2012-213206

THE STATE OF SOUTH CAROLINA
In The Supreme Court

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S.C. Supreme Court

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

Paul M. Burch, Circuit Court Judge

Circuit Court Case No. 2009-CP-10-7404
S.C. Court of Appeals Case No. 2011183026

Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees, Petitioner,

v.

South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina, Respondent.

APPENDIX TO THE PETITION FOR WRIT OF CERTIORARI

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ATTORNEYS FOR PETITIONER

APPENDIX

1. Petition for Writ of Certiorari to Review Decision of the South Carolina Court of Appeals (SCRAP 242(A))
2. Certificate of Counsel
3. Proof of Service
4. Record on Appeal,

   Volume I 1-437

   Volume II 438-593
5. Brief of Appellant
6. Brief of Respondent
7. Reply Brief of Appellant
8. Unpublished Opinion Heard filed July 18, 2012 594-96
9. Petition for Rehearing En Banc filed August 2, 2012 597-607
10. Order Denying the Petition for Rehearing filed September 19, 2012 608

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APPENDIX

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THIS OPINION HAS NO PRECEDENTIAL VALUE. IT SHOULD NOT BE CITED OR RELIED ON AS PRECEDENT IN ANY PROCEEDING EXCEPT AS PROVIDED BY RULE 268(d)(2), SCACR.

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees, Appellant,

v.

South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina, Respondents.

Appellate Case No. 2011-183026

Appeal From Charleston County
Paul M. Burch, Circuit Court Judge

Unpublished Opinion No. 2012-UP-433
Heard May 9, 2012 – Filed July 18, 2012

AFFIRMED

John A. Massalon, of Wills, Massalon & Allen, LLC, of Charleston, for Appellant.

Theodore DuBose Willard, Jr., of Montgomery Willard, LLC, of Columbia, for Respondent Blue Cross and Blue Shield of South Carolina; Kelly Hunter Rainsford, of

Columbia, for Respondent South Carolina Budget and Control Board Employee Insurance Program.

PER CURIAM: Jeffrey Allen appeals the circuit court's grant of summary judgment in favor of the South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina. He argues the circuit court erred in finding he was required to exhaust his administrative remedies before pursuing a claim in circuit court. He also contends the circuit court erred in not staying the circuit court litigation pending the resolution of the matter in the Administrative Law Court. We affirm pursuant to Rule 220(b)(1), SCACR, and the following authorities:

As to the issue of staying the circuit court proceedings: *Tallent v. S.C. Dep't of Transp.*, 363 S.C. 160, 165, 609 S.E.2d 544, 546 (Ct. App. 2005) ("A party cannot use a motion to reconsider, alter[,] or amend a judgment to present an issue that could have been raised prior to the judgment but was not."), *rev'd sub nom. on other grounds, Hardin v. S.C. Dep't of Transp.*, 371 S.C. 598, 641 S.E.2d 437 (2007); *MailSource, LLC v. M.A. Bailey & Assocs., Inc.*, 356 S.C. 370, 374, 588 S.E.2d 639, 641 (Ct. App. 2003) ("A party cannot raise an issue for the first time in a Rule 59(e), SCRCP motion which could have been raised at trial.").

As to whether the circuit court erred in requiring Allen to exhaust his administrative remedies: *Smith v. S.C. Ret. Sys.*, 336 S.C. 505, 523, 520 S.E.2d 339, 349 (Ct. App. 1999) ("The question of whether exhaustion of administrative remedies is required is a matter within the sound discretion of the trial court that will not be disturbed on appeal absent an abuse of that discretion."); *id.* ("An abuse of discretion occurs where the trial court is controlled by an error of law or where the [c]ourt's order is based on factual conclusions without evidentiary support."); *id.* at 527, 520 S.E.2d at 351 ("[A] court ordinarily will refuse to grant a declaratory judgment where a special statutory remedy has been provided."); *id.* ("'Gratuitous interference' in the administrative process should be avoided." (quoting *Williams Furniture Corp. v. S. Coatings & Chem. Co.*, 216 S.C. 1, 7-8, 56 S.E.2d 576, 579 (1949))); S.C. Code Ann. § 1-11-710(C) (2005) (stating "claims for benefits under any self-insured plan of insurance offered by the State to state and public school district employees and other eligible individuals must be resolved by procedures established by the board, which shall constitute the exclusive remedy for these claims . . .").

AFFIRMED.

PIEPER, KONDUROS, and GEATHERS, JJ., concur.

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

Paul M. Burch, Circuit Court Judge

Circuit Court Case No. 2009-CP-10-7404
S.C. Court of Appeals Case No. 2011183026

Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees,

Appellant,

v.

South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina,

Respondent.

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SC Court of Appeals

PETITION FOR REHEARING EN BANC

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STATEMENT OF ISSUES

1. This is a matter of exceptional importance as it impacts public employees in South Carolina and their access to judicial determination on the applicability of a diabetes statutory mandate to the state insurance plan.
2. In affirming the grant of summary judgment with prejudice against the Appellant, this Court's opinion failed to address the differences between the claims alleged in this civil action with those subject to the Administrative Law Court proceeding ("ALC") (which has been pending and fully briefed and

awaiting action by the ALJ for eighteen (18) months), and therefore whether the differences in those claims render the exhaustion requirement in S.C. Code Ann. § 1-11-710(C) inapplicable to this civil action.

ARGUMENT

1. *This is matter of exceptional importance as it impacts public employees in South Carolina and their access to judicial determination on the applicability of a diabetes statutory mandate to the state insurance plan.*

Due to the delays Appellant has experienced within the administrative process, this Court should have reversed the grant of summary judgment, and at a minimum, remanded the case for entry of a stay pending the outcome of the Administrative Law Court action. "Protecting against abusive delay *is* an interest of justice." *Martel v. Clair*, 132 S.Ct. 1276, 1286 (2012). The SC General Assembly mandated insurance coverage related to diabetes, a condition which affects nearly 10% of South Carolinians (R. pp. 17-18). Respondents unilaterally choose to ignore the legistlative mandate and do not provide the insurance coverage required. The ultimate question in this matter is whether the Respondents can overrule the SC General Assembly.

Appellant, Jeffrey D. Allen (referred to herein as "Appellant") is an employee of a local South Carolina school district and an insured/member of the State Health Plan (referred to herein as the "Plan"). (R. p. 170). His daughter (referred to herein as "Jane Doe"), a dependant covered by the Plan, was diagnosed with Type I Diabetes on November 27, 2007 at the age of two (2) years old. (R. pp. 175-76). Appellant submitted claims under the Plan for coverage of the cost of outpatient diabetes training and education in 2007 and in 2008, but Blue Cross and Blue Shield of South Carolina and the

South Carolina Budget and Control Board Employee Insurance Program (referred to herein as "Respondents") denied the claims on the basis that the Plan does not include coverage for education or training for diabetes. (R. pp. 175-80).

After attempting to proceed with the agency appeals process for some time and after getting no explanation of the denial, Appellant commenced the instant lawsuit on November 25, 2009, alleging, *inter alia*, that the Respondents' denial of the claim violated the statutory mandate for outpatient diabetes training and education contained in S.C. Code Ann. § 38-71-46[1], and that the case should be certified as a class action. (R. pp. 16-22).

---

[1] S.C. Code Ann. § 38-71-46 provides (with emphasis added):

> **Diabetes Mellitus coverage in health insurance policies, diabetes education.** (A) On or after January 1, 2000, *every* health maintenance organization, ***individual and group health insurance policy, or contract issued or renewed in this State must provide coverage for*** the equipment, supplies, Food and Drug Administration-approved medication indicated for the treatment of diabetes, and ***outpatient self-management training and education for the treatment of people with diabetes mellitus,*** if medically necessary, and prescribed by a health care professional who is legally authorized to prescribe such items and who demonstrates adherence to minimum standards of care for diabetes mellitus as adopted and published by the Diabetes Initiative of South Carolina. This subsection does not prohibit a health maintenance organization or an individual or a group health insurance policy from providing coverage for medication according to formulary or using network providers. Coverage must not be denied unless the health care professional demonstrates a persistent pattern of failure to adhere to the minimal standards of care and unless the health maintenance organization or insurer has first provided written notice to the health care professional that coverage will be denied if the health care professional fails to adhere to the minimal standards of care.
>
> (B) Services and payment for diabetes education programs shall conform to regulations of the Health Care Financing Administration, US Department of Health and Human Services, pursuant to Section 4105 of the Balanced Budget Act of 1997. Diabetes outpatient self-management training and education shall be provided by a registered or licensed health care professional with certification in diabetes by the National Certification Board of Diabetes Educators, or other accredited program approved by the Diabetes Initiative of South Carolina, or by the Diabetes Control Program of the SC Department of Health and Environmental Control in order to meet the needs of rural communities wherein certified health care professionals providing this service are not available.
>
> (C) Nothing contained in this section may be construed to affect in any way the ability of a managed care plan to credential or re-credential a provider.

In response to receiving written discovery from Appellant and in lieu of answering it, Respondents filed a motion for summary judgment. (R. pp. 294-320); (R. pp. 432-37); (R. pp. 321-431); (R. pp. 439-67). Appellant filed a motion to compel discovery responses, a motion to stay decision on Respondents' motion for summary judgment. (R. pp. 468-91); (R. pp. 492-507), and opposed the motion for summary judgment. On the eve of the circuit court hearing in August 2010, for the very first time, the SC Budget and Control Board Employee Insurance Program issued its decision attempting to explain why S.C. Code Ann. § 38-71-46 did not apply to the State Insurance Plan. (R.pp. 453-66). By this time, it had been over two (2) years since the date of Apellant's last claim denial, and over 18 months since Appellant had begun to navigate the internal agency appeals process prior to even being able to submit the appeal to the Administrative Law Court.

In the circuit court, the hearing was held on August 26, 2010, and the trial court denied Appellant's motions and granted Respondents' motion for summary judgment dismissing Appellant's Complaint with prejudice. (R. pp. 554-92); (R. pp. 4-13). This appeal was taken.

Respondents delayed this matter by taking eighteen (18) months from the Appellant's first objection to explain their position on why the diabetes mandate did not apply to them, and Appellant has now waited an additional eighteen (18) months for the ALC to set this matter for hearing or decide it. (Briefing there was fully complete as of March 3, 2011, and as of the date of this Petition, August 2, 2012, the ALC had not set a hearing nor issued its decision.)

(D) For purposes of this section: ***"Health insurance policy" means a health benefit plan***, contract, or evidence of coverage providing health insurance coverage as defined in Section 38-71-670(6) and Section 38-71-840(14).

"A party should not be required to 'roll the dice' on whether a collateral administrative proceeding will conclude prior to the running of an applicable statute of limitations in order to preserve a claim properly within the jurisdiction of the circuit court." *Capital City Ins. Co. v. BP Staff, Inc.*, 674 S.E.2d 524, 531 (S.C. Ct. App. 2009). The court in *Capital City* held that where a party would be harmed by the running of the statute of limitations or otherwise prejudiced if its claim is dismissed for failure to exhaust administrative remedies, and the court has determined that resolution of the administrative proceeding would impact the circuit court case, then the circuit court should properly consider a stay or continuance of the judicial action until the administrative proceedings have concluded. *Id.* While the outcome of the administrative proceeding could moot the instant lawsuit, another possible outcome is that the ALC (or possibly this Court on appeal from the ALC) determines the ALC does not have the power to grant the relief requested and that the issues should be decided by the circuit court. This is the classic *catch-22* for a plaintiff, and for this reason this Court should rehear this matter and reverse the grant of summary judgment. Appellant should not be prejudiced by his decision to protect himself (and all putative class members) against a possible statute of limitations defense, particularly when there is no guidance in the law of whether the ALC has the power to grant the relief requested in the instant lawsuit, including: (1) certification of a class; (2) a declaration that the Plan violates S.C. Code Ann. § 38-71-46; (3) a declaration of the future rights of the putative class members with regard to claims for diabetes education and training under the Plan; (4) reformation of the Plan to comply with S.C. Code Ann. § 38-71-46; (5) an injunction to stop the Respondents from continuing their unlawful actions in the future; (6) disgorgement and

return of all profits and/or monies which should have been paid to the putative class members; and (7) costs and attorneys' fees.

2. *In affirming the grant of summary judgment with prejudice against the Appellant, this Court's opinion failed to address the differences between the claims alleged in this civil action with those subject to the Administrative Law Court proceeding (which has been pending and fully briefed and awaiting action by the ALJ for eighteen (18) months), and therefore whether the differences in those claims render the exhaustion requirement in S.C. Code Ann. § 1-11-710(C) inapplicable to this civil action.*

This Court's opinion did not address the differences between what is subject to the administrative process and the causes of action asserted in the instant lawsuit. The causes of action asserted in the instant lawsuit are not "claims for benefits" within the meaning of section 1-11-710(C), and continuing with the administrative appeal would not provide Appellant with an adequate remedy.

In the instant lawsuit Appellant seeks: (1) certification of a class; (2) a declaration that the Plan violates S.C. Code Ann. § 38-71-46; (3) a declaration of the future rights of the putative class members with regard to claims for diabetes education and training under the Plan; (4) reformation of the Plan to comply with S.C. Code Ann. § 38-71-46; (5) an injunction to stop the Respondents from continuing their unlawful actions in the future; (6) disgorgement and return of all profits and/or monies which should have been paid to the putative class members; and (7) costs and attorneys' fees. (R. p. 22). The potential result in favor of Appellant from the pending administrative proceeding would not provide the relief sought by Appellant and the putative class members in the instant lawsuit.

Section 1-11-710(C) provides that "*claims for benefits* under any self-insured plan of insurance offered by the State to state and public school district employees and other

eligible individuals must be resolved by procedures established by the board [South Carolina Budget and Control Board], which shall constitute the exclusive remedy for these claims, subject only to appellate judicial review consistent with the standards provided in Section 1-23-380." S.C. Code Ann. § 1-11-710(C) (emphasis added). Section 1-23-380 entitled "Judicial Review Upon Exhaustion of Administrative Remedies" "does not limit utilization of or the scope of judicial review *available under other means of review, redress, relief,* or trial de novo provided by law." S.C. Code Ann. § 1-23-380(A) (Supp. 2009) (emphasis added).

If the denial of Appellant's claims for diabetes education and training benefits is reversed in the ALC, then presumably Appellant would receive coverage only for his diabetes education claims. However, neither the Appellant's benefit plan nor the putative class members' benefit plans would necessarily be reformed to provide the statutorily mandated insurance coverage for diabetes education. Appellant's prevailing in the administrative process would not require Respondents to review all denials made in violation of the diabetes education mandate statute since its enactment in 2000. Appellant's prevailing in the administrative process would not enjoin Respondents from violating the diabetes mandate in the future, nor force disgorgement of revenues and profits related to the illegal conduct.

"A party is not required to exhaust administrative remedies if the issue is one that cannot be ruled upon by the administrative body." *Capital City Ins. Co. v. BP Staff, Inc*, 674 S.E.2d 524, 529 (S.C. Ct. App. 2009) quoting *Charleston Trident Home Builders, Inc. v. Town Council of Town of Summerville*, 632 S.E.2d 864, 867 (S.C. 2006) (citing *Ward v. State*, 538 S.E.2d 245 (S.C. 2000)); *see also Stinney*, 675 S.E.2d at 763

(recognizing that inadequacy of the administrative appeal is an exception to the general rule requiring exhaustion). The purpose of the exhaustion requirement, to allow the agency to render a final decision and set forth its reason for denying the diabetes education claim, would not assist the Court in this case. The alleged wrong – violation of the statutory mandate as to an entire class of persons—is not one which the administrative process was designed to address.

CONCLUSION

For the reasons discussed herein, Appellant respectfully requests that the Court rehear this matter en banc.

Respectfully submitted,

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

Paul M. Burch, Circuit Court Judge

Circuit Court Case No. 2009-CP-10-7404
S.C. Court of Appeals Case No. 2011183026

Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees or retirees,.....Appellant,

v.

South Carolina Budget and Control Board,
Employee Insurance Program.....Respondent.

PROOF OF SERVICE

I certify that I have served the Appellant's Petition for Rehearing en Banc on Respondent of record by depositing a copy of it in the United States Mail, postage prepaid, on August 2, 2012, addressed to their attorneys of record, Theodore D. Willard, Jr., Montgomery Willard, LLC, P.O. Box 11886, Columbia, SC, 29211 and Kelly H. Rainsford, State Budget & Control Board, 1201 Main Street, Suite 300, Columbia, SC 29201.

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August 1, 2012

VIA OVERNIGHT MAIL
The Honorable Jeanette Barber
Clerk
South Carolina Court of Appeals
1015 Sumter Street
PO Box 11629
Columbia, SC 29211

RE: Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees v. SC Budget & Control Board
SC Court of Appeals Case No.: 2011183026
Circuit Court Case No.: 09-CP-10-7404
File No.: 595-1

Dear Ms. Barber:

With regard to the above referenced matter, enclosed please find the original and six (6) copies of the Petition for Rehearing en Banc of Appellant, Certificate of Service, and filing fee in the amount of $25.00. By copy of this letter to all counsel of record, I am serving them with a copy of the same. If you have any questions, please do not hesitate to give me a call.

With kind regards, I am

Sincerely,

WILLS MASSALON & ALLEN LLC

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AUG 02 2012
SC Court of Appeals

Enclosures

cc: Terry E. Richardson, Jr., Esquire
Theodore D. Willard, Jr., Esquire
Kelly H. Rainsford, Esquire

The South Carolina Court of Appeals

Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees, Appellant,

v.

South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina, Respondents

Appellate Case No. 2011-183026

ORDER

After careful consideration of the petition for rehearing, the Court is unable to discover that any material fact or principle of law has been either overlooked or disregarded, and hence, there is no basis for granting a rehearing. Accordingly, the petition for rehearing is denied.

Daniel G. Pieper J.

J.

John D. Dalton J.

Columbia, South Carolina

cc:
John A. Massalon
Theodore DuBose Willard, Jr.
Kelly Hunter Rainsford

FILED
19 September 2013

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Paul M. Burch, Circuit Court Judge

Jeffrey D. Allen, individually,
as guardian for Jane Doe, a
minor, and as representative of
other similarly situated State
of South Carolina employees,.....Appellant,

v.

South Carolina Budget and
Control Board Employee
Insurance Program and Blue
Cross and Blue Shield of
South Carolina.....Respondent.

RECORD ON APPEAL

2009-CP-10-7404

VOLUME 1

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STATE OF SOUTH CAROLINA	IN THE COURT OF COMMON PLEAS
COUNTY OF CHARLESTON	OF THE NINTH JUDICIAL CIRCUIT
Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees, Plaintiffs, v. South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina, Defendants.	C/A No.: 2009-CP-10-7404 **ORDER DENYING PLAINTIFF'S MOTION TO RECONSIDER**

FILED
2010 NOV 29 PM 1:50
JULIE J. ARMSTRONG
CLERK OF COURT
BY

After considering the well-reasoned memorandums of each party and reexamining my original order, I find the Plaintiff's motion should be denied.

THEREFORE, Plaintiff's Motion to Alter, Amend or Reconsider Pursuant to Rule 59, SCRCP is respectfully DENIED.

IT IS SO ORDERED.

Honorable Paul M. Burch
Judge, Fourth Judicial Circuit

Pageland, South Carolina
November 23, 2010

JULIE J. ARMSTRONG
CLERK OF COURT, C.P. & G.S.
100 BROAD STREET, SUITE 106
CHARLESTON, SC 29401-2258
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CHARLESTON COUNTY
SOUTH CAROLINA

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76

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CHARLESTON SC 29402-0859

NOTICE OF ENTRY OF JUDGMENT/ORDER PURSUANT TO RULE 77 SCRCP

ORDER - ORDER DENYING PLNTFF'S MOTION TO RECONSIDER

THIS JUDGMENT WAS ENTERED ON THE 29TH DAY OF NOVEMBER , 2010 AND A COPY MAILED FIRST-CLASS THIS 4TH DAY OF DECEMBER , 2010 TO ALL COUNSEL OF RECORD AND/OR ALL PERSONS ENTITLED TO RECEIVE NOTICE.
YOU MAY VIEW AND DOWNLOAD THIS DOCUMENT AT WWW3.CHARLESTONCOUNTY.ORG

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CHARLESTON SC 29402-0859

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Wills & Massalon

2009-CP-10-007404
ALLEN, JEFFREY D ETAL
VS.
SOUTH CAROLINA BUDGET AND CONT

1520111.20101202861101.00075

FORM ID: LECOCC - LEFOI

STATE OF SOUTH CAROLINA)	IN THE COURT OF COMMON PLEAS
)	FOR THE NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON)	
Jeffrey D. Allen, individually, as guardian) for Jane Doe, a minor, and as representative) of other similarly situated State of South) Carolina employees,)	Civil Action No.: 2009-CP-10-7404
Plaintiffs,)	**ORDER**
v.)	
South Carolina Budget and Control Board) Employee Insurance Program and Blue) Cross and Blue Shield of South Carolina,)	
Defendants.)	

10-02709
10-01710

FILED
2010 OCT 15 PM 3:40
JULIE J. ARMSTRONG
CLERK OF COURT
BY _____

This matter is before the Court on Defendants South Carolina Budget and Control Board Employee Insurance Program's ("EIP") and Blue Cross Blue Shield of South Carolina's ("BCBSSC") Motion for a Protective Order pursuant to South Carolina Rule of Civil Procedure 26 (c) and Motion for Summary Judgment pursuant to South Carolina Rule of Civil Procedure 56 and Plaintiff's Motion to Stay Defendants' Motion for Summary Judgment and Plaintiff's Motion to Compel responses to Plaintiff's discovery. On August 26, 2010, this Court heard arguments on the above motions. For the reasons stated below, based on the arguments of counsel, the written submissions, evidence, and affidavits submitted to the Court, this Court finds Defendants' Motion for a Protective Order and Motion for Summary Judgment should be granted, and Plaintiff's Motion to Stay Defendants' Motion for Summary Judgment and Plaintiff's Motion to Compel are denied.

I. BACKGROUND

The Group Health Benefits Plan of the Employees of the State of South Carolina, the

Public School Districts, and Participating Entities ("State Health Plan") is a self-funded, non-federal governmental health plan, which is administered by the South Carolina Budget and Control Board Employee Insurance Program ("EIP"). (Affidavit of Robin Tester, ¶ 3). BCBSSC is the third-party claims administrator for the State Health Plan. BCBSSC is not an insurer of the State Health Plan. (Affidavit of Robin Tester, ¶ 4).

Plaintiff, an employee of a South Carolina School District, brings this purported class action against the State Health Plan and BCBSSC, alleging S.C. Code Ann. § 38-71-46 mandates coverage under the State Health Plan for diabetes outpatient self-management training and education . Plaintiff alleges causes of action for declaratory judgment to interpret the terms of the State Health Plan, disgorgement of benefits under the State Health Plan, reformation of the State Health Plan and for injunctive relief. Plaintiff's Complaint alleges:

> 5. This is an action for declaratory judgment arising from Defendants' unlawful issuance and administration of the State of South Carolina EIP Standard Plan, a plan of health benefits and insurance offered to all current and retired state employees, including public school district employees, for violation of a SC Code Section 38-71-46, for disgorgement of revenues received as a result of the unlawful issuance and administration, and for declaration to determine the value of unlawfully withheld benefits.
>
> . . .
>
> 11. As the named Plaintiff is an employee of a South Carolina school district, has been enrolled in the EIP Standard Plan, has enrolled his dependent child in said plan who was diagnosed with Diabetes at the age of two years old, and has made multiple claims for his dependent child with a value of approximately One Thousand & 00/100 US Dollars ($1000.00) for diabetes outpatient self-management training and education which were denied by Defendant BCBSSC as administrator to the EIP, his claim, right and privileges are typical of the proposed class.
>
> . . .
>
> 19. Plaintiff seeks, individually and as legal guardian for Jane Doe, and on behalf of all class members, a declaration of the rights of the parties hereto: that Defendants are required to issue and administer all health benefit plans offered

through the EIP in compliance with the express mandate of South Carolina Code Section 38-71-46.

20. Plaintiff seeks an Order of the Court reforming the terms of the health benefit plan provided to all class members effective January 1, 2000 to provide the mandated diabetes coverage.

21. Plaintiff seeks an Order of the Court requiring the Defendants to disgorge monies received as a result of unlawful denials of the mandatory diabetes coverage, and to pay them to members of the putative class the present value of said unlawfully withheld revenues.

. . .

24. The Defendants should be enjoined from the wrongful takings as described above and from further denial of claims for the diabetes outpatient self-management training and education.

Defendants moved for summary judgment on the following grounds: (1) the administrative remedies under S.C. Code Ann. § 1-11-710 (C) are Plaintiff's exclusive remedy, subject only to appeal to the South Carolina Administrative Law Court pursuant to S.C. Code Ann. § 1-23-600 (D); and (2) S.C. Code Ann. § 38-71-46 does not apply to the State Health Plan. Defendants further moved for a protective order staying Plaintiff's discovery pending a determination of Defendants' Motion for Summary Judgment. Plaintiff moved to stay Defendants' Motion for Summary Judgment and to compel responses to Plaintiff's discovery.

