



Summary Plan Description

# Medical Plan: Appendices

*A: Definitions*

*B: Specified Covered Benefits*

*C: Expenses Not Covered*

# Medical Plan: Appendices A • B • C

Summary Plan Description

Effective January 1, 2025

Amended and Restated

**Appendix A: Definitions**

**Appendix B: Specified Covered Benefits**

**Appendix C: Expenses Not Covered**

## Contacts

### Claims/Customer Service

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

### Hospital Preauthorization & Medical Case Management

In South Carolina (BlueCross BlueShield of South Carolina)  
1.800.327.3238  
Outside SC (Blue Cross and Blue Shield 1.800.334.7287)

### Imaging Preauthorization

866.500.7664 or 888.642.9181  
for MRI, MRA, CAT, MSK or PET scans

### Mental Health & Substance Abuse Pre-authorization

1.800.790.5770 (Companion Benefit Alternatives  
through Blue Cross Blue Shield of South Carolina)

### Employee Assistance Program

On-site: 803.557.5729  
First Sun: 1.800.968.8143  
[www.firstsuneap.com](http://www.firstsuneap.com)

### Traveling Outside the U.S.:

BlueCross BlueShield Global Core Customer Service  
1.800.810.Blue (2583) or call collect 1.804.673.1177;  
[www.bcbglobalcore.com](http://www.bcbglobalcore.com)

### COBRA Administrator

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

### SRNS Service Center

803.725.7772 or 800.368.7333  
Service-Center@srs.gov;  
Service Center  
Building 730-1B, Aiken SC 29808

### SRNS Workforce Services

Plan Administrator  
803.952.8749  
Building 730-1B, Room 2184, Aiken SC 29808

### OptumRx

Prescription Mail Order: P.O. Box 2975, Mission, KS 66201  
Phone: 1.855.811.2218  
Prescription Reimbursement Form: OptumRx Claims Department  
P.O. Box 29044  
Hot Springs, AR 71903

### Oncology Case Management

Companion Care Solutions  
1.800.790.5770

# Appendix A: Definitions

<b>A</b>	
ACA	the Affordable Care Act of 2010, as amended. Also known as the Patient Protection and Affordable Care Act (PPACA).
Accountable Care Organization	a group of healthcare Providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their Member Populations.
Actively at Work	a permanent, full-time Employee or part-time Employee who works at least 20 hours per week, and the minimum number of weeks per year (each as set forth on the Schedule of Benefits) and who is not absent from work during the initial enrollment period because of a leave of absence or temporary layoff. An absence during the initial enrollment period due to a Health Status-Related Factor will not keep an Employee from qualifying for Actively at Work status.
Admission	the period of time between a Member's admission as a patient into a Hospital or Skilled Nursing Facility and the time the Member leaves or is discharged.
Adverse Benefit Determination	any denial, reduction or termination of, or failure to provide or make (in whole or in part) payment for a claim for Benefits, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in a Plan, and including, a denial, reduction or termination of, or failure to provide or make payment (in whole or in part), for a Benefit which results from the application of any utilization review as well as a failure to cover an item or services for which Benefits are otherwise provided because it is determined to be Investigational or Experimental or not Medically Necessary or appropriate. An Adverse Benefit Determination includes any cancellation or discontinuance of coverage that has retroactive effect (whether or not there is an adverse effect on any particular Benefit) except to the extent attributable to a failure to pay any required Premiums or Employee contributions.
Allowable Charge	<p>The amount the Corporation or licensee of the Blue Cross Blue Shield Association (BCBSA) agrees to pay a Provider as payment in full for a service, procedure, supply or equipment. Additionally:</p> <ol style="list-style-type: none"> <li>1. The Allowable Charge shall not exceed the Maximum Payment; and,</li> <li>2. In addition to the Member's liability for Benefit Year Deductibles, Copayments and/or Coinsurance, the Member may be balance billed by the Non-Participating Provider for any difference between the Allowable Charge and the Billed Charge.</li> </ol>
Alternate Recipient	any Child who is recognized under a Medical Child Support Order as having a right to enroll in this Plan of Benefits.
Ambulatory Surgical Center	<p>a licensed facility that:</p> <ol style="list-style-type: none"> <li>1. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;</li> <li>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;</li> <li>3. Does not provide inpatient accommodations; and,</li> <li>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.</li> </ol>
Applied Behavioral Analysis	behavioral modification to target cognition, language and social skills.
Authorized Representative	an individual (including a Provider) whom the Member designates in writing to act on his or her behalf.
Autism Spectrum Disorder	the diagnosis designated as such in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.
Autism Spectrum Disorder	the diagnosis designated as such in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

**B**

Behavioral Health Provider	a provider who renders Mental Health Services and/or Substance Use Disorder Services and is licensed to practice independently.
Behavioral Health Services	all Mental Health Services and/or Substance Use Disorder Services performed by a licensed Behavioral Health Provider.
Benefit Year	January 1 – December 31, as set forth on the Schedule of Benefits. The Initial Benefit Year may be more or less than twelve (12) months.
Benefit 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 Plan 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; 2. Preauthorized (when required under this Plan of Benefits or the Schedule of Benefits); and, 3. Not limited or exclude under the terms of this Plan of Benefits.
Billed Charges	the actual charges as billed by a Provider.
BlueCard Program	a program in which all members of the BCBSA participate. Details of the BlueCard Program are more fully set forth in Part One of the Summary Plan Description.
Brand Name Drug	a Prescription Drug that is manufactured under a registered trade name or trademark.

**C**

Care Coordination	organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.
Child	an Employee's child, whether a natural child, adopted child, stepchild, or child for who an Employee has custody or legal guardianship. The term "Child" also include an Incapacitated Dependent and a child of a divorced or divorcing Employee who, under a Qualified Medical Child Support Order, has a right to enroll under the Group Health Plan. The term "Child" does not include the Spouse of an eligible child.
Child Birthing Facility/Center	any facility, either Hospital-based or free-standing, in which births for a low-risk pregnant woman occur. Low-risk means normal, uncomplicated pregnancy.
Claims Amount	the amount paid (or payable) for Members' claims (including fees such as Access Fees, AEA Fees and amounts paid as part of a Value-Based Program (VBP) or in settlement of claims or in satisfaction of a judgment).
Clinical Trials	an approved clinical trial is one that is approved or funded through the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHRQ), the Centers for Medicare & Medicaid Services (CMS) the Department of Defense (DOD), the Department of Veterans Affairs (BA), a qualified non-governmental research entity identified in the guidelines issued by the NIH or is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA).
COBRA	these provision of the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended which require certain Employees to offer continuation of healthcare coverage to Employees and Dependents of Employees who would otherwise lose coverage.
COBRA Administrator	BCBSSC or its designated subcontractor that provides administrative services related to COBRA. Currently the subcontractor providing COBRA services is HealthEquity® (formerly WageWorks).

