

**MUSC GROUP HEALTH BENEFITS PLAN
FOR EMPLOYEES OF THE
MEDICAL UNIVERSITY OF SOUTH CAROLINA,
THE MEDICAL UNIVERSITY HOSPITAL AUTHORITY,
AND PARTICIPATING ENTITIES**

**ADOPTED BY
THE SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY
Effective January 1, 2025**

**S.C. Public Employee Benefit Authority
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Columbia, South Carolina 29223
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ARTICLE 1.

ESTABLISHMENT AND PURPOSE OF PLAN

1.1 Name and Purpose

The name of this Plan is the MUSC Group Health Benefits Plan for Employees of the Medical University of South Carolina, the Medical University Hospital Authority, and Participating Entities (hereinafter “MUSC Health Plan” or “Plan”). The State of South Carolina (“the State”), through the Public Employee Benefit Authority (“PEBA”) has established a self-funded employee welfare benefit plan for the exclusive benefit of the participants and has adopted this Plan. The purpose of this Plan is to provide for the payment of illness, accident, or other benefits to the participants of this Plan and their eligible dependents. This Plan is a self-funded governmental plan, as defined in 29 U.S.C. § 1002(32) of the Employee Retirement Income Security Act of 1974 (“ERISA”), that is exempt from the requirements of ERISA and certain other federal health insurance law requirements that are applicable to private health insurance plans, including certain provisions of the Public Health Service Act.

1.2 Establishment and Effective Date

The MUSC Health Plan was established on January 1, 2014. This Plan, as amended, became effective January 1, 2025.

1.3 Applicable Law

This Plan is established, and will be maintained, with the intention of meeting the requirements of all applicable federal and state laws. Any provision of this Plan that conflicts with the law of any governmental body or agency having jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

1.4 Entire Plan

This Plan document and the enrollment applications of the Covered Persons, if any, constitute the entire Plan of Benefits established by the Planholder.

1.5 Summary Plan Guide

The Medical University of South Carolina and Medical University Hospital Authority shall provide to eligible Subscribers a summary plan guide containing a summary of the benefits of this Plan and the rights and obligations of Covered Persons under this Plan. The Guide may provide more detail than this Plan document, but in the event of a conflict between the Guide and the Plan, the Plan is controlling.

1.6 Changes to Plan

The Planholder reserves the right at any time to alter, amend, change, supplement, revoke or reduce the benefits under this Plan or increase or decrease the premiums charged under this Plan. This Plan may be changed by the execution of an amendment to this Plan by the Planholder at any time without prior notice to, or the consent of, any Covered Person or of any person entitled to receive payment of benefits under the Plan. The Planholder shall provide to the Subscribers a summary of any material change to this Plan.

1.7 Effect of Changes

All changes to this Plan shall become effective as of a date established by the Plan Administrator EXCEPT that no increase or reduction in benefits shall be effective with respect to expenses Incurred prior to the date a material change was adopted by the Planholder, regardless of the effective date of the change.

1.8 Termination of Plan

The Planholder may terminate all or any portion of this Plan at any time by providing written notice to the Subscribers. Such termination will become effective on the date set forth in such notice.

1.9 Written Notice

Any written notice required by law shall be deemed received if sent by regular mail, postage prepaid, to the last address on the records of the Plan Administrator. Subscribers shall be solely responsible for providing the Plan Administrator with a current address for themselves and any persons authorized on their behalf and for notifying the Plan Administrator in writing of any change in any addresses.

1.10 Waiver

The failure of the Plan Administrator to enforce strictly any provision of this Plan shall not be construed as a waiver of the provision. Rather, the Plan Administrator reserves the right to enforce strictly each and every provision of this Plan at any time, regardless of prior conduct and regardless of the similarity of the circumstances or the number of prior occurrences.

1.11 Clerical Error or Delay

Clerical Errors made by PEBA, or its agents, on the records of the Plan Administrator, Third-Party Claims Processor, or Utilization Review Agency, and delays in making entries on such records, shall not invalidate coverage that otherwise would be validly in force, nor shall any such Clerical Errors cause to be in force or to continue in force coverage that would otherwise be terminated. Upon discovery of any such error or delay, an equitable adjustment will be made. Coverage changes and contribution reimbursements may be made retroactively up to 12 months from the date of discovery.

Clerical Errors and delays in processing made by the Employer and agents or employees of the Employer (including benefits administrators) may result in an equitable adjustment, at PEBA's sole discretion. Coverage changes and contribution reimbursements may be made retroactively up to no more than 12 months from the date of discovery.

1.12 Workers' Compensation

This Plan is not in lieu of workers' compensation and does not affect any requirement for coverage by workers' compensation insurance and is not intended to provide or duplicate benefits for work related injuries that are within any workers' compensation law.

1.13 Headings

The headings used in this Plan are for the purpose of convenience of reference only. Covered Persons may not rely on any heading to construe the meaning of a Plan provision. In all cases, the full text of this Plan will control.

1.14 Misstatements and Omissions

If any relevant fact has been misstated or omitted, in whole or in part, whether intentional or not, by, or on behalf of, any person on an application, the election of benefits (whether paper or electronic), or other document, or information submitted or required to be submitted to the Plan Administrator, Third-Party Claims Processor, or Utilization Review Agency to obtain or retain coverage under this Plan, the true facts shall be used to determine whether coverage is in force and the extent, if any, of such coverage. Upon the discovery of any such misstatement or omission, coverage may be terminated prospectively. If the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact, coverage may be terminated retroactively to the date of the act, practice, or omission, and an equitable adjustment of any contributions may be made and the Plan Administrator may recover the amount of any claims paid in error due to the act, practice, or omission.

1.15 Use of Social Security Numbers on Application

The Plan is required by federal law to obtain the Social Security Number of each Covered Person. The Subscriber's Social Security Number, as well as the Benefits Identification Number (BIN), and address will be used as the identification number and address for the Dependents of the Subscriber.

1.16 Dates

Any reference to a period of time in "days" means calendar days unless otherwise specified.

ARTICLE 2.

DEFINITIONS

As used in this Plan, the following words shall have the meanings indicated in this Article:

2.1 Active Employee

An Employee who is engaged in Active Employment.

2.2 Active Employment

The Employee is actively at work on a Full-Time basis, performing all the regular duties of their occupation at an established business location of the Employer or another location to which they may be required to travel to perform the duties of their employment. An Employee shall be deemed to be engaged in Active Employment while on jury duty or on any regular nonworking day including holidays or vacation days established and published by the Employer if the Employee was engaged in Active Employment on the last preceding regular working day.

The Employee's participation in the Plan will not be prevented or delayed if (i) the Employee's absence from work is due to any health-related reason, including a medical condition, Hospital confinement, or a disability; or (ii) the Employee is on leave under the Family and Medical Leave Act on the Effective Date of this Plan. In no event, however, will an Employee be considered to be in Active Employment if they have not reported for work or if they or their Employer has terminated their employment.

2.3 Advanced Practice Registered Nurse

An individual who has satisfied the State Board of Nursing's requirements as a nurse practitioner, certified nurse midwife, certified registered nurse anesthetist or clinical nurse specialist, who is functioning in the advanced practice registered nursing role, and who is in independent practice. The Plan only recognizes a certified nurse midwife licensed by the State Board of Nursing (or by a sister-state having substantially equivalent license standards) as a Provider for purposes of midwife coverage. A lay midwife or a midwife licensed by the Department of Public Health (DPH) is not recognized, or reimbursed, by the Plan as a Provider.

2.4 Agent for Service of Process

The Plan Administrator is the agent of the State for service of any process related to this Plan.

2.5 Alcoholism

A morbid state caused by excessive and compulsive consumption of alcohol that interferes with the patient's health and social or economic functioning.

2.6 Alcoholism Treatment Center

Any institution or facility, which is licensed by the State of South Carolina Department of Public Health, or by a sister-state, having substantially equivalent license standards, to render detoxification and rehabilitation services for the treatment of Alcoholism.

2.7 Allowed Amount

The amount established by the Plan Administrator in the Schedule of Reimbursement Rates for the applicable Provider Network. For charges not included in the Schedule of Reimbursement Rates, the Allowed Amount shall mean an amount measured and determined by comparing it with the charges customarily made for similar services to individuals of similar medical condition in the locality concerned, unless the charge is specifically excluded by this Plan or by other terms and conditions of coverage. In the absence of data referred to above, the Third-Party Claims Processor, through its medical staff or medical consultants, will determine the Allowed Amount based upon comparable or similar services or procedures.

2.8 Alternative Treatment Plan

The individual treatment plan developed for a particular Covered Person to treat an illness or injury covered under the Plan that requires a modification of the Coinsurance rate or some medical services or supplies that otherwise are not available under the Plan, but which, if the Coinsurance rate is modified, or if the medical services or supplies are provided, would permit treatment in a cost-effective manner and in a less intensive care setting, such as a Skilled Nursing Facility, Home Health Care, Hospice facility, or any facility providing less intensive care than the one in which the Covered Person is presently receiving medical care. An Alternative Treatment Plan requires the approval of the treating Physician, the Plan Administrator, and the patient, and notification of the approved Alternative Treatment Plan to the Third-Party Claims Processor.

2.9 Ambulatory Surgical Center

A specialized facility that fully meets all of the following tests:

- A. It is established, equipped, and operated in accordance with the applicable laws of the jurisdiction

in which it is located primarily for the purpose of performing surgical procedures;

- B. It is operated under the supervision of a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) devoted full-time to such supervision and who permits a surgical procedure to be performed only by a duly-qualified Physician privileged to perform such procedure in at least one area Hospital, as defined in this Plan, at the time the procedure is performed;
- C. It requires in all cases, other than those requiring only local infiltration anesthetics, that a licensed anesthesiologist or a certified registered nurse anesthetist administer the anesthetics and remain present throughout the surgical procedure;
- D. It provides at least two operating rooms and at least one post-anesthesia recovery room; is equipped to perform diagnostic x-ray and laboratory examinations; and has available, to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to a defibrillator, a tracheotomy set, and a blood bank or other blood supply;
- E. It provides the full-time services of one or more registered nurses for patient care in the operating rooms and in the post-anesthesia recovery room;
- F. It maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications or require post-operative confinement;
- G. It maintains an adequate medical record for each patient, such record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report; medical history, laboratory tests, and x-rays; an operative report; and a discharge summary.

2.10 Ambulatory Surgical Center Network

A group of Ambulatory Surgical Centers, which have contracted with the Plan Administrator or Third-Party Claims Processor to accept from the State a payment methodology for medical services rendered by the Ambulatory Surgical Center to Covered Persons utilizing the Tier B State Health Plan component of the Plan.

2.11 Behavioral Health Disorders

Neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind or other condition that is defined, described, or classified as a psychiatric disorder or condition in the latest publication of the American Psychiatric Association entitled *Diagnostic and Statistical Manual of Mental Disorders*, or other similar authority generally recognized by Behavioral Health Providers, and which is not otherwise excluded by the terms and conditions of this Plan.

2.12 Behavioral Health Manager

The entity retained by the Plan Administrator to manage Behavioral Health cases and process Behavioral Health claims under this Plan.

2.13 Behavioral Health Provider

A psychiatrist, psychologist, psychological/neuropsychological tester, Master's Level Therapist, Registered Nurse (including Advanced Practice Registered Nurse), full Board Certified Behavior Analyst (for Applied

Behavioral Analysis only), or any other entity or individual or institutional health care provider eligible to participate in the Behavioral Health Provider Network and acting within the scope of their or its own current, active license.

2.14 Child

Shall mean and include a Subscriber's:

- A. Natural child;
- B. Stepchild;
- C. Adopted child;
- D. Child placed for adoption, which means the Subscriber has assumed and retains a legal obligation for total or partial support of the child in anticipation of adopting the child;
- E. Foster child, placed by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;
- F. Child for whom Subscriber has legal custody, which means Subscriber has guardianship responsibility as well as financial responsibility; and
- G. Child for whom Subscriber is required to provide health insurance due to a court order.

2.15 Chiropractic Services

Any service payable by the Plan and provided by a licensed chiropractor or at a chiropractic clinic.

2.16 Clerical Error

An omission, mistake, misreading, or delay, made by the Plan Administrator, Third-Party Claims Processor, or Utilization Review Agency, in the entry, recording, reproduction, or reporting of information in the files relating to the operation of the Plan.

2.17 Coinsurance

That percentage of the Allowed Amount for Covered Medical Benefits, in excess of the individual or Family Deductible, that is payable by the Covered Person under the tier of the Plan utilized.

2.18 Copayment

A fixed amount established by the Plan payable by the Covered Person for a service or item.

2.19 Cost Sharing

Amounts paid by a Covered Person for Medical Care or Prescription Drug Expenses, including Deductibles, Coinsurance, and Copayments. The term does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

2.20 Covered Dependent

A Subscriber's Dependent, who has met the eligibility requirements and is enrolled under the Plan.

2.21 Covered Employee

An Employee who has met the eligibility requirements and is enrolled under this Plan.

2.22 Covered Hospital Services

Those inpatient and outpatient services, which are normally provided by the Hospital and for which benefits are provided under the Plan. Covered Hospital Services shall not include skilled nursing care, long-term rehabilitation, long-term cognitive retraining services, or other extended care services.

2.23 Covered Medical Benefit

Medical services and supplies Medically Necessary in the diagnosis or treatment of an illness or injury, performed and reimbursed in the least costly setting required by the Covered Person's condition, and that are within the benefits provided in the Plan and not otherwise excluded by any term, condition, limitation, or exclusion of this Plan.

2.24 Covered Medical Benefits Coinsurance Maximum

Means the total of the eligible Medical Benefits Coinsurance payable by the Covered Employee in one Plan Year for individual or family Covered Medical Benefits before the Plan provides coverage for 100% of the Allowed Amount for Covered Medical Benefits, not including applicable Copayments, as set out in Paragraphs 7.1.A.4, 7.1.B.4 and 7.1.C.4.

2.25 Covered Person

A Subscriber, or a Dependent thereof, who has met the eligibility requirements, and is enrolled in this Plan.

2.26 Custodial Care

Those activities undertaken for the protection or safety of the individual, or to provide food or shelter, or to assist in the activities of daily living, which constitute personal care such as, but not limited to: help in walking and getting in and out of bed, assistance in bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered and that does not entail or require the continuous attention of trained medical personnel, and that does not require the skills of qualified technical or professional caregiver.

2.27 Deductible

The annual aggregated Allowed Amount of charges for which the Covered Person is financially responsible before the Plan has financial responsibility, as indicated in Paragraphs 7.1.A.1, 7.1.B.1, and 7.1.C.1. There is an individual Deductible and a family Deductible.

- A.** Under Paragraph 7.1.A.1, there is a Deductible of \$385 for an individual and \$770 for family with respect to services under Tier A, the PCMH component of the Plan.
- B.** Under Paragraph 7.1.B.1, there is a Deductible of \$515 for an individual and \$1,030 for family with respect to services under Tier B (in-network State Health Plan Networks) of the Plan.
- C.** Under Paragraph 7.1.C.1 there is a Deductible of \$515 for an individual and \$1,030 for family with respect to services under Tier C (Out of Network) of the Plan.

- D. Amounts paid by a Covered Person for allowed charges under any tier of the Plan, other than Copayments, are counted toward the Tier A Deductible or the Tier B/Tier C Deductible without distinction. Thus, amounts required to be paid by the Covered Person because an applicable Deductible has not been met in any tier count toward the satisfaction of the Tier A Deductible and the Tier B/Tier C Deductible.
- E. Copayments do not apply toward satisfaction of the Deductible, and Copayments continue to apply after the Deductible has been met.

2.28 Dependent

Shall mean and include a Subscriber's:

- A. **Dependent Spouse.** Legally recognized spouse under South Carolina law.;
- B. **Dependent Child.** Child younger than 26 years of age. The Plan Administrator may require the Subscriber to submit due proof of the Child's relationship with the Subscriber within 31 days of enrollment, and at such other reasonable times; and
- C. **Incapacitated Dependent Child.** Unmarried Child, 26 years of age or older, who is incapable of self-sustaining employment because of mental illness, intellectual disability, or physical disability that occurred prior to turning age 26, and who is principally dependent (more than 50%) on the Subscriber for maintenance and support, provided that the Child was covered continuously under the Plan or a Predecessor Plan as a dependent prior to the date of incapacitation and since attaining age 26. The Plan Administrator may require the Subscriber to submit due proof of such incapacity and dependency satisfactory to the Plan Administrator within 31 days of initial enrollment, upon attaining age 26, and at such other reasonable times, but not more frequently than annually. It shall be the Subscriber's responsibility to notify the Plan Administrator when the Child is no longer incapacitated.

2.29 Diagnosis Related Groups ("DRG")

Shall be defined in accordance with the definition assigned "Diagnosis Related Groups" with respect to Section 1886(d) of the Social Security Act and as specified by the Final Rule promulgated by the Health Care Financing Administration (HCFA) in the Federal Register, 42 CFR, Parts 412 and 413, September 4, 1990, including such amendments or additions to the Final Rule that may be promulgated by HCFA and adopted by the Plan Administrator.

2.30 Drug Abuse

The excessive consumption, ingestion, injection, or other utilization of any drug or other substance not medically prescribed or administered, or the over-utilization or excessive consumption of any drug that is medically prescribed or administered.

2.31 Durable Medical Equipment

Any equipment that:

- A. Can withstand repeated use; and
- B. Is primarily and customarily used to serve a medical purpose; and
- C. Is generally not useful to a person in the absence of illness or injury; and
- D. Is appropriate for use in the home.

2.32 Effective Date

Shall mean:

- A. With respect to the Plan, the date on which this Plan takes effect;
- B. With respect to a Covered Person, the date on which such person is first covered under this Plan but no earlier than January 1, 2025.

2.33 Eligibility Date

The date upon which a person becomes eligible for coverage under this Plan.

- A. For newly hired Employees and their existing Dependents, the Eligibility Date is the date the Employee begins Active Employment.
- C. For Employees and their Dependents who enroll under the Special Eligibility Situations of Paragraph 3.7, the Eligibility Date is the date of occurrence of the Special Eligibility Situation.

2.34 Employee

A person employed by the Medical University of South Carolina, the Medical University Hospital Authority, or an entity created pursuant to Section 59-123-60(E)(13) and that elects to participate in the MUSC Plan, on a Full-Time basis, and who receives compensation from the Employer. If an Employer elects to obtain other health insurance coverage for its persons employed on a nonpermanent, Full-Time basis, such persons do not constitute Employees under this Paragraph.

2.35 Employer

The Medical University of South Carolina, the Medical University Hospital Authority, and an entity created pursuant to Section 59-123-60(E)(13) and that elects to participate in the MUSC Plan.

2.36 Enrollment Date

The Enrollment Date is (i) for Employees, the hire date; (ii) for persons who enroll under the special eligibility situations of Paragraph 3.7, the effective date of coverage.

2.37 Family

A Subscriber and their Covered Dependents.

2.35 Former Spouse

An Employee's former spouse for whom the Employee is required to provide insurance coverage pursuant to a court order or divorce decree and who is enrolled in coverage under the Plan under the Plan under Paragraph 10.5.

2.38 Full-Time

Shall mean an Employee who is credited with an average of at least 30 hours of service per week. Provided, however, an Employer may exercise a one-time, irrevocable option to elect the definition of Full-Time to mean an Employee who is credited with an average of at least 20 hours of service per week, and to apply this definition, upon notification to, and acceptance by, PEBA. Full-Time status for purposes of eligibility to participate in the Plan is determined in accordance with the process set out in Paragraphs 3.15, 3.16, and 3.17 of the Plan.

2.39 Health Care Professional

A Physician or other licensed health care provider acting within the scope of their or its current, active license.

2.40 Home Health Care

Part-time or Intermittent nursing care, health aide services, or physical, occupational, or speech therapy provided pursuant to a written plan for Home Health Care services and rendered in the home of the Covered Person by a private or public agency or organization licensed by the appropriate state regulatory agency, if licensing is required.

2.41 Hospice Agency

A private or public agency or organization that administers and provides care for terminally ill patients (i) pursuant to a written treatment plan approved by a Physician and reviewed at least once a month by the Physician, and (ii) that is licensed or certified as a Hospice or Hospice care agency by the appropriate state regulatory agency, if licensing is required.

2.42 Hospital

- A.** For other than a psychiatric facility, a short-term acute care (i) general Hospital, (ii) children's Hospital, (iii) eye, ear, nose, and throat Hospital, (iv) maternity Hospital, or (v) long-term acute care hospital licensed by the state in which it operates that, for compensation from its patients and on an inpatient basis, is primarily engaged in providing diagnostic and therapeutic facilities for the medical or surgical diagnosis and treatment of injured or sick persons, by or under the supervision of a staff of Physicians duly licensed to practice medicine, and that provides continuous 24 hours-a-day services by licensed nurses physically present and on duty. Such institutions or facilities, if located in South Carolina, must be licensed by the State of South Carolina and, if located outside of South Carolina, must be approved by the Joint Commission on Accreditation of Healthcare Organizations or a similarly nationally recognized accrediting organization.
- B.** A psychiatric facility for the treatment of Behavioral Health Disorders, Drug Abuse, or Alcoholism, that, for compensation from their patients and on an inpatient basis, is engaged in providing diagnostic and therapeutic care by or under the supervision of a staff of Physicians duly licensed to practice medicine to persons suffering from mental or nervous conditions or drug or alcohol dependency, and which provides continuous 24 hours-a-day services by licensed nurses physically

present and on duty. Such institutions or facilities for Behavioral Health Disorders, or Drug Abuse, or Alcoholism, if located in South Carolina, must be licensed by the State of South Carolina and, if located outside of South Carolina, must be approved by the Joint Commission on Accreditation of Healthcare Organizations or a similarly nationally recognized accrediting organization.

- C. Provided, however, the term “Hospital” does not include any long-term chronic care institutions or institutions that are, other than incidentally, a nursing home or place for (i) rest, (ii) the aged, (iii) rehabilitative care, whether or not such institution or facility is affiliated with or part of a Hospital, except as provided in Paragraph 7.17 Rehabilitation Care, (iv) cognitive/behavioral rehabilitative care, and (v) community re-entry programs.

Determination of whether an institution or facility is for long-term chronic care, the treatment of Behavioral Health Disorders, or rehabilitative care shall be made by reference to its average length of stay classification code set forth in the *American Hospital Association Guide to the Health Care Field*, as published annually, and for Behavioral Health Disorders, as determined by applicable license to provide specified services. This determination is made according to the institution’s or facility’s applicable license to provide specific services.

2.43 Hospital or Ambulatory Surgical Center Charges

The Allowed Amount for Medically Necessary services, medicines, supplies for diagnosis or treatment of an illness or injury (except services of a Physician and drugs or supplies not consumed or used in the Hospital) while the Covered Person is Hospital-confined and a charge is made for Room and Board, or if such services are rendered in connection with a surgical procedure performed on an outpatient basis by a Hospital or Ambulatory Surgical Center.

2.44 Hospital Network

The MUSC Health Plan Hospital Network and the State Health Plan Hospital Network.

2.45 Incurred

An expense, charge, penalty, or benefit is incurred for purposes of this Plan on the date the service or supply charged was rendered or received.

2.46 Intensive Care Unit

A separate, clearly designated service area maintained within a Hospital that meets all of the following tests:

- A. It is solely for the treatment of patients who require special medical attention because of their medical condition;
- B. It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital;
- C. It provides a concentration of special life-saving equipment immediately available at all times for the treatment of patients confined within such area;
- D. It contains at least two beds for the accommodation of critically ill patients; and

- E. It provides at least one professional registered nurse who continuously and constantly attends the patient confined in such area on a 24 hours-a-day basis.

2.47 Intermittent

Shall mean part-time Skilled Nursing or Home Health care provided on a less than daily basis for up to four hours per day, or Skilled Nursing or Home Health care provided on a daily basis not to exceed eight hours per day, for fixed and definite periods of time up to 21 days with such extensions for additional fixed and definite periods of time that, at the discretion of the Plan Administrator, may be granted for exceptional circumstances. The period of such extension must be predictable and fixed. Intermittent care is subject to the requirements of pre-approval by the Utilization Review Agency, and all limitations and exclusions on such benefits in Paragraphs 7.11 Hospice Care and 7.13 Home Health Care Services.

2.48 Medical Care

Shall mean and include only the types of medical treatment or care for which benefits are available under this Plan as defined in Article 7.

2.49 Medical Emergency (or Emergency)

A medical condition manifesting itself by acute symptoms of sufficient severity including severe pain, such that a prudent lay-person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following:

- A. Placing the health of the individual, or with respect to a pregnant woman, the health of a woman or her unborn child, in serious jeopardy; or
- B. Serious impairment of bodily functions; or
- C. Serious dysfunction of any bodily organ or part.

2.50 Medically Necessary (or Medical Necessity)

- A. A procedure, service, or supply that meets all of the following criteria:
 - 1. Is medically appropriate to identify or treat an existing condition, illness, disease, or injury; and
 - 2. Is provided for the direct care and treatment of the condition, illness, disease, or injury; and
 - 3. Is prescribed or ordered by a Physician; and
 - 4. Is rendered in accordance with recognized, appropriate medical and surgical practices prevailing in the medical specialty or field of medicine at the time rendered; and
 - 5. Is not primarily for the convenience of the patient, the patient's family, or the patient's provider; and
 - 6. Is not experimental, investigational, or cosmetic in purpose.
- B. The fact that a procedure, service, or supply is prescribed by a Physician, or that a Physician asserts that a procedure, service, or supply is necessary to avoid the potential onset of a condition or

abnormality in the future, is not sufficient to determine that such procedure, service, or supply is Medically Necessary or meets the definition of Medical Necessity in this Plan.

- C. In determining whether a procedure, service, or supply meets this definition, the Plan Administrator, Third Party Claims Processor, and Utilization Review Agency have the discretion to utilize and rely upon any medical, pharmaceutical, 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.
- D. “Generally accepted by the medical and/or behavioral health community” means United States standards that are based on credible scientific evidence published in peer-reviewed medical and/or behavioral health literature generally recognized by the relevant United States medical or behavioral health community, physician, or behavioral health specialty society recommendations, and/or any other factors deemed relevant in the discretion of the Plan Administrator, Third Party Claims Processor, and/or Utilization Review Agency.

2.51 MUSC Health Plan Hospital Network

A Hospital or group of Hospitals, which have contracted with the Plan Administrator or a Third-Party Claims Processor to accept from the State a standard payment methodology for medical services rendered by Hospitals to Covered Persons utilizing the Tier A component of the Plan.

2.52 MUSC Health Plan Physician Network

Those Health Care Providers who have contracted with the Plan Administrator or a Third-Party Claims Processor to accept from the State a standard payment methodology for their services rendered to Covered Persons utilizing the Tier A component of the Plan.

2.53 Obstetrical Care

Services for the prenatal and postpartum care and delivery of one or more fetuses.

2.54 Open Enrollment Period

The period held in October of every year, more fully described in Paragraph 3.11, when any eligible Subscriber may enroll or disenroll himself or eligible Dependents in the Medical Benefits Program without regard to any special eligibility situations. Changes made during the Open Enrollment Period will become effective the following January 1.

2.55 Orthopedic Appliance

Any rigid or semi-rigid support used to restrict or eliminate motion in a diseased, injured, weak, or deformed body member.

2.56 Partial Hospitalization Programs

Therapeutic services for Behavioral Health Disorders provided to patients who use only day or night hospital services or adult day health services rather than regular inpatient hospitalization services.

2.57 Patient-Centered Medical Home

A health care setting that facilitates partnerships between individual patients, their personal physicians and, when appropriate, the patient's family. Care is facilitated by patient registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it, and in a culturally and linguistically appropriate manner.

2.58 Pharmacy Benefits Manager

The entity retained by the Plan Administrator to manage the Prescription Drug Program and process prescription drug claims under this Plan.

2.59 Physician

A licensed medical doctor, dentist, oral surgeon, podiatrist, osteopath, chiropractor, or psychiatrist acting within the scope of their license, excluding an intern, resident, or house physician.

2.60 Plan

This MUSC Health Plan.

2.61 Planholder

The State of South Carolina, which provides the health plan for Employees of the Medical University of South Carolina and the Medical University Hospital Authority by law through the South Carolina Public Employee Benefit Authority.

2.62 Plan Administrator

The South Carolina Public Employee Benefit Authority.

2.63 Plan Year

The 12-month period of time beginning January 1 and ending December 31.

2.64 Prior Authorization or Authorization

The procedure through which a Covered Person may obtain a determination from a Utilization Review Agency that a proposed treatment, and length of stay determination, if required, is consistent with generally recognized medical standards and procedures.

2.65 Predecessor Plan

Shall mean: (i) the State Health Plan established January 1, 1990, as amended, or (ii) prior coverage in which a Covered Person was enrolled immediately prior to enrollment in this Plan, which qualifies as Creditable Coverage, pursuant to the Health Insurance Portability and Accountability Act of 1996.

2.66 Prescription Drug Program

The Prescription Drug Program is administered by the Pharmacy Benefits Manager which coordinates activities relating to prescription drug claims under the Plan. This includes, but is not limited to, processing of drug claims, managing the network of pharmacies that have agreed to accept a contracted payment methodology for prescription drugs, providing drug utilization review to determine appropriateness of the medication and its use, providing a drug formulary consisting of drugs with differing patient payment tiers, which may include non-coverage of certain brand products, providing

specialty pharmacy programs to promote the cost effective use of specialty medication, and other activities designed to promote cost effectiveness.

2.67 Preventive Care

Means the following: a) evidence-based items or services with an A or B rating in the current recommendation of the United States Preventive Services Task Force (USPSTF) with respect to the Covered Person involved; b) immunizations for routine use in children, adolescents, or adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person Involved; c) evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and d) other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women. The above Preventive Care services are required to be provided to participants with no Cost Sharing and are rendered solely for the purpose of health maintenance and not for the treatment of an illness. Recommendations and guidelines will be covered by this Plan on the first Plan Year that begins on or after the date that is one year after the date the recommendation or guideline is issued. A complete list of all required recommendations and guidelines is available at www.healthcare.gov/coverage/preventive-care-benefits. The Plan will use reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service to the extent not specified in the recommendation or guideline.

2.68 Primary Care Physician

The personal Physician a Covered Person selects from the MUSC Health Plan Physician Network to coordinate all aspects of care when the Covered Person is utilizing the Tier A MUSC Health Plan component of the Plan.

2.69 Professional Ambulance

A specifically designed and equipped automobile or other vehicle, such as a boat or plane, that meets all local, state, and federal regulations for transporting the sick and injured.

2.70 Prosthetic Appliance

Any device, item, or supply that replaces all or part of a missing body member or part. Provided, however, a wig, hairpiece, or any other artificial substitute for scalp hair is not a Covered Medical Benefit under the Plan.

2.71 Provider

A Physician, Advanced Practice Registered Nurse, Behavioral Health Provider, Ambulatory Surgical Center, Free Standing Emergency Care Center, or Hospital, as those terms are defined in this Plan.

2.72 Provider's Billed Charges

The Provider's full established prices or rates per individual unit of service, as recorded at their gross level, before application of discounts or allowances, in accordance with generally accepted accounting principles and Medicare principles of reimbursement.

2.73 Room and Board

Room, board, general duty nursing, and any other services, supplies, or items regularly furnished by the

Hospital and included in the total charge as a condition of occupancy of the class of accommodations occupied, including board. Room and board do not include professional services of Physicians or intensive nursing care by whatever name called.

2.74 Schedule of Reimbursement Rates

The rates established by the Plan Administrator as payment for the Provider's services listed therein. The Schedule of Reimbursement Rates, attached to the contract between the State and participating Providers in the Plan's Provider Networks, shall determine the reimbursement rates for Provider services under the Plan.

2.75 Second Opinion

A Second Opinion shall mean and consist of the Covered Person obtaining an examination or evaluation from a second qualified Physician to either confirm or challenge the Medical Necessity of a recommended, elective, non-Emergency surgical procedure, medical procedure, treatment, or hospitalization for treatment of mental illness or chemical dependency prior to undergoing or continuing the treatment, hospitalization, or procedure.

2.76 Semi-Private Room

A Hospital room containing two or more patient beds.

2.77 Skilled Nursing Care

The skilled nursing and skilled rehabilitation services furnished according to Physician's orders that require: (a) the skills of a qualified technical or licensed professional health care provider such as a registered nurse, licensed practical nurse, physical therapist, or speech pathologist, or (b) care provided by or under the general supervision of these skilled nursing and skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result. Custodial Care is not Skilled Nursing Care.