II. STANDARD FOR SUMMARY JUDGMENT

Summary judgment is appropriate when there is no genuine issue of material fact such that the moving party is entitled to prevail as a matter of law. Rule 56(c), SCRCP; Fleming v. Rose, 350 S.C. 488, 493, 567 S.E.2d 857, 860 (2002). "In determining whether any triable issues of fact exist, the court must view the evidence and all reasonable inferences that may be drawn from the evidence in the light most favorable to the non-moving party." David v. McLeod Reg'l Med. Ctr., 367 S.C. 242, 247, 626 S.E.2d 1, 3 (2006). The purpose of summary judgment is to

"expedite the disposition of cases which do not require the services of a fact finder." Dawkins v. Fields, 354 S.C. 58, 69, 580 S.E.2d 433, 438 (2003) (quoting George v. Fabri, 345 S.C. 440, 452, 548 S.E.2d 868, 874 (2001)); Rumpf v. Massachusetts Mut. Life Ins. Co., 357 S.C. 386, 593 S.E.2d 183 (Ct. App. 2004). When plain, palpable, and indisputable facts exist on which reasonable minds cannot differ, summary judgment should be granted. Pye v. Aycock, 325 S.C. 426, 480 S.E.2d 455 (Ct. App. 1997).

III. DISCUSSION

A. Defendants' Motion For Summary Judgment And Plaintiff's Motion To Stay Summary Judgment

The Court finds that the administrative remedies under S.C. Code Ann. § 1-11-710 (C) are Plaintiff's exclusive remedy, subject only to appellate review to the South Carolina Administrative Law Court ("ALC") pursuant to S.C. Code Ann. § 1-23-600 (D). A participant and/or beneficiary challenging an award of benefits under the State Health Plan is limited to the remedies set forth in S.C. Code Ann. § 1-11-710(C), which provides as follows:

> Notwithstanding Sections 1-23-310 and 1-23-320 or any other provision of law, claims for benefits under any self-insured plan of insurance offered by the State to state and public school district employees and other eligible individuals must be resolved by procedures established by the board, which shall constitute the exclusive remedy for these claims, subject only to appellate review consistent with standards provided in Section 1-23-380.

Id. (Emphasis added).

Pursuant to the allegations of Plaintiff's Complaint, Plaintiff is requesting the Court interpret the terms of the State Health Plan to include the coverage set out in S.C. Code Ann. § 38-71-46. Plaintiff further alleges he is entitled to disgorge benefits from the plan for unlawful denials of coverage and for injunctive relief enjoining "further denial of claims for diabetes out-patient self-management training and education." (Complaint ¶24). The interpretation of the

State Health Plan and the resolution of claims for benefits under the Plan are exactly the types of remedies contemplated by § 1-11-710(C).[1]

It is undisputed that prior to filing the current action, and while the current action was pending, Plaintiff continued to avail himself of his administrative remedies under § 1-11-710(C). On September 30, 2009, Plaintiff made a first level appeal to the BCBSSC Appeals Committee regarding the denial of his claim for benefits under the State Health Plan, making the exact same argument he makes here concerning the application of S.C. Code Ann. § 38-71-46 to the State Health Plan. (Affidavit of Robin E. Tester ¶7, Exhibit A). By including this issue as part of his administrative appeal, Plaintiff recognized EIP had the authority to rule on the application of S.C. Code Ann. § 38-71-46 to the State Health Plan.

On April 2, 2010, the BCBSSC Appeals Committee informed Plaintiff in a letter that it was upholding the denial of Plaintiff's claim because the requested services were specifically excluded under the terms of the State Health Plan. BCBSSC also stated S.C. Code Ann. § 38-71-46 did not apply to the State Health Plan. (Affidavit of Robin Tester ¶8, Exhibit B). This letter further gave Plaintiff 90 days from April 2, 2010, to appeal this decision to the EIP Health Appeals Committee.

On June 30, 2010, Plaintiff appealed the denial of his claim to the EIP Health Appeals Committee. (Exhibit A to Defendants' Memorandum). As can be seen from the contents of this

---

[1] Paragraph 1.3 of the State Health Plan states:

> 1.3 Applicable Law
>
> This Plan is established and will be maintained with the intention of meeting the requirements of all applicable federal and state laws. Any provision of this Plan, which is in conflict with the law of any governmental body or agency that has jurisdiction over this Plan, shall be interpreted to conform to the minimum requirements of such laws.

(Affidavit of Robin E. Tester, Exhibit C, p.1) (emphasis added).

letter, Plaintiff appealed the issue of the applicability of S.C. Code Ann. § 38-71-46 to the State Health Plan to the EIP Health Appeals Committee.

By letter dated August 24, 2010, the EIP Health Appeals Committee wrote Plaintiff that it was denying his claim for benefits and noted S.C. Code Ann. § 38-71-46 did not apply to the State Health Plan. This letter also informed Plaintiff that his next level of appeal was to the South Carolina Administrative Law Court. (Exhibit A to Defendants' Memorandum).

Appeals involving claims under the State Health Plan are under the exclusive jurisdiction of the ALC.[2] Pursuant to S.C. Code Ann. § 1-11-710(C), the exclusive remedy available to Plaintiff is the administrative review process provided by the Plan, "subject only to appellate judicial review consistent with the standards provided in Section 1-23-380." S.C. Code Ann. § 1-23-380 provides: "a party who has exhausted all administrative remedies available within the agency and who is aggrieved by a final decision in a contested case is entitled to judicial review under this article [the Administrative Procedures Act]." Additionally, S.C. Code Ann. § 1-23-600 (D) states: "[a]n administrative law judge also shall preside over all appeals from final decisions of contested cases pursuant to the Administrative Procedures Act...or another law..."

Plaintiff's argument that it was futile for Plaintiff to exhaust his administrative remedies, and that the letter of August 24, 2010 was evidence of this futility, is misplaced. Undeniably, Plaintiff purposely availed himself of the administrative remedies under the State Health Plan and fully exhausted the internal appeals process. Therefore, any futility argument was waived and/or mooted. Simply put, Plaintiff still has a viable remedy by appealing the denial of his claim to the ALC, which has exclusive jurisdiction over such actions.

The Court further finds Plaintiff's argument that summary judgment was premature

[2] Prior to July 1, 2006, appeals from EIP went directly to the Circuit Court. After July 1, 2006, pursuant to 2006 S.C. Acts 387, appeals from EIP go directly to the Administrative Law Court.

because discovery had not been completed also fails. The undisputed facts establish Plaintiff purposely availed himself of the State Health Plan's administrative remedies. Therefore, the Court was left to decide the purely legal issue of whether Plaintiff's exclusive remedy was an appeal to the ALC. The issue of interpretation of a statute is a question of law for the Court. Catawba Indian Tribe of South Carolina v. State, 372 S.C. 519, 524, 642 S.E.2d 751, 753 (2007). While Plaintiff's counsel did submit a Rule 56 (f) affidavit, that affidavit failed to identify any evidence Plaintiff expected to discover that would be relevant to the issue of whether the administrative remedies under S.C. Code Ann. § 1-11-710 (C) were Plaintiff's exclusive remedy, subject only to appellate review to the ALC pursuant to S.C. Code Ann. § 1-23-600 (D). When plain, palpable, and indisputable facts exist on which reasonable minds cannot differ, summary judgment should be granted. Pye v. Aycock, 325 S.C. 426, 480 S.E.2d 455 (Ct. App. 1997).

Plaintiff further argues that the issue of whether the administrative remedies under S.C. Code Ann. § 1-11-710 (C) were Plaintiff's exclusive remedy, subject only to appellate review to the ALC under S.C. Code Ann. § 1-23-600 (D), is a novel question of law that should not be decided at summary judgment. However, as the South Carolina Supreme Court held in Byrd v. Irmo High School, 321 S.C. 426, 468 S.E.2d 861 (1996), where the dispute is not regarding the underlying facts but the interpretation of the law, and the development of the record will not aid in the resolution of the issues, it is proper to decide even novel questions of law on demurrer. See also Brown v. Howe, 338 S.C. 305, 526 S.E.2d 232 (Ct. App. 1999) (even novel questions of law can be decided at the motion to dismiss stage where development of the record will not aid resolution of the issues). In the present case, the underlying facts are not in dispute and further development of the record will not aid the resolution of the issue of whether the administrative remedies under S.C. Code Ann. § 1-11-710 (C) were Plaintiff's exclusive remedy, subject only

to appellate review to the ALC pursuant to S.C. Code Ann. § 1-23-600 (D). Therefore, summary judgment is not premature.

Plaintiff also argues that based on Drummond v. State of South Carolina, 378 S.C. 362, 662 S.E.2d 587 (2008), the ALC cannot rule on whether or not S.C. Code Ann. § 38-71-46 applies to the State Health Plan. However, Drummond stands for the proposition that the ALC cannot rule on the validity of a statute because the ALC is a part of the executive branch. The ALC is charged with following the law "as written." Video Gaming Consultants, Inc. v. South Carolina Dept. of Revenue, 342 S.C. 34, 535 S.E.2d 642 (2000) ("ALJs are an agency of the executive branch of government and must follow the law as written until its constitutionality is judicially determined; ALJs have no authority to pass upon the constitutionality of a statute or regulation." (emphasis added)). Plaintiff argues that the final EIP Health Appeals Committee decision dated August 24, 2010, was a "regulation," the validity of which cannot be challenged by the ALC. However, the August 24, 2010, decision was not a regulation, but merely a decision by the EIP Health Appeals Committee, which was precisely the type of decision the ALC is authorized to hear in its appellate capacity. In the current case, no one was challenging the validity of S.C. Code Ann. § 38-71-46; rather, the challenge was whether S.C. Code Ann. § 38-71-46 did not apply to the State Health Plan. Therefore, the rule set forth in Drummond has no application to the present case.

The undisputed evidence establishes Plaintiff exhausted his administrative remedies under the State Health Plan. Pursuant to § 1-11-710(C) and S.C. Code Ann. § 1-23-600 (D) Plaintiff's exclusive remedy now is to appeal to the ALC. Accordingly, this Court finds Plaintiff's Motion To Stay Defendants' Motion For Summary Judgment is denied, Defendants' Motion for Summary Judgment is granted, and Plaintiff's Complaint should be dismissed with

prejudice as a matter of law.[3]

B. Defendants' Motion For Protective Order and Plaintiff's Motion To Compel

The Court Further finds Defendants were entitled to a protective order staying Plaintiff's discovery pending a determination of Defendants' Motion for Summary Judgment and denying Plaintiff's Motion to Compel. Pursuant to SCRCP 26 (c), a party may move for a protective order "for good cause shown ... to protect a party or person from annoyance...oppression, or undue burden by expense, including one or more of the following: (1) that discovery not be had; (2) that the discovery may be had only on specified terms and conditions...." The Court may control the timing and sequence of discovery pursuant to SCRCP 26 (d).

An order under Rule 26(c) to stay discovery pending determination of a dispositive motion is an appropriate exercise of a court's discretion. See Thigpen v. United States, 800 F.2d 393, 396-97 (4th Cir. 1986) ("Nor did the court err by granting the government's motion under Fed.R.Civ.P. 26(c) to stay discovery pending disposition of the 12(b) (1) motion.... Trial courts ... are given wide discretion to control this discovery process...."), overruled on other grounds, Sheridan v. United States, 487 U.S. 392, 108 S.Ct. 2449, 101 L. Ed. 2d 352 (1988); Tilley v. United States, 270 F. Supp. 2d 731, 734 (M.D.N.C. 2003), affirmed, 85 Fed. Appx. 333 (4th Cir. 2004), cert denied, 543 U.S. 819, 125 S.Ct. 64, 160 L. Ed. 2d 27 (2004); Simpson v. Specialty Retail Concepts, Inc., 121 F.R.D. 261, 263 (M.D.N.C.1988); Chavous v. D.C. Fin. Responsibility & Mgmt. Assistance Auth., 201 F.R.D. 1, 3 (D.D.C. 2001).

A stay of discovery until the determination of a dispositive motion is appropriate when (1) the issue raised is strictly one of law, (2) the motion, if successful, would be dispositive of the entire action, (3) the issue is one that cannot be cured by amending the pleadings, and (4) there is

[3] Because this Court finds Plaintiff's exclusive remedy is an appeal to the ALC, this Court need not address Defendants' second ground for summary judgment, whether S.C. Code Ann. § 38-71-46 applies to the State Health Plan.

no showing of any prejudice if the Court were to stay discovery. United States v. County of Nassau, 188 F.R.D. 187 (E.D.N.Y. 1999).

In the present case, the issues raised by Defendants' Motion for Summary Judgment are dispositive legal issues. As was previously discussed, the development of the record will not aid in the resolution of the issue of whether the Plaintiff's administrative remedies under S.C. Code Ann. § 1-11-710 (C) are Plaintiff's exclusive remedy, subject only to appellate review to the ALC pursuant to S.C. Code Ann. § 1-23-600 (D). Additionally, the dispositive issues involved cannot be cured by Plaintiff amending his pleadings. Also, staying discovery will not prejudice Plaintiff in that Plaintiff will be saved from wasting time on voluminous, burdensome, and costly discovery only to find out at a later stage in the litigation that his exclusive statutory remedy is an administrative appeal to the ALC. Therefore, the Court finds Defendants' Motion for a Protective Order should be granted and Plaintiff's Motion To Compel should be denied.

IV. CONCLUSION

For the foregoing reasons, the Court denies Plaintiff's Motion To Stay Defendants' Motion For Summary Judgment and Plaintiff's Motion To Compel, and grants Defendants' Motion for a Protective Order and Defendants' Motion for Summary Judgment. Accordingly, Plaintiff's Complaint is dismissed with prejudice.

IT IS SO ORDERED.

PAUL M. BURCH
PRESIDING JUDGE

~~September~~ 10th 2010
Charleston, South Carolina

STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON
IN THE COURT OF COMMON PLEAS

JUDGMENT IN A CIVIL CASE

Case No.: **2009-CP-10-7404**

Jeffrey D. Allen
Plaintiff

versus

S.C. Budget and Control
Defendant

FILED
2010 MAR -8 AM 9:24
JULIE J. ARMSTRONG
CLERK OF COURT
BY

CHECK ONE:

[☐] **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and the verdict has been rendered.

[☒] **DECISION BY COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

[☐] **ACTION DISMISSED (CHECK REASON):** [☐] Rule 12(b), SCRCP; [☐] Rule 41(a), SCRCP (Vol. nonsuit) [☐] Rule 43(k), SCRCP (Settled);
[☐] Other: _____

[☐] **ACTION STRICKEN (CHECK REASON):** [☐] Rule 40(j), SCRCP; [☐] Bankruptcy;
[☐]Other: _____

IT IS ORDERED AND ADJUDGED: [☐] See attached order [☐] Statement of Judgment by Court
Motion to dismiss is denied.

Dated at Charleston, South Carolina,

03/04/2010 _____ 2060
Date Judge

This judgment was entered on the _____ Day of _____, 20___, and a copy mailed first class this _____ Day of _____, 20___, to attorneys of record or to parties (when appearing pro-se) as follows:

John Massalon
Attorney(s) for Plaintiff(s)

Theodore Williard
Attorney(s) for Defendant(s)

SCRP Form 4 (Rev. 2/96)

_____
Clerk of Court

FORM 4
STATE OF SOUTH CAROLINA

JUDGMENT IN A CIVIL CASE

COUNTY OF CHARLESTON
IN THE COURT OF COMMON PLEAS

Case No.: **2009-CP-10-007404**

versus

Jeffrey Allen
PLAINTIFF(S)

South Carolina Budget and Control Board, et al.
DEFENDANT(S)

CHECK ONE:

[ ] **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and the verdict has been rendered.

[x] **DECISION BY COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

[ ] **ACTION DISMISSED (CHECK REASON):** [ ] Rule 12(b), SCRCP; [ ] Rule 41(a), SCRCP (Vol. nonsuit) [] Rule 43(k), SCRCP(Settled); [ ] Other -

[ ] **ACTION STRICKEN (CHECK REASON):** [ ] Rule 40(j),SCRCP; [ ] Bankruptcy; [ ] Binding Arbitration, subject to right to restore to confirm, vacate or modify arbitration award; [ ] Other_____

[ ] **DISPOSITION OF APPEAL TO THE CIRCUIT COURT** (CHECK APPLICABLE BOX):
[ ] Affirmed; [ ] Reversed; [ ] Remanded; [ ] Other
NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING THE LOWER COURT, TRIBUNAL OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

FILE

MAR 10 2010

JULIE J. ARMSTRONG
CLERK, C.P. & G.S.

IT IS ORDERED AND ADJUDGED: [ ] See attached order. (Formal order to follow)
[X] Statement of Judgment by the Court:

Defendant's Motion to Dismiss and For Judgment on the Pleadings is DENIED.

Dated at Charleston, South Carolina, this 8th day of March, 2010.

R. Markley Dennis, Jr., **PRESIDING JUDGE**

This judgment was entered on the _____ Day of _____, 20____, and a copy mailed first class this _____ Day of _____, 20____, to attorneys of record or to parties (when appearing pro-se) as follows:

ATTORNEY(S) FOR THE PLAINTIFF(S)

ATTORNEY(S) FOR THE DEFENDANT(S)

SCCA SCRP Form 4Revised 6/2008

Clerk of Court

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
COUNTY OF CHARLESTON	)	CASE NO: 2009-CP-10- 7404

Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees or retirees,

Plaintiffs,

v.

South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina,

Defendants.

COMPLAINT

FILED
2009 NOV 25 AM 10: 55
JULIE J. ARMSTRONG
CLERK OF COURT
BY _____

COMES NOW the Plaintiff, Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees, complaining of Defendants South Carolina Budget and Control Board Employee Insurance Program (hereinafter "EIP") and Blue Cross and Blue Shield of South Carolina (hereinafter "BCBS") alleges and says as follows:

JURISDICTION

1. Plaintiff Jeffrey D. Allen (hereinafter "Plaintiff") is a citizen and resident of Charleston County, South Carolina.
2. Defendant State of South Carolina Budget and Control Board Employee Insurance Program (hereafter "EIP") is an agency or department within the State of South Carolina government.
3. Defendant Blue Cross and Blue Shield of South Carolina (hereafter "BCBSSC") is a for profit corporation registered, licensed, and authorized to do business in the State of South

Carolina and does in fact do business in the County of Charleston.

4. The Defendants are subject to the jurisdiction of this court in which venue also lies.

5. This is an action for declaratory judgment arising from Defendants' unlawful issuance and administration of the State of South Carolina EIP Standard Plan, a plan of health benefits and insurance offered to all current and retired state employees, including public school district employees, for violation of a SC Code Section 38-71-46, for disgorgement of revenues received as a result of the unlawful issuance and administration, and for declaration to determine the value of unlawfully withheld benefits.

CLASS ALLEGATIONS

6. The allegations of paragraphs 1-5 above are incorporated herein by reference as if restated hereby.

7. Plaintiff brings this action pursuant to SC Rule of Civil Procedure 23 as a representative of a class of persons who are currently, or since January 1, 2000 have been, employed by the State of South Carolina and who are diabetics or have dependants with diabetes and who have enrolled in the Defendant EIP's standard health benefit plan, as administered by Defendant BCBSSC.

8. Upon information and belief, the proposed class consists of several thousand State of South Carolina current and former employees with diabetes or enrolled dependants with diabetes who have made insurance claims for outpatient self-management training and education for the treatment of people with diabetes, and who have not received the legally-mandated coverage for said services.

9. Upon information and belief in 2008, there were approximately 178,000 current State of South Carolina employees, including K-12 school district employees. According to the

South Carolina Department of Health and Environmental Control 2009 published data, approximately 9.6% of the population of South Carolina is affected by diabetes. The exact number of class members is known to the Defendants and will be ascertained in discovery. That number is reasonably anticipated to exceed one thousand persons.

10. There are common questions of law and fact that are common to the Plaintiff and all other members of the proposed class and these questions predominate over issues, if any, that may affect individual class members. The illegal conduct of Defendants is common to all class members as are the claims asserted hereby. Among the issues of law and fact common to all class members are the following :

a. Does the described conduct of the Defendants' – the failure to provide and/or lawfully administer benefits for diabetes outpatient self-management training and education -- violate S.C. Code Section 38-71-46?

b. Are the class members entitled to have the terms of their health benefit plan (dating back to January 1, 2000) reformed to comply with the provisions of S. C. Code Section 38-71-46?

c. Are the class members entitled to a disgorgement of the revenues and other valuable consideration received by the Defendant EIP since January 1, 2000 from the failure to issue health benefit plan coverage for diabetes outpatient self-management training and education?

d. Are the class members entitled to a disgorgement of the revenues and other valuable consideration received by the Defendant BCBSSC since January 1, 2000 from the failure to lawfully administer said benefit plan in accordance with S. C. Code Section 38-71-46?

e. Are the class members entitled to receive from the Defendants the value those benefits

unlawfully issued and/or withheld since January 1, 2000?

f. Are the class members entitled to injunctive relief requiring the Defendants to comply with S.C. Code Section 38-71-46 in the future?

11. As the named Plaintiff is an employee of a South Carolina school district, has been enrolled in the EIP Standard Plan, has enrolled his dependent child in said plan who was diagnosed with Diabetes at the age of two years old, and has made multiple claims for his dependant child with a value of approximately One Thousand & 00/100 US Dollars ($1000.00) for diabetes outpatient self-management training and education which were denied by Defendant BCBSSC as administrator to the EIP, his claim, right and privileges are typical of the proposed class.

12. The interests of the Plaintiff are consistent with the interests of all other members of the putative class and he will represent adequately the interests of the class.

13. Counsel for the Plaintiff and the proposed class is by training and experience qualified to represent them within the context of this litigation.

14. Each member of the proposed class has been damaged in an amount in excess of one hundred ($100.00) dollars as required by S.C.R.C.P. 23(a); however, as a declaration of rights and privileges of the litigants is sought, as well as injunctive relief, the one hundred ($100.00) dollar requirement is not applicable, even though met.

15. Class action treatment of the matters and issues in this controversy is superior to the alternative of having thousands of state employees and retirees flooding the dockets of courts across South Carolina resulting from the unlawful actions of Defendants. Class adjudication will also provide the added benefit of permitting the adjudication of relatively narrow question of law – the application of S.C. Code Section 38-71-46 to the Defendants, and will

permit the adjudication of a large number of small claims against a state government and wealthy insurance Defendant against which litigation by individual plaintiffs most likely would not be possible.

16. While the claims and denial records of the Defendants are voluminous and the review and analysis of thousands of documents is anticipated, Plaintiff does not anticipate any difficulty in the overall management of this case.

FOR A FIRST CAUSE OF ACTION
(Declaratory Judgment/Reformation/Disgorgement/Payment)

17. Plaintiffs restate all allegations of Paragraph 1-16 as if included herein verbatim.

18. In their failure to issue and/or administer the State of South Carolina EIP Standard Benefit Plan in a manner which complies with the statutory mandate for coverage of all diabetes mellitus equipment, supplies, FDA approved medication, outpatient self-management training, and education, when medically necessary as defined by the statutory mandate, Defendants have violated the rights of the Plaintiff and putative class members not to be subject to contract in violation of express public policy.

19. Plaintiff seeks, individually and as legal guardian for Jane Doe, and on behalf of all class members, a declaration of the rights of the parties hereto: that Defendants are required to issue and administer all health benefit plans offered through the EIP in compliance with the express mandate of South Carolina Code Section 38-71-46.

20. Plaintiff seeks an Order of the Court reforming the terms of the health benefit plan provided to all class members effective January 1, 2000 to provide the mandated diabetes coverage.

21. Plaintiff seeks an Order of the Court requiring the Defendants to disgorge monies received as a result of unlawful denials of the mandatory diabetes coverage, and to pay them to members of the putative class the present value of said unlawfully withheld revenues.

FOR A SECOND CAUSE OF ACTION
(Injunctive Relief)

22. Plaintiffs restate all allegations of Paragraph 1-21 as if included herein verbatim.

23. The Defendants have issued and administered past and current health benefit plans in violation of S. C. Code Section 38-71-46, which provides the following:

Diabetes Mellitus coverage in health insurance policies, diabetes education.

(A) On or after January 1, 2000, *every health maintenance organization, individual and group health insurance policy, or contract issued or renewed in this State must provide coverage for* the equipment, supplies, Food and Drug Administration-approved medication indicated for the treatment of diabetes, and *outpatient self-management training and education for the treatment of people with diabetes mellitus*, if medically necessary, and prescribed by a health care professional who is legally authorized to prescribe such items and who demonstrates adherence to minimum standards of care for diabetes mellitus as adopted and published by the Diabetes Initiative of South Carolina. This subsection does not prohibit a health maintenance organization or an individual or a group health insurance policy from providing coverage for medication according to formulary or using network providers. Coverage must not be denied unless the health care professional demonstrates a persistent pattern of failure to adhere to the minimal standards of care and unless the health maintenance organization or insurer has first provided written notice to the health care professional that coverage will be denied if the health care professional fails to adhere to the minimal standards of care.