Coinsurance	<p>the sharing of the Allowable Charge between the Member and the Group Health Plan. After the Member's Benefit Year Deductible requirement is met, the Group Health Plan will pay a percentage of Allowable Charges as set forth on the Schedule of Benefits. The Member is responsible for the remaining percentage of the Allowable Charge. Coinsurance is calculated after any applicable Benefit Year Deductible or Copayment is subtracted from the Allowable Charge based upon the network charge or the lesser charge of the Provider.</p> <p>For Prescription Drug Benefits, Coinsurance means the amount payable by the Member calculated as follows:</p> <ol style="list-style-type: none"> <li>1. The percentage listed on the Schedule of Benefits; multiplied by,</li> <li>2. The amount listed in the Participating Provider's schedule of allowance for that item calculated at the time of sale;</li> <li>3. Without regard to any credit or allowance that may be received by BlueCross.</li> </ol> <p>Companion Benefit Alternatives (CBA): a separate company that is responsible for managing Behavioral Healthcare Services (including Preauthorization) on behalf of BlueCross.</p>
Concurrent Care	an ongoing course of treatment to be provided over a period of time or number of treatments.
Congenital Disorder, Congenital Disease	a condition documented as existing at birth regardless of cause.
Continued Stay Review	the review that must be obtained by a Member (or the Member's Authorized 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 later in this document.
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 and BlueShield of South Carolina (BlueCross)
Covered Expenses	the amount payable by the Plan for Benefits. The amount of Covered Expenses payable for Benefits is determined as set forth in this Summary Plan Description and at the percentages set forth on the Schedule of Benefits. Covered Expenses are subject to the limitations and requirements set forth in the Summary Plan Description and on the Schedule of Benefits. Covered Expenses will not exceed the Allowable Charge.
Credit(s)	rebates and/or other amounts which may be received by the Corporation from drug manufactures, a Pharmacy Benefit Manager and/or other third party. Credits are not payment to Members and will be retained by the Plan to help stabilize overall rates and offset expenses. Reimbursements to a Participating Pharmacy, or discounted prices charged at pharmacies are not affected by these Credits. Any Coinsurance or Copayment that a Member must pay for Prescription Drugs or Specialty Drugs does not change due to receipt of any Credit by BlueCross.
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 and/or eating), which is not specific therapy for any illness or injury.

## D

Dependent(s)	<p>an individual who is:</p> <ol style="list-style-type: none"> <li>1. An Employee's lawful Spouse</li> <li>2. A Child under the age set forth on the Schedule of Benefits;</li> <li>3. An Incapacitated Dependent</li> </ol>
Discount Services	from time to time Benefits in the form of discounts for certain Provider Services or products will be provided to Members by networks of complementary healthcare Providers with which BlueCross (the administrator) has an agreement for various programs. The discount applies to services the Plan does not cover. BlueCross will not be responsible for any costs associated with these programs. The services available may include, but are not limited to chiropractors, massage therapists, acupuncturists, fitness clubs and hearing aids.
Durable Medical Equipment	<p>medical equipment that:</p> <ol style="list-style-type: none"> <li>1. Can withstand repeated use;</li> <li>2. Is Medically Necessary;</li> <li>3. Is customarily used for the treatment of a Member's illness, injury, disease or disorder;</li> <li>4. Is appropriate for use in the home;</li> </ol>

5. Is not useful to a Member in the absence of illness or injury;
6. Does not include appliances that are provided solely for the Member's comfort or convenience;
7. Is a standard, non-luxury item (as determined by the Plan); and
8. Is ordered by a licensed medical doctor, oral surgeon, podiatrist or osteopath. Prosthetic devices, orthopedic devices and orthotic devices are considered durable medical equipment.

## E

Emergency Admission Review	The review that must be obtained by a Member (or the Member's Authorized 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 is outlined later in this document.
Emergency Medical Condition	a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that prudent layperson who possess an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: <ol style="list-style-type: none"> <li>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;</li> <li>2. Serious impairment to bodily functions; or,</li> <li>3. Serious dysfunction of any bodily organ or part.</li> </ol>
Emergency Services	services, supplies and treatment for stabilization, evaluation and/or initial treatment of an Emergency Medical Condition when provided on an outpatient basis at a Hospital emergency room or department.
Employee	any employee of the Employer who is eligible for coverage, as provided in Part 1 of this SPD, and who is so designated to BlueCross by the Employer.
Employer	Savannah River Nuclear Solutions (SRNS), the entity providing this Summary Plan Description.
Employer's Effective Date	the date the Corporation begins to provide Services under this Agreement.
Enrollment Date	the date of the enrollment in the Group Health Plan.
ERISA	the Employee Retirement Income Security Act of 1974, as amended. Excepted Benefits: <ol style="list-style-type: none"> <li>1. Coverage only for accident, disability income insurance or any combination thereof;</li> <li>2. Coverage issued as a supplement to liability insurance;</li> <li>3. Liability insurance, including general liability insurance and automobile liability insurance;</li> <li>4. Worker's compensation or similar insurance;</li> <li>5. Automobile medical payment insurance;</li> <li>6. Credit-Only insurance;</li> <li>7. Coverage for on-site medical clinics; or,</li> <li>8. Other similar insurance coverage specified in regulations, under which benefits for medical care are secondary incidental to other insurance benefits;</li> <li>9. If offered separately: <ol style="list-style-type: none"> <li>a. Limited scope dental or vision benefits;</li> <li>b. Benefits for long-term care, nursing home care, Home Health Care, community-based care or any combination thereof; or,</li> <li>c. Such other similar, limited benefits as specified in regulations.</li> </ol> </li> <li>10. If offered as independent, non-coordinated benefits: <ol style="list-style-type: none"> <li>a. Coverage only for a specified disease or illness; or</li> <li>b. Hospital indemnity or other fixed indemnity insurance.</li> </ol> </li> </ol>

11. If offered as a separate insurance policy:
- a. Medicare supplemental health insurance (as defined under Section 1882(g)(l) of the Social Security Act.
  - b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code; or, c. Similar supplemental coverage under Group Health Plan

## G

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 ribonucleic acid (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/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.
Grace Period	a 31-day period of time as determined by SRNS after the initial due date that allows for the Member to pay any Premium due.
Group Health Plan	this Employee Welfare Benefit Plan established and/or sponsored by the SRNS to provide health Benefits to Employees and/or their Dependents, directly or through insurance, reimbursement or otherwise.

## H

Health Status-Related Factor	information about a Member's health, including: <ol style="list-style-type: none"> <li>1. Health Status</li> <li>2. Medical conditions (including both physical and mental illnesses);</li> <li>3. Claims experience;</li> <li>4. Receipt of healthcare;</li> <li>5. Medical history;</li> <li>6. Genetic Information;</li> <li>7. Evidence of Insurability (including conditions arising out of acts of domestic violence); or,</li> <li>8. Disability</li> </ol>
HIPAA	the Health Insurance Portability and Accountability Act of 1996, as amended.
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 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.

I	
Identification Card	the card issued by BlueCross to a Member that contains the Member's identification number
Incapacitated Dependent	<p>a Child who is:</p> <ol style="list-style-type: none"> <li>1. Incapable of financial self-sufficiency by reason of Total Disability; and,</li> <li>2. Dependent upon the Employee for at least fifty-one (51) percent of his or her support and maintenance.</li> </ol> <p>A Child must meet both requirements to qualify as an Incapacitated Dependent. A Child who is not incapacitated by the maximum Dependent Child age listed on the Schedule of Benefits will not be covered.</p>
Investigational or Experimental	<p>surgical or medical procedures, supplies, devices or drugs which, at the time provided or sought to be provided, are, in the judgment of the Corporation, not recognized as conforming to generally accepted medical or behavioral health practice in the United States, or the procedure, drug or device:</p> <ol style="list-style-type: none"> <li>1. Has not received required final approval in the United States to market from appropriate government bodies;</li> <li>2. Is one about which the peer-reviewed medical literature in the United States does not permit conclusions concerning its effect on health outcomes;</li> <li>3. Is not demonstrated in the United States to be superior to established alternatives;</li> <li>4. Has not been demonstrated in the United States to improve net health outcomes; or,</li> <li>5. Is one in which the improvement claimed is not demonstrated in the United States to be obtainable outside the Investigational or Experimental setting</li> </ol>

L	
Legal Intoxication, Legally Intoxicated	the Member's blood alcohol level was at or in excess of the amount established under applicable state law to create a presumption and/or inference that the Member was under the influence of alcohol when measured by law enforcement or medical personnel
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.