2.78 Skilled Nursing Facility

An institution or facility, which meets all of the following requirements:

- A.** Maintains permanent and full-time facilities for bed care of resident patients; and
- B.** Has available at all times the services of a Physician; and
- C.** Has a registered nurse or Physician on full-time duty in charge of patient care, and one or more registered nurses or licensed practical nurses on duty at all times; and
- D.** Maintains a daily medical record for each patient; and
- E.** Is primarily engaged in providing continuous Skilled Nursing Care for sick or injured persons during the convalescent stage of their illness or injuries and is not, other than incidentally, a rest home or a home for Custodial Care or for the aged; and
- F.** Is operating lawfully as a nursing home in the jurisdiction where it is located.

In no event, however, shall such term include an institution or facility primarily engaged in the care or treatment of Drug Abuse or Alcoholism.

2.79 Specialty Physician

A Physician who provides specialty care to a Covered Person who is utilizing the Tier A MUSC Health Plan component of the Plan.

2.80 State

The State of South Carolina.

2.81 State Health Plan Hospital Network

A group of Hospitals, which have contracted with the Plan Administrator or a Third-Party Claims Processor to accept from the State a standard payment methodology for medical services rendered by Hospitals to Covered Persons utilizing the Tier B State Health Plan components of the Plan.

2.82 State Health Plan Physician Network

Those health care providers who have contracted with the Plan Administrator or a Third-Party Claims Processor to accept from the State a standard payment methodology for their services rendered to Covered Persons under the Tier B State Health Plan component of the Plan.

2.83 Subscriber

An Employer's Active Employee, Former Spouse, Surviving Child, Surviving Spouse, or other enrollee with continuation coverage under Article 10 or 11. A Surviving Child, an enrollee with Child-Only continuation coverage, or a Former Spouse may not add a Dependent to their coverage.

2.84 Surgery

Any manual or operative procedures for the treatment of diseases or injuries, including the Medically Necessary treatment of fractures and dislocations, severe sprains and casting thereof, but not including simple sprains or bruises.

2.85 Surviving Child

The surviving eligible Child of a deceased Covered Employee, who, at the time of the Covered Employee's death, was enrolled in the Plan as a Dependent Child.

2.86 Surviving Spouse

The eligible Dependent Spouse of a deceased Covered Employee, who, at the time of the Covered Employee's death, was enrolled in the Plan as a Dependent Spouse. Remarriage terminates Surviving Spouse status under this Plan.

2.87 Telehealth

The exchange of a Covered Person's information during which the Covered Person can have a telephone or video consultation with a licensed health care professional in a HIPAA-compliant manner. Telehealth does not require two-way audio or video consultations between a Referring Provider and Consulting Provider, as these terms are defined in Paragraph 2.88.

2.88 Telemedicine

The exchange of a Covered Person's information from one eligible referring licensed provider (for purposes of Telemedicine outlined herein, the "Referring Provider") site to another eligible consulting licensed Provider (for purposes of Telemedicine outlined herein, the "Consulting Provider") site for the purpose of providing medical care to a Covered Person in circumstances in which in-person, face-to-face contact with the Consulting Provider is not necessary. The exchange must occur via two-way, real-time, interactive, HIPAA-compliant, electronic audio and video telecommunications systems.

2.89 Third-Party Claims Processor

An entity retained by the Plan Administrator to receive, process, and pay claims under this Plan, including, where applicable, the Pharmacy Benefits Manager, which processes prescription drug claims, and the Behavioral Health Manager, which processes Behavioral Health claims.

2.90 Transplant Network

Those Hospitals that have contracted with the Plan Administrator or the Third-Party Claims Processor to provide transplant procedures that are Covered Medical Benefits under the Plan to Covered Persons.

2.91 Utilization Review Agency

The entities retained by the Plan Administrator to review and determine that the proposed treatments, and length of stay determinations, if required, are consistent with generally recognized medical standards and procedures, and to provide other services specified in Article 15, Utilization Review and Mandatory Case Management.

ARTICLE 3.

ELIGIBILITY, CONDITIONS OF COVERAGE, EFFECTIVE DATES OF COVERAGE, AND TERMINATION OF COVERAGE

3.1 Eligibility

Subject to the provisions in this Paragraph, and all other terms, conditions, limitations, and exclusions of this Plan, the following individuals are eligible for coverage under this Plan:

- A.** All Employees and their Dependents;
- B.** The Surviving Spouse and Surviving Child of a deceased Covered Employee;
- C.** All Employees and Dependents eligible for coverage as the result of COBRA under Article 11; and
- D.** A Former Spouse of a Covered Employee.

3.2 Employee Enrollment

To enroll under this Plan, each eligible Employee must complete within 31 days of the date their coverage would commence under Paragraph 3.3: (i) an election of benefits, in a manner approved by PEBA, and (ii) any other forms required by the Plan Administrator. If the Employee fails to submit such timely election of benefits, payroll deduction authorization form, and other required forms within 31 days following that date, the Employee may be enrolled for coverage only during Open Enrollment Periods or Special Eligibility Situations as may be established by the Plan Administrator.

3.3 Commencement of Employee Coverage

Employee coverage under this Plan shall commence as follows:

- A.** Each Employee in Active Employment who elects coverage under this Plan by filing a timely election of benefits, in a manner approved by PEBA during an Open Enrollment Period and satisfying the other conditions shall be covered under this Plan on the subsequent January 1.
- B.** Each new Employee, who becomes eligible for coverage after the Effective Date of this Plan, and who has elected coverage by filing a timely election of benefits, in a manner approved by PEBA, shall be covered under this Plan (i) on the first day of the month that the Employee commences Active Employment, provided that the Employee commences Active Employment on the first calendar day of that month; or (ii) on the first day of the following month provided that the Employee commences Active Employment on any day other than the first calendar day and the first working day of the month. Otherwise, if the Employee commences Active Employment on the first working day of the month, other than the first calendar day of the month, the Employee may choose to commence coverage under this Plan on either the first day of that month or the first day of the following month. For purposes of this Paragraph, the first working day of the month is the first day that is not a Saturday, Sunday, or holiday. The first working day of the month is not an Employer-specific first working day.
- C.** An Employee who has not elected coverage during the Plan Year may elect coverage if they experience a Special Eligibility Situation set out in Paragraph 3.7 of the Plan. The Employee may elect coverage by filing a timely election of benefits, in a manner approved by PEBA within the time frame set forth in Paragraph 3.7. The Employee's coverage commences in accordance with the provisions of Paragraph 3.7.

3.4 Eligibility for Dependent Coverage

Each Employee, who has one or more Dependents on the date the Employee becomes eligible for coverage, shall be eligible to enroll each Dependent for coverage on such date. Each Employee without a Dependent on the date the Employee becomes eligible for coverage shall be eligible to enroll each Dependent for coverage on the date the Employee acquires a Dependent in accordance with the provisions of Paragraph 3.7 of the Plan. In both cases, the Employee must meet the requirements of Paragraph 3.5 below. A spouse of a Covered Employee who is also eligible for coverage or benefits as an Employee or Retiree under the State Health Plan is not eligible for coverage as a Dependent, but must have their own coverage. However, a Part-Time Teacher or other Employee or Retiree under the State Health Plan who would otherwise be required to pay some or all of the Employer portion of the premium for their own coverage may be covered as a Dependent of a Covered Employee, in lieu of individual coverage. A Child of a Covered Employee who is also an Employee may be covered as either an Employee or a Dependent, but not as both.

3.5 Dependent Enrollment

To obtain Dependent coverage under this Plan, each eligible Employee must be covered under this Plan and file a timely election of benefits, in a manner approved by PEBA selecting Dependent coverage for eligible Dependents. If the Employee acquires a Dependent after the Effective Date of the Employee's coverage, in accordance with Paragraph 3.7 of the Plan, the Employee has 31 days from the date the Dependent was acquired to enroll the Dependent in this Plan. If the Employee fails to notify the Plan Administrator within the 31-day period of time, the Dependent may be enrolled for coverage only during such Open Enrollment Periods or Special Eligibility Situations as may be established by the Plan Administrator.

3.6 Commencement of Dependent Coverage

Each eligible Employee, who has satisfied the requirements of Paragraph 3.5, and has enrolled eligible Dependents, will have Dependent coverage under this Plan for those eligible, enrolled Dependents commencing on the date the Employee's coverage commences, or for Dependents acquired thereafter, on the date they were acquired in accordance with Paragraph 3.7 of the Plan.

3.7 Special Eligibility Situations

A. Adding Coverage. If an Employee has not enrolled themselves or eligible Dependents for coverage within 31 days of first becoming eligible or during a prior Open Enrollment Period and subsequently wishes to elect such coverage, the Employee may do so under the following Special Eligibility Situations. If the Employee does not do so within the time frame specified for a Special Eligibility Situation, they must wait for the next Open Enrollment Period.

1. An Employee's Child may be added within 31 days of:
 - a. The Child's birth;
 - b. Adoption of the Child;
 - c. The Child's placement for adoption;
 - d. The Child's placement for foster care;
 - e. The Child becoming a stepchild; or
 - f. The Employee gaining legal custody of the Child.

Coverage under this Paragraph shall commence on the day of the event described in this Subparagraph; a court order is effective as of the date it is filed. . A child placed for adoption will be covered effective on the child's date of birth if they are placed for adoption within 31 days of their date of birth; otherwise, their coverage will be effective on the date they are placed for adoption. The Employee must submit an election of benefits, in a manner approved by PEBA, within 31 days of the date of the event. Satisfactory documentation of the circumstances surrounding the event must accompany the election of benefits. The Employee and all eligible Dependents may be enrolled in coverage at this time.

2. An Employee's spouse may be added within 31 days of marriage. Coverage under this Paragraph shall commence on the date of the marriage. The Employee must submit an election of benefits, in a manner approved by PEBA, within 31 days of the date of the marriage. Satisfactory documentation of the circumstances surrounding the marriage must accompany the election of benefits. The Employee and all eligible Dependents may be enrolled in coverage at this time.
3. An Employee, Employee's spouse, or Employee's Child covered under their own group health plan or health insurance coverage, as defined by applicable law, or the group health plan or health insurance coverage of the Employee's spouse or Child and who subsequently loses coverage because
 - a. The spouse's or Child's employer canceled its present group insurance,
 - b. The spouse's or Child's employer canceled its contribution to its group insurance,
 - c. Death of the Employee's spouse,
 - d. The Employee's spouse or Child left such employment or experienced a reduction in hours, or
 - e. Otherwise loses eligibility for health insurance coverage

is eligible for coverage under this Plan commencing on the date of loss of coverage. The Employee must submit an election of benefits, in a manner approved by PEBA, within 31 days of the date of loss of coverage. A satisfactory statement of the circumstances surrounding the loss of coverage must accompany the revised election of benefits. Termination of coverage for non-payment is not a loss of eligibility.

4. An Employee, Employee's spouse, or Employee's Child who loses coverage because of
 - a. Legal separation,
 - b. Divorce,
 - c. Cessation of dependent status; or
 - d. Other similar loss of coverage

is eligible for coverage under this Plan commencing on the date of loss of coverage. The Employee must submit an election of benefits, in a manner approved by PEBA, within 31 days of the date of loss of coverage. A satisfactory statement of the circumstances surrounding the loss of coverage must accompany the revised election of benefits.

5. An Employee, Employee's spouse, or Employee's Child who
 - a. Loses coverage under Medicaid or CHIP because of loss of eligibility may enroll for coverage within 60 days from the date of notification of the loss of coverage; or

- b. Becomes eligible for a premium assistance subsidy under Medicaid or CHIP may enroll within 60 days from the date of notification of eligibility for premium assistance subsidy.

Coverage for the Employee, the Employee's spouse, or the Employee's Child enrolled under this Paragraph shall commence on the date of loss of Medicaid or CHIP coverage, or the date eligibility for premium assistance is determined. The Employee must submit an election of benefits, in a manner approved by PEBA, within 60 days of the later of the date of loss of coverage, the date eligibility for premium assistance is determined, or the date of notification of either event. A satisfactory statement of the circumstances surrounding the loss of coverage or determination of eligibility for premium assistance must accompany the election of benefits. The Employee and all eligible Dependents may be enrolled in coverage at this time.

- 6. Eligible Employees and their Dependents may enroll in coverage upon release from incarceration. The Employee must submit an election of benefits, in a manner approved by PEBA, within 31 days of the date of release from incarceration.
- 7. An Employee, Employee's spouse, or Employee's Child who was mobilized or called to active duty with the National Guard or a Reserve unit and who dropped coverage under this Plan may re-enroll in the Plan upon discharge or release from active duty and resumption of employment with an eligible Employer. The Employee must submit an election of benefits, in a manner approved by PEBA, within 31 days of discharge, release from active duty, or resumption of employment, whichever is latest.

B. Dropping Coverage. An Employee or a Covered Dependent who otherwise continues to meet eligibility requirements under the Plan may drop coverage in the following Special Eligibility Situations. If the Employee does not do so within the time frame specified for a Special Eligibility Situation, the Employee and Covered Dependents either must wait (i) for the next Open Enrollment Period or (ii) for the Employee and Covered Dependents to cease meeting eligibility requirements under the terms of the Plan for coverage to be dropped.

- 1. An Employee or Covered Dependent who acquires other health insurance coverage may drop coverage within 31 days. Coverage under this Paragraph shall end at 11:59 p.m. on the last day of the month during which other coverage is gained or on the first of the month if coverage is gained on the first of the month. The Employee must submit an election of benefits, in a manner approved by PEBA, within 31 days of the gain of other group coverage. Satisfactory documentation of the circumstances surrounding the event must accompany the election of benefits.

An Employee or Covered Dependent acquires Medicare coverage for purposes of this Paragraph when they first enroll in Part A or Part B under Medicare. If an Employee or Covered Dependent defers enrollment in Part B when they enroll in Part A, subsequent enrollment in Part B is not a Special Eligibility Situation.

- 2. An Employee's spouse may be dropped within 31 days of divorce or legal separation. The Employee must submit an election of benefits, in a manner approved by PEBA, and divorce or legal separation order within 31 days of the date the divorce or legal separation

order is filed. Coverage under this Paragraph shall end at 11:59 p.m. on the last day of the month during which the election of benefits and divorce or legal separation order are submitted. A legal separation order must be signed by a judge in a jurisdiction that recognizes legal separation as a legal status change.

3. An Employee or Covered Dependent who

- a.** Gains coverage under Medicaid or CHIP may drop coverage within 60 days from the date of gain of coverage or the date of notification of gain of coverage, whichever is later; or
- b.** Loses eligibility for a premium assistance subsidy under Medicaid or CHIP may drop coverage within 60 days from the date of loss of eligibility or the date of notification of loss of eligibility.

Coverage for the Employee or Covered Dependent dropped under this Paragraph shall end on the date of gain of Medicaid or CHIP coverage, or the date of the notification regarding loss of eligibility for premium assistance. Otherwise, coverage shall end at 11:59 p.m. on the last day of the month during which the submission of an election of benefits, in a manner approved by PEBA, is provided in accordance with the time limits in this Paragraph. The Employee must submit an election of benefits, in a manner approved by PEBA, within 60 days from the later of the date of gain of coverage or notification of gain of coverage or the date of loss of eligibility or notification of loss of eligibility for premium assistance. A satisfactory statement of the circumstances surrounding the loss of coverage or determination of eligibility for premium assistance must accompany the revised election of benefits.

- 4.** A Covered Person who becomes incarcerated may drop coverage due to incarceration. The Employee must submit an election of benefits, in a manner approved by PEBA, within 31 days from the date of incarceration.

C. Other Changes in Status or Applicable Events. An Employee may change and make a new election or revoke an election to participate in the Plan during the Plan Year if the Employee is otherwise allowed to make such an election change under the Flexible Benefits Plan for Employees of the State of South Carolina and Local Subdivisions.

D. Notification Obligations. Each Employee must notify the Plan Administrator as soon as possible of:

- (i) A change in address;
- (ii) Entrance into the military;
- (iii) Eligibility or entitlement for Medicare;
- (iv) An individual ceasing to be a Dependent under the terms of the Plan; or
- (v) Any other change in status or other applicable event that might affect the Employee's or the Employee's Dependents' coverage or cost under Plan.

If an Employee does not provide such notice, the Employee may be liable for the costs, fees, and expenses incurred by the Plan, the Plan Sponsor, the Plan Administrator, or the Employer for failure to notify. The Plan Administrator may request whatever documentation it deems necessary to substantiate a claimed change in status or other applicable event. The failure to notify the Plan Administrator of any event listed above or other events affecting eligibility, coverage, or cost under the Plan may be deemed by the Plan Administrator to be an act that constitutes fraud and an intentional misrepresentation of material fact prohibited by the Plan, which may result in a retroactive termination of coverage. Coverage under the Plan will not continue beyond 11:59 p.m. on the last day of the month during which the Employee loses eligibility, even if an Employee or Retiree has failed to provide notice as required by this Paragraph.

3.8 Termination of Employee's Coverage

Except as provided in Article 10, Continuation of Coverage, or Article 11, COBRA, the coverage of an Employee shall cease as of 11:59 p.m. on the last day of the month during which:

- A. The Employee's employment terminates;
- B. The Employee ceases to qualify as an Employee;
- C. The Employee ceases to be in a class of Employees eligible for coverage;
- D. Coverage is discontinued with respect to the class of Employees to which such Employee belongs; or
- E. This Plan is terminated with respect to all Employees.

When an Employee requests the termination of coverage during the Open Enrollment Period, coverage will terminate at 11:59 p.m. the following December 31. When the Employee's contribution becomes 60 days past due, coverage will terminate retroactively to the last day of the month for which the Employee paid the full premium. When an Employee dies, coverage terminates on the day following the date of death of the Employee.

3.9 Termination of Dependent's Coverage

Except as provided in Article 10, Continuation of Coverage, or Article 11, COBRA, the coverage of an eligible Dependent shall cease as of midnight on the last day of the month during which:

- A. The Employee ceases to be in a class of Employees eligible for Dependent coverage under this Plan;
- B. The Employee is no longer covered under this Plan;
- C. All Dependent coverage under this Plan terminates;
- D. Any particular Dependent ceases to be a Dependent of the Employee under Paragraph 2.28. The existing coverage of any Surviving Child will not be affected by the remarriage of the Surviving Spouse; or
- E. Under such other conditions as established by the Planholder.

When an Employee requests the termination of Dependent coverage during the Open Enrollment Period, coverage will terminate at 11:59 p.m. the following December 31. When the Employee's contribution becomes 60 days past due, coverage will terminate retroactively to the last day of the month for which the Employee paid the full premium. When an Employee or a Covered Dependent dies, coverage terminates on the day following the date of death of the Employee or the Covered Dependent. However, after death of the Employee, coverage of the Covered Dependent may continue under Article 10, Continuation of Coverage, or Article 11, COBRA. The existing coverage of any Surviving Child will not be affected by the remarriage of the Surviving Spouse.

3.10

[Reserved]

3.11 Open Enrollment

An Open Enrollment Period will be held during the month of October every year for an effective date of coverage on the following January 1. During the Open Enrollment Period, the eligible Subscriber is given an opportunity to enroll or disenroll himself or eligible Dependents in the Plan without regard to Paragraph 3.7, Special Eligibility Situations.

Changes made during the Open Enrollment Period will become effective the following January 1. No other coverage changes may be made until the next Open Enrollment Period except in situations described in Paragraph 3.7, Special Eligibility Situations.

3.12 Termination of Retiree's Coverage

An Employee who retires shall terminate participation in this Plan as of 11:59 p.m. on the last day of the month during which he retired.

3.13 Termination of Coverage of Survivors; Continuation of Coverage

The coverage of a Surviving Spouse and Surviving Children of a deceased Employee shall terminate as provided in Paragraphs 3.9 unless extended under the Continuation of Coverage provisions in Article 10.

3.14 Effect of Termination of Coverage; Hospitalization at Time of Termination

All rights to receive benefits provided under this Plan for services Incurred by a Covered Person after the termination of coverage will automatically cease, provided, however, that a Covered Person confined to a Hospital or Skilled Nursing Facility on the date of termination of coverage shall be entitled to receive the benefits specified in the Plan for each day of that admission, subject to all the other terms, conditions, limitations, and exclusions of this Plan.

3.15 Ongoing Employees

- A.** An Ongoing Employee is an Employee who has been employed by an Employer for an entire Standard Measurement Period, as that term is defined in Paragraph 3.15.B.
- B.** A Standard Measurement Period for Ongoing Employees begins on October 4 of each calendar year and ends on October 3 of the next calendar year. For Plan Year 2025, the Standard Measurement Period runs from October 4, 2023, and ends on October 3, 2024.

- C. An Ongoing Employee meeting the requirements of Paragraph 3.15.E may enroll annually during an Open Enrollment Period with coverage effective for a Standard Stability Period beginning the following January 1. For Plan Year 2025, the Administrative Period begins October 4, 2024, and ends on December 31, 2024. Notwithstanding the length of the Administrative Period, all enrollment documents must be filed with PEBA during the Open Enrollment Period.
- D. A Standard Stability Period for Ongoing Employees begins January 1 of each year and ends on the following December 31, and is synonymous with the Plan Year as defined in Paragraph 2.63.
- E. An Ongoing Employee who is credited by their Employer with an average of at least 30 hours of service per week after completing a Standard Measurement Period is eligible to enroll under this Plan during the Open Enrollment Period held during the Administrative Period for coverage that will be effective for the entire duration of the following Standard Stability Period, provided the Ongoing Employee does not otherwise experience a termination event under the Plan. An Ongoing Employee who remains employed during a Standard Stability Period is eligible throughout that Standard Stability Period, regardless of the number of hours worked during that Standard Stability Period. An Ongoing Employee who ceases work and is not credited with an hour of service for less than 13 weeks (26 weeks for educational institutions) and who then resumes work with the same Employer during the same Standard Stability Period will be eligible to resume participation in the Plan as of the first day of the calendar month following resumption of work, even if the Ongoing Employee resumes employment in a position that is not reasonably expected to be a Full-Time position.
- F. An Ongoing Employee who has been found not to meet the 30-hour-per-week average during a Standard Measurement Period is not eligible for the Plan as an Ongoing Employee through the entirety of the following Standard Stability Period. However, such an Employee may be eligible for some or all of such Standard Stability Period under another provision of this Plan, such as reclassification of employment.
- G. In the case of a conflict between another provision of this Plan and this Paragraph, this Paragraph will govern an Ongoing Employee's eligibility and coverage. The Ongoing Employee's coverage is otherwise governed by the entirety of this Plan.

3.16 New Variable Hour, New Part-Time, and New Seasonal Employees

1. Definitions

- 1. A New Part-Time Employee is a new Employee who has not completed a Standard Measurement Period and who, upon hire, is reasonably expected to be employed on average fewer than 30 hours of service per week during an Initial Measurement Period, as defined in Paragraph 3.16.B.
- 2. A New Seasonal Employee is a new Employee who has not completed a Standard Measurement Period and who is hired into a position for which the customary annual employment is six months or fewer. The reference to customary means that by the nature of the position, an Employee in this position typically works for a period of six months or fewer, and that period begins each calendar year in approximately the same part of the year, such as summer or winter.

3. A New Variable Hour Employee is a new Employee who has not completed a Standard Measurement Period and who, upon hire, the Employer cannot determine whether the Employee is reasonably expected to be employed on average at least 30 hours of service per week during an Initial Measurement Period because the Employee's hours are variable or otherwise uncertain.
2. An Initial Measurement Period for New Variable Hour, Part-Time, and Seasonal Employees begins on the first day of the month following a New Variable Hour, Part-Time, or Seasonal Employee's date of hire and ends twelve months later. A Standard Measurement Period may begin during, and run concurrently with, portions of an Initial Measurement Period.
3. A New Variable Hour, Part-Time, or Seasonal Employee meeting the requirements of Paragraph 3.16.E may enroll during an Initial Administrative Period beginning the day following the end of their Initial Measurement Period and ending the last day of the same calendar month.
4. An Initial Stability Period for New Variable Hour, Part-Time, and Seasonal Employees begins the first of the calendar month after the end of the Initial Administrative Period and ends the day before in the following calendar year.
5. A New Variable Hour, Part-Time, or Seasonal Employee who is credited by their Employer with an average of at least 30 hours of service per week after completing an Initial Measurement Period is eligible to enroll in coverage under this Plan during the Administrative Period and for the entire duration of the following Initial Stability Period. A New Variable Hour, Part-Time, or Seasonal Employee who remains employed during an Initial Stability Period is eligible throughout that Initial Stability Period, regardless of the number of hours worked during that Initial Stability Period. A New Variable Hour, Part-Time, or Seasonal Employee who ceases work and is not credited with an hour of service for less than 13 weeks (26 weeks for educational institutions) and who then resumes work with the same Employer during the same Initial Stability Period will be eligible to resume participation in the Plan as of the first day of the calendar month following resumption of work, even if the New Variable Hour, Part-Time, or Seasonal Employee resumes employment in a position that is not reasonably expected to be a Full-Time position.
6. A New Variable Hour, Part-Time, or Seasonal Employee who has been found not to work an average of at least 30 hours per week during an Initial Measurement Period is not eligible for benefits as a Variable Hour, Part-Time, or Seasonal Employee through the entirety of the following Initial Stability Period. However, such an Employee may be eligible for some or all of such Standard Stability Period under another provision of this Plan (e.g., after becoming an Ongoing Employee and gaining coverage through the provisions of Paragraph 3.15). However, if a new Variable Hour, Part-Time, or Seasonal Employee materially changes employment status before the end of the Initial Measurement Period in such a way that, if the Employee had begun employment in the new position, the Employee would have reasonably been expected to be a Full-Time Employee, the Employee will be treated as a Full-Time Employee and will be eligible for coverage under the Plan no later than the first day of the month following the change in employment status or, if earlier, as of the first day of the first month following the end of the Initial Measurement Period if the Employee averages more than 30 Hours of Service per week during the Initial Measurement Period and related Administrative Period.

7. Once a New Variable Hour, Part-Time, or Seasonal Employee meets the definition of an Ongoing Employee in Paragraph 3.15.A, the Employee's eligibility to participate in the Plan is determined in accordance with the process set out in Paragraph 3.15.
8. In the case of a conflict between another provision of this Plan and this Paragraph, this Paragraph will govern the New Variable Hour, Part-Time, or Seasonal Employee's eligibility and coverage. The New Variable Hour, Part-Time, or Seasonal Employee's coverage is otherwise governed by the entirety of this Plan.

3.17 New Full-Time Employee

- A. If an Employer reasonably determines, based on the facts and circumstances at the date of hire, that a newly hired Employee will be a Full-Time Employee, the new Employee is eligible to participate in the Plan in accordance with Paragraphs 3.2 and 3.3. If the Employee's hours are reduced below the threshold for Full-Time employment before the Employee has completed a full Standard Measurement Period, then the Employee's eligibility will be determined on a month-to-month basis until completion of a Standard Measurement Period.
- B. Once a New Full-Time Employee meets the definition of an Ongoing Employee, the Employee's eligibility to participate in the Plan is determined in accordance with the process set out in Paragraph 3.15.

ARTICLE 4.

PAYMENT OR REIMBURSEMENT OF MEDICAL EXPENSES

4.1 Payment for Medical Care

Subject to all other terms, conditions, limitations, and exclusions of this Plan, the Plan Administrator, upon receipt of invoices from providers of medical care and/or of completed claim forms as may be required by the Plan Administrator, and after the claims have been processed by the Third-Party Claims Processor, will make payment for the medical care of a Covered Person according to the Schedule of Benefits in Article 7, provided the expense is not covered or reimbursable under any other group plan, insured or otherwise. If expenses for medical care are partially paid or reimbursed under any other group plan as provided in Article 8, Coordination of Benefits, that part of the expenses which is not so paid or reimbursed by the other plan shall be paid or reimbursed to, or for the benefit of, the Covered Person as provided in this Plan.

ARTICLE 5.

CONTRIBUTIONS

5.1 Subscriber Contribution

To be covered under this Plan, each eligible Subscriber shall contribute the amount determined by the State for each Plan Year for the benefit plan the Subscriber selects, commencing with the month in which coverage starts under this Plan. Each eligible Subscriber who elects to have their Dependents covered

under this Plan shall contribute the amount determined for each Plan Year by the State for the benefit plan the Subscriber selects commencing with the month in which such Dependents' coverage starts. A Subscriber is responsible for paying the full premium required for the coverage selected, except for any portion of the premium that is required to be contributed by the Employer. A Subscriber is also responsible for all premiums for any retroactive coverage initiated, except for any portion of the premiums for the retroactive coverage that are required to be contributed by the Employer. The Plan Administrator reserves the right at any time to alter, amend, change, supplement, revoke, or reduce the benefits under this Plan, or increase or decrease the premiums charged under this Plan.

5.2 Employer Contribution

The Employer shall contribute the amount determined by the State for each Plan Year as the minimum employer contribution for the coverage selected by each of its Subscribers, commencing with the month in which coverage starts for the Subscriber under this Plan. If a Subscriber receives retroactive coverage under the Plan, the Employer is responsible for paying the required Employer share of the premiums for any such retroactive coverage.

5.3 Tobacco-Use Premium

A tobacco-use premium is added to each Subscriber's health coverage contribution who does not certify with PEBA as a non-tobacco-user. A tobacco user is a person who uses any tobacco products or electronic cigarettes including but not limited to cigarettes, cigars, pipes, and oral tobacco products. The premium is \$40 per Subscriber per month for Subscriber Only coverage or \$60 per Subscriber per month for a Subscriber who covers any Dependents, regardless of the number of tobacco users covered on the Subscriber's health coverage.

- A.** To avoid the tobacco-use premium, the Subscriber must certify on a form prescribed by PEBA that no one on the Subscriber's health coverage uses or has used tobacco products or electronic cigarettes during the previous six months, or the Subscriber must complete a tobacco cessation program approved by the Plan Administrator within a time period established by the Plan Administrator.
- B.** To remove a tobacco-use premium, the Subscriber must certify on the form described in Subparagraph A. above that no one on the Subscriber's health coverage uses or has used tobacco products or electronic cigarettes during the previous six months, or the Subscriber must provide written proof that the tobacco user(s) has completed a tobacco cessation program approved by the Plan Administrator within a time period established by the Plan Administrator. The tobacco-use premium will be removed prospectively for the month following the processing of the certification or receipt of written proof.
- C.** If anyone covered on a non-tobacco-user Subscriber's health coverage begins using tobacco or electronic cigarettes, the Subscriber must notify PEBA within 31 days of the change. The tobacco-use premium will be applied in the following month.
- D.** If it is determined that a Subscriber submitted a false certification in order to avoid or remove the tobacco-use premium, the Subscriber will be subject to payment of the tobacco-user and non-tobacco user premium difference since last certification.

ARTICLE 6.

DUTIES AND RESPONSIBILITIES

6.1 Planholder Duties

The Planholder shall be responsible for all functions assigned or reserved to it under this Plan, including the authority and responsibility for:

- A. The appointment or removal of the Plan Administrator, Third-Party Claims Processor, Utilization Review Agency, and other entities or their delegates that implement the Plan;
- B. The design of this Plan, including the right to amend this Plan and any other document relating to this Plan;
- C. The qualification of this Plan under the applicable law;
- D. The formation and maintenance of the funding policy of this Plan;
- E. The amendment and termination of this Plan;
- F. The determination of the amount of participant contributions under this Plan; and
- G. The exercise of all functions provided in this Plan, or as may be necessary to the operation of this Plan, except such functions as are assigned to others pursuant to this Plan.

6.2 Plan Administrator Duties

The Plan Administrator shall have the sole responsibility for the administration of this Plan. The Plan Administrator's or its duly authorized agent's decision regarding any construction or interpretation of the Plan; determination of eligibility; other decision arising under the Plan; or exercise of judgment or discretion given to the Plan Administrator by the Plan or Planholder shall be binding and conclusive so long as the decision is not arbitrary, capricious, or in violation of applicable statutory law. The Plan Administrator shall have such duties and powers as may be necessary to administer this Plan, including but not limited to the following:

- A. To administer this Plan according to the Plan terms and to be accountable to the State with regard to the administration of this Plan;
- B. To construe and interpret this Plan in a nondiscriminatory manner; to decide all questions of eligibility; and to determine all questions arising in the administration and application of this Plan;
- C. To determine the types of benefits covered under this Plan;
- D. To be responsible for the reporting and disclosure requirements imposed upon plan administrators under applicable law;
- E. To receive from the State, Subscribers, and Dependents such information as shall be necessary for

the proper administration of this Plan, and to furnish the State, upon request, such reports with respect to the administration of this Plan as are reasonable and appropriate;

- F.** To receive, review, and keep on file, as it deems convenient or proper, reports of the Plan's financial condition, receipts, and disbursements;
- G.** To maintain all records of this Plan;
- H.** To review all claims for benefits under this Plan, as necessary;
- I.** To determine the manner and time of payment of benefits under this Plan;
- J.** To apprise the State as to the amounts and timing of disbursements for payment of benefits and expenses under this Plan;
- K.** To prescribe procedures to be followed by Subscribers and Dependents in filing claims for benefits under this Plan;
- L.** To furnish the State such reports with respect to the processing and payment of claims under this Plan as are reasonable and appropriate; and
- M.** To do all other acts as may be necessary for the proper administration of this Plan.

