SUMMARY PLAN DESCRIPTION

for the

SOUTHEASTERN FREIGHT LINES
MEDICAL COMPONENT PLAN

January 1, 2025

THIS SUMMARY PLAN DESCRIPTION IS NOT A CONTRACT, EITHER EXPRESS OR IMPLIED.

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I. Introduction

This Summary Plan Description ("SPD") is designed to describe the medical coverage provisions (the "Group Medical Coverage") of the Southeastern Freight Lines, Inc. Health Insurance Plan (the "Plan of Benefits") in effect on January 1, 2025, pursuant to which various medical coverage options are offered through your employment as a full-time associate of Southeastern Freight Lines, Inc. (the "Employer"). The Plan of Benefits is a component plan benefit under the Southeastern Freight Lines, Inc. Insurance Plan (the "Insurance Plan"). The terms of this SPD are incorporated into and should be read in conjunction with the Insurance Plan, which contains many of the governing provisions. This SPD is intended to summarize the Insurance Plan rules applicable only to Group Medical Coverage.

This SPD supersedes and replaces all prior SPDs for medical coverage provided under the Plan of Benefits. The Group Medical Coverage provided under the Plan of Benefits is referred to in this SPD as such or as the Employer's Group Health Plan. In the event there is a conflict between this SPD and the Plan of Benefits, the Plan of Benefits will control. BlueCross BlueShield of South Carolina ("BCBS") provides claim administration services with respect to the Group Medical Coverage, but does not insure the benefits described. This is in no way a contract or promise of continued employment with the Employer.

II. Explanation and Definitions of Terms

Throughout this booklet certain terms starting with capital letters are used to explain the benefits under this Plan of Benefits. Unless the context dictates otherwise, use of the male pronoun in this booklet will be deemed to include the female. To help you better understand the benefits most of these terms are defined within the text or in this Definitions section.

Admission: The period of time between a Member's Admission as a patient into a Hospital or Skilled Nursing Facility and the time the Member leaves or is discharged.

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

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

1. The Allowable Charge shall not exceed the Maximum Payment, unless otherwise required by applicable law;

2. The Allowable Charge for Emergency Services (including air ambulance services) provided by Non-Participating Providers, as well as non-Emergency Services provided by Non-Participating Providers at Participating Hospitals, Hospital outpatient departments, Critical Access Hospitals, or Ambulatory Surgical Centers, will pay in accordance with applicable federal law; and,

3. In addition to the Member's liability for Benefit Year Deductibles, Copayments and/or Coinsurance, the Member may be balance billed by the Non-Participating Provider for any difference between the Allowable Charge and the billed charges, except where prohibited by applicable law.

For covered items and services described in item 2, above, the Allowable Charge will be the Recognized Amount (less any applicable Benefit Year Deductible, Copayment and/or Coinsurance), unless otherwise prescribed under applicable law. If the Provider disputes such Allowable Charge and initiates a 30-day open

negotiation and/or independent dispute resolution process in accordance with applicable federal law, the Corporation will administer such processes.

Notwithstanding anything herein to the contrary, the Member's responsibility for Benefit Year Deductibles, Copayments and/or Coinsurance for covered items and services provided by Non-Participating Providers described in item 2, above, will be calculated as if the item or service was furnished by a Participating Provider, and based on the Recognized Amount (which may differ from the Allowable Charge).

Alternate Recipient: Any Child who is recognized under a Medical Child Support Order as having a right to enroll for Group Medical Coverage.

Ambulatory Surgical Center: A licensed facility that:

1. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;

2. Provides treatment by or under the supervision of licensed medical doctors or oral surgeons and provides nursing services when the Member is in the facility;

3. Does not provide inpatient accommodations; and,

4. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a licensed medical doctor or oral surgeon.

An Ambulatory Surgical Center includes any licensed facility described in section 1833(i)(1)(A) of the Social Security Act.

Associate: A person who is employed by the Employer.

Benefit Year: The Benefit Year for the Group Medical Coverage is January 1 through December 31.

Benefit Year Deductible: The amount, if any, listed on the Schedule of Benefits that must be paid by the Member each Benefit Year before the Group Health Plans will pay Covered Expenses. The Benefit Year Deductible is subtracted from the Allowable Charge before Coinsurance is calculated. Members must refer to the Schedule of Benefits to determine if the Benefit Year Deductible applies to the Out-of-Pocket Maximum.

Benefit(s): Medical services or Medical Supplies that are:
1) Medically Necessary; and,
2) Preauthorized (when required under this SPD); and,
3) Included in this SPD; and,
4) Not limited or excluded under the terms of this SPD.

Benefits available under the Plan of Benefits are described herein.

Billed Charges: The actual charges as billed by a Provider.

BlueCard® Program: A program in which all Members of the Blue Cross and Blue Shield Association ("BCBSA") participate. Details of the BlueCard Program are more fully set forth in Section XI.

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

COBRA: Those provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended, and Sections 601 through 608 of ERISA, as amended, and Section 4980B of the IRC, as amended, and Sections 2201 through 2208 of the Public Health Service Act, as amended, which require certain employers

to offer continuation of health care coverage to Associates and Dependents of Associates who would otherwise lose coverage. The COBRA provisions applicable to the Plan of Benefits are discussed in the Insurance Plan.

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

For Prescription Drug Benefits, Coinsurance means the amount payable by the Member calculated as follows:
1) The percentage listed on the Schedule of Benefits; multiplied by,
2) The amount listed in the Participating Provider's schedule of allowance for that item calculated at the time of sale;
3) Without regard to any credit or allowance that may be received by the Plan of Benefits or Corporation.

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

Continued Stay Review: The review that must be obtained by a Member (or the Member's representative) regarding an extension of an Admission to determine if an Admission for longer than the time that was originally Preauthorized is Medically Necessary (when required). The Continued Stay Review process is outlined in Section VII. This is also known as "Care Coordination Process."

Continuing Care Patient: a Member who, with respect to a Provider or facility, is either:
1) Undergoing a course of treatment for a serious and complex condition f rom the Provider or facility;
2) Undergoing a course of institutional or inpatient care f rom the Provider or facility;
3) Scheduled to undergo nonelective surgery f rom the Provider or facility, including receipt of postoperative care;
4) Pregnant and undergoing a course of treatment for the pregnancy from the Provider or facility; or
5) Receiving treatment for a terminal illness f rom the Provider or facility.

For this purpose, a serious and complex condition means a condition that, in the case of an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm, or in the case of a chronic illness or condition, is life-threatening, degenerative, potentially disability, or congenital and requires specialized medical care over a prolonged period of time.

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

Corporation: BlueCross BlueShield of South Carolina.

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

Critical Access Hospital: A facility that is designated by the state in which it is located, and certified by the United States Department of Health and Human Services, as a critical access hospital.

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

Discount Services: Services (including discounts on services) that are not Benefits, but which may be offered to Members from time to time as a result of being a Member.

Disease Management Program: The Disease Management Program is provided as part of the Plan of Benefits. The Disease Management Program offers Members the opportunity to better understand and address their diagnosed conditions as well as other ancillary products or services depending on the nature of the condition.

Durable Medical Equipment: Medical equipment that:
1) Can withstand repeated use; and,
2) Is Medically Necessary; and,
3) Is customarily used for the treatment of a Member's illness, injury, disease or disorder; and,
4) Is appropriate for use in the home; and,
5) Is not useful to a Member in the absence of illness or injury; and,
6) Does not include appliances that are provided solely for the Member's comfort or convenience; and,
7) Is a standard, non-luxury item (as determined by the Plan Administrator/Corporation); and,
8) Is ordered by a medical doctor, oral surgeon, podiatrist or osteopath.

Prosthetic Devices, Orthopedic Devices and Orthotic Devices are considered Durable Medical Equipment when the required Precertification is obtained.

Employer: Southeastern Freight Lines, Inc.

Emergency Admission Review: The review that must be obtained by a Member (or the Member's representative) within twenty-four (24) hours of or by the end of the first working day after the commencement of an Admission to a Hospital to treat an Emergency Medical Condition. The Emergency Admission Review process is outlined in Section VII.

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

Emergency Medical Condition: A medical condition, including a mental health condition or Substance Use Disorder, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the Member, or with respect to a pregnant Member, the health of the Member or her unborn Child, in serious jeopardy;

2. Serious impairment to bodily functions; or,

3. Serious dysfunction of any bodily organ or part.

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

Family: Any coverage tier that covers more than one member.

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

Genetic Information: Information about genes, gene products (messenger RNA and transplanted protein) or genetic characteristics derived from an individual or family member of the individual. Genetic Information includes information regarding carrier status and information derived from laboratory tests that identify

mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes. However, Genetic Information shall not include routine physical measurements, chemical, blood, and urine analyses unless conducted purposely to diagnose a genetic characteristic; tests for abuse of drugs; and tests for the presence of human immunodeficiency virus.

Global Payment/Total Cost of Care: A payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient such as outpatient, physician, ancillary, hospital services and Prescription Drugs.

Group Health Plan: An employee welfare benefit plan to the extent that such plan provides health benefits to employees or their dependents, as defined under the terms of such group health plan, directly or through insurance, reimbursement, or otherwise. The Plan of Benefits is a Group Health Plan.

Health Status-Related Factor: Information about a Member's health, including:
1) Health status;
2) Medical conditions (including both physical and mental illnesses);
3) Claims experience;
4) Receipt of health care;
5) Medical history;
6) Genetic Information;
7) Evidence of insurability (including conditions arising out of acts of domestic violence); or,
8) Disability.

HIPAA: The Health Insurance Portability and Accountability Act of 1996, and any amendments and regulations thereto.

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

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

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

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

Identification Card: The card issued by the Corporation to a Member that contains the Member's identification number.

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

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

Long-Term Acute Care Hospital: A long-term, acute care facility licensed as a long term care Hospital by the state in which it operates and which meets the other requirements of this definition. A Long-Term Acute Care Hospital provides highly skilled nursing, therapy and medical treatment to Members (typically over an extended period of time) although such Members may no longer need general acute care typically provided in a Hospital. A Long-Term Acute Care Hospital is primarily engaged in providing diagnostic services and medical treatment to Members with chronic diseases or complex medical conditions. The term Long-Term Acute Care Hospital does not include chronic care institutions or facilities that principally provide custodial, rehabilitative or long-term care, whether or not such institutions or facilities are affiliated with or are part of a Long-Term Acute Care Hospital. A Long-Term Acute Care Hospital may participate in a teaching program. This means medical students, interns, or residents participating in a teaching program may treat Members.

Mail Service Pharmacy: A Pharmacy maintained by the Pharmacy Benefit Manager that fills prescriptions and sends Prescription Drugs by mail.

Maximum Payment: The maximum amount the Plan of Benefits will pay for a particular Benefit. The Maximum Payment will not be affected by any Credit. The Maximum Payment will be one of the following as determined by the Corporation in its discretion, subject to any different amount that may be required under applicable law:

1. The actual charge submitted to the Corporation for the service, procedure, supply or equipment by a Provider;

2. An amount based upon the reimbursement rates established by the Plan Sponsor;

3. An amount that has been agreed upon in writing by a Provider and the Corporation or a licensee of the BCBSA;

4. An amount established by the Corporation, based upon factors including, but not limited to:

    a. Governmental reimbursement rates applicable to the service, procedure, supply or equipment; or,

    b. Reimbursement for a comparable or similar service, procedure, supply or equipment, taking into consideration the degree of skill, time and complexity involved; geographic location and circumstances giving rise to the need for the service, procedure, supply or equipment; or,

5. The lowest amount of reimbursement the Corporation allows for the same or similar service, procedure, supply or equipment when provided by a Participating Provider.

In addition, the Maximum Payment for Emergency Services or air ambulance services by a Non-Participating Provider, or non-Emergency Services by a Non-Participating Provider at a Participating Hospital, Hospital

outpatient department, Critical Access Hospital, or Ambulatory Surgical Center, will be the Recognized Amount, unless a different Maximum Payment amount is permitted or required under applicable law.

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

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

A Medical Child Support Order must clearly specify:

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

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

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

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

Medical Supplies: Supplies that are:

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

Medically Necessary/Medical Necessity: Means health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

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

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

Member: An Associate or Eligible Dependent, as defined in the Insurance Plan, who has enrolled under one of the Employer's Group Medical Coverage options. These are also known as "Covered Members."

Member Effective Date: The date on which an Associate or Eligible Dependent is covered for Benefits, as described in the Insurance Plan.

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

Natural Teeth: Teeth that:
1) Are free of active or chronic clinical decay; and,
2) Have at least 50% bony support; and,
3) Are functional in the arch; and,
4) Have not been excessively weakened by multiple dental procedures; or,
5) Teeth that have been treated for one (1) or more of the conditions referenced in 1-4 above, and as a result of such treatment have been restored to normal function.

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

Non-Preferred Drug: A Prescription Drug that does not appear on the list of Preferred Drugs.

Orthopedic Device: Any ridged or semi-ridged leg, arm, back or neck brace and casting materials that are directly used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.

Orthotic Device: Any device used to mechanically assist, restrict, or control function of a moving part of the Member's body.

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

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

Participating Pharmacy: A pharmacy that has a contract with the Corporation, Employer or with the Pharmacy Benefit Manager to provide Prescription Drugs or Specialty Drugs to Members.

Participating Provider: A Provider who has a current, valid Provider Agreement.

Patient-Centered Medical Home (PCMH): A model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified physicians.

Pharmacy Benefit Manager: An entity that has contracted with the Employer or with the Corporation and is responsible for the administration of the Prescription Drug Benefit in accordance with the Plan of Benefits.

Plan: any program that provides Benefits or services for medical or dental care or treatment including:

Individual or group coverage, whether insured or self-insured. This includes, but is not limited to, prepayment, group practice or individual practice coverage; and

Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Each contract or other arrangement for coverage is a separate Plan for purposes of this SPD. If a Plan has two (2) or more parts and the coordination of benefit rules in Section XIX apply only to one (1) of the parts, each part is considered a separate Plan.

Plan Administrator: The Employer, who is charged with the administration of the Plan of Benefits.

Plan of Benefits: The Southeastern Freight Lines, Inc. Health Insurance Plan.

Plan Sponsor: The Employer.

Plan Year: The term "Plan Year" means each twelve-month period, which begins on January 1 and ends on December 31.

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

Preadmission Review: The review that must be obtained by a Member (or the Member's representative) prior to all Admissions that are not related to an Emergency Medical Condition. The Preadmission Review process is outlined in Section VII.

Preauthorized/Preauthorization/PreCertification: The approval of Benefits based on Medical Necessity prior to the rendering of such Benefits to a Member. Preauthorization (or Precertification) means only that the Benefit is Medically Necessary. Preauthorization is not a guarantee of payment or a verification that Benefits will be paid or are available to the Member. Notwithstanding Preauthorization, payment for Benefits is subject to a Member's eligibility, and all other limitations and exclusions contained in this SPD. A Member's entitlement to Benefits is not determined until the Member's claim is processed. The Preauthorization process is outlined in Section VII.

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

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

Premium: The amount paid to the Employer by the Member for Group Medical Coverage. Payment of Premiums by the Member constitutes acceptance by the Member of the terms of the Plan of Benefits and this SPD.

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

Additionally, to qualify as a Prescription Drug, the drug must be prescribed by a licensed Provider acting within the scope of his or her license.

Certain Over-the-Counter Drugs may be designated as Prescription Drugs, at the discretion of the Group Health Plan or Corporation. Such designated Over-the-Counter Drugs will be listed on the PDL.

Prescription Drug Copayment: The amount payable, if any, set forth on the Schedule of Benefits, by the Member for each Prescription Drug filled or refilled.

Prescription Drug Preauthorization/Precertification Program: Programs that prohibit patients from obtaining medications until approvals have been obtained.

Prescription Drug List (PDL)/Formulary: A listing of drugs approved for a specified level of Benefits by the Corporation under the Plan of Benefits. This list shall be developed and subject to periodic review and modification by the Corporation. The most up-to-date version of the PDL is available on the Corporation's website.

Pre-Service Claim: Any request for a Benefit where Precertification must be obtained before receiving the medical care, service or supply.

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

Private Duty Nursing (PDN): hourly or shift skilled nursing care provided in a patient's home. PDN provides more individual and continuous skilled care than can be provided in a skilled nurse visit through a Home Health Agency. The intent of PDN is to assist the patient with complex direct skilled nursing care, to develop caregiver competencies through training and education and to optimize patient health status and outcomes. The frequency and duration of PDN services is intermittent and temporary in nature and is not intended to be provided on a permanent ongoing basis. PDN is not long-term care.

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

Provider: Any person or entity licensed by the appropriate state regulatory agency and legally engaged within the scope of such person or entity's license in the practice of any of the following:
1) Medicine
2) Dentistry
3) Optometry
4) Podiatry
5) Chiropractic services
6) Behavioral Health
7) Physical therapy
8) Oral surgery
9) Speech therapy
10) Occupational therapy or
11) Osteopathy.