(B) Services and payment for diabetes education programs shall conform to regulations of the Health Care Financing Administration, US Department of Health and Human Services, pursuant to Section 4105 of the Balanced Budget Act of 1997. Diabetes outpatient self-management training and education shall be provided by a registered or licensed health care professional with certification in diabetes by the National Certification Board of Diabetes Educators, or other accredited program approved by the Diabetes Initiative of South Carolina, or by the Diabetes Control Program of the SC Department of Health and Environmental Control in order to meet the needs of rural communities wherein certified health care professionals providing this service are not available.

(C) Nothing contained in this section may be construed to affect in any way the ability of a managed care plan to credential or re-credential a provider.

(D) For purposes of this section: "*Health insurance policy" means a health benefit plan*, contract, or evidence of coverage providing health insurance coverage as defined in Section 38-71-670(6) and Section 38-71-840(14).

(emphasis added).

24. The Defendants should be enjoined from the wrongful takings as described above and from further denial of claims for the diabetes outpatient self-management training and education.

WHEREFORE, Plaintiff respectfully prays:

1. That he be allowed to serve as representatives of a class of persons as defined herein and that such class be certified;
2. That the Court declare the rights and obligations of the parties;
3. That the health benefits plans belonging to the class members be reformed as requested herein;
4. That a disgorgement of ill-gotten monies be ordered and that payment to class members be required of the present value of said wrongfully withheld benefits;
5. That Defendants be enjoined from future non-compliance with S.C. Code Ann. Section 38-71-46;
6. That the Plaintiff be awarded attorneys fees and cost; and
7. That the Court grant such other relief as it deems just and proper.

Respectfully submitted,

John A. Massalon
WILLS & MASSALON, LLC
Post Office Box 859
Charleston, South Carolina 29402
(843) 727-1144

-and-

Terry E. Richardson, Jr
Matthew D. Hamrick
Richardson, Patrick, Westbrook & Brickman, LLC
1017 Chuck Dawley Blvd.
Mt. Pleasant, SC 29464
(843) 727-6500

ATTORNEYS FOR PLAINTIFF

8

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	))))	IN THE COURT OF COMMON PLEAS FOR THE NINTH JUDICIAL CIRCUIT
Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees, Plaintiffs, v. South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina, Defendants.	)))))))))))))	Civil Action No.: 2009-CP-10-7404 **ANSWER**

FILED
2010 MAR 22 PM 1:03
JULIE J. ARMSTRONG
CLERK OF COURT
BY

Defendants, The South Carolina Budget and Control Board Employee Insurance Program ("EIP") and Blue Cross Blue Shield of South Carolina ("BCBSSC"), answering the complaint of the Plaintiff, allege as follows:

GENERAL RESPONSE

1. Each and every allegation of Plaintiff's Complaint not herein after specifically admitted, qualified, or explained is denied with strict proof demanded thereof.

ANSWERING GENERAL ALLEGATIONS

(Denial)

2. The allegations of Paragraph 1 are admitted upon information and belief.

TPW#1

3. Answering Paragraph 2, Defendants allege that EIP is a division of the South Carolina Budget and Control Board, which is an agency of the State of South Carolina. The remaining allegations of Paragraph 2 are denied with strict proof demanded thereof.

4. Answering Paragraph 3, Defendants allege that BCBSSC is a corporation organized and existing pursuant to the laws of the State of South Carolina, and at all times relevant hereto was acting as the claim administrator of the State Health Plan. The remaining allegations of Paragraph 3 are denied with strict proof demanded thereof.

5. The allegations of Paragraph 4 are denied with strict proof demanded thereof.

6. The allegations of Paragraph 5 are denied with strict proof demanded thereof.

ANSWERING CLASS ALLEGATIONS
(Denial)

7. Answering Paragraph 6, each and every allegation of Defendants' Answer is incorporated herein to the same extent as if set forth verbatim.

8. The allegations of Paragraphs 7, 8, 9 and 10 are denied with strict proof demanded thereof.

9. Answering Paragraph 11, Defendants allege that Plaintiff was an employee of a South Carolina School Districtand was enrolled in the State Health Plan-Standard Plan. Defendants further allege that Plaintiff enrolled his dependent child in the Plan, and that Plaintiff made claims for benefits for diabetes outpatient self-management training and education for his dependent, which claims were initially denied. Defendants further allege that Plaintiff appealed the denial of these claims and that as of the date of this answer, this appeal was still pending. The remaining allegations of Paragraph 11 are denied with strict proof demanded thereof.

10. The allegations of Paragraphs 12, 13, 14, 15 and 16 are denied with strict proof demanded thereof.

FOR A FIRST DEFENSE AS TO
PLAINTIFF'S FIRST CAUSE OF ACTION
(Declaratory Judgment/Reformation/Disgorgement/Payment)
(Denial)

11. Answering Paragraph 17, each and every allegation of Defendants' Answer is incorporated herein to the same extent as if set forth verbatim.

12. The allegations of Paragraphs 18, 19, 20 and 21 are denied with strict proof demanded thereof.

FOR A FIRST DEFENSE AS TO
PLAINTIFF'S SECOND CAUSE OF ACTION
(Injunctive Relief)
(Denial)

13. Answering Paragraph 22, each and every allegation of Defendants' Answer is incorporated herein to the same extent as if set forth verbatim.

14. The allegations of Paragraphs 23 and 24 are denied with strict proof demanded thereof.

FOR A SECOND DEFENSE AS
TO ALL CAUSES OF ACTION
(Failure To State a Claim)

15. Each and every allegation of Defendants' Answer is realleged herein as if set forth verbatim.

16. Plaintiff's Complaint fails to state sufficient facts to constitute causes of action.

FOR A THIRD DEFENSE AS
TO ALL CAUSES OF ACTION
(Failure Of Conditions Precedent)

TDW #3

17. Each and every allegation of Defendants' Answer is realleged herein as if set forth verbatim.

18. Plaintiff failed to plead and/or perform all conditions precedent required on his part to be performed under the Plan.

FOR A FOURTH DEFENSE AS TO ALL CAUSES OF ACTION (S.C. Code Ann. § 1-11-710(C))

19. Each and every allegation of Defendants' Answer is realleged herein as if set forth verbatim.

20. Plaintiff's causes of action are preempted by the exclusive statutory remedies in S.C. Code Ann. § 1-11-710 (C).

FOR A FIFTH DEFENSE AS TO ALL CAUSES OF ACTION (Failure To Exhaust Administrative Remedies)

21. Each and every allegation of Defendants' Answer is realleged herein as if set forth verbatim.

22. Plaintiff failed to exhaust the administrative remedies under the Plan as required by S.C. Code Ann. § 1-11-710 (C) and/or failed to exhaust the administrative remedies in a timely manner.

FOR A SIXTH DEFENSE AS TO ALL CAUSES OF ACTION (Lack of Jurisdiction)

23. Each and every allegation of Defendants' Answer is realleged herein as if set forth verbatim.

TDW #4

24. This Court lacks jurisdiction over this matter in that pursuant to S.C. Code Ann. § 1-11-710(C) and the procedures established by the South Carolina Budget and Control Board pursuant thereto as well as § 1-23-600 (D), any action reviewing a decision under the State Health Plan is subject to the exclusive jurisdiction of the Administrative Law Court.

FOR A SEVENTH DEFENSE AS TO ALL CAUSES OF ACTION (Plan Terms, Conditions and Exclusions)

25. Each and every allegation of Defendants' Answer is realleged herein as if set forth verbatim.

26. Plaintiff's claims are barred by, or his recovery is strictly limited by, the terms, conditions and exclusions of the Plan.

FOR AN EIGHTH DEFENSE AS TO ALL CAUSES OF ACTION (Statute of Limitations)

27. Each and every allegation of Defendants' Answer is realleged herein as if set forth verbatim.

28. Plaintiff's causes of action are barred by the applicable statutes of limitations.

FOR A NINTH DEFENSE AS TO ALL CAUSES OF ACTION (Laches)

29. Each and every allegation of Defendants' Answer is realleged herein as if set forth verbatim.

30. Plaintiff delayed in asserting that S.C. Code Ann. §38-71-46 applied to Plaintiff's claim for benefits under the State Health Plan and/or failed to exhaust administrative remedies under the Plan in a timely manner.

TDW #5

31. Plaintiff's delay was unreasonable and resulted in prejudice to Defendants. Plaintiff's causes of action are barred by the doctrine of laches.

FOR A TENTH DEFENSE AS TO ALL CAUSES OF ACTION (Unclean Hands)

32. Each and every allegation of Defendants' Answer is realleged herein as if set forth verbatim.

33. Plaintiff's causes of action are barred by the doctrine of unclean hands in that Plaintiff failed to assert the application of S.C. Code Ann. §38-71-46 during the claim process, and/or failed to exhaust administrative remedies under the Plan.

FOR AN ELEVENTH DEFENSE AS TO ALL CAUSES OF ACTION (Estoppel)

34. Each and every allegation of Defendants' Answer is realleged herein as if set forth verbatim.

35. Plaintiff failed to assert the application of S.C. Code Ann. §38-71-46 during the claim process and/or failed to exhaust administrative remedies under the Plan, which amounted to a false representation, or conduct which was calculated to convey the impression that the facts are otherwise than, and inconsistent with, those which the Plaintiff now attempts to assert.

36. Plaintiff intended that such conduct would be acted upon by Defendants, and Plaintiff had actual or constructive knowledge of Plaintiff's assertion.

37. Defendants lacked knowledge, and the means of knowledge, of the truth as to Plaintiff's assertion, and relied upon the conduct of Plaintiff, and prejudicially changed their

position in reliance on the conduct of Plaintiff. Plaintiff's causes of action are barred by the doctrine of estoppel.

FOR A TWELFTH DEFENSE AS TO ALL CAUSES OF ACTION (Waiver)

38. Each and every allegation of Defendants' Answer is realleged herein as if set forth verbatim.

39. Plaintiff's causes of action are barred by the doctrine of waiver in that Plaintiff failed to assert the application of S.C. Code Ann. §38-71-46 during the claim process and/or failed to exhaust administrative remedies under the Plan.

FOR A THIRTEENTH DEFENSE AS TO ALL CAUSES OF ACTION (Adequate Remedy at Law)

40. Each and every allegation of Defendants' Answer is realleged herein as if set forth verbatim.

41. Plaintiff's equitable causes of action fail in that Plaintiff failed to plead and/or prove that he had no adequate remedy at law.

FOR A FOURTEENTH DEFENSE AS TO ALL CAUSES OF ACTION (S.C. Code Ann. §38-71-46 Has No Application)

42. Each and every allegation of Defendants' Answer is realleged herein as if set forth verbatim.

43. S.C. Code Ann. § 38-71-46 does not apply to the State Health Plan.

FOR A FIFTEENTH DEFENSE AS TO ALL CAUSES OF ACTION (Venue Is Improper Pursuant to S.C. Code Ann. § 15-77-50)

TMH7

44. Each and every allegation of Defendants' Answer is realleged herein as if set forth verbatim.

45. Pursuant to S.C. Code Ann. § 15-77-50, venue is proper in Richland County.

FOR A SIXTEENTH DEFENSE AS TO ALL CAUSES OF ACTION (Venue Is Improper Pursuant to S.C. Code Ann. § 15-7-30)

46. Each and every allegation of Defendants' Answer is realleged herein as if set forth verbatim.

47. Pursuant to S.C. Code Ann. § 15-7-30, the convenience of witnesses and the ends of justice would be promoted by changing venue to Richland County.

FOR A SEVENTEENTH DEFENSE AS TO ALL CAUSES OF ACTION (Payment)

48. Each and every allegation of Defendants' Answer is realleged herein as if set forth verbatim.

49. Plaintiff and/or Plaintiff's medical provider were paid all benefits to which they were entitled under the terms of the Plan.

FOR AN EIGHTEENTH DEFENSE AS TO ALL CAUSES OF ACTION (Sovereign Immunity)

50. Each and every allegation of Defendants' Answer is realleged herein as if set forth verbatim.

51. Plaintiff's causes of action are barred by the doctrine of sovereign immunity.

FOR A NINETEENTH DEFENSE AS TO ALL CAUSES OF ACTION

TDW #6

(BCBSSC Not a Proper Party)

52. Each and every allegation of Defendants' Answer is realleged herein as if set forth verbatim.

53. BCBSSC is not a proper party in that it was merely the claims administrator of the Plan and not the insurer.

FOR A TWENTIETH DEFENSE AS TO ALL CAUSES OF ACTION
(Lack of Privity)

54. Each and every allegation of Defendants' Answer is realleged herein as if set forth verbatim.

55. Plaintiff's causes of action against BCBSSC fail in that Plaintiff lacks contractual privity with BCBSSC.

FOR A TWENTY-FIRST DEFENSE AS TO ALL CAUSES OF ACTION
(Ratification)

56. Each and every allegation of Defendants' Answer is realleged herein as if set forth verbatim.

57. Plaintiff's causes of action are barred by the doctrine of ratification.

FOR A TWENTY-SECOND DEFENSE AS TO ALL CAUSES OF ACTION
(Accord and Satisfaction)

58. Each and every allegation of Defendants' Answer is realleged herein as if set forth verbatim.

59. Plaintiff's causes of action are barred by the doctrine of accord and satisfaction.

FOR A TWENTY-THIRD DEFENSE AS

TDW #9

TO ALL CAUSES OF ACTION
(Lack of Standing)

60. Each and every allegation of Defendants' Answer is realleged herein as if set forth verbatim.

61. Plaintiff lacks standing to assert claim on behalf of the putative class.

WHEREFORE, having fully answered, Defendants pray that the Complaint of the Plaintiff be dismissed as to them with costs.

Theodore D. Willard, Jr.
MONTGOMERY WILLARD, LLC
1002 Calhoun Street
Post Office Box 11886
Columbia, South Carolina 29211
Telephone: (803) 779-3500

Kelly H. Rainsford
State Budget & Control Board
1201 Main Street, Ste. 300
Columbia, South Carolina
Telephone: (803) 734-2375
Fax: (803) 737-0825

ATTORNEYS FOR DEFENDANTS

March 19, 2010
Columbia, South Carolina

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	)	IN THE COURT OF COMMON PLEAS FOR THE NINTH JUDICIAL CIRCUIT
Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees, Plaintiffs, v. South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina, Defendants.	)	Civil Action No.: 2009-CP-10-7404 **CERTIFICATE OF SERVICE**

I, Tracey D. Smith, an employee of the law firm of Montgomery Willard, LLC, attorneys for the Defendants do hereby certify that I have served the below named counsel with a copy of the *Answer* by mailing a copy of same by United States mail, proper postage affixed, return address clearly marked, and addressed as follows:

John A. Massalon, Esquire
Wills & Massalon, LLC
Post Office Box 859
Charleston, South Carolina 29402

Tracey D. Smith

Tracey D. Smith

March 19, 2010
Columbia, South Carolina

RECEIVED
MAR 22 2010
Wills & Massalon

STATE OF SOUTH CAROLINA)	IN THE COURT OF COMMON PLEAS
)	FOR THE NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON)	
Jeffrey D. Allen, individually, as guardian) for Jane Doe, a minor, and as representative) of other similarly situated State of South) Carolina employees,)	Civil Action No.: 2009-CP-10-7404
Plaintiffs,)	**DEFENDANTS' NOTICE OF MOTION AND MOTION TO DISMISS AND FOR JUDGMENT ON THE PLEADINGS**
v.)	
South Carolina Budget and Control Board) Employee Insurance Program and Blue) Cross and Blue Shield of South Carolina,)	
Defendants.)	

FILED
2010 JAN -6 PM 4:38
JULIE J. ARMSTRONG
CLERK OF COURT

2010-2990

TO: John A. Massalon, Esquire, Attorney for Plaintiff:

YOU WILL PLEASE TAKE NOTICE that Defendants, South Carolina Budget and Control Board Employee Insurance Program ("EIP") and Blue Cross Blue Shield of South Carolina ("BCBSSC") by and through their undersigned counsel, will move before the Presiding Judge on the tenth (10th) day after service hereof, or as soon thereafter as the parties might be heard, pursuant to S.C.R.C.P. 12 (b) (1), 12 (b) (6) and 12 (c), for an order dismissing Plaintiff's Complaint and/or entering judgment on the pleadings for Defendants.

The grounds for this motion are as follows:

1. Plaintiff's causes of action are preempted by the remedies set forth in S.C. Code Ann. § 1-11-710 (C);

2. Plaintiff failed to exhaust his administrative remedies under the State Health Plan pursuant to S.C. Code Ann. § 1-11-710(C) and § 1-23-380;

3. This Court lacks subject matter jurisdiction over this matter in that pursuant to

S.C. Code Ann. § 1-23-600 (D), any action reviewing a decision under the State Health Plan is subject to the exclusive jurisdiction of the Administrative Law Court;

4. Plaintiff's causes of action as to BCBSSC fail in that BCBSSC is not the insurer of the State Health Plan, but merely the claim administrator; and

5. Plaintiff's equitable causes of action for reformation, disgorgement of benefits and injunction fail in that Plaintiff has an adequate remedy at law.

This motion is supported by the pleadings, any memorandum in support, any supporting affidavits and the applicable law.

Theodore D. Willard, Jr.
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Kelly H. Rainsford
State Budget & Control Board
1201 Main Street, Ste.300
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Telephone: (803) 734-2375
Fax: (803) 737-0825

ATTORNEY FOR DEFENDANTS

January 5, 2010
Columbia, South Carolina

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	FOR THE NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON	)	
Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees,	)	Civil Action No.: 2009-CP-10-7404
Plaintiffs,	)	
	)	**AFFIDAVIT OF ROBIN E. TESTER**
v.	)	
South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina,	)	
Defendants.	)	

Personally appeared before me, Robin E. Tester, who, after duly having been sworn, deposes and says:

1. He has personal knowledge of the matters contained herein and is authorized to give this affidavit.

2. He is employed by the State of South Carolina, State Budget and Control Board, Employee Insurance Program ("EIP") as the Director of Employee Insurance Program.

3. The Group Health Benefits Plan of the Employees of the State of South Carolina, the Public School Districts, and Participating Entities ("State Health Plan") is a self-funded health plan for state employees, which is administered by the South Carolina Budget and Control Board, Employee Insurance Program ("EIP").

4. Blue Cross Blue Shield of South Carolina ("BCBSSC") is the claims administrator for the State Health Plan. BCBSSC is not an insurer of the State Health Plan.

5. Upon information and belief, Jeffrey D. Allen was a participant of the State of South Carolina health plan.

6. Plaintiff's complaint alleges that Jeffrey Allen filed a claim for benefits under the State of South Carolina health plan for benefits for diabetes outpatient, self-management training and education, which claim Plaintiff alleges was denied.

7. EIP has no record of Jeffrey D. Allen requesting an appeal of the alleged denial of benefits to the EIP Health Appeals Committee as is required under the procedures set out in the State Health Plan. Therefore, Jeffrey D. Allen failed to exhaust his administrative remedies.

8. Pursuant to the terms of the State Health Plan, in order to challenge a denial of benefits, participants and/or beneficiaries are required to exhaust their administrative remedies by appealing the denial of benefits. A true and correct copy of the applicable State Health Plan is attached hereto as Exhibit A.

9. The State Health Plan states in relevant part:

> **12.5 Review of Claims Denied in Whole or Part**
>
> If the Third Party Claims Processor, or the Utilization Review Agency or their designee determines that any person who has submitted a claim for the payment or pre-certification of benefits under the Plan is not entitled to receive all or part of the benefits sought, the Third Party Claims Processor, Utilization Review Agency or their designee, shall inform the claimant of such determination and the reasons therefore, with specific reference to pertinent provisions of the Plan. The exclusive remedy for the denial of benefits shall be as provided by statute and by the procedures of the Budget and Control Board.(Emphasis added).
>
> A. **Reconsideration by Third Party Claims Processor or Utilization Review Agency.** A Covered Person, after receipt of notification of the Third Party Claims Processor's or the Utilization Review Agency's action on his claim, must request a review of any benefits denied in whole or in part within six months of notice of the denial of benefits by the Third Party Claims Processor or the Utilization

Review Agency. To request a review of that agency's decision, the Covered Person must write the appropriate agency giving reasons why the claim should be approved. The claimant may also request an expedited reconsideration of the decision denying benefits.

The Third Party Claims Processor or the Utilization Review Agency shall render its decision within 60 days after the request for review is received, unless medical records are requested, in which case the decision will be rendered no later than 30 days after the requested information is received. If the requested information is not received within 30 days, the decision will be made on the information available at that time. The decision shall be made by one not involved in the original decision to deny benefits or pre-certification. The reconsideration under this section shall be exhausted before any appeal to the Plan Administrator. The Third Party Claims Processor or the Utilization Review Agency will send the Covered Person a written decision stating the specific reasons for its final decision with specific reference to pertinent Plan provisions.

B. Appeal of Denial of Benefits to Plan Administrator. After the review provided in 12.5.A, a Covered Person, who is informed that the claim has been denied in whole or in part, or that benefits will not be paid, and who desires review of that determination, may request from the Plan Administrator's director a review of that decision within 90 days after notice of the denial of benefits after reconsideration. The filing of an appeal shall be deemed to be consent for the director or his designee to review all medical records necessary for a determination of the appeal. To hear the appeal, the director may appoint up to five representatives, who are familiar with group health benefits and the State Health Plan and who have not been involved in the denial of benefits in the case under consideration.

The director, or his designees, may request from the Third Party Claims Processor information reviewed by it, including the pertinent medical records, and may request any additional information from the Third Party Claims Processor, the Utilization Review Agency or the claimant, or from independent medical personnel or other source as in their judgment may be required to make a determination. The director or his designees shall consider all information submitted, the terms and conditions of the Plan and shall render a decision within 30 days of the receipt of any requested material, providing reasons for the decision and citation of any applicable Plan provisions.

The director, or his designee, shall provide specific reasons for the decision and citation of the pertinent Plan provisions, and may, if the director or his designee agrees with the Third Party Claims Processor or Utilization Review Agency, deny the claim of the Covered Person, and if he agrees with the Covered Person, approve the claim or such portion as is

appropriate, provided, however, the director, or his designee, must state in writing the provisions of the Plan justifying the result. The decision of the director, or his designee, on these matters is binding and conclusive, subject to review pursuant to 12.6.

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

12.6 Legal Actions
The exclusive remedy for the denial of benefits shall be as provided in 12.5 and by judicial review of that decision under 1976 S.C. Code Ann § 1-23-380. (as amended) as provided by statute. No appeal may be brought until a Covered Person has exhausted the review procedure set forth in 12.5, nor will such action be brought after the expiration of the applicable period for commencing such actions, following the occurrence giving rise to the action. Any construction or interpretation of the Plan, determination of eligibility, or any other decision arising under the Plan, or exercise of judgment or discretion given to the Plan Administrator by the Plan or Planholder, shall be binding and conclusive so long as the decisions of the Plan Administrator or its duly authorized agent are not arbitrary or capricious or in violation of applicable statutes. (Emphasis added).

10. The Insurance Benefits Guide ("IBG") additionally informs participants exactly how to pursue appeals under the State Health Plan. A true and correct copy of that portion of the applicable IBG addressing appeals is attached hereto as Exhibit B.

Robin E. Tester

Sworn to before me this
5th day of January, 2010

Notary Public for South Carolina
My Commission Expires:

My Commission Expires
October 13, 2013

ARTICLE 1.

ESTABLISHMENT AND PURPOSE OF PLAN

1.1 Name and Purpose

The name of this Plan is the Group Health Benefits Plan of the Employees of the State of South Carolina, the public school districts, and participating entities (hereinafter "Plan"). The State of South Carolina (hereinafter the State), through the Employee Insurance Program (EIP) has established a self-funded employee welfare benefit plan for the exclusive benefit of the participants and has adopted this Plan. The purpose of this Plan is to provide for the payment of sickness, accident, or other benefits to the participants of this Plan and their eligible dependents.

1.2 Establishment and Effective Date

This Plan is a continuation of and replaces the Health Benefits Plan initially established on July 1, 1972, and this Plan became effective January 1, 2009.

1.3 Applicable Law

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

1.4 Entire Plan

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

1.5 Plan Description

The Plan Administrator shall provide to Employees who are Covered Persons a summary plan description containing the benefits of this Plan and the rights and obligations of Covered Persons under this Plan.

1.6 Changes to Plan

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

1.7 Effect of Changes

All changes to this Plan shall become effective as of a date established by the Plan Administrator EXCEPT that:

A. No increase or reduction in benefits shall be effective with respect to Covered Expenses incurred prior to the date a material change was adopted by the Planholder, regardless of the effective date of the change; and,

B. No change shall become effective with respect to any Covered Person who was hospitalized on the effective date of such change until the date such person ceases to be hospitalized.

1.8 Termination of Plan

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

1.9 Written Notice

Any written notice required by law shall be deemed received by a Covered Employee if sent by regular mail, postage prepaid, to the last address of such Covered Employee on the records of the Plan Administrator.

1.10 Waiver

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

1.11 Clerical Error or Delay

Clerical errors made by EIP, or its agents, on the records of the Plan Administrator, Third Party Claims Processor or Utilization Review Agency, and delays in making entries on such records shall not invalidate coverage that otherwise would be validly in force or cause coverage to be in force or to continue in force which would otherwise be terminated. Upon discovery of any such error or delay, an equitable adjustment will be made not to exceed 12 months contribution by the Employee.