**M**

Mail Service Pharmacy	a pharmacy maintained by the Pharmacy Benefit Manager that fills prescriptions and sends Prescription Drugs by mail.
Maintenance Medication	Maintenance drugs are <b>prescriptions commonly used to treat conditions that are considered chronic or long-term</b> . These conditions usually require regular, daily or routine use of medicines. Examples of maintenance drugs include, but are not limited to those used to treat high blood pressure, heart disease, asthma and diabetes.
Maximum Payment	<p>the maximum amount the Plan will pay (as determined by the BlueCross) for a Benefit. The Maximum Payment will not be affected by any Credit. The Maximum Payment will be one of the following as determined by the BlueCross in its discretion:</p> <ol style="list-style-type: none"> <li>1. The actual charge submitted to the Corporation for the service, procedure, supply or equipment by a Provider;</li> <li>2. An amount based upon the reimbursement rates established by SRNS;</li> <li>3. An amount that has been agreed upon in writing by a Provider and the BlueCross or a licensee of the BCBSA;</li> <li>4. An amount established by the BlueCross, based upon factors including, but not limited to: <ol style="list-style-type: none"> <li>a. Governmental reimbursement rates applicable to the service, procedure, supply or equipment; or,</li> <li>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,</li> </ol> </li> <li>5. The lowest amount of reimbursement BlueCross allows for the same or similar service, procedure, supply or equipment when provided by a Participating Provider.</li> </ol>
Medical Child Support Order	<p>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:</p> <ol style="list-style-type: none"> <li>1. Provides Child support with respect to a Child or provides for health benefit coverage to a Child, is made pursuant to a state domestic relations law (including a community property law) and relates to the Plan of Benefits; or</li> <li>2. Enforces a law relating to medical Child support described in Section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a Group Health Plan.</li> </ol> <p>A Medical Child Support Order must clearly specify:</p> <ol style="list-style-type: none"> <li>1. The name and the last known mailing address (if any) of each participant Employee and the name and mailing address of each Alternate Recipient covered by the order;</li> <li>2. A reasonable description of the type of coverage to be provided by the Group Health Plan to each such Alternate Recipient or the way such type of coverage is to be determined;</li> <li>3. The period to which such order applies; and,</li> <li>4. Each Group Health Plan to which such order applies.</li> </ol> <p>If the Medical Child Support Order is a national medical support notice, the order must also include:</p> <ol style="list-style-type: none"> <li>1. The name of the issuing agency;</li> <li>2. The name and mailing address of an official or agency that has been substituted for the mailing address of any Alternate Recipient; and,</li> <li>3. The Identification of the underlying Medical Child Support Order.</li> </ol> <p>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).</p>
Medical Supplies	<p>supplies that are:</p> <ol style="list-style-type: none"> <li>1. Medically Necessary;</li> <li>2. Prescribed by a Provider acting within the scope of his or her license;</li> <li>3. Are not available on an over-the-counter basis (unless such supplies are provided to a Member in a Provider's office and should not (in BCBS's discretion) be included as part of the treatment received by the Member); and,</li> <li>4. Are not prescribed in connection with any treatment or Benefit that is excluded under this Benefit Plan.</li> </ol> <p><b>Medically Necessary, Medical Necessity</b></p>

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

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

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

For the purposes of determining Medical Necessity:

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

**Member** an Employee or Dependent who has enrolled under this Group Health Plan.

**Member Effective Date** the date on which an Employee or Dependent is covered for Benefits under the terms of this Plan.

**Membership Application** any mechanism agreed upon by the BlueCross and SRNS for transmitting necessary Member enrollment information from SRNS to BlueCross.

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

**N**

Natural Teeth	teeth that: <ol style="list-style-type: none"> <li>1. Are free of active or chronic clinical decay;</li> <li>2. Have at least fifty percent (50%) bony support;</li> <li>3. Are functional in the arch; and,</li> <li>4. Have not been excessively weakened by multiple dental procedures; or</li> <li>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, haven't been restored to normal function.</li> </ol>
Negotiated Arrangement, Negotiated National Account Arrangement	an agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard Program
Non-Participating Provider	any Provider who does not have a current, valid Provider Agreement.
Non-Preferred Drug	a Prescription Drug that bears a recognized brand name of a particular manufacturer but does not appear on the list of Preferred Brand Drugs and has not been chosen by BlueCross or its designated Pharmacy Benefit Manager to be a Preferred Drug, including any Brand Name Drug with an "A" rated Generic Drug available.

**O**

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.
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.

**P**

Participating Pharmacy	a pharmacy that has a contract with BlueCross, SRNS or with OptumRxto provide Prescription Drugs or Specialty Drugs to Members.
Participating Provider	a Provider who has a current, valid Provider Agreement
Patient-Centered Medical Home	a model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified physicians.
Pharmacy Benefit Manager	an entity that has contracted with SRNS or with BlueCross and is responsible for the administration of the Prescription Drug Benefit in accordance with the Plan.
Plan	any program that provides Benefits or services for medical or dental care or treatment, including: <ol style="list-style-type: none"> <li>1. Individual or group coverage, whether insured or self-insured. This includes, but is not limited to, prepayment, group practice or individual practice coverage; and,</li> <li>2. 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).</li> </ol> <p>Each contract or other arrangement for coverage is a separate Plan for purposes of the BlueCross Plan of Benefits. If a Plan has two (2) or more parts and the coordination of benefit rules in Section 6 (BlueCross Article V) apply only to one (1) of the parts, each part is considered a separate Plan.</p>

