necessary Member enrollment information from SRNS to BlueCross.

**Non-Participating Provider**

Any Provider who does not have a current, valid provider agreement.

**Out-of-Pocket Maximum**

The maximum amount (listed on the Schedule of Benefits) incurred during a Benefit Year that a Member will be required to pay.

**Participating Provider**

A Provider who has a current, valid provider agreement

**Patient-Centered Medical Home**

A model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified physicians.

**Pharmacy Benefit Manager**

An entity that has contracted with SRNS or with BlueCross and is responsible for the administration of the Prescription Drug Benefit in accordance with the Plan.

**Plan**

This Pre-65 Retiree Health Plan sponsored by Savannah River Nuclear Solutions, LLC.

**Plan Administrator**

The SRNS Health and Welfare Committee is the Plan Administrator of this Plan. These duties are currently delegated to a Plan Administrator.

**Plan of Benefits**

The benefit booklet as prepared by BlueCross which reflects the Benefits offered under the SRNS Plan based on the Benefits Checklist. The Plan of Benefits includes the Schedule of Benefits and all endorsements, amendments, riders or addenda.

**Plan Sponsor**

SRNS is the Plan Sponsor of the Pre-65 Retiree Health Plan.

**Post-Service Claim**

Any claim for a Benefit that is not a Pre-Service Claim.

**Preauthorized, Preauthorization**

The approval of Benefits based on Medical Necessity prior to the rendering of such Benefits to a Member.

**Prescription Drug**

A drug or medicine that is:

1. Required to be labeled that it has been approved by the FDA; and,
2. Bears the legend, "Caution: Federal Law prohibits dispensing without a prescription" prior to being dispensed or delivered, or labeled in a similar manner.

Additionally, to qualify as a Prescription Drug, the drug must

1. Be prescribed by a licensed Provider acting within the scope of his or her license; and,
2. Not be entirely consumed at the time and place where the prescription is dispensed.

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

**Prescription Drug List**

A listing of the drugs approved for a specified level of Benefits by the Corporation under the Plan. This list shall be developed and subject to periodic review and modification by BlueCross. The most up-to-date version of the PDL is available on the BlueCross website at [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com).

**Pre-Service Claim**

Any request for a benefit where Preauthorization must be obtained before receiving the medical care, service or supply.

## Primary Plan

A Plan whose Benefits must be determined without taking into consideration the existence of another Plan.

Protected Health Information Has the same meaning as the term defined under HIPAA.

## Provider

Any person or entity licensed by the appropriate state regulatory agency and legally entitled to practice within the scope of such person or entity's license in the practice of the following: Medicine, dentistry, optometry, podiatry, chiropractic services, behavioral health, physical therapy, oral surgery, speech therapy, occupational therapy, osteopathy.

The term Provider also includes a Hospital; a rehabilitation facility; a skilled nursing facility; a physician assistant; nurses practicing in expanded roles (such as pediatric nurse practitioners, family practice nurse practitioners and certified nurse midwives) when supervised by a licensed medical doctor or oral surgeon; and Behavioral Health Services when performed by a Behavioral Health provider, licensed professional counselor, master level licensed social worker, licensed marriage and family therapist or other licensed Behavioral Health Provider approved by BlueCross. The term Provider does not include interns, residents, in-house physicians, physical trainers, lay midwives or masseuses.

## Qualifying Event

A Qualifying Event is any one of the following:

1. Termination of the Employee's employment (other than for gross misconduct) or reduction of hours worked that renders the Employee is no longer Actively at Work and therefore ineligible for coverage under the Plan.
2. Death of the Employee;
3. Divorce or legal separation of the Employee from his or her Spouse;
4. A Child ceasing to qualify as a Dependent under the Plan; or
5. Entitlement to Medicare by an Employee or by a parent or a Child.

## Quantity versus Time Limit

Limits that restrict the quantity of Prescription Drugs that are covered under a Member's Benefit within a certain time frame. The limits established for these drugs are based on food and Drug Administration (FDA) approved indication.

## Schedule of Benefits

The pages of the Plan, titled as the Summary Plan Description, which specify the coverage provided and the applicable Copayments, Coinsurance, Benefit Year Deductibles and Benefit limitations.

## Second Surgical Opinion

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

## Secondary Plan

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

## Step Therapy Program

Programs that require a Member to use lower-cost medications that are used to treat the same condition before obtaining higher-cost medications. The list of Prescription Drugs that require you to try a first-choice alternative is updated periodically and can be accessed by logging into My Heat Toolkit. If your doctor prescribes a Second-Choice medication, because a first-choice medication is not right for you, please have your doctor call the Caremark Prior Authorization department at 800.294.5979. Your doctor may also fax requests to 888.836.0730.

## TeleHealth

The exchange of Member information during which Members can have a telephone or video consultation with a licensed health care professional.

## Urgent Care Claim

Any claim for medical care or treatment where making a determination under other than normal time frames could seriously jeopardize the Member's life or health or the Member's ability to regain maximum function, or, in the opinion of a licensed medical doctor or oral surgeon with a knowledge of the Member's medical condition, would subject the Member to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.

## Appendix A: Specified Covered Benefits

The payment of Covered Expenses for Benefits is subject to all terms and conditions of the Plan of Benefits and Schedule of Benefits as published by BlueCross. In the event of a conflict between the Plan of Benefits and the Schedule of Benefits, the Schedule of Benefits controls. In the event of a conflict between the BCBS Plan of Benefits and Schedule of Benefits and this SPD, BCBS plan of Benefits will control. Oral statements cannot alter the terms of the Plan of Benefits or Schedule of Benefits. Covered Expenses will only be paid for Benefits as described below.

- 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 Preadmission Review, Emergency Admission Review, Pre-Authorization and/or Continued Stay Review has been requested and Pre-Authorization was received from BlueCross;
- That are Medically Necessary (not more or less expensive than the required Standard of Care);
- That are not subject to an exclusion under the Charges Not Covered section of this booklet;
- After the payment of all required Deductibles, Coinsurance and Copayments;
- Are not subject to an exclusion under the BlueCross Plan of Benefits or Schedule of Benefits.