6.3 Duties and Powers of Third-Party Claims Processor

The Third-Party Claims Processor shall have such duties and powers as may be necessary to process claims and make payments under this Plan, consistent with the contract between the Plan Administrator and the Third-Party Claims Processor, including but not limited to the following:

- A.** To act under the direction and control of the Plan Administrator;
- B.** To receive, review, verify, and investigate all claims for benefits under this Plan, as necessary;
- C.** To determine the amounts, manner, and item of payment of benefits under this Plan;
- D.** To apprise the Plan Administrator as to the amounts and dates of disbursements for payment of benefits and expenses under this Plan;
- E.** To receive from the State, the Plan Administrator, the Utilization Review Agency, Subscribers, and Dependents such information as shall be necessary for the proper processing and payment of claims under this Plan;
- F.** To furnish the Plan Administrator, upon request, such reports with respect to the processing and payment of claims under this Plan as are reasonable and appropriate;
- G.** To maintain records relating to claims for benefits, processing of claims, and payment or denial of claims for benefits;

- H. To administer contracts between the Plan Administrator and providers as a part of a provider network; and
- I. Any other related duties.

6.4 Duties and Powers of Utilization Review Agency

The Utilization Review Agency shall have such duties and powers as may be necessary to conduct the utilization review activities under this Plan, including but not limited to:

- A. To act under the direction and control of the Plan Administrator;
- B. To receive, review, verify, investigate, and monitor as necessary, all requests for Prior Authorization required under the Plan including but not limited to non-Emergency Hospital admissions, surgical procedures, length of stay limitations, and extended care benefits provided under this Plan; to conduct, monitor, and undertake a concurrent review of hospitalizations; and to conduct individual case management as necessary and all other utilization review activity required by this Plan;
- C. To apprise the Plan Administrator and Third-Party Claims Processor, if applicable, as to the Utilization Review Agency's determination as to Prior Authorization, extended care benefits, concurrent review of hospitalization, case management, maternity management, behavioral health case management, and other utilization review activities as may affect the amounts and timing of the payment of benefits under this Plan;
- D. To receive from the State, the Plan Administrator, the Third-Party Claims Processor, Subscribers, and Dependents such information as shall be necessary for the proper processing and administration of the utilization review activities under the Plan;
- E. To furnish the State and the Plan Administrator upon request, and Third-Party Claims Processor, if applicable, such reports with respect to the utilization review activities under this Plan as are reasonable and appropriate;
- F. To maintain records relating to Prior Authorization, extended care benefits, concurrent review of hospitalization, case management, and other utilization review and case management activities required by the Plan;
- G. To perform DRG validation audits and administer out-of-state policies as related to the Plan's Hospital Network; and
- H. To do such other acts as may be necessary, requested by the Plan Administrator, or required by the contract between the Plan Administrator and the Utilization Review Agency to properly handle the administration of the utilization review activities under this Plan.

ARTICLE 7.

SCHEDULE OF BENEFITS

7.1 Benefit Design

The Plan's benefit structure is divided into three tiers:

- Tier A benefits apply to care delivered to a Covered Person within the MUSC Health Plan Hospital Network or MUSC Health Plan Physician Network.
- Tier B benefits apply to care delivered to a Covered Person by a provider participating in the State Health Plan Ambulatory Surgical Center Network, State Health Plan Hospital Network, or State Health Plan Physician Network.
- Tier C benefits apply to out-of-network care delivered to a Covered Person by a provider not participating in the State Health Plan Ambulatory Surgical Center Network, State Health Plan Hospital Network, State Health Plan Physician Network, MUSC Health Plan Hospital Network, or MUSC Health Plan Physician Network.

Payment for Covered Medical Benefits is subject to all terms and conditions of the Plan including but not limited to all exclusions and limitations, and will be made as follows:

A. Tier A: MUSC Health Plan Benefit

1. **Deductible.** The annual Individual Deductible for care delivered within the Tier A MUSC Health Plan Hospital Network or MUSC Health Plan Physician Network shall be \$385, and a Covered Person shall pay annually the first \$385 of Allowed Amounts Incurred in one Plan Year for Covered Medical Benefits before becoming eligible for Plan benefits under Tier A. Copayments do not apply toward satisfaction of the Deductible, and Copayments continue to apply after the Deductible has been met. The annual Family Deductible shall be \$770. The annual Family Deductible is not considered satisfied for any Covered Person until the Family's total Covered Medical Benefits exceed \$770. Payment of Deductible amounts, by any two or more Family members, totaling \$770 of Covered Medical Benefits for that Plan Year shall satisfy the Deductible for all Covered Persons in that Family. If an Employee's spouse is covered by the State Health Plan Standard Plan, the Employee and Spouse shall share the Tier A MUSC Health Plan Deductible. Amounts paid by a Covered Person for allowed charges under any tier of the Plan, other than Copayments, are counted toward the Tier A Deductible or the Tier B/Tier C Deductible without distinction. Thus, amounts required to be paid by the Covered Person because an applicable Deductible has not been met in any tier count toward the satisfaction of the Tier A Deductible and the Tier B/Tier C Deductible.
2. **Medical Benefit Coinsurance.** After the Individual or Family Deductible has been met during the Plan Year, the Plan will pay 80% of the Allowed Amount for the Covered Person's Covered Medical Benefits for care rendered under the Tier A MUSC Health Plan Hospital Network and MUSC Health Plan Physician Network. Copayments continue to

apply after the Deductible has been met.

- 3. Penalty.** A patient, who is a Covered Person, who does not obtain Prior Authorization from the Utilization Review Agency as required by Article 15 for care delivered within the Tier A MUSC Health Plan Hospital Network or MUSC Health Plan Physician Network shall be responsible for all the costs Incurred for these professional services.
- 4. Medical Benefit Coinsurance Maximum.** For care delivered within the Tier A MUSC Health Plan Hospital Network or MUSC Health Plan Physician Network, after the annual Deductible has been met and a Covered Person has Incurred in the Plan Year Coinsurance of \$2,200 for Covered Medical Benefits, or Coinsurance of \$4,400 for Covered Medical Benefits Incurred in the Plan Year by any combination of Family members, the Plan will pay 100% of the Allowed Amount of the Covered Person's Covered Medical Benefits, except that Copayments continue to apply after the Medical Benefit Coinsurance Maximum has been reached. Coinsurance amounts paid by a Covered Person in either Tier A or Tier B will count toward both for the Tier A and Tier B Coinsurance Maximum; however amounts Incurred under Tier C do not count toward the Coinsurance Maximum related to care delivered under Tier A or Tier B, and amounts Incurred under Tier A or Tier B do not count toward the Coinsurance Maximum related to care delivered under Tier C. Provided that the penalty in Paragraph 3 above is not included in those expenses used to satisfy the Coinsurance Maximum, and provided further, that the Covered Medical Benefits Incurred for such treatment or during such admission are always subject to Coinsurance. To the extent the Covered Person participates in any copayment assistance program through a pharmaceutical manufacturer, the amounts received will not contribute to the Covered Person's Coinsurance Maximum.
- 5. Shared Medical Benefit Coinsurance Maximum.** The payments for Covered Medical Benefits that may satisfy the Deductible and Coinsurance Maximum provisions of Paragraphs 7.1.A.1 and 7.1.A.4 are those Incurred by one or more Covered Family members enrolled in the Plan or the State Health Plan.
- 6. Cost Sharing.** The cost-sharing set out below is applicable to care delivered to a Covered Person within the Tier A MUSC Health Plan Hospital Network or MUSC Health Plan Physician Network:

 - a.** Inpatient-Facility: \$0 copay and no coinsurance or deductible.
 - b.** Inpatient-Professional: Anesthesia and Other \$0 copay; coinsurance and deductible apply.
 - c.** Outpatient-Facility-Surgical: \$290 copay; no coinsurance or deductible applies.
 - d.** Outpatient-Minor Surgery: \$75 copay; no coinsurance or deductible applies.
 - e.** Outpatient-Facility-Radiological Advanced: \$85 copay; no coinsurance or deductible applies.

- f.** Outpatient-Facility-Radiological Regular: \$85 copay; no coinsurance or deductible applies.
- g.** Outpatient-Facility-Pathology/LAB: \$20 copay; no coinsurance or deductible applies.
- h.** Outpatient-Facility-Preventive ACA: \$0 copay; no coinsurance or deductible applies.
- i.** Outpatient-Facility-Clinic Visit: \$0 copay; no coinsurance or deductible applies.
- j.** Outpatient-Facility-ER: An Emergency Room visit is subject to a \$193 Copayment per Emergency Room visit. Copayment is waived if the patient is admitted to the Hospital
- k.** Outpatient-Facility-Cancer Diagnosis: \$0 copay; no coinsurance or deductible applies.
- l.** Outpatient-Facility-Physical Therapy/Occupational Therapy/Speech Therapy: \$0 copay; coinsurance and deductible apply.
- m.** Outpatient-Facility-Venipuncture: \$0 copay; no coinsurance or deductible applies.
- n.** Outpatient-Facility-Behavioral Health: \$25 copay; no coinsurance or deductible applies.
- o.** Outpatient-Facility-Infertility: \$0 copay; deductible and 30% coinsurance apply.
- p.** Outpatient-Facility-ESRD Diagnosis: \$0 copay; no coinsurance or deductible applies.
- q.** Outpatient-Facility-Other: \$75 copay; no coinsurance or deductible applies.
- r.** Outpatient-Professional-True Primary Care Physician (processed as a PCP): \$25 copay; no coinsurance or deductible applies.
- s.** Outpatient-Professional-Specialist: \$45 copay; no coinsurance or deductible applies.
- t.** Outpatient-Professional-Preventive ACA: \$0 copay; no coinsurance or deductible applies.
- u.** Outpatient-Professional-Behavioral Health: \$25 copay; no coinsurance or deductible applies.
- v.** Outpatient-Professional-Infertility: \$0 copay; deductible and 30% coinsurance apply.
- w.** Outpatient-Professional-Anesthesia: \$0 copay; no coinsurance or deductible applies.
- x.** Outpatient-Professional-Venipuncture: \$0 copay; no coinsurance or deductible applies.

- y. Office-True Primary Care Physician (processed as a PCP): \$25 copay; no coinsurance or deductible applies.
- z. Office- Specialist: \$45 copay; no coinsurance or deductible applies.
- aa. Office-Preventive ACA: \$0 copay; no coinsurance or deductible applies.
- bb. Office-Radiological Advanced: \$75 copay; no coinsurance or deductible applies.
- cc. Office-PT/OT/ST: \$ 0 copay; coinsurance and deductible apply.
- dd. Office-Anesthesia: \$0 copay; no coinsurance or deductible applies.
- ee. Office-Behavioral Health: \$25 copay; no coinsurance or deductible applies.
- ff. Office-Infertility: \$0 copay; deductible and 30% coinsurance apply.
- gg. Office-Venipuncture: \$0 copay; no coinsurance or deductible applies.
- hh. Home Health-All: \$0 copay; coinsurance and deductible apply.
- ii. Other Non-ACA Preventive Care: To the extent not otherwise covered under ACA Preventive care, the following other preventive measures provided under Article 7 will have cost shares provided in those Paragraphs: Mammography (7.14), Pap Test (7.16), Well Care (7.19), Preventive Screenings for Employees (7.20), and Colonoscopy (7.23).

B. Tier B: State Health Plan Networks

1. **Deductible.** The annual Individual Deductible for care delivered by a provider participating in the State Health Plan Ambulatory Surgical Center Network, State Health Plan Hospital Network, or State Health Plan Physician Network shall be \$515, and a Covered Person shall pay annually the first \$515 of the Allowed Amount for Covered Medical Benefits Incurred in the Plan Year before becoming eligible for Plan benefits under Tier B. Copayments do not apply toward satisfaction of the Deductible, and Copayments continue to apply after the Deductible has been met. The annual Family Deductible shall be \$1,030. Payment of Deductible amounts by any two or more Family members totaling \$1,030 of Covered Medical Benefits for that Plan Year shall satisfy the Deductible for all Covered Persons in that Family. If an Employee's spouse is covered by the Standard State Health Plan Family, the Employee and Spouse shall share the Tier B State Health Plan Networks Deductible. Amounts paid by a Covered Person for allowed charges under any tier of the Plan, other than Copayments, are counted toward the Tier A Deductible or the Tier B/Tier C Deductible without distinction. Thus, amounts required to be paid by the Covered Person because an applicable Deductible has not been met in any tier count toward the satisfaction of the Tier A Deductible and the Tier B/Tier C Deductible.
2. **Medical Benefit Coinsurance.** After the Individual or Family Deductible has been met for

the Plan Year, the Plan will pay 80% of the Allowed Amount for the Covered Person's Covered Medical Benefits, for care delivered by a provider participating in the State Health Plan Ambulatory Surgical Center Network, State Health Plan Hospital Network, or State Health Plan Physician Network. Copayments continue to apply after the Deductible has been met.

- 3. Medical Benefit Coinsurance Maximum.** For care delivered within the State Health Plan Ambulatory Surgical Center Network, State Health Plan Hospital Network or State Health Plan Physician Network, after the annual Deductible has been met and a Covered Person has Incurred Coinsurance of \$3,000 for Covered Medical Benefits in the Plan Year, or Coinsurance of \$6,000 for Covered Medical Benefits have been Incurred in the Plan Year by any combination of Family members, the Plan will pay 100% of the Allowed Amount of the Covered Person's Covered Medical Benefits, except that Copayments continue up to apply after the Medical Benefit Coinsurance Maximum has been reached. Coinsurance amounts paid by a Covered Person in either Tier A or Tier B will count toward both the Tier A and Tier B Coinsurance Maximum; however amounts Incurred under Tier C do not count toward the Coinsurance Maximum related to care delivered under Tier A or Tier B, and amounts Incurred under Tier A or Tier B do not count toward the Coinsurance Maximum related to care delivered under Tier C. Provided that the penalty in Paragraph 3 above is not included in those expenses used to satisfy the Coinsurance Maximum, and provided further, that the Covered Medical Benefits Incurred for such treatment or during such admission are always subject to Coinsurance. To the extent the Covered Person participates in any copayment assistance program through a pharmaceutical manufacturer, the amounts received will not contribute to the Covered Person's Coinsurance Maximum.
- 4. Shared Medical Benefit Coinsurance Maximum.** The payments for Covered Medical Benefits that may satisfy the Deductible and Coinsurance Maximum provisions of Paragraphs 7.1.B.1 and 7.1.B.3 are those Incurred by one or more Covered Family members enrolled in the Plan or the State Health Plan.
- 5. Copayments.** In addition to the Deductible referenced in Paragraph 7.1.B.1., separate Copayments will be applied to care delivered by a provider participating in the State Health Plan Ambulatory Surgical Center Network, State Health Plan Hospital Network or State Health Plan Physician Network to a Covered Person under Tier B of the Plan:

 - a.** \$193 per Emergency Room visit, to be waived if the patient is admitted to the hospital.
 - b.** \$115 per Outpatient Hospital visit, to be waived for Emergency Room services, oncology services, dialysis, clinic visits (an office visit at an outpatient facility), partial hospitalization, intensive outpatient services, electric-convulsive therapy, and psychiatric medication management. The Outpatient Hospital copay is reduced to the office visit copay in Subparagraph 7.1.B.5.c. per visit for physical therapy services, speech therapy services, occupational therapy services, cardiac rehabilitation and for pulmonary rehabilitation.
 - c.** \$15 per office visit.

Copayments under this Paragraph are not included in those expenses used to satisfy the Deductibles in Paragraph 7A.1.B.1 or the Coinsurance Maximum referenced in Paragraph 7A.1.B.3.

C. Tier C: Out-of-Network

- 1. Deductible.** The annual individual Deductible for care delivered by a provider not participating in the MUSC Hospital Network, MUSC Physician Network, State Health Plan Ambulatory Surgical Center Network, State Health Plan Hospital Network, or State Health Plan Physician Network shall be \$515, and a Covered Person shall pay annually the first \$515 of the Allowed Amount for Covered Medical Benefits Incurred in the Plan Year before becoming eligible for Plan benefits under Tier C. Copayments do not apply toward satisfaction of the Deductible, and Copayments continue to apply after the Deductible has been met. The annual Family Deductible shall be \$1,030. Payment of Deductible amounts by any two or more Family members totaling \$1,030 of Covered Medical Benefits for that Plan Year shall satisfy the Deductible for all Covered Persons in that Family. If an Employee's spouse is covered by the Standard State Health Plan, the Employee and Spouse shall share the Tier C Out-of-Network Deductible. Amounts paid by a Covered Person for allowed charges under any tier of the Plan, other than Copayments, are counted toward the Tier A Deductible or the Tier B/Tier C Deductible without distinction. Thus, amounts required to be paid by the Covered Person because an applicable Deductible has not been met in any tier count toward the satisfaction of the Tier A Deductible and the Tier B/Tier C Deductible.
- 2. Medical Benefit Coinsurance.** After the individual or Family Deductible has been met for the Plan Year, the Plan will pay 60% of the Allowed Amount for the Covered Person's Covered Medical Benefits for care delivered by a provider not participating in the MUSC Health Plan Hospital Network, MUSC Health Plan Physician Network, State Health Plan Ambulatory Surgical Center Network, State Health Plan Hospital Network, or State Health Plan Physician Network. Copayments continue to apply after the Deductible has been met.
- 3. Coinsurance Maximum.** For care delivered by a provider not participating in the MUSC Health Plan Hospital Network, MUSC Health Plan Physician Network, State Health Plan Ambulatory Surgical Center Network, State Health Plan Hospital Network or State Health Plan Physician Network, after the annual Deductible has been met and a Covered Person has Incurred Coinsurance of \$6,000 for Covered Medical Benefits in the Plan Year, or Coinsurance of \$12,000 for Covered Medical Benefits have been Incurred in the Plan Year by any combination of Family members, the Plan will pay 100% of Allowed Amount of the Covered Person's Covered Medical Benefits, except that Copayments continue to apply after the Medical Benefit Coinsurance Maximum has been reached. Amounts Incurred under Tier C do not count toward the Coinsurance Maximum related to care delivered under Tier A or Tier B, and amounts Incurred under Tier A or Tier B do not count toward the Coinsurance Maximum related to care delivered under Tier C. Provided that the penalty in Paragraph 3 above is not included in those expenses used to satisfy the Coinsurance Maximum, and provided further, that the Covered Medical Benefits Incurred for such treatment or during such admission are always subject to Coinsurance. To the extent the Covered Person participates in any copayment assistance program through a

pharmaceutical manufacturer, the amounts received will not contribute to the Covered Person's Coinsurance Maximum.

4. **Shared Out-of-Pocket Maximum.** The payments for Covered Medical Benefits that may satisfy the Deductible and Coinsurance Maximum provisions of Paragraphs 7.1.C.1 and 7.1.C.3 are those Incurred by one or more Covered Family members enrolled in the Plan or the State Health Plan.
5. **Copayments.** In addition to the Deductible referenced in Paragraph 7.1.C.1., separate Copayments will be applied to care delivered to a Covered Person receiving care from a provider not participating in the MUSC Health Plan Hospital Network, MUSC Health Plan Physician Network, State Health Plan Ambulatory Surgical Center Network, State Health Plan Hospital Network, or State Health Plan Physician Network under Tier C of the Plan:
 - a. \$193 per Emergency Room visit, to be waived if the patient is admitted to the hospital.
 - b. \$115 per Outpatient Hospital visit, to be waived for Emergency Room services, oncology services, dialysis, clinic visits (an office visit at an outpatient facility), partial hospitalization, intensive outpatient services, electric-convulsive therapy, and psychiatric medication management. The Outpatient Hospital copay is reduced to the office visit copay in Subparagraph 7.1.C.5.c. per visit for physical therapy services, speech therapy services, occupational therapy services, cardiac rehabilitation and for pulmonary rehabilitation.
 - c. \$15 per office visit.

Copayments under this Paragraph are not included in those expenses used to satisfy the Deductibles in Paragraph 7A.1.C.1 or the Coinsurance Maximum referenced in Paragraph 7A.1.C.3.

7.2 Maximum Out of Pocket Limits

The Maximum Out-of-Pocket Limit during a Plan Year is Cost Sharing of \$8,150 for an individual and Cost Sharing of \$16,300 for any combination of covered Family members. The Plan will pay 100% of the Allowed Amount with respect to Covered Medical Benefits and there is no Copayment with respect to the Prescription Drug Program after the Maximum Out-of-Pocket Limit has been reached during a Plan Year. The Maximum Out-of-Pocket Limit applies regardless of whether the Covered Person has met the Medical Benefits Coinsurance Maximum during the Plan Year in any tier. Cost sharing amounts Incurred under Tier C, penalties imposed under the Plan (e.g., for failing to follow Prior Authorization requirements), premiums, and balance-billed charges to not count toward the Maximum Out-of-Pocket Limit.

7.3 Covered Medical Benefits

Covered Medical Benefits include the following:

- A. Charges made by a Physician or Behavioral Health Provider, as those terms are defined in this Plan, except as they may be limited by any provision of the Plan, but not to exceed the Allowed Amount or the Provider's Billed Charge, whichever is less.

The benefits for Chiropractic Services are for services relating to spinal subluxation, including the detection and correction by manual or mechanical means (including x-rays incidental thereto) of structural imbalance, distortion, or subluxation in the human body for the removal of nerve interference where such interference is the result of or related to distortion, misalignment, or subluxation of or in the vertebral column. The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment. The manipulative services rendered must have a direct therapeutic relationship to the patient's condition. Spinal axis aches, sprains, nerve pains, and functional disabilities of the spine are considered to provide therapeutic grounds for chiropractic treatment. Most other non-spinal diseases and pathological disorders do not provide therapeutic grounds for chiropractic treatment; examples of these types of diseases and disorders are rheumatoid arthritis, muscular dystrophy, multiple sclerosis, pneumonia, and emphysema. The maximum amount payable for Chiropractic Services for the Plan Year is \$2,000.

- B.** The benefits for services of a podiatrist, acting within the scope of their license, are payable only to the extent that benefits under this Plan will not exceed benefits that would have been paid to an M.D. or D.O. for treatment of the given condition, except that no payment is provided when the services consist of, either in whole or in part, the removal of corns, callosities, hypertrophy, or hyperplasia of the skin or any subcutaneous tissues, or the cutting, trimming, or other partial removal of toenails;
- C.** Blood transfusions, including the cost of blood and blood plasma, either inpatient or outpatient, but excluding blood and blood products replaced by donors and related storage fees.
- D.** Licensed registered nurse charges for nursing care in a Hospital where no special care units are provided.
- E.** Nursing care charges for services provided in the home by a licensed registered nurse if Medically Necessary, or by licensed practical nurses, if appropriate, provided in the home by a home health agency certified by the State of South Carolina, subject to Prior Authorization by the Utilization Review Agency.
- F.** Rental cost, up to the purchase price, of Durable Medical Equipment required for temporary therapeutic use by an individual Covered Person for a specific condition when such equipment is ordinarily used under the direction of a Physician and it has received Prior Authorization by the Utilization Review Agency. If such equipment is not available for rent, the monthly payments toward the purchase of the equipment may be approved by the Plan. Life sustaining Durable Medical Equipment will be covered only as a rental.

Equipment, including Durable Medical Equipment, which has a non-therapeutic use, purchased or requested by the Covered Person with or without a prescription including but not limited to home and vehicle modifications; an air conditioner; air filter or air filtration system; wigs, hairpiece, or any other artificial device or procedure to replace scalp hair; dehumidifier; home whirlpool; exercise equipment; ace bandages; shoe supports; knee braces; and bandages, gauze, and similar equipment are not Covered Medical Benefits.

- G.** Medical supplies, limited to the following:
 - 1.** Syringes, and related supplies, for conditions such as diabetes;

2. Dressings, for conditions such as cancer or burns;
3. Catheters;
4. Colostomy bags and related supplies;
5. Test tape;
6. Necessary supplies for renal dialysis equipment or machines; and
7. Surgical trays.

Supplies and equipment that have solely non-therapeutic uses are not Covered Medical Benefits.

H. Ambulance transport, subject to the following:

1. Professional ground or air ambulance services for Emergency transportation to the nearest Hospital within the United States providing the necessary service as an immediate response to an accidental injury or Medical Emergency.
2. Prior Authorization is required for:
 - a. Professional ground or air ambulance services for transportation from one Hospital to another Hospital. Such transport will be covered if:
 - (i) The first Hospital cannot provide necessary services that the second hospital can provide (e.g., burn care, cardiac care, trauma care, and critical care);
 - (ii) The second Hospital is the nearest medically appropriate facility that can provide the necessary services; and
 - (iii) The ambulance transport is Medically Necessary, as determined by the Third Party Claims Processor.

Air ambulance transport will only be Authorized under this Subparagraph if ground transport would endanger the Covered Person's medical condition and the transport is not related to a hospitalization outside of the United States.

- b. Non-emergency transport, including, but not limited to, routine transportation to a facility for scheduled medical or surgical treatments, and transportation from a higher level of care to a lower level of care (e.g., transportation from inpatient hospital care to a rehabilitation facility or hospice care).

Air ambulance transport will only be Authorized under this Subparagraph if ground transport would endanger the Covered Person's medical condition and the transport is not related to a hospitalization outside of the United States.

No benefits are payable for transport that requires but does not receive Prior Authorization under this Subparagraph, whether due to denial or the Covered Person's failure to request Prior Authorization.

- I. Prosthetic Appliances necessary for the correction of conditions caused by trauma or disease and that restore a function to the body. The Plan will provide benefits for the replacement of those prosthetic appliances that assist the body to function when the replacement is Medically Necessary and required by wear to the appliance or growth of the Covered Person. Charges for Prosthetic Appliances that have solely non-therapeutic uses, including a wig or hairpiece, are not Covered Medical Benefits.
 - 1. The Plan provides benefits that are consistent with the Women's Health and Cancer Rights Act, which requires coverage for prostheses and physical complications at all states of a mastectomy. Accordingly, the Plan covers the initial breast prosthesis and subsequent replacements thereof for Covered Persons undergoing a Medically Necessary mastectomy.
 - 2. The Plan provides in-network and out-of-network benefits for bone-anchored hearing aids and bone-anchored hearing aid supplies (such as batteries) for Covered Persons age 18 and under with hearing loss resulting from a congenital or surgically-induced malformation of the external ear canal or middle ear, when determined medically necessary by the medical policies of the Third Party Claims Processor or Utilization Review Agency, and subject to the normal Plan Copayment, Deductible, and Coinsurance requirements.
 - a. Benefits for bone-anchored hearing aids are provided no more frequently than once every three years, up to \$2,500 per appliance, and subject to normal Plan rules regarding network status.
 - b. Bone-anchored hearing aid supplies (such as batteries) are covered with no dollar or frequency limitations, and subject to normal Plan rules regarding network status.
- J. Oxygen and rental of equipment for its administration outside of a Hospital.
- K. Orthopedic braces, crutches, lifts attached to braces, and orthopedic shoes that are Medically Necessary and required by a specific diagnosis. Orthopedic shoes are limited to one pair per six-month interval. Supplies or shoes that have solely non-therapeutic uses are not a Covered Medical Benefit.
- L. Occupational and physical therapy services, when provided by a licensed Occupational Therapist or Physical Therapist.
- M. Treatment of Behavioral Health Disorders, Alcoholism, and Drug Abuse in the outpatient department of a Hospital or outside of a Hospital, limited to the benefits specified in Paragraph 7.8, and, where applicable, subject to Prior Authorization by the Behavioral Health Manager.
- N. Inpatient treatment in a Hospital of Behavioral Health Disorders, Alcoholism, and Drug Abuse, up to the benefits specified in Paragraph 7.8 in a Hospital, and, where applicable, subject to Prior

Authorization by the Behavioral Health Manager.

- O.** Speech Therapy. The Plan covers short-term speech therapy to restore speech or swallowing function to a person who has lost existing speech (the ability to express thoughts, speak words, and form sentences) or swallowing function as a result of non-chronic disease or injury. Speech therapy must be prescribed by a physician and rendered by a licensed speech therapist.

The Plan covers habilitation speech therapy services for Covered Persons ages 6 and under. Otherwise, the speech therapy benefit is provided for acute phase treatment only, in accordance with the therapeutic goals of a written treatment plan. Maintenance speech therapy is not covered. Benefits are provided only to the extent that documented, functional progress is occurring to achieve the therapeutic goals of a written treatment plan.

Speech therapy requires Prior Authorization by the Utilization Review Agency when provided in a home setting. Notwithstanding the Prior Authorization requirement, any claim for speech therapy services may be reviewed by the Third-Party Claims Processor for Medical Necessity after the claim is submitted.

The Plan does not cover speech therapy associated with the following:

- 1.** Services rendered for the treatment of delays in speech development for Covered Persons ages 7 and older, unless the speech delay is due to a specific non-chronic disease, brain injury, or congenital defect (e.g., cleft palate, cleft lip, etc.).
 - 2.** Speech therapy for dysfunctions that are self-correcting, such as natural dysfluency or developmental articulation errors.
 - 3.** Speech therapy for verbal apraxia or stuttering/stammering unless due to a specific disease or brain injury.
 - 4.** Speech therapy associated with any of the following conditions:
 - a.** Behavioral disorders;
 - b.** Attention disorders;
 - c.** Conceptual handicap; and
 - d.** Intellectual disability.
- P.** Dental care and treatments, dental surgery, or dental applications, limited to:
- 1.** Allowed Amount for Physician services for excision or extraction of bony impacted teeth, when supported by dental X-rays.
 - 2.** Hospital services for excision or extraction of three or more bony impacted teeth, when supported by dental X-rays, and in connection with dental services, if the procedure is of such complexity as to require hospitalization or if hospitalization is required to ensure

proper medical management, control, or treatment of a non-dental physical condition, when Prior Authorization has been obtained from the Utilization Review Agency.

- 3.** Allowed Amount for natural and artificial teeth, dentures, bridges, etc., made necessary by accidental bodily injury occurring while a Covered Person is continuously covered, limited to care begun within 365 days of such accident, and while the Covered Person remains continuously covered under this Plan.
- 4.** Allowed Amount for natural and artificial teeth, dentures, bridges, etc., made necessary by loss of teeth due to cancer treatment or as a result of a congenital birth defect.

Q. Subject to the general provisions of the Plan, and specifically Paragraph 8.7(D), major human organ transplant procedures are eligible for benefits under the Plan as specified below:

- 1.** Specified major human organ transplant procedures are Covered Medical Benefits of this Plan when such procedures conform to the following circumstances:
 - a.** Covered procedures are liver, lung (single or double), heart, heart/lung, kidney, intestinal, and pancreas transplants;
 - b.** In order for benefits to be available for the above major organ transplant procedures listed in Paragraph A, pre-approval in writing must be obtained from the Utilization Review Agency;
 - c.** Covered Medical Benefits resulting from, or directly related to, the completion of one of the above organ transplant procedures are subject to the Deductible amount and Coinsurance specified in the Plan;
 - d.** The transplant procedure is performed by a member of the Transplant Network; and
 - e.** The organ transplant is the only treatment for the illness or injury that has an equivalent or better prognosis than an alternative form of treatment.
- 2.** Allogeneic or syngeneic bone marrow transplants or other forms of stem cell rescue (with or without high dose chemotherapy or radiation) are available for benefits under the following conditions:
 - a.** There are no other recognized treatments that provide the Covered Person with an equivalent or better prognosis;
 - b.** Bone marrow transplantation is the Covered Person's only reasonable opportunity to survive;
 - c.** The Utilization Review Agency and the Third-Party Claims Processor recommend that the Covered Person is an acceptable candidate for the treatment; and
 - d.** The bone marrow transplant is performed by a member of the Transplant Network that has accepted the Covered Person as a candidate for the transplant using

generally accepted standards for the procedure.