Plan Administrator	the entity charged with the administration of the Plan. The SRNS Benefits Committee is the Plan Administrator of this Plan. These duties are currently delegated to a Plan Administrator.
Plan of Benefits	the benefit booklet as prepared by BlueCross which reflects the Benefits offered under the SRNS Plan based on the Benefits Checklist. The Plan of Benefits includes the Schedule of Benefits and all endorsements, amendments, riders or addenda.
Plan Sponsor	the party sponsoring this Group Health Plan. The Employer is the Plan Sponsor of the Group Health Plan.
Plan of Benefits Effective Date	12:01 a.m. EST on the date listed on the Schedule of Benefits
Plan Sponsor	the party sponsoring this Group Health Plan. SRNS is the Plan Sponsor of this Plan.
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 Authorized Representative) prior to all Admissions that are not related to an Emergency Medical Condition. The Preadmission Review process is outlined in Section 16, Appendix B (BlueCross Article III).
Preauthorized, Preauthorization	the approval of Benefits based on Medical Necessity prior to the rendering of such Benefits to a Member. The Preauthorization process is outlined in Section 16, Appendix B (BlueCross Article III).
Preferred Brand Drug	a Preferred Drug that bears a recognized brand name of a particular manufacturer and appears on the list of preferred brand drugs.
Preferred Drug	a Prescription Drug that has been reviewed for cost effectiveness, clinical efficacy and quality that is preferred by the Pharmacy Benefit Manager. Preferred Drugs are subject to periodic review and modification by the Corporation, or its designated Pharmacy Benefit Manager, and include Brand Name Drugs and Generic Drugs.
Premium	the monthly amount paid to the Employer by the Member for coverage under this Plan. Payment of Premiums by the Member constitutes acceptance by the Member of the terms of this Plan.
Prescription Drug	<p>a drug or medicine that is:</p> <ol style="list-style-type: none"> <li>1. Required to be labeled that it has been approved by the FDA; and,</li> <li>2. Bears the legend, "Caution: Federal Law prohibits dispensing without a prescription" prior to being dispensed or delivered, or labeled in a similar manner.</li> </ol> <p>Additionally, to qualify as a Prescription Drug, the drug must:</p> <ol style="list-style-type: none"> <li>1. Be prescribed by a licensed Provider acting within the scope of his or her license; and,</li> <li>2. Not be entirely consumed at the time and place where the prescription is dispensed.</li> </ol> <p>Certain Over-the-Counter Drugs may be designated as Prescription Drugs, at the discretion of BlueCross. Such designated Over-the-Counter Drugs will be listed on the PDL.</p>
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 List	a listing of the drugs approved for a specified level of Benefits by the Corporation under the Plan. This list shall be developed and subject to periodic review and modification by BlueCross. The most up-to-date version of the PDL is available on the BlueCross web site at <a href="http://www.SouthCarolinaBlues.com">www.SouthCarolinaBlues.com</a> .
Prescription Drug Preauthorization Program	programs that prohibit patients from obtaining medications until approvals have been obtained.
Pre-Service Claim	any request for a benefit where Preauthorization must be obtained before receiving the medical care, service or supply.
Primary Plan	a Plan whose Benefits must be determined without taking into consideration the existence of another Plan.
Private Duty Nursing	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.
Probationary Period	the period of continuous employment (if included on the Schedule of Benefits) with SRNS that an Employee must complete before becoming eligible to enroll in the Plan. SRNS does not require a probationary period or an additional orientation period.
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.
Protected Health Information	has the same meaning as the term defined under HIPAA.
Provider	<p>any person or entity licensed by the appropriate state regulatory agency and legally entitled to practice within the scope of such person or entity's license in the practice of the following: Medicine, dentistry, optometry, podiatry, chiropractic services, behavioral health, physical therapy, oral surgery, speech therapy, occupational therapy, osteopathy.</p> <p>The term Provider also includes a Hospital; a Rehabilitation Facility; a Skilled Nursing Facility; a physician assistant; nurses practicing in expanded roles (such a pediatric nurse practitioners, family practice nurse practitioners and certified nurse midwives) when supervised by a licensed medical doctor or oral surgeon; and Behavioral Health Services when performed by a Behavioral Health provider, licensed professional counselor, master level licensed social worker, licensed marriage and family therapist or other licensed Behavioral Health Provider approved by BlueCross. The term Provider does not include interns, residents, in-house physicians, physical trainers, lay midwives or masseuses.</p>
Provider Agreement	an agreement between BlueCross (or another BCBSA licensee) and a Provider under which the Provider has agreed to accept BlueCross allowance (as set forth in the Provider Agreement) as payment in full for Benefits (subject to the Member liability amounts) and other mutually acceptable terms and conditions.
Provider Incentive	an additional amount of compensation paid to a healthcare Provider by a BlueCross BlueShield Plan, based on the Provider's compliance with agreed-upon procedural and/or outcome measure for a particular population of covered persons.
Provider Services	<p>includes the following services:</p> <ol style="list-style-type: none"> <li>1. When performed by a Provider or Behavioral Health Provider within the scope of his or her license, training and specialty and within the scope of generally acceptable medical standards as determined by BlueCross: <ol style="list-style-type: none"> <li>a. Office visits, which are for the purpose of seeking or receiving care for a preventive service, illness, or injury;</li> <li>b. Basic diagnostic services and machine tests; or,</li> <li>c. Behavioral Health Services.</li> </ol> </li> <li>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. <ol style="list-style-type: none"> <li>a. Benefits rendered to a Member in a Hospital or Skilled Nursing Facility;</li> <li>b. Benefits rendered in a Member's home;</li> <li>c. Surgical Services;</li> <li>d. Anesthesia services, including the administration of general or spinal block anesthesia;</li> <li>e. Radiological examinations;</li> <li>f. Laboratory tests; and,</li> <li>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 when supervised by a licensed medical doctor.</li> </ol> </li> </ol>

**Q**

Qualified Medical Child Support Order	a Medical Child Support Order that: <ol style="list-style-type: none"> <li>1. Creates or recognizes the existence of an Alternate Recipient's right to enroll under this Plan of Benefits: or,</li> <li>2. Assigns to an Alternate Recipient the right to enroll under this Plan of Benefits.</li> </ol>
Qualifying Event	for continuation of coverage purposes under Section 8 (BlueCross Article VII) a Qualifying Event is any one of the following: <ol style="list-style-type: none"> <li>1. Termination of the Employee's employment (other than for gross misconduct) or reduction of hours worked that renders the Employee is no longer Actively at Work and therefore ineligible for coverage under the Plan.</li> <li>2. Death of the employee;</li> <li>3. Divorce or legal separation of the Employee from his or her Spouse;</li> <li>4. A Child ceasing to qualify as a Dependent under the Plan; or</li> <li>5. Entitlement to Medicare by an Employee or by a parent or a Child.</li> </ol>
Quantity versus Time Limit	limits that restrict the quantity of Prescription Drugs that are covered under a Member's Benefit within a certain time frame. The limits established for these drugs are based on food and Drug Administration (FDA) approved indication.

**R**

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	a licensed institution, other than a Hospital, which meets all six (6) of these requirements: <ol style="list-style-type: none"> <li>1. Maintains permanent and full-time facilities for bed care of resident patients;</li> <li>2. Has the services of a psychiatrist (addictionologist, when applicable) or physical extender available at all times and is responsible for the diagnostic evaluation and provides face-to-face evaluation services with documentation a minimum of once/week and as needed as indicated.</li> <li>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.</li> <li>4. Keeps a daily medical record for each patient.</li> <li>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</li> <li>6. Is operating lawfully as a residential treatment center in the area where it is located.</li> </ol>

**S**

Schedule of Benefits	the pages of the Plan, titled as the Summary Plan Description, which specify the coverage provided and the applicable Copayments, Coinsurance, Benefit Year Deductibles and Benefit limitations.
Second Surgical Opinion	the medical opinion of a board-certified surgeon regarding an elective surgical procedure. The opinion must be based on the surgeon's examination of the patient. The examination must be performed after another licensed medical doctor has proposed to perform surgery, but before the surgery is performed. The second licensed medical doctor must not be associated with the primary licensed medical doctor.
Secondary Plan	a Plan that is not a Primary Plan. When this Plan constitutes a Secondary Plan, availability of Benefits is determined after those of the other Plan and may be reduced because of benefits payable under the other Plan.
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.
Special Enrollment	the time period during which an Employee or eligible Dependent who is not enrolled for coverage under this Plan of Benefits may enroll for coverage due to the involuntary loss of other coverage or under permitted circumstances described in Section 2 (BlueCross Article II) of the Plan.
Specialist	a licensed medical doctor who 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).
Spouse	any individual who is legally married under any state law.
Step Therapy Program	programs that require a Member to use lower-cost medications that are used to treat the same condition before obtaining higher-cost medications. The list of Prescription Drugs that require you to try a first-choice alternative is updated periodically and can be accessed by logging into My Health Toolkit. If your doctor prescribes a Second-Choice medication, because a first-choice medication is not right for you, please have your doctor call the Caremark Prior Authorization department at 800.294.5979. Your doctor may also fax requests to 888.836.0730.
Substance Use Disorder	the continued use of abuse of and/or dependence on 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 pre-operative and post-operative care when performed by a licensed medical doctor.