1.12 Workers' Compensation

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

1.13 Gender

The use of masculine pronouns in this Plan shall apply to persons of both sexes unless the context clearly indicates otherwise.

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

1.15 Misstatements and Omissions
If any relevant fact has been misstated or omitted, in whole or in part, whether intentional or not, by, or on behalf of, any person on an application, on the Notice of Election Form, or other document, or information submitted or required to be submitted to the Plan Administrator, Third Party Claims Processor or Utilization Review Agency to obtain or retain coverage under this Plan, the true facts shall be used to determine whether coverage is in force and the extent, if any, of such coverage. Upon the discovery of any such misstatement or omission, coverage may be terminated retroactively to the date of the misstatement or omission, and an equitable adjustment of any contributions will be made if this is in order and the Plan Administrator may recover the amount of any claims paid in error due to the misstatement or omission.

1.16 Use of Social Security Numbers on Application
The Plan is required by federal law to obtain the Social Security Account Number of each subscriber and dependent. The Employee's or the Retiree's Social Security Account Number, as well as the Benefits Identification Number (BIN), and address will be used as the identification number and address for the Dependents of the Employee or Retiree.

ARTICLE 2.

DEFINITIONS

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

2.1 Active Employee
A permanent, Full-Time Employee of the State, who receives compensation from a department, agency, board, commission or institution of the state or a public school district or a participating entity.

2.2 Active Employment
The Employee is performing all the regular duties of his occupation at an established business location of the Employer or another location to which he may be required to travel to perform the duties of his employment. An Employee shall be deemed to be engaged in Active Employment on holidays or vacation days established and published

by the Employer if the Employee was engaged in Active Employment on the last preceding regular working day. In no event will an Employee be considered to be in Active Employment if he has not reported for work or if he or his Employer has effectively terminated his employment.

2.3 Provider Billed Charges

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

2.4 Acute Medical Illness

A serious illness requiring immediate medical attention as directed by the Physician; an illness which could result in subsequent death and/or an emergency occurring at a time other than during normal office daytime hours of a licensed Physician.

2.5 Agent for Service of Process

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

2.6 Alcoholism

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

2.7 Alcoholism Treatment Center

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

2.8 Allowable Charge

A Provider's actual charge, or the amount established by the Plan Administrator in the Schedule of Reimbursement Rates for the Physician Network, whichever is less. For charges not included in the Schedule of Reimbursement Rates, the Allowable Charges shall mean an amount measured and determined by comparing it with the charges customarily made for similar services to individuals of similar medical condition in the locality concerned. In the absence of data referred to above, the Third Party Claims Processor, through its medical staff and/or medical consultants, will determine the Allowable Charge based upon comparable or similar services or procedures.

2.9 Alternative Treatment Plan

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

the treating Physician, the Plan Administrator and the patient, and notification of the approved Alternative Treatment Plan to the Third Party Claims Processor.

2.10 Ambulatory Surgical Center

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

A. It is established, equipped and operated in accordance with the applicable laws of the jurisdiction in which it is located primarily for the purpose of performing surgical procedures;

B. It is operated under the supervision of a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is devoting full time to such supervision and permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform such procedure in at least one Hospital, as defined in this Plan, in the area;

C. It requires in all cases, other than those requiring only local infiltration anesthetics, that a licensed anesthesiologist or a certified registered nurse anesthetist administer the anesthetics and remain present throughout the surgical procedure;

D. It provides at least two operating rooms and at least one post-anesthesia recovery room; is equipped to perform diagnostic x-ray and laboratory examinations; and has available, to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to a defibrillator, a tracheotomy set, and a blood bank or other blood supply;

E. It provides the full-time services of one or more registered graduate nurses (R.N.) for patient care in the operating rooms and in the post-anesthesia recovery room;

F. It maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications or require post-operative confinement;

G. It maintains an adequate medical record for each patient, such record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or x-rays, an operative report and a discharge summary.

2.11 Ambulatory Surgical Center Network

A group of ambulatory surgical centers, which have contracted with the Plan Administrator to accept from the State a payment methodology for medical services rendered by the Ambulatory Surgical Center to Covered Persons of the Plan.

2.12 Behavioral Health Disorders

Neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind or other condition that is defined, described or classified as a psychiatric disorder or condition in the latest publication of the American Psychiatric

Association entitled *Diagnostic and Statistical Manual of Mental Disorders*, or other similar authority generally recognized by Behavioral Health Providers, and which is not otherwise excluded by the terms and conditions of this Plan.

2.13 Behavioral Health Manager

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

2.14 Behavioral Health Provider

A Physician, psychiatrist, health professional or any other entity or institutional health care provider under agreement to participate in a Behavioral Health Provider network administered by the Behavioral Health Manager.

2.15 Benefit Year

A period of 12 consecutive months commencing with the first day of January and ending with the last day of December.

2.16 Bodily Injury and Sickness

All bodily injuries sustained by an individual in connection with any one accident. The term "sickness" shall include covered pregnancy, as defined herein, disease, mental illness, and functional nervous disorder.

2.17 Child

An Employee's natural or adopted child, stepchild, foster child or child for whom the Employee has legal custody, and who resides in the Employee's home in a parent-child relationship, or for whom the Employee provides support and maintenance because of a Court order.

2.18 Clerical Error

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

2.19 Coinsurance

That percentage of the Reasonable and Customary Charges for Covered Medical Expenses, in excess of the individual or family Deductible, that is payable by the Covered Employee under the Plan selected.

2.20 Congenital

Existing and apparent or manifest at, and usually before, birth.

2.21 Co-payment

A fixed amount established by the Plan payable by the Covered Employee for a service.

2.22 Covered Dependent

A Dependent of a Covered Employee, who has met the eligibility requirements and is

enrolled under the Plan and to whom benefits are payable under this Plan.

2.23 Covered Employee

An Employee or Retiree who has met the eligibility requirements and is enrolled under this Plan and to whom benefits are payable under this Plan.

2.24 Covered Hospital Services

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

2.25 Covered Medical Expense

The Market Charge or per diem rate, as determined by the Plan Administrator, for each Diagnosis Related Groups (DRG) category, or for those not included in a DRG category, a Reasonable and Customary expense, or where applicable under this Plan an Allowable Charge, for medical services and supplies Medically Necessary in the diagnosis or treatment of an illness or injury, performed and reimbursed in the least costly setting required by the Covered Person's condition, and which are within the benefits provided in the Plan and not otherwise excluded by any term, condition, limitation or exclusion of this Plan.

2.26 Covered Person

An Employee, Retiree, Surviving Dependent Child/Surviving Spouse, or COBRA enrollee, or a Dependent thereof, who has met the eligibility requirements and is enrolled in this Plan and to whom benefits are payable under this Plan.

2.27 Creditable Coverage

For purposes of applying the Pre-existing Condition exclusion, prior coverage under a group health plan or insurance coverage or health benefits provided by certain state and federal statutes, as described or defined in the Health Insurance Portability and Accountability Act of 1996 and regulations.

2.28 Custodial Care

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

2.29 Customary Charge or Reasonable and Customary Charge

The Market Charge as determined by the Plan Administrator for each DRG category. For other charges not included in a DRG category, the Customary Charge or Reasonable and Customary Charge shall mean an amount measured and determined by comparing it with the charges customarily made for similar services and supplies to

individuals of similar medical condition in the locality concerned. In the absence of data as referred to above, the Third Party Claims Processor will, through its medical staff and/or medical consultants, determine the Reasonable and Customary Charge based upon comparable or similar services or procedures.

2.30 Deductible

The amount indicated in 7.1.A.1, or 7.1.B.1 for the Plan selected during enrollment. In the event that two or more Covered Persons of one Family incur charges for Covered Medical Expenses as a result of injuries received in the same accident, only one Deductible amount will be deductible from the aggregate of all charges for Covered Medical Expenses which are incurred by all such Covered Persons as a result of injuries in the same accident.

2.31 Dependent

Shall mean and include a Covered Employee's:

A. Legally recognized spouse, or former spouse who is required to be covered by either a divorce decree or court order, but not both. Provided, however, that if a spouse is also eligible for coverage or benefits as an Employee of the State, school district or a participating entity, the spouse is eligible for coverage only as an Employee and not as a Dependent. However, a Part-Time Teacher who is the spouse of a Covered Employee may be covered as either an Employee or as a Dependent, but not as both;

B. Unmarried Child under 19 years of age, who is principally dependent (more than fifty percent) upon the Covered Employee for maintenance and support. The Plan Administrator may require the Covered Employee to submit due proof of the Dependent Child relationship with the Covered Employee within 31 days of enrollment, and at such other reasonable times;

C. Unmarried Child, over 19 years of age, who is incapable of self-sustaining employment because of mental illness, retardation or physical handicap and is principally dependent (more than fifty percent) on the Covered Employee for maintenance and support, provided that the Child was covered continuously under the Plan or a Predecessor Plan, prior to the date of incapacitation. The Plan Administrator may require the Covered Employee to submit due proof of such incapacity and dependency satisfactory to the Plan Administrator within 31 days of initial enrollment, upon attaining age 19 and at such other reasonable times, but not more frequently than annually. It shall be the Employee's responsibility to notify the Plan Administrator when the Child is no longer incapacitated;

D. Unmarried Child, over 19 years of age, but under 25 years of age, who is a Full-Time Student as defined in 2.45, and is principally dependent (more than fifty percent) upon the Covered Employee for maintenance and support. The Plan Administrator may require the Covered Employee to submit due proof of such Full-Time Student status and dependency satisfactory to the Plan Administrator within 31 days of enrollment, upon attaining age 19 and at such other reasonable times, but not more frequently than annually. It shall be the Employee's responsibility to

notify the Plan Administrator when the Child is no longer a Full-Time Student.

2.32 Diagnosis Related Groups (hereinafter "DRG")

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

2.33 Drug Abuse

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

2.34 Durable Medical Equipment

Any equipment which:

A. Can withstand repeated use; and

B. Is primarily and customarily used to serve a medical purpose; and

C. Is generally not useful to a person in the absence of illness or injury; and

D. Is appropriate for use in the home.

2.35 Effective Date

Shall mean:

A. With respect to the Plan, the date on which this Plan takes effect;

B. With respect to a Covered Person, the date on which such person is first covered under this Plan.

2.36 Eligible Expense

A Covered Medical Expense as that term is defined in the Plan.

2.37 Employee

A person employed by the State on a permanent and Full-Time basis who works continuously for more than one year, and who receives compensation from a department, agency, board, commission or institution of the State, including clerical and administrative employees of the General Assembly, and judges in the State courts. For purposes of this Plan, the term shall include other Employees that the General Assembly has made eligible for coverage by statute, including Employees of a school district, county, municipality, or other State-Covered Entity that has qualified for and is participating in coverage under the Plan. The members of the South Carolina General Assembly and elected members of the councils of participating counties or

municipalities, whose council members participate in the South Carolina Retirement Systems, and Part-Time Teachers, are also Employees for purposes of the Plan.

2.38 Employer

A department, agency, board, commission or institution of the State, including the General Assembly, the State courts and school districts and participating entities, that hire and provide compensation to an Employee.

2.39 Enrollment Date

For purposes of determining Creditable Coverage and applying the Pre-existing Condition exclusion, (1) for Employees, the hire date; (2) for persons who enroll under the special eligibility situations of paragraphs 3.7 and Late Entrants, the effective date of coverage; and (3) for Retirees, the retirement date.

2.40 Expense Incurred

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

2.41 Extended Role Nurse or Advanced Practice Registered Nurse

An individual who has satisfied the State Board of Nursing's requirements as a nurse practitioner, certified nurse midwife, certified registered nurse anesthetist or clinical nurse specialist, who is functioning in the extended or advanced practice registered nursing role, and who is in independent practice. The Plan only recognizes a certified nurse midwife licensed by the State Board of Nursing as a Provider for purposes of midwife coverage. A lay midwife or a midwife licensed by the Department of Health and Environmental Control (DHEC) is not recognized, or reimbursed, as a Provider, by the Plan.

2.42 Family

A Covered Employee and his Covered Dependents, if any.

2.43 Free Standing Emergency Care Center

An ambulatory facility designed as a place for acute medical treatment. The Free Standing Emergency Care Center includes a specialty facility for industrial accidents and a community based emergency care center provided that they are not designed to house or hospitalize patients after the initial acute treatment. The emergency room of a Hospital is not a Free Standing Emergency Care Center.

2.44 Full-Time

With regard to an Employee shall mean a permanent Employee who works at least 30 hours per week continuously for more than one year. Provided, however, an Employer may exercise a one-time, irrevocable option to elect the definition of Full-Time to mean at least 20 hours per week continuously for more than one year, and to apply this definition, upon notification and acceptance by EIP.

2.45 Full-Time Student

A Dependent Child who has not attained the age of 25 and is enrolled in and attending:

A. High school. Correspondence course participation does not constitute attendance as a Full-Time Student under this section; or

B. An accredited or licensed school, which is commonly recognized as a vocational, technical or trade school, if such scheduled attendance qualifies for Full-Time Student status under the rules of the institution. Correspondence course participation does not constitute attendance as a Full-Time Student under this section; or,

C. A college or university with such enrollment in at least enough regular academic courses to attain the status of a Full-Time Student at the institution. A time period between graduation from high school and college entry, or between college graduation and graduate school entry, shall be included only if such Child has made application for admission beginning with the next regular semester immediately following graduation. Time periods between semesters, such as summer periods shall be included if such Child was attending as a Full-Time Student during the immediately preceding regular semester, quarter or summer school session. Correspondence course participation does not constitute attendance as a Full-Time Student under this section.

Except as provided above, a Child shall cease to be a Dependent eligible for coverage as a Full-Time Student at 12 midnight on the last day of the month after: (1) attaining the age of 25; or (2) notice that the Child ceased being a Full-Time Student by not attending school for any reason other than injury or sickness which prevents the student from attending, provided such Child would otherwise be a Full-Time Student but for such injury or sickness; or (3) failure to provide evidence of Full-Time Student status as required by 2.31.D.

2.46 Health Care Professional

A Physician or other licensed health care provider acting within the scope of the license.

2.47 Home Health Care

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

2.48 Hospice

A private or public agency or organization that administers and provides care for terminally ill patients (1) pursuant to a written treatment plan approved by a Physician and reviewed at least once a month by the Physician, and (2) is licensed or certified as a Hospice or Hospice care agency by the appropriate state regulatory agency, if licensing is required.

2.49 Hospital

A. For other than a psychiatric facility, a short-term acute care (1) general Hospital, (2) children's Hospital, (3) eye, ear, nose and throat Hospital, or (4) maternity Hospital, licensed by the state in which it operates that, for compensation from its patients and on an inpatient basis, is primarily engaged in providing diagnostic and therapeutic facilities for the medical or surgical diagnosis and treatment of injured or sick persons, by or under the supervision of a staff of Physicians duly licensed to practice medicine, and that provides continuous 24 hours-a-day services by licensed, registered, graduate nurses physically present and on duty.

B. A psychiatric facility for the treatment of Behavioral Health Disorders, drug addiction or alcoholism for compensation from their patients and on an inpatient basis, and which is engaged in providing diagnostic and therapeutic care by or under the supervision of a staff of Physicians duly licensed to practice medicine to persons suffering from mental or nervous conditions or drug or alcohol dependency, and which provides continuous 24 hours-a-day services by licensed, registered, graduate nurses physically present and on duty. Such institutions or facilities for Behavioral Health Disorders, or drug addiction or alcoholism, if located in South Carolina must be licensed by the State of South Carolina and if located outside of South Carolina must be approved by the Joint Commission on Accreditation of Hospitals;

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

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

2.50 Hospital or Ambulatory Surgical Center Miscellaneous Charges

The Reasonable and Customary charges, or the Market Charge, where payment is by DRG category, for necessary services, medicines, supplies for diagnosis or treatment of an illness or injury (except services of a Physician and drugs or supplies not consumed or used in the Hospital) while the Covered Person is Hospital confined and a charge is made for Room and Board, or if such services are rendered in connection with a surgical procedure performed on an "outpatient" basis by a Hospital or Ambulatory Surgical Center.

2.51 Hospital Network

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

2.52 Intensive Care Unit

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

A. It is solely for the treatment of patients who require special medical attention because of their medical condition;

B. It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital;

C. It provides a concentration of special life-saving equipment immediately available at all times for the treatment of patients confined within such area;

D. It contains at least two beds for the accommodation of critically ill patients; and

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

2.53 Intermittent

As that term is used in 7.11 Hospice care and 7.13 Home Health Care services, shall mean part-time (less than, or up to, four hours) Skilled Nursing or Home Health care that is provided on a less than daily basis, or if provided on a daily basis (not to exceed eight hours per day), for temporary and definitely fixed periods of time up to 21 days with such extensions for additional fixed and definite periods of time that, at the discretion of the Plan Administrator, may be granted when there are exceptional circumstances and the period of such extension is predictable and fixed. Intermittent care is subject to the requirements of pre-approval by the Utilization Review Agency, and all monetary limitations on such benefits in 7.11 Hospice Care and 7.13 Home Health Care services.

2.54 Late Entrant

A Full-Time Employee, and any Dependent of that Employee, as those terms are defined in the Plan, who did not enroll, or was not enrolled, within 31 days of that person's first date of eligibility for enrollment in a plan of benefits offered by the State, and who subsequently enrolls in the Plan. A Late Entrant is subject to the Preexisting Condition exclusion for 18 months after coverage commences. Provided, however, that any person who qualifies for enrollment under the special eligibility situations of paragraph 3.7, and meets the requirements thereof or who becomes eligible for retirement under the South Carolina Retirement Systems, shall not be considered a Late Entrant if enrolled or re-enrolled in the Plan within the time period provided by the Plan.

2.55 Market

The aggregation of peer group hospitals based on criteria established by the Plan

Administrator.

2.56 Market Charge

The amount determined by the Plan Administrator to be the prevailing charge for a specific DRG category within a specified market.

2.57 Medical Care

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

2.58 Medical Necessity; Medically Necessary or Necessary Service and Supply

A procedure, service or supply that meets all of the following criteria:

A. Is required to identify or treat an existing condition, illness or injury; and

B. Is prescribed or ordered by a Physician; and

C. Is consistent for treatment of the Covered Person's illness, injury, or condition, and is rendered in accordance with recognized, appropriate medical and surgical practices prevailing in the medical specialty or field of medicine at the time rendered; and

D. Is required for reasons other than the convenience of the patient; and

E. Results in measurable, identifiable progress in treating the Covered Person's condition, illness, or injury.

The fact that a service or supply is prescribed by a Physician, or that a Physician asserts that a procedure, service or supply is necessary to avoid the potential onset of a condition or abnormality in the future, does not necessarily mean that such service is Medically Necessary or meets the definition of Medical Necessity in this Plan.

2.59 Obstetrical Care

Services for the prenatal and postpartum care and delivery of one or more fetuses including Cesarean section, miscarriage, or abortion.

2.60 Open Enrollment Period

A period in which eligible Employees and Retirees may enroll or disenroll themselves and/or eligible Dependents in the Program without regard to any special eligibility situations. An Open Enrollment was held in October 2007, for a January 1, 2008, effective date of coverage. An Open Enrollment period will be held in October every two years thereafter. Changes made during the Open Enrollment Period will become effective the following January 1.

2.61 Orthopedic Appliance

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

2.62 Outpatient

A Covered Person who is treated at a Hospital and is not confined for the Room and Board charge.

2.63 Out-of-Pocket Limitation

For Covered Medical and Behavioral Health Expenses, the total of the eligible coinsurance payable by the Covered Employee in one Plan Year for individual or family Covered Medical and Behavioral Health Expenses, in excess of the individual or family Deductible, before the Plan provides coverage for 100 percent of the Reasonable and Customary Charges for Covered Medical Expenses and Behavioral Health Expenses; for covered prescription drug expenses, shall mean the total of the eligible co-payments payable by a Covered Person in one Plan Year for covered prescription drug expenses before the Plan provides coverage for 100 percent of the Allowable Charges for covered prescription drug expenses.

2.64 Partial Hospitalization Programs

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

2.65 Part-Time Teacher

A teacher employed by a school district, the South Carolina Department of Corrections, or the South Carolina Department of Juvenile Justice, on a permanent and part-time basis working at least 15, but no more than 29, hours a week continuously for more than one year.

2.66 Pharmacy Benefits Manager

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

2.67 Physician

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

2.68 Physician Network

Those health care providers who have contracted with the Plan Administrator or Third Party Claims Processor to accept from the State a standard payment methodology for their services rendered to Employees, Retirees and their Dependents.

2.69 Plan

This Group Health Benefits Plan for the Employees of the State of South Carolina, the Public School Districts and Participating Entities. The Plan is composed of the Savings

Plan, the Standard Plan and the Medicare Supplemental Plan.

2.70 Planholder

The State of South Carolina, which provides the health plan for its Full-Time Employees, Retirees and others by statute through the Employee Insurance Program acting on behalf of the State Budget and Control Board.

2.71 Plan Administrator

The Employee Insurance Program of the State Budget and Control Board.

2.72 Plan Year

The 12-month period of time beginning January 1 and ending December 31, 2009.

2.73 Predecessor Plan

(1) The Employee Health Benefit Plan of the State that was in effect immediately before the effective date of this Plan or (2), prior coverage in which a Covered Person was enrolled immediately prior to enrollment in this Plan, which qualifies as Creditable Coverage, pursuant to the Health Insurance Portability and Accountability Act of 1996.

2.74 Pre-Certification or Certification

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

2.75 Pre-existing Condition

Any medical condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended by, or received from, a licensed health care provider or practitioner in the six months preceding the Covered Person's Enrollment Date under the Plan. Benefits for a pre-existing condition are payable only for treatment rendered 12 months after the Enrollment Date of a Covered Person, or 18 months after the Enrollment Date for a Late Entrant; provided, however, that Creditable Coverage without a break in coverage of greater than 62 days prior to the Enrollment Date is applied toward the waiting period for services related to a pre-existing condition to be payable. Pregnancy does not constitute a pre-existing condition.

2.76 Prescription Drug Program

The network of pharmacies that have agreed to accept a standard payment methodology for prescription drugs, provide drug utilization review of the appropriateness of the medication and its use, provide a drug formulary consisting of Tier 2 drugs obtainable at lower cost, and the Pharmacy Benefits Manager which processes drug claims and coordinates the activities of the Prescription Drug Program.

2.77 Professional Ambulance

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

2.78 Program

The Medical Benefits program provided for the Employees of the State of South Carolina, the Public School Districts, and Participating Entities, including the Plan, and participating Health Maintenance Organization (HMO) plans. Covered Employees shall have the option annually, during the month of October, of changing plans offered as part of the Program. Changes made during the October enrollment period become effective the following January 1.

2.79 Prosthetic Appliance

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

2.80 Provider

A Physician, Extended Role Nurse, Advanced Practice Registered Nurse, Behavioral Health Provider or Hospital as those terms are defined in this Plan.

2.81 Allowed Amount

The Market Charge as determined by the Plan Administrator for each DRG category. For other charges not included in a DRG category, the Customary or Reasonable and Customary Charge shall mean an amount measured and determined by comparing it with the charges customarily made for similar services and supplies to individuals of similar medical condition in the locality concerned. In the absence of data as referred to above, the Third Party Claims Processor will, through its medical staff and/or medical consultants, determine the Reasonable and Customary Charge based upon comparable or similar services or procedures.

2.82 Retiree

An Employee who is retired under the terms and conditions of the State Retirement Systems and meets one or more of the following eligibility requirements in order to participate in the State's Plan of Benefits. For employees who were hired before May 2, 2008, an eligible retiree shall be defined as:

A. A person covered by the Plan who terminates employment with at least 20 years of earned service credit with a State-Covered Entity before eligibility for retirement under a State retirement system is eligible for the Plan effective with the date of retirement under a State retirement system, if the last five years are consecutive and in a Full-Time, permanent position with a State-Covered Entity. Provided, however, that a person covered by the Plan who terminated employment with at least 18 years earned service credit with a State-Covered Entity before eligibility for retirement under a State retirement system prior to 1990 is eligible for the Plan effective on the date of retirement, if this person returns to a State-Covered Entity and is covered by the Plan and completes at least two consecutive years in a full-time permanent position prior to the date of retirement.

B. A member of the General Assembly, who leaves office or retires with at least eight years of credited service in the General Assembly Retirement System, is eligible to

participate in the Plan by paying the full premium costs as determined by the State Budget and Control Board.

C. Former municipal and county council members, who have served on council for at least 12 years and were covered under the State's plans at the time of termination from council, are eligible to continue the state insurance benefits by paying full premium costs, provided the county or municipal council elects to allow this coverage for former members.

D. An Active Employee covered by the Plan and retiring with 10 or more years of State-Covered Entity service credited under a State retirement system is eligible for state-paid premiums, if the last five years of service are consecutive and in a Full-Time permanent position with a State-Covered Entity. Special conditions apply to the following:

1. A person covered by the Plan, who has attained the age of 55, has at least 25 years of credited service under a State-Covered Entity and elects early retirement must pay the full premium costs as determined by the State Budget and Control Board until the earlier of attaining age 60 or the date the person would have 28 years' creditable service if early retirement had not occurred.