- 3.** Autologous bone marrow transplants or other forms of autologous stem cell rescue (in which the Covered Person is the donor) with high dose chemotherapy or radiation, is covered, provided the Covered Person meets the following criteria:

 - a.** There are no other recognized treatments that provide the Covered Person with an equivalent or better prognosis;
 - b.** The autologous bone marrow transplantation or peripheral stem cell rescue with high dose chemotherapy is the Covered Person's only reasonable opportunity to survive;
 - c.** Both the Utilization Review Agency and the Third-Party Claims Processor recommend that the Covered Person is an acceptable candidate for the treatment; and
 - d.** The bone marrow transplant is performed by a member of the Transplant Network that has accepted the Covered Person as a candidate for the transplant using generally accepted standards for the procedure
- 4.** The Plan will pay benefits for a major human organ transplant listed in Paragraphs 1–3 above performed in a Hospital that is not a member of the Transplant Network only if all of the following additional conditions are met:

 - a.** The Covered Person is otherwise eligible for a transplant and has been approved by the Utilization Review Agency for the transplant; and
 - b.** The Covered Person has been accepted as a candidate for the transplant by a facility that used generally accepted standards for the procedure.
- 5.** The following transplants of tissue (rather than whole major organs) are eligible for benefits under this Plan when Medically Necessary. Such procedures are subject to all the provisions of this Plan, and prior approval in writing must be obtained from the Utilization Review Agency:

 - a.** Blood transfusions;
 - b.** Autologous parathyroid transplants;
 - c.** Corneal transplants;
 - d.** Bone and cartilage grafting; and
 - e.** Skin grafting.

No other tissue transplant procedures are covered unless it can be determined that: (i) there are no other recognized treatments that provide the Covered Person with a better prognosis for the illness or injury; (ii) the tissue transplant is the only treatment for the illness or injury that has an equivalent or better prognosis than an alternative form of

treatment; and (iii) the Utilization Review Agency, the Third-Party Claims Processor, and the facility performing the procedure, using generally recognized standards, recommend that the Covered Person is an acceptable candidate for treatment.

6. All medical costs Incurred in the identification of a donor, including surgical, storage, and transportation expenses directly related to the donation of an organ used in a covered organ transplant procedure for liver, lung (single or double), heart, heart/lung, kidney, pancreas, kidney/pancreas, intestinal, and bone marrow transplants are subject to a maximum payment hereunder of \$10,000 for each such procedure completed;
 7. Transportation expenses to and from the site of a covered organ transplant procedure for liver, lung, heart, heart/lung, kidney, intestinal, bone marrow or pancreas are covered for the Covered Person who is the transplant recipient and one other individual. If the recipient is a minor, transportation costs are covered for two other individuals accompanying the recipient. All reasonable and necessary lodging and meal expenses are covered, up to a daily maximum of \$150 per individual accompanying the recipient. The aggregate sum of transportation, lodging, and meal expenses under this Subparagraph shall not exceed \$10,000 for expenses Incurred within five days immediately prior to and 365 days immediately following a covered organ transplant procedure. These transportation expenses are specifically for transportation of the Covered Person and an accompanying individual to the site of the transplantation. This benefit is not available for transportation expenses related to evaluation of a Covered Person for an organ transplant procedure.
- R. Telehealth:** The Plan will pay Covered Expenses for Telehealth services which are initiated by either a Covered Person or Provider and are provided by licensed health care professionals who have been credentialed as eligible Telehealth Providers.
- S. Telemedicine:** The Plan will pay Covered Expenses for Telemedicine services under the following circumstances:
1. The medical care is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and not in excess of the Covered Person's need;
 2. The medical care can be safely furnished, and there is no equally effective, more conservative, and less costly treatment available; and
 3. Consulting and referring Providers must be Participating Contracting Providers who have been credentialed as eligible Telemedicine Providers by the Third-Party Claims Administrator.

Office and outpatient visits that are conducted via Telemedicine are counted towards any applicable Benefit limits for these services.

Examples of interactions that are not reimbursable Telemedicine services and will not be reimbursed include, but are not limited to, (i) telephone conversations, (ii) e-mail messages, (iii)

facsimile transmissions, or (iv) internet-based audio-video communication that is not secure and HIPAA-compliant (e.g., Skype).

7.4 Hospital or Ambulatory Surgical Center Benefits

Upon receipt of due proof satisfactory to the Third-Party Claims Processor that a Covered Person while covered under this Plan has Incurred expenses that are recommended and approved by a Physician for inpatient Hospital care or outpatient care at a Hospital or Ambulatory Surgical Center for diagnosis or treatment of an illness or injury, the Plan, subject to all the terms, conditions, limitations, and exclusions contained in the Plan, including the Deductible and Coinsurance requirements, will pay benefits for the following Hospital or Ambulatory Surgical Center Charges:

- A. Inpatient Hospitals In-Network — Fixed Rate DRG or Per Diem.** The Plan will pay to a Hospital in the Hospital Network compensation calculated from the applicable fixed rate DRG or per diem rate provided in the agreement between the Planholder and the In-Network Hospital as full payment for the Plan's share of the inpatient, Medically Necessary, Covered Medical Benefits rendered to a Covered Person by the Hospital. The Subscriber payment to the Hospital shall be limited to the appropriate Deductible or Coinsurance calculated from the lesser of (i) the fixed rate DRG or per diem rate established in the Agreement or (ii) the Provider's Billed Charge. The Subscriber is responsible for any other charges for goods or services that are not Medically Necessary or not covered by the Plan that were Incurred with the specific consent of the Covered Person.
- B. Out-of-Network Inpatient Hospital — Fixed Rate DRG or Per Diem.** The Plan will pay to a Hospital compensation calculated from the lesser of (i) the applicable fixed rate DRG or per diem rate established for In-Network Hospitals or (ii) the Provider's Billed Charge as full payment of the Plan's share of Medically Necessary, Covered Medical Benefits rendered to a Covered Person by the Hospital.
- C. Outpatient Hospitals In-Network — APC Priced.** The Plan will pay to a Hospital in the Hospital Network compensation calculated from the applicable Ambulatory Patient Classifications (APC) rate provided in the agreement between the Planholder and the In-Network Hospital as full payment for the Plan's share of the outpatient, Medically Necessary, Covered Medical Benefits rendered to a Covered Person by the Hospital. The Subscriber payment to the Hospital shall be limited to appropriate Deductible or Coinsurance calculated from the lesser of (i) the APC rate established in the Agreement or (ii) the Provider's Billed Charge. The Subscriber is responsible for any other charges for goods or services that are not Medically Necessary or not covered by the Plan that were Incurred with the specific consent of the Covered Person.
- D. Out-of-Network Outpatient Hospital — APC Priced.** The Plan will pay to a Hospital compensation calculated from the lesser of (i) the applicable APC rate established for In-Network Hospitals or (ii) the Provider's Billed Charge as full payment of the Plan's share of outpatient, Medically Necessary, Covered Medical Benefits rendered to a Covered Person by the Hospital.
- E. Ambulatory Surgical Centers in Networks — Payment Group Priced.** The Plan will pay to an Ambulatory Surgical Center in the Ambulatory Surgical Center Network compensation calculated from the applicable Payment Group rate provided in the agreement between the Planholder and the In-Network Ambulatory Surgical Center as full payment for the Plan's share of the Medically Necessary, Covered Medical Benefits rendered to a Covered Person by the Ambulatory Surgical

Center. The Subscriber payment to the Ambulatory Surgical Center shall be limited to appropriate Deductible or Coinsurance calculated from the lesser of (i) the Payment Group rate established in the Agreement or (ii) the Provider's Billed Charge. The Subscriber is responsible for any other charges for goods or services that are not Medically Necessary or not covered by the Plan that were Incurred with the specific consent of the Covered Person.

- F. Out-of-Network Ambulatory Surgical Centers — Payment Group Priced.** The Plan will pay to an Ambulatory Surgical Center compensation calculated from the lesser of (i) the applicable Payment Group rate established for Ambulatory Surgical Centers or (ii) the Provider's Billed Charge as full payment of the Plan's share of Medically Necessary, Covered Medical Benefits rendered to a Covered Person by the Ambulatory Surgical Center.

G. Charges by DRG, Per Diem, APC, or Payment Group

- 1. Hospital Room and Board.** In all cases not payable as provided in Paragraphs A through F above, the Plan will pay the lesser of the Provider's Billed Charge or the Allowed Amount for the semi-private room, board, and general nursing care for the Covered Person, and the lesser of the Provider's Billed Charge or the Allowed Amount for a newborn Child delivered from the Covered Person. When Medically Necessary, the Plan will pay the lesser of the Provider's Billed Charge or the Allowed Amount of an Intensive Care Unit. No benefit is provided for a bed accommodation "reserved" for a Covered Person in an intensive care facility.
- 2. Other Hospital Charges for Covered Services.** The Plan will pay the lesser of the Provider's Billed Charge or the Allowed Amount for Medically Necessary services, medicines, blood, blood plasma not replaced, and supplies for diagnosis or treatment of the illness or injury for which the Covered Person is confined (except services of a Physician, dentist, special nursing in any form, or drugs or supplies not consumed or used in the Hospital) and not exceeding the overall Plan maximum, provided:
 - a. The Covered Person is in the Hospital, confined as a bed patient; or
 - b. The Covered Person has surgery performed in the Hospital; or
 - c. The Covered Person received Medically Necessary Emergency treatment as a result of an accident or acute Emergency illness, or the Covered Person Incurred expenses for Emergency Professional Ambulance service to the Hospital for illness or injury; or
 - d. The Covered Person Incurred expenses for pre-admission diagnostic x-ray and laboratory services; or
 - e. The Covered Person Incurred expenses for administration of anesthesia. This does not include any charge made by the operating Physician, or their assistant, or any charges made for infiltration anesthesia.
- 3. Other Ambulatory Surgical Center charges for Covered Services.** The Plan will pay the lesser of the Provider's Billed Charge or the Allowed Amount for Medically Necessary services, medicines, blood, blood plasma not replaced, and supplies for diagnoses or

treatment of the illness or injury which the Covered Person receives on the day of services at the Ambulatory Surgical Center (except services of a Physician, dentist, special nursing in any form, or drugs or supplies not consumed in the Ambulatory Surgical Center) and not exceeding the Plan maximum provided:

- a. The Covered Person has outpatient surgery performed in the Ambulatory Surgical Center; or
- b. The Covered Person Incurred expenses for the administration of anesthesia. This does not include any charge made by the operating Physician, their assistant, or any charges made for infiltration anesthesia.

H. Limitation. No benefit shall be payable under 7.4, Hospital or Ambulatory Surgical Center Benefits, with respect to charges for care of the sick or injured made by any institution or facility that does not qualify as a Hospital or Ambulatory Surgical Center as defined in Article 2, Definitions.

7.5 Medical Surgical Benefits

Subject to all the terms, conditions, limitations and exclusions including the Deductible and Coinsurance requirements of the Plan, the Plan will pay benefits for services performed by a Physician to a Covered Person on or after the Effective Date of coverage for treatment and diagnosis of disease or injury or for Obstetrical services, as follows:

- A. Surgical Service**, which consists of operative or cutting procedures, or the treatment of fractures or dislocations; such service includes the usual, necessary and related preoperative and postoperative care, when performed by a Physician, subject to the following:
 - 1. If two 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 Allowed Amount for the major procedure only;
 - 2. If two 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 Allowed Amount for the operation or procedure bearing the highest allowance plus 50% of the Allowed Amount for all other operations or procedures performed;
 - 3. If an operation consists of the excision of multiple skin lesions, the total amount covered will be the Allowed Amount for the procedure bearing the highest allowance, 50% for the procedures bearing the second and third highest Allowed Amount, 25% for the procedures bearing the fourth through the eighth highest Allowed Amount, and 10% for all other procedures. If the operation consists of the excision of multiple malignant lesions, the total amount covered will be the Allowed Amount for the procedure bearing the highest allowance and 50% of the Allowed Amount for each subsequent procedure;
 - 4. If an operation or procedure is performed in two or more steps or stages, coverage for the entire operation or procedure will be limited to the Allowed Amount set forth for such operation or procedure;

5. If two or more Physicians perform operations or procedures in conjunction with one another, other than as an assistant at surgery or anesthesiologist, the Allowed Amount, subject to the above Paragraphs, will be covered for the services of only one Physician or will be prorated between them by the Plan when so requested by the Physician in charge of the case;
 6. Certain surgical procedures that normally are exploratory in nature are designated as "Independent Procedures" by the Plan, and the Allowed Amount is payable when such procedure is performed as a separate and single entity. However, when an Independent Procedure is performed as an integral part of another Surgical Service, the total amount covered will be the Allowed Amount for the major procedure only;
 7. Medically Necessary surgical correction of disorders of the temporomandibular joint will be covered by the Plan when there is documentation that there is anatomical derangement of the joint and there is significant symptomatology. Such disorders include displacement of the joint meniscus and/or other joint structures coupled with significant locking, clicking, popping, and pain sufficient to interfere with the patient's ability to speak, masticate food, and otherwise carry on normal oral functions. Pre-approval by the Utilization Review Agency for these procedures is required and the total amount covered will be the Allowed Amount for the procedure performed. Except as provided in this Subparagraph, however, services or supplies for temporomandibular joint conditions are not covered under the Plan. See Paragraph 9.KK.
 8. Medically Necessary surgical correction of skeletal mal-relationships or deformities of the jaws that cause documented chronic, persistent pain or debilitating loss of function and have required treatment or medication are covered by the Plan. The presence of a documented congenital anomaly alone does not establish Medical Necessity. Prior approval by the Utilization Review Agency is required. See Paragraph 9.LL.
- B. Surgical Assistant Service**, which consists of the Medically Necessary service of one Physician, Physician Assistant, or Nurse Practitioner who actively assists the operating surgeon when a covered Surgical Service is performed in a Hospital, and when such surgical assistant service is not available by an intern, resident, or house Physician. The Plan will cover charges equal to 20% of the Allowed Amount for the Surgical Service, not to exceed the Provider's Billed Charge.
- C. Anesthesia Service**, which consists of services rendered by a Physician or a certified registered nurse anesthetist, other than the attending surgeon or their assistant, and includes the administration of spinal or rectal anesthesia, or the administration of 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 preoperative anesthesia consultation.
- D. In-Hospital Medical Service**, which consists of a Physician's visit or visits to a Covered Person who is a registered bed patient in a Hospital or Skilled Nursing Facility for treatment of a condition other than that for which Surgical Service or obstetrical service is required, as follows:
1. In-Hospital medical benefits will be provided based on the Provider's Billed Charge but not to exceed the Allowed Amount;

2. In-Hospital medical benefits primarily for treatment of mental or nervous conditions, Alcoholism, or Drug Abuse will be provided for each Covered Person subject to limitations of Paragraph 7.8;
 3. In-house medical benefits in a Skilled Nursing Facility will be provided for the visits of a Physician, limited to one visit per day, not to exceed 60 visits;
 4. When two or more Physicians render in-Hospital medical visits at the same time, payment for such services will be made only to one Physician;
 5. Concurrent Medical/Surgical Care benefits for in-Hospital medical services, in addition to benefits for Surgical Service, will be provided only: (i) when the condition for which in-Hospital medical services requires medical care not related to surgical or obstetrical service and does not constitute a part of the usual, necessary, and related preoperative or post-operative care but requires supplemental skills not possessed by the attending surgeon or their assistant, (ii) when a Physician, other than a surgeon, admits a Covered Person to the Hospital for medical treatment and it later develops that surgery becomes necessary, such benefits to cease on the date of surgery, or (iii) when the surgical procedure performed is designated by the Administrator as a "warranted diagnostic procedure" or as a "minor surgical procedure;"
 6. When the same Physician renders different levels of care on the same day, benefits will only be provided for the highest level of care.
- E. **Intensive Medical Care Service**, which consists of medical care rendered by the attending Physician to a Covered Person who is eligible for in-Hospital medical service or Medical Care in the Outpatient department of a Hospital immediately prior to an admission, and who is confined with a serious disease or injury requiring additional time and study over and above the usual in-Hospital medical service.
- F. **Consultation Service**, which consists of services of a consulting Physician, requested by the attending Physician and rendered during an admission. This service is limited to one consultation per consulting Physician for each continuous period of disability and includes discussion with the attending Physician and family, and a written expression of opinion by the consultant based on examination of the patient. Consultation service does not include radiological consultations and staff consultations required by institutional rules and regulations, nor when primary care of the patient is transferred to the Physician providing consultation service.
- G. **Obstetrical Care** shall refer to services for the prenatal and postpartum care and delivery of one or more fetuses, as well as in-Hospital medical service for conditions related directly to pregnancy, limited to the Allowed Amount for the delivery only.
- H. **Pediatric Medical Care**, which consists of the initial inpatient examination of the newborn when such care is given by a Physician other than the delivering Physician or the Physician who administered anesthesia during delivery.
- I. **Radiation Therapy Service**, which consists of the use of x-ray, radium, or radioactive isotopes in the treatment of disease, when ordered by the attending Physician. Benefits for radiation therapy

service are provided only when a Physician performs the service.

J. Diagnostic X-Ray and Laboratory and Pathological Services, which consist of the following, only when a Physician performs or orders the service:

1. X-ray examinations, laboratory, and pathological services ordered by the attending Physician for a Covered Person who is a registered bed patient in a Hospital, Skilled Nursing Facility, or admitted at an Ambulatory Surgical Center;
2. X-ray examinations, laboratory and pathological services, wherever performed, when such examination or service is required as the direct result of an accident, for the initial visit only; and
3. X-ray examinations, laboratory and pathological services wherever performed, when rendered on the same day and when directly related to surgery.

7.6 Outpatient Diagnostic Services

Subject to all terms, conditions, limitations and exclusions, including the Deductible and Coinsurance requirements of this Plan, the Plan will pay for the following outpatient diagnostic services only when such service is performed or ordered by a Physician:

- A. Diagnostic X-ray examinations for the diagnosis of an illness or injury; and
- B. Clinical laboratory and tissue diagnostic examinations and medical diagnostic procedures for the diagnosis of an illness or injury. The Physician charges for any machine-generated tests are not a Covered Medical Benefit under this Plan.

7.7 Human Organ Transplants

Subject to all the terms, conditions, limitations and exclusions of the Plan, including the Deductible and Coinsurance requirements of the Plan, the Plan will provide benefits to a Covered Person when hospitalized for a human organ or tissue transplant from a living donor or a donor under a living will to a transplant recipient that requires the surgical removal of the donated part, subject to the following conditions:

- A. When both the transplant recipient and the donor are Covered Persons, benefits will be provided for both;
- B. When the transplant recipient is a Covered Person and the donor is not, benefits will be provided for both recipient and donor, to the extent that benefits to the donor are not provided by any other source. This includes, but is not limited to, other insurance coverage, other Blue Cross Blue Shield coverage, any government program, or any employee welfare benefit plan. Benefits provided to the donor will be charged against the recipient's coverage under the Plan and are limited only to charges arising out of the surgical removal of the donated part;
- C. When the transplant recipient is not a Covered Person and the donor is, the donor will receive benefits to the extent that such benefits are not provided by any coverage available to the recipient of the organ or tissue transplant procedure. This includes, but is not limited to, other insurance

coverage, other Blue Cross Blue Shield coverage, any government program, or any employee welfare benefit plan. Benefits will not be provided to a non-eligible transplant recipient.

7.8 Behavioral Health Disorders

Subject to all the terms, conditions, limitations, and exclusions of the Plan, and including the requirements herein, the Plan will pay covered expenses for inpatient, outpatient, or Partial Hospitalization Programs rendered by a Behavioral Health Provider for Behavioral Health Disorders, Alcoholism, and Drug Abuse. All care must be in accordance with the utilization guidelines established by the Behavioral Health Manager for specified levels of care, and, where applicable, receive Prior Authorization by the Behavioral Health Manager. Notwithstanding anything in this Plan to the contrary, in accordance with the Mental Health Parity Act of 1996 (Act), as amended, and any regulations issued thereunder, the Plan will provide parity in the application of aggregate lifetime and annual dollar limits for mental health and substance use disorder benefits as compared with other dollar limits for medical benefits. The Plan will not place financial requirements or treatment limitations on mental health and substance use disorder benefits that are more restrictive than the most common financial requirements and treatment limitations placed on other medical benefits, as such requirements and limitations placed on other medical benefits are set forth in the Schedule of Benefits. To the extent the Plan provides out-of-network coverage for other medical benefits, it will also provide out-of-network coverage for mental health and substance use disorder benefits. This Paragraph shall not apply to any Plan Year in which the Plan meets the cost exemption under Section 712(c)(2) of the Act and the Plan Administrator, in its sole discretion, chooses to apply such exemption. The criteria for a medical necessity determination made under this Plan with respect to mental health or substance use disorder benefits shall be made available by the Plan Administrator to any current or potential Covered Person, beneficiary, or contracting Provider upon request.

7.9 Extended Care Programs

Subject to all of the terms, conditions, limitations, and exclusions of the Plan, and the requirements specified herein, the Plan will provide coverage for the extended care programs for Skilled Nursing Facility, Hospice Care, Alternative Treatment Plan, and Home Health Care services as provided in Paragraphs 7.10 to 7.13 below.

7.10 Skilled Nursing Facility

Subject to all the terms, conditions, limitations, and exclusions of the Plan, including the limitation on Physician visits under Paragraph 7.5.D.3 and the requirement that all admissions and readmissions to a Skilled Nursing Facility receive Prior Authorization by the Utilization Review Agency, the Plan will provide benefits for the Allowed Amount for room, board, and a skilled nursing level of treatment in such facility for up to 60 days in any Plan Year.

7.11 Hospice Care

Subject to all the terms, conditions, limitations, and exclusions of the Plan, and including the requirements herein, the Plan will pay covered Hospice expenses subject to the following conditions:

- A.** The Covered Person is diagnosed as having a terminal illness with a life expectancy of six months or less;
- B.** Admission into the Hospice program is Authorized by the Utilization Review Agency and the care is monitored by it;

- C.** The services are provided by a Hospice care agency or by others who are not its employees but who are supervised or coordinated by the Hospice care agency;
- D.** The services are provided pursuant to a written treatment plan approved by a Physician and reviewed by the Physician at least once a month;
- E.** The expenses Incurred are Covered Hospice Expenses that are defined as services provided by a Hospice care agency, or provided under the supervision or coordination of the Hospice care agency by others who are not its employees, in an inpatient Hospice setting or a private residence, for:

- 1.** Medical social services provided under the direction of a Physician including:
 - a.** Assessment of the Covered Person's home and family situation and that person's social, emotional, and medical needs;
 - b.** Identification of community resources available to the Covered Person;
 - c.** Assisting the Covered Person to obtain community resources to meet the Covered Person's needs;
 - d.** Psychological and dietary counseling;
 - e.** Consultation and case management services by a Physician;
 - f.** Physical or occupational therapy;
 - g.** Medical supplies, drugs, and medicines prescribed by a Physician.
- 2.** Hospice services provided for a Covered Person in a private home are subject to the following:
 - a.** Part-time or Intermittent nursing care provided by a registered nurse or licensed practical nurse;
 - b.** Part-time or Intermittent home health aide services which consist mainly of caring for the Covered Person.

F. Limitations and Exclusions

- 1.** The maximum benefit payable under the Plan for Hospice care services is 80 days per person including bereavement counseling.
- 2.** Benefits are not payable for:
 - a.** Funeral expenses;
 - b.** Financial or legal counseling, including estate planning or the drafting of a will;

- c. Pastoral counseling;
- d. Homemaker or caretaker services that are not solely related to the care of the Covered Person; transportation; housecleaning; or maintenance of the Covered Person's dwelling;
- e. Sitter or companion services for either the ill Covered Person or other members of their family;
- f. Respite care that is care furnished during a period when the Covered Person's family or usual caretaker cannot, or will not, attend to the Covered Person's needs.

7.12 Alternative Treatment Plan

- A. **Allowed Amount.** For purposes of this Paragraph only an Allowed Amount includes: (i) all costs otherwise allowed under this Plan; and (ii) all other costs for medical goods and services that are essential to the implementation and maintenance of the Alternative Treatment Plan, even if not otherwise covered under the Plan, and provided that the Utilization Review Agency has approved Prior Authorization that the particular medical goods or services are essential to the implementation and maintenance of the Alternative Treatment Plan.
- B. **Limitation.** The Alternative Treatment Plan is subject to:
 - 1. The Plan Deductible and Plan maximums; and
 - 2. The Allowed Amount for the Alternative Treatment Plan, as defined in this Paragraph, may not exceed those payable for comparable treatment or services in an acute care facility or a Skilled Nursing Facility.

7.13 Home Health Care Services

Subject to all the terms and conditions of the Plan, including the Deductible requirement, the Coinsurance requirement, and the requirement that these services must receive Prior Authorization by the Utilization Review Agency, and including other conditions and limitations herein, the Plan will provide benefits for the Allowed Amount for the following Medically Necessary services and supplies provided a Covered Person in the home:

- A. Covered Medical Benefits for purposes of this Paragraph shall be limited to:
 - 1. Part-time or Intermittent nursing care by a registered nurse or a licensed practical nurse, where appropriate;
 - 2. Part-time or Intermittent home health aide services that consist primarily of caring for the individual;
 - 3. Physical, occupational, or speech therapy provided by the Home Health Care agency; and
 - 4. Medical drugs, supplies, Durable Medical Equipment, and medicines prescribed by a Physician and required for the care rendered by the nurse or physical, occupational, or

speech therapist, but only to the extent that the medical drugs, supplies, Durable Medical Equipment, and medicines are otherwise covered under this Plan.

- B.** The payment of benefits for Home Health Care is subject to the following additional requirements, in addition to all other limitations and exclusions of the Plan:
- 1.** That the Home Health Care benefits, if provided, would permit the Covered Person to remain in a less intensive care facility, or at home, than would otherwise be required without these benefits;
 - 2.** The annual maximum benefit for professional services only is 100 visits. A visit shall consist of up to four hours, whether consecutive or non-consecutive, within any 24-hour period, and Incurred by a registered nurse or a licensed practical nurse to provide nursing care, by a therapist to provide physical, occupational, or speech therapy, or by a Home Health Care aide to provide services within the scope of the license;
 - 3.** Covered Medical Benefits under this Paragraph shall not include:
 - a.** Any service or supply rendered by a person who ordinarily resides in the home of the Covered Person, is a member of the Covered Person's family, or is a member of the family of the spouse of the Covered Person; or
 - b.** Any transportation services;
 - 4.** The Plan will provide benefits for Medical Social Worker Services if Authorized and required by the Utilization Review Agency under Paragraph 15.1.8.E at 100% of the Allowed Amount or the Provider's Billed Charge, whichever is less.

7.14 Mammography Testing

The Plan will provide benefits for routine mammography testing for female Covered Persons over the age of 35 enrolled in the Plan and without regard to the Plan Deductible, Coinsurance, or Copayment, subject to the following terms and conditions:

- A.** Benefits under this Paragraph are limited to one mammogram for a female Covered Person between the ages of 35 through 39; one mammogram, each Plan Year, for a female Covered Person, over the age of 40.
- B.** Benefits under this Paragraph are payable only for routine four-view mammograms that are defined as elective procedures undertaken without the presence of symptoms, and are performed only at facilities in Tier A or B;
- C.** Benefits under this Paragraph are in addition to benefits for diagnostic mammography otherwise available under this Plan, which are subject to the other terms, conditions, limitations, and exclusions of this Plan, including the Copayment, Deductible, and Coinsurance;

7.15 Required Second Opinion

The Plan will provide benefits for a Second Opinion required to be obtained by the Utilization Review Agency under 15.1.8.C at 100 percent of the Allowed Amount or the Provider's Billed Charge, whichever is less.

7.16 Cervical Cancer Screening

The Plan will pay a benefit for one routine Pap test each Plan Year for a female Covered Person between the ages of 18 through 65, or as otherwise recommended by the U.S Preventative Services Task Force. The Plan will pay a benefit for human papillomavirus testing once every five years for women ages 30–65, or as otherwise recommended by the U.S. Preventative Services Task Force. Benefits under this Paragraph are not subject to the Plan Copayment, Deductible, or Coinsurance.

Benefits under this Paragraph are in addition to benefits for diagnostic Pap tests and human papillomavirus testing otherwise available under this Plan, which are subject to the other terms, conditions, limitations, and exclusions of this Plan, including the Copayment, Deductible, and Coinsurance. This Paragraph applies to all tiers of the Plan, provided that the member is responsible for any balance bill that may be charged by a provider in Tier C.

7.17 Rehabilitation Care

The Plan will provide benefits for physical rehabilitation designed to restore bodily function that has been lost because of trauma or disease process. The rehabilitation care may consist of physical therapy; speech therapy; occupational therapy; and therapy to teach ambulation, transfer technique, bed mobility, dressing, feeding technique, bowel and bladder training, and other activities of daily living. For the purposes of this provision the following terms are defined as follows:

Acute Rehabilitation shall refer to therapy beginning soon after the onset of illness or injury. In many cases, acute rehabilitation is appropriately done in an outpatient setting. In complex cases, the appropriate setting may be an acute care facility and then a sub-acute rehabilitation facility or a full service rehabilitation unit. Acute rehabilitation may last days, weeks, or several months, depending on the severity of illness or injury beginning soon after onset of illness or injury.

Long Term Rehabilitation shall refer to the point where further functional improvement is theoretically possible but the gains are slow and the cause/effect relationship with formal treatment is unclear. Benefits are not payable for long term rehabilitation after the acute rehabilitation phase.

Rehabilitation Care is subject to all terms and conditions of the Plan including the following:

- A. Prior Authorization is required for any inpatient rehabilitation care, regardless of the reason for the admission, and is required for any outpatient rehabilitation therapy that occurs subsequent to an inpatient admission for rehabilitation therapy;
- B. The rehabilitation therapy must be performed in the most cost-effective setting as required by the Covered Person's condition;
- C. The Provider must submit and have approved by the Utilization Review Agency a treatment plan with the proposed treatment, the expected result, and the length of the treatment required to reach that result;
- D. There must be a reasonable expectation that sufficient function can be restored for the patient to live outside the institutional setting;

- E. Continued rehabilitation therapy is dependent upon documentation that progress is continuing to be made, and only so long as there is a significant improvement in the capabilities of the patient;
- F. An inpatient admission must be to a rehabilitation facility under the same licensure as a short term general Hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or, if to a freestanding rehabilitation facility, one accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF);
- G. Rehabilitation benefits are not payable for vocational rehabilitation intended to teach a patient how to be gainfully employed; and long term rehabilitation after the acute rehabilitation phase, including cognitive retraining and community re-entry programs.

7.18 Infertility Treatment

The Plan will pay benefits for the diagnosis and treatment of infertility, subject to the exclusion in Paragraph 9.V. and to all other terms and conditions of the Plan, including the following special terms and conditions:

- A. The benefits are limited to a lifetime maximum payment of \$15,000 for any Covered Medical Benefits and Covered Prescription Drug Expenses Incurred by either the Subscriber or the Covered Spouse, whether covered as a Dependent or as an Employee. Included in the \$15,000 maximum are up to 6 cycles of Intrauterine Insemination (IUI) and a maximum total of three completed cycles of zygote or gamete intrafallopian transfer (ZIFT or GIFT) or In Vitro Fertilization (IVF). A cycle reflects the cyclic changes of fertility with the cycle beginning with each new insemination or assisted reproductive technology (ART) transfer or implantation attempt. ART procedures not specifically referenced in this policy are not covered, including but not limited to: tubal embryo transfer (TET), pronuclear stage tubal embryo transfer (PROUST), or Oocyte donation. Benefits paid under this Plan, the State Health Plan Standard Plan, the State Health Plan Savings Plan, or the Medicare Supplemental Plan for infertility treatments since January 1, 1990, are used in computing the lifetime maximum benefit;
- B. The benefits for infertility treatment are always subject to Coinsurance at a rate of 30% of the Allowed Amount for Covered Medical Benefits or Covered Prescription Drug Expenses;
- C. Coinsurance paid by the Covered Person for the infertility services cannot be used to satisfy the Medical Benefits Coinsurance Maximum in 7.1.A.4, 7.1.B.3, or 7.1.C.3;
- D. All IVF procedures must receive prior approval from the Utilization Review Agency;
- E. No benefits are payable for infertility treatments to a Covered Person who has received a tubal ligation or vasectomy, whether or not surgically reversed.

7.19 Well Care

- A. **Well Child Care.** The Plan will provide benefits for routine Well Child Care visits for a covered Child through age 18 and immunizations for Covered Persons enrolled in the Plan and without regard to the Plan Deductible, Copayments, or Coinsurance, subject to the following terms and conditions:
 - 1. Well Child Care visits will be paid at 100% of the allowed amount for approved routine

exams, Centers for Disease Control-recommended immunizations, American Academy of Pediatrics-recommended services specific to certain ages, and lab tests when an in-network doctor provides these checkups. Well Child Care visits benefits for will be allowed as follows:

- a. Younger than 1 year old (up to six visits);
- b. 1 year old (up to three visits);
- c. 2 years old (up to two visits); and
- d. 3 years old until they turn 19 years old (one visit a year).