ABA Related to Autism Spectrum Disorder	Benefits will be paid for ABA related to Autism Spectrum Disorder as set forth on the Schedule of Benefits for in and out-of-network. Any Preauthorization Requirements, if applicable, will be listed on the BlueCross Schedule of Benefits.
Allergy Injections	<p>The Plan will pay Covered Expenses for allergy injections as set forth below:</p> <ol style="list-style-type: none"> <li>1. For patients with demonstrated hypersensitivity that cannot be managed by medications or avoidance;</li> <li>2. To ensure the potency and efficacy of the antigens, the provision of multiple dose vials is restricted to sufficient antigen for (12) weeks at either once per week or twice per week dosing; and</li> <li>3. When any of the following conditions are met: <ol style="list-style-type: none"> <li>a) The patient has symptoms of allergic rhinitis and/or asthma after natural exposure to the allergen or,</li> <li>b) The patient has a life-threatening allergy to insect stings or,</li> <li>c) The patient has skin test and/or serologic evidence of a potent extract of the antigen or,</li> <li>d) Avoidance or pharmacological (drug) therapy cannot control allergic symptoms.</li> </ol> </li> </ol>
Ambulance Services	<p>(Special Note: Many ambulances are not in network and you may be responsible for the billed amount over the Network Allowed Amount). The Plan will pay Allowable Expenses for professional ground and air ambulance services to the nearest network Hospital in case of an accident or Emergency Medical Condition. (Refer to the "No Surprise Act" section for protections from Surprise billing) The following requirements apply to all ground and air ambulance services* and transports:</p> <ol style="list-style-type: none"> <li>1. The transport is Preauthorized as Medically Necessary and reasonable under the circumstances;</li> <li>2. A Member is transported;</li> <li>3. The destination is local within the United States; and,</li> <li>4. The facility is medically appropriate to treat the Member's condition.</li> </ol> <p>The Plan will pay Allowable Expenses for ground transportation between two Hospitals only when such ground ambulance transport has been Preauthorized and BlueCross confirms that the receiving Hospital is the closest facility that can provide medically appropriate care to treat the Member's condition. However, no Benefits are available for ground or air ambulance services or transport if a Member is transferred from one facility to a new facility for the purpose of the Member obtaining a lower level of care at the new receiving facility. A Non-Participating Provider may balance bill the Member for charges not paid by the Plan. You need to request a network provider. Repatriation is excluded and is not a Benefit for which Covered Expenses are payable.</p> <p>If a Member seeks Preauthorization to be transported as an inpatient from one Hospital to a second Hospital using an air ambulance, the following requirements must be met:</p> <ol style="list-style-type: none"> <li>1. The first Hospital does not have the needed Hospital or skilled nursing care to treat the Member's illness or injury (such as burn care, cardiac care, trauma care, and critical care);</li> <li>2. The second Hospital is the nearest medically appropriate facility to treat the Member's illness or injury;</li> <li>3. A ground ambulance transport would endanger the Member's medical condition; and,</li> <li>4. The transport is not related to a hospitalization outside the United States.</li> </ol>

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Child Birthing Facility/Center	The Plan will pay Covered Expenses for child birthing facility/center as set forth on the BlueCross Schedule of Benefits
Chiropractic Services	The Plan will pay Covered Expenses for Services and Medical Supplies required in connection with the detection and correction, by manual or mechanical means, of structural imbalance, distortion, or subluxation in the human body, for purposes of removing nerve interference and the effects of such nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column. Limited to a \$750 Maximum Payment per Member per Benefit Year
Christian Science Facilities	The Plan will pay Covered Expenses for Pre-Authorized Christian Science Practitioner/Christian Science Facilities Admissions as set forth in the BCBS Schedule of Benefits.
Circumcision	The Plan will pay Covered Expenses for circumcision performed by licensed Physician or a Rabbi certified as a Mohel.
Cleft Lip or Palate	<p>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. Benefits shall include but not be limited to:</p> <ol style="list-style-type: none"> <li>1. Oral and facial Surgical Services, surgical management and follow-up care;</li> <li>2. Prosthetic Device treatment, such as obturators, speech appliances and feeding appliances;</li> <li>3. Orthodontic treatment and management;</li> <li>4. Prosthodontia treatment and management;</li> <li>5. Otolaryngology treatment and management;</li> <li>6. Audiological assessment, treatment and management, including surgically implanted amplification devices; and,</li> <li>7. Physical therapy assessment and treatment.</li> </ol> <p>Benefits for a cleft lip or palate must be Preauthorized. If a Member with a cleft lip or palate is covered by a dental policy, then teeth capping, prosthodontics and orthodontics shall be covered by the dental policy to the limit of coverage provided under such dental policy prior to coverage under this Employer's Group Health Plan. Covered Expenses for any excess medical expenses after coverage under any dental policy is exhausted shall be provided as for any other condition or illness under the terms and conditions of this Employer's Group Health Plan.</p>
Clinical Trials	<p>The Plan will pay for routine Member costs for items and services related to Clinical Trials when:</p> <ol style="list-style-type: none"> <li>1. The member has cancer or other life-threatening disease or condition; and</li> <li>2. Either: <ol style="list-style-type: none"> <li>a. The referring Provider is a Participating Provider that has concluded that the Member's participation in such a trial would be appropriate; or</li> <li>b. The Member provides medical and scientific information establishing that the Member's participation in such a trial would be appropriate; and</li> </ol> </li> <li>3. The services are furnished in connection with an Approved Clinical Trial</li> </ol>

**D**

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 the Member is in the act of chewing or biting. Services for conditions that are not directly related to the accidental injury are not covered. The first visit to a dentist does not require Preauthorization; however, the
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	dentist must submit a plan for any future treatment to BlueCross for review and Preauthorization before such treatment is rendered if Covered Expenses are to be paid. Benefits are limited to treatment for only one (1) year from the date of the accidental injury.
Diabetic Supplies	Benefits will be paid for diabetic supplies as set forth on the BCBS Schedule of Benefits.
Diabetes Education	The Plan will pay Covered Expenses for outpatient self-management training and education for Members with diabetes mellitus provided that such training and educational Benefits are rendered by a Provider whose program is recognized by the American Diabetes Association.
Durable Medical Equipment	The Plan will pay Covered Expenses for Durable Medical Equipment when the required Preauthorization (over \$500) is obtained. The Plan will decide (in its discretion) whether to buy or rent equipment and whether to repair or replace damaged or worn Durable Medical Equipment. The Plan will not Pay Benefits for Durable Medical Equipment that is solely used by a Member in a Hospital or that the Plan determines (in its discretion) is included in any Hospital room charge. Any Preauthorization requirements, if applicable, will be listed on the BCBS Schedule of Benefits.