## T

Telehealth	the exchange of Member information during which Members can have a telephone or video consultation with a licensed health care professional.
Totally Disabled, Total Disability	the Member is able to perform none of the usual and customary duties of such Member's occupation. With respect to a Member who is a Dependent, the terms refer to disability to the extent that such Member can perform none of the usual and customary duties or activities of a person in good health of the same age. The Member must provide a licensed medical doctor's statement of disability upon periodic request by the Group Health Plan.

## U

Urgent Care Claim	any claim for medical care or treatment where making a determination under other than normal time frames could seriously jeopardize the Member's life or health or the Member's ability to regain maximum function, or, in the opinion of a licensed medical doctor or oral surgeon with a knowledge of the Member's medical condition, would subject the Member to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.
USERRA	The Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

**V**

Value-Based Program	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 the 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/factor and is reflected in Provider payment. The VBP is described further in the BlueCross Plan of Benefits.
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.

**W**

Well Baby Care, Well Child Care	care for Dependents. Benefits are payable as specified on the Schedule of Benefits.
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# Appendix B: Specified Covered Benefits

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

- Performed or provided on or after the Effective Date of coverage;
- Performed or provided prior to termination of coverage;
- Provided by a covered Provider within the scope of his or her license;
- For which the required Preadmission Review, Emergency Admission Review, Pre-Authorization and/or Continued Stay Review has been requested and Pre-Authorization was received from BlueCross;
- That are Medically Necessary (not more or less expensive than the required Standard of Care);
- That are not subject to an exclusion under the Charges Not Covered section of this booklet;
- After the payment of all required Deductibles, Coinsurance and Copayments;
- Are not subject to an exclusion under the BlueCross Plan of Benefits or Schedule of Benefits.

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

1. The first Hospital does not have the needed Hospital or skilled nursing care to treat the Member's illness or injury (such as burn care, cardiac care, trauma care, and critical care);
2. The second Hospital is the nearest medically appropriate facility to treat the Member's illness or injury;
3. A ground ambulance transport would endanger the Member's medical condition; and,
4. The transport is not related to a hospitalization outside the United States.

## C

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

## D

Dental Care for Accidental Injury	The Plan will pay Covered Expenses for dental services to Natural Teeth required because of accidental injury. For purposes of this section, an accidental injury is defined as an injury caused by a traumatic force such as a car accident or a blow by a moving object. No Covered Expenses will be paid for injuries that occur while the Member is in the act of chewing or biting. Services for conditions that are not directly related to the accidental injury are not covered. The first visit to a dentist does not require Preauthorization; however, the dentist must submit a plan for any future treatment to BlueCross for review and Preauthorization before such treatment is rendered if Covered Expenses are to be paid. Benefits are limited to treatment for only one (1) year from the date of the accidental injury.
Diabetic Supplies	Benefits will be paid for diabetic supplies as set forth on the BCBS Schedule of Benefits.
Diabetes Education	The Plan will pay Covered Expenses for outpatient self-management training and education for Members with diabetes mellitus provided that such training and educational Benefits are rendered by a Provider whose program is recognized by the American Diabetes Association.
Durable Medical Equipment	The Plan will pay Covered Expenses for Durable Medical Equipment when the required Preauthorization (over \$500) is obtained. The Plan will decide (in its discretion) whether to buy or rent equipment and whether to repair or replace damaged or worn Durable Medical Equipment. The Plan will not Pay Benefits for Durable Medical Equipment that is solely used by a Member in a Hospital or that the Plan determines (in its discretion) is included in any Hospital room charge. Any Preauthorization requirements, if applicable, will be listed on the BCBS Schedule of Benefits.

## E

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

Fertility Coverage	<p>The Plan Fertility Services: A <b>covered subscriber</b> [employee, dependent spouse] will be eligible for Fertility Services by SRNS for a combined [Medical &amp; Pharmacy] Lifetime Maximum of \$25,000.</p> <p>Fertility coverage is an inclusive benefit and does not require a diagnosis of 'infertility' for access. For more details, please review the "Fertility Services" section of the Medical Plan Summary Plan Description Part One.</p>
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## G

Gender Dysphoria	The Plan will pay Covered Expenses for Medical Supplies, services or charges related to the diagnosis or treatment of gender dysphoria as outlined in BlueCross medical policy.
Gender Reassignment	Benefits will be paid for the following services related to gender reassignment: <ol style="list-style-type: none"><li>1. Twelve (12) month of cognitive behavioral therapy (CBT) while living and dressing full-time as the gender of preference: and</li></ol>

	<p>2. Twelve (12) additional months of CBT and living/dressing as gender of preference plus hormone therapy.</p> <p>3. Gender reassignment surgery may be performed after completion of requirements listed above.</p>
Gynecological Examination	The Plan will pay Covered Expenses for routine gynecological examinations each Benefit Year for female Members.

<b>H</b>	
Habilitation	<p>The Plan will pay Covered Expenses for habilitation, including assisting a Child with achieving developmental skills when impairments have caused delaying or blocking of initial acquisition of the skills. Habilitation can include fine motor, gross motor or other skills that contribute to mobility communication and performance of activities of daily living. The services will be described in an individual's plan of care.</p>
Hearing Aid Coverage	<p>Covered IN-NETWORK and OUT-OF-NETWORK</p> <p>The plan allows up to a maximum of \$3,000 per device (pair) every 36 months once the plan deductible has been met. Coinsurance applies.</p> <p>Covered Medical Expenses include charges incurred for hearing aids, as prescribed by a physician. Charges for hearing aids and associated exam for device testing and fitting, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.</p>
Home Health Care	<p>The Plan will pay for Home Health Care, including Private Duty Nursing, when rendered to a homebound Member in the Member's current place of residence. Any Preauthorization requirements, if applicable, will be listed on the BlueCross Schedule of Benefits.</p>
Hospice Care	<p>The Plan will pay Covered Expenses for Preauthorized Hospice Care. Preauthorization requirements are listed on the BlueCross Schedule of Benefits.</p> <p>Hospice Care refers to the medical, psychological and nursing care provided to terminally ill patients with a life expectancy of less than six (6) months. It permits someone with no hope of recovery to leave a Hospital for a more comfortable and dignified setting. Preauthorization is required. The following will be considered Covered Expenses when ordered by the patient's attending physician and provided and billed by a hospice:</p> <ol style="list-style-type: none"> <li>1. Semiprivate room and board and special services;</li> <li>2. Nursing and therapy services;</li> <li>3. Outpatient services;</li> <li>4. Psychological and dietary counseling;</li> <li>5. Home care by professional hospice workers (other than household or family members); and,</li> <li>6. Pain-relief treatment, including drugs and supplies.</li> </ol>
Hospital Services	<p>The Plan will pay Covered Expenses for Admissions as follows:</p> <ol style="list-style-type: none"> <li>1. Semiprivate room, board, and general nursing care and,</li> <li>2. Private room, at semiprivate rate as determined by the Plan;</li> <li>3. Services performed in a Special Care Unit when it is Medically Necessary that such services be performed in such unit rather than in another portion of the Hospital;</li> <li>4. Ancillary services and Medical Supplies including services performed in operating, recovery and delivery rooms;</li> <li>5. Diagnostic services including interpretation of radiological and laboratory examinations, electrocardiograms, and electroencephalograms; and,</li> <li>6. In a Long-Term Acute Care Hospital.</li> </ol>