Benefits under this Paragraph are payable only for services rendered by the participating providers in Tier A and B Networks in accordance with guidelines established by the Plan Administrator.

Benefits under this Paragraph are payable without regard to the Plan Deductible or Coinsurance.

B. Tier B – Adult Well Care. The Plan will provide benefits for the following routine annual exams for non-Medicare primary Covered Persons ages 19 and older enrolled in the Plan, subject to the following provisions:

- 1. Adult Well Exam and Well Woman Exam.** Services covered in an Adult Well Exam or a Well Woman Exam shall include all indicated evidence-supported services set out in the United States Preventive Services Task Force (USPSTF) A and B Recommendations (“Recommended Services”). These Recommended Services will be available as a Covered Medical Benefit annually or based on the frequency determined by the USPSTF, without regard to Copayment, Deductible, or Coinsurance requirements.
 - a. If services otherwise covered under Article 7, but that are not included as part of an Adult Well Exam or Well Woman Exam under Subparagraph (1) of this Paragraph, are performed at the same visit as the Adult Well Exam or Well Woman Exam, these non-included services are subject to normal Copayment, Deductible, and Coinsurance requirements.
 - b. If follow-up services are performed at a visit after the Adult Well Exam or Well Woman Exam visit, these follow-up services are subject to Plan provisions.
 - c. An Adult Well Exam visit must be received at a participating provider specializing in General Practice, Family Practice, Internal Medicine, and Gerontology.
 - d. A Well Woman Exam visit must be received at a participating provider specializing in Obstetrics and Gynecology, General Practice, Family Practice, Internal Medicine, or Gerontology.
 - e. A female Participant may receive both an Adult Well Exam and a Well Woman Exam in the same Plan Year, subject to the following restriction:

- i. Recommended Services will not be covered more frequently than once per Plan Year and may not be received at both an Adult Well Exam and a Well Woman Exam in the same Plan Year. Duplicate services will be denied.
2. **Immunizations.** Benefits are provided for all immunizations for adults as recommended by the Centers for Disease Control and Prevention and at the recommended intervals.

7.20 Preventive Screenings

The Plan will provide benefits for a routine screening that includes procedures recommended by the United States Preventive Services Task Force, consisting of a health risk appraisal, blood lipid profile, blood chemistry profile, hemogram, blood pressure measurement, height and weight measurement, and counseling on identified individual health risk factors. The Plan will pay benefits only for one screening per Covered Person per Plan Year at providers designated by the Plan Administrator. The screening is provided without regard to the Plan Deductible and Coinsurance. Preventive screening benefits are payable only for (i) Subscribers for whom the Plan is Primary and (2) Dependent Spouses for whom the Plan is Primary. Subscribers with child-only coverage are not eligible for the preventive screening benefit.

7.21 Covered Prescription Drug Expenses

Drugs and medicines that are required to bear the legend “Caution: Federal law prohibits dispensing without prescription,” insulin and related supplies, or drugs and medicines licensed or accepted for a specific diagnosis as listed in the U.S. Pharmacopoeia Publication, DRUG INFORMATION FOR HEALTH CARE PROFESSIONALS are Covered Prescription Drug Expenses, up to the allowance established for that drug in the State Pharmacy Network. The expenses described in this Paragraph are subject to all terms and conditions of the Plan.

Covered Prescription Drug expenses are subject to the utilization review and management standards established by the Pharmacy Benefits Manager under the Prescription Drug Program.

A. **Exclusions.** There is no coverage for:

1. Except as provided in Paragraph 7.26, any medicines or drugs that are in the Food and Drug Administration (FDA) phases I, II, or III testing, whether or not prescribed by a Physician;
2. Prescription drugs or medicines obtained by or for the Covered Person in violation of the utilization review and management standards established by the Pharmacy Benefits Manager under the Prescription Drug Program.
3. Prescription drugs or medicines purchased at pharmacies not participating in the State Pharmacy Network. Out-of-network drug benefits may be allowable only in specific geographic areas in which the Plan Administrator has determined that there is no access to a participating pharmacy.
4. Specialty medications, as defined and determined by the Pharmacy Benefit Manager, not obtained from the Plan Sponsor’s Custom Credentialed Specialty Network.

B. For Covered Persons enrolled in the Plan, the expenses described in this Paragraph are not Covered

Medical Benefits for purposes of Paragraph 7.1. of the Plan of Benefits.

C. Prescription Drugs Obtained at MUSC Health Network (Tier A):

1. The Covered Person shall pay for up to a 31-day supply of a drug: (a) the lesser of the allowance established for a Tier 2 brand name drug or a \$34 Copayment; (b) the lesser of the allowance established for a Tier 3 brand name drug or a \$57 Copayment; or (c) the lesser of the allowance established for a generic drug or a \$10 Copayment. If an FDA-approved generic equivalent is available, payment for a brand name drug is limited to what is payable for the FDA-approved generic equivalent. Covered Persons may obtain up to a maximum of a 90-day supply of medication; however, a separate Copayment is required for each additional 31-day supply of medication received at retail.
2. A voluntary mail service prescription drug benefit is available at a pharmacy established by the Pharmacy Benefits Manager for home delivery of 90-day supplies of covered prescription medications. A retail maintenance network of certain participating pharmacies operating in the State may also be utilized to obtain 90-day supplies of covered prescription medications at the same price as mail order. Patient copayments at the mail service pharmacy, or at a pharmacy participating in the Retail Maintenance Network, for a 90-day supply of covered medication shall be: (a) the lesser of the allowance established for a Tier 2 brand name drug or an \$90 Copayment; (b) the lesser of the allowance established for a Tier 3 brand name drug or a \$157 Copayment; or (c) the lesser of the allowance established for a generic drug or an \$25 Copayment.

D. Prescription Drugs Obtained at a State Health Plan In-network Provider (Tier B):

1. The Covered Person shall pay for up to a 31-day supply of a drug: (a) the lesser of the allowance established for a Tier 2 brand name drug or a \$46 Copayment; (b) the lesser of the allowance established for a Tier 3 brand name drug or a \$77 Copayment; or (c) the lesser of the allowance established for a generic drug or a \$13 Copayment. Provided, however, that if an FDA-approved generic equivalent is available, payment for a brand name drug is limited to what is payable for the FDA-approved generic equivalent. Covered Persons may obtain up to a maximum of a 90-day supply of medication, provided, however, a separate Copayment is required for each additional 31-day supply of medication received at retail.
2. A voluntary mail service prescription drug benefit is available at a pharmacy established by the Pharmacy Benefits Manager for home delivery of 90-day supplies of covered prescription medications. A retail maintenance network of certain participating pharmacies operating in the State may also be utilized to obtain 90-day supplies of covered prescription medications at the same price as mail order. Patient copayments at the mail service pharmacy, or at a pharmacy participating in the Retail Maintenance Network, for a 90-day supply of covered medication shall be: (a) the lesser of the allowance established for a Tier 2 brand name drug or a \$115 copayment; (b) the lesser of the allowance established for a Tier 3 brand name drug or a \$192 copayment; or (c) the lesser of the allowance established for a generic drug or a \$32 copayment.

- E. There is an annual prescription drug Copayment maximum of \$3,000 per Covered Person. The difference between the cost of a brand name drug and the cost of a generic drug is not counted towards the annual Copayment maximum.
- F. The State of South Carolina Group Health Benefits Plan has adopted an Employee Group Waiver Plan (EGWP) Prescription Drug Plan for the benefit of Covered Persons enrolled in the Medicare Supplemental Plan and for those enrolled in the State Health Plan Standard Plan who are eligible for Medicare Part D. The EGWP Prescription Drug Plan provides at least the same prescription benefit the Covered Person receives as an enrollee in the Standard Plan in terms of Copayment and out-of-pocket maximum but may provide more. A Covered Person eligible for the EGWP Prescription Drug Plan may elect out of the EGWP program and return to the Standard Plan drug benefit. A Covered Person who did not disenroll with the Pharmacy Benefit Manager when first eligible, may disenroll from the EGWP Prescription Drug Plan during the Medicare Open Enrollment and will be enrolled in Standard Plan Drug Benefit effective January 1 of the following year. In addition, a Covered Person may also disenroll anytime throughout the year effective the first of the following month; however the Covered Person will not be eligible to enroll in the Standard Plan Drug benefit plan until an established enrollment period.
- G. FDA-approved tobacco cessation pharmaceuticals will be provided at no costs to the Covered Person through pharmacies participating in the State Pharmacy Network.
- H. **Specialty Pharmacy Copay Assistance Program.** Under the Plan's specialty pharmacy copay assistance program ("Copay Assistance Program") through SaveOnSP, certain specialty pharmacy drugs ("Program Drugs") are considered non-essential health benefits under the Plan and are not subject to the copays described in Paragraphs 7.21(C)(1) and 7.21(D)(1). The medications included in the program ("Program Drugs") can be found on the Program Drug List at www.saveonsp.com/pebasc. Program Drugs are subject to a 30% coinsurance. However, Participants who are prescribed a Program Drug and who enroll in the Copay Assistance Program will receive the Program Drug at no charge; the cost of Program Drug will be reimbursed through the Copay Assistance Program at no cost to the Participant. Participants who are prescribed a Program Drug and who refuse to enroll in the Copay Assistance Program will pay a 30% coinsurance of the cost of the drug on the Program Drug List. The cost of Program Drugs and the 30% coinsurance will not be applied toward satisfying the Participant's prescription drug out-of-pocket maximum in Paragraph 7.21(E), or any other out-of-pocket maximum, whether the Participant is enrolled in the Copay Assistance Program.

7.22 Cranial Band

The Plan covers the use of a cranial remodeling band when Prior Authorization review determines it to be Medically Necessary for the correction of a child's moderate to severe positional head deformities associated with premature birth, restrictive intrauterine positioning, cervical abnormalities, birth trauma, torticollis, and sleeping positions. Remodeling must be initiated between 3 and 18 months of age. For services requested for a child between 3 and 5 months of age, the child must have tried and failed a two-month trial of conservative treatment (e.g., repositioning, neck exercises).

7.23 Colorectal Cancer Screening

The Plan will provide benefits for colonoscopies, fecal occult blood tests, and fecal immunochemical tests, subject to the limitations of this Paragraph. The consultation, generic prep kit, and the associated

anesthesia during the procedure will be covered at no cost to the Covered Person at in-network providers for both diagnostic services and routine services. Routine services will be covered within the age ranges and intervals specified by the U.S. Preventive Services Task Force A and B recommendations. Benefits under this Paragraph are not subject to the Plan Deductible and Coinsurance. Any associated lab work as a result of the screening may be subject to patient liability.

This Paragraph applies to all tiers of the Plan, provided that the member is responsible for any balance bill that may be charged by a provider in Tier C.

7.24 Autism Spectrum Disorders

The Plan will provide benefits for Applied Behavioral Analysis for a Covered Person who is diagnosed with Autism Spectrum Disorder. Notwithstanding Paragraph 7.3.O, benefits are provided for speech therapy for treatment of Autism Spectrum Disorders. All services are subject to the guidelines formulated by the Behavioral Health Manager, are limited to the benefits specified in Paragraph 7.8, and must receive Prior Authorization by the Behavioral Health Manager.

7.25 Preventive Care

All Preventive Care shall be provided to a Covered Person without a Copayment, Deductible or Coinsurance under Tier A of the Plan. Preventive Care is not covered under Tier B or Tier C of the Plan. To the extent not otherwise covered under Preventive Care, other preventive measures set out in Article 7 of the Plan are covered in accordance with those Paragraphs: Mammography (7.14), Cervical Cancer Screening (7.16), Well Care (7.19), Preventive Screenings (7.20) and Colorectal Cancer Screening (7.23).

7.26 Coverage of Clinical Trials

- A.** The Plan will not deny a Covered Person who is a "Qualified Individual" participation "Approved Clinical Trial" with respect to treatment of a "Life Threatening Condition" where the Utilization Review Agency has determined the Covered Person is eligible to participate in the Approved Clinical Trial. Furthermore, the Plan will not deny (or limit or impose additional conditions on) the coverage of "Routine Patient Costs" for items and services furnished in connection with participation in the Approval Clinical Trial. Finally, the Plan will not discriminate against a Qualified Individual on the basis of the individual's participation in an Approved Clinical Trial. To be eligible to participate in the Approved Clinical Trial, the Utilization Review Agency must determine that the Covered Person's participation in the Approved Clinical Trial is appropriate to treat the Covered Person's Life Threatening Condition. The Utilization Review Agency's determination may be based on the referring Physician's conclusions or medical or scientific information provided by the Covered Person.
- B.** If one or more MUSC Health Plan Physician Network Providers is participating in an Approved Clinical Trial, the Plan may require that a Qualified Individual participate in the Approved Clinical Trial through such a MUSC Health Plan Physician Network Provider if the Network Provider will accept the Qualified Individual as a participant in the Approved Clinical Trial.
- C.** Notwithstanding Paragraph (B) above, Paragraph (A) above shall apply to a Qualified Individual participating in an Approved Clinical Trial that is conducted outside the State in which the Qualified Individual resides.
- D.** For purposes of Paragraph 7.26.A of the Plan, the following terms are defined as follows:

- 1.** "Approved Clinical Trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following subsections:
 - a.** The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following: (a) the National Institutes of Health; (b) the Centers for Disease Control and Prevention; (c) the Agency for Health Care Research and Quality; (d) The Centers for Medicare & Medicaid Services; (e) cooperative group or center of any of the entities described in subsections (a) through (d) above or the Department of Defense or the Department of Veteran Affairs; (f) a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or (g) the Department of Veteran Affairs, the Department of Defense, or the Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines: (i) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and (ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - b.** The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
 - c.** The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- 2.** "Life-Threatening Condition" is a disease or condition likely to result in death unless the course of the disease or condition is interrupted.
- 3.** "Qualified Individual" is means a Covered Person who meets the following conditions: (a) the Covered Person is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and (b) either:
 - a.** The referring Health Care Professional is a participating health care provider and has concluded that the Covered Person's participation in such Approved Clinical Trial would be appropriate based upon the Covered Person meeting the conditions of the trial protocol; or
 - b.** The Covered Person provides medical and scientific information establishing that the Covered Person's participation in the Approved Clinical Trial would be appropriate based upon the Covered Person meeting the conditions of the trial protocol.

"Routine Patient Costs" include items and services typically provided under the Plan for a Covered Person not enrolled in an Approved Clinical Trial. However, such items and services do not include (a) the investigational item, device, or service itself; (b) items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis; or (c) a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

7.27 Diabetes Education

Outpatient and office based self-management training and education for the treatment of Covered Persons with diabetes mellitus, if Medically Necessary and prescribed by a health care professional who is legally authorized to prescribe such items and who demonstrates adherence to minimum standards of care for diabetes mellitus as adopted and published by the Diabetes Initiative of South Carolina, shall be provided at no cost to the Covered Person, provided that the self-management training and education conforms to regulations of the Health Care Financing Administration, US Department of Health and Human Services, pursuant to Section 4105 of the Balanced Budget Act of 1997 and is provided by an in-network provider.

7.28 Physician Administered Specialty Drugs

Physician administered specialty medications require prior Authorization, to include site of care requirements to ensure Covered Persons are receiving their specialty medications at the lowest cost, clinically appropriate site of care.

7.29 Contraceptives

No cost sharing shall be applied to otherwise covered contraceptives.

7.30 No Surprises Act Compliance

The Plan will comply in good faith with the No Surprises Act as enacted under the Consolidated Appropriations Act of 2021 (the “CAA”). The Plan may rely on any enforcement delays announced by federal agencies with respect to compliance deadlines under the CAA, and in the absence of regulations, the Plan will implement provisions in accordance with a good faith, reasonable interpretation of the statute.

ARTICLE 8.

COORDINATION OF BENEFITS

8.1 Definitions for this Article

- A. Plan.** For purposes of this Article, “Plan” means any program that provides benefits or services for or by reason of medical care or treatment including:
- 1.** Any group insurance and group subscriber contracts;
 - 2.** Any uninsured arrangements of group coverage;
 - 3.** Any group coverage through health maintenance organizations (HMOs) and other prepayment, group practice, and individual practice plans;
 - 4.** Any group hospital indemnity plans to the extent that the benefits exceed \$100 per day;
 - 5.** Any medical benefits coverage in group and individual automobile “no fault” and traditional automobile “fault” type contracts;
 - 6.** Any coverage under a governmental plan, or coverage required to be provided by law,

but does not include a State Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the Social Security Act, as amended);

7. But does not include insurance contracts, subscriber contracts, or coverage through HMOs or other prepayment, group practice, or individual practice plans, to the extent that they provide individual or family coverage; and does not include blanket insurance contracts, franchise insurance contracts, or a State Plan under Medicaid; and shall not include a law or plan when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

Each program or other arrangement for coverage is a separate Plan for purposes of coordination of benefits (COB), and if a program or other arrangement for coverage has more than one part and the COB provisions apply to one part, then each part of the program or arrangement is considered a separate Plan.

- B. **Dependent.** With respect to this Article, any person included in the definition of Dependent in Paragraph 2.28 herein and, with respect to any other Plan, any person who qualifies as a dependent under such Plan.
- C. **Primary Plan.** A Plan under which benefits must be determined without taking the existence of another Plan into consideration. There may be more than one Primary Plan. The provisions of Paragraph 8.2 determine whether a Plan is Primary or Secondary.
- D. **Secondary Plan.** A Plan that is not a Primary Plan. When this Plan is a Secondary Plan its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits. The provisions of Paragraph 8.2 determine whether a Plan is Primary or Secondary.

8.2 Order of Determination of Benefits

When there is a basis for a claim under this Plan and another Plan, this Plan is a Secondary Plan that has its benefits determined after those of the other Plan unless: (1) the other Plan has rules coordinating its benefits with those of this Plan; and (2) both those rules and this Plan's rules, as specified below, require that this Plan's benefits be determined before those of the other Plan.

This Plan determines its order of benefits using the first of the following rules that applies:

- A. **Coverage as a Non-Dependent or Dependent.** The benefits of a Plan that covers the person as an employee, member, or subscriber (that is, other than as a dependent) are determined before those of the Plan that covers the person as a dependent.
- B. **Dependent Child — Parents Not Separated or Divorced.** Except as provided in Paragraph C below, when this Plan and another Plan cover the same child as a dependent of different persons called parents:
 1. The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year (the birthday rule); but
 2. If both parents have the same birthday, the benefits of the Plan that covered a parent

longer are determined before those of the Plan that covered the other parent for a shorter period of time;

3. If the other Plan does not have the birthday rule so that the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

C. Dependent Child — Parents Separated or Divorced. If two or more Plans cover a person as a dependent child of divorced or separated parents, the benefits for the dependent child are determined in this order:

1. First, the plan of the parent with custody of the child;
2. Second, the plan of the spouse of the parent with custody of the child;
3. Third, the plan of the parent who does not have custody of the child;
4. If the specific terms of a court decree state that one of the parents is responsible for the health care expenses 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, the benefits of that Plan are determined first. The plan of the other parent shall be the Secondary Plan;
5. 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 health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules in Paragraph B above.

D. Active - Inactive Employee. The benefits of a Plan that covers a person as an employee who is neither laid off nor retired, or as a dependent of an employee who is neither laid off nor retired, are determined before those of a Plan that covers that person as a laid off or retired employee, or as a dependent of a laid off or retired employee. This Paragraph does not apply if the other plan does not have the rule of Paragraph D and if, as a result, the plans do not agree on the order of benefits.

E. Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination.

1. First, the benefits of a Plan covering the person as an employee, member, or subscriber, or as that person's dependent;
2. Second, the benefits under the continuation of coverage.

F. Longer - Shorter Length of Coverage. If none of the above Paragraphs A–E determine the order of benefits, the benefits of the Plan that covered an employee, member, or subscriber for a longer term are determined before those of the Plan that covered that person for the shorter term.

Note: The Consolidated Omnibus Budget Reconciliation Act of 1987 (COBRA) originally provided that coverage under a new group health plan caused the COBRA coverage to end. An amendment passed as part of H.R. 3299 (1989) allows the COBRA coverage to continue if the other group plan contains any pre-

existing condition limitation. In this instance, two policies will cover an individual, and the above rule will be used to determine which one of them assumes the primary position.

8.3 Effect of Order of Determination of Benefits on this Plan

- A. This Plan is Primary.** When the order of determination rules of this Plan establish that this Plan is the Primary Plan, the benefits provided by this Plan shall be determined without consideration of the benefits of any other Plan.
- B. This Plan is Secondary.** When the order of determination rules of this Plan establish that this Plan is the Secondary Plan, this Plan will pay the lesser of:
- 1.** The benefits that would be payable for the Covered Medical Benefit(s) under this Plan if it were the Primary Plan, without regard to this coordination of benefits provision; or
 - 2.**
 - a.** If the Provider is a Participating Provider in the Primary Plan, the difference between the other Plan's allowed amount(s) for the Covered Medical Benefit(s) and the benefits the other Plan would pay as Primary, without regard to any coordination of benefits or similarly intended provision in that Plan and whether or not the claim was filed; or
 - b.** If the Provider is a Non-Participating Provider for the Primary Plan, the difference between the Provider's Billed Charge and the benefits the other Plan would pay as Primary, without regard to any coordination of benefits or similarly intended provision in that Plan and whether or not the claim was filed.

Payment for each Covered Medical Benefit will be determined in the manner above when this Plan is Secondary. When this Plan is Secondary, it will not pay any benefits for expenses this Plan would not cover as Primary. The benefits this Plan pays as Secondary will not exceed the total benefits this Plan would pay as Primary, nor will the payments from this Plan exceed the other Plan's patient liability amount(s). Any benefits paid under this provision are charged against any applicable benefit limit of this Plan.

- C. Subscriber's Responsibility.** The Subscriber is responsible for filing or processing claims through another health insurance plan.

8.4 Right to Receive and Release Information

For the purpose of determining the applicability of, and implementing the terms of, this Article or any provision of similar purpose of any other Plan, the Third-Party Claims Processor may, without the consent of or notice to any person, release to or obtain from any insurance company, other organization, or person any information that it deems to be necessary for such purposes. Any person claiming benefits under this Plan will furnish to the Third-Party Claims Processor such information as may be necessary to implement this Article.

8.5 Facility of Payment

Whenever payments that should have been made under this Plan in accordance with this Article have been made under any other Plan, the Third-Party Claims Processor will have the right to pay over to any organization making such other payments any amounts it determines to be warranted in order to satisfy

the intent of this Article. Amounts so paid will be deemed to be benefits paid under this Plan. To the extent of such payments for Covered Medical Benefits, the Plan will be fully discharged from liability. The term “payments” includes providing benefits in the form of services, in which case the term “payment made” means the reasonable cash value of the benefits provided in the form of services.

8.6 Right of Recovery

Whenever payments have been made under this Plan by the Third-Party Claims Processor with respect to Covered Medical Benefits in a total amount in excess of the amount necessary to satisfy the purposes of this Article (regardless of whether such overpayments were made as a result of an error by the Third-Party Claims Processor, the Plan Administrator, or any other person or entity related to the Plan), the Third-Party Claims Processor will be entitled to recover on behalf of the Plan such excess amounts from a Covered Person or any group insurer, Plan, or other person or organization contractually obligated to such Covered Person with respect to such Covered Medical Benefits. The Subscriber, for themselves or on behalf of their Dependents will, upon request, execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to this Plan or any other Plan.

8.7 Medicare

- A.** This Plan will provide Primary coverage for Active Employees ages 65 and over and their Dependents who have elected to enroll in Medicare and who are also enrolled in this Plan, except as provided in subsection C below, Coordination of Benefits for End Stage Renal Disease (ESRD). Federal law prohibits active Employees who elect Medicare as their Primary coverage from enrolling in the Plan as a supplement.
- B.** This Plan is Primary and Medicare is Secondary for an Active Employee or Dependent of an Active Employee under age 65 and eligible for Medicare by reason of disability, except as provided in subsection C below, Coordination of Benefits for ESRD.
- C.** For COBRA subscribers eligible for Medicare before electing COBRA coverage under this Plan and their Dependents, the benefits paid under this Plan will be determined in the following manner:
 - 1.** Benefits available under this Plan less benefits paid or payable under Parts A and B of Medicare.
 - 2.** When Medicare is Primary and this Plan is Secondary, benefits will be coordinated with both Parts A and B of Medicare, whether the Covered Person is receiving both Parts A and B of Medicare.
- D. Coordination of Benefits for End Stage Renal Disease (ESRD).** Subscribers diagnosed with ESRD and/or undergoing a renal transplant must apply for Medicare coverage when enrolled in this Plan. This Plan requires Covered Persons diagnosed with ESRD to apply for Medicare coverage (parts A and B) under the ESRD entitlement reason during the first 33 months of treatment. After the Covered Person's first dialysis treatment, a three-month waiting period will begin before Medicare coverage is available. A 30-month coordination period exists in which this Plan is primary and Medicare is secondary. Covered members, including dependent children, who have had a kidney (renal) transplant and meet Medicare's criteria are also subject to this coordination period with Medicare Parts A and B.

The coordination period is 30 months long and starts on the date the Subscriber is eligible to receive Medicare benefits. On the 31 month, Medicare becomes the primary payer and this Plan becomes secondary. If the Subscriber applies for Medicare and does not qualify, this Plan will continue as primary payer.

If the Subscriber chooses not to enroll in Medicare Parts A and B, but is eligible to participate in the Medicare program, this Plan will limit coverage to coordinate benefits with what would have been paid by Parts A and B of Medicare if the subscriber was enrolled after the 33rd month from the first date of dialysis.

Notes:

1. The Medicare three month waiting period may be shortened or eliminated if the Covered Person:
 - a. Takes part in a home dialysis program;
 - b. Is admitted to a Medicare–approved hospital for services related to kidney transplant; or
 - c. Is scheduled for a kidney transplant prior to the end of the coordination period.
2. Medicare coverage due to ESRD ends 12 months after dialysis treatments end. However, termination of dialysis is unlikely unless the person receives a kidney transplant. For Covered Persons who undergo a kidney transplant, Medicare coverage would end 36 months after a successful transplant. An unsuccessful transplant usually requires a resumption of dialysis treatment.

ARTICLE 9.

EXCLUSIONS AND LIMITATIONS

No benefits will be provided under any Article of this Plan for any service, supply, or charge for the following:

- A. Any service or charge for service that is not Medically Necessary; any service or charge for service that is performed in a more costly setting than that required by a Covered Person's condition.
- B. Any service or charge for service to the extent a Covered Person is entitled to payment or benefits (whether any such payment or benefits have been applied for or paid) pursuant to any law (now existing or as may be enacted or amended) of the United States (except Medicaid) or any state or political subdivision thereof. Without limiting the generality of the foregoing, this exclusion applies to benefits provided by or payable under Workers' Compensation Laws, the Veterans Administration, or any state or federal hospital for which hospital services the Covered Person is not legally obligated to pay. This exclusion applies if the Covered Person receives any benefits or payments in whole or in part, and it applies to any settlement or other agreement, including any

settlement of “doubtful and disputed” claims, “clincher” agreements, or any other agreement regardless of how characterized, and even if the document or release specifically excludes payment for medical expenses.

- C. Any service or charge for service to the extent a Covered Person is entitled to payment or benefits under state or federal programs of health care, excluding Medicare and amendments thereto, but only to the extent that benefits are provided or reimbursement is paid or payable hereunder.
- D. Illness contracted or injury sustained as a result of declared or undeclared war, any act of war, or while in the military service.
- E. Any charges for services commencing prior to the Covered Person’s coverage under this Plan or rendered after the termination of coverage under this Plan, except as provided in Article 10, Continuation of Coverage, or Article 11, COBRA, of this Plan.
- F. Services or charges incurred for acupuncture.
- G. Except for Clinical Trials covered pursuant to Paragraph 7.26 of the Plan, any surgical or medical procedures determined by the medical staff of the Third-Party Claims Processor, with appropriate consultation, to be experimental, investigational, or not accepted medical practice. Experimental or investigational procedures are those medical or surgical procedures, supplies, devices, or drugs that, at the time provided or sought to be provided:
 - 1. Are not recognized as conforming to accepted medical practice in the relevant medical specialty or field of medicine; or
 - 2. Have not received final unrestricted market approval from the Food and Drug Administration or other appropriate governmental regulatory body for use in the treatment of a specified condition; or
 - 3. Are those about which the peer-reviewed medical literature does not permit conclusions concerning their effect on health outcomes; or
 - 4. Are not demonstrated to be as beneficial as established alternatives; or
 - 5. Have not been demonstrated, to a statistically significant level, to improve the net health outcomes; or
 - 6. Are those in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting.
- H. Services, supplies, or charges for premarital, pre-employment, or routine physical examinations when no injury or illness is present, and except as provided in Paragraphs 7.19 Well Care, 7.25 Preventive Care, and other Plan provisions.
- I. Admissions or portions thereof for Custodial Care.
- J. Hospital and Physicians services and prescription drugs related to procedures or goods that have

primarily cosmetic effects, including but not limited to liposuction or lipectomy, cosmetic goods, procedures, or surgery, or the complications resulting therefrom. Cosmetic goods, procedures, or surgery shall mean all goods, procedures, and surgical procedures performed to improve appearance or to correct a deformity without restoring a bodily function.

1. The following procedures, when determined medically necessary by the medical policies of the Third Party Claims Processor or Utilization Review Agency, are not excluded under this provision:
 - a. Procedures that would otherwise be considered cosmetic but are performed to restore a bodily function due to physical trauma, surgery, or congenital anomaly (as opposed to familial characteristics or aging phenomenon); and
 - b. Surgeries that would otherwise be considered cosmetic but are performed to correct a cleft palate, or for restoration required because of burn injuries, or other similar procedures performed in stages or after certain growth has been attained.
 2. If a Covered Person is receiving benefits under the Plan in connection with a mastectomy and if the Covered Person elects breast reconstruction in connection with such mastectomy, the Plan shall cover:
 - a. Reconstruction of the breast on which the mastectomy has been or will be performed;
 - b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - c. Prostheses and physical complications at all stages of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the Covered Person.
 3. The Plan shall not: (i) deny any Covered Person eligibility or continued eligibility to enroll or to renew coverage under the terms of the Plan solely for the purpose of avoiding the coverage provided under this Subparagraph; or (ii) penalize or otherwise reduce or limit the reimbursement of an attending Provider, or provide incentives (monetary or otherwise) to an attending Provider to induce the Provider to provide care to a Covered Person in a manner inconsistent with the coverage provided in this Paragraph.
- K. Hospital and Physician services for dental procedures, including those related to tooth structures, extractions, gingival tissue, alveolar process, dental X-rays, or other procedures of dental origin that are principally for the preserving of teeth or the preparation of the mouth for dentures, except as specified under Paragraph 7.3.P.
- L. Physician's charges for medicine, drugs, appliances, supplies, blood, and blood derivatives, unless these items are Covered Medical Benefits under the Plan, and then only to the extent the charges do not exceed the usual charge for such items from other providers.
- M. Eyeglasses, contact lenses, and examination for the prescription or fitting thereof; any Hospital or

Physician's charges related to refractive surgery such as radial keratotomy, keratomileusis, or lamellar keratoplasty; and any other procedure the purpose of which is to alter the refractive properties of the cornea, except for the treatment of keratoconus.