## E

Emergency Services	<p>The Plan will pay Covered Expenses for care that is necessary as a result of an Emergency Medical Condition. Benefits are only available to treat an emergency Medical Condition provided on an outpatient basis at a Hospital Emergency room or department and only for as long as the condition continues to be considered an Emergency.</p> <p>The Maximum Payment for Emergency Medical Services at a Non-Participating Provider will be the greatest of the following:</p> <ol style="list-style-type: none"> <li>1. The amount negotiated with Participating Providers for the particular Emergency Services (reduced by any in-network Copayment or Coinsurance);</li> <li>2. The amount for Emergency Services calculated using the same method BlueCross uses for out-of-network services but substituting the relevant in-network Copayment or Coinsurance for the out-of-network Copayment or Coinsurance requirements; or,</li> <li>3. The amount for Emergency Services that would be paid under Medicare, reduced by any in-network Copayment or Coinsurance for the services.</li> </ol>
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## G

Gender Dysphoria	The Plan will pay Covered Expenses for Medical Supplies, services or charges related to the diagnosis or treatment of gender dysphoria as outlined in BlueCross medical policy.
Gender Reassignment	<p>Benefits will be paid for the following services related to gender reassignment:</p> <ol style="list-style-type: none"> <li>1. Twelve (12) month of cognitive behavioral therapy (CBT) while living and dressing full-time as the gender of preference; and</li> <li>2. Twelve (12) additional months of CBT and living/dressing as gender of preference plus hormone therapy.</li> <li>3. Gender reassignment surgery may be performed after completion of requirements listed above.</li> </ol>
Gynecological Examination	The Plan will pay Covered Expenses for routine gynecological examinations each Benefit Year for female Members.

## H

Habilitation	The Plan will pay Covered Expenses for habilitation, including assisting a Child with achieving developmental skills when impairments have caused delaying or blocking of initial acquisition of the skills. Habilitation can include fine motor, gross motor or other skills that contribute to mobility communication and performance of activities of daily living. The services will be described in an individual's plan of care.
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Home Health Care	The Plan will pay for Home Health Care, including Private Duty Nursing, when rendered to a homebound Member in the Member's current place of residence. Any Preauthorization requirements, if applicable, will be listed on the BlueCross Schedule of Benefits.
Hospice Care	<p>The Plan will pay Covered Expenses for Preauthorized Hospice Care. Preauthorization requirements are listed on the BlueCross Schedule of Benefits.</p> <p>Hospice Care refers to the medical, psychological and nursing care provided to terminally ill patients with a life expectancy of less than six (6) months. It permits someone with no hope of recovery to leave a Hospital for a more comfortable and dignified setting. Preauthorization is required. The following will be considered Covered Expenses when ordered by the patient's attending physician and provided and billed by a hospice:</p> <ol style="list-style-type: none"> <li>1. Semiprivate room and board and special services;</li> <li>2. Nursing and therapy services;</li> <li>3. Outpatient services;</li> <li>4. Psychological and dietary counseling;</li> <li>5. Home care by professional hospice workers (other than household or family members); and,</li> <li>6. Pain-relief treatment, including drugs and supplies.</li> </ol>
Hospital Services	<p>The Plan will pay Covered Expenses for Admissions as follows:</p> <ol style="list-style-type: none"> <li>1. Semiprivate room, board, and general nursing care and,</li> <li>2. Private room, at semiprivate rate as determined by the Plan;</li> <li>3. Services performed in a Special Care Unit when it is Medically Necessary that such services be performed in such unit rather than in another portion of the Hospital;</li> <li>4. Ancillary services and Medical Supplies including services performed in operating, recovery and delivery rooms;</li> <li>5. Diagnostic services including interpretation of radiological and laboratory examinations, electrocardiograms, and electroencephalograms; and,</li> <li>6. In a Long-Term Acute Care Hospital.</li> </ol> <p>Benefits for Admissions are subject to the requirements for Preadmission Review, Emergency Admission Review, and Continued Stay Review.</p> <p>The day on which a Member leaves a Hospital, with or without permission, is treated as a day of discharge and will not be counted as a day of Admission, unless such Member returns to the Hospital by midnight of the same day. The day a Member enters a Hospital is treated as a day of Admission. The days during which a Member is not physically present for inpatient care are not counted as Admission days.</p>
Hospital Services	January 1 – December 31, as set forth on the Schedule of Benefits. The Initial Benefit Year may be more or less than twelve (12) months
Human Organ and Tissue Transplants	<ol style="list-style-type: none"> <li>1. The Plan will pay Covered Expenses for certain Preauthorized human organ and tissue transplants. To be covered, such transplants must be provided from a human donor to a Member and provided at a transplant center approved by the Plan. Covered Expenses shall only be provided for the human organ and tissue transplants as set forth on the Schedule of Benefits.</li> <li>2. The payment of Covered Expenses for living donor transplants will be subject to the following conditions: <ol style="list-style-type: none"> <li>a. When both the transplant recipient and the donor are Members, Covered Expenses will be paid for both.</li> <li>b. When the transplant recipient is a Member and the donor is not, Covered Expenses will be paid for both the recipient and the donor to the extent that Covered Expenses to the donor are not provided by any other source.</li> <li>c. When the donor is a Member and the transplant recipient is not, no Covered Expenses will be paid to either the donor or the recipient.</li> </ol> </li> <li>3. Human organ and tissue transplant coverage includes expenses incurred for legal donor organ and tissue procurement and all inpatient and outpatient Hospital and medical expenses for the transplant procedure and related pre-operative and post-operative care, including immunosuppressive drug therapy and air ambulance expenses.</li> <li>4. Transplants of tissue as set forth below (rather than whole major organs) are Benefits under the Plan, subject to all the provisions of the Plan as follows: <ol style="list-style-type: none"> <li>a. Blood transfusions</li> <li>b. Autologous parathyroid transplants;</li> <li>c. Corneal transplants;</li> </ol> </li> </ol>

- d. Bone and cartilage grafting; and,
- e. Skin grafting.