2. A person covered by the Plan, who has at least 25 years credited service under a State-Covered Entity, and who purchases up to three years of additional service credit under the "Special Monthly Contributor Provision" and retires, shall pay the full premium costs as determined by the State Budget and Control Board for the service credit purchased.

E. A person covered by the Plan who retires with at least five years of service with a State-Covered Entity credited under a State retirement system is eligible to participate in the Plan by paying the full premium costs as determined by the State Budget and Control Board, provided the last five years are consecutive and in a Full-Time permanent position with a State-Covered Entity.

F. All Employees of State-Covered Entities whose most recent hire date was before July 1, 1984, who were or would have been eligible for the Plan upon completion of five years of service are exempt from the provisions of this section and are eligible for the Plan, effective on the date of their retirement, provided the last five years are consecutive and in a Full-Time permanent position with a State-Covered Entity.

G. Those Retirees, who by the terms of their retirement, are covered by the Plan but are not receiving any State contribution to their premium for health insurance.

For employees hired on or after May 2, 2008, an eligible retiree shall be defined as:

A. An active employee covered by the Plan, who retires with at least five (5) years of earned retirement service credit under a State retirement system with a State-Covered Entity, is eligible to participate as a retiree in the Plan if the last five (5)

years of the person's covered employment were consecutive and in a full-time permanent position.

B. A person covered by the Plan who terminates employment before the person's date of retirement with at least twenty (20) years of earned retirement service credit under a State retirement system with a State-Covered Entity is eligible to participate as a retiree in the Plan on the person's date of retirement under a State retirement system, if the last five (5) years of the person's covered employment before termination were consecutive and in a full-time permanent position.

C. A retired state employee or a retired employee of a public school district who retires under a State retirement system and who is eligible for Plan coverage under the provisions of item (A) or (B) of this section, is eligible for trust fund paid premiums as follows:

(a) If the retiree's earned service credit in a State retirement system is five (5) or more years but fewer than fifteen (15) years with a State-Covered Entity, then the retiree shall pay the full premium for the Plan.

(b) If the retiree's earned service credit in a State retirement system is more than fifteen (15) years, but fewer than twenty-five (25) years with a State-Covered Entity, then the retiree is eligible for fifty percent trust fund paid premiums and the retiree shall pay the remainder of the premium cost.

(c) If the retiree's earned service credit in a State retirement system is twenty-five (25) or more years with a State-Covered Entity, then the retiree is eligible for trust fund paid premiums and the retiree is responsible for the entire employee premium.

D. If a retiree under a State retirement system was employed by an entity that participates in the Plan pursuant to the provisions of Section 1-11-720 and is eligible to participate in the Plan as a retiree pursuant to the provisions of item (A) or (B) of this section, then the retiree's employer, at its discretion, may elect to pay all or a portion of the premium for the retiree's Plan.

E. Those Retirees, who by the terms of their retirement, are covered by the Plan but are not receiving any state contribution to their premium for health insurance.

2.83 Room and Board

Room, board, general duty nursing, and any other services, supplies, or items regularly furnished by the Hospital and included in the total charge as a condition of occupancy of the class of accommodations occupied, including blood. Room and board does not include professional services of Physicians or intensive nursing care by whatever name called.

2.84 Schedule of Reimbursement Rates

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

2.85 Second Opinion

A second opinion shall mean and consist of the Covered Person obtaining a second opinion from a qualified Physician regarding the Medical Necessity of a recommended, elective, non-emergency surgical procedure, medical procedure or treatment or hospitalization for treatment of mental illness or chemical dependency prior to undergoing or continuing the treatment, hospitalization or procedure.

2.86 Semi-Private Room

A Hospital room containing two or more patient beds.

2.87 Significant Break in Creditable Coverage

For purposes of applying the Pre-existing Condition limitation, a period of 63 consecutive days during which the individual does not have any Creditable Coverage, except that neither a waiting period, nor an affiliation period, is taken into account in determining a Significant Break in Creditable Coverage.

2.88 Skilled Nursing Care

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

2.89 Skilled Nursing Facility

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

A. Maintains permanent and full-time facilities for bed care of resident patients; and

B. Has available at all times the services of a Physician; and

C. Has a registered nurse (R.N.) or Physician on full-time duty in charge of patient care, and one or more registered nurses (R.N.) or licensed practical nurses (L.P.N.) on duty at all times; and

D. Maintains a daily medical record for each patient; and

E. Is primarily engaged in providing continuous skilled nursing care for sick or injured persons during the convalescent stage of their illness or injuries and is not, other than incidentally, a rest home or a home for custodial care or for the aged; and

F. Is operating lawfully as a nursing home in the jurisdiction where it is located; in no event, however, shall such term include an institution or facility primarily engaged in the care or treatment of substance abuse or Alcoholism.

2.90 State-Covered Entity

Any State agency, public school district, or any other entity granted by statute the right to

participate in the Plan and participating in the Plan.

2.91 Subscriber

An Active or Retired Employee, Surviving Dependent Child/Surviving Spouse or COBRA enrollee of a State-Covered Entity.

2.92 Surgery

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

2.93 Surviving Dependent Child

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

2.94 Surviving Spouse

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

2.95 Third Party Claims Processor

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

2.96 Transplant Network

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

2.97 Utilization Review Agency

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

ARTICLE 3.

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

3.1 Eligibility

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

A. All Full-Time Employees, as defined in 2.37 and 2.44, and their Dependents, as defined in 2.31, provided however, that a spouse or a child of a Covered Employee who is also an Employee may be covered only as an Employee and not as a Dependent.

B. All Full-Time Employees who are on leave without pay status or disabled but not retired status, and their Dependents, as defined in 2.31, for up to one year. The Employer may apply to the Plan Administrator to extend leave without pay status for an Employee beyond one year with demonstration of extraordinary circumstances. The Plan Administrator shall have the sole discretion to determine if leave without pay status may be extended beyond one year;

C. All Retirees, as defined in 2.82, and their Dependents, as defined in 2.31;

D. The Surviving Spouse, as defined in 2.94, and Covered Dependent Child, as defined in 2.31, of a deceased Covered Employee, as defined in 2.23 and 2.93;

E. All Employees and Dependents eligible for coverage as the result of COBRA in Article 11;

F. All Part-Time Teachers, as defined in 2.65, and their Dependents, as defined in 2.31, provided however, that a Part-Time Teacher who is the Spouse of a Covered Employee who is an Employee may be covered as either an Employee or as a Dependent, but not as both.

3.2 Employee Enrollment

To enroll under this Plan, each eligible Employee must complete within 31 days of his eligibility for coverage: (1) a Notice of Election, and (2) any other forms required by the Plan Administrator. If the Employee fails to complete such timely Notice of Election, payroll deduction authorization form, and other required forms within 31 days following the Employee's eligibility date, and such Employee is not eligible for coverage under 3.7,

Special Eligibility Situations, such Employee may be enrolled for coverage only during such Open Enrollment Periods as may be established by the Plan Administrator.

3.3 Commencement of Employee Coverage

Employee coverage under this Plan shall commence as follows:

A. Each Employee in Active Employment, who did not elect coverage under this Plan or a State approved Health Maintenance Organization (HMO) plan when first eligible and subsequently elects coverage under this Plan as a Late Entrant by filing a timely Notice of Election form during an Open Enrollment Period and satisfying the other conditions, shall be covered under this Plan on the subsequent January 1, provided that the Employee is on Active Employment on the first working day of that month. Otherwise, coverage commences on the first day of the following month;

B. Each new Employee, who becomes eligible for coverage after the Effective Date of this Plan, and who has elected coverage by filing a timely Notice of Election, shall be covered under this Plan (1) on the first day of the month that the Employee commences Active Employment provided that the Employee commences Active Employment on the first calendar day of that month; or (2) on the first day of the following month provided that the Employee commences Active Employment on any day other than the first calendar day and the first working day of the month. Otherwise, if the Employee commences Active Employment on the first working day of the month, other than the first calendar day of the month, the Employee may choose to commence coverage under this Plan on either the first day of that month or the first day of the following month.

For purposes of this paragraph, the first working day of the month is the first day that is not a Saturday, Sunday, or holiday. The first working day of the month is not an Employer-specific first working day.

3.4 Eligibility for Dependent Coverage

Each Employee, who has one or more Dependents on the date he becomes eligible for coverage, shall be eligible to enroll for Dependent Coverage on such date. Each Employee without a Dependent on the date he becomes eligible for coverage shall be eligible to enroll each Dependent for coverage on the date he acquires a Dependent, provided in both cases the Employee has met the requirements of 3.5 below.

3.5 Dependent Enrollment

To obtain Dependent Coverage under this Plan, each eligible Employee must: (1) be covered under this Plan, (2) file a timely Notice of Election form selecting Dependent Coverage for eligible Dependents and (3) agree in writing to make any required contributions toward the cost of the Dependents' coverage prior to his eligibility date. If the Employee acquires a Dependent as defined herein after the Effective Date of his coverage, the Employee has 31 days from the date the Dependent was acquired to enroll the Dependents in this Plan. If the Employee fails to notify the Plan Administrator within the 31-day period of time, the Dependent may be enrolled for coverage only

during such Open Enrollment periods under such conditions as may be established by the Plan Administrator.

3.6 Commencement for Dependent Coverage

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

3.7 Special Eligibility Situations

A. The spouse of an Employee, who was covered as an Employee under another employer's health plan, and any Dependent covered under the spouse's plan including the Employee, who subsequently loses coverage because that employer canceled its present group insurance, the employer canceled its contribution to its group insurance, or the spouse of the employee left such employment, is eligible for coverage under this Plan commencing on the date of loss of coverage, provided that a satisfactory statement of the circumstances surrounding the loss of coverage accompanies the revised Notice of Election.

B. An Employee, and any Dependent of an Employee, who loses coverage as a Dependent under another employer's health plan as the result of separation or divorce or other similar involuntary loss of coverage, is eligible for coverage under this Plan commencing on the date of loss of coverage provided that a satisfactory statement of the circumstances surrounding the loss of coverage accompanies the Notice of Election.

C. Coverage under the special eligibility situations in Paragraph A and B above commences upon the date of loss of the earlier coverage, and those eligible under Paragraph A and B are not considered Late Entrants, provided that such persons comply with the requirements of sections 3.2 and 3.5 within 31 days of the loss of coverage.

D. An Employee, and any Dependent of an Employee, who was called to active duty with the National Guard or a Reserve unit, or who was mobilized and who dropped coverage under this Plan or under an HMO offered by the State as an alternative to this Plan, upon discharge or release from active duty and resumption of employment with an eligible Employer, may re-enroll in this Plan. The time period for exclusions based upon pre-existing condition commences upon the original date of employment, and not the date of re-employment.

E. Notwithstanding any other provisions, an Employee may enroll for coverage for the Employee and all eligible Dependents provided that (1) the Employee is eligible for coverage under the Plan but is not currently enrolled; (2) the Employee declined coverage under the Plan when it was offered previously; (3) another individual (a spouse or child) has become a Dependent of the Employee through marriage, birth, adoption or placement for adoption; and (4) the request for enrollment is made within 31 days of the events described in (3) above. Coverage for the

Employee and any Dependent enrolled under this paragraph shall commence on the day of the qualifying event.

3.8 Termination of Employee's Coverage

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

A. Termination of the Employee's employment;

B. The date the Employee ceases to qualify as an Employee;

C. The date the Employee ceases to be in a class of Employees eligible for coverage;

D. Sixty days from the date that the Employee's contribution for coverage is due;

E. The date coverage is discontinued with respect to the class of Employees to which such Employee belongs;

F. The date this Plan is terminated with respect to all Employees;

G. Provided, however, that when an Employee requests the termination of coverage during the Open Enrollment period, coverage will terminate at midnight the following December 31st;

H. Provided, however, that coverage of an Employee ceases on the day following the date of death of the Employee.

3.9 Termination of Dependent's Coverage

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

A. The date the Employee ceases to be in a class of Employees eligible for Dependent coverage under this Plan;

B. The date all Dependent coverage under this Plan terminates;

C. Sixty days from the date that the Employee's contribution for coverage is due;

D. The date that any particular Dependent ceases to be a Dependent of the Employee as defined in 2.31. The existing coverage of any Surviving Dependent Child will not be affected by the remarriage of the Surviving Spouse;

E. The 31st day after the date of birth of a newborn, unless the Employee has enrolled the newborn as required by paragraph 3.5, or under such conditions as established by the Planholder;

F. Provided, however, that when an Employee requests the termination of dependent coverage during the Open Enrollment period, coverage will terminate at midnight the following December 31st;

G. Provided, however, that coverage of a Dependent ceases on the day following the date of death of the Dependent or the Employee, however after death of the Employee, coverage of the Dependent may continue under Article 10, Continuation of Coverage, or Article 11 COBRA.

3.10 Effect of Divorce or Annulment on Dependent Eligibility

A former Dependent Child of an Employee or Retiree, whose coverage terminated upon the Child's marriage, shall again be eligible for coverage upon the Child's divorce or annulment, if the conditions of paragraph 2.31 B, C, or D are met.

3.11 Retiree Enrollment

A. An Employee, who is covered under this Plan or an HMO approved by the State as an alternative to this Plan, at the time he elects retirement, may elect coverage under this Plan as a Retiree by completing within 31 days of eligibility for coverage: (1) Notice of Election, and (2) any other forms required by the Plan Administrator. If the Employee fails to complete such Notice of Election, retirement check authorization form, and other required forms within 31 days following the Employee's eligibility date, such Employee may be enrolled for coverage only during such Open Enrollment periods as may be established by the Plan Administrator.

B. An Employee, who is not covered by this Plan or an HMO approved by the State as an alternative to this Plan, at the time he elects retirement, may enroll as a Retiree by completing within 31 days of eligibility for coverage as a Retiree: (1) Notice of Election, and (2) any other forms required by the Plan Administrator. If the Employee fails to complete such Notice of Election, retirement check deduction authorization form, and other required forms within 31 days following the Employee's eligibility date, such Employee may be enrolled for coverage only during such Open Enrollment periods as may be established by the Plan Administrator.

C. Medicare Supplemental Plan Open Enrollment was held in October 2007 for an effective date of coverage on January 1, 2008. An Open Enrollment period will be held every two years thereafter. During the enrollment period, the eligible Retiree may change from or to the Medicare Supplemental coverage. Coverage changes will become effective the following January 1.

3.12 Enrollment of Dependents of the Retiree

A. A Dependent of an Employee, who is covered under this Plan or an HMO approved by the State as an alternative to this Plan, at the time the Employee elects retirement, and any Dependent acquired after retirement, may be covered

as the Dependent of a Retiree under this Plan provided that the Employee/ Retiree completes within 31 days of eligibility for coverage as a Retiree, or the date the Dependent was acquired after retirement: (1) Notice of Election, and (2) any other forms required by the Plan Administrator. If the Employee fails to complete such Notice of Election and other required forms within 31 days following the Employee's eligibility date, the Dependent may be enrolled for coverage only during such Open Enrollment periods as may be established by the Plan Administrator.

B. A Dependent of an Employee, who is not covered by this Plan or an HMO approved by the State as an alternative to this Plan, at the time the Employee elects retirement, may be enrolled as the Dependent of a Retiree by completing within 31 days of the Employee's eligibility for coverage as a Retiree: (1) Notice of Election, and (2) any other forms required by the Plan Administrator. If the Employee fails to complete such Notice of Election, retirement check deduction authorization form, and other required forms within 31 days following the Employee's eligibility date, the Dependent may be enrolled for coverage only during such Open Enrollment periods as may be established by the Plan Administrator.

C. A Medicare Supplemental Plan Open Enrollment was held in October 2007 for an effective date of coverage on January 1, 2008. An Open Enrollment period will be held every two years thereafter. During the enrollment period, the eligible Retiree may change from or to the Medicare Supplemental coverage. Coverage changes will become effective the following January 1.

3.13 Open Enrollment

An Open Enrollment Period was held in October 2007 for an effective date of coverage on January 1, 2008. An Open Enrollment Period will be held during the month of October every two years thereafter. During the Open Enrollment Period, the eligible subscriber is given an opportunity to add or drop themselves or eligible dependents to or from coverage. Changes made during the Open Enrollment Period will become effective the following January 1. No other coverage changes may be made until the next Open Enrollment Period except in situations described in paragraph 3.7, Special Eligibility Situations, or the following:

1. Dependent Children:

A. May be added within 31 days of birth, adoption or legal custody;

B. May be added within 31 days of when they are no longer covered under other group insurance because the employer discontinued such insurance, the employer canceled its contribution to its group insurance, or the parent lost coverage due to employment termination, and provided that proof of loss of coverage is supplied;

C. May be added within 31 days of when they are acquired by marriage, so long as they are living in a parent-child relationship with the Employee or Retiree;

D. Must be dropped when dependency ends at age 19, unless approved as an incapacitated dependent, or unless proof of Full-Time Student status is provided for dependents age 19 through 24;

E. Must be dropped at age 25 and older (regardless of whether a Full-Time Student) unless approved as an incapacitated dependent;

F. Must be dropped upon marriage of the Dependent, upon full-time employment of the Dependent, or when the Dependent is no longer principally dependent (more than fifty percent); upon the Employee or Retiree.

G. May be dropped within 31 days of acquisition of other group coverage, provided proof of such coverage is established.

2. Dependent Spouse:

A. May be added within 31 days of marriage; or

B. May be added within 31 days of loss of coverage because such group insurance was discontinued by the employer, the employer canceled its contribution to its group insurance, or employment was terminated, and provided that proof of loss of coverage is supplied;

C. Must be dropped from Dependent status when they are eligible to enroll as a State Employee or Retiree;

D. May be dropped within 31 days of when they are divorced or legally separated; or

E. May be dropped within 31 days of acquisition of other group coverage, provided proof of such coverage is established.

3. A Covered Employee or Retiree may select coverage under the Plan or a Participating HMO within the Program annually during the month of October.

3.14 Commencement of Coverage for Retiree and Dependents

Retirees and Dependents, who are Covered Persons under this Plan or an HMO approved by the State as an alternative to this Plan, at the time of the retirement of the Employee, and who are re-enrolled as Covered Persons at the time of retirement, remain covered under this Plan. Retirees and Dependents, who are not Covered Persons under this Plan or an HMO approved by the State as an alternative to this Plan, at the time of the retirement of the Employee, and who are enrolled in this Plan at the time of retirement, shall be covered on the first day of the month following the approval of the application for enrollment as a Retiree or Dependent under this Plan. A Dependent who is acquired after retirement, and enrolled within 31 days of the date the Dependent is acquired, shall be covered from the date the Dependent was acquired. A Retiree, not otherwise eligible for coverage as a Retiree, who is approved for disability benefits through the South Carolina Retirement Systems (SCRS), shall have the

coverage under the Plan commence no earlier than the first day of the month following SCRS' approval of the disability.

3.15 Termination of Retiree's Coverage

Except as provided in Article 10, Continuation of Coverage, or Article 11, COBRA, the coverage of a Retiree shall cease as of midnight on the last day of the month following:

A. The date the Retiree ceases to be in a class of Retirees eligible for coverage under this Plan;

B. The date the Retiree ceases to be in a class eligible for coverage;

C. Sixty days from the date the Retiree fails to make the required contribution for coverage;

D. The date coverage is discontinued with respect to the class of Retiree to which such Retiree belongs;

E. The date this Plan is terminated with respect to all Retirees;

F. Provided, however, that when a retiree requests the termination of coverage during the Open Enrollment period, coverage will terminate at midnight the following December 31st.

G. Provided, however, that coverage of a Retiree ceases on the day following the date of death of the Retiree.

3.16 Termination of Coverage of Dependent of Retiree

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

A. The date the Retiree ceases to be in a class of Employees eligible for Dependent coverage under this Plan;

B. The date all Dependent coverage under this Plan terminates;

C. Sixty days from the date that the Retiree's contribution for coverage is due;

D. The date that any particular Dependent ceases to be a Dependent of the Employee as defined in 2.31. The existing coverage of any Surviving Dependent Child will not be affected by the remarriage of the Surviving Spouse;

E. Provided, however, that when an Retiree requests the termination of dependent coverage during the Open Enrollment period, coverage will terminate at midnight the following December 31st;

F. Provided, however, that coverage of a Dependent ceases on the day following the date of death of the Dependent or the Retiree. However, after death of the Retiree,

coverage of the Dependent may continue under Article 10, Continuation of Coverage, or Article 11, COBRA.

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

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

ARTICLE 4.

PAYMENT OR REIMBURSEMENT OF MEDICAL EXPENSES

4.1 Payment for Medical Care

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

4.2 Changes to Plan

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

ARTICLE 5.

CONTRIBUTIONS

5.1 Employee Contribution

To be covered under this Plan, each eligible Active Employee or Retiree shall contribute the amount determined by the State for each Plan Year for the benefit plan the Employee selects, commencing with the pay period in which coverage starts under this Plan. Each eligible Employee or Retiree, who elects to have his Dependents covered under this Plan, shall contribute the amount determined for each Plan Year by the State for the benefit plan the Employee selects commencing with the pay period in which such Dependents' coverage starts. The Plan Administrator reserves the right at any time to alter, amend, change, supplement, revoke or reduce the benefits under this Plan or increase or decrease the premiums charged under this Plan.

5.2 Contribution of Entire Premium

To be covered under this Plan, the following persons eligible for coverage shall contribute the full amount of the premium determined for each Plan Year by the State for the type of coverage selected, commencing with the period in which the person elects coverage in the categories listed below. These individuals are not eligible to receive any State contribution for health insurance:

A. Full-Time Employees who elect leave-without-pay status;

B. A Surviving Spouse (excluding a Spouse who is a State Employee) and eligible Dependents of a deceased Active or Retired Employee who elect coverage under Article 10, Continuation of Coverage, provided, however:

1. The full premium for coverage for the Surviving Spouse (who is not a State Employee) and/or Dependent of a deceased Active or Retired Employee, who elected coverage under the Savings Plan, the Standard Plan or the Medicare Supplemental Plan and for which there was a State contribution to the premium is waived for one year after the Active or Retired Employee's death; and

2. Provided, however, that following the one-year waiver, the premium for coverage for the Surviving Spouse and/or Dependent of a deceased Active or Retired Employee who was killed in the line of duty after December 31, 2001, and while working for a State-Covered Entity; for whom there was a state contribution to the premium, may contribute the amount determined under 5.1 as long as eligible.

C. Those electing to extend coverage as provided in Article 11 under COBRA;

D. Those hired on or after July 1, 1984, and who retired with five years, but less than 10 years, active service;

E. Those Retirees who, by the terms of their retirement, are covered by the Plan but are not receiving any State contribution to their premium for health insurance.

ARTICLE 6.

DUTIES AND RESPONSIBILITIES

6.1 Planholder Duties

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

A. The appointment or removal of the Plan Administrator, Third Party Claims Processor, Utilization Review Agency and other entities or their delegates that implement the Plan;

B. The design of this Plan, including the right to amend this Plan and any other document relating to this Plan;

C. The qualification of this Plan under the applicable law;

D. The formation and maintenance of the funding policy of this Plan;

E. The amendment and termination of this Plan;

F. The determination of the amount of participant contributions under this Plan;

G. The exercise of all functions provided in this Plan, or as may be necessary to the operation of this Plan, except such functions as are assigned to others pursuant to this Plan.