The term Provider also includes a Hospital; a Rehabilitation Facility; a Skilled Nursing Facility; a physician assistant; nurses practicing in expanded roles (such as pediatric nurse practitioners, family practice nurse practitioners and certified nurse midwives) when supervised by a medical doctor or oral surgeon; and Behavioral Health Services when performed by a Behavioral Health Provider, licensed professional counselor, masters level licensed social worker, licensed marriage and family therapist or other licensed Behavioral Health Provider approved by the Corporation. The term Provider does not include interns, residents, physical trainers, lay midwives or masseuses.

Provider Agreement: An agreement between the Corporation (or another member of the BCBSA) and a Provider under which the Provider has agreed to accept an allowance (as set forth in the Provider Agreement) as payment in full for Benefits and other mutually acceptable terms and conditions (subject to the Member liability amounts).

Provider Incentive: an additional amount of compensation paid to a healthcare Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.

Provider Services: includes the following services:

1) When performed by a Provider or a Behavioral Health Provider within the scope of his or her license, training and specialty and within the scope of generally acceptable medical standards:
    a. Office visits, which are for the purpose of seeking or receiving care for a preventive service, illness or injury;
    b. Basic diagnostic services and machine tests; or,
    c. Behavioral Health Services.
2) When performed by a licensed medical doctor, osteopath, podiatrist or oral surgeon, but specifically excluding such services when performed by a chiropractor, optometrist, dentist, physical therapist, speech therapist, occupational therapist or licensed psychologist with a doctoral degree:
    a. Benefits rendered to a Member in a Hospital or Skilled Nursing Facility;
    b. Benefits rendered in a Member's home;
    c. Surgical Services;
    d. Anesthesia services, including the administration of general or spinal block anesthesia;
    e. Radiological examinations;
    f. Laboratory tests; and,
    g. Maternity services, including consultation; prenatal care; conditions directly related to pregnancy, delivery and postpartum care and delivery of one (1) or more infants. Provider Services also include maternity services performed by certified nurse midwives.

Qualified Medical Child Support Order: A Medical Child Support Order that:

1) Creates or recognizes the existence of an Alternate Recipient's right to enroll under the Plan of Benefits; or,
2) Assigns to an Alternate Recipient the right to enroll under the Plan of Benefits.

Quantity versus Time (QVT) Limits: Limits that restrict the quantity of Prescription Drugs that are covered under a Member's Benefit within a certain time frame. The limits established for these drugs are based on FDA approved indication.

Recognized Amount: The lesser of the Non-Participating Provider's billed charges or the Corporation's median contracted rate for Participating Providers for the same or similar item or service furnished in the same or similar specialty in the same geographic region; provided that, except in connection with air ambulance services, if there is a recognized amount specified for this purpose under an applicable All-Payer Model Agreement under Section 1115A of the Social Security Act, or if not, under applicable state law, then such amount, as applicable, will instead serve as the Recognized Amount.

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

Residential Treatment Center (RTC): A licensed institution, other than a Hospital, which meets all six (6) of these requirements:

1) Maintains permanent and full-time facilities for bed care of resident patients;
2) Has the services of a psychiatrist (addictionologist, when applicable) or physician extender available at all times and is responsible for the diagnostic evaluation, provides face-to-face evaluation services with documentation a minimum of once/week and as needed as indicated;
3) Has a registered nurse (RN) present onsite who is in charge of patient care along with one (1) or more RNs or licensed practical nurses (LPNs) onsite at all times twenty-four (24) hours per day and seven (7) days per week; and
4) Keeps a daily medical record for each patient;
5) Is primarily providing a continuous structured therapeutic program specifically designed to treat behavioral health disorders and is not a group or boarding home, boarding or therapeutic school, half-way house, sober living residence, wilderness camp or any other facility that provides Custodial Care; and
6) Is operating lawfully as a RTC in the area where it is located.

Schedule of Benefits: The pages of this SPD so titled, which specify the coverage provided and the applicable Copayments, Coinsurance, Benefit Year Deductibles and Benefit limitations.

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

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

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

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

Specialist: A licensed medical doctor that specializes in a particular branch of medicine.

Specialty Drugs: Prescription Drugs, as identified by the Corporation, that treat a complex clinical condition and/or require special handling such as refrigeration. They generally require complex clinical monitoring, training and expertise. Specialty Drugs include but are not limited to infusible Specialty Drugs for chronic diseases, injectable and self-injectable drugs for acute and chronic diseases and specialty oral drugs. Specialty Drugs are used to treat acute and chronic disease states (e.g. growth deficiencies, Hemophilia, Multiple Sclerosis, Rheumatoid Arthritis, Gaucher's Disease, Hepatitis, cancer, organ transplantation, Alpha 1-Antitrypsin Disease and immune deficiencies).

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

Substance Use Disorder Services: Services or treatment relating to Substance Use Disorder.

Surgical Services: An operative or cutting procedure, including the usual, necessary and related preoperative and post-operative care when performed by a licensed medical doctor.

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

Telemedicine: The exchange of Member 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 Member 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.

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

Utilization Management: The use of techniques, such as step therapy, that allow the Plan of Benefits to manage the cost of Benefits by assessing their appropriateness using evidence-based criteria or guidelines before they are provided.

Value-Based Program (VBP): A healthcare delivery model such as a patient-centered medical home ("PCMH"), accountable care organization ("ACO"), capitation arrangements or episode-based arrangements aimed at improving patient health quality and outcomes with respect to certain diseases and/or conditions. These services are facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

Value-Based Shared Savings: A payment mechanism in which the Provider and payer share cost savings achieved against a target cost budget based upon agreed upon terms and may include downside risk.

You and Your: The terms "you" and "your" mean the Associate.

III. Premiums

The Premium schedule will be established annually by the Employer and communicated to you as part of the annual Open Enrollment materials. Failure to pay any Premium when due may result in termination of your elected Group Medical Coverage.

IV. Disclosure of Medical Information

By accepting Benefits or payment of Covered Expenses, the Member agrees that 1) the Employer's Group Health Plan (including BlueCross and Quantum on behalf of the Employer's Group Health Plan) may obtain claims information, medical records, and other information necessary for the Employer's Group Health Plan to consider a request for Precertification, a Continued Stay Review, an Emergency Admission Review, a Preadmission Review or to process a claim for Benefits; and 2) Blue Cross and Quantum, on behalf of the Employer's Group Health Plan, may exchange information so that your medical claims can be paid.

V. Schedule of Benefits

This Schedule of Benefits and the Benefits described herein are subject to all terms and conditions of the Plan of Benefits.

When a Benefit is listed below and has a dollar or percentage amount associated with it then the Benefit will be provided to Members subject to the terms of the Plan of Benefits. When a Benefit has a "Covered" notation associated with it, the Benefit will pay based on the location of the service. When a Benefit has a "Non-Covered" notation associated with it, the Benefit is not available to the Member. All Benefits are subject to the dollar or percentage amount limitation associated with each Benefit in this Schedule of Benefits.

A. Co-Pay Plan Schedule of Benefits

General Provisions	
Benefit Year Deductible:	$950 for Single Coverage for Participating Providers. $1,900 per Family with no one Member meeting more than $950 for Participating Providers. $3,400 per Family with no one Member meeting more than $1,700 for Non-Participating Providers. Covered Expenses that are applied to the Benefit Year Deductible shall contribute to both the Participating and Non-Participating Provider Benefit Year Deductibles.
Out-of-Pocket Maximums for Participating Providers:	$3,250 per Member and $6,500 per Family Allowable Charges are paid at 100% after the Out-of-Pocket Maximum is met. Covered Expenses which apply to the Participating Provider Out-of-Pocket Maximum shall also contribute to the Non-Participating Provider Out-of-Pocket Maximum.
Out-of-Pocket Maximums for Non-Participating Providers:	$6,500 per Member and $13,000 per Family Allowable Charges are paid at 100% after the Out-of-Pocket Maximum is met. Copayments do not contribute to the Out-of-Pocket Maximum determination. Covered Expenses which apply to the Non-Participating Provider Out-of-Pocket Maximum shall also contribute to the Participating Out-of-Pocket Maximum.
Benefit Year Deductibles and any Copayments must be met before any Covered Expenses can be paid.	
This Schedule of Benefits applies during the January 1 through December 31 Benefit Year. The Anniversary Date is January 1.	
All Admissions require Precertification. If Precertification is not obtained, room and board charges will be denied. Some services may require Precertification. Please see the Schedule of Benefits and Plan of Benefits for more information. See Section VII. for additional information regarding Precertification, including the penalties for not obtaining Precertification.	
Benefits for any other outpatient services that require Precertification will be reduced by 50% of the Allowable Charge when Precertification is not obtained or approved.	

Admissions/Inpatient Benefits		
	Participating Provider	**Non-Participating Provider**
Hospital Charges for Room and Board Related to Admissions	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
All other Benefits in a Hospital During an Admission (Including for example, Facility Charges related to the Administration of Anesthesia, Obstetrical Services Including Labor and Delivery Rooms, Drugs, Medicine, Lab and X-Ray Services)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Inpatient Physical Rehabilitation Services when Precertified and Performed at a Provider Designated by the Plan	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Skilled Nursing Facility Admissions, Limited to Sixty (60) Days per Benefit Year (Precertification is Required)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

Outpatient Benefits Other Than Mental Health Services and Substance Use Disorder Services		
	Participating Provider	**Non-Participating Provider**
Hospital and Ambulatory Surgical Center Charges for Benefits Provided on an Outpatient Basis, Including: Lab, X-Ray and other Diagnostic Services	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
True Emergency Room Visits	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Non-True Emergency Room Visits	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
All other Covered Outpatient Benefits	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

Provider Services Other Than Mental Health Services and Substance Use Disorder Services		
	Participating Provider	**Non-Participating Provider**
Provider Services in a Hospital	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Surgical Services, When Rendered in a Hospital or Ambulatory Surgical Center	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider Services for Treatment in a Hospital Outpatient Department or Ambulatory Surgical Center	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider's Services in the Office, Including Surgical Services, Lab, X-Ray and other Diagnostic Services, Contraceptives and Birth Control Devices* (Excluding Maternity Care, and Dialysis Treatment)	Office services by a Primary Care Provider will be paid at 100% of the Allowable Charge after a $25 Copayment Office services by a Specialist will be paid at 100% of the Allowable Charge after a $45 Copayment	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider's Services Rendered Through Blue CareOnDemand	Services rendered through Blue CareOnDemand will be paid at 100% of the Allowable Charge after a $10 Copayment	Non-Covered

*Contraceptives and birth control devices covered under Patient Protection and Affordable Care Act (PPACA) will pay at 100% of the Allowable Charge at Participating Providers. No Benefits are payable at Non-Participating Providers.

Physician Services Other Than Mental Health Services and Substance Use Disorder Services		
	Participating Provider	**Non-Participating Provider**
Provider Services in the Member's Home	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Second Surgical Opinion	Office services by a Primary Care Provider will be paid at 100% of the Allowable Charge after a $25 Copayment Office services by a Specialist will be paid at 100% of the Allowable Charge after a $45 Copayment	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Specialty Drugs Dispensed or Administered in a Provider's Office	The Plan of Benefits pays 100% of the Allowable Charge after the Member pays a $100 Copayment, up to a 31-day supply	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible, up to a 31-day supply
All other Provider Services	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

Mental Health Services and Substance Use Disorder Services

Precertification is required for Applied Behavioral Analysis (ABA) therapy related to Autism Spectrum Disorder, psychological testing, repetitive transcranial magnetic stimulation (rTMS) and such other in-patient and facility-based outpatient services specified "(Precertification is Required)" in the table below. If Precertification is not obtained or approved, the following penalties will apply.

If Precertification is not obtained for facility-based in-patient services, room and board charges will be denied. If Precertification is not obtained for the other services as required, benefits will be reduced by 50% of the Allowable Charge. Please see the Schedule of Benefits and Plan of Benefits for more information. See Section VII. for additional information regarding Precertification, including the penalties for not obtaining Precertification.

Notwithstanding any provision herein to the contrary, it is intended that the Plan of Benefits provide coverage for Mental Health Services and Substance Use Disorder Services in conformance with Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as may be amended or superseded, and the Plan of Benefits and this SPD shall be interpreted and administered consistent with this intention.

	Participating Provider	**Non-Participating Provider**
Inpatient Hospital Charges for Mental Health Services and Substance Use Disorder Services (Precertification is Required)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Residential Treatment Center Admissions for Mental Health Services and Substance Use Disorder Services (Precertification is Required)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Outpatient Hospital or Clinic Charges for Mental Health Services and Substance Use Disorder Services (Precertification is Required)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

Mental Health Services and Substance Use Disorder Services		
	Participating Provider	**Non-Participating Provider**
Inpatient Provider Charges for Mental Health Services and Substance Use Disorder Services	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Outpatient Provider Charges for Mental Health Services and Substance Use Disorder Services	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Office Provider Charges for Mental Health Services and Substance Use Disorder Services	The Plan of Benefits pays 100% of the Allowable Charge after the Member pays a $25 Copayment	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Outpatient Hospital or Provider Emergency Room Charges for Mental Health Services and Substance Use Disorder Services	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider's Services Rendered Through Blue CareOnDemand	Services rendered through Blue CareOnDemand will be paid at 100% of the Allowable Charge after a $10 Copayment	Non-Covered

Mental Health Services and Substance Use Disorder Services		
	Participating Provider	**Non-Participating Provider**
Outpatient Provider Charges for ABA Therapy related to Autism Spectrum Disorder (Pre-Certification is Required)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Office Provider Charges for ABA Therapy related to Autism Spectrum Disorder (Pre-Certification is Required)	The Plan of Benefits pays 100% of the Allowable Charge after the Member pays a $25 Copayment	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

Other Services		
	Participating Provider	**Non-Participating Provider**
Ambulance Service	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 80% of the Billed Charges after the Participating Provider Benefit Year Deductible The Member must pay the balance of the Provider's charge
Air Ambulance Service	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 80% of the Billed Charges after the Participating Provider Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible
Durable Medical Equipment, Prosthetics and Orthopedic Devices (If Purchase or Rental of Durable Medical Equipment is $1,500 or More, Precertification is Required)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Medical Supplies	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Home Health Care, Including Private Duty Nursing, Limited to Sixty (60) Visits per Benefit Year (Precertification is Required)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

Other Services		
	Participating Provider	**Non-Participating Provider**
Hospice Care (Precertification is Required)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's chargep
Habilitation and Rehabilitation related to Physical Therapy and Occupational Therapy performed in a Provider's Office (Please See "Outpatient Rehabilitation" Section In Section VI of the SPD for Further Limitations)	The Plan of Benefits pays 100% of the Allowable Charge after the Member pays a $25 Copayment Office services by a Specialist will be paid at 100% of the Allowable Charge after a $45 Copayment	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Habilitation and Rehabilitation related to Physical Therapy and Occupational Therapy (Please See "Outpatient Rehabilitation" Section in Section VI of the SPD for Further Limitations)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Habilitation and Rehabilitation related to Speech Therapy, Including Developmental Delays (Limited To Twenty (20) Visits per Member per Benefit Year)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

Other Services		
	Participating Provider	**Non-Participating Provider**
Habilitation and Rehabilitation related to Speech Therapy performed in a Provider's Office, Including Developmental Delays (Limited To Twenty (20) Visits per Member per Benefit Year)	The Plan of Benefits pays 100% of the Allowable Charge after the Member pays a $25 Copayment Office services by a Specialist will be paid at 100% of the Allowable Charge after a $45 Copayment	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Radiation Therapy Cancer Chemotherapy Respiratory Therapy (Precertification is Required)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

Other Services		
	Participating Provider	**Non-Participating Provider**
Human Organ and Tissue Transplant Services (Excluding Drugs) Human Organ and Tissue Transplant Services are only Covered if Provided at a Blue Distinction Center of Excellence or a Transplant Center Approved by the Plan in Writing Provider Charges are Subject to the Benefit Year Deductible.	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Travel and Lodging for Human Organ and Tissue Transplant Services for Donors, Recipients and their Family Members, Limited to $10,000 per Member per Transplant	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Allergy Injections	Office services by a Primary Care Provider will be paid at 100% of the Allowable Charge after a $25 Copayment Office services by a Specialist will be paid at 100% of the Allowable Charge after a $45 Copayment	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Chiropractic Services, Including related X-Rays, Spinal Manipulation/Subluxation, Modalities and Office Visits, Limited to 30 Visits per Member per Benefit Year	The Plan of Benefits pays 100% of the Allowable Charge after the Member pays a $25 Copayment	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Cosmetic Services	Non-Covered	Non-Covered
Hearing Aids (Including But Not Limited to Semi-Implantable Hearing Devices, Audient Bone Conductors and Bone Anchored Hearing Aids (Bahas)), Limited to a $1500 Maximum Payment per Member Every Thirty-Six (36) Months	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 80% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member must pay the balance of the Provider's charge

Other Services		
	Participating Provider	**Non-Participating Provider**
Hearing Exams, Limited to One (1) per Member per Benefit period	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 80% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member must pay the balance of the Provider's charge
Temporomandibular Joint Disorder (TMJ) Including Treatment and Surgical Services (Please See the "Temporomandibular Joint (TMJ) Disorder" Section In Section VI of the SPD for Limitations)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Orthognathic Surgery (Please see the "Orthognathic Surgery" Section In Section VI of the SPD for Limitations)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Hemophilia (Must Have Care Coordinated Through a Center for Disease Control (CDC) Designated Hemophilia Treatment Center at least once per Benefit Year Or Coverage Of Services for Treatment Of Hemophilia Will Be Reduced 50%)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