## I

### In-Hospital Medical Service

The Plan will pay for a licensed medical doctor or Behavioral Health Provider's visits to a Member during a Medically Necessary Admission for treatment of a condition other than that for which Surgical Service or obstetrical service is required as follows:

1. In-Hospital Medical Benefits primarily for Mental Health Services and Substance Use Disorder Services;
2. In-Hospital Medical Benefits in a Skilled Nursing Facility will be provided for visits of a Provider., limited to one (1) visit per day., not to exceed the number of visits if set forth on the Schedule of Benefits;
3. Where two (2) or more Providers of the same general specialty render in-Hospital medical visits on the same day, payment for such services will be made only to one (1) Provider.
4. Concurrent medical and surgical Benefits for in-Hospital medical services are only provided:
  - a. When the condition for which in-Hospital medical services requires medical care not related to Surgical Services or obstetrical service and does not constitute a part of the usual necessary and related pre-operative or post-operative care but requires supplemental skills not possessed by the attending surgeon or his or her assistant; and,
  - b. When the surgical procedure performed is designated by the Plan as a warranted diagnostic procedure or as a minor surgical procedure.
5. When the same Provider renders different levels of care on the same day. Benefits will only be provided for the highest level of care.

## M

### Mammography Testing

The Plan will pay Covered Expenses for mammography testing regardless of Medical Necessity for Members that are within the appropriate age guidelines. The Plan will pay Covered Expenses for additional mammograms during a Benefit Year based on Medical Necessity.

### Medical Supplies

The Plan will pay Covered Expenses for Medical Supplies provided that the Plan will not pay Covered Expenses separately for Medical Supplies that are (or in BlueCross on behalf of the Plan's determination, should be) provided as part of another Benefit.

### Mental Health Services

The Plan will pay Covered Expenses for the inpatient and outpatient treatment for Mental Health Services. Preauthorization may be required. Contact Companion Benefit Alternatives at 1.800.868.1032 for questions about pre-authorization for mental health services.

## O

### Obesity Related Procedures

The Plan will pay Covered Expenses for the following if set forth on the BlueCross Schedule of Benefits:

Services, supplies, treatment or medication for the management of morbid obesity, obesity, weight reduction, weight control or dietary control (collectively referred to as "obesity-related treatment") including, but not limited to, gastric bypass or stapling, intestinal bypass and related procedures or gastric restrictive procedures. Also included are services, supplies or charges for the treatment or correction of complications from obesity-related treatment. Services, supplies or charges for the reversal of obesity-related treatments and reconstructive procedures necessitated by weight loss are covered

### Obstetrical Services

The Plan will pay Covered Expenses for Preauthorized obstetrical services. Midwives licensed and practicing in compliance with the Nurse Practices Act in a Hospital will be covered under this Benefit.

Under the terms of the Newborn and Mother's Health Act of 1996, the Plan generally may not restrict Covered Expenses for any Hospital length of stay about childbirth for the mother or newborn Child to less than forty-eight (48) hours following a vaginal delivery (not including the day of delivery) or less than ninety-six (96) hours following a cesarean section (not including the day of surgery). Nothing in this paragraph prohibits the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than the specified time frames or from requesting additional time for hospitalization. In any case, the Plan may not require that a Provider obtain authorization from BlueCross for prescribing a length of stay not in excess of forty-eight (48) or ninety-six (96) hours as applicable. However, Preauthorization is required to use certain Providers or facilities or to reduce out-of-pocket costs.

Orthognathic Surgery	The Plan will pay Covered Expenses for any service related to the treatment of malpositions or deformities of the jawbone(s), dysfunction of the muscles of mastication, or orthognathic deformities.
Orthopedic Devices	The Plan will pay Covered Expenses for Preauthorized Orthopedic Devices. Any Preauthorization requirements, if applicable will be listed on the BlueCross Schedule of Benefits.
Orthotic Devices	The Plan will pay Covered Expenses for Preauthorized Orthotic Devices.
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, subject to the following paragraph, for physical therapy, occupational therapy, and for outpatient rehabilitation services as set forth on the BlueCross Schedule of Benefits. Covered Expenses for outpatient rehabilitation services will be paid only following an acute incident involving disease, trauma or surgery that requires such care.
Oxygen	The Plan will pay Covered Expenses for Preauthorized oxygen. Durable Medical Equipment for oxygen use in your home is covered under the Durable Medical Equipment Benefit.