6.2 Plan Administrator Duties

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

A. To administer this Plan according to its terms and to be accountable to the State with regard to the administration of this Plan;

B. To construe and interpret this Plan in a nondiscriminatory manner; to decide all questions of eligibility; and to determine all questions arising in the administration and application of this Plan;

C. To determine the types of benefits allowable under this Plan;

D. To be responsible for the reporting and disclosure requirements imposed upon administrators under applicable law;

E. To receive from the State and from Employee participants and Dependents such information as shall be necessary for the proper administration of this Plan, and to furnish the State, upon request, such reports with respect to the administration of this Plan as are reasonable and appropriate;

F. To receive, review and keep on file (as it deems convenient or proper) reports of the financial condition, and of the receipts and disbursements;

G. To maintain all records of this Plan;

H. To review as necessary, all claims for benefits under this Plan;

I. To determine the manner and time of payment of benefits under this Plan;

J. To apprise the State as to the amounts and timing of disbursements for payment of benefits and expenses under this Plan;

K. To prescribe procedures to be followed by participants and dependents in filing claims for benefits under this Plan;

L. To furnish the State such reports with respect to the processing and payment of claims under this Plan as are reasonable and appropriate;

M. To do all other acts or things as may be necessary for the proper administration of this Plan.

6.3 Duties and Powers of Third Party Claims Processor

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

A. To act under the direction and control of the Plan Administrator;

B. To receive, review and verify and investigate as necessary, all claims for benefits under this Plan;

C. To determine the amounts, manner and item of payment of benefits under this Plan;

D. To apprise the Plan Administrator as to the amounts and dates of disbursements for payment of benefits and expenses under this Plan;

E. To receive from the State, the Plan Administrator, the Utilization Review Agency and participants and Dependents such information as shall be necessary for the proper processing and payment of claims under this Plan;

F. To furnish the Plan Administrator, upon request, such reports with respect to the processing and payment of claims under this Plan as are reasonable and appropriate;

G. To maintain records relating to claims for benefits, processing of claims, and payment or denial or claims for benefits;

H. To administer contracts between the Plan Administrator and providers as a part of a provider network;

I. Any other related duties.

6.4 Duties and Powers of Utilization Review Agency

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

A. To act under the direction and control of the Plan Administrator;

B. To receive, review and verify and investigate and monitor as necessary, all requests for pre-certification required under the Plan including, but not limited to, non-emergency Hospital admissions, surgical procedures, length of stay limitations, and extended care benefits provided under this Plan; and to conduct and monitor and undertake a concurrent review of hospitalizations and conduct individual case management as necessary and all other utilization review activity required by this Plan;

C. To apprise the Plan Administrator and Third Party Claims Processor, if applicable, as to the Utilization Review Agency's determination as to Pre-certification, extended care benefits, concurrent review of hospitalization, case management, maternity management, behavioral health case management and other utilization review activities as may affect the amounts and timing of the payment of benefits under this Plan;

D. To receive from the State, the Plan Administrator, the Third Party Claims Processor and participants and dependents such information as shall be necessary for the proper processing and administration of the utilization review activities under the Plan;

E. To furnish the State and the Plan Administrator upon request, and Third Party Claims Processor, if applicable, such reports with respect to the utilization review activities under this Plan as are reasonable and appropriate;

F. To maintain records relating to pre-certification, extended care benefits, concurrent review of hospitalization, case management and other utilization review and case management activities required by the Plan;

G. To perform DRG validation audits and administer out-of-state policy as related to the Plan's Hospital Network;

H. To do such other acts as may be necessary, or as requested by the Plan Administrator, or required by the contract between the Plan Administrator and the Utilization Review Agency to properly handle the administration of the utilization review activities under this Plan.

ARTICLE 7.

SCHEDULE OF BENEFITS

7.1 Covered Medical Expenses

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

A. Savings Plan

1. Deductible. The annual individual Deductible shall be $3,000, and a Covered Person shall pay annually the first $3,000 of Covered Medical Expenses incurred in one Plan year before becoming eligible for Plan benefits. There is no individual Deductible if more than one family member is covered. The annual Family Deductible shall be $6,000. The annual Family Deductible is not considered satisfied for any Covered Person until the Family's total Covered Medical Expenses exceed $6,000. Payment of Deductible amounts, by any two or more Family members, totaling $6,000 of Covered Medical Expenses for that Plan year, shall satisfy the Deductible for all Covered Persons in that Family. In order for the Employee, and his employed spouse, who is also covered as an Employee, to share the same plan family deductible, both spouses must select the Savings Plan.

2. Coinsurance. After the individual or Family Deductible has been paid during the Plan year, the Savings Plan will pay 80 percent of the Covered Person's Covered Medical Expenses in excess of the deductible, provided, however, the Plan will pay 60 percent of the Covered Person's Covered

Medical Expenses if a Covered Person uses a Provider that is not participating in the Plan's Physician or Hospital Networks.

3. Penalty. A patient, who is a Covered Person, who does not obtain Pre-certification from the Utilization Preview Agency as required by Article 15, shall, in addition to the normal Deductible, and all other terms and conditions of the selected Plan, be subject to a $200 penalty for each admission to a Hospital or Skilled Nursing Facility. No amount of a penalty incurred by a Covered Person shall be applied or counted towards the coinsurance amount required to be paid.

4. Out-of-Pocket Limitation. For care delivered within the Plan's networks, after the annual Deductible has been paid and a Covered Person has incurred in the Plan year Coinsurance of $2,000 for Covered Medical Expenses, or Coinsurance of $4,000 for Covered Medical Expenses incurred in the Plan year by any combination of family members, the Plan will pay 100 percent of the allowable cost of the Covered Person's Covered Medical Expenses, up to the Benefit Maximum for each Covered Person, for the rest of the Plan year. Provided, however, for a Covered Person using a Physician or Hospital that is not participating in the Plan's networks, the Out-of Pocket Limitation is Coinsurance of $4,000 for Covered Medical Expenses in one Plan Year, or Coinsurance of $8,000 for Covered Medical Expenses incurred in one Plan Year by any combination of Family members, after which the Plan will pay 100 percent of Covered Medical Expenses up to the Benefit Maximum for each Covered Person for the rest of the Plan Year. Provided further, that: (1) the penalty in paragraph 3 above, or (2) Covered Medical Expenses incurred because of a failure to notify or follow utilization review procedures required by Article 15, are not included in those expenses used to satisfy the Out-of-Pocket Limitation, and provided further, that the Covered Medical Expenses incurred for such treatment or during such admission are always subject to Coinsurance.

5. Eligible Expense Limitations. The payments for Covered Medical Expenses that may satisfy the Deductible and Out-of-Pocket Limitations provisions of 7.1.A.1 and 7.1.A.4 are those incurred by one or more Covered Family members enrolled in the Savings Plan. Deductible and Coinsurance amounts made under the Medicare Supplemental Plan or the Standard Plan may not be used to satisfy the requirements of 7.1.A.1 and 7.1.A.4.

B. Standard Plan

1. Deductible. The annual individual Deductible shall be $350, and a Covered Person shall pay annually the first $350 of Covered Medical Expenses incurred in the Plan Year before becoming eligible for Plan benefits. The annual Family Deductible shall be $700. Payment of Deductible amounts by any two or more Family members totaling $700 of Covered Medical Expenses for that Plan Year shall satisfy the Deductible for all Covered Persons in that Family. In the event that two or more Covered Persons of one Family incur charges for Covered Medical Expenses as a result of injuries received in the same accident, only one Deductible will be deducted from the aggregate of all

charges for Covered Medical Expenses which are incurred by all such Covered Persons as a result of injuries in the same accident. In order for the Employee, and his employed spouse covered as an Employee, to share the same plan family deductible, both spouses must select the same plan.

2. **Coinsurance.** After the individual or family deductible has been paid for the Plan year, the Standard Plan will pay 80 percent of the Covered Person's Covered Medical Expenses in excess of the deductible, provided, however, the Plan will pay 60 percent of the Covered Person's Covered Medical Expenses if a Covered Person uses a Provider that is not participating in the Plan's Physician or Hospital Networks.

3. **Penalty.** A patient or Covered Person who does not obtain Pre-certification from the Utilization Review Agency as required by Article 15, in addition to the normal Deductible, and all other terms and conditions of the selected Plan, shall be subject an additional $200 penalty for each admission to a Hospital or Skilled Nursing Facility.

4. **Out-of-Pocket Limitation.** For care delivered within the Plan's Networks, after the annual Deductible has been paid and a Covered Person has incurred Coinsurance of $2,000 for Covered Medical Expenses in the Plan Year, or Coinsurance of $4,000 for Covered Medical Expenses have been incurred in the Plan Year by any combination of Family members; the Plan will pay 100 percent of Covered Medical Expenses up to the Benefit Maximum for each Covered Person for the rest of the Plan Year. Provided, however, for a Covered Person using a Physician or Hospital that is not participating in the Plan's networks, the Out-of-Pocket Limitation is Coinsurance of $4,000 for Covered Medical Expenses in one Plan Year, or Coinsurance of $8,000 for Covered Medical Expenses incurred in one Plan Year by any combination of Family members, after which the Plan will pay 100 percent of Covered Medical Expenses up to the Benefit Maximum for each Covered Person for the rest of the Plan Year. Provided further, that:

(1) the penalty in paragraph 3 above, or

(2) Covered Medical Expenses incurred because of a failure to notify or follow utilization review procedures required by Article 15, are not included in those expenses used to satisfy the Out-of-Pocket Limitation, and provided further, that the Covered Medical Expenses incurred for such treatment or during such admission are always subject to Coinsurance.

5. **Eligible Expense Limitations.** The payments for Covered Medical Expenses that may satisfy the Deductible and Out-of-Pocket Limitations provisions of 7.1.B.1 and 7.1.B.4 are those incurred by one or more Covered Family members under the Standard Plan, so long as all members of the Family are enrolled in the same Plan. Deductible and Coinsurance amounts paid under the Medicare Supplemental Plan or Savings Plan may not be used to satisfy the provisions of 7.1.B.1 and 7.1.B.4.

6. **Per Occurrence Deductibles** In addition to the Deductible referenced

in Section 7.1.B.1, separate per occurrence deductibles will be applied under the Standard Plan, in the following circumstances:

a. $125 per Emergency Room visit, to be waived if the patient is admitted to the hospital.

b. $75 per Outpatient Hospital visit, to be waived for Emergency Room services, physical therapy services, speech therapy services, occupational therapy services, oncology services, dialysis, routine mammograms, routine pap tests, clinic visits (an office visit at an outpatient facility), electric-convulsive therapy and psychiatric medication management.

c. $10 per office visit Deductible, to be waived for routine Pap smears, routine mammograms and well child care visits.

Per Occurrence Deductibles are not included in those expenses used to satisfy the Out-of-Pocket Limitation of 7.1.B.4.

7.2 Benefit Maximum

All payments made under this Plan, and any successor plan, for services or supplies provided to, or on behalf of, a Covered Person shall be included to determine if the amounts paid reach or exceed the maximum benefit, regardless of whether the payments were for medical services or supplies received by the Covered Person as a Dependent, Employee or Retiree, and regardless of any break in coverage.

The maximum amount payable for all benefits is $1,000,000 for each Covered Person.

7.3 Covered Medical Expense

Shall mean the Market Charge or per diem rate as determined by the Plan Administrator for each DRG category, or for those not included in a DRG category, a Reasonable and Customary or, if applicable, an Allowable Charge, for medical services and supplies that are Medically Necessary in the diagnosis or treatment of an illness or injury, and not otherwise excluded by any term, condition, limitation or exclusion of the Plan, and which are within the benefits provided in the Plan and are performed and reimbursed in the least costly setting required by the Covered Person's condition, including the following:

A. Charges made by a Physician, or Behavioral Health Provider, as those terms are defined in this Plan, except as they may be limited by any provision of the Plan, but not to exceed an Allowable Charge or the applicable amount in the Schedule of Reimbursement Rates as defined in this Plan or the Actual Charges, whichever is less.

   The benefits for services rendered by a chiropractor are for the detection and correction by manual or mechanical means (including x-rays incidental thereto) of structural imbalance, distortion or subluxation in the human body, for the removal of nerve interference where such interference is the result of, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column. The patient

must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition. Spinal axis aches, sprains, nerve pains, and functional disabilities of the spine are considered to provide therapeutic grounds for chiropractic treatment. Most other non-spinal diseases and pathological disorders do not provide therapeutic grounds for chiropractic treatment. Examples of these types of diseases and disorders are rheumatoid arthritis, muscular dystrophy, multiple sclerosis, pneumonia, and emphysema. In the Savings Plan, the maximum amount payable for chiropractic benefits for the Plan year is $500 for each Covered Person after the annual deductible has been paid.

The benefits for services of a podiatrist, acting within the scope of his license, are payable only to the extent that benefits under this Plan will not exceed benefits that would have been paid to an M.D. or D.O. for treatment of the given condition, except that no payment is provided when the services consist of, either in whole or in part, the removal of corns, callosities, hypertrophy or hyperplasia of the skin or any subcutaneous tissues; or the cutting, trimming, or other partial removal of toenails;

B. Blood transfusions, including cost of blood and blood plasma, either inpatient or outpatient, but excluding blood and blood products replaced by donors and related storage fees;

C. Licensed registered nurse (R.N.) charges for nursing care in a Hospital where no special care units are provided;

D. Nursing care charges for services provided in the home by a licensed registered nurse (R.N.) if Medically Necessary, or by licensed practical nurses, if appropriate, provided in the home by a home health agency certified by the State of South Carolina, subject to Pre-certification by the Utilization Review Agency;

E. Rental cost, up to the purchase price, of Durable Medical Equipment required for temporary therapeutic use by an individual Covered Person for a specific condition when such equipment is ordinarily used under the direction of a Physician and if certified by the Utilization Review Agency. If such equipment is not available for rent, the monthly payments toward the purchase of the equipment may be approved by the Plan. Equipment, including Durable Medical Equipment, which has a non-therapeutic use, purchased or requested by the Subscriber with or without a prescription including but not limited to home and vehicle modifications, an air conditioner, air filter or air filtration system, wigs, hairpiece, or any other artificial device or procedure to replace scalp hair, dehumidifier, home whirlpool, exercise equipment, ace bandages, tennis shoe supports, knee braces, bandages and gauze and similar equipment, are not Covered Medical Expenses;

F. Medical supplies, limited to the following:

1. Syringes, and related supplies, for conditions such as diabetes;

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

Provided, however, that supplies and equipment which have non-therapeutic uses are not Covered Medical Expenses;

G. Professional ambulance service used locally to or from a Hospital outpatient department providing the necessary service in connection with accidental injury or medical emergency and to or from the nearest Hospital providing the necessary service in connection with inpatient care. No benefits are payable for ambulance service used for routine, non-emergency transport, including, but not limited to, transportation to a facility for scheduled medical or surgical treatments;

H. Prosthetic Appliances necessary for the correction of conditions caused by trauma or disease and that restore a function to the body. The Plan will provide benefits for the replacement of those prosthetic appliances that assist the body to function when the replacement is Medically Necessary and required by wear to the appliance, or growth of the Covered Person, provided, however, that charges for Prosthetic Appliances that have non-therapeutic uses, including a wig or hairpiece, are not a Covered Medical Expense, and further provided that the Plan will provide benefits for the initial breast prosthesis, and a subsequent replacement thereof;

I. Oxygen and rental of equipment for its administration outside a Hospital, with rental payments not to exceed the equipment's purchase price;

J. Orthopedic braces, crutches, lifts attached to braces, and orthopedic shoes, which are Medically Necessary and required by a specific diagnosis and limited to one pair of shoes at six months intervals, provided, however, that charges for supplies or shoes that have non-therapeutic uses are not a Covered Medical Expense;

K. Occupational and physical therapy services when provided by a licensed Occupational Therapist or Physical Therapist;

L. Treatment of Behavioral Health Disorders in the outpatient department of a Hospital or outside of a Hospital, and outpatient treatment for alcoholism and drug abuse at those facilities designated by the South Carolina Commission on Alcohol and Drug Abuse and with which the Behavioral Health Manager has a written agreement and in accordance with such agreement, limited to the benefits specified in section 7.8 and subject to Pre-certification by the Behavioral Health Manager;

M. Inpatient treatment of Behavioral Health Disorders and alcoholism and drug abuse, up to the benefits specified in Section 7.8 in a Hospital or in those State Institutions with which the Behavioral Health Manager has a written agreement and in

accordance with such agreement;

N. Speech Therapy:

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

The speech therapy benefit is provided for acute phase treatment only, in accordance with the therapeutic goals of a written treatment plan. Maintenance speech therapy is not covered. Benefits are provided only to the extent that documented, functional progress is occurring to achieve the therapeutic goals of a written treatment plan.

Speech therapy requires pre-certification by the Utilization Review Agency when provided in an inpatient setting or a home setting. Notwithstanding the pre-certification requirement, any claim for speech therapy services may be reviewed by the Third Party Claims Processor for Medically Necessary treatment after the claim is submitted.

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

A. Services rendered for the treatment of delays in speech development in young children unless the speech delay is due to a specific non-chronic disease, brain injury, or congenital defect (e.g., cleft palate, cleft lip, etc.).

B. Speech therapy for dysfunctions that are self-correcting, such as natural dysfluency or developmental articulation errors in young children.

C. Speech therapy for verbal apraxia or stuttering/stammering unless due to a specific disease or brain injury.

D. Speech therapy associated with any of the following conditions:
1. Psychosocial speech delay
2. Behavioral disorders
3. Attention disorders
4. Conceptual handicap
5. Mental retardation

O. Dental care and treatments, dental surgery or dental applications, limited to:

1. Allowable Charges for Physician services for excision or extraction of bony impacted teeth, when supported by dental x-rays;

2. Hospital services for excision or extraction of three or more bony impacted teeth, when supported by dental X-rays, and in connection with dental services, if the procedure is of such complexity as to require hospitalization or if hospitalization is required to ensure proper medical management, control or treatment of a non-dental physical condition, when Pre-certification has been obtained from the Utilization Review Agency;

3. Allowable Charges involving natural and artificial teeth, dentures, bridges, etc., made necessary by accidental bodily injury occurring while a Covered Person is continuously covered, limited to care completed within one year of such accident, and while the Covered Person remains continuously covered under this Plan;

P. Subject to the general provisions of the Plan, major human organ transplant procedures are eligible for benefits under the Plan as specified below:

1. Specified human major organ transplant procedures are Covered Medical Expenses of this Plan when such procedures conform to the following circumstances:

a. Covered procedures are liver, lung (single or double), heart, heart/lung, kidney, intestinal and pancreas transplants;
b. In order for benefits to be available for the above major organ transplant procedures listed in paragraph A, pre-approval in writing must be obtained from the Utilization Review Agency;
c. Covered Medical Expenses resulting from, or directly related to, the completion of one of the above organ transplant procedures are subject to the Deductible amount and Coinsurance specified in the Plan; and
d. The transplant procedure is performed by a member of the Transplant Network; and
e. The organ transplant is the only treatment for the illness or injury that has an equivalent or better prognosis than an alternative form of treatment;

2. Allogeneic or syngeneic bone marrow transplants or other forms of stem cell rescue (with or without high dose chemotherapy and/or radiation) are available for benefits under the following conditions:

a. There are no other recognized treatments that provide the Covered Person with an equivalent or better prognosis; and,
b. Bone marrow transplantation is the Covered Person's only reasonable opportunity to survive; and,
c. The Utilization Review Agency and the Third Party Claims Processor recommend that the Covered Person is an acceptable candidate for the treatment; and,
d. The bone marrow transplant is performed by a member of the Transplant Network that has accepted the Covered Person as a candidate for the transplant using generally accepted standards for the procedure;

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

a. There are no other recognized treatments that provide the Covered Person with an equivalent or better prognosis; and,
b. The autologous bone marrow transplantation or peripheral stem cell rescue with high dose chemotherapy is the Covered Person's

only reasonable opportunity to survive; and,

c. Both the Utilization Review Agency and the Third Party Claims Processor recommend that the Covered Person is an acceptable candidate for the treatment; and,

d. The bone marrow transplant is performed by a member of the Transplant Network that has accepted the Covered Person as a candidate for the transplant using generally accepted standards for the procedure;

4. Provided, however, the Plan will pay benefits for a major human organ transplant listed in paragraph 1-3 above performed in a Hospital that is not a member of the Transplant Network only if all of the following additional conditions are met:

   a. The Covered Person is otherwise eligible for a transplant and has been approved by the URA for the transplant; and

   b. The Covered Person has been accepted as a candidate for the transplant by a facility that used generally accepted standards for the procedure;

   c. The benefits for the transplants, including patient workup, pre-transplant care, organ acquisition, the transplant and post-transplant care are limited to the lesser of actual charges or:

      i) liver $115,000
      ii) lung ..... $115,000 - single
      As determined by the Utilization Review Agency - double
      iii) heart ..... $ 85,000
      iv) kidney ..... $ 42,000
      v) pancreas ..... $ 57,000
      vi) kidney and pancreas ..... $ 90,000
      vii) allogeneic bone marrow .....$110,000 - match
      .....$135,000 - mismatch- related
      .....$145,000 - match- unrelated
      viii) autologous bone marrow .....$ 75,000
      ix) peripheral stem cell ..... $ 65,000
      x) tandem bone marrow or
      tandem peripheral stem
      cell procedures ..... $ 65,000 1st infusion
      ..... $ 50,000 2nd infusion

      xi) intestinal transplant.....$500,000
      xii) multiple transplants .....
      As determined by the Utilization Review Agency

5. The following transplants of tissue (rather than whole major organs) are eligible for benefits under this Plan when Medically Necessary. Such procedures are subject to all the provisions of this Plan, and prior approval in writing must be obtained from the Utilization Review Agency:

a. Blood transfusions;

b. Autologous parathyroid transplants;

c. Corneal transplants;

d. Bone and cartilage grafting; and

e. Skin grafting.

No other tissue transplant procedures are covered unless it can be determined that: (1) there are no other recognized treatments that provide the Covered Person with a better prognosis for the illness or injury; and, (2) the tissue transplant is the only treatment for the illness or injury that has an equivalent or better prognosis that an alternative form of treatment; and, (3) both the Utilization Review Agency and the Third Party Claims Processor, and the facility performing the procedure using generally recognized standards, recommend that the Covered Person is an acceptable candidate for treatment;

6. All medical costs incurred in the identification of a donor, including surgical, storage and transportation expenses incurred and directly related to the donation of an organ used in a covered organ transplant procedure for liver, lung (single or double) heart, heart/lung, kidney, pancreas, kidney/ pancreas, intestinal, and bone marrow transplants are subject to a maximum payment hereunder of $10,000 for each such procedure completed;

7. Transportation expenses to and from the site of a covered organ transplant procedure for liver, heart, heart/lung, kidney, intestinal, bone marrow or pancreas are covered for the Covered Person who is the transplant recipient and one other individual. If the recipient is a minor, transportation costs are covered for two other individuals accompanying the recipient. All reasonable and necessary lodging and meals expenses are covered, up to a daily maximum of $150 per individual accompanying the recipient. The aggregate sum of transportation, lodging and meal expenses under this provision shall not exceed $10,000 for expenses incurred within five days immediately prior to, and one year immediately following, a covered organ transplant procedure. These transportation expenses are specifically for transportation of the Covered Person and/or a family member to the site of the transplantation. This benefit is not available for transportation expenses related to evaluation of a Covered Person for an organ transplant procedure.

7.4 Hospital or Ambulatory Surgical Center Expense Benefits

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

A. **Ambulatory Surgical Center and Hospitals in Networks - Fixed Rate DRG or Per Diem.** The Plan will pay to a Hospital in the Hospital Network, or an Ambulatory Surgical Center in that Network, compensation calculated from the applicable fixed rate DRG or per diem rate provided in the agreement between the Planholder and the Network Hospital, or Ambulatory Surgical Center as full payment for the Plan's share of the inpatient, Medically Necessary, Covered Services rendered to a Covered Person by the Hospital or Ambulatory Surgical Center. The Subscriber payment to the Hospital or Ambulatory Surgical Center shall be limited to appropriate deductible or coinsurance calculated from the lesser of (1) the fixed rate DRG or per diem rate established in the Agreement, or, (2) the Hospital's or Ambulatory Surgical Center's actual charges. The Subscriber is responsible for any other charges for goods or services that are not Medically Necessary or not covered by the Plan that were incurred with the specific consent of the Covered Person.

B. **In-State Non-Network Hospital or Ambulatory Surgical Center - Fixed Rate DRG or Per Diem.** The Plan will pay to an In-State Hospital or Ambulatory Surgical Center compensation calculated from the lesser of (1) the applicable fixed rate DRG or per diem rate established for Network Hospitals, or Network Ambulatory Surgical Centers, or, (2) the Hospital's or Ambulatory Surgical Center's actual charges, as full payment of the Plan's share of Medically Necessary, Covered Services rendered to a Covered Person by the Hospital or Ambulatory Surgical Center.

C. **Charges by DRG or Per Diem**

1. **Hospital Room and Board** - In all cases not payable as provided in paragraph A and B above, the Plan will pay the lesser of the actual charges or the Market Charge for the semi-private room, board and general nursing care, and the lesser of the actual charges or the Market Charge for the newborn Child delivered from the Covered Person. When Medically Necessary, the Plan will pay the lesser of the actual charge or the Market Charge of an Intensive Care Unit. No benefit is provided for a bed accommodation "reserved" for a Covered Person in an intensive care facility.

2. **Other Hospital Charges for Covered Services** - The Plan will pay the lesser of the actual charges or the Market Charges for necessary services, medicines, blood, or blood plasma not replaced, and supplies for diagnosis or treatment of the illness or injury, for which the Covered Person is confined (except services of a Physician, dentist, special nursing in any form, or drugs or supplies not consumed or used in the Hospital) and not exceeding the overall Plan maximum, provided:

a) The Covered Person is in the Hospital, confined as a bed patient; or

b) The Covered Person has surgery performed in the Hospital; or

c) The Covered Person received necessary emergency treatment as a

result of an accident, acute emergency illness or incurred expenses for emergency Professional Ambulance service to the Hospital for illness or injury; or

d) The Covered Person incurred expenses for pre-admission diagnostic X-ray and laboratory services; or

e) The Covered Person incurred expenses for administration of anesthesia. This does not include any charge made by the operating Physician, or his assistant, or any charges made for infiltration anesthesia.