Other Services		
	Participating Provider	**Non-Participating Provider**
Varicose Vein Treatment, (Precertification Is Required)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Cochlear Implants (Please See "Cochlear Implants" Section in Section VI of the SPD for Further Limitations)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
DNA analysis of stool sample using the Cologuard stool sample test, one per member, per year, regardless of diagnosis or age	The Plan of Benefits pays 100% of the Allowable Charge and is not subject to the Benefit Year Deductible	Non-Covered.
First Colonoscopy per Benefit Year, regardless of diagnosis or age, to include a colonoscopy if Cologuard stool sample test gives positive results.	The Plan of Benefits pays 100% of the Allowable Charge and is not subject to the Benefit Year Deductible	Non-Covered.
Subsequent Colonoscopy per Benefit Year	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Cranial Orthotics (Please See "Cranial Orthotics" Section in Section VI of the SPD for Further Limitations)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

Other Services		
	Participating Provider	**Non-Participating Provider**
Penile Implants (Please See "Penile Implants" Section in Section VI of the SPD for Further Limitations)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
SleepCharge Sleep Apnea Program by Nox HealthNox Health	During the first year of treatment, will be paid at 100% of the Allowable Charge, after the Member pays a $250 Co-Payment, which is due when the course of treatment begins. During subsequent years of treatment, beginning on or without needing a new APAP device and at which time you are covered by the Co-Pay Plan, the Co-Pay Plan will pay for services rendered by the SleepCharge Sleep Apnea Program at 100% of the Allowable Charge after a $100 Copayment. In order to qualify for coverage during subsequent years of treatment, the Member must have a 30% adherence rate during the preceding year, as determined by Nox Health. Years are measured by a 365-day cycle, rather than a Plan Year cycle.	Non-Covered
SleepCharge Insomnia Program by Nox Health	The Co-Plan will pay 100% of the Allowable Charge, after the Member pays a $25 Co-Payment, which is due when the course of treatment begins.	Non-Covered

Other Services		
	Participating Provider	**Non-Participating Provider**
SleepCharge Restless Legs Program by Nox Health	The Co-Pay Plan will pay 100% of the Allowable Charge, after the Member pays a $75 Co-Payment, which is due when the course of treatment begins. During subsequent years of treatment, at which time you are covered by the Co-Pay Plan, the Co-Pay Plan will pay for services rendered by the SleepCharge Restless Legs Program at 100% of the Allowable Charge after a $50 Copayment.	Non-Covered
SleepCharge Circadian Rhythms Program by Nox Health	The Co-Pay Plan will pay 100% of the Allowable Charge, after the Member pays a $50 Co-Payment, which is due when the course of treatment begins. During subsequent years of treatment, at which time you are covered by the Co-Pay Plan, the Co-Pay Plan will pay for services rendered by the SleepCharge Circadian Rhythms Program at 100% of the Allowable Charge after a $50 Copayment.	Non-Covered
Mayo Clinic Complex Care Program	The Co-Pay Plan will pay the full cost of the following eligible covered services when you are a participant in the Mayo Clinic Complex Care Program (including the related services of) and are receiving services at any Mayo Clinic location: • Copayment(s) • Benefit Year Deductible • Coinsurance • Travel expenses when travel is booked through the Mayo Clinic Complex Care Program The Member is responsible for the following: • Incidentals including food, toiletries, and clothing	Not Covered

Preventive Benefits The Benefit Year Deductible does not apply to these Benefits		
	Participating Provider	**Non-Participating Provider**
Preventive Benefits Under PPACA (Refer to www.Healthcare.Gov for Guidelines). Examples of These Benefits Include Well-Baby Visits, Well-Woman Exams, and Flu Shots.	Covered	Non-Covered

Prescription Drug Benefit			
Prescription Drugs	**Mail Service Pharmacy**	**Participating Pharmacy**	**All Other Pharmacies**
Generic Drugs	The Member pays a $25 Copayment for each prescription or refill, up to a 90 day supply	For all pharmacies except CVS and Target the Member pays a $10 copayment for each monthly prescription (maintenance or non-maintenance drugs). **Members pay a $25 retail Copayment for up to a 90 day supply of maintenance medications at CVS or Target pharmacies.**	Non-Covered
Preferred Brand Drug	The Member pays a $125 Copayment for each prescription or refill, up to a 90 day supply	For all pharmacies except CVS and Target the Member pays a $50 copayment for each monthly prescription (maintenance or non-maintenance drugs). **Members pay a $125 retail Copayment for up to a 90 day supply of maintenance medications at CVS or Target pharmacies.**	Non-Covered
Non-Preferred Brand Drug	The Member pays a $162.50 Copayment per Member for each prescription or refill, up to a 90 day supply	For all pharmacies except CVS and Target the Member pays a $65 copayment for each monthly prescription (maintenance or non-maintenance drugs). **Members pay a $162.50 retail Copayment for up to a 90 day supply of maintenance medications at CVS or Target pharmacies.**	Non-Covered
Over-The-Counter Proton Pump Inhibitors (PPIs)	$25 Copayment per Member for each prescription or refill after the Benefit Year Deductible, up to a 90 day supply	For all pharmacies except CVS and Target the Member pays a $10 copayment for each monthly prescription (maintenance or non-maintenance drugs). **Members pay a $25 retail Copayment for up to a 90 day supply of maintenance medications at CVS or Target pharmacies.**	Non-Covered
Sexual Dysfunction Prescription Drugs, Limited to Fifteen (15) Pills per Month	Covered	Covered	Non-Covered

Prescription Drug Benefit			
Prescription Drugs	**Mail Service Pharmacy**	**Participating Pharmacy**	**All Other Pharmacies**
Diabetic Syringes and Supplies***	Covered	Covered	Non-Covered
Over-The-Counter Non-Sedating Antihistamines	$25 Copayment per Member for each prescription or refill after the Benefit Year Deductible, up to a 90 day supply	For all pharmacies except CVS and Target the Member pays a $10 copayment for each monthly prescription (maintenance or non-maintenance drugs). Members pay a $25 retail Copayment for up to a 90 day supply of maintenance medications at CVS or Target pharmacies.	Non-Covered
*Contraceptives: oral contraceptives, cervical cap, diaphragms, emergency contraception, female condom, implantable rod, intrauterine device (IUD), patch, shot/injection, spermicide, sponge, vaginal contraceptive ring and approved sterilization procedures for women A complete list of specific Prescription Drugs or supplies covered at 100% is available at www.SouthCarolinaBlues.com	Prescription Drugs will be covered at 100%, up to a 90 day supply	Prescription Drugs will be covered at 100%, up to a 90 day supply	The Member will be responsible for 100% of the Allowable Charge at the pharmacy then will be reimbursed at 100%, up to a 90 day supply
**All Other Contraceptives (Prescription Drugs)	Covered	Covered	Non-Covered
*Contraceptives listed above are covered under the participating medical Benefits at the same payment levels. Refill quantities for the contraceptives listed above may vary. **All other contraceptives are paid at the Generic, Preferred Brand and Non-Preferred Brand Drug payment levels. ***A separate Copayment applies for each supply purchase			

Specialty Drug Benefit		
	Participating Pharmacy	**All Other Pharmacies**
Specialty Drug	$100 Copayment per Member for each prescription or refill, up to a 31 day supply	Non-Covered

B. HSA Plan Schedule of Benefits

General Provisions	
Benefit Year Deductible:	$2,100 for Single Coverage for Participating Providers and $4,000 for Non-Participating Providers. $4,200 per Family with no one Member meeting more than $3,300 for Participating Providers. $8,000 per Family with no one Member meeting more than $4,000 for Non-Participating Providers. Covered Expenses that are applied to the Benefit Year Deductible shall contribute to both the Participating and Non-Participating Provider Benefit Year Deductibles.
Out-of-Pocket Maximums for Participating Providers:	$4,750 per Member and $9,500 per Family Allowable Charges are paid at 100% after the Out-of-Pocket Maximum is met. Covered Expenses which apply to the Participating Provider Out-of-Pocket Maximum shall also contribute to the Non-Participating Provider Out-of-Pocket Maximum.
Out-of-Pocket Maximums for Non-Participating Providers:	$9,500 per Member and $19,000 per Family Allowable Charges are paid at 100% after the Out-of-Pocket Maximum is met. Copayments do not contribute to the Out-of-Pocket Maximum determination. Covered Expenses which apply to the Non-Participating Provider Out-of-Pocket Maximum shall also contribute to the Participating Out-of-Pocket Maximum.
Benefit Year Deductibles and any Copayments must be met before any Covered Expenses can be paid.	
This Schedule of Benefits applies during the January 1 through December 31 Benefit Year. The Anniversary Date is January 1.	
All Admissions require Precertification. If Precertification is not obtained, room and board charges will be denied. Some services may require Precertification. Please see the Schedule of Benefits and Plan of Benefits for more information. See Section VII. for additional information regarding Precertification, including the penalties for not obtaining Precertification.	
Benefits for any other outpatient services that require Precertification will be reduced by 50% of the Allowable Charge when Precertification is not obtained.	

Admissions/Inpatient Benefits		
	Participating Provider	**Non-Participating Provider**
Hospital Charges for Room and Board related to Admissions	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
All other Benefits in a Hospital During An Admission (Including for Example, Facility Charges related to The Administration Of Anesthesia, Obstetrical Services Including Labor and Delivery Rooms, Drugs, Medicine, Lab and X-Ray Services)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Inpatient Physical Rehabilitation Services When Precertified and performed at a Provider Designated By The Plan	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Skilled Nursing Facility Admissions, Limited to Sixty (60) Days per Benefit Year (Precertification Is Required)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

Outpatient Benefits Other Than Mental Health Services and Substance Use Disorder Services		
	Participating Provider	**Non-Participating Provider**
Hospital and Ambulatory Surgical Center Charges for Benefits Provided On An Outpatient Basis, Including: Lab, X-Ray and other Diagnostic Services	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
True Emergency Room Visits	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Non-True Emergency Room Visits	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
All other Covered Outpatient Benefits	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

Provider Services		
	Participating Provider	**Non-Participating Provider**
Provider Services in a Hospital	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Surgical Services, When Rendered in a Hospital, Provider's Office Or Ambulatory Surgical Center	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider Services for Treatment in a Hospital Outpatient Department Or Ambulatory Surgical Center	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider's Services in The Office, Including Contraceptives and Birth Control Devices*	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

*Contraceptives and birth control devices covered under Patient Protection and Affordable Care Act (PPACA) will pay at 100% of the Allowable Charge at Participating Providers. No Benefits are payable at Non-Participating Providers.

Provider Services		
	Participating Provider	**Non-Participating Provider**
Provider Services in The Member's Home	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Second Surgical Opinion	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider's Services Rendered Through Blue CareOnDemand	For services rendered through Blue CareOnDemand the Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	Non-Covered
Specialty Drugs Dispensed Or Administered in a Provider's Office	The Plan of Benefits pays 100% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $100 Copayment, up to a 31-day supply	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible, up to a 31-day supply
All other Provider Services	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

Mental Health Services and Substance Use Disorder Services

Precertification is required for Applied Behavioral Analysis (ABA) therapy related to Autism Spectrum Disorder, psychological testing, repetitive transcranial magnetic stimulation (rTMS) and such other in-patient and facility-based outpatient services specified "(Precertification is Required)" in the table below. If Precertification is not obtained or approved, the following penalties will apply.

If Precertification is not obtained for facility-based in-patient services, room and board charges will be denied. If Precertification is not obtained for the other services as required, benefits will be reduced by 50% of the Allowable Charge.

Please see the Schedule of Benefits and Plan of Benefits for more information. See Section VII. for additional information regarding Precertification, including the penalties for not obtaining Precertification.

Notwithstanding any provision herein to the contrary, it is intended that the Plan of Benefits provide coverage for Mental Health Services and Substance Use Disorder Services in conformance with Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as may be amended or superseded, and the Plan of Benefits and this SPD shall be interpreted and administered consistent with this intention.

	Participating Provider	**Non-Participating Provider**
Inpatient Hospital Charges for Mental Health Services and Substance Use Disorder Services (Precertification Is Required)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Residential Treatment Center Admissions for Mental Health Services and Substance Use Disorder Services (Precertification Is Required)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Outpatient Hospital Or Clinic Charges for Mental Health Services and Substance Use Disorder Services (Precertification Is Required)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

Mental Health Services and Substance Use Disorder Services		
	Participating Provider	**Non-Participating Provider**
Inpatient Provider Charges for Mental Health Services and Substance Use Disorder Services	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
ABA Therapy related to Autism Spectrum Disorder (Pre-Certification is Required)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Outpatient Or Office Provider Charges for Mental Health Services and Substance Use Disorder Services	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Outpatient Hospital Emergency Room Charges for Mental Health Services and Substance Use Disorder Services	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider's Services Rendered Through Blue CareOnDemand	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	Non-Covered

Other Services		
	Participating Provider	**Non-Participating Provider**
Ambulance Service	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 80% of the Billed Charges after the Participating Provider Benefit Year Deductible The Member must pay the balance of the Provider's charge
Air Ambulance Service	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 80% of the Billed Charges after the Participating Provider Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible
Durable Medical Equipment, Prosthetics and Orthopedic Devices (If Purchase Or Rental Of Durable Medical Equipment Is $1500 Or More, Precertification Is Required)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Medical Supplies	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Home Health Care, Including Private Duty Nursing, Limited to Sixty (60) Visits per Benefit Year (Precertification Is Required)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

Other Services		
	Participating Provider	**Non-Participating Provider**
Hospice Care (Precertification Is Required)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Habilitation and Rehabilitation related to Physical Therapy and Occupational Therapy (Please See "Outpatient Rehabilitation Services" Section In Section VI Of The SPD for Further Limitations)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Habilitation and Rehabilitation related to Speech Therapy, Including Developmental Delays (Limited to Twenty (20) Visits per Member per Benefit Year)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Radiation Therapy Cancer Chemotherapy Respiratory Therapy (Precertification Is Required)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

Other Services		
	Participating Provider	**Non-Participating Provider**
Human Organ and Tissue Transplant Services (Excluding Drugs) Human Organ and Tissue Transplant Services are only Covered If Provided at a Blue Distinction Center Of Excellence Or a Transplant Center Approved By The Plan in Writing Provider Charges are Subject to The Benefit Year Deductible.	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Travel and Lodging for Human Organ and Tissue Transplant Services for Donors, Recipients and their Family Members, Limited to $10,000 per Member per Transplant	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Allergy Injections	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Chiropractic Services, Including related X-Rays, Spinal Manipulation/Subluxation, Modalities and Office Visits, Limited to Thirty (30) Visits per Member per Benefit Year	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

Other Services		
	Participating Provider	**Non-Participating Provider**
Hearing Aids (Including But Not Limited to Semi-Implantable Hearing Devices, Audient Bone Conductors and Bone Anchored Hearing Aids (Bahas)), Limited to a $1500 Maximum Payment per Member Every Thirty-Six (36) Months	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 80% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member must pay the balance of the Provider's charge
Hearing Exams, Limited to One (1) per Member per Benefit period	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 80% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member must pay the balance of the Provider's charge
Temporomandibular Joint Disorder (TMJ) Including Treatment and Surgical Services (Please See The "Temporomandibular Joint (TMJ) Disorder" Section in Section VI Of The SPD for Limitations)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Orthognathic Surgery (Please See The "Orthognathic Surgery" Section in Section VI Of The SPD for Limitations)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 80% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member must pay the balance of the Provider's charge
Hemophilia (Must Have Care Coordinated Through a Center for Disease Control (CDC) Designated Hemophilia Treatment Center at least once per Benefit Year Or Coverage Of Services for Treatment Of Hemophilia Will Be Reduced 50%)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 80% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member must pay the balance of the Provider's charge

Other Services		
	Participating Provider	**Non-Participating Provider**
Varicose Vein Treatment, (Precertification Is Required)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 80% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member must pay the balance of the Provider's charge
Cochlear Implants (Please See "Cochlear Implants" Section in Section VI Of The SPD for Further Limitations)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
DNA analysis of stool sample using the Cologuard stool sample test, one per member, per year, regardless of diagnosis or age	The Plan of Benefits pays 100% of the Allowable Charge and is not subject to the Benefit Year Deductible	Non-Covered.
First Colonoscopy per Benefit Year, regardless of diagnosis or age, to include a colonoscopy if Cologuard stool sample test gives positive results.	The Plan of Benefits pays 100% of the Allowable Charge and is not subject to the Benefit Year Deductible	Non-Covered
Subsequent Colonoscopy per Benefit Year	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Cranial Orthotics (Please See "Cranial Orthotics" Section in Section VI Of The SPD for further Limitations)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