## P

Physical Examination	The Plan will pay Covered Expenses for physical examinations as set forth on the BlueCross Schedule of Benefits.
Prescription Drugs	See Prescription Drugs in Part One of the Medical Plan.
Preventive Services	<p>The Plan will pay for preventive health services required under PPACA as follows:</p> <ol style="list-style-type: none"> <li>1. Evidence based services that have a rating of A or B in the current United States Preventive Services Task Force (USPSTF) recommendations;</li> <li>2. Immunizations as recommended by the Center for Disease Control and Prevention (CDC); and</li> <li>3. Preventive care and screenings for children and women as recommended by the Health Resources and Services Administration (HRSA).</li> </ol> <p>The USPSTF, CDC and the HRSA are independent companies that provide health information on behalf of BlueCross. These Benefits are provided without any cost-sharing by the Member when the services are provided by a Participating Provider. Any other covered preventive screenings will be provided as specified in the BlueCross Schedule of Benefits.</p>
Private Duty Nursing	The Plan will pay Covered Expenses for private duty nursing as set forth on the BlueCross Schedule of Benefits.
Prostate Examination	The Plan will pay Covered Expenses for prostate examinations per Benefit Year regardless of Medical Necessity as set forth in the Schedule of Benefits for Members that are within the appropriate age guidelines. The Employer's Group Health Plan will pay Covered Expenses for additional prostate examinations during a Benefit Year based on Medical Necessity.
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 the Plan) 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.
Provider Services	The Plan will pay Covered Expenses for Provider Services, provided that when different levels (as determined by BlueCross on behalf of the Plan) of Provider Services are provided on the same day, Covered Expenses for such Benefits will only be paid for the highest level (as determined by the Corporation on behalf of the Employer's Group Health Plan) of Provider Services

## R

Reconstructive Surgery following Mastectomies	In the case of a Member who is receiving Covered Expenses in connection with a mastectomy the Plan will pay Covered Expenses for each of the following (if requested by such Member):
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	<ol style="list-style-type: none"> <li>1. Reconstruction of the breast on which the mastectomy has been performed;</li> <li>2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and</li> <li>3. Prosthetic devices and physical complications at all stages of the mastectomy, including lymphedema.</li> </ol>
Rehabilitation	<p>The Plan will pay Covered Expenses for participation in a multidisciplinary team rehabilitation program only following severe neurologic or physical impairment as specified on the Schedule of Benefits if the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. All such treatment must be ordered by a licensed medical doctor;</li> <li>2. All such treatment may require Preauthorization and must be performed by a Provider and at a location designated by the Plan;</li> <li>3. The documentation that accompanies a request for rehabilitation Benefits must contain a detailed Member evaluation from a licensed medical doctor that documents that to a degree of medical certainty the Member has rehabilitation potential such that there is an expectation that the Member will achieve an ability to provide self-care and perform activities of daily living; and,</li> <li>4. All such rehabilitation Benefits are subject to periodic review by the Plan.</li> </ol> <p>After the initial rehabilitation period, continuation of rehabilitation Benefits will require documentation that the Member is making substantial progress and that there continues to be significant potential for the achievement of the established rehabilitation goals.</p>
Residential Treatment Centers	The Plan will pay Covered Expenses for residential treatment centers as set forth on the BlueCross Schedule of Benefits.

## S

Skilled Nursing Facility Services	<p>The Plan will pay Covered Expenses for Admissions in a Skilled Nursing Facility as follows:</p> <ol style="list-style-type: none"> <li>1. Semiprivate room, board, and general nursing care;</li> <li>2. Private room, at semiprivate rate as determined by the Plan;</li> <li>3. Services performed in a Special Care Unit when it is Medically Necessary that such services be performed in such unit;</li> <li>4. Ancillary services and Medical Supplies including services performed in operating, recovery and delivery rooms;</li> <li>5. Diagnostic services including interpretation of radiological and laboratory examinations, electrocardiograms, and electroencephalograms; and,</li> <li>6. In a Long-Term Acute Care Hospital.</li> </ol> <p>Benefits for Admissions are subject to the requirements for Preadmission Review, Emergency Admission Review and Continued Stay Review. The day on which the Member 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 returns 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.</p>
Specialty Drugs	<p>The Plan will pay Covered Expenses for Specialty Drugs as set forth on the BlueCross Schedule of Benefits. Covered Expenses for Specialty Drugs dispensed to a Member shall not exceed the quantity and Benefit maximum set by the Plan. Certain Specialty Drugs may only be covered under the pharmacy Benefit. Certain Specialty Drugs may require Preauthorization. For any Specialty Drug, the Benefit Year Deductible, Out-of-Pocket Maximum and/or Benefit maximum may apply. A list of Specialty Drugs, as well as information about any related requirements and/or restrictions, may be obtained by contacting BlueCross at the number listed on the Identification Card or at <a href="http://www.SouthCarolinaBlues.com">www.SouthCarolinaBlues.com</a>.</p> <p>Any Coinsurance percentage for Specialty Drugs is based on the Allowable Charge at the Participating Pharmacy and does not change due to receipt of any Credits by BlueCross. Prescription Drug Copayments likewise do not change due to receipt of any Credits by the Corporation.</p>
Speech Therapy	The Plan will pay Covered Expenses for Speech Therapy as set forth on the BlueCross Schedule of Benefits.
Substance Use Disorder Services	The Plan will pay Covered Expenses for Substance Use Disorder Services as set forth on the BlueCross Schedule of Benefits. Methadone is covered for treatment of substance use disorders, please refer to the BlueCross Schedule of Benefits for coverage information.
Surgery in a Podiatrist's Office	The Plan will pay Covered Expenses for surgery in a Podiatrist's office as set forth on the BlueCross Schedule of Benefits.
Surgical Services	The Plan will pay Covered Expenses for Surgical Services performed by a licensed medical doctor or oral surgeon as applicable, for treatment and diagnosis of disease or injury or for obstetrical services, as follows:

1. Surgical Services, subject to the following:
  - a. If two (2) or more operations or procedures are performed at the same time, through the same surgical opening or by the same surgical approach, the total amount covered for such operations or procedures will be the Allowable Charge for the major procedure only.
  - b. If two (2) or more operations or procedures are performed at the same time, through different surgical openings or by different surgical approaches, the total amount covered will be the Allowable Charge for the operation or procedure bearing the highest Allowable Charge, plus one-half of Allowable Charge for all other operations or procedures performed.
  - c. If an operation consists of the excision of multiple skin lesions, the total amount covered will be the Allowable Charge for the procedure bearing the highest Allowable Charge, fifty (50%) percent for the procedure bearing the second and third highest Allowable Charges, twenty-five (25%) percent for the procedures bearing the fourth through the eighth highest Allowable Charges, and ten (10%) percent for all other procedures. Provided, however, if the operation consists of the excision of multiple malignant lesions, the total amount covered will be the Allowable Charge for the procedure bearing the highest Allowable Charge, and fifty (50%) percent of the charge for each subsequent procedure.
  - d. If an operation or procedure is performed in two (2) or more steps or stages, coverage for the entire operation or procedure will be limited to the Allowable Charge set forth for such operation or procedure.
  - e. If two (2) or more medical doctors or oral surgeons perform operations or procedures in conjunction with one another, other than as an assistant surgeon or anesthesiologist, the Allowable Charge subject to the above paragraphs, will be coverage for the services of only one (1) medical doctor or oral surgeon (as applicable) or will be prorated between them by the Employer's Group Health Plan when so requested by the medical doctor or oral surgeon in charge of the case.
  - f. Certain surgical procedures are designated as separate procedures by the Plan, and the Allowable Charge is payable when such procedure is performed as a separate and single entity; however, when a separate procedure is performed as an integral part of another surgical procedure, the total amount covered will be the Allowable Charge for the major procedure only.
2. Assistant Surgeon services that consists of the Medically Necessary service of one (1) medical doctor or oral surgeon who actively assists the operating surgeon when a covered Surgical Service is performed in a Hospital, and when such surgical assistant service is not available by an intern, resident or in-house physician. The Plan will pay charges at the percentage of the Allowable Charge set forth on the Schedule of Benefits for the Surgical Service, not to exceed the medical doctors or oral surgeon's (as applicable) actual charge.
3. Anesthesia services that consists of services rendered by a medical doctor, oral surgeon or a certified registered nurse anesthetist, other than the attending surgeon or his or her assistant, and includes the administration of spinal or rectal anesthesia, or a drug or other anesthetic agent by injection or inhalation, except by local infiltration, the purpose and effect of which administration is the obtaining of muscular relaxation, loss of sensation or loss of consciousness. Additional Benefits will not be provided for pre-operative anesthesia consultation.

Sustained Health Benefits

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

**T**

Telehealth

The Employer's Group Health Plan will pay Covered Expenses for Telehealth services which are initiated by either a Member or Provider and are provided by licensed health care professionals who have been credentialed as eligible Telehealth Providers.

Temporomandibular Joint (TMJ) Disorder	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.
Travel and Lodging	<p>The Plan will pay Covered Expenses for travel and lodging as set forth on the BlueCross Schedule of Benefits. Travel and lodging will be reimbursed for travel and housing accommodation expenses for the transplant patient and one family member or companion if the transplant is done at a Blue Distinction Center of Excellence. There is a \$10,000 limit on reimbursement for travel and housing per transplant. The Medical Plan Benefits include the following general travel reimbursement guidelines under the Blue Distinction Centers for Transplants:</p> <ol style="list-style-type: none"> <li>1. 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),</li> <li>2. 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</li> <li>3. The actual cost of meals (with a receipt, excluding any incidentals such as tips, etc.) up to \$40 per day per person for the family member* or companion, and up to \$40 per day for the patient when the patient is not hospitalized during the trip.</li> </ol> <p>* Travel expenses for two family members are reimbursable when the patient is a dependent child.</p>

## Appendix B: Expenses Not Covered

This section lists expenses that the Medical Plan does not cover. The Plan will not pay any amount for the services and products listed in this section except: (1) Services are rendered by a Health Care Provider as part of a Value-Based Program or by (2) if required by law. The list is intended to provide you with only the more common non-covered services, and is not a complete listing. Contact BlueCross to determine if a particular service or treatment program not mentioned in this book is covered.

<b>A</b>	
Acts of War	Illness contracted or injury sustained as a result of a Member's participation as a combatant in a declared or undeclared war, or any act of war, or while in military service.
Acupuncture	Acupuncture treatment or services.
Admissions that are not Preauthorized	If Preauthorization is not received for an otherwise Covered Expense related to an Admission, Benefits may be reduced, as set forth on the Schedule of Benefits.
Auto Accidents	This Plan does not provide coverage for claims paid or payable under an automobile insurance policy or any other type of liability insurance policy. Automobile insurance policies include, but are not limited to, no fault, personal injury protection, medical payments, liability, uninsured and underinsured policies, umbrella or any other insurance coverage which may be paid or payable for the injury or illness.

<b>B</b>	
Behavioral, Educational or Alternate Therapy Programs	Any behavioral, educational or alternative therapy techniques to target cognition, behavior language and social skills modification, including: <ol style="list-style-type: none"> <li>1. Applied Behavioral Analysis (ABA) therapy unless Medically Necessary for the treatment of Autism Spectrum Disorder;</li> <li>2. Teaching, Expanding, Appreciating, Collaborating and Holistic (TEACCH) programs;</li> <li>3. Higashi schools/daily life;</li> <li>4. Facilitated communication;</li> <li>5. Floor time;</li> <li>6. Developmental Individual-Difference Relationship-based model (DIR);</li> <li>7. Relationship Development Intervention (RDI);</li> <li>8. Holding therapy;</li> <li>9. Movement therapies;</li> <li>10. Music therapy; and</li> <li>11. Animal assisted therapy</li> </ol>
Benefits Provided by State or Federal Programs	Any service or charge for a service to the extent that the Member is entitled to payment or benefits relating to such service under any state or federal program that provides healthcare benefits, including Medicare, but only to the extent that benefits are paid or are payable under such programs. This exclusion includes, but is not limited to, benefits provided by the Veterans Administration for care rendered for a service-related disability or any state or federal hospital services for which the Member is not legally obligated to pay.
Bio-feedback Services	Bio-feedback when related to psychological services.