- N.** Hearing aids (including bone-anchored hearing aids and other bone conduction devices) and the examination for the prescription or fitting thereof, except as provided in Paragraph 7.3.I.2.
- O.** Travel, whether or not recommended by a Physician, unless related to a human organ transplant specified under Paragraph 7.3.Q.7.
- P.** Any medical social services (except for those provided under the Hospice program and Home Health Care program upon recommendation of the Utilization Review Agency), or vocational, visual, recreational, educational (except for Diabetes Education under Paragraph 7.27), or milieu therapy.
- Q.** Weight loss treatments and surgery, including but not limited to the following: medications; gastric bypass or stapling; intestinal bypass and any related procedures; the reversal of such procedures; and conditions and complications as a result of such procedures or treatment.
- R.** Any service or supply rendered by a member of the Covered Person's immediate family (parent, child, spouse, sibling, or grandparent, whether biological, adopted, or in-law).
- S.** Room and Board charges for elective non-Emergency Hospital admissions for certain surgical procedures that can safely be performed on an outpatient basis. Benefits will be provided when Prior Authorization of coverage is requested and it is determined that the Covered Person's medical condition warrants hospitalization. If Prior Authorization is not obtained and, upon subsequent review, it is determined that the admission was Medically Necessary, Room and Board benefits will be provided, subject to the Deductible and Copayment requirements in Paragraphs 7.1.A, B, and C and Paragraphs 15.1.8 and 15.2.8.
- T.** Charges for chronic pain management programs or any program developed by centers with multidisciplinary staffs intended to provide the interventions necessary to allow the patient to develop pain coping skills and freedom from dependence on analgesic medications.
- U.** With respect to a Dependent Child, Surviving Child, or a Subscriber on Child-Only continuation coverage, charges that are the result of the Dependent Child's, Surviving Child's, or a Subscriber on child-only continuation coverage's infertility treatment, pregnancy, or complications from the Dependent Child's, Surviving Child's, or a Subscriber on child-only continuation coverage's pregnancy or childbirth.
- V.** Any services, supplies, or charges for, or in connection with, any procedure or surgery designed to reverse a prior vasectomy or tubal ligation, provided that the procedure is elective and not Medically Necessary to treat a pre-existing condition.
- W.** Assisted reproductive technologies, except as provided in Paragraph 7.18.
- X.** Physician charges for clinical pathology, defined as services for reading any machine-generated reports on mechanical laboratory tests.

- Y.** Any psychological tests to determine job or occupational placement; school placement or for other educational purposes; milieu therapy; or to determine learning disability.
- Z.** Transcutaneous electrical nerve stimulation when the primary purpose is the treatment of pain. This exclusion does not include muscle stimulation units when they are used to strengthen specific muscles in situations where electrical stimulation is more effective than resistance exercise programs (e.g., quadriceps, shoulder, paraspinal muscle groups weakened or atrophied by disease, injury, or surgery).
- AA.** When a patient in a Hospital receives only a Skilled Nursing level of care, benefits for inpatient Hospital care are limited to the average daily statewide per diem rate plus additional medical services rendered, as determined by the Third-Party Claims Processor, paid to Skilled Nursing Facilities. Benefits for related Physician services are limited to one visit per week for up to the maximum benefits provided in Paragraph 7.9.
- BB.** Benefits will not be provided for services or supplies not specifically listed in Article 7, Schedule of Benefits, inclusive.
- CC.** Benefits will be limited to the extent a Covered Person proves entitlement to any benefits under the Plan by filing or causing to be filed a claim and documentation in support of the claim.
- DD.** Equipment purchased or requested by the Covered Person with or without a prescription, including Durable Medical Equipment, that has a solely non-therapeutic use, including but not limited to: home and vehicle modifications; an air conditioner; air filter or air filtration system; speech augmentation or communication devices, including computers; dehumidifier; home whirlpool; exercise equipment; ace bandages; wigs, hairpieces, or any other artificial device or procedure to replace scalp hair; foot orthotics, ankle, or knee braces whose primary or sole purpose is to allow participation in athletics; and bandages, gauze; and similar equipment. Breast pumps are not covered except for those specific models available at no cost to Covered Persons through the Third-Party Claims Processor, subject to the exclusion in Paragraph 9.U.
- EE.** Items, including but not limited to medications purchased over the counter.
- FF.** Fees for medical records or claims filing.
- GG.** Any service, supply, or charge for which the Employee or Dependent is not legally obligated to pay, as well as any deductible, coinsurance, or charges, or parts thereof that a Hospital or health care Provider waives on an other than isolated case-by-case basis, including prescription drugs or supplies procured with a manufacturer, pharmacy, or third party coupon, or through a manufacturer, pharmacy, or third party discount program, unless specifically allowed under this Plan.
- HH.** Additional benefits will not be provided for preoperative anesthesia consultation.
- II.** When the same Physician renders different levels of care on the same day, benefits will only be provided for the highest level of care.
- JJ.** Any medical service, supply, or charge that is prescribed or ordered by a Physician because an

anatomical variation causes psychological problems.

- KK.** Any service or supply related to dysfunctional conditions of the muscles of mastication, or derangement of the temporomandibular joint (TMJ), including office visits, splints, braces, guards, etc. This exclusion shall not apply to the Medically Necessary surgical correction of disorders of the temporomandibular joint that meet the conditions of Paragraph 7.5.A.7.
- LL.** Any service or supply related to orthognathic surgery or skeletal mal-relationships or deformities of the jaws. Provided, however, this exclusion shall not apply to Medically Necessary surgical correction as provided in Paragraph 7.5.A.8.
- MM.** Sclerotherapy, including injections of sclerosing solutions for varicose veins of the leg, unless prior approved ablation (chemical, radiofrequency or endovascular laser) procedure has been performed in the same treatment area within three years and documentation establishes that some varicosities remained after the prior procedure.
- NN.** Benefits will not be provided for varicose vein surgery performed for cosmetic purposes. The treatment of visible subcuticular veins (i.e. spider angiomas, telangiectasis) less than two mm in size is considered to be cosmetic in nature and is not a Covered Medical Benefit.
- OO.** Food supplements, even if ordered or prescribed by a Physician, including, but not limited to, infant formula, enteral nutrition, Boost/Ensure or related supplements.
- PP.** Services and supplies rendered after death including but not limited to transportation and autopsies.
- QQ.** Smoking cessation or deterrence products or services, with the exception of provisions established under the Prescription Drug Program, or as Authorized by the Behavioral Health Manager for eligible participants in its tobacco cessation program, or as covered under Paragraph 7.25, Preventive Care.
- RR.** Services performed by service or therapy animals or their handlers.
- SS.** An otherwise legal abortion, except as allowed by law.
- TT.** Any services or charges related to Employee Assistance Programs.
- UU.** Complications arising from Covered Person's receipt of either Hospital services, medical services, medical supplies or other treatments that are not considered Covered Medical Benefits, including complications arising from a Covered Person's use of discount services.
- VV.** All expenses, accommodations, materials, services, and care related to non-Covered Medical Benefits are not covered, including complications resulting directly from non-Covered Medical Benefits. "Complications" include all services, equipment, and supplies provided or ordered to treat a secondary disease, accident, or negative reaction during the course of, or on account of, a non-covered illness, injury, condition, situation, procedure, or treatment.
- WW.** Services or charges Incurred for, or in connection with, gender reassignment or related procedures.

ARTICLE 10.

CONTINUATION OF COVERAGE

10.1 Incapacitated Dependent Child

The coverage of an unmarried Incapacitated Dependent Child under this Plan may be continued after the Child reaches age 26. To continue coverage for an Incapacitated Dependent Child, the Employee's coverage must remain in force, and the Employee must provide proof of the Dependent Child's incapacity and dependency to the Plan Administrator within 31 days of the Dependent Child reaching the age of 26 and at such other reasonable times, but not more than annually.

10.2 Effect of Termination of Coverage; Hospitalization at Time of Termination

All rights to receive benefits provided under this Plan for services rendered to a Covered Person after the termination of coverage will automatically cease. A Covered Person confined to a Hospital or Skilled Nursing Facility on the date of termination of coverage shall be entitled to receive the benefits specified in the Plan for each day of that admission, subject to all the other terms, conditions, limitations, and exclusions of this Plan.

10.3 Surviving Spouse and Surviving Children

The Covered Surviving Spouse and Covered Surviving Children of a deceased Active Employee, including any Child of the deceased, born after the death of the Employee but before the remarriage of the Surviving Spouse, shall be eligible to continue the coverage, provided they pay the premium as set forth in Paragraph 10.3(F) below, subject to the following limitations:

- A. The Surviving Spouse or Surviving Children must be covered as dependents under the Plan at the time of the Employee's death (other than any Child born to a female Surviving Spouse after the death of the Employee but before the expiration of ten months after the date of death of the Employee).
- B. Termination.
 - 1. Remarriage shall terminate the coverage of a Surviving Spouse, effective on the first day of the month after the remarriage. If the remarriage occurs fewer than 36 months after the death of the Active Employee, the Surviving Spouse may elect to continue coverage for the remainder of the 36 months from the date of death. The Surviving Spouse must pay the premiums for the coverage elected as detailed in Paragraph 11.7.
 - 2. The existing coverage of any Surviving Children will not be affected by the remarriage of the Surviving Spouse, but such coverage is subject to all the terms, conditions, limitations, and exclusions of the Plan, including the requirement that coverage ceases on the date that the Surviving Child no longer meets the definition of a Dependent Child.
 - 3. The coverage of a Surviving Spouse and Surviving Children shall terminate as provided in Paragraph 3.9.

4. If a Surviving Spouse or Surviving Child is or becomes eligible for coverage under the Plan as an Active Employee, the Surviving Spouse or Surviving Child is not eligible for continued survivor coverage, including any premium waiver, and may only enroll in coverage under the Plan as an Active Employee. This Subparagraph does not apply to a Surviving Spouse or Surviving Child who is eligible for and receiving a waiver and/or trust fund paid premiums under Paragraph 10.3(F)(1)(c).
- C. In no event shall any Surviving Spouse or Surviving Child who feloniously and intentionally kills the Active Employee be entitled to coverage;
- D. **Reenrollment.** Upon the termination of this continuation coverage for a Surviving Spouse or a Surviving Child, such Surviving Spouse or Surviving Child may not reenroll in the Plan thereafter unless:
1. The Surviving Spouse or Surviving Child remains enrolled in the State Dental or State Vision Plan. If enrolled in State Dental or State Vision, an otherwise eligible Surviving Spouse or Surviving Child may reenroll in the Plan within 31 days of a Special Eligibility Situation or during an Open Enrollment Period; or
 2. If the survivor coverage of a Surviving Spouse or Surviving Child is terminated pursuant to Paragraph 10.3(B)(4) above, the Surviving Spouse or Surviving Child, if otherwise eligible, may reenroll in survivor coverage under the Plan within 31 days of losing eligibility as an Active Employee.
- E. **Waiver of COBRA rights.** Upon the death of the Active Employee that would entitle a Surviving Spouse or Surviving Child to continuation coverage pursuant to Paragraph 10.3, the Surviving Spouse or Surviving Child shall, in accordance with applicable law, be provided with an opportunity to elect COBRA continuation coverage as described in Article 11. The Surviving Spouse or Surviving Child may elect COBRA continuation coverage or the continuation coverage offered in Paragraph 10.3. A Surviving Spouse or Surviving Child shall not be eligible for the continuation coverage provided under Paragraph 10.3 unless the Surviving Spouse or Surviving Child declines to elect continuation coverage under COBRA as set forth in Article 11.
- F. **Contributions.** A Surviving Spouse or Surviving Child who elects coverage under this Paragraph 10.3 must pay the full amount of the required premium for the selected coverage, except as provided below:
1. **Active Employee Death**
 - a. Upon the death of an Active Employee, the Employee's Surviving Spouse or Surviving Child who elects coverage under this Paragraph is not required to pay a premium for such coverage for a period of twelve months after the Employee's death.
 - b. After this 12-month period, the Surviving Spouse or Surviving Child must pay the full amount of the required premium for any continuing coverage, except as provided in Paragraph 10.3(F)(1)(c) below.

- c. Upon the death of an Active Employee who was Killed in the Line of Duty while employed by the Employer, the Employee's Surviving Spouse or Surviving Child who elects coverage under this Paragraph is required to pay only the employee portion of the premium for any continuing coverage after the twelve-month premium waiver provided in Paragraph 10.3(F)(1)(a). The employer portion of the premium for any such coverage will be paid by the SCRHI Trust Fund.

For the purposes of this Paragraph, "Killed in the Line of Duty" means that the death of an Active Employee was a natural and proximate result of an injury by external accident or violence while the Employee was performing acts connected with, or resulting from, duties assigned, required, or authorized by his or her Employer. An Employee is not considered to have been Killed in the Line of Duty if: (i) the death of the Employee was caused by the Employee's intentional misconduct or intention to bring about his or her own death; (ii) the Employee was voluntarily intoxicated at the time of death; or (iii) the Employee was performing his or her duties in a grossly negligent manner at the time of death.

- d. A Retiree who has returned to Active Employment in an insurance-eligible position and has enrolled in coverage as an Active Employee is considered an Active Employee for the purposes of this Paragraph 10.3(F)(1).

2. General contribution rules

- a. The waiver of any premium pursuant to Paragraph 10.3(F)(1) or 10.3(F)(2) only applies if the premium for the Employee's coverage at the time of death included a required contribution from the Employer.
- b. The waiver of the employee portion of any premium pursuant to Paragraph 10.3(F)(1) or 10.3(F)(2) also includes the waiver of any required tobacco-use premium.

10.4 Child-Only Continuation Coverage

A Covered Dependent Child who loses coverage due to a Qualifying Event in Paragraph 11.2 may elect to continue coverage under the Plan with Child-Only coverage, as described and subject to the limitations below:

- A. The Dependent Child must be covered under the Plan at the time of the Qualifying Event.
- B. **Billing and Premiums.** Child-Only coverage will be billed at a child-only rate, as determined by PEBA.
- C. **Coverage.** Subscribers with Child-Only continuation coverage may not add their own Dependents. Only Subscribers who were Dependent Children may be covered under a Child-Only continuation coverage policy.

- D. Exclusions.** Child-Only continuation coverage is subject to the exclusions of Paragraph 9.T and other Plan exclusions specific to Dependent Children.
- E. Duration of Coverage.** Child-Only continuation coverage will be available for the durations and terms described in Paragraph 11.8 and 11.9.
- F. Waiver of COBRA rights.** Upon the Qualifying Event that would entitle a Covered Dependent Child to continuation coverage pursuant to Paragraph 10.4, the Covered Dependent Child shall, in accordance with applicable law, be provided with an opportunity to elect COBRA continuation coverage as described in Article 11. The Covered Dependent Child may elect COBRA continuation coverage or the continuation coverage in Paragraph 10.4. A Covered Dependent Child shall not be eligible for the continuation coverage provided under Paragraph 10.4 unless the Covered Dependent Child declines to elect continuation coverage under COBRA as set forth in Article 11.

10.5 Former Spouse Continuation Coverage

A Covered Dependent Spouse who loses coverage due to divorce may elect to continue coverage under the Plan with Former Spouse continuation coverage, as described and subject to the limitations below:

- A. Court Order Required.** A Covered Dependent Spouse may only elect Former Spouse continuation coverage if the Employee through whom they had coverage under the Plan is required by a court order or divorce decree to provide coverage to the Covered Dependent Spouse after the divorce.
- B. Individual Coverage.** The Former Spouse's coverage is separate from the Employee's coverage. The Former Spouse may only elect individual coverage and may not add dependents.
- C. Eligibility.** The Former Spouse must submit an election of benefits, in a manner approved by PEBA, within 31 days of the date the court order or divorce decree is filed, and submit the filed, signed, dated copy of the order or decree. If a Former Spouse does not submit all required documents within 31 days of the date the court order or divorce decree is filed, the Former Spouse is not eligible to enroll in Former Spouse continuation coverage at a later date.
- D. Effective Date of Coverage.** Coverage is effective the first day of the month after the date the court order or divorce decree is filed.
- E. Duration of Coverage.** Coverage is effective only so long as the Employee required to provide insurance coverage maintains insurance coverage through PEBA, and so long as required by the court order or divorce decree.
- F. Changes to Coverage.** A Former Spouse may make changes to their coverage during Open Enrollment. If a Former Spouse disenrolls from all insurance coverage through PEBA, the Former Spouse is not eligible to re-enroll at a later date.
- G. Billing and Payment.** Former Spouse coverage is billed at the full amount of the premium, as determined by PEBA. If a Former Spouse's coverage is cancelled due to non-payment, the Former Spouse is not eligible to re-enroll.
- H. Termination of Coverage.** A Former Spouse's coverage shall cease when the Employee is no longer

required to provide insurance coverage, the Plan is terminated with respect to all Former Spouses, when the Former Spouse's contribution becomes 60 days past due, or for other reasons described in Paragraph 11.9. In the event of coverage cancellation due to payment delinquency, coverage will terminate retroactively to the last day of the month for which the Former Spouse paid the full premium.

- I. **Waiver of COBRA rights.** Upon the divorce that would entitle a Covered Dependent Spouse to continuation coverage pursuant to Paragraph 10.5, the Covered Dependent Spouse shall, in accordance with applicable law, be provided with an opportunity to elect COBRA continuation coverage as described in Article 11. The Covered Dependent Spouse may elect COBRA continuation coverage or the continuation coverage in Paragraph 10.5. A Covered Dependent Spouse shall not be eligible for the continuation coverage provided under Paragraph 10.5 unless the Covered Dependent Spouse declines to elect continuation coverage under COBRA as set forth in Article 11.

ARTICLE 11.

COBRA

11.1 The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

COBRA requires that a Qualified Beneficiary who would otherwise lose coverage as a result of a Qualifying Event, as defined in that act, is entitled to elect to temporarily extend health coverage under this Plan. The coverage will be identical to the coverage provided to the Qualified Beneficiary before the Qualifying Event and identical to the coverage provided to similarly situated Employees to whom a Qualifying Event has not occurred. Continuation Coverage may not be conditioned upon evidence of good health. If the Plan provides an Open Enrollment Period during which similarly situated Active Employees may choose to be covered under another group health plan, or to add or eliminate coverage of family members, the Plan shall provide the same opportunity to Qualified Beneficiaries who have elected continuation coverage. If continuation coverage under the Plan is elected by a Qualified Beneficiary, expenses already credited to the Plan's applicable Cost Sharing features for the year will be carried forward into the continuation coverage elected for that year.

Qualified Beneficiaries may be eligible for more affordable coverage options through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as through special enrollment in a Spouse's plan if elected within 30 days after the loss of coverage under this Plan). Some of these options may cost less than COBRA continuation coverage. Qualified Beneficiaries should compare other coverage options with COBRA continuation coverage. Once the choice is made, it is difficult or impossible to modify the decision.

The Health Insurance Marketplace offers "one-stop shopping" to find and compare private health insurance options. Qualified Beneficiaries might be eligible for a tax credit that lowers monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) for policies purchased on the Marketplace. The Marketplace may be accessed at www.HealthCare.gov. Qualified Beneficiaries have a 60-day special enrollment period from the time that coverage is lost under the Plan to enroll in the Marketplace. If enrollment does not occur in the 60-day special enrollment period, enrollment in the Marketplace may occur during the Marketplace's annual

open enrollment period.

11.2 Qualifying Event

A Qualifying Event is any one of the following:

- A. Termination of the Employee's employment (other than for gross misconduct) or reduction of hours worked so as to render the Employee ineligible for coverage;
- B. The death of the Employee;
- C. Divorce or legal separation of the Employee from a spouse; and
- D. A Dependent Child ceasing to qualify as an eligible Dependent under the Plan.

11.3 Qualified Beneficiary

A Qualified Beneficiary is any individual who, on the day before the Qualifying Event, is a beneficiary under the Plan and is any of the following:

- A. The Employee whose employment was terminated (other than for gross misconduct) or work hours were reduced so as to render the Employee ineligible for coverage;
- B. The Spouse of the Employee; or
- C. The Dependent Child of the Employee, including a Child who is born to or placed for adoption with the Employee during the period of continuation coverage.

11.4 Notice by Employee, Spouse, or Child

- A. **Qualifying Event.** In cases of divorce or legal separation of the Employee from a Spouse, or when a Child ceases to qualify as an eligible Dependent under the Plan, the Employee or eligible Dependent is responsible for notifying the benefits office of the Employer or the Plan Administrator within 60 days after the later of (i) the date of the Qualifying Event, or (ii) the date the Dependent would lose coverage on account of the Qualifying Event.

If the Plan Administrator is not notified within 60 days of the occurrence of either event, the Dependent will not be given the opportunity to continue coverage.

- B. **Disability.** An Employee or Dependent who is determined to be disabled under Title II or XVI of the Social Security Act, either before the Qualifying Event or during the first 60 days of continued coverage under COBRA, must provide notice of the determination of disability before the end of the first 18 months of coverage to be eligible for up to 29 months of continuation coverage. The notice must be provided within 60 days after the latest of: (i) the date of the determination of disability under the Social Security Act; (ii) the date the Qualifying Event occurs; (iii) the date the Qualified Beneficiary loses or would lose coverage due to the Qualifying Event; or (iv) the date the Qualified Beneficiary is notified of their notice obligation. In addition, the Qualified Beneficiary must also notify the Plan Administrator within 30 days of any determination that the Employee or Dependent is no longer disabled.

- C. Second Qualifying Event.** In cases of a Second Qualifying Event under Paragraph 11.8.E, the Qualified Beneficiary must notify the Plan Administrator within 60 days of the occurrence of the Second Qualifying Event.

11.5 Notice by Plan Administrator

The Plan Administrator shall provide, at the time of commencement of coverage under the Plan, written notice to each Covered Employee and to the Spouse of the Covered Employee (if any) of their rights to continuation coverage. The Plan may satisfy this obligation by furnishing a single notice addressed to both a Covered Employee and the Covered Employee's Spouse if they both reside at the Covered Employee's address, and the Spouse's coverage commences on or after the date on which the Covered Employee's coverage commences, but not later than the date by which this general notice must be provided. No separate notice is required to be sent to Dependent Children who share a residence with a Covered Employee or a Covered Employee's Spouse. This general notice shall be provided not later than the earlier of: (i) 90 days after such individual's coverage commencement date under the Plan; or (ii) the date on which the Plan Administrator is required to furnish a COBRA election notice as described in this Paragraph.

The Employer shall notify the Plan Administrator or its designee in the event of a Covered Employee's death, termination of employment (other than gross misconduct), or reduction in hours within 30 days after the later of: (i) the date of the Qualifying Event; or (ii) the date that the Qualified Beneficiary would lose coverage due to the Qualifying Event.

The Covered Employee and the Covered Employee's Dependent(s) shall be notified by the Plan Administrator or its designee of their right to elect continuation coverage: (i) in the event of the Covered Employee's death, termination, or reduction in hours; and (ii) if the Covered Employee is notified by the Plan Administrator or its designee initially, in the event of divorce or legal separation of the Covered Employee from the Covered Employee's Spouse, disability, or in the event of a Child ceasing to be a Dependent Child under the Plan, within 14 days of the date on which the Plan Administrator or its designee was notified of these Qualifying Events. Election form shall be sent by U.S. Mail, postage pre-paid, to the last known address of the Qualified Beneficiaries unless the Plan Administrator has been notified in writing to the contrary. The last known address shall be deemed to be the most recent address in the records of the Plan Administrator. In the event the Covered Employee/former Covered Employee changes address, it is their responsibility to notify the Plan Administrator of any change in address. The Plan Administrator shall not be responsible for notices sent to the wrong address if the more recent address was not provided in the above manner. Notification to a Covered Employee/former Covered Employee who elected spousal coverage shall be sent with an envelope addressed to the Covered Employee and Spouse. Election forms sent to an Covered Employee/former Covered Employee that has one or more Children/Dependents covered shall be addressed to the Covered Employee (if the Spouse was not covered) or to the Covered Employee and Spouse (if spousal coverage was elected), and each shall be deemed to include notification to any Dependent Children, unless the Plan Administrator has actual knowledge of a different address for a Dependent Child before the date the election form is mailed and any such notification to the Plan Administrator was in writing sent via either U.S. Mail or facsimile.

In addition, if a Covered Employee or Dependent is not entitled to receive Continuation Coverage, they will be so notified and will be provided with an explanation as to why they are not entitled to this Continuation Coverage. This notice shall be provided within 14 days of the date that the Plan Administrator was provided with the notice of the purported qualifying event.

11.6 Election of Coverage

Continued coverage is not automatic. Coverage must be elected within 60 days of the later of the following: (i) the date coverage ceases because of the Qualifying Event; or (ii) the date the Qualified Beneficiary is sent notice of the right to elect continuation coverage.

11.7 Premium Required

The Plan will determine the amount of premium to be charged for continued coverage for any period, which will be a reasonable estimate of the cost of providing coverage for such period for similarly situated individuals, determined on an actuarial basis and considering such factors as may be provided by law.

- A. The Plan may require a Qualified Beneficiary to pay a contribution for coverage that does not exceed 102% of the applicable premium for that period.
- B. For Qualified Beneficiaries whose coverage is continued as a result of disability, the Plan may require the Qualified Beneficiary to pay a contribution for coverage that does not exceed 150% of the applicable premium for continued coverage months 19–29.
- C. Contributions for coverage shall be paid in monthly installments.
- D. If continued coverage is elected, the monthly contribution for coverage for those months up to and including the month in which the election is made must be made within 45 days of the date of election. Failure to pay this premium on the date due shall result in cancellation of continued coverage back to the initial date coverage would have terminated as a result of the Qualifying Event.
- E. Without further notice from the Plan, the Qualified Beneficiary must pay each following monthly contribution for coverage by the tenth day of the month for which coverage is to be effective. If payment is not received by the Plan within 60 days of the payment due date, continued coverage will terminate. This 60-day grace period does not apply to the first contribution required under Paragraph D.
- F. No claim will be payable under this Paragraph for any period for which the contribution for coverage is not received from or on behalf of the Qualified Beneficiary.
- G. It is Qualified Beneficiary's responsibility to pay the premium on time. If the Plan Administrator provides a Qualified Beneficiary with payment reminders or payment coupons, but later ceases to do so, it still remains the Qualified Beneficiary's responsibility to make the premium payments on time even if the Qualified Beneficiary no longer receives the payment reminders or coupons, and even if the Qualified Beneficiary is not notified of the cessation of the payment reminders or coupons.

11.8 Maximum Length of Coverage

Continuation Coverage is a temporary continuation of coverage. In general, the following rules will determine the length of the coverage. However, there are two situations that can extend the coverage: disability and second qualifying events.

- A. **18 Months.** A Qualified Beneficiary who loses coverage due to the reduction in hours or termination of employment (other than for gross misconduct) of a Covered Employee may continue coverage

under the Plan for up to 18 months from the date of the Qualifying Event or the date notice of the right to elect continuation coverage is sent.

- B. 36 Months.** A Qualified Beneficiary who loses coverage due to the Covered Employee's death, divorce, or legal separation, and Dependent Children who have become ineligible for coverage, may continue coverage under the Plan for up to 36 months from the date of the Qualifying Event or the date notice of the right to elect continuation coverage is sent. In the event of the Covered Employee's death, the Spouse and Child are entitled to continuation coverage as described in Article 10 above in lieu of COBRA continuation coverage (see Paragraph 10.4).
- C. Medicare.** If a Covered Employee became entitled to Medicare benefits less than 18 months before the Participant's employment ended or their hours were reduced, the Spouse and Children of the Covered Employee may continue coverage under the Plan for up to thirty-six 36 months from the date of the Medicare entitlement
- D. Disability.** In the event of a disability determination when the initial Qualifying Event is a termination or reduction of hours under Paragraph 11.2.A, the Qualified Beneficiary is entitled to 29 months of continuation coverage if the Qualified Beneficiary provides notice as required in Paragraph 11.4.B.
- E. Second Qualifying Event.** If a Qualified Beneficiary is continuing coverage due to a Qualifying Event for which the maximum continuation coverage is 18 or 29 months, and a second Qualifying Event occurs during the 18 or 29 month period, all individuals who were Qualified Beneficiaries in connection with the initial Qualifying Event and who are still Qualified Beneficiaries at the time of the second Qualifying Event may elect to continue coverage under the Plan for up to 36 months from the date of the first Qualifying Event.

For example, this extension may be available to the Spouse and any Dependent Children who are already receiving continuation coverage if the Covered Employee or former Covered Employee dies, or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

11.9 Early Termination of Continuation Coverage

Coverage under Paragraph 11.8 may end before the end of the maximum coverage period and will occur on the date of the earliest of any of the following:

- A.** The date the State or the Employer associated with the Qualified Beneficiary ceases to provide any group health plan to any Employee;
- B.** The date, including any grace period provided herein, the Qualified Beneficiary fails to make any required payment;
- C.** The first date after the date of election in which the Qualified Beneficiary is covered under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary. An Employee who, on the date of the Qualifying Event, is covered by

a plan (including Medicare) other than this Plan, remains eligible for continuation coverage under COBRA under this Plan;

- D. The date the Employee or eligible Dependent already enrolled for continuation coverage under COBRA becomes entitled to Medicare; and
- E. For disabled Qualified Beneficiaries continuing coverage for up to 29 months, the last day of the month coincident with or following 30 days from the date of a final determination by the Social Security Administration that such Qualified Beneficiary is no longer disabled.

Notwithstanding the foregoing, the Plan may also terminate the continuation coverage of a Qualified Beneficiary for cause on the same basis that the Plan could terminate the coverage of a similarly situated non-COBRA beneficiary for cause (*e.g.*, in the case of submitting fraudulent claims to the Plan).

In the event a Qualified Beneficiary's continuation coverage terminates before the duration of continuation coverage (either 18, 29, or 36 months after the Qualifying Event), the Plan Administrator shall notify the Qualified Beneficiary of the early termination date and the reason for early termination of continuation coverage. Such notice will be provided as soon as practicable following the Plan Administrator's determination that continuation coverage should terminate.

11.10 Persons on Military Leave

Any Covered Employee who is covered under this Plan immediately prior to the Covered Employee's covered absence for Service in the Uniformed Service shall be entitled to elect to continue coverage under this Plan for the Covered Employee and the Covered Employee's Dependent(s) during the Covered Employee's leave for Service in the Uniformed Service pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Such coverage is available if the Covered Employee is absent from employment because of voluntary or involuntary performance of duty in the Army; Navy; Marine Corps; Air Force; Coast Guard; the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty; the commissioned corps of the Public Health Service; the reserve components of each of these services; and any other category of persons designated by the President of the United States in time of war or national emergency. Uniformed services also include certain types of service by members in the National Disaster Medical System and certain types of service by certain members of the Reserve Officers' Training Corps.

The Covered Employee may elect to continue coverage described in this Article by reason of Service in the Uniformed Services for themselves and their covered Dependents. Dependents do not have an independent right to elect USERRA continuation coverage. The election period for continued coverage shall begin on the date the Covered Employee gives the Employer advance notice that they are required to report for Uniformed Service (whether such service is voluntary or involuntary) and shall end 60 days after the date the Covered Employee would lose coverage under the Plan.

If the Covered Employee is unable to give advance notice of Uniformed Service, the Covered Employee may still be able to elect USERRA continuation coverage if the failure to give advance notice was because giving such notice was impossible, unreasonable, or precluded by military necessity. In such case, the election period shall begin on the date the Covered Employee leaves for Uniformed Service and shall end on the earlier of: (i) the 36-month period beginning on the date on which the Covered Employee's absence for the Uniformed Service begins; or (ii) the date on which the Covered Employee fails to return from

Uniformed Service or apply for a position of employment as provided under 20 CFR. §§ 1002.115-123. For these purposes, "military necessity" occurs only when deemed to be so by a designated military authority as described in 20 CFR § 1002.86 and may include situations where a mission, operation, exercise, or requirement is classified or could be compromised or otherwise adversely affected by public knowledge. It may be impossible or unreasonable to give advance notice under certain circumstances such as when the Employer is unavailable or the Covered Employee is required to report for Uniformed Service in an extremely short period of time.

The election of USERRA continuation coverage must be made on a form provided by the Plan Administrator and made within the 60-day period described herein. An election is considered to be made on the date it is sent to the Plan Administrator. If timely elected pursuant to this Paragraph, coverage shall be reinstated as of the date the Covered Employee lost coverage due to absence for Service in the Uniformed Service and shall last for the period set forth below, provided the Covered Employee pays all unpaid costs for the coverage as described in this Paragraph.

Any Covered Employee or Dependent who elects to continue coverage under this provision shall be required to pay 102% of the applicable premium as discussed in Paragraph 11.7 above. Any Covered Employee (and the Dependents of such Covered Employee) who is on military leave for less than 31 days shall not be required to pay more than the cost of coverage typically charged to similarly situated Covered Employees (and their Dependents).

A Covered Employee who is absent from work by reason of Service in the Uniformed Services may be eligible for COBRA continuation coverage. The USERRA continuation coverage provided in this Paragraph shall not limit or otherwise interfere with those COBRA continuation coverage rights detailed above. Any USERRA continuation coverage provided under this Paragraph shall run concurrently with any COBRA Continuation Coverage available under this Plan.

The Employer shall promptly reinstate Plan coverage when a Covered Employee is reemployed after Service in the Uniformed Service. A request to reinstate Plan coverage must be made by the Covered Employee within 31 days of reemployment (presuming the Covered Employee has sought reemployment with the Plan in compliance with 20 CFR Part 1002, Subpart C). If no request is made within this time period, no coverage shall be reinstated under the Plan. When a Covered Employee's coverage under the Plan is reinstated, they will not be subject to any exclusion or waiting periods. However, this rule does not apply to any conditions that were Incurred or that were aggravated during the Covered Employee's service in uniformed services.