Other Services		
	Participating Provider	**Non-Participating Provider**
Penile Implants (Please See "Penile Implants" Section in Section VI Of The SPD for Further Limitations)	The Plan of Benefits pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Plan of Benefits pays 50% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
SleepCharge Sleep Apnea Program by Nox Health	The Member pays 20% Co-Insurance after the Benefit Year Deductible In order to qualify for coverage during subsequent years of treatment, the Member must have a 30% adherence rate during the preceding year, as determined by Nox Health. For purposes of the forgoing, years are measured by a 365-day cycle, starting when the course of treatment begins. Subsequent years of treatment begin when you are covered by the Plan and do not need a new APAP device.	Non-Covered
SleepCharge Insomnia Program by Nox Health	The Member pays 20% Co-Insurance after the Benefit Year Deductible	Non-Covered
SleepCharge Restless Legs Program by Nox Health	The Member pays 20% Co-Insurance after the Benefit Year Deductible.	Non-Covered
SleepCharge Circadian Rhythms Program by Nox Health	The Member pays 20% Co-Insurance after the Benefit Year Deductible.	Non-Covered

Other Services		
	Participating Provider	**Non-Participating Provider**
Mayo Clinic Complex Care Program	The HSA Plan will pay the full cost of the following eligible covered services when you are a participant in the Mayo Clinic Complex Care Program (including the related services of) and are receiving services at any Mayo Clinic location: • Copayment(s) after satisfaction of Benefit Year Deductible • Coinsurance, after satisfaction of Benefit Year Deductible • Travel expenses when travel is booked through the Mayo Clinic Complex Care Program. The Member is responsible for the following: • Benefit Year Deductible • incidentals including food, toiletries, and clothing	Not Covered

Preventive Benefits The Benefit Year Deductible does not apply to these Benefits		
	Participating Provider	**Non-Participating Provider**
Preventive Benefits Under PPACA (Refer to Www.Healthcare.Gov for Guidelines). Examples of These Benefits Include Well-Baby Visits, Well-Woman Exams, and Flu Shots.	Covered	Non-Covered

Prescription Drug Benefit			
Prescription Drugs	**Mail Service Pharmacy**	**Participating Pharmacy**	**All Other Pharmacies**
Preventive Generic Drugs	The Member pays a $25 Copayment for each prescription or refill, up to a 90 day supply	For all pharmacies except CVS and Target the Member pays a $10 copayment for each monthly prescription (maintenance or non-maintenance drugs). **Members pay a $25 retail Copayment for up to a 90 day supply of maintenance medications at CVS or Target pharmacies.**	Non-Covered
Preventive Preferred Brand Drug	The Member pays a $125 Copayment for each prescription or refill, up to a 90 day supply	For all pharmacies except CVS and Target the Member pays a $50 copayment for each monthly prescription (maintenance or non-maintenance drugs). **Members pay a $125 retail Copayment for up to a 90 day supply of maintenance medications at CVS or Target pharmacies.**	Non-Covered
Preventive Non-Preferred Brand Drug	The Member pays a $162.50 Copayment per Member for each prescription or refill, up to a 90 day supply	For all pharmacies except CVS and Target the Member pays a $65 copayment for each monthly prescription (maintenance or non-maintenance drugs). **Members pay a $162.50 retail Copayment for up to a 90 day supply of maintenance medications at CVS or Target pharmacies.**	Non-Covered

Prescription Drug Benefit			
Prescription Drugs	**Mail Service Pharmacy**	**Participating Pharmacy**	**All Other Pharmacies**
Generic Drugs	After satisfying the Benefit Year Deductible, the Member pays a $25 Copayment for each prescription or refill, up to a 90 day supply	After satisfying the Benefit Year Deductible, for all pharmacies except CVS and Target the Member pays a $10 copayment for each monthly prescription (maintenance or non-maintenance drugs). **Members pay a $25 retail Copayment for up to a 90 day supply of maintenance medications at CVS or Target pharmacies.**	Non-Covered
Preferred Brand Drug	After satisfying the Benefit Year Deductible, the Member pays a $125 Copayment for each prescription or refill, up to a 90 day supply	After satisfying the Benefit Year Deductible, for all pharmacies except CVS and Target the Member pays a $50 copayment for each monthly prescription (maintenance or non-maintenance drugs). **Members pay a $125 retail Copayment for up to a 90 day supply of maintenance medications at CVS or Target pharmacies.**	Non-Covered
Non-Preferred Brand Drug	After satisfying the Benefit Year Deductible, the Member pays a $162.50 Copayment per Member for each prescription or refill, up to a 90 day supply	After satisfying the Benefit Year Deductible, for all pharmacies except CVS and Target the Member pays a $65 copayment for each monthly prescription (maintenance or non-maintenance drugs). **Members pay a $162.50 retail Copayment for up to a 90 day supply of maintenance medications at CVS or Target pharmacies.**	Non-Covered
Sexual Dysfunction Prescription Drugs, Limited to Fifteen (15) Pills per Month	Covered	Covered	Non-Covered

Prescription Drug Benefit			
Prescription Drugs	**Mail Service Pharmacy**	**Participating Pharmacy**	**All Other Pharmacies**
Diabetic Syringes and Supplies***	Covered	Covered	Non-Covered
Non-Sedating Antihistamines	$25 Copayment per Member for each prescription or refill after the Benefit Year Deductible, up to a 90 day supply	For all pharmacies except CVS and Target the Member pays a $10 copayment for each monthly prescription (maintenance or non-maintenance drugs). **Members pay a $25 retail Copayment for up to a 90 day supply of maintenance medications at CVS or Target pharmacies.**	Non-Covered
Proton Pump Inhibitors (Ppis)	$25 Copayment per Member for each prescription or refill after the Benefit Year Deductible, up to a 90 day supply	For all pharmacies except CVS and Target the Member pays a $10 copayment for each monthly prescription (maintenance or non-maintenance drugs). **Members pay a $25 retail Copayment for up to a 90 day supply of maintenance medications at CVS or Target pharmacies.**	Non-Covered

Prescription Drug Benefit			
Prescription Drugs	**Mail Service Pharmacy**	**Participating Pharmacy**	**All Other Pharmacies**
Contraceptives: oral contraceptives, cervical cap, diaphragms, emergency contraception, female condom, implantable rod, intrauterine device (IUD), patch, shot/injection, spermicide, sponge, vaginal contraceptive ring and approved sterilization procedures for women A complete list of specific Prescription Drugs or supplies covered at 100% is available at www.SouthCarolinaBlues.com	Prescription Drugs will be covered at 100%, up to a 90 day supply	Prescription Drugs will be covered at 100%, up to a 90 day supply	The Member will be responsible for 100% of the Allowable Charge at the pharmacy then will be reimbursed at 100%, up to a 90 day supply
**All other Contraceptives (Prescription Drugs)	Covered	Covered	Non-Covered
*Contraceptives listed above are covered under the participating medical Benefits at the same payment levels. Refill quantities for the contraceptives listed above may vary. **All other contraceptives are paid at the Generic, Preferred Brand and Non-Preferred Brand Drug payment levels. ***A separate Copayment applies for each supply purchase.			

Specialty Drug Benefit		
	Participating Pharmacy	All Other Pharmacies
Specialty Drugs	$100 Copayment per Member for each prescription or refill after the Benefit Year Deductible, up to a 31 day supply	Non-Covered

VI. Covered Benefits

A. Payment

The payment of Covered Expenses for Benefits is subject to all terms and conditions of the Plan of Benefits and the Schedule of Benefits. Covered Expenses will only be paid for Benefits:

1) Performed or provided on or after the Member Effective Date; and
2) Performed or provided prior to termination of coverage; and
3) Provided by a Provider within the scope of his or her license; and
4) For which the required Preadmission Review, Emergency Admission Review, Precertification and/or Continued Stay Review has been requested and Precertification was received from the Plan (the Member should refer to the Schedule of Benefits for services that require Precertification); and
5) That are Medically Necessary; and
6) That are not subject to an exclusion under Section VIII of this SPD; and
7) After the payment of all required Benefit Year Deductibles, Coinsurance and Copayments.

B. Limitation on Assignments

A Member's rights and benefits under this Plan of Benefits cannot be assigned, sold, or transferred to any person, including a healthcare provider or other creditor, without the express written consent of the Plan Administrator, except as permitted by a Qualified Medical Child Support Order. This means that a Member may not assign a right to receive benefit payments. At its option, the Plan Administrator may direct the Corporation to make payments directly to a healthcare provider, but a direct payment to a healthcare provider shall not constitute an assignment of health benefits or rights under the Plan of Benefits. This also means that a Member may not assign a right to dispute coverage, to appeal an adverse benefit determination, or to maintain any other ERISA action with respect to this Plan of Benefits. Any purported assignment of benefits or rights under the Plan of Benefits made without the express written consent of the Plan Administrator shall be void and shall not apply to the Plan of Benefits. The Plan Administrator's or the Corporation's direct payment to a healthcare provider or direct communication with a healthcare provider regarding this Plan of Benefits shall not constitute consent to an assignment or a waiver of this limitation.

C. Specific Covered Benefits

If all of the following requirements are met, the Employer's Group Health Plan will provide the Benefits described in this Section VI:

1) All of the requirements of Section VI must be met; and,
2) The Benefit must be listed in this Section VI; and,
3) The Benefit (separately or collectively) must not exceed the dollar or other limitations contained on the Schedule of Benefits; and,
4) The Benefit must not be subject to one or more of the exclusions set forth in Section VIII.

The Employer's Group Health Plan will provide the following Benefits:

Allergy Injections

The Employer's Group Health Plan will pay Covered Expenses for allergy injections as set forth below:

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

Ambulance
The Employer's Group Health Plan will pay Covered Expenses for ambulance transportation (including air ambulance when necessary) when used:
1) Locally to or from a Hospital providing Medically Necessary services in connection with an accidental injury or that is the result of an Emergency Medical Condition; and,
2) To or from a Hospital in connection with an Admission.

Chiropractic Services
The Employer's Group Health Plan will pay Covered Expenses for services and Medical Supplies required in connection with the detection and correction, by manual or mechanical means, of structural imbalance, distortion, or subluxation in the human body, for purposes of removing nerve interference and the effects of such nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

Cleft Lip or Palate
The Employer's Group Health Plan will pay Covered Expenses for the care and treatment of a congenital cleft lip or palate, or both, and any physical condition or illness that is related to or developed as a result of a cleft lip or palate.

Benefits shall include but not be limited to:
1) Oral and facial Surgical Services, surgical management and follow-up care; and
2) Prosthetic Device treatment such as obdurators, speech appliances and feeding appliances; and
3) Orthodontic treatment and management; and
4) Prosthodontia treatment and management; and
5) Otolaryngology treatment and management; and
6) Audiological assessment, treatment and management, including surgically implanted amplification devices; and
7) Physical therapy assessment and treatment.

Benefits for a cleft lip or palate must be Preauthorized. If a Member with a cleft lip or palate is covered by a dental plan or policy, then teeth capping, prosthodontics and orthodontics shall be covered by the dental plan or policy to the limit of coverage provided under such dental plan or policy prior to coverage under this Employer's Group Health Plan. Covered Expenses for any excess medical expenses after coverage under any dental policy is exhausted shall be provided as for any other condition or illness under the terms and conditions of this Plan of Benefits.

Clinical Trials
The Employer's Group Health Plan will pay for routine Member costs for items and services related to clinical trials when:
1) The Member has cancer or other life-threatening disease or condition; and
2) The referring Provider is a Participating Provider that has concluded that the Member's participation in such trial would be appropriate; and
3) The Member provides medical and scientific information establishing that the Member's participation in such trial would be appropriate; and
4) The services are furnished in connection with an Approved Clinical Trial.

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

Cochlear Implants
The Employer's Group Health Plan will pay Covered Expenses for Cochlear Implants for adults and children as set forth on the Schedule of Benefits but only for the following diagnoses:
1) Severe to profound bilateral sensorineural hearing loss at 70-dB or above;
2) Severely deficient speech discrimination with no benefit from a conventional hearing aid; and
3) Post-Lingual sensorineural deafness in an adult.

Colonoscopy
The Employer's Group Health Plan will pay Covered Expenses for a Colonoscopy as set forth on the Schedule of Benefits.

Covered Obesity Services
The Employer's Group Health Plan will pay for an initial screening and ongoing behavioral intervention sessions to promote improvements in weight status for Covered Members who are overweight or obese and have additional cardiovascular risk factors.

Cranial Orthotics
The Employer's Group Health Plan will pay Covered Expenses for Cranial Orthotics as set forth on the Schedule of Benefits when rendered as treatment of either of the following conditions:
1) Synostic plagiocephaly (craniosynostosis) following surgical correction; or
2) Moderate to severe nonsynostotic postional plagioecephaly when the medical criteria is met.

Dental Care for Accidental Injury
The Employer's Group Health Plan will pay Covered Expenses for dental services to Natural Teeth required because of accidental injury. For purposes of this section, an accidental injury is defined as an injury caused by a traumatic force such as a car accident or a blow by a moving object. No Covered Expenses will be paid for injuries that occur while the Member is in the act of chewing or biting. Services for conditions that are not directly related to the accidental injury are not covered. The first visit to a dentist does not require Preauthorization; however, the dentist must submit a plan for any future treatment to the Plan for review and Precertification before such treatment is rendered if Covered Expenses are to be paid. Benefits are limited to treatment for only six (6) months from the date of the accidental injury.

Diabetes Education
The Employer's Group Health Plan will pay Covered Expenses for outpatient self-management training and education for Members with diabetes mellitus provided that such training and educational Benefits are rendered by a Provider whose program is recognized by the American Diabetes Association.

Disease Management Program
The Employer's Group Health Plan may offer a Disease Management Program for the management of certain diagnosed medical conditions. A Member's participation in any Disease Management Program is voluntary. More information about the covered medical conditions is available from the Plan Administrator/Quantum.

Durable Medical Equipment
The Employer's Group Health Plan will pay Covered Expenses for Durable Medical Equipment when the required Preauthorization is obtained. The Plan Administrator will decide (in its sole discretion) whether to buy or rent equipment and whether to repair or replace damaged or worn Durable Medical Equipment. The Employer's Group Health Plan will not pay Covered Expenses for Durable Medical Equipment that is solely used by a Member in a Hospital or that the Plan Administrator determines (in its sole discretion) is included in any Hospital room charge.

Emergency Services
When you experience an emergency medical condition, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance help.

Covered services include only services to evaluate and stabilize an emergency medical condition in a hospital emergency room. For those plans that use a network of providers, you can get emergency services from network or out-of-network providers.

Your coverage for emergency services will continue until the following conditions are met:

- You are evaluated and your condition is stabilized
- Your attending physician determines that you are medically able to travel or be transported, by non-medical or non-emergency transportation, to another provider if you need more care

If both of the above conditions are met and you continue stay in the hospital (emergency admission) or receive follow-up care, these are not emergency services. Different benefits and requirements apply. Please refer Covered Benefits section, as well as the Exclusions and Limitations section that fits your situation (for example, Hospital care or Physician services). You can also contact us or your physician.

Gynecological Examination
The Employer's Group Health Plan will pay Covered Expenses for routine gynecological examinations each Benefit Year for female Members.

Hearing Aids and Exams
The Employer's Group Health Plan will pay Covered Expenses for hearing aids and examinations for the prescription or fitting of hearing aids as set forth on the Schedule of Benefits.

Home Health Care
The Employer's Group Health Plan will pay Covered Expenses for Preauthorized Home Health Care, including private duty nursing, when rendered to a homebound Member in the Member's current place of residence.

Hospice Care
The Employer's Group Health Plan will pay Covered Expenses for Preauthorized Hospice Care provided in an outpatient setting.

Hospital Services
The Employer's Group Health Plan will pay Covered Expenses for Admissions as follows:

1) Semi-private room, board, and general nursing care; and,
2) Private room, at semi-private rate as determined by the Employer's Group Health Plan; and,
3) Services performed in a Special Care Unit when it is Medically Necessary that such services be performed in such unit rather than in another portion of the Hospital; and,
4) Ancillary services and Medical Supplies including services performed in operating, recovery and delivery rooms; and,
5) Diagnostic services including interpretation of radiological and laboratory examinations, electrocardiograms, and electroencephalograms; and,
6) In a Long-Term Acute Care Hospital.

Benefits for Admissions may be subject to the requirements for Preadmission Review, Emergency Admission Review and Continued Stay Review.

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

Human Organ and Tissue Transplants
The Employer's Group Health Plan will pay Covered Expenses for certain Preauthorized human organ and tissue transplants. To be covered, such transplants must be provided from a human donor to a Member and provided at a transplant center approved by the Plan Administrator. Benefits shall only be paid for the human organ and tissue transplants as set forth on the Schedule of Benefits.

The payment of Benefits for living donor transplants will be subject to the following conditions:

1) When both the transplant recipient and the donor are Members, Benefits will be paid for both.

2) When the transplant recipient is a Member and the donor is not, Benefits will be paid for both the recipient and the donor to the extent that the donor does not have health benefits provided by any other source.

3) When the donor is a Member and the transplant recipient is not, no Benefits will be paid for either the donor or the recipient.

Human organ and tissue transplant coverage includes expenses incurred for legal donor organ and tissue procurement and all inpatient and outpatient Hospital and medical expenses for the transplant procedure and related pre-operative and post-operative care, including immunosuppressive drug therapy and air ambulance expenses.