<b>C</b>	
Clinical Pathologist	a provider who renders Mental Health Services and/or Substance Use Disorder Services and is licensed to practice independently.
<b>Complications from Failure to Complete Treatment</b>	Complications that occur because a Member did not follow the course of treatment prescribed by a Provider, including complications that occur because a Member left a Hospital against medical advice.
Complications from Non-Covered Services	January 1 – December 31, as set forth on the Schedule of Benefits. The Initial Benefit Year may be more or less than twelve (12) months.
Contraceptives	Medical Supplies, services or devices for the purpose of contraception, except as specified on the Schedule of Benefits.
Copying Charges	Fees for copying or production of medical records and/or claims filing

Cosmetic and Reconstructive Services	<p>This Plan of Benefits excludes cosmetic or reconstructive procedures, and any related services or Medical Supplies, which alter appearance but do not restore or improve impaired physical function. Examples of services that are cosmetic or reconstructive, which are not covered include, but are not limited to, the following:</p> <ol style="list-style-type: none"> <li>1. Rhinoplasty (nose);</li> <li>2. Mentoplasty (chin);</li> <li>3. Rhytidoplasty (face lift);</li> <li>4. Glabellar rhytidoplasty (forehead lift);</li> <li>5. Surgical planning (dermabrasion);</li> <li>6. Blepharoplasty (eyelid);</li> <li>7. Mammoplasty (reduction, suspension or augmentation of the breast);</li> <li>8. Superficial chemosurgery (chemical peel of the face); and,</li> <li>9. Rhytidectomy (abdomen, legs, hips, buttocks or elsewhere including lipectomy or adipectomy).</li> </ol> <p>A cosmetic or reconstructive service may, under certain circumstances (in BlueCross's discretion), be considered restorative in nature for which Benefits are available, but only if the following requirements are met:</p> <ol style="list-style-type: none"> <li>1. The service is intended to correct, improve or restore a bodily function; or,</li> <li>2. The service is intended to correct, improve or restore a malappearance or deformity that was caused by physical trauma or accident, congenital anomaly or covered surgical service; and,</li> <li>3. The proposed service must be Preauthorized.</li> </ol>
Custodial Care	Services or supplies related to Custodial Care, except as specified on the BlueCross Schedule of Benefits.

## D

Dental Services	Any dental procedures involving tooth structures, excision or extraction of teeth, gingival tissue, alveolar process, dental X-rays, preparation of mouth for dentures, or other procedures of dental origin. However, that such procedures may be Preauthorized if the need for dental services results from an accidental injury within one (1) year prior to the date of such services.
Discount Services	Any charges that result from the use of Discount Services including charges related to any injury or illness that results from a Member's use of Discount Services. Discount Services are not covered under the Plan of Benefits and Members must pay for Discounted Services.

## E

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

Food Supplements	Orthomolecular therapy, including infant formula, nutrients, vitamins and food supplements. Enteral feedings when not a sole source of nutrition, except as specified on the BlueCross Schedule of Benefits.
Foot Care	Routine foot care such as paring, trimming or cutting of nails, calluses or corns, except in conjunction with diabetic foot care.

## G

Gender Affirmation Surgery	Any Medical Supplies or services or charges incurred for consultation, therapy, surgery or any procedures related to changing a Member's sex, except as specified in Section 5 – Specified Covered Benefits.
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## H

Hearing Aids	Hearing aids or examinations for the prescription or fitting of hearing aids.
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Human Organ and Tissue Transplants	Human organ and tissue transplants that are not: <ol style="list-style-type: none"> <li>1. Preauthorized;</li> <li>2. Performed by a Provider as designated by the Corporation;</li> <li>3. Listed as covered on the Schedule of Benefits; and,</li> <li>4. Performed at a Blue Distinction® Center of Excellence or transplant center approved by BlueCross in writing.</li> </ol>
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I	
Illegal Acts	Any illness or injury received while committing or attempting to commit a crime, felony or misdemeanor or while engaging or attempting to engage in an illegal act or occupation.
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.
Incapacitated Dependents	Any service, supply or charge for an Incapacitated Dependent that is not enrolled by the maximum Dependent Child age listed on the BlueCross Schedule of Benefits.
Infertility	Services, supplies or drugs related to any treatment for infertility, including, but not limited to, fertility drugs, gynecological or urological procedures the purpose of which is primarily to treat infertility, artificial insemination, in- vitro fertilization, reversal of sterilization procedures and surrogate parenting.
Inpatient Diagnostic and Evaluative Procedures	Inpatient care and related Provider Services rendered in conjunction with an Admission, which is principally for diagnostic studies or evaluative procedures that could have been performed on an outpatient basis are not covered unless the Member's medical condition alone required Admission.
Intoxication or Drug Use	Any service (other than Substance Use Disorder Services), Medical Supplies, charges or losses resulting from a Member being Legally Intoxicated or under the influence of any drug or other substance or taking some action the purpose, of which is to create a euphoric state or alter consciousness. The Member, or Member's representative, must provide any available test results showing blood alcohol and/or drug/substance levels upon request by the Corporation. If the Member refuses to provide these test results, no Benefits will be provided.
Investigational or Experimental Services	Services or supplies or drugs that are Investigational or Experimental.

L	
Lifestyle Improvement Services	Services or supplies relating to lifestyle improvements including, but not limited to, nutrition counseling or physical fitness programs.
Long-Term Care Services	Admissions or portions thereof for long-term care, including: <ol style="list-style-type: none"> <li>1. Rest care;</li> <li>2. Long-term acute or chronic psychiatric care;</li> <li>3. Care to assist a Member in the performance of activities of daily living (including, but not limited to: walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation and taking medication);</li> <li>4. Custodial or long-term care; or</li> <li>5. Psychiatric or Substance Use Disorder treatment including: therapeutic schools, wilderness/boot camps, therapeutic boarding homes, half-way houses and therapeutic group homes.</li> </ol>

M	
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 a Member's appointment with a Provider that the Member did not attend.
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<b>N</b>	
No Legal Obligation to Pay	Any service, supply or charge the Member is not legally obligated to pay.
Not Medically Necessary Services or Supplies	Any service or supply that is not Medically Necessary. However, if a service is determined to be not Medically Necessary because it was not rendered in the least costly setting, Covered Expenses will be paid in an amount equal to the amount payable had the service been rendered in the least costly setting