3. **Other Ambulatory Surgical Center charges for Covered Services** -The Plan will pay the lesser of actual charges or the Market Charges for necessary services, medicines, blood, or blood plasma not replaced, and supplies for diagnoses or treatment of the illness or injury for which the Covered Person receives on the day of services at the Ambulatory Surgical Center (except services of a Physician, dentist, special nursing in any form, or drugs or supplies not consumed in the Ambulatory Surgical Center) and not exceeding the Plan maximum provided:

a) The Covered Person has outpatient surgery performed in the Ambulatory Surgical Center; or

b) The Covered Person incurred expenses for the administration of anesthesia. This does not include any charge made by the operating Physician, his assistant or any charges made for infiltration anesthesia.

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

7.5 Medical Surgical Benefits

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

A. **Surgical Service**, which consists of operative or cutting procedures, or the treatment of fractures or dislocations; such service includes the usual, necessary and related preoperative and postoperative care, when performed by a Physician, subject to the following:

1. If two or more operations or procedures are performed at the same time, through the same surgical opening or by the same surgical approach, the total amount covered for such operations or procedures will be the Allowable Charge for the major procedure only;

2. If two or more operations or procedures are performed at the same time, through different surgical openings or by different surgical approaches, the total amount covered will be the Allowable Charge for the operation or procedure bearing the highest allowance, plus one-half of Allowable Charge for all other operations or procedures performed;

3. If an operation consists of the excision of multiple skin lesions, the total amount covered will be the Allowable Charge for the procedure bearing the highest allowance, 50 percent for the procedure bearing the second and third highest Allowable Charges, 25 percent for the procedures bearing the fourth through the eighth highest Allowance Charges, and 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 allowance, and 50 percent of the charge for each subsequent procedure;

4. If an operation or procedure is performed in two or more steps or stages, coverage for the entire operation or procedure will be limited to the Allowable Charge set forth for such operation or procedure;

5. If two or more Physicians perform operations or procedures in conjunction with one another, other than as an assistant at surgery or anesthesiologist, the Allowable Charge subject to the above paragraphs, will be coverage for the services of only one Physician or will be prorated between them by the Plan when so requested by the Physician in charge of the case;

6. Certain surgical procedures, which are normally exploratory in nature, are designated as "Independent Procedures" by the Plan, and the Allowable Charge is payable when such procedure is performed as a separate and single entity; however, when an Independent Procedure is performed as an integral part of another Surgical Service, the total amount covered will be the Allowable Charge for the major procedure only;

7. Medically Necessary surgical correction of disorders of the temporo mandibular joint will be covered by the Plan when there is documentation that there is anatomical derangement of the joint and there is significant symptomatology. Such disorders include displacement of the joint meniscus and/or other joint structures coupled with significant locking, clicking, popping and pain sufficient to interfere with the patient's ability to speak, masticate food and otherwise carry on normal oral functions. Pre-approval for these procedures is required and the total amount covered will be the Allowable Charge for the procedure performed. Except as provided in this provision, however, services or supplies for temporo mandibular joint conditions are not covered under the Plan. See 9.1.MM.

8. Medically Necessary surgical correction of skeletal malrelationships or deformities of the jaws that cause documented chronic, persistent pain or debilitating loss of function and have required treatment or medication, are covered by the Plan. The presence of a documented congenital anomaly alone does not establish Medical Necessity. Prior approval by the Utilization Review Agency is required.

B. **Surgical Assistant Service,** which consists of the Medically Necessary service of one Physician who actively assists the operating surgeon when a covered surgical service is performed in a Hospital, and when such surgical assistant service is not available by an intern, resident or house Physician. The Plan will cover charges equal to 20 percent of the Allowable Charge for the surgical service, not to exceed the Physician's actual charge;

C. **Anesthesia Service,** which consists of services rendered by a Physician or a certified registered nurse anesthetist, other than the attending surgeon or his assistant, and includes the administration of spinal or rectal anesthesia, or the administration of a drug or other anesthetic agent by injection or inhalation, except by local infiltration, the purpose and effect of which administration is the obtaining of muscular relaxation, loss of sensation, or loss of consciousness. Additional benefits will not be provided for preoperative anesthesia consultation;

D. **In-Hospital Medical Service,** which consists of a Physician's visit or visits to a Covered Person who is a registered bed patient in a Hospital or Skilled Nursing Facility for treatment of a condition other than that for which surgical service or obstetrical service is required, as follows:

1. In-Hospital medical benefits will be provided based on the actual expense incurred but not to exceed the Allowable Charges;
2. In-Hospital medical benefits primarily for treatment of mental or nervous conditions, acute and chronic alcoholism, or drug addiction will be provided for each Covered Person subject to limitations of Section 7.8;
3. In-house medical benefits in a Skilled Nursing Facility will be provided for the visits of a Physician, limited to one visit per day, not to exceed 60 visits;
4. When two or more Physicians render in-Hospital medical visits at the same time, payment for such services will be made only to one Physician;
5. Concurrent Medical/Surgical Care benefits for in-Hospital medical services, in addition to benefits for surgical service, will be provided only: (a) when the condition for which in-Hospital medical services requires medical care not related to surgical or obstetrical service and does not constitute a part of the usual, necessary and related preoperative or post-operative care, but requires supplemental skills not possessed by the attending surgeon or his assistant, (b) when a Physician, other than a surgeon, admits a Covered Person to the Hospital for medical treatment and it later develops that surgery becomes necessary, such benefits to cease on the date of surgery, or (c) when the surgical procedure performed is designated by the Administrator as a "warranted diagnostic procedure" or as a "minor surgical procedure";
6. When the same Physician renders different levels of care on the same day, benefits will only be provided for the highest level of care;

E. **Intensive Medical Care Service,** which consists of medical care rendered by the attending Physician to a Covered Person who is eligible for in-Hospital medical service or Medical Care in the Outpatient department of a Hospital immediately

prior to an admission, and who is confined with a serious disease or injury requiring additional time and study over and above the usual in-Hospital medical service;

F. **Consultation Service,** which consists of services of a consulting Physician, requested by the attending Physician and rendered during an admission. This service is limited to one consultation per consulting Physician for each continuous period of disability and includes discussion with the attending Physician and/or family, and a written expression of opinion by the consultant based on examination of the patient. Consultation service does not include radiological consultations and staff consultations required by institutional rules and regulations, nor when primary care of the patient is transferred to the Physician providing consultation service;

G. **Obstetrical Care** shall refer to services for the prenatal and postpartum care and delivery of one or more fetuses, including Cesarean section, miscarriage, or abortion, as well as in-Hospital medical service for conditions related directly to pregnancy, limited to the Allowable Charge for the delivery only;

H. **Pediatric Medical Care,** which consists of the initial inpatient examination of the newborn when such care is given by a Physician other than the delivering Physician or the Physician who administered anesthesia during delivery;

I. **Radiation Therapy Service,** which consists of the use of x-ray, radium, or radioactive isotopes in the treatment of disease, when ordered by the attending Physician. Benefits for radiation therapy service are provided only when a Physician performs the service;

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

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

7.6 Outpatient Diagnostic Services

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

A. Diagnostic X-ray examinations for the diagnosis of an illness or injury;

B. Clinical laboratory and tissue diagnostic examinations and medical diagnostic

procedures for the diagnosis of an illness or injury, provided, however, that the Physician charges for any machine generated tests are not a Covered Medical Expense under this Plan.

7.7 Human Organ Transplants

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

A. When both the transplant recipient and the donor are Covered Persons, benefits will be provided for both;

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

C. When the transplant recipient is not a Covered Person and the donor is, the donor will receive benefits to the extent that such benefits are not provided by any coverage available to the recipient of the organ or tissue transplant procedure. This includes, but is not limited to, other insurance coverage, other Blue Cross or Blue Shield coverage, any government program, or any employee welfare benefit plan. Benefits will not be provided to a non-eligible transplant recipient.

7.8 Behavioral Health Disorders

Subject to all the terms and conditions of the Plan, and including the requirements herein, the Plan will pay covered expenses for inpatient, outpatient, or Partial Hospitalization Programs rendered by a Behavioral Health Provider for Behavioral Health Disorders and Alcoholism and Drug Abuse. All care must be in accord with the utilization guidelines established by the Behavioral Health Manager and, for specified levels of care, pre-authorized by the Behavioral Health Manager.

7.9 Extended Care Programs

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

7.10 Skilled Nursing Facility

Subject to all the terms, conditions, limitations and exclusions of the Plan including the limitation on Physician visits under 7.5.D.3. and the requirement that all admissions and readmissions to a Skilled Nursing Facility be Pre-certified by the Case Management

Agency, the Plan will pay the Covered Medical Expense for room and board and a skilled nursing level of treatment in such facility for 60 days, or up to $6,000 in any Benefit Year, whichever is less. Refer to 16.1, B.2.(a) and (b) for the Medicare Supplemental Plan benefits concerning Skilled Nursing Facility.

7.11 Hospice Care

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

A. The Covered Person is diagnosed as having a terminal illness with a life expectancy of six months or less;

B. Admission into the Hospice program is certified by the Utilization Review Agency and the care is monitored by it;

C. The services are provided by a Hospice care agency or by others who are not its employees but who are supervised or coordinated by the Hospice care agency;

D. The services are provided pursuant to a written treatment plan approved by a Physician and reviewed by the Physician at least once a month;

E. The expenses incurred are Covered Hospice Expenses which are defined as services provided by a Hospice care agency, or provided under the supervision or coordination of the Hospice care agency by others who are not its employees, in an inpatient Hospice setting or a private residence, for:

1. Medical social services provided under the direction of a Physician including:

a) Assessment of the Covered Person's home and family situation and that person's social, emotional and medical needs;

b) Identification of community resources available to the Covered Person;

c) Assisting the Covered Person to obtain community resources to meet the Covered Person's needs;

d) Psychological and dietary counseling;

e) Consultation and case management services by a Physician;

f) Physical or occupational therapy;

g) Medical supplies, drugs, medicines prescribed by a Physician.

2. Hospice services provided for a Covered Person in a private home are subject to the following:

a. Part-time or Intermittent (less than or up to four hours per day, if provided on a less-than-daily basis, or if provided on a daily basis not to exceed eight hours per day, for temporary and definitely fixed periods of time up to 21 days, with such extensions for additional fixed and definite periods of time that, in the discretion of the Plan Administrator, may be granted when there are exceptional circumstances and the period of such extension is predictable and fixed) nursing care provided by a registered nurse or licensed practical nurse;

b. Part-time or Intermittent (less than or up to four hours per day, if provided on a less-than-daily basis, or if provided on a daily basis not to exceed eight hours per day, for temporary and definitely fixed periods of time up to 21 days, with such extensions for additional fixed and definite periods of time that, in the discretion of the Plan Administrator, may be granted when there are exceptional circumstances and the period of such extension is predictable and fixed) home health aid services which consist mainly of caring for the Covered Person;

F. Limitations and Exclusions

1. The maximum benefit payable under the Plan for Hospice care services is $6,000 per person including bereavement counseling not to exceed $200.

2. Benefits are not payable for:

a) Funeral expenses;

b) Financial or legal counseling, including estate planning or the drafting of a will;

c) Pastoral counseling;

d) Homemaker or caretaker services which are not solely related to the care of the Covered Person, or transportation, housecleaning or maintenance of the Covered Person's dwelling;

e) Sitter or companion services for either the ill Covered Person or other members of his family;

f) Respite care, which is care furnished during a period when the Covered Person's family or usual caretaker cannot, or will not, attend to the Covered Person's needs.

7.12 Alternative Treatment Plan

A. **Allowable Charge.** For purposes of this section only an Allowable Charge includes: (1) all costs otherwise allowed under this Plan; (2) all other costs for

medical goods and services that are essential to the implementation and maintenance of the Alternative Treatment Plan even if not otherwise covered under the Plan, provided that the Utilization Review Agency has Pre-certified that the particular medical goods or services are essential to the implementation and maintenance of the Alternative Treatment Plan.

B. Limitation. The Alternative Treatment Plan is subject to:

1. The Plan Deductible, and Plan maximums;
2. And, in addition, the Allowable Charges for the Alternative Treatment Plan, as defined in this section, may not exceed those payable for comparable treatment or services in an acute care facility or a Skilled Nursing Facility.

7.13 Home Health Care Services

Subject to all the terms and conditions of the Plan, including the Deductible and Coinsurance requirement, and the requirement that these services are Pre-certified by the Utilization Review Agency, and including other conditions and limitations herein, the Plan will provide benefits for the Reasonable and Customary Charges for the following Medically Necessary services and supplies provided a Covered Person in the home:

A. Covered Medical Expenses for purposes of this section shall be limited to:

1. Part-time or Intermittent (less than or up to four hours per day, if provided on a less-than-daily basis, or if provided on a daily basis, not to exceed eight hours per day, for temporary and definitely fixed periods of time of up to 21 days, with allowances for extensions and exceptional circumstances where the need for care in excess of 21 days is finite and predictable) nursing care by a registered nurse (R.N.), or by a licensed practical nurse (L.P.N.) where appropriate;

2. Part-time or Intermittent (less than or up to four hours per day, if provided on a less-than-daily basis, or if provided on a daily basis, not to exceed eight hours per day, for temporary and definitely fixed periods of time of up to 21 days, with allowances for extensions and exceptional circumstances where the need for care in excess of 21 days is finite and predictable) home health aide services which consist primarily of caring for the individual; and

3. Physical, occupational or speech therapy provided by the home health care agency;

4. Medical drugs, supplies and medicines prescribed by a Physician and required for the care rendered by the nurse or physical, occupational or speech therapist, but only to the extent that the medical drugs, supplies, durable medical equipment and medicines are otherwise covered under this Plan.

B. The payment of benefits for Home Health Care is subject to the following additional requirements, in addition to all other limitations and exclusions of the Plan:

1. That the Home Health Care benefits, if provided, would permit the

Covered Person to remain in a less intensive care facility, or at home, than would otherwise be required without these benefits;

2. The annual maximum benefit for professional services only, is the lesser of $5,000 or 100 visits. A visit shall consist of up to four hours, whether consecutive or non-consecutive, within any 24-hour period, incurred by a registered nurse or a licensed practical nurse to provide nursing care, by a therapist to provide physical, occupational or speech therapy, or by a home health care aide to provide services within the scope of the license; and

3. Covered Medical Expenses under this section shall not include:

   a) Any service or supply rendered by a person who ordinarily resides in the home of the Covered Person, or is a member of the family, or of the family of the spouse of the Covered Person; or

   b) any transportation services;

4. The Plan will provide benefits for Medical Social Worker Services if authorized and required by the Utilization Review Agency under section 15.1.8.E at 100 percent of the Reasonable and Customary or Allowable Charge, or the Actual Charge, whichever is less.

7.14 Mammography Testing

The Plan will provide benefits for routine mammography testing for Active female Employees, female Retirees, and female Dependents of Employees or Retirees from ages 35 through 74 enrolled in the Savings Plan or the Standard Plan or the Medicare Supplemental Plan and without regard to the Plan Deductible, Coinsurance or need for a referral by a Physician, subject to the following terms and conditions:

A. Benefits under this section are limited to one mammogram for a Covered female every year between the ages of 35 through the age of 74;

B. Benefits under this section are payable only for routine four view mammograms which are defined as elective procedures undertaken without the need for a Physician's referral or presence of symptoms, and performed only at facilities specified by the Plan Administrator;

C. Benefits under this section are in addition to benefits for diagnostic mammography otherwise available under this Plan. The Plan will pay the same benefit to the participating facility as it does for routine mammograms. Any charges above that amount and/or additional mammograms are subject to the other terms, conditions, limitations and exclusions of this Plan including the Deductible, Coinsurance and requirement of a Physician referral;

D. Approved charges for diagnostic mammograms performed at non-participating facilities will be subject to the Plan Deductible and Coinsurance, up to the Out-of-pocket Maximum.

7.15 Required Second Opinion

The plan will provide benefits for a Second Opinion required to be obtained by the Utilization Review Agency under 15.1.8.C at 100 percent of the Reasonable and Customary Charge or Allowable Charge, or the actual charge, whichever is less.

7.16 Pap Test

The Plan will pay a benefit for one Pap Test per female subscriber or Dependent ages 18 through 65 per Benefit Year, including an appropriate-level office visit associated with the Pap Test, without any requirement for a Deductible or Coinsurance.

7.17 Rehabilitation Care

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

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

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

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

A. Pre-certification is required for any inpatient rehabilitation care, regardless of the reason for the admission, and is required for any outpatient rehabilitation therapy that occurs subsequent to an inpatient admission for rehabilitation therapy;

B. The rehabilitation therapy must be performed in the most cost-effective setting as required by the Covered Person's condition;

C. The Provider must submit and have approved by the Utilization Review Agency a treatment plan with the proposed treatment, the expected result and the length of the treatment required to reach that result;

D. There must be reasonable expectation that sufficient function can be restored for the patient to live outside the institutional setting;

E. Continued rehabilitation therapy is dependent upon documentation that progress is continuing to be made, and only so long as there is a significant improvement in the capabilities of the patient;

F. An inpatient admission must be to a rehabilitation facility under the same licensure as a short term general hospital accredited by the Joint Commission on Accreditation of Hospitals (JCAH), or if to a freestanding rehabilitation facility, one accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF);

G. Rehabilitation benefits are not payable for vocational rehabilitation intended to teach a patient how to be gainfully employed; or pulmonary rehabilitation, except in conjunction with a covered and approved lung transplant; or long term rehabilitation after the acute phase, including cognitive retraining and community re-entry programs.

7.18 Infertility Treatment

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

A. The benefits are limited to a lifetime maximum payment of $15,000 for any Covered Medical Expenses and Covered Prescription Drug Expenses incurred by either the Subscriber or the Covered Spouse whether covered as a Dependent or as an Employee. Included in the $15,000 maximum are up to six (6) cycles of Intrauterine Insemination (IUI) and/or a maximum total of three completed cycles of zygote or gamete intrafallopian transfer (ZIFT or GIFT), or In Vitro Fertilization (IVF), is allowed. A cycle reflects the cyclic changes of fertility with the cycle beginning with each new insemination or assisted reproductive technology (ART) transfer or implantation attempt. ART procedures not specifically referenced in this policy are not covered, including, but not limited to: tubal embryo transfer (TET), pronuclear stage tubal embryo transfer (PROUST), Oocyte donation, and Intracytoplasmic sperm injection (ICSI). Benefits paid for infertility treatments after January 1, 1990, will be considered in computing the lifetime maximum benefit; and,

B. The benefits for infertility treatment are always subject to Coinsurance at a rate of 30 percent of the Covered Medical Expenses or Covered Prescription Drug Expenses regardless of the Plan selected; and

C. Coinsurance paid by the Covered Person for the infertility services cannot be used to satisfy the Out-of-pocket Limitation in 7.1.A.4 and 7.1.B.4 or in paragraph 7.21;

D. All IVF procedures must receive prior approval from the Utilization Review Agency;

E. No benefits are payable for infertility treatments to a Covered Person who has received a tubal ligation, whether or not surgically reversed.

7.19 Well Care

A. The Plan will provide benefits for routine Well Child Care visits and immunizations for Covered Persons through age 18 enrolled in the Savings Plan, Standard Plan or Medicare Supplemental Plan and without regard to the Plan Deductible or Coinsurance, subject to the following terms and conditions:

1. Benefits for routine visits are limited to five visits for a Child under age one; three visits for a Child age one; one visit per year for Children age two through 18 years of age.

2. Benefits are provided for all immunizations at the appropriate ages recommended by the American Academy of Pediatrics for children through age 18;

B. The Plan will provide benefits for one routine annual physical for covered persons age 18 and older enrolled in the Savings Plan, and without regard to the Plan Deductible or Coinsurance. Benefits are provided for one annual influenza immunization.

C. Benefits under this section are payable only for services rendered by the participating providers in the State Health Plan Physician Network in accordance with guidelines established by the Plan Administrator.

7.20 Preventive Screenings for Employees at Worksite

The Plan will provide benefits, for Covered Employees and their Covered Spouses, for a routine worksite screening that includes procedures recommended by the United States Preventive Services Task Force, consisting of a health risk appraisal, blood lipid profile, blood chemistry profile, hemogram, blood pressure measurement, height and weight measurement, and counseling on identified individual health risk factors. The screening is limited to one occurrence per year, is provided only at the Employee's worksite, and is subject to the ability of the Plan Administrator and the Provider to schedule a screening session at the worksite. The screening is provided without regard to the Plan Deductible and Coinsurance, but is subject to a Co-payment determined by the Plan Administrator. Worksite screening benefits are payable only for a) Covered Employees who are actively at work, and their Covered Spouses and b) Covered Retirees for whom the Plan is Primary, and their Covered Spouses.

7.21 Covered Prescription Drug Expenses

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

Provided, however, that there is no coverage for:

A. any medicines or drugs which are in the Food and Drug Administration phases I, II, or III testing, whether or not prescribed by a Physician;

B. prescription drugs or medicines obtained by or for the Covered Person in violation of the utilization review and management standards established by the Pharmacy Benefits Manager under the Prescription Drug Program.

C. prescription drugs or medicines purchased at pharmacies not participating in the State Pharmacy Network; provided, however, out-of-network drug benefits may be allowable only in specific geographic areas in which the Plan Administrator has determined that there is no access to a participating pharmacy.

D. In the Savings Plan, nonsedating antihistamine medications or drugs to treat erectile dysfunction.

For Covered Persons enrolled in the Standard Plan, the expenses described in this paragraph are not Covered Medical Expenses for purposes of Paragraphs 7.1.B and 7.2 of the Plan of Benefits. In the Standard Plan, the Covered Person shall pay for up to a 31-day supply of a drug (a) the lesser of the allowance established for a Tier 2 brand name drug or a $25 co-payment; (b) the lesser of the allowance established for a Tier 3 brand name drug or a $40 co-payment; or (c) the lesser of the allowance established for a generic drug or a $10 co-payment. Provided, however, that if a generic equivalent is available, payment for a brand name drug is limited to what is payable for the generic equivalent. Covered Persons may obtain up to a maximum of a 90-day supply of medication, provided, however, a separate co-payment is required for each additional 31-day supply of medication received at retail. There is an annual out-of-pocket maximum for prescription drugs of $2,500 per person.

A voluntary mail service prescription drug benefit is available at a pharmacy established by the Pharmacy Benefits Manager. In the Standard Plan, patient co-payments at the mail service pharmacy for a 90-day supply of covered medication are established at an amount equal to 2.50 times (rounded down to the nearest dollar) the retail co-payment for a 31-day supply.

For Covered Persons enrolled in the Savings Plan, the expenses described in this paragraph are Covered Medical Expenses for purposes of Paragraphs 7.1.A and 7.2 of the Plan of Benefits. In the Savings Plan, the Covered Person shall pay for up to a maximum of a 90-day supply of a drug, the allowance established for a brand name or generic drug. Provided, however, that if a generic equivalent is available, payment (or amount to be applied to the deductible) for a brand name drug is limited to what is payable for the generic equivalent.

7.22 Cranial Band

The Plan covers the use of a cranial remodeling band when pre-certification review determines it to be Medically Necessary for the correction of a child's moderate to severe positional head deformities associated with premature birth, restrictive intrauterine positioning, cervical abnormalities, birth trauma, torticollis and sleeping positions. Remodeling must be initiated between 4 and 12 months of age, following a failed two-month trial of conservative treatment (e.g., repositioning, neck exercises).

7.23 Colonoscopy

The Plan will provide benefits for one routine colonoscopy screening for colorectal cancer every 10 years for a Covered Person, beginning at age 50. Benefits under this section are subject to the Plan Deductible and Coinsurance.

7.24 Autism Spectrum Disorders

The Plan shall cover behavior therapy related to autism spectrum disorder pursuant to Act 65 of 2007, as enacted by the South Carolina General Assembly. All services are subject to the guidelines formulated by the Behavioral Health Manager and must be approved by the Behavioral Health Manager.

ARTICLE 8.

COORDINATION OF BENEFITS

8.1 Definitions for this Article

A. **Plan.** For purposes of this Article means any program which provides benefits or services for or by reason of medical care or treatment including:

1. Any group insurance and group subscriber contracts;

2. Any uninsured arrangements of group coverage;

3. Any group coverage through health maintenance organizations (HMOs) and other prepayment, group practice and individual practice plans;

4. Any group hospital indemnity plans to the extent that the benefits exceed $100 per day;

5. Any medical benefits coverage in group and individual automobile "no fault" and traditional automobile "fault" type contracts;

6. Any coverage under a governmental plan, or coverage required to be provided by law, but does not include a State Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the Social Security Act, as amended);

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

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

B. **Dependent.** With respect to this Article, any person included in the definition of Dependent in 2.31 herein and, with respect to any other Plan, any person who qualifies as a dependent under such Plan.

C. **Primary Plan.** A Plan whose benefits must be determined without taking the existence of another Plan into consideration. There may be more than one Primary

Plan. The provisions of paragraph 8.2 determine whether a Plan is Primary or Secondary.

D. **Secondary Plan.** A Plan that is not a Primary Plan. When this Plan is a Secondary Plan its benefits are determined after those of the other Plan's and may be reduced because of the other Plan's benefits. The provisions of paragraph 8.2 determine whether a Plan is Primary or Secondary.

8.2 Order of Determination of Benefits

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

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

A. **Coverage as a Non-Dependent or Dependent.** The benefits of a Plan, which covers the person as an employee, member or subscriber (that is other than as a Dependent), are determined before those of the Plan that covers the person as a Dependent.