The USERRA continuation coverage provided to a Covered Employee serving in the Uniformed Services shall be identical to the coverage provided under the Plan to similarly situated persons covered by the Plan who are active. If coverage is modified under the Plan for any group of similarly situated beneficiaries, such coverage shall also be modified in the same manner for all individuals who are covered under USERRA continuation coverage. Continuation coverage may not be conditioned on evidence of good health. If the Plan provides an Open Enrollment Period during which similarly situated active Employees may choose to be covered under another group health plan or under another benefit package within the Plan, or to add or eliminate coverage of family members, the Plan shall provide the same opportunity to individuals who have elected USERRA continuation coverage.

ARTICLE 12.

CLAIMS PROCEDURE

12.1 Categories of Claims

As described below, there are four categories of claims that can be made under the Plan, each with somewhat different claim and appeal rules. The primary difference is the timeframe within which claims and appeals must be determined.

- A. Pre-Service Claim.** A claim is a pre-service claim if the Plan specifically conditions receipt of the benefit, in whole or in part, on receiving approval in advance of obtaining the medical care, unless the claim involves urgent care, as defined below. Benefits under the Plan that require approval in advance are specifically noted in the Plan as being subject to Prior Authorization.
- B. Urgent Care Claim.** An urgent care claim is a special type of pre-service claim. A claim involving urgent care is any pre-service claim for medical care or treatment with respect to which the application of the time periods that otherwise apply to pre-service claims could seriously jeopardize the Covered Person's life or health or ability to regain maximum function or would, in the opinion of a physician with knowledge of the Covered Person's medical condition, subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

On receipt of a pre-service claim, the Plan will make a determination of whether it involves urgent care, provided that, if a physician with knowledge of the Covered Person's medical condition determines that a claim involves urgent care, the claim shall be treated as an urgent care claim.

- C. Post-Service Claim.** A post-service claim is any claim for a benefit under the Plan that is not a pre-service claim, an urgent care claim, or a concurrent care claim.
- D. Concurrent Care Claim.** A concurrent care decision occurs where the Plan approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims: (a) where reconsideration of the approval results in a reduction or termination of the initially approved period of time or number of treatments; and (b) where an extension is requested beyond the initially approved period of time or number of treatments.
- B. Change in Claim Type.** The claim type is determined initially when the claim is filed. However, if the nature of the claim changes as it proceeds through these claims procedures, the claim may be re-characterized. For example, a claim may initially be an urgent care claim. If the urgency subsides, it may be re-characterized as a pre-service claim.

12.2 Making a Claim for Benefits

- A.** A Covered Person will present an identification card when applying for services covered under this Plan;
- B.** Except for Urgent Care Claims, discussed below in Paragraph 12.3, written notice of care on which a claim is based must be furnished to the Third-Party Claims Processor within 90 days of the

beginning of care, or as soon thereafter as is reasonably possible. Upon receipt of the notice, the Third-Party Claims Processor will furnish or cause to be furnished to the Covered Person a claim form. If the claim form is not furnished within 15 days after the receipt of the notice by the Third-Party Claims Processor, the Covered Person will be deemed to have complied with the requirements of this Plan as to proof of loss, provided the Covered Person submits written proof covering the character and extent of the loss as described in Paragraphs C–E below;

- C. A Covered Person must complete or cause to be completed and file or cause to be filed a claim on forms prescribed by the Plan Administrator or Third-Party Claims Processor, along with all documentation, including medical records, required by the Plan Administrator or Third-Party Claims Processor. The claim will be deemed written proof of loss and written authorization from the Covered Person to the Third-Party Claims Processor to obtain any medical records, financial records, and other documents useful to the Third-Party Claims Processor. However, the Third-Party Claims Processor is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied to it at the time the claim was processed;
- D. The claim must be received by the Third-Party Claims Processor within 90 days after the beginning of care. However, failure to file the claim within the 90-day period will not prevent payment of benefits if the Covered Person shows that it was not reasonably possible to file the claim timely, provided the claim is filed as soon as is reasonably possible but in no event, except in the absence of legal capacity, later than 12 months following the end of the Plan Year in which the goods or services were provided;
- E. Any party who submits medical or financial reports and documents to the Third-Party Claims Processor in support of a Covered Person's claim will be deemed to be acting as the agent of the Covered Person.

12.3 Urgent Care Claims

In light of the expedited timeframes for decision of Urgent Care Claims, an Urgent Care Claim for benefits may be submitted to the Third-Party Claims Processors by telephone, by fax, or by e-mail. The claim should include at least the following information:

- A. The identity of the Covered Person;
- B. A specific medical condition or symptom; and
- C. A specific treatment, service, or product for which approval or payment is requested.

12.4 Incorrectly Filed Claims

These claims procedures do not apply to any request for benefits that is not made in accordance with these claims procedures, except that: (a) in the case of an incorrectly filed Pre-service Claim, the Covered Person shall be notified as soon as possible but no later than five days following receipt by the Plan of the incorrectly filed claim; and (b) in the case of an incorrectly filed Urgent Care Claim, the Covered Person shall be notified as soon as possible but no later than 24 hours following receipt by the Plan of the incorrectly filed claim. The notice shall explain that the request is not a claim and describe the proper procedures for filing a claim. The notice may be oral unless written notice is specifically requested by the Covered Person. This special timing rule applies only to urgent care claims and pre-service claims that:

(a) are received by the person or unit customarily responsible for handling benefit matters; and (b) specify a claimant, a medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

12.5 Payment of Claims

The Third-Party Claims Processor will pay benefits, as described in Article 7, Schedule of Benefits, of this Plan directly to Providers who are members in the Plan's Provider Networks ("Participating Providers") and to any other Providers with whom the Plan Administrator has agreed to make direct payments ("Contracting Providers"). These payments will be made automatically and without any assignment of benefits by the Subscriber when the Participating or Contracting Provider files a health insurance claim form with the Third-Party Claims Processor that is: (i) signed by a Covered Person, and (ii) completed in full, using procedure codes designated by the Third-Party Claims Processor for all services rendered.

The right to assign any benefits due and payable hereunder is expressly prohibited except as provided herein. In particular, and without limiting the generality of the foregoing, the Covered Person may not assign any benefits, and the Plan Administrator shall not recognize any assignment of benefits, to: (i) a non-participating provider who was offered and declined membership in the networks; (ii) a non-participating Provider who did not meet the standards and qualifications for membership in the networks; or (iii) a supplier of medical goods, supplies, or drugs, unless specifically authorized by the Plan Administrator. The Covered Person may assign benefits to non-participating Providers rendering Medical Care under the Plan who are not within the scope of the networks, who were not offered and did not decline membership in the networks, or as specifically authorized by the Plan Administrator. Failure by the Plan Administrator or the Third-Party Claims Processor to reject an assignment of benefits prohibited by this Paragraph shall not be construed as a waiver of its rights to enforce this Paragraph in the event of subsequent assignments.

If a Provider who may accept assignment of benefits files a health insurance claim form with the Third-Party Claims Processor that is: (i) signed by a Covered Person, and (ii) completed in full, using procedure codes designated by the Third-Party Claims Processor for all services rendered, the Third-Party Claims Processor will pay the benefits to the Provider. Except as provided above, the Third-Party Claims Processor on behalf of the Plan will pay all benefits directly to the Covered Person upon receipt of due proof of loss.

12.6 Right to Examine Covered Person

The Third-Party Claims Processor, on behalf of the Plan Administrator and at the Third-Party Claims Processor's own expense, has the right and opportunity to examine the person of any Covered Person whose injury or illness is the basis of a claim when and as often as it may reasonably be required during the pendency of a claim or action hereunder.

12.7 Allocation and Apportionment of Benefits

The Third-Party Claims Processor, on behalf of the Plan, has the right to allocate the Deductible to any eligible charges and to apportion the benefits to the Covered Person and any assignees. Such allocation and apportionment shall be conclusive and binding upon the Covered Person and all assignees.

12.8 Timeframe for Third-Party Claims Processor or Utilization Review Agency to Make Initial Determination Regarding Benefit Claims

- A. **Pre-Service Claims:** The Third-Party Claims Processor or Utilization Review Agency shall decide an initial Pre-Service Claim within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim.
- B. **Urgent Care Claims:** The Third-Party Claims Processor or Utilization Review Agency shall decide an initial Urgent Care Claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim.
- C. **Concurrent Care Extension Request:** If a claim is a request to extend a concurrent care decision (defined above) involving Urgent Care and if the claim is made at least 24 hours prior to the end of the initially approved period of time or number of treatments, the Third-Party Claims Processor or Utilization Review Agency shall decide the claim within no more than 24 hours after receipt of the claim. Any other request to extend a concurrent care decision shall be decided by the Third-Party Claims Processor or Utilization Review Agency in the otherwise applicable timeframes for Pre-Service, Urgent Care, or Post-Service Claims.
- D. **Concurrent Care Early Termination:** A decision by the Third-Party Claims Processor or Utilization Review Agency to reduce or terminate an initially approved course of treatment is an adverse benefit decision that may be appealed by the Covered Person under these claims procedures, as explained below. Notification to the Covered Person of a decision by the Third-Party Claims Processor or Utilization Review Agency to reduce or terminate an initially approved course of treatment shall be provided sufficiently in advance of the reduction or termination to allow the Covered Person to appeal the adverse decision and receive a decision on review under these procedures prior to the reduction or termination.
- E. **Post-Service Claim:** The Third-Party Claims Processor or Utilization Review Agency shall decide an initial Post-Service Claim within a reasonable time but no later than 30 days after receipt of the claim.
- F. **When Extensions of Time Are Permitted:** Despite the specified timeframes, nothing prevents the Covered Person from voluntarily agreeing to extend the above timeframes. In addition, if the Third-Party Claims Processor or Utilization Review Agency is not able to decide a Pre-Service or Post-Service Claim within the above timeframes due to matters beyond its control, one 15-day extension of the applicable timeframe is permitted, provided that the Covered Person is notified in writing prior to the expiration of the initial timeframe applicable to the claim. The extension notice shall include a description of the matters beyond the Third-Party Claims Processor's or Utilization Review Agency's control that justify the extension and the date by which a decision is expected. No extension is permitted for Urgent Care Claims.
- G. **Incomplete Claims:** If any information needed to process a claim is missing, the claim shall be treated as an incomplete claim.
- H. **How Incomplete Urgent Care Claims Are Treated:** If an Urgent Care Claim is incomplete, the Third-Party Claims Processor or Utilization Review Agency shall notify the Covered Person as soon as possible, but no later than 24 hours following receipt of the incomplete claim. The notification may be made orally to the Covered Person, unless the Covered Person requests written notice and the

notification shall describe the information necessary to complete the claim and shall specify a reasonable time, no less than 48 hours, within which the claim must be completed. The Third-Party Claims Processor or Utilization Review Agency shall decide the claim as soon as possible but not later than 48 hours after the earlier of: (a) receipt of the specified information; or (b) the end of the period of time provided to submit the specified information.

- I. **How Other Incomplete Claims Are Treated:** If a Pre-Service or Post-Service Claim is incomplete, the Third-Party Claims Processor or Utilization Review Agency may deny the claim or may take an extension of time, as described above. If the Third-Party Claims Processor or Utilization Review Agency takes an extension of time, the extension notice shall include a description of the missing information and shall specify a timeframe, no less than 45 days, in which the necessary information must be provided. The timeframe for deciding the claim shall be suspended from the date the extension notice is received by the Covered Person until the date the missing necessary information is provided to the Third-Party Claims Processor or Utilization Review Agency. If the requested information is provided, the Third-Party Claims Processor or Utilization Review Agency shall decide the claim within the extended period specified in the extension notice. If the requested information is not provided within the time specified, the claim may be decided without that information.

12.9 Notification of Initial Benefit Decision by Third-Party Claims Processor or Utilization Review Agency

- A. **Pre-Service and Urgent Care:** Written notification of the Third-Party Claim Processor's or Utilization Review Agency's decision on a Pre-Service or Urgent Care Claim shall be provided to the Covered Person whether or not the decision is adverse.
- B. **Definition of Adverse:** A decision on a claim is "adverse" if it is: (a) a denial, reduction, or termination of; or (b) a failure to provide or make payment (in whole or in part) for a Plan benefit, including determinations based on eligibility and utilization review, or a failure to cover a benefit because it is determined to be experimental or investigational or not Medically Necessary. It also means a Rescission of coverage whether or not, in connection with the Rescission, there is an adverse effect on any particular benefit at that time.
- C. **Notification of Adverse Benefit Decision:** Written notification shall be provided to the Covered Person of the Third-Party Claims Processor's or Utilization Review Agency's adverse decision on a claim and shall include the following, in a manner calculated to be understood by the Covered Person:
 - 1. A statement of the specific reason(s) for the decision;
 - 2. Reference(s) to the specific Plan provision(s) on which the decision is based;
 - 3. A description of any additional material or information necessary to perfect the claim and why such information is necessary;
 - 4. A description of the Plan procedures and time limits for appeal of the decision and the right to obtain information about those procedures, information on the External Review process under Paragraph 12.10.B, and the right to appeal to a court of law;

5. A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
6. If the decision involves scientific or clinical judgment, either: (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to the Covered Person's medical circumstances; or (b) a statement that such explanation will be provided at no charge upon request;
7. Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
8. The denial code and its corresponding meaning, as well as a description of the Benefit Administrator's standard, if any, that was used in the denial of the claim;
9. 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 Services Act to assist individuals with the internal claims and appeals and External Review processes; and
10. In the case of an Urgent Care Claim, an explanation of the expedited review methods available for such claims.

Notification of the Third-Party Claims Processor's or Utilization Review Agency's adverse decision on an Urgent Care Claim may be provided orally, but written notification shall be furnished not later than three days after the oral notice.

12.10 Appeal Procedure

A Covered Person has a right to appeal an adverse decision under these claims procedures. The exclusive remedy for the denial of benefits shall be as provided by statute and by the procedures of PEBA.

A. Request for Reconsideration

1. **Non-Urgent Care Claim Appeal.** Except for Urgent Care Claims, discussed below, an appeal of an adverse benefit decision is filed when a Covered Person (or authorized representative) submits a written Request for Reconsideration to the Third-Party Claims Processor or Utilization Review Agency. Appeals regarding eligibility decisions will be referred by the Third-Party Claims Processor or the Utilization Review Agency to the Plan Administrator for determination. A written Request for Reconsideration will be treated as received by the Third-Party Claims Processor or Utilization Review Agency: (a) on the date it is hand-delivered to the Third-Party Claims Processor or Utilization Review Agency; or (b) on the date that it is deposited in the U.S. Mail for first-class delivery in a properly stamped envelope containing the address of the Third-Party Claims Processor or Utilization Review Agency. The postmark on any such envelope will be proof of the date of mailing.

2. **Urgent Care Appeals.** In light of the expedited timeframes for decision of Urgent Care Claims, an Urgent Care Request for Reconsideration may be submitted to the Third-Party Claims Processor or Utilization Review Agency by telephone, by fax, or by e-mail. The Urgent Care Request for Reconsideration should include at least the following information:
 - a. The identity of the Covered Person;
 - b. A specific medical condition or symptom;
 - c. A specific treatment, service, or product for which approval or payment is requested; and
 - d. Any reasons why the appeal should be processed on a more expedited basis.
3. **Submission of Comments.** A Covered Person has the right to submit documents, written comments, or other information in support of a Request for Reconsideration, without regard to whether such information was submitted or considered in the initial benefit determination.
4. **Request for Reconsideration Deadline.** The Request for Reconsideration of an adverse benefit decision must be filed within 180 days following the Covered Person's receipt of the notification of adverse benefit decision, except that the appeal of a decision by the Third-Party Claims Processor or Utilization Review Agency to reduce or terminate an initially approved course of treatment (see the definition of Concurrent Care decision) must be filed within 30 days of the Covered Person's receipt of the notification of the decision of the Third-Party Claims Processor or Utilization Review Agency to reduce or terminate. Failure to comply with this deadline will cause the Covered Person to forfeit any right to any further review of an adverse decision under these procedures or in a court of law.
5. **How the Request of Reconsideration Will Be Decided.** The Reconsideration of an adverse benefit decision will be reviewed and decided by the Plan Administrator (with regard to appeals of eligibility decisions), Third-Party Claims Processor, or the Utilization Review Agency. The person who reviews and decides the Reconsideration request will be a different individual than the person who made the Initial Benefit decision and will not be a subordinate of the person who made the Initial Benefit decision. Before issuing a final decision on Reconsideration that is based on a rationale that was not included in the Initial Benefit determination, the Plan Administrator, Third-Party Claims Processor, or the Utilization Review Agency will provide the Covered Person, free of charge, with the rationale as soon as possible and sufficiently in advance of the final Reconsideration decision to give the Covered Person a reasonable opportunity to respond. The Plan Administrator, Third-Party Claims Processor, or the Utilization Review Agency will follow these procedures when deciding any Request for Reconsideration:
 - a. **Consideration of Comments.** The Plan Administrator, Third-Party Claims Processor, or the Utilization Review Agency will take into account all information submitted by the Covered Person, whether or not presented or available at the Initial Benefit

decision. The Plan Administrator, Third-Party Claims Processor, or the Utilization Review Agency will give no deference to the Initial Benefit decision.

- b. Consultation with Expert.** In the case of a claim denied on the grounds of a medical judgment, the Third-Party Claims Processor or the Utilization Review Agency will consult with a health professional with appropriate training and experience. The Health Care Professional who is consulted upon Reconsideration will not be the same individual who was consulted, if any, regarding the Initial Benefit decision or a subordinate of that individual.
- c. Access to Relevant Information.** A Covered Person shall, on request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Person's claim for benefits. If the advice of a medical or vocational expert was obtained in connection with the Initial Benefit decision, the names of each such expert shall be provided on request by the Covered Person, regardless of whether the advice was relied on by the Plan Administrator, Third-Party Claims Processor, or the Utilization Review Agency.
- d. Expedited Methods for Urgent Care.** All necessary information in connection with an Urgent Care Request for Reconsideration shall be transmitted between the Plan Administrator, Third-Party Claims Processor, or the Utilization Review Agency and the Covered Person by telephone, fax, or e-mail.

6. Timeframes for Deciding Request for Reconsideration

- a. Pre-Service Claims.** The Plan Administrator, Third-Party Claims Processor, or the Utilization Review Agency shall decide the Reconsideration of a Pre-Service Claim within a reasonable time appropriate to the medical circumstances but no later than 30 days after receipt by the Plan Administrator, Third-Party Claims Processor, or the Utilization Review Agency of the Request for Reconsideration.
- b. Urgent Care Claims.** The Plan Administrator, Third-Party Claims Processor, or the Utilization Review Agency shall decide the Reconsideration of an Urgent Care Claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt by the Plan Administrator, Third-Party Claims Processor, or the Utilization Review Agency of the Request for Reconsideration.
- c. Post-Service Claims.** The Plan Administrator, Third-Party Claims Processor, or the Utilization Review Agency shall decide the reconsideration of a Post-Service Claim within a reasonable period but no later than 60 days after receipt by the Plan Administrator, Third-Party Claims Processor, or the Utilization Review Agency Plan of the Request for Reconsideration. Provided that if medical records have been requested, the decision will be rendered no later than 30 days after the requested information is received. If the requested information is not received within 30 days, the decision will be made on the information available at that time.
- d. Concurrent Care Claims.** The Third-Party Claims Processor or the Utilization Review Agency shall decide the Reconsideration of a decision by the Third-Party Claims

Processor or the Utilization Review Agency to reduce or terminate an initially approved course of treatment (see the definition of Concurrent Care Decision) before the proposed reduction or termination takes place. The Third-Party Claims Processor or the Utilization Review Agency shall decide the Reconsideration of a denied request to extend any Concurrent Care decision in the Reconsideration timeframe for Pre-Service, Urgent Care, or Post-Service Claims described above, as appropriate to the request.

7. Notification of Decision on Reconsideration. The Plan Administrator, Third-Party Claims Processor, or the Utilization Review Agency shall provide written notification of the Reconsideration decision to the Covered Person whether or not the decision is adverse.

a. Definition of Adverse: A decision on a Request for Reconsideration is "adverse" if it is: (a) a denial, reduction, or termination of; or (b) a failure to provide or make payment (in whole or in part) for a Plan benefit, including determinations based on eligibility and utilization review, or a failure to cover a benefit because it is determined to be experimental or investigational or not Medically Necessary. It also means a Rescission of coverage whether or not, in connection with the Rescission, there is an adverse effect on any particular benefit at that time.

b. Notification of Adverse Request for Reconsideration Decision: Written notification shall be provided to the Covered Person of an adverse decision on Reconsideration and shall include the following, written in a manner calculated to be understood by the Covered Person:

- i. A statement of the specific reason(s) for the decision;
- ii. Reference(s) to the specific Plan provision(s) on which the decision is based;
- iii. A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
- iv. If the decision involves scientific or clinical judgment, either: (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to the Covered Person's medical circumstances; or (b) a statement that such explanation will be provided at no charge upon request;
- v. Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- vi. The denial code and its corresponding meaning, as well as a description of the Plan Administrator's, Third-Party Claims Processor's, or Utilization Review Agency's standard, if any, that was used in the denial of the claim;

- vii. 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 Services Act to assist individuals with the internal claims and appeals and External Review processes;
- viii. A description of the review procedures and time limits, including information regarding how to initiate an appeal information on the External Review process, and a statement of the claimant's right to appeal to a court of law;
- ix. If the denial is a Final Denial, a discussion of the decision; and
- x. A statement indicating entitlement to receive on request, and without charge, reasonable access to or copies of all documents, records, or other information relevant to the determination.

Notification of an adverse decision on Reconsideration of an Urgent Care Claim may be provided orally, but written notification shall be furnished not later than three days after the oral notice.

B. Request for External Review and Plan Administrator Review

1. **Filing of Request for External Review and Plan Administrator Review.** A Covered Person (or someone acting on the Covered Person's behalf) may request External Review and Plan Administrator Review of an adverse benefit decision by the Third-Party Claims Processor or Utilization Review Agency of a Request for Reconsideration by filing a written Request for External Review and Plan Administrator Review with the Plan Administrator within four months after the Covered Person's date of receipt of a notice of an adverse benefit determination.
2. **Preliminary Review of Standard External Review by Plan Administrator.** Within five business days following the date of receipt of the Request for a standard External Review and Plan Administrator Review, the Plan Administrator shall conduct a Preliminary Review of the Request to determine whether:
 - a. The Covered Person is (or was) covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, the Covered Person was covered under the Plan at the time the health care item or service was provided;
 - b. The adverse benefit determination is not based on the fact that the Covered Person was not eligible for coverage under the Plan;
 - c. The adverse benefit determination involved medical judgment (including, but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational) or a Rescission of coverage (whether or not the Rescission has any effect on any particular benefit at that time);

- d. The Covered Person has exhausted the Plan's internal appeal process (unless exhaustion is not otherwise required); and
- e. The Covered Person has provided all the information and forms required to process an External Review.

The Covered Person will be notified of the results of the Preliminary Review within one business day after completion of the Preliminary Review. If the Request is incomplete, the notice must describe the information needed to complete the Request, and set forth the time limit for the Covered Person to provide the additional information needed (the longer of the initial four month period within which to request an External Review or, if later, 48 hours (or such longer period specifically identified in the notice) after the receipt of the notice).

If the claim is eligible for External Review, the Plan Administrator will randomly assign one of three accredited Independent Review Organizations (IRO) to conduct the External Review.

If the claim is not eligible for External Review, the Plan Administrator shall notify the Covered Person and the notification shall include the reasons for its ineligibility. Such a claim may be appealed to the Administrative Law Court within 30 days of the Covered Person's receipt of the adverse decision in accordance with Paragraph C below. Instead of appealing directly to the Administrative Law Court, the Covered Person may first seek a Voluntary Additional Appeal to the Plan Administrator in accordance with Subparagraph (5) below.

3. **Expedited External Review of Urgent Care Claims.** Expedited External Review may be requested by the Covered Person when the Third-Party Claims Processor or Utilization Review Agency issues an adverse benefit determination of a Request for Reconsideration involving an Urgent Care Claim. The request for an Expedited External Review must be made in writing to the Plan Administrator. Immediately upon receipt of the request for an Expedited External Review, the Plan Administrator will determine whether the request meets the eligibility requirements described above in Subparagraph (2) for a standard External Review. If the request meets the requirements for standard External Review, the Covered Person will be notified of the determination, and an IRO will be assigned as described above for a standard External Review.

If the claim is not eligible for External Review, the Plan Administrator shall notify the Covered Person and the notification shall include the reasons for its ineligibility. At the Covered Person's request, such a claim may be appealed to the Administrative Law Court within 30 days of the Covered Person's receipt of the adverse decision in accordance with Paragraph C below. Instead of appealing directly to the Administrative Law Court, the Covered Person may first seek a Voluntary Additional Appeal to the Plan Administrator in accordance with Subparagraph (5) below.

4. **External Review by IRO.** The IRO shall forward any information submitted by the Covered Person to the Third-Party Claims Processor or Utilization Review Agency within one business day of receipt. Upon receipt of any such information, the Third-Party Claims

Processor or Utilization Review Agency may reconsider its adverse benefit determination that is the subject of the External Review Reconsideration, but the reconsideration by the Plan Administrator must not delay the External Review. The External Review may be terminated as a result of reconsideration only if the Third-Party Claims Processor or Utilization Review Agency decides to reverse its adverse benefit determination and provide coverage or payment. In such case, the Third-Party Claims Processor or Utilization Review Agency must provide written notice of its decision to the claimant and the IRS within one business day and the IRO shall then terminate the External Review.

The Third-Party Claims Processor or Utilization Review Agency will provide the IRO with the documents and information considered in making the adverse benefit determination within five business days after the date of assignment of the IRO. Failure by the Third-Party Claims Processor or Utilization Review Agency to timely provide the documents and information shall not delay the conduct of the External Review. If the Third-Party Claims Processor or Utilization Review Agency fails to timely provide the documents and information, the assigned IRO may terminate the External Review and make a decision to reverse the adverse benefit determination. In such case, the IRO shall notify the claimant and the Third-Party Claims Processor or Utilization Review Agency of its decision within one business day.

The Covered Person shall be notified that the Covered Person may submit additional information in writing to the IRO within 10 business days of the IRO's notification that it has been assigned the Request for External Review. The IRO will review all of the information and documents timely received. In making its decision, the IRO is not bound by the Third-Party Claim Processor's or Utilization Review Agency's prior determination. To the extent additional information or documents are available and the IRO considers them appropriate, the IRO may also consider the following in reaching a decision:

- a. The Covered Person's medical records;
- b. The attending Health Care Professional's recommendation;
- c. Reports from appropriate Health Care Professionals and other documents submitted by the Plan, the Third-Party Claims Processor, the Utilization Review Agency, the Covered Person, or the Covered Person's treating health care provider;
- d. The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- e. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- f. Any applicable clinical review criteria developed and used by the Plan; and
- g. The opinion of the IRO's clinical reviewer or reviewers after considering information noted above, as appropriate.

The IRO will provide written notice of the final External Review decision to the Covered Person and the Plan Administrator within 45 days after the IRO receives the request for External Review. The notice will contain the following:

- a. A general description of the reason for the request for External Review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial;
- b. The date the IRO received the assignment to conduct External Review and the date of the adverse benefit determination;
- c. References to the evidence or documentation, including 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 upon in making its decision;
- 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 the Plan or the claimant;
- f. A statement that judicial review may be available to the claimant; and
- g. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

To the extent the final External Review decision reverses the Third-Party Claims Processor's or Utilization Review Agency's decision (as was reflected in the notice of adverse benefit determination), the Plan shall follow the final External Review decision of the IRO.

In the case of an Expedited External Review, the IRO will provide the notice of the final External Review decision as expeditiously as the Covered Person's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the Request for an Expedited External Review. To the extent the final External Review decision reverses the Third-Party Claims Processor's or Utilization Review Agency's decision (as was reflected in the notice of adverse benefit determination), the Plan shall follow the final External Review decision of the IRO. If the IRO's notice of decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours.

To the extent the IRO's final External Review decision is adverse to the Covered Person and upholds the adverse benefit determination by the Third-Party Claims Processor or Utilization Review Agency, the IRO's External Review decision may be appealed to the Administrative Law Court within 30 days of the Covered Person's receipt of the adverse

decision in accordance with Paragraph C below. Instead of appealing directly to the Administrative Law Court, the Covered Person may first seek a Voluntary Additional Appeal to the Plan Administrator in accordance with Subparagraph (5) below.

5. **Voluntary Additional Appeal to Plan Administrator.** After an adverse determination by the IRO pursuant to an External Review provided in Paragraph 12.10(B)(4), after a Preliminary Determination that a claim is not eligible for External Review under Paragraphs 12.10(B)(2) and 12.10(B)(3), or that benefits will not be paid, the Covered Person may request a review by the Plan Administrator or its designee who shall review the Covered Person's claim. This additional review is voluntary. The Covered Person must make the request for review within 90 days after notice of the denial of benefits. Appeals may be brought only by the Covered Person at issue, their legal representative (who cannot be, including but not limited to, a Provider, medical device manufacturer, pharmaceutical manufacturer, , Employer, or a representative or agent of any of the foregoing), or a licensed attorney admitted to practice in South Carolina. The filing of this appeal shall be deemed to be consent for the Plan Administrator or its designee to review all medical records necessary for a determination of the appeal. To hear the appeal, the Plan Administrator may appoint up to five representatives who are familiar with group health benefits and the MUSC Health Plan and who were not involved in the initial denial of benefits.

The Covered Person may submit additional information for review within 30 days of filing their appeal. The Plan Administrator or its designee may request from the Third-Party Claims Processor, the Utilization Review Agency, and the External IRO information they reviewed by it, including the pertinent medical records, and may request any additional information from the Third-Party Claims Processor, the Utilization Review Agency, the External IRO, the Covered Person, independent medical personnel, or other sources as in its judgment may be required to make a determination. The Plan Administrator or its designee shall consider all information submitted by the Covered Person and received in response to requests for additional information, along with the terms and conditions of the Plan. The Plan Administrator or its designee shall issue a written decision within 180 days after the receipt of all material provided by the Covered Person and requested by the Plan Administrator or its designee. In the event the Covered Person does not respond to a request for information within 60 days, the appeal will be deemed to be waived and will be dismissed.

The Plan Administrator or its designee shall provide specific reasons for the decision, including citation to the pertinent Plan provisions, and may, if the Plan Administrator or the Plan Administrator's designee agrees with the External IRO, Third-Party Claims Processor, or Utilization Review Agency, deny the claim of the Covered Person. If the Plan Administrator or its designee agrees with the Covered Person, they may approve the claim or such portion as is appropriate. The Plan Administrator or the Plan Administrator's designee must state in writing the provisions of the Plan justifying the result. The decision of the Plan Administrator or its designee on these matters is binding and conclusive, subject to review pursuant to Paragraph 12.5.C.

The discretionary authority provided to the Plan Administrator or its designee under this provision is not in lieu of, or in derogation of, and does not alter, affect, or reduce the

authority or power of the director to administer this Plan.

- C. Judicial Review.** The exclusive remedy for the denial of benefits shall be as provided in Paragraphs 12.10.A and 12.10.B and by judicial review of that decision under S.C. Code Ann § 1-23-380, as amended, as provided by statute. No appeal may be brought until a Covered Person has exhausted the review procedure set forth in Paragraphs 12.10.A and 12.10.B, nor will such action be brought after the expiration of the applicable period for commencing such actions. Any construction or interpretation of the Plan; determination of eligibility; any decision arising under the Plan; or any exercise of judgment or discretion given to the Plan Administrator by the Plan or Planholder shall be binding and conclusive so long as the decisions of the Plan Administrator or its duly authorized agent are not arbitrary, capricious, or in violation of applicable statutes.

12.11 Effect of Federal Guidance on Claims Procedures

Any information, processes, standards of review, or other elements that are required to be provided under this Article shall be provided or applied only if the Plan is required to do so under applicable legal requirements and the U.S. Departments of Labor, Treasury, and Health and Human Services are currently enforcing such requirements. For these purposes, the Plan may rely fully on the U.S. Department of Labor Technical Release 2011-01, the U.S. Department of Labor Technical Release 2011-02, the June 24, 2011, amendment to the interim final regulations published July 23, 2010, and any subsequent guidance.