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 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

1. The Plan will pay Covered Expenses for certain Preauthorized human organ and tissue transplants. To be covered, such transplants must be provided from a human donor to a Member and provided at a transplant center approved by the Plan. Covered Expenses shall only be provided for the human organ and tissue transplants as set forth on the Schedule of Benefits.
2. The payment of Covered Expenses for living donor transplants will be subject to the following conditions:
  - a. When both the transplant recipient and the donor are Members, Covered Expenses will be paid for both.
  - b. When the transplant recipient is a Member and the donor is not, Covered Expenses will be paid for both the recipient and the donor to the extent that Covered Expenses to the donor are not provided by any other source.
  - c. When the donor is a Member and the transplant recipient is not, no Covered Expenses will be paid to either the donor or the recipient.
3. Human organ and tissue transplant coverage includes expenses incurred for legal donor organ and tissue procurement and all inpatient and outpatient Hospital and medical expenses for the transplant procedure and related pre-operative and post-operative care, including immunosuppressive drug therapy and air ambulance expenses.
4. Transplants of tissue as set forth below (rather than whole major organs) are Benefits under the Plan, subject to all the provisions of the Plan as follows:
  - a. Blood transfusions
  - b. Autologous parathyroid transplants;
  - c. Corneal transplants;
  - d. Bone and cartilage grafting; and,
  - e. Skin grafting.

I

In-Hospital Medical Service

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

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

M

Mammography Testing

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

Medical Supplies	The Plan will pay Covered Expenses for Medical Supplies provided that the Plan will not pay Covered Expenses separately for Medical Supplies that are (or in BlueCross on behalf of the Plan's determination, should be) provided as part of another Benefit.
Mental Health Services	The Plan will pay Covered Expenses for the inpatient and outpatient treatment for Mental Health Services. Preauthorization may be required. Contact Companion Benefit Alternatives at 1.800.868.1032 for questions about pre-authorization for mental health services.

## O

Obesity Related Procedures	<p>The Plan will pay Covered Expenses for the following if set forth on the BlueCross Schedule of Benefits:</p> <p>Services, supplies, treatment or medication for the management of morbid obesity, obesity, weight reduction, weight control or dietary control (collectively referred to as "obesity-related treatment") including, but not limited to, gastric bypass or stapling, intestinal bypass and related procedures or gastric restrictive procedures. Also included are services, supplies or charges for the treatment or correction of complications from obesity-related treatment. Services, supplies or charges for the reversal of obesity-related treatments and reconstructive procedures necessitated by weight loss are covered</p>
Obstetrical Services	<p>The Plan will pay Covered Expenses for Preauthorized obstetrical services. Midwives licensed and practicing in compliance with the Nurse Practices Act in a Hospital will be covered under this Benefit.</p> <p>Under the terms of the Newborn and Mother's Health Act of 1996, the Plan generally may not restrict Covered Expenses for any Hospital length of stay about childbirth for the mother or newborn Child to less than forty-eight (48) hours following a vaginal delivery (not including the day of delivery) or less than ninety-six (96) hours following a cesarean section (not including the day of surgery). Nothing in this paragraph prohibits the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than the specified time frames or from requesting additional time for hospitalization. In any case, the Plan may not require that a Provider obtain authorization from BlueCross for prescribing a length of stay not in excess of forty-eight (48) or ninety-six (96) hours as applicable. However, Preauthorization is required to use certain Providers or facilities or to reduce out-of-pocket costs.</p>
Orthognathic Surgery	The Plan will pay Covered Expenses for any service related to the treatment of malposition's or deformities of the jawbone(s), dysfunction of the muscles of mastication, or orthognathic deformities.
Orthopedic Devices	The Plan will pay Covered Expenses for Preauthorized Orthopedic Devices. Any Preauthorization requirements, if applicable will be listed on the BlueCross Schedule of Benefits.
Orthotic Devices	The Plan will pay Covered Expenses for Preauthorized Orthotic Devices.
Outpatient Hospital and Ambulatory Surgical Center Services	The Plan will pay Covered Expenses for Surgical Services and diagnostic services, including radiological examinations, laboratory tests and machine tests, performed in an outpatient Hospital setting or an Ambulatory Surgical Center.
Outpatient Rehabilitation Services	The Plan will pay Covered Expenses, subject to the following paragraph, for physical therapy, occupational therapy, and for outpatient rehabilitation services as set forth on the BlueCross Schedule of Benefits. Covered Expenses for outpatient rehabilitation services will be paid only following an acute incident involving disease, trauma or surgery that requires such care.
Oxygen	The Plan will pay Covered Expenses for Preauthorized oxygen. Durable Medical Equipment for oxygen use in your home is covered under the Durable Medical Equipment Benefit.

## P

Physical Examination	The Plan will pay Covered Expenses for physical examinations as set forth on the BlueCross Schedule of Benefits.
Prescription Drugs	See Prescription Drugs in Part One of the Medical Plan.
Preventive Services	<p>The Plan will pay for preventive health services required under PPACA as follows:</p> <ol style="list-style-type: none"> <li>1. Evidence based services that have a rating of A or B in the current United States Preventive Services Task Force (USPSTF) recommendations;</li> <li>2. Immunizations as recommended by the Center for Disease Control and Prevention (CDC); and</li> </ol>

	<p>3. Preventive care and screenings for children and women as recommended by the Health Resources and Services Administration (HRSA).</p> <p>The USPSTF, CDC and the HRSA are independent companies that provide health information on behalf of BlueCross. These Benefits are provided without any cost-sharing by the Member when the services are provided by a Participating Provider. Any other covered preventive screenings will be provided as specified in the BlueCross Schedule of Benefits.</p>
Private Duty Nursing	The Plan will pay Covered Expenses for private duty nursing as set forth on the BlueCross Schedule of Benefits.
Prostate Examination	The Plan will pay Covered Expenses for prostate examinations per Benefit Year regardless of Medical Necessity as set forth in the Schedule of Benefits for Members that are within the appropriate age guidelines. The Employer's Group Health Plan will pay Covered Expenses for additional prostate examinations during a Benefit Year based on Medical Necessity.
Prosthetic Devices	The Plan will only pay Covered Expenses for Prosthetic Devices when prescribed for the alleviation or correction of conditions caused by physical injury, trauma, disease or birth defects and is an original replacement for a body part. Covered Expenses will only be paid for standard, non-luxury items (as determined by the Plan) as a replacement of a Prosthetic Device when such Prosthetic Device cannot be repaired for less than the cost of replacement, or when a change in your condition warrants replacement.
Provider Services	The Plan will pay Covered Expenses for Provider Services, provided that when different levels (as determined by BlueCross on behalf of the Plan) of Provider Services are provided on the same day, Covered Expenses for such Benefits will only be paid for the highest level (as determined by the Corporation on behalf of the Employer's Group Health Plan) of Provider Services