<b>O</b>	
Obesity Related Procedures	<ol style="list-style-type: none"> <li>1. Services, supplies, treatment or medication for the management of morbid obesity, obesity, weight reduction, weight control or dietary control (collectively referred to as "obesity-related treatment"), including, but not limited to, gastric bypass or stapling, intestinal bypass and related procedures or gastric restrictive procedures, except as specified on the BlueCross Schedule of Benefits.</li> <li>2. Also, the treatment or correction of complications from obesity-related treatment are non-covered services, regardless of Medical Necessity, prescription by a Provider or the passage of time from a Member's obesity-related treatment, except as specified on the Schedule of Benefits. This includes the reversal of obesity-related treatments and reconstructive procedures necessitated by weight loss.</li> <li>3. Membership fees to weight control programs, except as specified on the BlueCross Schedule of Benefits.</li> </ol>
Outpatient Services that are not Preauthorized	If Preauthorization is not received for an otherwise Covered Expense related to an outpatient service, Benefits may be reduced as set forth on the BlueCross Schedule of Benefits.
Over-The-Counter Drugs	Drugs that are available on an over-the-counter basis or are otherwise available without a prescription, except for Over-the-Counter Drugs that are designated as Prescription Drugs by the Corporation, listed as covered on the PDL accordingly and are prescribed by a Provider.

<b>P</b>	
Pain Management Programs	Chronic pain management programs or multi-disciplinary pain management programs.
Pharmacy	"Maintenance Medications" or "Maintenance Drugs" not purchased pursuant to the Mail Service Saver Program (Mandatory)
Physical Therapy Admissions	All Admissions solely for physical therapy except as provided in Section 5 – Specified Covered Benefits.
Pre-Marital and Pre-Employment Examinations	Charges for services, supplies or fees for pre-marital or pre-employment examinations.
Pre-Operative Anesthesia Consultation Charges	Charges for pre-operative anesthesia consultation.
Prescription Drug Exclusions	See Prescription Drugs in Part One of this SPD.
Provider Charges	Charges by a Provider for blood and blood derivatives and for charges for Prescription Drugs or Specialty Drugs that are not consumed at the Provider's office.

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

Radiology Management	All charges for MRIs, MRAs, CAT scans or PET scans in an office or outpatient facility when the required Preauthorization is not obtained.
Relationship Counseling	Relationship counseling, including marriage counseling, for the treatment of pre-marital, marital or relationship dysfunction.
Repatriation	Services and supplies received as the result of transporting a Member, regardless of cause, from a foreign country to the Member's residence in the United States.

**S**

Self-Inflicted Injury	Services and supplies received as the result of any intentionally self-inflicted injury that does not result from a medical condition or domestic violence.
Services for Certain Diagnoses Or Disorders	Medical Supplies or services or charges for the diagnosis or treatment of sexual and gender identity disorders, personality disorders, learning disorders, dissociative disorders, developmental speech delay, communication disorders, developmental coordination disorders, intellectual disabilities or vocational rehabilitation.
Services for Counseling Or Psychotherapy	Counseling and psychotherapy services for the following conditions are not covered: <ol style="list-style-type: none"> <li>1. Feeding and eating disorders in early childhood and infancy;</li> <li>2. Tic disorders, except when related to Tourette's disorder;</li> <li>3. Elimination disorders;</li> <li>4. Mental disorders due to a general medical condition;</li> <li>5. Sexual function disorders;</li> <li>6. Sleep disorders;</li> <li>7. Medication induced movement disorders; or</li> <li>8. Nicotine dependence, unless specifically listed as a Benefit in Summary Plan Description or on the Schedule of Benefits.</li> <li>9. Wilderness therapy is not provided under the group health plan including nor health resorts, recreational programs, outdoor skills programs, relaxation or lifestyle programs, and services provided in conjunction with (or as part of) those programs.</li> </ol>
Services not listed as Covered Benefits	Medical Supplies or services or other items not specifically listed as a Benefit in Section 5 or on the BlueCross Schedule of Benefits.
Services prior to Member Effective Date or Plan of Benefits Effective Date	Any charges for Medical Supplies or services rendered to the Member prior to the Member's Effective Date, the Employer's Effective Date or after the Member's coverage terminates, except as provided in BlueCross Articles VI (Termination of this Plan of Benefits) and X (ERISARights).
Services Rendered by Family	Any Medical Supplies or services rendered by a Member to him or herself or rendered by a Member's immediate family (parent, Child, Spouse, brother, sister, grandparent or in-law).

**T**

Temporomandibular Joint (TMJ) Disorder	Any service for the treatment of dysfunctions or derangements of the temporomandibular joint, regardless of cause. This exclusion also applies to orthognathic surgery for the treatment of dysfunctions or derangements of the temporomandibular joint, regardless of cause, except as specified on the BlueCross Schedule of Benefits.
Travel	Travel, whether or not recommended by a Provider unless directly related to human organ or tissue transplants when Preauthorized and except as specified on the BlueCross Schedule of Benefits

**V**

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

Workers' Compensation	<p>This Plan does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained or alleged by a Member that arises out of, in connection with, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the Member.</p> <p>Benefits will not be provided under this Plan if coverage under the Workers' Compensation Act or similar law would have been available to the Member but the Member or Employer elected exemption from available workers' compensation coverage, waived entitlement to workers' compensation benefits for which he/she is eligible, failed to timely file a claim for workers' compensation benefits or the Member sought treatment for the injury or illness from a Provider which is not authorized by the Member's Employer or Workers' Compensation Carrier.</p> <p>If the Plan pays Benefits for an injury or illness and the Plan determines the Member also received a recovery from the Employer or Employer's Workers' Compensation Carrier by means of a settlement, judgment or other payment for the same injury or illness, the Plan shall have the right of recovery as outlined in Section 10.</p>
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Bldg. 992-2W Savannah River Site  
Aiken, SC 29808

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# **Savannah River Nuclear Solutions Pre-65 Retiree Health Plan Summary Plan Description**

AMENDED AND RESTATED EFFECTIVE  
JANUARY 1, 2026