12.12 Form and Manner of Notices

Notices provided pursuant to this Article with respect to internal claims and appeals and External Reviews shall be provided in a culturally and linguistically appropriate manner pursuant to Department of Labor regulations. Accordingly, with respect to an address in any United States county to which a notice is sent, if 10% or more of the population residing in the county is literate only in the same non-English language (the "applicable non-English language"), the Third-Party Claims Processor or Utilization Review Agency, as applicable shall: (i) provide oral language services (such as a telephone customer assistance hotline) that include answering questions in the applicable non-English language; (ii) provide notices sent under this Article in the applicable non-English language upon request; and (iii) include a statement in the English versions of all notices sent under this Article, prominently displayed in the applicable non-English language, clearly indicating how to access the language services provided by the Plan. Any information, processes, standards of review, or other elements that are required to be provided under this

12.13 Identification Cards and Booklets

The Plan Administrator or Third-Party Claims Processor will issue to each Covered Person an identification card evidencing coverage and an individual booklet summarizing the benefits to which the Covered Person is entitled. If any amendment to this Plan shall materially affect any benefits described in such booklet, new booklets or booklet pages describing the changes will be issued.

12.14 Privacy of Protected Health Information

- A.** The Plan shall use Protected Health Information to the extent of and in accordance with the uses and disclosures permitted by Health Insurance Portability and Accountability Act of 1996, as amended, (HIPAA) and its implementing regulations (45 CFR Parts 160-64). Specifically, the Plan shall use and disclose Protected Health Information for purposes related to health care treatment, Payment for health care, and Health Care Operations. For purposes of this Paragraph, Plan Sponsor shall mean, for the sole purpose of compliance with the mandates of the HIPAA, the Public Employee Benefit Authority, which established, and maintains, the Group Health Benefits Plan for

the Employees of the State of South Carolina, the Public School Districts and Participating Entities. For purposes of this Paragraph, the terms "Payment" and "Health Care Operations" (as well as any other capitalized term not otherwise defined in this Plan) shall have the meanings provided under 45 CFR Parts 160-64.

B. The Plan may:

1. Disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of: (i) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (ii) modifying, amending, or terminating the Plan.
2. Disclose to the Plan Sponsor information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer offered by the Plan.
3. Disclose Protected Health Information to the Plan Sponsor to carry out Plan administration functions that the Plan Sponsor performs.
4. With an authorization from the Covered Person, disclose Protected Health Information to the Plan Sponsor for purposes related to the administration of other employee benefit plans and fringe benefits sponsored by the Plan Sponsor.
5. Not permit a health insurance issuer with respect to the Plan to disclose Protected Health Information to the Plan Sponsor except as permitted by this Paragraph.
6. Not disclose (and may not permit a health insurance issuer to disclose) Protected Health Information to the Plan Sponsor as otherwise permitted by this Paragraph unless a statement is included in the Plan's notice of privacy practices that the Plan (or a health insurance issuer with respect to the Plan) may disclose Protected Health Information to the Plan Sponsor.
7. Not disclose Protected Health Information to the Plan Sponsor for the purpose of employment related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

C. Prior to disclosing any Protected Health Information to the Plan Sponsor, the Plan Sponsor must certify (and the Plan is hereby amended to state) that the Plan Sponsor agrees to the following (and the Plan will require that the Plan Sponsor):

1. Not use or further disclose Protected Health Information other than as permitted or required by the Plan document or as required by law;
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information;
3. Not use or disclose Protected Health Information for employment-related actions and decisions unless authorized by an individual;

4. Not use or disclose Protected Health Information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
 5. Report to the Plan any Protected Health Information use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
 6. Make Protected Health Information available to an individual in accordance with HIPAA's access requirements pursuant to 45 CFR § 164.524;
 7. Make Protected Health Information available for amendment and incorporate any amendments to Protected Health Information in accordance with 45 CFR § 164.526;
 8. Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;
 9. Make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of the Department of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA; and
 10. If feasible, return or destroy all Protected Health Information received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such Protected Health Information when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).
- D. With respect to PHI, the Plan Administrator agrees to reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the Plan Administrator on behalf of the Plan. Specifically, such safeguarding entails an obligation to:
1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that the Plan Administrator creates, receives, maintains, or transmits on behalf of the Plan;
 2. Ensure that the adequate separation as required by 45 CFR 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
 3. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
 4. Report to the Plan any security incident of which it becomes aware.
- E. The Plan Administrator and any business associate servicing the Plan will disclose Plan participants' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions for the Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended, (HIPAA) and its implementing regulations (45 CFR Parts 160-64). Plan Sponsor shall mean, for the sole purpose of compliance with

the mandates of the HIPAA, the Public Employee Benefit Authority, which established, and maintains, the Group Health Benefits Plan for the Employees of the State of South Carolina, the Public School Districts and Participating Entities.

Neither the Plan Administrator nor any business associate servicing the Plan will disclose Plan participants' Protected Health Information to the Plan Sponsor for the purpose of employment-related actions or decisions in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Third-Party Claims Processor, as agent of the Plan Administrator, is entitled to obtain such authorization for medical and Hospital records as it may reasonably require from any provider of services incident to the administration of the benefits hereunder and the attending Physician's certification as to the Medical Necessity for care or treatment.

The Plan Administrator will be provided access to all claims data and supporting documents of any person covered under the Plan for purpose of auditing the claims adjudication procedures. According to the guidelines set forth under HIPAA, the Plan Administrator agrees to restrict access to all such data and documents to those of the Plan Administrator's employees directly responsible for conduct of the audit, and to assure that the data and documents are handled on a strictly confidential basis.

ARTICLE 12A

REVIEW OF ADMINISTRATIVE CLAIMS BY PEBA

12A.1 Review of Administrative Claims under Article 12A

An "administrative claim" is an administrative decision by PEBA that does not involve the filing of a claim for Covered Medical Benefits under Article 12 of the Plan, including, but not limited to, decisions concerning: an individual's eligibility to participate in the Plan; a subscriber's COBRA eligibility; enrollment matters; tobacco-use premium; and dependent documentation. An individual may request review of PEBA's determination concerning administrative claims in accordance with the procedures set forth in this Article.

12A.2 Claims for Covered Medical Benefits Reviewed under Article 12

A claim for Covered Medical Benefits is a request for a plan benefit or benefits made by a claimant in accordance with the Plan's procedure for filing benefit claims set out in Article 12 of the Plan. If a participant files a claim for Covered Medical Benefits under Article 12, appeals regarding the denial of the claim for Covered Medical Benefits must be reviewed under the procedures set forth in Article 12 even if the basis for the denial of the claim is ineligibility to participate in the Plan or some other non-medical administrative reason.

12A.3 Informal Denial

If an individual or their employer's benefits administrator makes an informal oral or written request regarding an administrative claim that is denied by PEBA, the subscriber or their employer's benefits administrator may seek review of this informal denial by filing a written request for Departmental Review in accordance with Paragraph 12A.4.

12A.4 Departmental Review

- A.** An individual or their employer's benefits administrator may submit a written request to PEBA for Departmental Review of an administrative claim. The individual or their employer's benefits administrator may submit the written request for Departmental Review: (i) of a previous informal denial of the administrative claim under Paragraph 12A.3; or (ii) as an initial request to PEBA regarding an administrative claim.
- B.** The relevant department of PEBA shall review the written request and shall make a written determination regarding the administrative claim. If the written request concerning an administrative claim is denied, the written determination shall contain an appeals notice informing the subscriber that the Departmental Review denial may be appealed to the PEBA Administrative Appeals Committee within 90 days of the date of the Departmental Review denial.

12A.5 Administrative Appeals to PEBA

- A.** The Covered Person at issue, their legal representative (who cannot be, including but not limited to, a Provider, medical device manufacturer, pharmaceutical manufacturer, Employer, or a representative or agent of any of the foregoing) or a licensed attorney admitted to practice in South Carolina may appeal an administrative claim denied in whole or in part pursuant to Departmental Review under Paragraph 12A.4 may appeal the denial to the PEBA within 90 days of the date of the Departmental Review denial. The individual may submit additional information for review within 30 days of filing their appeal.
- B.** The Plan Administrator or its designee shall appoint up to five representatives who are familiar with group health benefits, the State Health Plan, and the MUSC Health Plan and who have not been involved in any previous denial determination in the matter under consideration.
- C.** The Plan Administrator or its designee shall consider all written information submitted, the terms and conditions of the MUSC Health Plan, all information received in response to requests for information, and other sources as in its judgment may be required to make a determination. The Plan Administrator or its designee shall issue a written decision within 180 days after the receipt of all material provided by the Covered Person and requested by the Plan Administrator or its designee. In the event the Covered Person does not respond to a request for information within 60 days, the appeal will be deemed to be waived and will be dismissed.

The Plan Administrator or its designee shall provide specific reasons for the decision, including citation to the pertinent Plan provisions, and may deny the claim of the individual. The Plan Administrator or its designee may approve the claim or such portion as is appropriate. The Plan Administrator or the Plan Administrator's designee must state in writing the provisions of the Plan justifying the result. The decision of the Plan Administrator or its designee on these matters is binding and conclusive, subject to review pursuant to Paragraph 12A.6.

The discretionary authority provided to the Plan Administrator or its designee under this provision is not in lieu of, or in derogation of, and does not alter, affect, or reduce the authority or power of the director to administer this Plan.

12A.6 Judicial Review

The exclusive remedy for the denial of an administrative claim shall be as provided in Paragraphs 12A.3, 12A.4, and 12A.5, and by judicial review of that decision under S.C. Code Ann. Section 1-23-380, as amended, as provided by statute. No appeal may be brought until an individual exhausts the review procedure set forth in Paragraphs 12A.4 and 12A.5, nor will such action be brought after the expiration of the applicable period for commencing such actions, following the occurrence giving rise to the action. Any construction or interpretation of the Plan, determination of eligibility or any other decision arising under the Plan, or exercise of judgment or discretion given to the Plan Administrator by the Plan or Planholder, shall be binding and conclusive so long as the decisions of the Plan Administrator or its duly authorized agent are not arbitrary, capricious, or in violation of applicable statutes.

ARTICLE 13.

NOTICE

Except as otherwise provided in this Plan, any notice that may be required hereunder shall be effective: to the Plan Administrator, when sent to its office; to a Third-Party Claims Processor, when sent to its office; to a Utilization Review Agency, when sent to its office; and to a Covered Person, when sent to the Covered Person at the address as it appears in the records of the Plan Administrator.

ARTICLE 14.

SUBROGATION RIGHTS

In the event benefits are provided to, or on behalf of, a Covered Person under the terms of this Plan, the Covered Person 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. If, however, a Covered Person receives payment for such medical expenses from another person, firm, corporation, organization, or business entity paid by, or on behalf of, the person or entity who allegedly caused the injury or illness, the Covered Person agrees to reimburse the Plan in full for any medical expenses paid by the Plan and the Plan's right of full recovery shall not be limited by any characterization of the nature or purpose of the amounts recovered or by the identity of the party from which recovery is obtained. If a payment is made under this Plan, and the person to or for whom it is made recovers monies from a Third-Party described above as a result of settlement, judgment, or otherwise, that person shall hold in trust for the Plan the proceeds of such recovery and reimburse the Plan to the extent of such payments by the Plan. The Plan's right of full recovery may be from the Third-Party, any liability or other insurance covering the Third-Party, the insured's own uninsured motorist insurance, underinsured motorist insurance, any medical payments, or no fault or malpractice insurance coverages that are paid or payable. The Plan shall have a first priority lien against the proceeds of any recovery by the Covered Person and against future benefits due under the Plan in the amount of any claims paid. The Plan shall have the right to impose a constructive trust over such proceeds, and shall be reimbursed from them. If the Covered Person fails to repay the Plan from the proceeds of any recovery, the Plan Administrator or its designee may satisfy the lien by deducting the amount from future claims otherwise payable under the Plan.

The Plan may enforce its reimbursement rights by requiring the Covered Person to cooperate and to assert a claim to any of the foregoing coverages to which the Covered Person may be entitled. The Plan will not pay fees or costs associated with a claim or lawsuit without its express written authorization. Any attorney's fees or other expenses owed by the Covered Person shall not reduce the amount of reimbursement due to the Plan. To the full extent allowed by law, the Plan hereby disclaims any "make whole" or "common fund" doctrine that might otherwise be applicable to its recovery hereunder. The Covered Person shall cooperate with the Planholder and Third-Party Claims Processor, if appropriate, on behalf of the Planholder and execute all instruments and do all things necessary to protect and secure the Planholder's right of subrogation, including the giving of testimony in any action filed by the Plan. The Covered Person may not release any responsible party from its obligation, or otherwise take any other action that could prejudice recovery by the Plan, without the written consent of the Planholder. If a Covered Person fails or refuses to cooperate in connection with the assertion of claims against a responsible Third-Party, the Plan Administrator or its designee may deny payment of claims (regardless of whether such claims are related to the acts or omissions of the Third-Party or other persons against whom the Covered Person may have a right of recovery) and treat prior claims paid as overpayments recoverable by offset against future Plan benefits or by other action of the Plan Administrator or its designee. Further, if a Covered Person fails or refuses to comply with these provisions by reimbursing the Plan as required herein, the Plan has the right to impose a constructive trust over such any and all funds received by the Covered Person, or as to which the Covered Person has the right to receive. The Plan, through the Plan Administrator, has the authority to pursue any and all legal and equitable relief available to enforce the rights contained in this Paragraph, against any and all appropriate parties who may be in possession of the funds described herein.

In the event benefits are provided to, or on behalf of, a Covered Person under the terms of this Plan, the Planholder shall be subrogated, at its expense and unless specifically prohibited by law, to the rights of recovery of such Covered Person against any person, firm, corporation, or organization, including such Covered Person's right to uninsured motorists benefits as defined by the South Carolina Motor Vehicle Financial Responsibility Act, as amended; provided, however, that the Planholder shall not be subrogated to such Covered Person's rights to Personal Injury Protection (PIP) benefits as defined by the South Carolina Automobile Reparation Reform Act of 1974, as amended. The Covered Person shall cooperate with the Planholder and Third-Party Claims Processor, if appropriate, on behalf of the Planholder and execute all instruments and do all things necessary to protect and secure the Planholder's right of subrogation. The Plan, through the Plan Administrator shall have full discretionary authority to interpret the provisions of this Paragraph, and to administer and pursue the Plan's subrogation and reimbursement rights under this Paragraph.

ARTICLE 15.

UTILIZATION REVIEW AND MANDATORY CASE MANAGEMENT

SECTION 1

15.1.1 Application

The payment of benefits under the Plan is subject to, and contingent upon, the Covered Person's compliance with the following procedures. Provided, however, the payment of benefits for behavioral disorders under the Plan is subject to, and contingent upon, the Covered Person's compliance with the

provisions of Section 2 of this Article and the utilization guidelines established by the Behavioral Health Manager.

15.1.2 Prior Authorization of Medical Care

The Covered Person, a family member, treating Physician, or Hospital treating the Covered Person shall contact the Utilization Review Agency designated by the Plan Administrator for pre-admission review and Authorization at least 48 hours or two working days, whichever is greater, before receiving the following medical services or treatments at any medical facility in the United States or Canada:

- A.** Any non-Emergency admission to a Hospital;
- B.** Any non-Emergency surgical procedure, whether performed in a Hospital, Free Standing Surgical Center, or Ambulatory Surgical Center;
- C.** Any non-Emergency surgical procedure on the foot or knee performed in a Physician's office;
- D.** Any admission for obstetrical and neonatal (sick newborn) services;
- E.** Any hospitalization that exceeds the length of stay limitation previously Authorized by the Utilization Review Agency;
- F.** Any admission or re-admission to Extended Benefit Programs, whether or not the benefits payable under this Plan are Primary or Secondary, such as:
 - 1.** Hospice program;
 - 2.** Skilled Nursing Facility (whether or not the benefits payable under this Plan are Primary or Secondary);
 - 3.** Home Health Care Program;
 - 4.** Alternative Treatment Plan;
- G.** Any medical services or procedures involving:
 - 1.** Inpatient physical therapy;
 - 2.** Any second surgical opinion;
 - 3.** Any extended care benefits;
- H.** Any prosthetic appliance or orthopedic brace, crutch, or lift attached braces;
- I.** Any admission, or procedure involving any organ transplant, bone marrow transplant, or other stem cell rescue or tissue transplant for which benefits are provided under this Plan;
- J.** Any purchase or rental of Durable Medical Equipment;

- K.** High-cost outpatient non-surgical procedures, to be determined at the discretion of the Utilization Review Agency;
- L.** Advanced diagnostic imaging procedures, including but not limited to: Magnetic Resonance Imaging (MRI); Magnetic Resonance Angiogram (MRA); Computed Axial Tomography (CT scan); and Positron Emission Tomography (PET scan); and
- M.** Physician-administered specialty medications, as defined and determined by the Third-Party Claims Processor.
- N.** Non-Emergency ambulance transport.

15.1.3 Limited Exception to Prior Authorization

Pre-admission Authorization is not required:

- A.** For any Hospital admission outside the United States or Canada, that occurs while the Covered Person is in that country for reasons other than obtaining medical services;
- B.** When the benefits provided under this Plan are secondary to the benefits provided under any other Plan as determined under Article 8, Coordination of Benefits. All extended care benefits in Paragraphs 7.10 to 7.13 are subject to Prior Authorization under this Article.

15.1.4 Notification of Emergency Admission or Surgical Procedure

The Covered Person, family member, Physician, or Hospital shall notify the Utilization Review Agency within 48 hours or the next working day, whichever is longer, after any Emergency admission to a Hospital, or any Emergency surgical procedure that results in an admission to a Hospital, whether the procedure is performed in a Hospital, Ambulatory Surgical Center, or Physician's office.

15.1.5 Concurrent Review of Hospitalization and Individual Case Management

The Utilization Review Agency shall review and determine whether the services provided or to be provided to a Covered Person for a Hospital stay are Medically Necessary, including but not limited to whether hospitalization, length-of-stay, or diagnostic ancillary services are necessary and appropriate for a Covered Person's condition. The Utilization Review Agency also ensures that alternative methods of care are considered and it monitors all hospitalizations to identify the most appropriate and cost-effective setting for continued medical care.

15.1.6 Alternative Treatment Plan

The individual treatment plan developed for a particular Covered Person to treat an illness or injury covered under the Plan that requires a modification of the Coinsurance rate or some medical services or supplies that otherwise are not available under the Plan, but which, if the Coinsurance rate is modified or the medical services or supplies are provided, would permit treatment in a cost-effective manner and in a less intensive care setting, such as a Skilled Nursing Facility, Home Health Care, Hospice facility, or any facility providing less intensive care than the one in which the Covered Person is presently receiving medical care. An Alternative Treatment Plan requires the approval of the treating Physician, the Plan Administrator, and the patient.

The Utilization Review Agency, after consulting with the treating Physician and others as appropriate, may

recommend an Alternative Treatment Plan in a less intensive care setting. If accepted by the treating Physician, Covered Person, and Plan Administrator, the Utilization Review Agency will assist, as necessary, in implementing the Alternative Treatment Plan. Subject to limitations, exclusions, and eligibility requirements, Physician benefits will be paid in accordance with the schedule of benefits. The medical costs paid by the Covered Person shall be counted towards satisfaction of the Coinsurance Maximum under Paragraphs 7.1.A.4, 7.1.B.4, and 7.1.C.4. In addition, services and supplies that are Medically Necessary because of the Alternative Treatment Plan and which would otherwise not be covered under the Plan will be considered as Covered Medical Benefits.

15.1.7 Authorization by Utilization Review Agency

- A. Authorization and Length of Stay Granted.** The Utilization Review Agency shall reply to the Covered Person, family member, Physician, or Hospital within 24 hours. The Utilization Review Agency may certify the procedure or admission and designate a length of stay limitation, if appropriate. The Authorization and length of stay limitation constitute a preliminary determination made on the basis of the information then known to the Utilization Review Agency that the procedure or admission and the designated length of stay are consistent with generally recognized medical standards and procedures, and that, subject to eligibility requirements, other limitations or exclusions, satisfaction of deductibles, and other provisions of the Plan, the procedure or service is eligible for reimbursement under the Plan. The Authorization is sent to the Third-Party Claims Processor.
- B. Authorization or Requested Length of Stay Denied.** If the Utilization Review Agency determines on the information then available that the proposed procedures or services are not within generally recognized medical standards and procedures or the length of stay requested by the health care provider is excessive, the Utilization Review Agency shall inform the Covered Person, family member, the Physician or Hospital, and Third-Party Claims Processor of that decision. The selection of the course of treatment remains with the Covered Person and the treating Physician. The final decision on whether some or all of a claim will be paid shall be made by the Third-Party Claims Processor on the basis of all information known at the time the claim for reimbursement is submitted to the Third-Party Claims Processor. The Utilization Review Agency shall reconsider the decision denying Authorization only if the Covered Person, treating Physician, or Hospital provides new information that may change the result.

15.1.8 Failure to Comply with Utilization Review Requirements

- A. Stays in Excess of Length of Stay Limitation.** The length of stay limitation is established by the Utilization Review Agency after consultation with the treating Physician, and in light of the information on the Covered Person's condition provided by the Physician, and communicated to the Covered Person, family member, Physician, and Hospital. Confinements beyond the length of stay designated by the Utilization Review Agency may be determined to be without Medical Necessity, and reimbursement denied for Room and Board. Other Medically Necessary charges may be covered.
- B. Second Opinions** may be required by the Utilization Review Agency as a condition to Prior Authorization, ongoing Authorization, in conjunction with case management, or when providing an alternative treatment option. If the opinions are divided, a third opinion may be required, which shall be controlling. The Plan will pay the benefits for the second opinions required by the Utilization Review Agency as provided in Paragraph 7.15.

- C. Other Services or Supplies Obtained without Authorization** from the Utilization Review Agency required by this Plan shall be subject to all the terms, conditions, limitations, and exclusions of the Plan.
- D. Medical Social Worker Services.** The Utilization Review Agency may require medical social worker services as a condition of Prior Authorization of covered services. The Plan will pay for the services of a medical social worker as provided in Paragraph 7.13.B, at 100% of the Allowed Amount, or the Provider's Billed Charge, whichever is less, for the purpose of evaluating the patient's needs and identifying other resources, both family and community, for which the patient is eligible but are not covered by insurance.
- E. Failure to Obtain Prior Authorization of Advanced Diagnostic Imaging Procedures.** If an in-network South Carolina Provider does not receive Prior Authorization for advanced diagnostic imaging services including but not limited to: Magnetic Resonance Imaging (MRI); Magnetic Resonance Angiogram (MRA); Computed Axial Tomography (CT scan); and Positron Emission Tomography (PET scan), the Provider will not be paid for the service, and no liability shall accrue to the Subscriber or Covered Person for the cost of the service. If a Covered Person, without Prior Authorization, receives advanced diagnostic imaging services from an out-of-network or out-of-state Provider, the Provider will not be paid for the service, and the Subscriber or Covered Person shall be responsible for the entire cost of the service.

15.1.9 The Utilization Review Agency's Recommendation and the Payment of Benefits

The attending Physician is in charge of providing medical care and selecting the course of treatment in consultation with the Covered Person. The Utilization Review Agency, the Third-Party Claims Processor, and the Plan Administrator do not make treatment decisions. They determine whether the medical services rendered are eligible for reimbursement under the terms, conditions, and limitations of the Plan. The fact the Physician authorized or recommended certain treatment, procedures, or medical services does not automatically make them Medically Necessary or eligible for reimbursement under the Plan.

The recommendation of the Utilization Review Agency regarding any of the matters in this section is a preliminary determination made on the information then available. This decision will be communicated to the Covered Person, Physician, Hospital, and the Third-Party Claims Processor. A determination by the Utilization Review Agency that the proposed treatment is within generally recognized medical standards and procedures does not guarantee payment because other conditions, including eligibility requirements, other limitations or exclusions, satisfaction of deductibles, and other provisions of the Plan must be satisfied before payment is made by the Third-Party Claims Processor.

The Utilization Review Agency, after consulting with the treating Physician and reviewing the matter under its internal procedures, may disagree with some medical services recommended or provided by the Physician. This preliminary determination by the Utilization Review Agency that some or all of the medical services are not within generally recognized medical standards and procedures is an important factor in the Third-Party Claims Processor's subsequent determination of whether benefits ultimately are to be paid. The Third-Party Claims Processor will make the final decision on the payment of any claim after a review of all information. The Covered Person may seek review of that decision under the appeal procedures.

15.1.10 Comprehensive Maternity Management

A Covered Person, upon becoming aware of pregnancy, shall notify the Utilization Review Agency. A maternity coordinator providing education and counseling for the mother shall monitor each case. The Covered Person must also separately notify the Utilization Review Agency of the hospital admission as described in Paragraphs 15.1.2 and 15.1.4, and is subject to all requirements for hospital admission in that section. Notwithstanding anything in this Plan to the contrary, in accordance with the Newborns' and Mothers' Health Protection Act, the Plan shall not restrict any Inpatient Hospital confinement 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 caesarean section or require that a provider obtain authorization from the Plan for prescribing a confinement not in excess of the above time periods. However, the mother's or Newborn's attending provider, after consulting with the mother, may discharge the mother or the Newborn earlier than 48 hours (or 96 hours as applicable). The provisions of this Paragraph shall apply to that portion of a confinement that exceeds the above time periods.

SECTION 2

15.2.1 Application

The payment of benefits under the Plan for treatment of Behavioral Health Disorders, Alcoholism, or Drug Abuse is subject to, and contingent upon, the Covered Person's compliance with the following procedures and in accordance with the utilization review procedures established by the Behavioral Health Manager.

15.2.2 Prior Authorization for Covered Behavioral Health Services

For treatment of a Behavioral Health Disorder, Alcoholism, or Drug Abuse in the United States or Canada, the Covered Person, an authorized family member, or the Behavioral Health Provider treating the Covered Person shall contact the Behavioral Health Manager for Prior Authorization of Medical Necessity at least 24 hours before the Covered Person's receipt of facility inpatient, partial hospitalization, intensive outpatient program, electroconvulsive therapy services, professional psychological/ neuropsychological testing, applied behavior analysis therapy services, and repetitive transcranial magnetic therapy.

15.2.3 Limited Exception to Prior Authorization

Prior Authorization is not required:

- A.** For any Hospital admission outside the United States or Canada that occurs while the Covered Person is in that country for reasons other than obtaining medical services;
- B.** When the benefits provided under this Plan are secondary to the benefits provided under any other Plan as determined under Article 8, Coordination of Benefits.

15.2.4 Notification of Psychiatric Emergency

The Behavioral Health Provider, Covered Person, or family member shall notify the Behavioral Health Manager within 48 hours or the next working day, whichever is longer, of any Emergency admission. The determination of whether a particular set of facts constitutes an Emergency shall be made by the Behavioral Health Manager in conformity with applicable criteria.

15.2.5 Review of Hospitalization and Individual Case Management

The Behavioral Health Manager shall review and determine whether the services provided or to be

provided to a Covered Person for a Behavioral Health Disorder, Alcoholism, or Drug Abuse are Medically Necessary, including but not limited to whether hospitalization, length-of-stay, or diagnostic ancillary services are necessary and appropriate for a Covered Person's condition. The Behavioral Health manager also ensures that alternative methods of care are considered and it monitors all hospitalizations to identify the most appropriate and cost-effective setting for continued care.

15.2.6 Alternative Treatment Plan

The individual treatment plan developed for a particular Covered Person for a Behavioral Health Disorder, Alcoholism, or Drug Abuse treatment covered under the Plan that requires a modification of the Coinsurance rate or some medical services or supplies that otherwise are not available under the Plan, but which, if the Coinsurance rate is modified or the medical services or supplies are provided, would permit treatment in a cost-effective manner and in a less intensive care setting such as a Skilled Nursing Facility, Home Health Care, Hospice facility, or any facility providing less intensive care than the one in which the Covered Person is presently receiving medical care. An Alternative Treatment Plan requires the approval of the treating Behavioral Health Provider, the Plan Administrator, and the Covered Person.

The Behavioral Health Manager, after consulting with the treating Behavioral Health Provider and others as appropriate, may recommend an Alternative Treatment Plan in a less intensive care setting. If accepted by the treating Behavioral Health Provider, Covered Person, and Plan Administrator, the Behavioral Health Manager will assist, as necessary, in implementing the Alternative Treatment Plan. Subject to limitations, exclusions, and eligibility requirements, Behavioral Health Provider benefits will be paid in accordance with the schedule of benefits. The medical costs paid by the Covered Person shall be counted towards satisfaction of the Coinsurance Maximum under Paragraphs 7.1.A.4 and 7.1.B.4. In addition, services and supplies that are Medically Necessary because of the Alternative Treatment Plan and that would otherwise not be covered under the Plan will be considered as Covered Medical Benefits.

15.2.7 Authorization by Behavioral Health Manager

- A. Authorization or Length of Stay Granted.** The Behavioral Health Manager shall reply to the Behavioral Health Provider or Covered Person within 24 hours. The Behavioral Health Manager may certify the procedure or admission and designate a length of stay limitation, if appropriate. The Authorization constitutes a preliminary determination made on the basis of the information then known to the Behavioral Health Manager that the determination is consistent with generally recognized medical standards and procedures, and that, subject to eligibility requirements, other limitations and exclusions, satisfaction of deductibles, and other provisions of the Plan, the procedure or service is eligible for reimbursement under the Plan. The Authorization is sent to the Third-Party Claims Processor.
- B. Authorization or Length of Stay Denied.** If the Behavioral Health Manager determines, on the information then available, that the proposed procedures or services are not within generally recognized medical standards and procedures or the length of stay requested by the Behavioral Health Provider is excessive, the Behavioral Health Manager shall inform the Behavioral Health Provider and the Covered Person of that decision. The selection of the course of treatment remains with the patient or Covered Person and the treating Behavioral Health Provider. The final decision on whether some or all of a claim will be paid shall be made by the Behavioral Health Manager on the basis of all information known at the time the claim for reimbursement is submitted to the Behavioral Health Manager. The Behavioral Health Manager shall reconsider the decision denying Authorization only if the Covered Person or treating Behavioral Health Provider provides new

information that may change the result.

15.2.8 Failure to Comply with Utilization Review Requirements

A. Failure to Obtain Prior Authorization.

If the Covered Person requests services after being informed by the Behavioral Health Provider prior to the rendition of such services that the Behavioral Health Manager has denied Prior Authorization of such services, reimbursement will be denied and payments by the Covered Person will be subject to Paragraph 2 above.

B. Stays in Excess of Length of Stay Limitation. The length of stay limitation is established by the Behavioral Health Manager after consultation with the treating Behavioral Health Provider, and in light of the information on the Covered Person or patient's condition provided by the Behavioral Health Provider, and communicated to the Covered Person and Behavioral Health Provider. Confinements beyond of the length of stay designated by the Behavioral Health Manager may be determined to be without Medical Necessity and reimbursement will be denied. Other Medically Necessary charges may be covered.

C. Second Opinions. Second Opinions may be required by the Behavioral Health Manager as a condition of Prior Authorization, ongoing Authorization, or in conjunction with case management or when providing an alternative treatment option. If the opinions are divided, a third opinion may be required, which shall be controlling. The Plan will pay the benefits for the second opinions required by the Behavioral Health Manager as provided in 7.15, subject to all other terms and conditions of the Plan.

15.2.9 Behavioral Health Manager's Recommendation and the Payment of Benefits

The attending Behavioral Health Provider is in charge of providing care and selecting the course of treatment in consultation with the Covered Person. The Behavioral Health Manager and the Plan Administrator do not make treatment decisions. They determine whether the services provided or to be provided are eligible for reimbursement under the terms and conditions and limitations of the Plan. The fact the Behavioral Health Provider authorized or recommended certain treatment, procedures, or services does not automatically make them Medically Necessary or eligible for reimbursement under the Plan.

The recommendation of the Behavioral Health Manager regarding any of the matters in this section is a preliminary determination made on the information then available. This decision will be communicated to the Behavioral Health Provider and Covered Person or patient. A determination by the Behavioral Health Manager that the proposed treatment is within generally recognized medical standards and procedures does not guarantee payment because other conditions, including eligibility requirements, other limitations or exclusions, satisfaction of deductibles, and other provisions of the Plan, must be satisfied before payment is made.

The Behavioral Health Manager, after consulting with the treating Behavioral Health Provider and reviewing the matter under its internal procedures, may disagree with some medical services recommended or provided by the treating Behavioral Health Provider. This preliminary determination by the Behavioral Health Manager that some or all of the services are not within generally recognized medical

standards and procedures is an important factor in the subsequent determination of whether benefits ultimately are to be paid. The Behavioral Health Manager will make the final decision on the payment of any claim after a review of all information. In the event that a Covered Person does not agree with a determination made by the Behavioral Health Manager, the Covered Person may seek review of that decision under the appeal procedures.

End of Plan