In-Hospital Medical Service
Benefits will be paid for a licensed medical doctor or Behavioral Health Provider's visits to a Member during a Medically Necessary Admission for treatment of a condition other than that for which Surgical Service or obstetrical service is required as follows:
1) In-hospital medical Benefits primarily for Mental Health Services and Substance Use Disorder Services; and,
2) In-hospital medical Benefits in a Skilled Nursing Facility will be provided for visits of a Provider, limited to one (1) visit per day.
3) Where two (2) or more Providers render in-hospital medical visits on the same day, payment for such services will be made only to one (1) Provider.
4) Concurrent medical and surgical Benefits for in-hospital medical services are only provided:
    a) When the condition for which in-hospital medical services requires medical care not related to Surgical Services or obstetrical service and does not constitute a part of the usual, necessary, and related pre-operative or post-operative care, but requires supplemental skills not possessed by the attending surgeon or his/her assistant; and,
    b) When the surgical procedure performed is designated by the Employer's Group Health Plan as a warranted diagnostic procedure or as a minor surgical procedure.
5) When the same Provider renders different levels of care on the same day, Benefits will only be provided for the highest level of care.

Mammography Testing
The Employer's Group Health Plan will pay Covered Expenses for one (1) mammography test per Benefit Year regardless of Medical Necessity for female Members that are within the appropriate age guidelines that apply to the Plan of Benefits. The Employer's Group Health Plan will pay Covered Expenses for additional mammograms during a Benefit Year based on Medical Necessity.

Mayo Clinic Complex Care Program
The Group Health Plan offers the Mayo Clinic Complex Care Program to Members with Complex Care needs. "Complex Care" is defined as conditions that are one or more of the following:
- Life-threatening
- Cause serious disability

- Associated with severe consequences
- Affect multiple organ systems
- Require coordinated care by multiple medical specialties
- Require treatments that carry a risk of serious complications
- Undiagnosed or difficult to diagnose

The Mayo Clinic Complex Care Program benefit is available to, but not required to be utilized by, all eligible Members who have received an undifferentiated diagnosis, or diagnosis of a complex condition and have completed the Mayo Clinic Complex Care Program referral coordination process. The Member must elect to travel to and receive treatment at Mayo Clinic's designated facility, must be safe to travel, must designate a companion caregiver, and must meet other Plan requirements to participate in the Mayo Clinic Complex Care Program.

The Group Health Plan will pay expenses for a Member's participation in the Mayo Clinic Complex Care Program as shown on the Schedule of Benefits.

The Mayo Clinic Complex Care Program is not subject to any components of the Plan's Review and Coordination Process, to include Preauthorization/PreCertification, Utilization Review, Concurrent Review, Case Management, Chronic Condition Management, or Care Coordination. This shall include any and all services and supplies associated with a Member's care through the Mayo Clinic Complex Care Program when recommended by and provided at any Mayo Clinic location.

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

Mental Health Services
The Employer's Group Health Plan will pay Covered Expenses for the inpatient and outpatient treatment for Mental Health Services.

Non-Sedating Antihistamines
The Employer's Group Health Plan will pay Covered Expenses for Non-Sedating Antihistamines as set forth on the Schedule of Benefits.

Obstetrical Services
The Employer's Group Health Plan will pay Covered Expenses for Preauthorized obstetrical services. Notwithstanding the preceding sentence, no maternity or obstetrical services are covered for a Member who is a Child. Midwives licensed and practicing in compliance with the Nurse Practices Act in a Hospital will be covered under this Benefit.

Orthognathic Surgery
The Employer's Group Health Plan will pay Covered Expenses for any service related to the treatment of malpositions or deformities of the jaw bone(s), dysfunction of the muscles of mastication or orthognathic deformities for which the resulting disorder is breathing, nutritional or speech related. Services exclude dental conditions related to biting, chewing or teeth.

Orthopedic Devices
The Employer's Group Health Plan will pay Covered Expenses for Preauthorized Orthopedic Devices.

Orthotic Devices
The Employer's Group Health Plan will pay Covered Expenses for Preauthorized Orthotic Devices that are not available on an over-the-counter basis and are not otherwise excluded under the Plan of Benefits.

Outpatient Hospital and Ambulatory Surgical Center Services
The Employer's Group Health Plan will pay Covered Expenses for Surgical Services and diagnostic services including radiological examinations, laboratory tests, and machine tests, performed in an outpatient Hospital setting or an Ambulatory Surgical Center.

Outpatient Rehabilitation Services
The Employer's Group Health Plan will pay Covered Expenses, subject to the following paragraph, for physical therapy, occupational therapy and rehabilitation services as set forth on the Schedule of Benefits.

Covered Expenses for outpatient rehabilitation services will be paid only following an acute incident involving disease, trauma or surgery that requires such care.

Oxygen
The Employer's Group Health Plan will pay Covered Expenses for Preauthorized oxygen. Durable Medical Equipment for oxygen use in a Member's home is covered under the Durable Medical Equipment Benefit.

Pap Smear
The Employer's Group Health Plan will pay Covered Expenses for a single Pap smear as part of the annual gynecological examination Benefit regardless of Medical Necessity. The Employer's Group Health Plan will pay Covered Expenses for additional Pap smears during a Benefit Year based on Medical Necessity.

Penile Implants
The Employer's Group Health Plan will pay Covered Expenses for Penile Implants as set forth on the Schedule of Benefits for Members suffering from medical conditions such as postoperative prostatectomy and diabetes that are clearly the cause of erectile dysfunction.

Physical Examination
The Employer's Group Health Plan will pay Covered Expenses for a single annual physical examination each Benefit Year for Members that are within the appropriate age guidelines that apply to this Plan of Benefits regardless of Medical Necessity.

Prescription Drugs
The Employer's Group Health Plan will pay Covered Expenses for Prescription Drugs (as specified on the Schedule of Benefits) that are used to treat a condition for which Benefits are otherwise available. Any Coinsurance percentage for Prescription Drugs is based on the Allowable Charge at the Participating Pharmacy and does not change due to receipt of any credits by the Employer's Group Health Plan. Copayments likewise do not change due to receipt of any credits by the Employer's Group Health Plan.

If a Provider prescribes a Brand Name Drug and an equivalent Generic Drug is available, any difference between the cost of a Generic Drug and the higher cost of a Brand Name Drug shall be the responsibility of the Member. However, if the Provider indicates in the prescription that a substitution is not allowed then the cost difference of the Brand Name Drug will not be the responsibility of the Member.

Insulin shall be treated as a Prescription Drug whether injectable or otherwise.
The Employer's Group Health Plan may, in its sole discretion, place quantity limits on Prescription Drugs.

For more additional information regarding Prescription Drugs, contact a Quantum Health Care Coordinator at (855) 576-9984.

Preventive Services
The Employer's Group Health Plan will pay for preventive health services required under PPACA as follows:

1) Evidence based services that have a rating of A or B in the current United States Preventive Services Task Force (USPSTF) recommendations; and,
2) Immunizations as recommended by the Center for Disease Control and Prevention (CDC); and
3) Preventive care and screenings for children and women as recommended by the Health Resources and Services Administration (HRSA).

These Benefits are provided without any cost-sharing by the Member when the services are provided by a Participating Provider.

Prostate Examination
The Employer's Group Health Plan will pay Covered Expenses for one (1) prostate examination per Benefit Year regardless of Medical Necessity as set forth in the Schedule of Benefits for Members that are within the appropriate age guidelines that apply to the Plan of Benefits. The Employer's Group Health Plan will pay Covered Expenses for additional prostate examinations during a Benefit Year based on Medical Necessity.

Prosthetic Devices
The Employer's Group Health Plan will only pay Covered Expenses for a Prosthetic Device, other than a dental prosthetic, which is a replacement for a body part and which meets minimum specifications for the body part it is replacing regardless of the functional activity level. Coverage is provided for the cost of the standard, non-luxury item only (as determined by the Employer's Group Health Plan). Components that are considered deluxe or upgraded over a standard model are not a covered service. Except as provided below, Benefits are provided for only the initial temporary prosthesis and one (1) permanent prosthesis. No Benefits are provided for repair, replacement or duplicates, nor are Benefits provided for services related to the repair or replacement of such prosthetics except when necessary due to a change in the Member's medical condition, and with prior authorization from the Plan.

Prosthetic Devices do not include bioelectric, microprocessor or computer programmed prosthetic components.

Proton Pump Inhibitors
The Employer's Group Health Plan will pay Covered Expenses for Proton Pump Inhibitors as set forth on the Schedule of Benefits.

Provider Services
The Employer's Group Health Plan will pay Covered Expenses for Provider Services, provided that when different levels (as determined by the Employer's Group Health Plan) of ProviderProvider Services are provided on the same day, Covered Expenses for such Benefits will only be paid for the highest level (as determined by the Employer's Group Health Plan) of Provider Services.

Reconstructive Surgery Following Mastectomies
In the case of a Member who is receiving Covered Expenses in connection with a mastectomy the Employer's Group Health Plan will pay Covered Expenses for each of the following (if requested by such Member):

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

Rehabilitation
The Employer's Group Health Plan will pay Covered Expenses for participation in a multidisciplinary team rehabilitation program only following severe neurologic or physical impairment as specified on the Schedule of Benefits if the following criteria are met:

1) All such treatment must be ordered by a medical doctor; and
2) All such treatment may require Precertification and must be performed by a Provider and at a location designated by the Employer's Group Health Plan; and
3) The documentation that accompanies a request for rehabilitation Benefits must contain a detailed Member evaluation from a medical doctor that documents that to a degree of medical certainty the Member has rehabilitation potential such that there is an expectation that the Member will achieve an ability to provide self-care and perform activities of daily living; and

All such rehabilitation Benefits are subject to periodic review by the Employer's Group Health Plan.

After the initial rehabilitation period, continuation of rehabilitation Benefits will require documentation that the Member is making substantial progress and that there continues to be significant potential for the achievement of the established rehabilitation goals.

Residential Treatment Center
The Employer's Group Health Plan will pay Covered Expenses for a Preauthorized Residential Treatment Center as set forth on the Schedule of Benefits.

Skilled Nursing Facility Services
The Employer's Group Health Plan will pay Covered Expenses for Admissions in a Skilled Nursing Facility as follows:

1) Semi-private room, board, and general nursing care;
2) Private room, at semi-private rate as determined by the Employer's Group Health Plan;
3) Services performed in a Special Care Unit when it is Medically Necessary that such services be performed in such unit;
4) Ancillary services and Medical Supplies including services performed in operating, recovery and delivery rooms;
5) Diagnostic services including interpretation of radiological and laboratory examinations, electrocardiograms, and electroencephalograms;
6) In a Long-Term Acute Care Hospital.

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

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

Specialty Drugs
The Employer's Group Health Plan will pay Covered Expenses for Specialty Drugs. Covered Expenses for Specialty Drugs dispensed to a Member shall not exceed the quantity and Benefit maximum set by the Employer's Group Health Plan. Specialty Drugs may be considered medical Benefits. For any Specialty Drugs paid as medical Benefits the Benefit Year Deductible, Out-of-Pocket Maximum and/or Benefit maximum will apply. The Member may obtain a list of Specialty Drugs by contacting the Employer's Group Health Plan at the number listed on the Identification Card or at www.SouthCarolinaBlues.com.

Any Coinsurance percentage for Specialty Drugs is based on the Allowable Charge at the Participating Pharmacy, and does not change due to receipt of any credits by the Employer's Group Health Plan. Copayments likewise do not change due to receipt of any credits by the Employer's Group Health Plan.

Speech Therapy
The Employer's Group Health Plan will pay Covered Expenses for Speech Therapy as set forth on the Schedule of Benefits.

Substance Use Disorder Services
The Employer's Group Health Plan will pay Covered Expenses for Substance Use Disorder Services as set forth on the Schedule of Benefits.

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

Surgical Services, subject to the following:
1) If two (2) or more operations or procedures are performed at the same time, through the same surgical opening or by the same surgical approach, the total amount covered for such operations or procedures will be the Allowable Charge for the major procedure only.
2) If two (2) or more operations or procedures are performed at the same time, through different surgical openings or by different surgical approaches, the total amount covered will be the Allowable Charge for the operation or procedure bearing the highest Allowable Charge, plus one-half of Allowable Charge for all other operations or procedures performed.
3) If an operation consists of the excision of multiple skin lesions, the total amount covered will be the Allowable Charge for the procedure bearing the highest Allowable Charge, fifty (50%) percent for the procedure bearing the second and third highest Allowable Charges, twenty-five (25%) percent for the procedures bearing the fourth through the eighth highest Allowable Charges, and, ten (10%) percent for all other procedures. Provided, however, if the operation consists of the excision of multiple malignant lesions, the total amount covered will be the Allowable Charge for the procedure bearing the highest Allowable Charge, and fifty (50%) percent of the charge for each subsequent procedure.
4) If an operation or procedure is performed in two (2) or more steps or stages, coverage for the entire operation or procedure will be limited to the Allowable Charge set forth for such operation or procedure.
5) If two (2) or more medical doctors or oral surgeons perform operations or procedures in conjunction with one another, other than as an assistant surgeon or anesthesiologist, the Allowable Charge, subject to the above paragraphs, will be coverage for the services of only one (1) medical doctor or oral surgeon (as applicable) or will be prorated between them by the Employer's Group Health Plan when so requested by the medical doctor or oral surgeon in charge of the case.
6) Certain surgical procedures are designated as separate procedures by the Employer's Group Health Plan, and the Allowable Charge is payable when such procedure is performed as a separate and single entity; however, when a separate procedure is performed as an integral part of another surgical procedure, the total amount covered will be the Allowable Charge for the major procedure only.

Surgical assistant services, that consist of the Medically Necessary service of one (1) medical doctor or oral surgeon or 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 in-house physician. The Employer's Group Health Plan will pay charges at the percentage of the Allowable Charge set forth on the Schedule of Benefits for the Surgical Service, not to exceed the medical doctor's or oral surgeon's (as applicable) actual charge.

Anesthesia services, that consist of services rendered by a medical doctor, oral surgeon or a certified registered nurse anesthetist, other than the attending surgeon or his or her assistant, and includes the administration of spinal or rectal anesthesia, or a drug or other anesthetic agent by injection or inhalation,

except by local infiltration, the purpose and effect of which administration is the obtaining of muscular relaxation, loss of sensation, or loss of consciousness. Additional Benefits will not be provided for pre-operative anesthesia consultation.

Telehealth Consultation Services
Covered Expenses includes a medical or health consultation provided exclusively through Blue CareOnDemand, for purposes of patient diagnosis, consultation, treatment, transfer of medical data, and education, which requires the use of advanced telecommunications technology.

Temporomandibular Joint (TMJ) Disorder
The Employer's Group Health Plan will pay Covered Expenses for any service for the treatment of dysfunctions or derangements of the temporomandibular joint, including orthognathic surgery for the treatment of dysfunctions or derangements of the temporomandibular joint.

Wellness
The Plan of Benefits may offer wellness programs to all covered Associates and their covered Eligible Dependents. These wellness benefits are subject to change from time to time and may include, but may not be limited to, a tobacco cessation program and fitness services. For example, effective June 1, 2022, the Plan contracted with Sword Health to provide Sword Thrive, a wellness coaching, education, and exercise support program to improve the overall health of those with Musculoskeletal (MSK) conditions. Effective January 1, 2025, the Plan has added a wellness program through Sword called Bloom to support female pelvic health. Any covered person who is interested in learning more about, and/or participating in, the wellness program(s),should call a Quantum Health Care Coordinator at (855) 576-9984.

VII. Care Coordination Process

The Plan incorporates a "Care Coordination" process by Quantum Health. This process includes a staff of Quantum Health Care Coordinators who receive a notification regarding most healthcare services sought by Covered Members, and coordinate activities and information flow between the providers.

Care Coordination is intended to help Covered Members obtain quality healthcare and services in the most appropriate setting, help reduce unnecessary medical costs, and for early identification of complex medical conditions. The Quantum Health Care Coordinators are available to Covered Members and their providers for information, assistance, and guidance, and can be reached toll-free by calling: Quantum Health Care Coordinators at (855) 576-9984.

In order to receive coverage at the level described in the Schedule of Benefits, Covered Members must follow the "Care Coordination Process" outlined in this section. Failure to follow this process of care can result in significant benefit reductions, penalties, or even loss of benefits for specific services. The process of care generally includes:

- Designating a coordinating Provider (Primary Care Physician, referred to as the PCP)
- Review and coordination process, including:
- Precertification of certain procedures
- Utilization Review
- Concurrent Review of hospitalization and courses of care
- Case Management

As described below, referral and Precertification authorizations are generally requested by the providers on behalf of their Covered Members.

A. Designated Coordinating Provider

Upon enrollment, all Covered Members are asked to designate a coordinating Primary Care Physician (PCP) for each member of their family. While such designation is not mandatory, it is strongly recommended. Covered Members who designate a Participating Provider primary care physician to be their

coordinating Provider will maximize their benefits available under the terms of this Plan and receive the best coordination of care.