## R

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

## S

Skilled Nursing Facility Services	<p>The Plan will pay Covered Expenses for Admissions in a Skilled Nursing Facility as follows:</p> <ol style="list-style-type: none"> <li>1. Semiprivate room, board, and general nursing care;</li> <li>2. Private room, at semiprivate rate as determined by the Plan;</li> <li>3. Services performed in a Special Care Unit when it is Medically Necessary that such services be performed in such unit;</li> <li>4. Ancillary services and Medical Supplies including services performed in operating, recovery and delivery rooms;</li> </ol>
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	<p>5. Diagnostic services including interpretation of radiological and laboratory examinations, electrocardiograms, and electroencephalograms; and,</p> <p>6. In a Long-Term Acute Care Hospital.</p> <p>Benefits for Admissions are subject to the requirements for Preadmission Review, Emergency Admission Review and Continued Stay Review. The day on which the Member leave a Skilled Nursing Facility, with or without permission, is treated as a day of discharge and will not be counted as a day of Admission, unless returns to the Skilled Nursing Facility by midnight of the same day. The day you enter a Skilled Nursing Facility is treated as a day of Admission. The days during which you are not physically present for inpatient care are not counted as Admission days.</p>
Specialty Drugs	<p>The Plan will pay Covered Expenses for Specialty Drugs as set forth on the BlueCross Schedule of Benefits. Covered Expenses for Specialty Drugs dispensed to a Member shall not exceed the quantity and Benefit maximum set by the Plan. Certain Specialty Drugs may only be covered under the pharmacy Benefit. Certain Specialty Drugs may require Preauthorization. For any Specialty Drug, the Benefit Year Deductible, Out-of-Pocket Maximum and/or Benefit maximum may apply. A list of Specialty Drugs, as well as information about any related requirements and/or restrictions, may be obtained by contacting BlueCross at the number listed on the Identification Card or at <a href="http://www.SouthCarolinaBlues.com">www.SouthCarolinaBlues.com</a>.</p> <p>Any Coinsurance percentage for Specialty Drugs is based on the Allowable Charge at the Participating Pharmacy and does not change due to receipt of any Credits by BlueCross. Prescription Drug Copayments likewise do not change due to receipt of any Credits by the Corporation.</p>
Speech Therapy	The Plan will pay Covered Expenses for Speech Therapy as set forth on the BlueCross Schedule of Benefits.
Substance Use Disorder Services	The Plan will pay Covered Expenses for Substance Use Disorder Services as set forth on the BlueCross Schedule of Benefits. Methadone is covered for treatment of substance use disorders, please refer to the BlueCross Schedule of Benefits for coverage information.
Surgery in a Podiatrist's Office	The Plan will pay Covered Expenses for surgery in a Podiatrist's office as set forth on the BlueCross Schedule of Benefits.
Surgical Services	<p>The Plan will pay Covered Expenses for Surgical Services performed by a licensed medical doctor or oral surgeon as applicable, for treatment and diagnosis of disease or injury or for obstetrical services, as follows:</p> <ol style="list-style-type: none"> <li>1. Surgical Services, subject to the following: <ol style="list-style-type: none"> <li>a. If two (2) or more operations or procedures are performed at the same time, through the same surgical opening or by the same surgical approach, the total amount covered for such operations or procedures will be the Allowable Charge for the major procedure only.</li> <li>b. If two (2) or more operations or procedures are performed at the same time, through different surgical openings or by different surgical approaches, the total amount covered will be the Allowable Charge for the operation or procedure bearing the highest Allowable Charge, plus one-half of Allowable Charge for all other operations or procedures performed.</li> <li>c. If an operation consists of the excision of multiple skin lesions, the total amount covered will be the Allowable Charge for the procedure bearing the highest Allowable Charge, fifty (50%) percent for the procedure bearing the second and third highest Allowable Charges, twenty-five (25%) percent for the procedures bearing the fourth through the eighth highest Allowable Charges, and, ten (10%) percent for all other procedures. Provided, however, if the operation consists of the excision of multiple malignant lesions, the total amount covered will be the Allowable Charge for the procedure bearing the highest Allowable Charge, and fifty (50%) percent of the charge for each subsequent procedure.</li> <li>d. If an operation or procedure is performed in two (2) or more steps or stages, coverage for the entire operation or procedure will be limited to the Allowable Charge set forth for such operation or procedure.</li> <li>e. If two (2) or more medical doctors or oral surgeons perform operations or procedures in conjunction with one another, other than as an assistant surgeon or anesthesiologist, the Allowable Charge subject to the above paragraphs, will be coverage for the services of only one (1) medical doctor or oral surgeon (as applicable) or will be prorated between them by the Employer's Group Health Plan when so requested by the medical doctor or oral surgeon in charge of the case.</li> <li>f. Certain surgical procedures are designated as separate procedures by the Plan, and the Allowable Charge is payable when such procedure is performed as a separate and single entity; however, when a separate procedure is performed as an integral part of another surgical procedure, the total amount covered will be the Allowable Charge for the major procedure only.</li> </ol> </li> <li>2. Assistant Surgeon services that consists of the Medically Necessary service of one (1) medical doctor or oral surgeon who actively assists the operating surgeon when a covered Surgical Service is performed in a Hospital, and when such surgical assistant service is not available by an intern, resident or in-house physician. The Plan will pay charges at the percentage of the Allowable Charge set forth on the Schedule of Benefits for the Surgical Service, not to exceed the medical doctors or oral surgeon's (as applicable) actual charge.</li> <li>3. Anesthesia services that consists of services rendered by a medical doctor, oral surgeon or a certified registered nurse anesthetist, other than the attending surgeon or his or her assistant, and includes the administration of spinal or rectal anesthesia, or a drug or other anesthetic</li> </ol>

	agent by injection or inhalation, except by local infiltration, the purpose and effect of which administration is the obtaining of muscular relaxation, loss of sensation or loss of consciousness. Additional Benefits will not be provided for pre-operative anesthesia consultation.
Sustained Health Benefits	The Plan may offer certain routine annual Benefits (known as Sustained Health Benefits) as set forth on the BlueCross Schedule of Benefits. These Benefits are designed to cover costs associated with routine care and are provided in addition to the Preventive Services covered under PPACA. Because these are additional Benefits, age and monetary limitations may be imposed and cost-sharing may be required by the Member.

**T**

Telehealth	The Employer's Group Health Plan will pay Covered Expenses for Telehealth services which are initiated by either a Member or Provider and are provided by licensed health care professionals who have been credentialed as eligible Telehealth Providers.
Temporomandibular Joint (TMJ) Disorder	The Plan will pay Covered Expenses for any service for the treatment of dysfunctions or derangements of the temporomandibular joint, including orthognathic surgery for the treatment of dysfunctions or derangements of the temporomandibular joint.
Travel and Lodging	<p>The Plan will pay Covered Expenses for travel and lodging as set forth on the BlueCross Schedule of Benefits. Travel and lodging will be reimbursed for travel and housing accommodation expenses for the transplant patient and one family member or companion if the transplant is done at a Blue Distinction Center of Excellence. There is a \$10,000 limit on reimbursement for travel and housing per transplant. The Medical Plan Benefits include the following general travel reimbursement guidelines under the Blue Distinction Centers for Transplants:</p> <ol style="list-style-type: none"> <li>1. The cost of round-trip airline tickets (or personal vehicle travel expenses will be reimbursed at the mileage rate set by the Federal Travel Regulations at the time of the travel.) For the pre-transplant work-up, the actual transplant procedure and post-transplant care, for both the patient and a family member* or companion (airline ticket receipts are required, if flying),</li> <li>2. The actual cost of lodging (with a receipt, excluding any incidentals such as phone calls, etc.) up to \$100 per day (combined expenses for the patient and a family member* or companion), and</li> <li>3. The actual cost of meals (with a receipt, excluding any incidentals such as tips, etc.) up to \$40 per day per person for the family member* or companion, and up to \$40 per day for the patient when the patient is not hospitalized during the trip.</li> </ol> <p>* Travel expenses for two family members are reimbursable when the patient is a dependent child.</p>