The care coordination process generally begins with the "coordinating Provider," who is a Primary Care Physician who maintains a relationship with the Covered Member and provides general healthcare guidance, evaluation, and management. The following types of physicians can be selected by Covered Members as their coordinating PCP:

- Family Medicine
- General Practice
- Internal Medicine
- Pediatrician (for children)
- An OB/GYN may serve as a primary care physician ONLY during the course of a woman's pregnancy

When a Covered Member begins all healthcare events or inquiries with a call or visit to a PCP, the PCP then will be positioned to guide patients as appropriate, in addition to providing care coordination and submitting referral and pre-notification requests when necessary. This allows the PCP to provide ongoing healthcare guidance.

If you have trouble obtaining access to a PCP, the Quantum Health Care Coordinators may be able to assist you by providing a list of available PCPs and even contacting PCP offices on your behalf. Please contact the Quantum Health Care Coordinators at (855)576-9984.

B. Use of Participating Providers

The Plan offers a broad network of providers and provides the highest level of benefits when Covered Members utilize Participating Providers. These networks will be indicated on your Plan identification card. Services provided by out-of-network providers will not be eligible for the highest benefits. Specific benefit levels are shown in the Schedule of Benefits.

You may have to find a new provider when:

- You join the Plan and the provider or facility you have now is not in the network
- You are already a Covered Member and your provider or facility stops being in our network

However, in some cases, you may be able to keep going to your current provider or facility to complete a treatment or to have treatment that was already scheduled at the in-network cost sharing levels for up to 90 days of the provider or facility ceasing to be in our network. This is called continuity of care. . If we know you are under an active treatment plan, we will notify you of the provider's or facility's contract termination and how you can submit a request to keep going to your current provider or facility. Contact Quantum Health for additional information.

C. Review and Coordination Process

The Mayo Clinic Complex Care Program is not subject to any components of the Plan's Review and Coordination Process, to include Preauthorization/PreCertification, Utilization Review, Concurrent Review, Case Management, Chronic Condition Management, or Care Coordination. This shall include any and all services and supplies associated with a Member's care through the Mayo Clinic Complex Care Program when recommended by and provided at any Mayo Clinic location.

The Care Coordination process includes the following components:

1. Precertification of Certain Procedures*

In order to receive coverage at the level described in the Schedule of Benefits and to ensure complete care coordination, the Plan requires that certain care, services and procedures be precertified before

they are provided. Precertification requests are submitted to the Quantum Health Care Coordinators by a specialty Provider, designated PCP, other PCP, or other healthcare provider. Your Plan identification card includes instructions. Depending on the request, the Quantum Health Care Coordinators may contact the requesting provider to obtain additional clinical information to support the need for the pre-notification request and to ensure that the care, service and/or procedure meet Plan criteria. If a Precertification request does not meet Plan criteria, the Quantum Health Care Coordinators will contact the Covered Member and healthcare provider and assist in redirecting care if appropriate.

The following services require Precertification:

- Inpatient and Skilled Nursing Facility Admissions
- Inpatient or Outpatient Surgeries
- MRI/MRA and PET scans
- Oncology Care and Services (chemotherapy and radiation therapy)
- Genetic Testing
- Home Health Care
- Hospice Care
- DME – all rentals and any purchase over $1,500
- Organ, Tissue and Bone Marrow Transplants
- Dialysis
- Partial Hospitalization and Intensive Outpatient for Mental Health/Substance Abuse
- Applied Behavior Analysis (ABA) therapy related to Autism Spectrum Disorder
- Psychological testing,
- Repetitive transcranial magnetic stimulation (rTMS)

PENALTIES FOR NOT OBTAINING PRECERTIFICATION:
Benefits for any outpatient services that require Precertification will be reduced by 50% of the Allowable Charge when Precertification is not obtained or approved by the Plan. For Admissions, including Mental Health/Substance Abuse, all or a portion of Room and Board Charges will be denied. Outpatient Partial Hospitalization, Repetitive Transcranial Magnetic Stimulations, Electroconvulsive Therapy and Intensive Outpatient Programs: 50% of the Allowable Charge.

2. Utilization Review
Quantum Health Care Coordinators will review each Precertification request to evaluate whether the care, requested procedures, and requested care setting all meet utilization criteria established by the Plan. The Plan has adopted the utilization criteria in use by the Quantum Health Care Coordinators. If a precertification request does not meet these criteria, the request will be reviewed by one of the medical directors for Quantum Health, who will review all available information and if needed consult with the requesting provider. If required, the medical director will also consult with other professionals and medical experts with knowledge in the appropriate field. He or she will then provide, through the Quantum Health Care Coordinators, a recommendation to the Plan Administrator whether the request should be approved, denied, or allowed as an exception. In this manner, the Plan ensures that Precertification requests are reviewed according to nationally accepted standards of medical care, based on community healthcare resources and practices.

3. Concurrent Review
The Quantum Health Care Coordinators will regularly monitor a hospital stay, other institutional admission, or ongoing course of care for any Covered Member, and examine the possible use of alternate facilities or forms of care. The Quantum Health Care Coordinators will communicate regularly with attending Providers, the Utilization Management staff of such facilities, and the Covered Member and/or family, to monitor the patient's progress and anticipate and initiate planning for future needs (discharge planning). Such concurrent review, and authorization for Plan coverage of hospital days, is conducted in accordance with the utilization criteria adopted by the Plan and Quantum Health.

4. Case Management

Case Management is ongoing, proactive coordination of a Covered Members' care in cases where the medical condition is, or is expected to become catastrophic, chronic, or when the cost of treatment is expected to be significant. Examples of conditions that could prompt case management intervention include but are not limited to, cancer, chronic obstructive pulmonary disease, multiple trauma, spinal cord injury, stroke, head injury, AIDS, multiple sclerosis, severe burns, severe psychiatric disorders, high risk pregnancy, and premature birth.

Case Management is a collaborative process designed to meet a covered Member's health care needs, maximize their health potential, while effectively managing the costs of care needed to achieve this objective. The case manager will consult with the Covered Member, the attending physician, and other members of the Covered Member's treatment team to assist in facilitating/implementing proactive plans of care which provides the most appropriate health care and services in a timely, efficient and cost-effective manner.

If the case manager, covered Member, and the Plan Administrator all agree on alternative care that can reasonably be expected to achieve the desired results without sacrificing the quality of care provided, the Plan Administrator may alter or waive the normal provisions of this Plan to cover such alternative care, at the benefit level determined in the sole discretion of the Plan Administrator acting on a basis that precludes individual selection.

In developing an alternative plan of treatment, the case manager will consider:

- The covered Member's current medical status
- The current treatment plan
- The potential impact of the alternative plan of treatment
- The effectiveness of such care and
- The short-term and long-term implications this treatment plan could have.

The Plan Administrator retains the right to review the covered Member's medical status while the alternative plan of treatment is in process, and to discontinue the alternative plan of treatment with respect to medical services and supplies which are not covered charges under the Plan if:

- The attending physician does not provide medical records or information necessary to determine the effectiveness of the alternative plan of treatment
- The goal of the alternative care of treatment has been met
- The alternative plan of care is not achieving the desired results or is no longer beneficial to the covered Member

5. Chronic Condition Management

Chronic Condition Management (also referred to as Disease Management) is specialized support and coordination for Members with lifelong, chronic conditions such as diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease and asthma. Chronic Condition Management is a collaborative process that is designed to help Members with such conditions self-manage based on care pathways with respect to such disease state, including but not limited to assisting members in understanding the care pathway, assisting members in setting goals, facilitating dialog with physicians if there are complications or conflicts with the member's care, evaluating ways to eliminate barriers to successful self-management and generally maximize their health. Members who are identified from claims, biometrics or other sources will be assessed for level of risk for each disease state and may be contacted proactively by a Chronic Condition Case Manager (also referred to as Disease Manager). Members whose information indicates they are high risk will be contacted by a Chronic Condition Case Manager for an assessment and ongoing assistance and will be asked to update their care pathway information bi-annually. Members who are low or moderate risk may request assistance of a Chronic Condition Case Manager and will also be asked to update their care pathway information on a bi-annual basis. Participation in chronic condition care management is voluntary, but participants may receive various prescription medications and/or supplies at a reduced cost or may be entitled to benefits that non-participants do not receive.

D. General Provisions for Care Coordination

1. Authorized Representative

The Covered Member is ultimately responsible for ensuring that all precertifications are approved and in place prior to the time of service to receive the highest level of benefits. However, in most cases, the actual referral and Precertification process will be executed by the Covered Member's Provider(s) or other providers. By subscribing to this Plan, the Covered Member authorizes the Plan and its designated service providers (including Quantum Health, the third party administrator, and others) to accept healthcare providers making referral and Precertification submissions, or who otherwise have knowledge of the Covered Member's medical condition, as their authorized representative in matters of Care Coordination.

2. Time of Notice

The referral and Precertification notifications must be made to the Quantum Health Care Coordinators within the following timeframe:

- At least three business days, before a scheduled (elective) Inpatient Hospital admission
- By the next business day after, an emergency Hospital admission
- Upon being identified as a potential organ or tissue transplant recipient
- At least three business days before receiving any other services requiring Precertification

3. "Emergency" admissions and procedures

Any Hospital admission or Outpatient procedure that has not been previously scheduled and cannot be delayed without harming the patient's health is considered an emergency for purposes of the utilization review notification.

4. Maternity Admissions

A notice regarding admissions for childbirth should be submitted to the Quantum Health Care Coordinators in advance, preferably 30 days prior to expected delivery. The Plan and the Care Coordination process complies with all state and federal regulations regarding utilization review for maternity admissions. The Plan will not restrict benefits for any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require prior notification or authorization for prescribing a length of stay not in excess of these periods. If the mother's or newborn's attending provider, after consulting with the mother, discharges the mother or her newborn earlier than the

applicable 48 or 96 hours, the Plan will only consider benefits for the actual length of the stay. The Plan will not set benefit levels or out-of-pocket costs so that any later portion of the 48 or 96 hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

5. **Care Coordination is not a guarantee of payment of benefits**
   The Care Coordination process does not provide a guarantee of payment of benefits. Approvals of referral and Precertification notices for specialty visits, procedures, hospitalizations and other services, indicate that the medical condition, services, and care settings meet the utilization criteria established by the Plan. The Care Coordination approvals do not indicate that the service is a covered benefit, that the Covered Member is eligible for such benefits, or that other benefit conditions such as co-pay, deductible, co-insurance, or maximums have been satisfied. Final determinations regarding coverage and eligibility for benefits are made by the Plan.

6. **Result of not following the coordinated process of care**
   Failure to comply with the Care Coordination "process of care" may result in reduction or loss in benefits. Please refer to the Section entitled PENALTIES FOR NOT OBTAINING PRECERTIFICATION for the applicable penalty amounts. Charges you must pay due to any penalty for failure to follow the care coordination process do not count toward satisfying any deductible, co-insurance or out-of-pocket limits of the Plan.

VIII. Exclusions and Limitations

Regardless of language contained elsewhere in this SPD, the following are not Benefits under the Plan of Benefits. The only exceptions to this are as follows: (1) where such items are specifically included (up to the corresponding dollar amount and/or coverage percentage) in the Schedule of Benefits or in Section VI-benefits, (2) services rendered by a health care provider as part of a physician incentive program (e.g. patient-centered medical home program), an accountable care organization or episode-based arrangement or (3) as the law requires (i.e. intentional or unreasonable injuries or illnesses that result from medical conditions or domestic violence). Subject to the above-listed exceptions, the Employer's Group Health Plan will not pay any amount for the following:

Acupuncture
Acupuncture treatment or services.

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

Admissions That Are Not Preauthorized
If Precertification is not received for an otherwise Covered Expense related to an Admission penalties will be applied (up to and including denial of the Covered Expenses) as set forth on the Schedule of Benefits.

Auto Accidents
The Plan of Benefits does not provide coverage for claims paid or payable under an automobile insurance policy or any other type of liability insurance policy. Automobile insurance policies include, but are not limited to, no fault, personal injury protection, medical payments, liability, uninsured and underinsured policies, umbrella or any other insurance coverage which may be paid or payable for the injury or illness.

Behavioral, Educational or Alternate Therapy Programs
Any behavioral, educational or alternative therapy techniques to target cognition, behavior language and social skills modification, including:
1) Teaching, Expanding, Appreciating, Collaborating and Holistic (TEACCH) programs;
2) Higashi schools/daily life;
3) Facilitated communication;
4) Floor time;

5) Developmental Individual-Difference Relationship-based model (DIR);
6) Relationship Development Intervention (RDI);
7) Holding therapy;
8) Movement therapies;
9) Music therapy; and
10) Animal assisted therapy.

Benefits Provided By State or Federal Programs
Any service or charge for a service to the extent that the Member is entitled to payment or benefits relating to such service under any state or federal program that provides health care benefits, including Medicare, but only to the extent that benefits are paid or are payable under such programs.

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

Bio-Feedback Services
Bio-feedback when related to psychological services.

Complications from Failure To Complete Treatment
Complications that occur because a Member did not follow the course of treatment prescribed by a Provider, including complications that occur because a Member left a Hospital against medical advice.

Complications from Non-Covered Services
Complications arising from a Member's receipt or use of either services or Medical Supplies or other treatment that are not Benefits, including complications arising from a Member's use of Discount Services.

Concierge Medical Fees
Concierge Medical Fees charged for non-medical expenses, such as amenities to include timely access to see medical personnel. Concierge Medical Fees include retainer, membership, or administrative fees, voluntary or otherwise.

Copying Charges
Fees for copying or production of medical records and/or claims filing.

Cosmetic Services
The Plan of Benefits excludes cosmetic or reconstructive procedures, and any related services or Medical Supplies, which alter appearance but do not restore or improve impaired physical function. Examples of services that are cosmetic and are not covered are:
1) Rhinoplasty (nose);
2) Mentoplasty (chin);
3) Rhytidoplasty (face lift);
4) Glabellar rhytidoplasty (forehead lift);
5) Surgical planing (dermabrasion);
6) Blepharoplasty (eyelid);
7) Mammoplasty (reduction, suspension or augmentation of the breast);
8) Superficial chemosurgery (chemical peel of the face); and,
9) Rhytidectomy (abdomen, legs, hips, buttocks, or elsewhere including lipectomy or adipectomy).

A cosmetic service may, under certain circumstances, be considered restorative in nature. In order for Benefits to be available for such restorative surgery, the following requirements must be met:
- The service must be necessary to correct a loss of physical function or alleviate significant pain; or,

- The service must be necessary due to a malappearance or deformity that was caused by physical trauma, surgery or congenital anomaly; and,
- The proposed surgery or treatment must be Preauthorized.

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

Dental Services
Any dental procedures involving tooth structures, excision or extraction of teeth, gingival tissue, alveolar process, dental x-rays, preparation of mouth for dentures, or other procedures of dental origin. However, such procedures may be Preauthorized in the sole discretion of the Plan Administrator if the need for dental services results from an accidental injury to Natural Teeth within six (6) months prior to the date of such services.

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

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

Food Supplements
Orthomolecular therapy including infant formula, nutrients, vitamins and food supplements. Enteral feedings when not a sole source of nutrition.

Foot Care
Routine foot care such as paring of nails, calluses or corns.

Growth Hormone Therapy
Growth hormone therapy for patients over eighteen (18) years of age. Growth hormone therapy for patients eighteen (18) years of age or younger is excluded unless for documented growth hormone deficiency.

Hemophilia Services
A percentage of the Allowable Charge (as set forth on the Schedule of Benefits) for services, treatment or medications related to the management of all types of blood clotting or coagulation disorders, such as, but not limited to Hemophilia, unless the Member has received treatment at least once in a given Benefit Year at a Hemophilia Treatment Center (HTC) as designated by the U.S. Centers for Disease Control and Prevention.

Human Organ and Tissue Transplants
Human organ and tissue transplants that are not:
1) Preauthorized; or,
2) Performed by a Provider as designated by the Group Health Plan or Corporation; or,
3) Listed as covered on the Schedule of Benefits; or,
4) Performed at a Blue Distinction Center of Excellence or a transplant center approved by the Group Health Plan or Corporation in writing.

Medical and surgical expenses for care and treatment of a living human organ transplant donor are not covered.

Hypnotism
Hypnotism treatment or services.

Impacted Tooth Removal
Services or Medical Supplies for the removal of impacted teeth.

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

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

Injury or Illness Resulting From Criminal Activity
Illness contracted or injury sustained as a result of participating in a riot or insurrection or while engaged in the commission of a felony or an illegal occupation.

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

Investigational or Experimental Services
Services or supplies or drugs that are Investigational or Experimental. Services or supplies or drugs will not be considered Investigational or Experimental Services when recommended by and provided at any Mayo Clinic while the Member is a participant in the Mayo Clinic Complex Care Program.

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

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

Missed Provider Appointments
Charges for a member's appointment with a provider that the member did not attend.

No Legal Obligation to Pay
Any service, supply or charge the Member is not legally obligated to pay.

Non-Emergency Services
If you go to an emergency room for what is not an emergency medical condition, the plan may not cover your expenses. See the Schedule of Benefits for more information.

Not Medically Necessary Services or Supplies
Any service or supply that is not Medically Necessary. However, if a service is determined to be not Medically Necessary because it was not rendered in the least costly setting, Covered Expenses will be paid in an amount equal to the amount payable had the service been rendered in the least costly setting.