## Appendix C: Expenses Not Covered

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

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

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

<b>C</b>	
Clinical Pathologist	Charges made by a clinical pathologist, as related to automated laboratory testing, for supervising a Hospital's laboratory.
Complications from Failure to Complete Treatment	Complications that occur because 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.
Contraceptives	Medical Supplies, services or devices for the purpose of contraception, except as specified on the Schedule of Benefits.
Copying Charges	Fees for copying or production of medical records and/or claims filing
Cosmetic and Reconstructive Services	<p>This Plan of Benefits excludes cosmetic or reconstructive procedures, and any related services or Medical Supplies, which alter appearance but do not restore or improve impaired physical function. Examples of services that are cosmetic or reconstructive, which are not covered include, but are not limited to, the following:</p> <ol style="list-style-type: none"> <li>1. Rhinoplasty (nose);</li> <li>2. Meatoplasty (chin);</li> <li>3. Rhytidoplasty (face lift);</li> <li>4. Glabellar rhytidoplasty (forehead lift);</li> <li>5. Surgical planning (dermabrasion);</li> <li>6. Blepharoplasty (eyelid);</li> <li>7. Mammoplasty (reduction, suspension or augmentation of the breast);</li> <li>8. Superficial chemosurgery (chemical peel of the face); and,</li> <li>9. Rhytidectomy (abdomen, legs, hips, buttocks or elsewhere including lipectomy or adenectomy).</li> </ol> <p>A cosmetic or reconstructive service may, under certain circumstances (in BlueCross's discretion), be considered restorative in nature for which Benefits are available, but only if the following requirements are met:</p> <ol style="list-style-type: none"> <li>1. The service is intended to correct, improve or restore a bodily function; or,</li> <li>2. The service is intended to correct, improve or restore an untypical appearance or deformity that was caused by physical trauma or accident, congenital anomaly or covered surgical service; and,</li> <li>3. The proposed service must be Preauthorized.</li> </ol>
Custodial Care	Services or supplies related to Custodial Care, except as specified on the BlueCross Schedule of Benefits.

## D

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

## E

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

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

**G**

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

Human Organ and Tissue Transplants	Human organ and tissue transplants that are not: <ol style="list-style-type: none"> <li>1. Preauthorized;</li> <li>2. Performed by a Provider as designated by the Corporation;</li> <li>3. Listed as covered on the Schedule of Benefits; and,</li> <li>4. Performed at a Blue Distinction® Center of Excellence or transplant center approved by BlueCross in writing.</li> </ol>
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**I**

Illegal Acts	Any illness or injury received while committing or attempting to commit a crime, felony or misdemeanor or while engaging or attempting to engage in an illegal act or occupation.
Impacted Tooth Removal	Services or Medical Supplies for the removal of impacted teeth.
Impotence	Services, supplies or drugs related to any treatment for impotence, including but not limited to penile implants.
Incapacitated Dependents	Any service, supply or charge for an Incapacitated Dependent that is not enrolled by the maximum Dependent Child age listed on the BlueCross Schedule of Benefits.
Inpatient Diagnostic and Evaluative Procedures	Inpatient care and related Provider Services rendered in conjunction with an Admission, which is principally for diagnostic studies or evaluative procedures that could have been performed on an outpatient basis are not covered unless the Member's medical condition alone required Admission.
Intoxication or Drug Use	Any service (other than Substance Use Disorder Services), Medical Supplies, charges or losses resulting from a Member being Legally Intoxicated or under the influence of any drug or other substance or taking some action the purpose, of which is to create a euphoric state or alter consciousness. The Member, or Member's representative, must provide any available test results showing blood alcohol and/or drug/substance levels upon request by the Corporation. If the Member refuses to provide these test results, no Benefits will be provided.
Investigational or Experimental Services	Services or supplies or drugs that are Investigational or Experimental.

**L**

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

5. Psychiatric or Substance Use Disorder treatment including: therapeutic schools, wilderness/boot camps, therapeutic boarding homes, half-way houses and therapeutic group homes.

## M

Membership Dues and Other Fees	Amounts payable (whether in the form of initiation fees, annual dues or otherwise) for membership or use of any gym, workout center, fitness center, club, golf course, wellness center, health club, weight control organization or other similar entity or payable to a trainer of any type.
Missed Provider Appointments	Charges for a Member's appointment with a Provider that the Member did not attend.

## N

No Legal Obligation to Pay	Any service, supply or charge the Member is not legally obligated to pay.
Not Medically Necessary Services or Supplies	Any service or supply that is not Medically Necessary. However, if a service is determined to be not Medically Necessary because it was not rendered in the least costly setting, Covered Expenses will be paid in an amount equal to the amount payable had the service been rendered in the least costly setting.

## O

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

**P**

Pain Management Programs	Chronic pain management programs or multi-disciplinary pain management programs.
Pharmacy	"Maintenance Medications" or "Maintenance Drugs" not purchased pursuant to the Mail Service Saver Program (Mandatory)
Physical Therapy Admissions	All Admissions solely for physical therapy except as provided in Section 5 – Specified Covered Benefits.
Pre-Marital and Pre-Employment Examinations	Charges for services, supplies or fees for pre-marital or pre-employment examinations.
Pre-Operative Anesthesia Consultation Charges	Charges for pre-operative anesthesia consultation.
Provider Charges	Charges by a Provider for blood and blood derivatives and for charges for Prescription Drugs or Specialty Drugs that are not consumed at the Provider's office.
Psychological and Educational Testing	Psychological or educational diagnostic testing to determine job or occupational placement, school placement or for other educational purposes, or to determine if a learning disability exists.

**R**

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

**S**

Self-Inflicted Injury	Services and supplies received as the result of any intentionally self-inflicted injury that does not result from a medical condition or domestic violence.
Services for Certain Diagnoses Or Disorders	Medical Supplies or services or charges for the diagnosis or treatment of sexual and gender identity disorders, personality disorders, learning disorders, dissociative disorders, developmental speech delay, communication disorders, developmental coordination disorders, intellectual disabilities or vocational rehabilitation.
Services for Counseling Or Psychotherapy	Counseling and psychotherapy services for the following conditions are not covered: 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 Summary Plan Description or on the Schedule of Benefits 9. <a href="#">Wilderness therapy is not provided under the group health plan including nor health resorts, recreational programs, outdoor skills programs, relaxation or lifestyle programs, and services provided in conjunction with (or as part of) those programs.</a>

Services not listed as Covered Benefits	Medical Supplies or services or other items not specifically listed as a Benefit in Section 5 or on the BlueCross Schedule of Benefits.
Services prior to Member Effective Date or Plan of Benefits Effective Date	Any charges for Medical Supplies or services rendered to the Member prior to the Member's Effective Date, the Employer's Effective Date or after the Member's coverage terminates, except as provided in BlueCross Articles VI (Termination of this Plan of Benefits) and X (ERISA Rights).
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).

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

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

Amended And Restated Effective January 1, 2025