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

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

Over-The-Counter Drugs
Except as provided on the Schedule of Benefits, Drugs that are available on an over-the-counter basis or otherwise available without a prescription.

Pain Management Programs
Chronic pain management programs or multi-disciplinary pain management programs including Transcutaneous Electrical Nerve Stimulation (TENS) units, unless Medically Necessary.

Physical Therapy Admissions
All Admissions solely for physical therapy except as provided in Section VI for rehabilitation Benefits.

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

Premarital and Pre-Employment Examinations
Charges for services, supplies or fees for premarital or pre-employment examinations.

Preoperative Anesthesia Consultation
Charges for preoperative anesthesia consultation.

Prescription Drug Exclusions
Charges for:
1) Prescription Drugs that are specifically listed on the website as excluded;
2) Prescription Drugs that have not been prescribed by a Provider acting within the scope of his or her license;
3) Prescription Drugs for non-covered therapies, services, devices or conditions;
4) Prescription Drug refills in excess of the number specified on the Provider's prescription order or Prescription Drug refills dispensed more than one (1) year after the original prescription date;
5) Any type of service or handling fee for Prescription Drugs;

6) Dosages that exceed the recommended daily dosage of any Prescription Drug based on the following guidelines as described in the current:
    a. United States Pharmacopeia (USP);
    b. Facts and Comparisons; and/or,
    c. Physicians' Desk Reference.
7) Prescription Drugs used for or related to cosmetic purposes (including hair growth, and skin wrinkles), obesity or weight control, contraceptives, tobacco cessation (except when prescribed as part of the Plan of Benefits's tobacco cessation program), travel vaccinations, infertility (including but not limited to fertility drugs) or impotence (except when prescribed for benign prostatic hypertrophy), except as specified on the Schedule of Benefits;
8) Over-the-Counter Drugs and over-the-counter supplies or supplements, except for Over-the-Counter Drugs that are designated by the Corporation as Prescription Drugs and are listed as covered on the PDL and are prescribed by a Provider;
9) Prescription Drugs that are being prescribed for a specific medical condition that are not approved by the FDA for treatment of that condition, except for:
    a. Prescription Drugs for a specific medical condition that have at least two (2) formal clinical studies; or,
    b. Prescription Drugs for the treatment of a specific type of cancer, provided the drug is recognized for treatment of that specific cancer in at least one (1) standard, universally accepted reference compendia or is found to be safe and effective in formal clinical studies, the results of which have been published in peer reviewed professional medical journals.
10) Prescription Drugs that are not consistent with the diagnosis and treatment of a Member's illness, injury or condition, are excessive in terms of the scope, duration, dosage or intensity of drug therapy that is needed to provide safe, adequate and appropriate care or are not provided in compliance with any applicable place of service requirements;
11) Prescription Drugs or services administered or dispensed when the required Preauthorization is not obtained;
12) Prescription Drugs for injury or disease that are paid by worker's compensation benefits (if a worker's compensation claim is settled, it will be considered paid by worker's compensation benefits);
13) Prescription Drugs which are part of a Utilization Management program and do not meet the requirements of such program;
14) Prescription Drugs which are new to the market and which are under clinical review by the Corporation shall be listed on the PDL as excluded until the clinical review has been completed and a final determination has been made as to whether the drug should be covered;
15) Prescription Drugs, regardless of therapeutic class, that are determined to offer no clinical or cost effective advantage over other comparable Prescription Drugs already covered under the PDL; and,
16) Non-prescription mineral supplements, non-prescription vitamins, food supplements or replacements, orthomolecular therapy, including infant formula, nutrients, nutritional or dietary supplements, formulas or special foods of any kind, except for prescription prenatal vitamins or prescription vitamin B-12 injections for anemias, neuropathies or dementias secondary to a vitamin B-12 deficiency. Enteral feedings available on an over-the-counter basis, except as specified on the Schedule of Benefits.

Prosthetic Devices
Repair or replacement for routine wear and tear is not a covered Benefit.

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

Pulmonary Rehabilitation
Pulmonary rehabilitation, except in conjunction with a covered lung transplant.

Relationship Counseling
Relationship counseling, including marriage counseling, for the treatment of premarital, marital or relationship dysfunction.

Services for Certain Diagnoses or Disorders
Medical Supplies or services or charges for the diagnosis or treatment of learning disabilities, perceptual disorders, mental retardation, vocational rehabilitation, animal assisted therapy, eye movement desensitization and reprocessing (EMDR), behavioral therapy for solitary maladaptive habits, or rapid opiate detoxification.

Services for Counseling or Psychotherapy
Counseling and psychotherapy services for the following conditions are not covered:
1) Feeding and eating disorders in early childhood and infancy;
2) Tic disorders except when related to Tourette's disorder;
3) Elimination disorders;
4) Mental disorders due to a general medical condition;
5) Sexual function disorders;
6) Sleep disorders;
7) Medication induced movement disorders; or
8) Nicotine dependence unless specifically listed as a Benefit in Section VI of the SPD or on the Schedule of Benefits.

Services Not Listed As Covered Benefits
Medical Supplies or services or other items not specifically listed as a Benefit in Section VI of this SPD or on the Schedule of Benefits.

Services Prior To Member Effective Date or Plan of Benefits Effective Date
Any charges for Medical Supplies or services rendered to the Member prior to the Member's Effective Date, January 1, 2015, or after the Member's coverage terminates, except as provided in the Insurance Plan.

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

Services Resulting From Intoxication or Drug Use
Any services (other than Substance Use Disorder Services), Medical Supplies, charges or losses resulting from a Member being intoxicated or under the influence of any drug or other substance; abusing alcohol, drugs, or other substance; or taking some action the purpose of which is to create a euphoric state or alter consciousness unless taken on the advice of a Provider.

Sleep Apnea
Any Medical Supplies or services or charges incurred for sleep apnea treatment for a Member who is an Associate of the Employer and is a driver subject to the safety regulations of the U.S. Department of Transportation.

Sex Change
Any Medical Supplies or services or charges incurred for consultation, therapy, surgery or any procedures related to changing a Member's sex.

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

Virtual Office Visits
Charges incurred as a result of virtual office visits on the Internet, including Prescription Drugs or Specialty Drugs. A virtual office visit on the Internet occurs when a Member was not physically seen or physically examined by an approved Internet Participating Provider unless otherwise included on the Schedule of Benefits.

Wheelchairs or Power Operated Vehicles
Manual or motorized wheelchairs or power operated vehicles such as scooters for mobility outside of the home setting. Coverage for these devices to assist with mobility in the home setting is subject to the establishment of Medical Necessity by the Employer's Group Health Plan.

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

IX. Coordination of Benefits

A. Applicability
The coordination of benefits rules are intended to prevent duplicate payments from different Plans that otherwise cover a Member for the same Covered Expenses. The rules determine which is the Primary Plan and which is the Secondary Plan.

Generally, unless a specific rule applies, where a claim is submitted for payment under the Plan of Benefits and one or more other Plans, the Plan of Benefits is the Secondary Plan. Additionally, special rules for the coordination of benefits with Medicare may also apply.

B. Coordination of Benefits with Auto Insurance
This is a self-funded ERISA plan, which does not provide benefits for claims which are paid or payable under automobile insurance coverage. Automobile insurance coverage shall include, but is not limited to, no-fault, personal injury protection, medical payments, liability, uninsured and underinsured coverage, umbrella or any other insurance coverage which may be paid or payable for the injury or illness.
Although benefits for claims which are paid or payable under automobile insurance coverage are not covered by the Plan of Benefits, the Plan Administrator may, in its sole discretion, agree to extend Benefits to a Member for the injury or illness. In this instance, if a Member has automobile no-fault, personal injury protection or medical payments coverage, or if such coverage is extended to the Member through a group or their own automobile insurance carrier, that coverage is primary to the Plan of Benefits. The Plan of Benefits will always be secondary to automobile no-fault, personal injury protection or medical payments coverage plans and the Plan of Benefits will coordinate benefits for claims which are payable under those automobile policies.

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

This coordination of benefits provision applies whether or not the Member submits a claim under the automobile no-fault, personal injury protection or medical payments coverage.

As a condition of receiving Benefits, the Member must:

- Immediately notify the Plan Administrator/Corporation of an injury or illness for which automobile insurance coverage may be liable, legally responsible, or otherwise makes a payment in connection with the injuries or illness;
- Execute and deliver an accident questionnaire within one hundred eighty (180) days of the accident questionnaire being mailed to the Member;
- Deliver to the Plan Administrator/Corporation a copy of your Personal Injury Protection Log, Medical Payments log and/or Medical Authorization within ninety (90) days of being requested to do so;
- Deliver to the Plan Administrator/Corporation a copy of the police report, incident or accident report, or any other reports issued as a result of the injuries or illness within ninety (90) days of being requested to do so; and,
- Cooperate fully with the Plan Administrator/Corporation in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan Administrator/Corporation.
- Failure to cooperate with the Plan of Benefits as required under this section will entitle the Plan Administrator/Corporation to invoke the Auto Accident Exclusion and deny payment for all claims relating to the injury or illness up to the amount of available or state mandated coverage.

1) Order of Determination Rules For Associate Members

When a Member's claim is submitted under the Employer's Group Health Plan and another Plan, the Employer's Group Health Plan is a Secondary Plan unless:

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

2) Additional Order of Determination Rules

The Employer's Group Health Plan coordinates Benefits using the first of the following rules that apply:

a. Dependents
The Plan that covers an individual as an Associate or retiree is the Primary Plan.

b. Dependent Child - Parents not Separated or Divorced
When the Employer's Group Health Plan and another Plan cover the same Child as a Dependent then benefits are determined in the following order:
   i. The Plan of the parent whose birthday falls earlier in the year (month and date) is the Primary Plan.
   ii. If both parents have the same birthday, the Plan that has covered a parent longer is the Primary Plan.
   iii. If the other Plan does not have the rule described in (a) above but instead has a rule based upon the gender of the parent and if, as a result, the Plan and the Corporation do not agree on the order of benefits, the gender rule in the other Plan will apply.

   The "birthday rule" does not use the years of the parents' birth in determining which has the earlier birthday.

c. Dependent Child - Parents Separated or Divorced

If two (2) or more Plans cover a person as a Dependent Child of divorced, separated, or unmarried parents, benefits for the Child are determined in the following order:

i. First, the Plan of the parent with custody of the Child;
ii. Second, the Plan of the parent's spouse with the custody of the Child;
iii. Third, the Plan of the parent not having custody of the Child;
iv. Fourth, the Plan of the parent's spouse not having custody of the Child.

Notwithstanding the foregoing, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses (or health insurance coverage) of the Child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, that Plan is the Primary Plan. If the parent with responsibility for health care expenses has no health insurance coverage for the Dependent Child, but that parent's spouse does have coverage, the spouse's Plan is the Primary Plan. This paragraph does not apply with respect to any claim determination period or plan year during which any Benefits are actually paid or provided before the Plan has actual knowledge of the existence of an applicable court decree.

If the specific terms of a court decree state that the parents shall share joint custody without stating that one of the parents is responsible for the health care expenses of the Child (or if the order provides that both parents are responsible), the Plans covering the Child shall follow the order of determination rules outlined in Section IX.

d. Active and Inactive Associates
The Plan that covers a person as an Associate who is neither laid off nor retired or as that Associate's dependent is the Primary Plan. If the Secondary Plan does not have this rule, and if, as a result, the Plans do not agree on the order of Covered Expenses, this rule does not apply.

e. Medicare
The Employer's Group Health Plan is a Secondary Plan with respect to Medicare benefits except where federal law mandates that the Employer's Group Health Plan be the Primary Plan. Any claims where Medicare is primary must be filed by the Member after Medicare payment is made.

f. Longer and Shorter Length of Coverage
If none of the above rules determines the order of benefits, the Plan that has covered the Member longer is the Primary Plan.

g. COBRA
COBRA allows coverage to begin or continue under certain circumstances if the Member already has or obtains coverage under a Group Health Plan. In these instances, two policies may cover the Member, and the Plan providing COBRA coverage will be the Secondary Plan.

3) Effect On Benefits of the Plan of Benefits

a. The Employer's Group Health Plan as Primary Plan
When the Employer's Group Health Plan is the Primary Plan, the Benefits shall be determined without consideration of the benefits of any other Plan.

b. The Employer's Group Health Plan as Secondary Plan
When the Employer's Group Health Plan is a Secondary Plan, the Benefits will be reduced when the sum of the following exceeds the Covered Expenses in a Benefit Year:

i. The Covered Expenses in the absence of this coordination of benefits provision; plus
ii. The expenses that would be payable under the other Plan, in the absence of provisions with a purpose like that of this coordination of benefits provision, whether or not a claim is made.

When the sum of these two (2) amounts exceeds the maximum amount payable for Covered Expenses in a Benefit Year, the Covered Expenses will be reduced so that they and the Benefits

payable under the Primary Plan do not total more than the Covered Expenses. When the Covered Expenses of the Employer's Group Health Plan are reduced in this manner, each Benefit is reduced in proportion and then charged against any applicable limit of the Employer's Group Health Plan.

c. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be a Covered Expense.

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

4) Right To Receive and Release Needed Information

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

5) Payment

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

6) Right of Recovery

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

X. Workers' Compensation Provision

The Plan of Benefits does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained or alleged by a Member that arises out of, in connection with, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the Member. Benefits will not be provided under the Plan of Benefits if coverage under the Workers' Compensation Act or similar law would have been available to the Member but the Member or the employer elected exemption from available workers' compensation coverage; waived entitlement to workers' compensation benefits for which he/she is eligible; failed to timely file a claim for workers' compensation benefits; or, the Member sought treatment for the injury or illness from a Provider not authorized by the Member's employer or Workers' Compensation carrier.

Although treatment for work-related or alleged work-related injuries or illness is excluded under the Plan of Benefits, the Plan Administrator may, in its sole discretion, agree to extend Benefits to a Member for the injury or illness. In this instance, the Member agrees, as a condition of receiving Benefits, to reimburse the Employer's Group Health Plan in full from any workers' compensation recovery as described herein. The Member further agrees as a condition of receiving Benefits, to execute and deliver all required instruments and papers provided by the Plan Administrator/Corporation, including an accident questionnaire, as well as doing and providing whatever else is needed, to secure the Plan's right of recovery, before any medical or other Benefits will be paid by the Plan of Benefits for the injuries or illness. The Plan Administrator may determine, in its sole discretion, that it is in the Plan of Benefits' best interests to pay medical or other Benefits for the injuries or illness before these papers are signed (for example, to obtain a prompt payment discount); however, in that event, the

Employer's Group Health Plan will remain entitled to reimbursement from any workers' compensation recovery the Member may receive.

As a condition of receiving Benefits, the Member must:

- Immediately notify the Plan Administrator/Corporation of an injury or illness for which his/her employer and/or employers' Workers' Compensation carrier may be liable, legally responsible, or otherwise makes a payment in connection with the injuries or illness;

- Execute and deliver an accident questionnaire within one hundred eighty (180) days of the accident questionnaire being mailed to the Member;

- Deliver to the Plan Administrator/Corporation a copy of the police report, incident or accident report, or any other reports issued as a result of the injury or illness within ninety (90) days of being requested to do so;

- Assert a claim or lawsuit against the employer and/or employer's Workers' Compensation carrier or any other insurance coverage to which the Member may be entitled;

- Include the Benefits paid by the Plan of Benefits as a part of the damages sought against his/her employer and/or employer's Workers' Compensation carrier. Immediately reimburse the Plan of Benefits, out of any recovery made from the employer and/or employer's Workers' Compensation carrier, the amount of medical or other Benefits paid for the injuries or illness by the Plan of Benefits up to the amount of the recovery and without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise;

- Immediately notify the Plan Administrator/Corporation in writing of any proposed settlement and obtain the Plan Administrator's written consent before signing any release or agreeing to any settlement; and,

- Cooperate fully with the Plan Administrator/Corporation in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan Administrator/Corporation.

The Plan Administrator has sole discretion to determine whether claims for Benefits submitted to the Plan of Benefits are related to the injuries or illness to the extent this provision applies. If the Plan Administrator/Corporation pays Benefits for an injury or illness and the Plan Administrator/Corporation determines the Member also received a recovery from the employer and/or employer's Workers' Compensation carrier by means of a settlement, judgment, or other payment for the same injury or illness, the Member shall reimburse the Plan of Benefits from the recovery for all Benefits paid by the Plan of Benefits relating to the injury or illness. However, under no circumstances shall the Member's reimbursement to the Plan of Benefits exceed the amount of such recovery.

If the Member receives a recovery from the employer and/or employer's Workers' Compensation carrier, the Plan's right of reimbursement from the recovery will be applied even if: liability is denied, disputed, or is made by means of a compromised, doubtful and disputed, clincher or other settlement; no final determination is made that the injury or illness was sustained in the course of or resulted from the Member's employment; the amount of workers' compensation benefits due to medical or health care is not agreed upon or defined by the Member, employer or the Workers' Compensation carrier; or, the medical or health care benefits are specifically excluded from the settlement or compromise.

Failure to reimburse the Employer's Group Health Plan from the recovery as required under this section will entitle the Plan Administrator/Corporation to invoke the Workers' Compensation exclusion and deny payment for all claims relating to the injury or illness.

XI. BlueCard Program

A. Out-of-Area Services.

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

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

B. BlueCard® Program

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

2) Liability Calculation Method Per Claim.
The calculation of the Member liability on claims for covered healthcare services processed through the BlueCard Program will be based on the lower of the participating healthcare provider's billed covered charges or the negotiated price made available to Corporation by the Host Blue.

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

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

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

submitted by a Host Blue to Corporation is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

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

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

3) Return of Overpayments.

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

C. Non-Participating Providers Outside Corporation's Service Area

For information regarding payment of a Non-Participating Provider see the front of the benefit booklet and Section V.

XII. Claims Filing and Appeal Procedures

A. Claims Filing Procedures

1) Where a Participating Provider renders services, generally the Participating Provider should either file the claim on a Member's behalf or provide an electronic means for the Member to file a claim while the Member is in the Participating Provider's office. However, the Member is responsible for ensuring that the claim is filed.

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

3) For Benefits not provided by a Participating Provider, the Member is responsible for filing claims with the Corporation. When filing the claims, the Member will need the following:

a. A claim form for each Member. Members can get claim forms from a member services representative at the telephone number indicated on the Identification Card or via the Corporation's website, www.SouthCarolinaBlues.com.
b. Itemized bills from the Provider (s). These bills should contain all the following:
    i. Provider's name and address;
    ii. Member's name and date of birth;
    iii. Member's Identification Card number;

iv. Description and cost of each service;
v. Date that each service took place; and
vi. Description of the illness or injury and diagnosis.

c. Members must complete each claim form and attach the itemized bill(s) to it. If a Member has other insurance that already paid on the claim(s), the Member should also attach a copy of the other Plan's EOB notice.
d. Members should make copies of all claim forms and itemized bills for the Member's records since they will not be returned. Claims should be mailed to the Corporation's address listed on the claim form.

4) The Corporation must receive the claim within ninety (90) days after the beginning of services. Failure to file the claim within the ninety (90) day period, however, will not prevent payment of Covered Expenses if the Member shows that it was not reasonably possible to file the claim timely, provided the claim is filed as soon as is reasonably possible. Except in the absence of legal capacity, claims must be filed no later than fifteen (15) months following the date services were received.

5) Receipt of a claim by the Corporation will be deemed written proof of loss and will serve as written authorization from the Member to the Corporation to obtain any medical or financial records and documents useful to the Corporation. The Corporation, however, is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at the time the claim was processed. Any party who submits medical or financial reports and documents to the Corporation in support of a Member's claim will be deemed to be acting as the agent of the Member. If the Member desires to appoint an Authorized Representative in connection with such Member's claims, the Member should contact the Corporation for an Authorized Representative form.

6) There are four (4) types of claims: Pre-Service Claims, Urgent Care Claims, Post-Service Claims, and Concurrent Care claims. The Employer's Group Health Plan will make a determination for each type of claim within the following time periods:

a. Pre-Service Claim
   i. A determination will be provided in writing or in electronic form within a reasonable period of time, appropriate to the medical circumstances, but no later than fifteen (15) days from receipt of the claim.
   ii. If a Pre-service Claim is improperly filed, or otherwise does not follow applicable procedures, the Member will be sent notification within five (5) days of receipt of the claim.
   iii. An extension of fifteen (15) days is permitted if the Corporation (on behalf of the Employer's Group Health Plan) determines that, for reasons beyond the control of the Corporation, an extension is necessary. If an extension is necessary the Corporation will notify the Member within the initial fifteen (15) day time period that an extension is necessary, the circumstances requiring the extension, and the date the Corporation expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Member will have at least forty-five (45) days to provide the required information. If the Corporation does not receive the required information within the forty-five (45) day time period, the claim will be denied. The Corporation will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If the Corporation receives the requested information after the forty-five (45) days, but within two hundred twenty-five (225) days, the claim will be reviewed as a first level appeal. Reference Section XII for details regarding the appeals process.

b. Urgent Care Claim
   i. A determination will be sent to the Member in writing or in electronic form as soon as possible taking into account the medical exigencies, but no later than seventy-two (72) hours from receipt of the claim.
   ii. If the Member's Urgent Care Claim is determined to be incomplete, the Member will be sent a notice to this effect within twenty-four (24) hours of receipt of the claim. The Member will

then have forty-eight (48) hours to provide the additional information. Failure to provide the additional information within forty-eight (48) hours may result in the denial of the claim.

iii. If the Member requests an extension of urgent care Benefits beyond an initially determined period and makes the request at least twenty-four (24) hours prior to the expiration of the original determination period, the Member will be notified within twenty-four (24) hours of receipt of the request for an extension.

c. Post-Service Claim

i. A determination will be sent within a reasonable time period, but no later than thirty (30) days from receipt of the claim.

ii. An extension of fifteen (15) days may be necessary if the Corporation (on behalf of the Employer's Group Health Plan) determines that, for reasons beyond the control of the Corporation, an extension is necessary. If an extension is necessary, the Corporation will notify the Member within the initial thirty (30) day time period that an extension is necessary, the circumstances requiring the extension, and the date the Corporation expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Member will have at least forty-five (45) days to provide the required information. If the Corporation does not receive the required information within the forty-five (45) day time period, the claim will be denied. The Corporation will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If the Corporation receives the requested information after the forty-five (45) days, but within two hundred twenty-five (225) days, the claim will be reviewed as a first level appeal. Reference Section XII for details regarding the appeals process.

d. Concurrent Care Claim

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

7) Notice of Determination

a. If the Member's claim is filed properly, and the claim is in part or wholly denied, the Member will receive notice of an Adverse Benefit Determination.

i. State the specific reason(s) for the Adverse Benefit Determination;

ii. Reference the specific Plan of Benefits provisions on which the determination is based;

iii. Describe additional material or information, if any, needed to complete the claim and the reasons such material or information is necessary;

iv. Describe the claims review procedures and the time limits applicable to such procedures, including a statement of the Member's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review;

v. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request); and,

vi. If the reason for denial is based on a lack of Medical Necessity or Investigational or Experimental Services exclusion or similar limitation, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request).

b. The Member will also receive a notice if the claim is approved.

B. Appeal Procedures for an Adverse Benefit Determination

1) Member has one hundred eighty (180) days from receipt of an Adverse Benefit Determination to file an appeal. An appeal must meet the following requirements:

a. An appeal may be submitted/requested via mail, fax, email or verbally; and,

b. An appeal may be sent (via U.S. mail) at the address below:
Quantum Health, Inc.
Attention: Appeals

7450 Huntington Park Drive
Columbus, OH 43235

Or by telephone to 855-576-9984

c. The appeal request must state that a formal appeal is being requested and include all pertinent information regarding the claim in question; and,
d. An appeal must include the Member's name, ID number, claim number, name of the person filing the appeal, address, and any other information, documentation or materials that support the Member's appeal.

2) The Member may submit written comments, documents, or other information in support of the appeal, and will (upon request) have access to all documents relevant to the claim. A person other than the person who made the initial decision will conduct the appeal. No deference will be afforded to the initial determination.

3) If the appealed claim involves an exercise of medical judgment, the Plan Administrator will consult with an appropriately qualified health care practitioner with training and experience in the relevant field of medicine. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on the appeal.

4) The final decision on the appeal will be made within the time periods specified below:
a. Pre-Service Claim
Quantum Health (on behalf of the Employer's Group Health Plan) will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than thirty (30) days after receipt of the appeal.
b. Urgent Care Claim
The Member may request an expedited appeal of an Urgent Care Claim. This expedited appeal request may be made orally, and Quantum Health (on behalf of the Employer's Group Health Plan) will communicate with the Member by telephone or facsimile. Quantum Health (on behalf of the Employer's Group Health Plan) will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than seventy-two (72) hours after receipt of the request for an expedited appeal.
c. Post-Service Claim
Quantum Health (on behalf of the Employer's Group Health Plan) will decide the appeal within a reasonable period of time, but no later than sixty (60) days after receipt of the appeal.

d. Concurrent Care Claim
Quantum Health (on behalf of the Employer's Group Health Plan) will decide the appeal of Concurrent Care claims within the time frames set forth in Section XII depending on whether such claim is also a Pre-Service Claim, an Urgent Care Claim or a Post-Service Claim.

5) Notice of Final Internal Appeals Determination
a. If a Member's appeal is denied in whole or in part, the Member will receive notice of an Adverse Benefit Determination.
i. State specific reason(s) for the Adverse Benefit Determination;
ii. Reference specific provision(s) of the Plan of Benefits on which the benefit determination is based;
iii. State that the Member is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for Benefits;
iv. Disclose and provide any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination;
v. If the reason for an Adverse Benefit Determination on appeal is based on a lack of Medical Necessity, Investigational or Experimental services or other limitation or exclusion, explain the

scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);

vi. Include a statement regarding the Member's right to request an external review; and

vii. Include a statement regarding the Member's right to bring an action under section 502(a) of ERISA.

b. The Member will also receive a notice if the claim on appeal is approved.

6) The Plan Administrator may retain Quantum Health to assist the Plan Administrator in making the determination on appeal. Regardless of its assistance, Quantum Health is only acting in an advisory capacity and is not acting in a fiduciary capacity. The Plan Administrator at all times retains the right to make the final determination.

C. External Review Procedures

1) After a Member has completed the appeal process, a Member may be entitled to an additional, external review of the Member's claim at no cost to the Member. An external review may be used to reconsider the Member's claim if Quantum Health (on behalf of the Employer's Group Health Plan) has denied, either in whole or in part, the Member's claim. In order to qualify for external review, the claim must have been denied, reduced, or terminated or the Member received an adverse benefit determination related to compliance with the surprise billing and cost-sharing protections of the No Surprises Act.

2) After a Member has completed the appeal process, (and an Adverse Benefit Determination has been made) such Member will be notified in writing of such Member's right to request an external review. The Member should file a request for external review within four (4) months of receiving the notice of Quantum Health's decision on the Member's appeal. In order to receive an external review, the Member will be required to authorize the release of such Member's medical records (if needed in the review for the purpose of reaching a decision on Member's claim).

3) Within six (6) business days of the date of receipt of a Member's request for an external review, Quantum Health will respond by either:

a. Assigning the Member's request for an external review to an independent review organization and forwarding the Members records to such organization; or,

b. Notifying the Member in writing that the Member's request does not meet the requirements for an external review and the reasons for Quantum Health's decision.

4) The external review organization will take action on the Member's request for an external review within forty-five (45) days after it receives the request for external review from Quantum Health.

5) Expedited external reviews are available if the Member's Provider certifies that the Member has a Serious Medical Condition. A Serious Medical Condition, as used in this Section XII, means one that requires immediate medical attention to avoid serious impairment to body functions, serious harm to an organ or body part, or that would place the Member's health in serious jeopardy. If the Member may be held financially responsible for the treatment, a Member may request an expedited review of the Quantum Health's decision if the Group Health Plan's denial of Benefits involves Emergency Medical Care and the Member has not been discharged from the treating Hospital.

XIII. Subrogation and Reimbursement

A. Benefits Subject To This Provision

This provision shall apply to all Benefits provided under any section of the SPD.

B. Statement of Purpose

Subrogation and Reimbursement represent significant assets and are vital to the financial stability of the Plan of Benefits. Subrogation and Reimbursement recoveries are used to pay future claims by other covered

Members. Anyone in possession of these assets holds them as a fiduciary and constructive trustee for the benefit of the Plan of Benefits. The Employer's Group Health Plan has a fiduciary obligation under ERISA to pursue and recover these assets of the Plan of Benefits to the fullest extent possible. By accepting Benefits related to an injury or illness under this Plan, a Member agrees to the terms and conditions provided herein.

C. Definitions

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

Another Party shall include the party or parties who caused the injuries or illness; the liability insurer, guarantor or other indemnifier of the party or parties who caused the injuries or illness; a Member's own insurance coverage, such as uninsured, underinsured, medical payments, no fault, homeowner's, renter's or any other insurer; a workers' compensation insurer or governmental entity; or, any other individual, corporation, association or entity that is liable or legally responsible for payment in connection with the injuries or illness.

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

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

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

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

D. When this Provision Applies

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

E. Duties of the Member

The Member will execute and deliver all required instruments and papers provided by the Plan Administrator/Corporation, including an accident questionnaire, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other Benefits will be paid by the Plan of Benefits for the injuries or illness. The Plan Administrator/Corporation may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other Benefits for the injuries or illness before these papers are signed (for example, to obtain a prompt payment discount); however, in that event, the Plan of Benefits will remain entitled to Subrogation and Reimbursement. In addition, the Member will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan of Benefits precludes operation of the double-recovery, made whole and common fund doctrines. A Member who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the portion of the Recovery subject to the Plan's lien to the Plan of Benefits under the terms of this provision. A Member who receives any such Recovery and does not immediately tender the Plan's portion of the Recovery to the Plan of Benefits will be deemed to hold the Plan's portion of the Recovery in constructive trust for the Plan, because the Member is not the rightful owner of the Plan's portion of the Recovery and should not be in possession of the Recovery until the Plan of Benefits has been fully reimbursed. The portion of the Recovery owed by the Member for the Plan's lien is an asset of the Plan.

As a condition of receiving Benefits, the Member must:

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

F. First Priority Right of Subrogation and/or Reimbursement

Any amounts recovered will be subject to Subrogation or Reimbursement. The Employer's Group Health Plan will be subrogated to all rights the Member may have against that other person or Another Party and will be entitled to first priority Reimbursement out of any Recovery to the extent of the Plan's payments. In addition, by accepting Benefits under this Plan, a Member acknowledges and agrees that the Employer's

Group Health Plan has established a first priority equitable lien against any Recovery to the extent of Benefits paid and to be payable in the future. The Plan's first priority equitable lien supersedes any right that the Member may have to be "made whole." In other words, the Employer's Group Health Plan is entitled to the right of first Reimbursement out of any Recovery the Member procures or may be entitled to procure regardless of whether the Member has received full compensation for any of his or her damages or expenses, including attorneys' fees or costs and regardless of whether the Recovery is designated as payment for medical expenses or otherwise, and regardless of whether the Member is not fully compensated or made whole for his or her loss. Additionally, the Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative or contributory negligence, limits of collectability or responsibility, characterization of Recovery as pain and suffering or otherwise. The Employer's Group Health Plan may enforce its right to Reimbursement by filing a lawsuit, recouping the amount owed from a Member's future benefit payments (regardless of whether benefits have been assigned by a Member to a hospital or other medical provider), and any other remedy available under the Plan. As a condition to receiving Benefits under the Plan, the Member agrees that acceptance of Benefits is constructive notice of this provision.

G. When a Member Retains an Attorney

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

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

H. When the Member is a Minor or is Deceased or Incapacitated

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

I. When a Member Does Not Comply

When a Member does not comply with the provisions of this section, the Plan Administrator/Corporation shall have the authority, in its sole discretion, to deny payment of any claims for Benefits by the Member and to deny or reduce future Benefits payable (including payment of future Benefits for other injuries or illnesses) under the Plan of Benefits by the amount due as satisfaction for the Reimbursement to the Plan. The Plan Administrator /Corporation may also, in its sole discretion, deny or reduce future Benefits (including future Benefits for other injuries or illnesses) for the Member under any other group benefits plan maintained by the Employer. The reductions will equal the amount of the required Reimbursement;

however, under no circumstances shall the Reimbursement, denial or reduction of Benefits exceed the amount of the Recovery. If the Employer's Group Health Plan must bring an action against a Member to enforce the provisions of this section, then the Member agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

J. Prior Recoveries

In certain circumstances, a Member may receive a Recovery that exceeds the amount of the Plan's payments for past and/or present expenses for treatment of the injuries or illness that is the subject of the Recovery. In other situations, based on the extent of the Member's injuries or illness, the Member may have received a prior Recovery for treatment of the injuries or illness that is the subject of a claim for Benefits under the Plan. In these situations, the Plan of Benefits will not provide Benefits for any expenses related to the injuries or illness for which compensation was provided through a current or previous Recovery. The Member is required to submit full and complete documentation of any such Recovery in order for the Employer's Group Health Plan to consider eligible expenses. To the extent a Member's Recovery exceeds the amount of the Plan's lien, the Plan of Benefits is entitled to deny that amount as an offset against any claims for future Benefits relating to the injuries or illness. In those situations, the Member will be solely responsible for payment of medical bills related to the injuries or illness. The Employer's Group Health Plan also precludes operation of the made-whole and common-fund doctrines in applying this provision.

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

K. Recovery of Overpayments

This Subrogation and Reimbursement Provision shall also apply in the event of any overpayment of Benefits by this Plan. In the event of any overpayment of Benefits by this Plan, the Employer's Group Health Plan will have the right to recover the overpayment. If a Member is paid Benefits greater than allowed in accordance with the provisions of this Plan, the Member shall be requested to refund the overpayment. If payment is made on behalf of the Member to a hospital, doctor, or other medical care provider, and that payment is found to be an overpayment, the Employer's Group Health Plan will request a refund of the overpayment from the provider first. If the provider does not honor the Plan's request for a refund, the Employer's Group Health Plan will then request the overpayment from the Member. If the refund is not received from the provider or the Member, the amount of the overpayment may be deducted from future benefits.