B. **Dependent Child - Parents Not Separated or Divorced.** Except as provided in paragraph C below, when this Plan and another Plan cover the same child as a Dependent of different persons called parents:

1. The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

2. If both parents have the same birthday, the benefits of the Plan that covered a parent longer are determined before those of the Plan that covered the other parent for a shorter period of time;

3. Provided, however, that if the other Plan does not have the rule described in B(1) above (the birthday rule) but has the gender rule so that the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

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

1. First, the plan of the parent with custody of the child;

2. Second, the plan of the spouse of the parent with custody of the child;

3. Third, the plan of the parent who does not have custody of the child;

4. Provided, however, that if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The plan of the other parent shall be the Secondary Plan;

5. Provided further, that if the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules in paragraph B above.

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

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

1. First, the benefits of a plan covering the person as an employee, member or subscriber (or as that person's dependent);

2. Second, the benefits under the continuation coverage.

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

Note: The Consolidated Omnibus Budget Reconciliation Act of 1987 (COBRA) originally provided that coverage under a new group health plan caused the COBRA coverage to end. An amendment passed as part of H.R. 3299 (1989) allows the COBRA coverage to continue if the other group plan contains any pre-existing condition limitation. In this instance, two policies will cover an individual, and the COBRA coverage will be the Secondary Payor.

8.3 Effect of Order of Determination of Benefits on this Plan

A. This Plan is Primary. When the order of determination rules of this Plan establish that this Plan is the Primary Plan, the benefits provided by this Plan shall be determined without consideration of the benefits of any other Plan.

B. This Plan is Secondary. When the order of determination of benefits rules of this Plan determines that this Plan is the Secondary Plan, the benefits of this Plan will be reduced when the sum of: (1) the benefits that would be payable for the Covered Medical Expense under this Plan in the absence of this COB provision; and (2) the benefits that would be payable for the Covered Medical Expenses under the other plans, in the absence of provision with a purpose like that of this COB provision, whether or not claim is made, exceeds the Allowable Charge for the Covered Medical Expense. In that case, the benefits of this Plan will be reduced so that they, and the benefits payable under the other plans, do not total more than the Allowable Charge for the Covered Medical Expense. In no event will the total benefits paid by this Plan exceed the total benefits that would have been paid by this Plan if this Plan had been Primary. When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

8.4 Right to Receive and Release Information

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

8.5 Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this Article have been made under any other Plan, the Third Party Claims Processor will have the right to pay over to any organization making such other payments any amounts it determines to be warranted in order to satisfy the intent of this Article, and amounts so paid will be deemed to be benefits paid under this Plan, and to the extent of such payments for Covered Medical Expenses, the Plan will be fully discharged from liability. The term "payments" includes providing benefits in the form of services, in which case the term "payment made" means the reasonable cash value of the benefits provided in the form of services.

8.6 Right of Recovery

Whenever payments have been made under this Plan by the Third Party Claims Processor with respect to Covered Medical Expenses in a total amount in excess of the amount necessary to satisfy the purposes of this Article, the Third Party Claims Processor will be entitled to recover on behalf of the Plan such excess amounts from a Covered Person or any group insurer, Plan, or other person or organization contractually obligated to such Covered Person with respect to such Covered Medical Expenses. The employee, for himself, or on behalf of, his Dependents will, upon request, execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to this Plan or any other plan.

8.7 Medicare

A. This Plan will provide Primary coverage for Active Employees, age 65 and over, and their Dependents who have elected to enroll in Medicare and who are also enrolled in this Plan. Medicare is Secondary for a Covered Person during the first 30 months in which the Covered Person is eligible for Medicare solely because of permanent kidney failure, and thereafter, Medicare is Primary and the Plan is Secondary. Federal law prohibits active Employees, who elect Medicare as their Primary coverage, from enrolling in the Plan as a supplement.

B. This Plan is Primary and Medicare is Secondary for an Active Employee or Dependent of an Active Employee under age 65 and eligible for Medicare by reason of disability, other than end stage renal disease.

C. For Retired Employees and their Dependents eligible for Medicare, the benefits paid under this Plan will be determined in the following manner:

1. Benefits available under this Plan less benefits paid or payable under Parts A and B of Medicare.

2. When Medicare is Primary and this Plan is Secondary, benefits will be coordinated with both Parts A and B of Medicare, whether or not the Covered Person is actually receiving both Parts A and B of Medicare.

3. Retirees who return to Active Employment, again, are eligible for the Plan. Federal law prohibits active Employees who elect Medicare as their Primary coverage from enrolling in the Plan as a supplement.

ARTICLE 9

EXCLUSIONS AND LIMITATIONS

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

A. Any service or charge for service which is not Medically Necessary as defined in paragraph 2.58; any service or charge for service which is performed in a more costly setting than that required by a Covered Person's condition, in which case benefits will be limited to the benefits due had the services been performed in the least costly setting required by the Covered Person's condition;

B. Any service or charge for service to the extent a Covered Person is entitled to payment or benefits (whether or not any such payment or benefits have been applied for or paid) pursuant to any law (now existing or as may be amended) of the United States, (except Medicaid) or any state or political subdivision thereof. Without limiting the generality of the foregoing, this exclusion applies to benefits provided by, or payable under, Workers' Compensation Laws, the Veterans Administration, or any state or federal hospital for which hospital services the Covered Person is not legally obligated to pay. This exclusion applies if the Covered Person receives any benefits or payments in whole or in part, and it applies to any settlement or other agreement, including any settlement of "doubtful and disputed" claims, or "clincher" agreements, or any other agreement regardless of how characterized, and even if the document or release specifically excludes payment for medical expenses;

C. Any service or charge for service to the extent a Covered Person is entitled to payment or benefits under state or federal programs of health care, excluding Medicare and amendments thereto, but only to the extent that benefits are provided or reimbursement is paid or payable hereunder;

D. Illness contracted or injury sustained as a result of declared or undeclared war or any act of war, or while in the military service;

E. Any charges for services commencing prior to the Covered Person's coverage hereunder or rendered after the termination of coverage, except as provided in Article 10, Continuation of Coverage, or Article 11, COBRA, of this Plan. This exclusion also applies to all hospital charges incurred during a continuous hospital stay when the admission occurred before, and the discharge occurred after, the effective date of coverage, and there is pre-existing coverage for that admission. Physician charges are payable from the date of commencement of coverage;

F. Services or charges incurred for acupuncture;

G. Any surgical or medical procedures determined by the medical staff of the Third Party Claims Processor with appropriate consultation, to be experimental or investigational or not accepted medical practice. Experimental or investigational procedures are those medical or surgical procedures, supplies, devices, or drugs, which at the time provided, or sought to be provided:

1. Are not recognized as conforming to accepted medical practice in the relevant medical specialty or field of medicine; or

2. The procedures, drugs or devices have not received final approval to Market from appropriate government bodies; or

3. Are those about which the peer-reviewed medical literature does not permit conclusions concerning their effect on health outcomes; or

4. Are not demonstrated to be as beneficial as established alternatives; or

5. Have not been demonstrated, to a statistically significant level, to improve the net health outcomes; or

6. Are those in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting;

H. Services, supplies or charges for premarital, pre-employment, or routine physical examinations, when no injury or illness is present, and except as provided in 7.19, well care and immunizations;

I. Admissions or portions thereof for: (1) sanitarium care or rest cures, (2) physical or occupational therapy, or (3) Custodial Care;

J. Hospital and Physicians services and prescription drugs related to procedures or goods that have primarily cosmetic effects including but not limited to cosmetic surgery, or the complications resulting there from. Cosmetic goods, procedures or surgery shall mean all goods, procedures, and surgical procedures performed to improve appearance or to correct a deformity without restoring a bodily function. In the instances of the following and other procedures which might be considered "cosmetic"— e.g., rhinoplasty (nose), mentoplasty (chin), rhytidoplasty (face lift), glabellar rhytidoplasty, surgical planing (dermabrasion), blepharoplasty (eyelid), mammoplasty (suspension or augmentation), superficial chemosurgery (acid peel of the face) and rhytidectomy (abdomen, legs, hips, or buttocks including lipectomy or adipectomy)—benefits may only be provided when the malappearance or deformity was caused by physical trauma, surgery, or congenital anomaly (as opposed to familial characteristics or aging phenomenon) occurring after the Covered Person's Effective Date of coverage under this Plan; provided, however, that surgery to correct a cleft palette, or for restoration required because of burn injuries, or other similar procedures performed in stages or after certain growth has been attained, are not excluded because the physical trauma, surgery or

congenital anomaly (as opposed to familial characteristics or aging phenomenon), occurred after the Covered Person's Effective Date of Coverage under this Plan or a Predecessor Plan;

K. Hospital and Physician services for dental procedures, including those related to tooth structures, extractions, gingival tissue, alveolar process, dental X-rays, or other procedures of dental origin, which are principally for the preserving of teeth or the preparation of the mouth for dentures, except as specified under 7.3.O.

L. Physician's charges for medicine, drugs, appliances, supplies, blood and blood derivatives, unless these items are Covered Medical Expenses under the Plan, and then only to the extent that the charges do not exceed the usual charge for such items from other providers;

M. Eyeglasses, contact lenses, hearing aids and examination for the prescription or fitting thereof and any hospital or Physician's charges related to refractive surgery such as radial keratotomy, keratomileusis, or lamellar keratoplasty and any other procedure the purpose of which is to alter the refractive properties of the cornea, except for the treatment of keratoconus;

N. Travel, whether or not recommended by a Physician, unless related to a human organ transplant specified under 7.3.P.6;

O. Any medical social services (except for those provided under the Hospice program and Home Health Care Program upon recommendation of the Utilization Review Agency) or vocational, visual, recreational, educational, or milieu therapy;

P. Diet treatments, and all weight loss surgery, including, but not limited to the following: gastric bypass or stapling; intestinal bypass and any related procedures; the reversal of such procedures; and conditions and complications as a result of such procedures or treatment.

Q. Any service or supply rendered by a member of the Covered Person's immediate family (parent, child, spouse, grandparent or in-law);

R. Room and Board charges for elective non-emergency Hospital admissions for certain surgical procedures that can safely be performed on an outpatient basis. Benefits will be provided when Pre-certification of coverage is requested and it is determined that the Covered Person's medical condition warrants hospitalization. If Pre-certification is not obtained and upon subsequent review, it is determined that the admission was Medically Necessary, Room and Board benefits will be provided, subject to the Deductible and Co-payment requirements in 7.1.A and B and 15.8.1 and 15.2.8.

S. Charges for chronic pain management programs or any program developed by centers with multidisciplinary staffs intended to provide the interventions necessary to allow the patient to develop pain coping skills and freedom from dependence on analgesic medications;

T. With respect to a Dependent Child, for charges which are the result of the Dependent Child's pregnancy, or complications from the Dependent Child's pregnancy or childbirth;

U. Any services, supplies or charges for, or in connection with, a vasectomy or tubal ligation performed within one year of enrollment, or any procedure or surgery designed to reverse a prior vasectomy or tubal ligation;

V. Assisted reproductive technologies, except as provided in 7.18.A;

W. Physician charges for clinical pathology defined as services for reading any machine-generated reports on mechanical laboratory tests;

X. Any psychological tests to determine job or occupational placement, school placement or other educational purposes or milieu therapy or to determine learning disability or behavior disorder;

Y. Transcutaneous electrical nerve stimulation whose primary purpose is the treatment of pain;

Note: This exclusion does not include muscle stimulation units when they are used to strengthen specific muscles when electrical stimulation is more effective than resistance exercise programs. (e.g., quadriceps, shoulder, paraspinal muscle groups weakened or atrophied by disease, injury or surgery).

Z. Any services or supplies for Pre-existing Conditions, as that term is defined in the Plan. Benefits for a Pre-existing Condition are payable only for treatment rendered 12 months after a Covered Person's Enrollment Date, or 18 months after a Late Entrant's Enrollment Date. Notwithstanding any other provision of the Plan, the Pre-existing Condition exclusion shall not apply to a newborn child, an adopted child under age 18, or a child under age 18 who has been placed for adoption as a Dependent of an Employee or Retiree who is covered under this Plan, or under any other Creditable Coverage, within 31 days of the first date such person was eligible for such coverage.

Notwithstanding any other provision of this Plan, any period during which benefits for a Pre-existing Condition as described herein, would be excluded shall be reduced by the length of an individual's Creditable Coverage, which is calculated by determining all days during which the individual had one or more types of Creditable Coverage, without regard to specific benefits included in coverage. However, days of Creditable Coverage that occurred before a Significant Break in Coverage shall not be counted for the purpose of reducing any period of exclusion.

AA. When a patient in a Hospital receives only a Skilled Nursing level of care, benefits for inpatient Hospital Care are limited to the average daily statewide per diem rate, plus additional medical services rendered, as determined by the Third Party Claims Processor paid to Skilled Nursing Facilities, and benefits for related Physician services are limited to one visit per week up to the maximum benefits provided in

7.10;

BB. Benefits will not be provided for services or supplies not specifically listed in Article 7, Schedule of Benefits, inclusive;

CC. Services or supplies received as a result of any intentionally self-inflicted injury (or injuries resulting from attempted suicide) that does not result from a medical condition or domestic violence;

DD. Benefits will be limited to the extent a Covered Person proves entitlement to any benefits under the Plan by filing or causing to be filed a claim and documentation in support of the claim;

EE. Equipment, including durable medical equipment, which has a non-therapeutic use, purchased or requested by the Subscriber with or without a prescription including but not limited to home and vehicle modifications, an air conditioner, air filter or air filtration system, speech augmentation or communication devices, including computers, dehumidifier, home whirlpool, exercise equipment, ace bandages, wigs, hairpieces, or any other artificial device or procedure to replace scalp hair, foot orthotics or ankle or knee braces whose primary or sole purpose is to allow participation in athletics but are not documented to be Medically Necessary, bandages and gauze and similar equipment, are not Covered Medical Expenses;

FF. Over-the-counter medicine;

GG. Fees for medical records and/or claims filing;

HH. Any service, supply or charge for which the Employee, Retiree or Dependent is not legally obligated to pay, as well as any deductible, coinsurance or charges, or parts thereof, which a Hospital or Health Care Provider waives on an other than isolated case by case basis;

II. Additional benefits will not be provided for preoperative anesthesia consultation;

JJ. When the same Physician renders different levels of care on the same day, benefits will only be provided for the highest level of care;

KK. Any medical service, supply or charge, which is prescribed or ordered by a Physician because an anatomical variation causes psychological problems;

LL. Any service or supply related to dysfunctional conditions of the muscles of mastication, or derangement of the temporo mandibular joint (TMJ), including office visits, splints, braces, guards, etc. Provided however, this exclusion shall not apply to the Medically Necessary surgical correction of disorders of the temporo mandibular joint that meet the conditions of 7.5.A.7;

MM. Any service or supply related to orthognathic surgery or skeletal malrelationships or deformities of the jaws. Provided, however, this exclusion shall not apply to

Medically Necessary surgical correction as provided in 7.5.A.8.;

NN. Schlerotherapy, including injections of sclerosing solutions for varicose veins of the leg, unless prior approved ligation or stripping procedure has been performed within three years and documentation establishes that some varicosities remained after the prior procedure.

Benefits will not be provided for varicose vein surgery performed for cosmetic purposes. The treatment of visible subcuticular veins (i.e. spider angiomas, telangiectasis) less than 2 mm in size is considered to be cosmetic in nature and therefore is not a covered benefit.

OO. Services or charges incurred for, or in connection with, transexuality, gender reassignment or related procedures;

PP. Food supplements, even if the supplements are ordered or prescribed by a Physician;

QQ. Services and supplies rendered after death including, but not limited to, transportation and autopsies;

RR. Smoking cessation or deterrence products, with the exception of provisions established under the Prescription Drug Program, or as authorized by the Behavioral Health Manager for eligible participants in its tobacco cessation p program;

SS. Services performed by service or therapy animals or their handlers.

TT. Abortion, except for an abortion performed in accordance with federal Medicaid guidelines;

UU. Any services or charges related to Employee Assistance Programs.

VV. Complications arising from Covered Person's receipt of either hospital services, medical services, medical supplies, or other treatments that are not considered Covered Hospital Services or Covered Medical Expenses, including complications arising from a Covered Person's use of discount services.

WW. In the Savings Plan, non-sedating antihistamine medications or prescription drugs to treat erectile dysfunction are not a covered benefit.

ARTICLE 10.

CONTINUATION OF COVERAGE

10.1 Incapacitated Dependent Child

The coverage of a Dependent Child under this Plan will not be terminated upon the attainment of the limiting age specified in the Plan while the Child is, and continues to be both (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap, and (b) principally dependent (more than 50%) upon the Subscriber for support and maintenance, so long as continued provided proof of such incapacity and dependency is furnished to the Plan Administrator by the Employee within 31 days of such Child's attainment of the limiting age of 19, and at such other reasonable times, but not more than annually, and provided further, that coverage remains in force for the Employee.

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

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

10.3 Surviving Spouse and/or Dependent Children

The Covered Surviving Spouse and/or Covered Dependent Children of a deceased Active or Retired Employee, including any Child born after the death of the Employee but before the remarriage of the Surviving Spouse, shall be eligible to continue the coverage; provided they pay the entire premium without any contribution by the Employer or State, provided however:

A. The premium due from a Covered Surviving Spouse (who is not a State Employee) and/or Covered Dependent Children of a deceased Active or Retired Employee (whose surviving parent is not an Active or Retired Employee) and for which there was a State contribution to the Employee/Retiree premium shall be waived for one year from the date of the Employee's or Retiree's death.

   After one year, the Surviving Spouse and Dependent Children shall be eligible to continue the coverage, provided that they pay the entire premium for such coverage without any contribution by the Employer or State; provided, however the Surviving Spouse and/or Dependent may pay the premium at the employer-funded rate as long as eligible if the deceased Active or Retired Employee was killed in the line of duty after December 31, 2001, and while working for State-Covered Entity;

B. The coverage of a Surviving Spouse provided under this section shall terminate upon remarriage but, in no event shall any Surviving Spouse or Dependent who feloniously and intentionally kills the Active or Retired Employee be entitled to any premium waiver;

C. The existing coverage of any Dependent Children will not be effected by the remarriage of the Surviving Spouse, but such coverage is subject to all the terms, conditions, limitations and exclusions of the Plan, including the requirement that coverage ceases on the date that a Covered Dependent no longer meets the definition of a Dependent.

ARTICLE 11.

COBRA

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

COBRA requires that a Covered Person who would otherwise lose coverage as a result of a "qualifying event" as defined in that act, is entitled to elect to temporarily extend health coverage under this Plan. The coverage will be identical to the coverage provided to the Covered Employee before the qualifying event and identical to the coverage provided similarly situated Employees to whom a qualifying event has not occurred.

11.2 Qualifying Event

A qualifying event is any one of the following:

A. Termination of the Employee's employment (other than for gross misconduct) or reduction of hours worked so as to render the Employee ineligible for coverage;

B. The death of the Employee;

C. Divorce or legal separation of the Employee from his spouse;

D. A Dependent Child ceasing to qualify as an eligible Dependent under the Plan;

E. Entitlement to Medicare by the Covered Employee.

11.3 Qualified Beneficiary

A qualified beneficiary is any individual who, on the day before the qualifying event for

the Employee, is a beneficiary under the plan and is any of the following:

A. The Employee whose employment was terminated (other than for gross misconduct) or work hours were reduced so as to render the Employee ineligible for coverage;

B. The Spouse of the Employee; or

C. The Dependent Child of the Employee, including a child who is born to or placed for adoption with the Employee during the period of continuation coverage.

11.4 Notice by Employee, Spouse or Dependent

In cases of divorce or legal separation of the Employee from his spouse or a Dependent ceasing to qualify as an eligible Dependent under the Plan, the Employee or eligible Dependent is responsible for notifying the benefits office of the Employer or the Plan Administrator within 60 days after the later of (a) the date of the qualifying event, or (b) the date the Dependent would lose coverage on account of the qualifying event. If the Plan Administrator is not notified within 60 days of the happening of either event, the Dependent will not be given the opportunity to continue coverage. Provided further, that an Employee or Dependent who is determined to be disabled under Title II or XVI of the Social Security Act, either before the qualifying event or during the first 60 days of COBRA coverage, must provide notice of the determination of disability before the end of the first 18 months of coverage to be eligible for up to 29 months of continuation coverage, and must also notify the Plan Administrator within 30 days of any determination that the Employee or Dependent is no longer disabled.

11.5 Notice By Plan Administrator

The Plan Administrator or employing entity shall provide written notice, as required by statute, to the Covered Employee and his spouse (if any) when commencing coverage of the right to continue health and dental coverage, and to any Qualified Beneficiary within 14 days of the termination or reduction of hours or other qualifying event for which the Plan Administrator must notify the Employee. Notice to the Spouse is deemed notice to any Covered Dependent of the Employee residing with such spouse at the time of notification.

11.6 Election of Coverage

Continued coverage is not automatic. Coverage must be elected within 60 days of the later of the following:

1. The date coverage ceases because of the "qualifying event;"

2. The date the Qualified Beneficiary is sent notice of the right to elect continuation coverage.

11.7 Premium Required

Except as provided below, the Qualified Beneficiary will be required to pay a premium calculated as provided by law for the continued coverage and have the option to make

these payments in monthly installments. The eligible Qualified Beneficiary will have 45 days from the date of election to pay the first premium, which shall include the period when coverage commenced, regardless of the date that the first premium is due. Subsequent premiums are subject to a grace period of 30 days.

11.8 Length of Coverage

The maximum period for continued coverage for a "qualifying event" involving termination of employment or a reduction in hours is 18 months. Provided, however, that an Qualified Beneficiary, who is determined to be disabled under Title II or XVI of the Social Security Act, either before the qualifying event or during the first 60 days of COBRA coverage, is entitled to 29 months of continuation coverage, but only if the Qualified Beneficiary has provided notice of the determination of disability before the end of 18 months of coverage. If a second qualifying event occurs within this 18- (or 29-) month period, the coverage for any affected Dependent who was a Covered Person under the Plan at the time of the first qualifying event, and, at the time of the second qualifying event, may be extended up to 36 months from the first qualifying event. For all other qualifying events, the maximum period of coverage is 36 months.

Coverage under this section may end sooner than the periods listed in the preceding paragraph, and will occur on the date of the earliest of any of the following:

A. The date the State ceases to provide any group health plan to any Employee;

B. The date, including any grace period provided herein, the Employee or eligible Dependent fails to make any required payment;

C. The first date after the date of election in which the Qualified Beneficiary is covered under any other group health plan which does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary. Provided, however, that an Employee who, on the date of the qualifying event, is covered by a plan (including Medicare), other than this Plan, remains eligible for COBRA coverage under this Plan;

D. The date the Employee or eligible Dependent already enrolled for COBRA coverage becomes entitled to Medicare.

11.9 Order of Determination of Benefits

If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of determination:

1. First, the benefits of a plan covering the person as an employee, member or subscriber (or as the person's Dependent); and

2. Second, the benefits under the continuation coverage.

11.10 Premium Assistance for COBRA Benefits pursuant to the

American Recovery and Reinvestment Act of 2009

Notwithstanding any other paragraph in this Plan, an Assistance Eligible Individual shall be treated as having paid the full amount of his COBRA premium if such individual pays (or anyone else other than the individual's employer pays on his behalf) 35 percent of the amount of the COBRA premium.

A. Assistance Eligible Individual is any Qualified Beneficiary if:

1. At any time during the period of September 1, 2008, through December 31, 2009, such Qualified Beneficiary is eligible for COBRA continuation coverage;

2. Such Qualified Beneficiary elects such coverage; and

3. The qualifying event with respect to the COBRA continuation coverage consists of the involuntary termination of the Employee's employment and occurred during the period of September 1, 2008, through December 31, 2009.

B. An Assistance Eligible Individual may, not later than 90 days after the date of notice, elect to enroll in coverage under a plan offered by EIP that is different than coverage under the plan in which the Assistance Eligible Individual was enrolled at the time the qualifying event occurred, provided the premium for such different coverage does not exceed the premium for coverage in which the individual was enrolled at the time the qualifying event occurred.

C. An individual who does not have an election of COBRA continuation coverage in effect on February 17, 2009, but who would be an Assistance Eligible Individual if such election were so in effect, such individual may elect the COBRA continuation coverage during the period beginning February 17, 2009, and ending 60 days after the date of notice to such individual, provided such coverage shall commence March 1, 2009, and shall not extend beyond the period of COBRA continuation coverage that would have been required if the coverage had been elected. With respect to this election, the period beginning on the date of the qualifying event and ending with February 28, 2009, shall be disregarded for purposes of determining pre-existing conditions.

D. Eligibility for premium assistance shall cease on the earlier of:

1. The first date that the Assistance Eligible Individual is eligible for coverage under any other group health plan or Medicare; or

2. The earliest of:

   a. The date that is 9 months after the first day of the first month that the individual receives premium assistance;

   b. The date following the expiration of the maximum period of

continuation coverage; or

c. The date following the expiration of the period of continuation coverage allowed under 11.10.C.

E. Any Assistance Eligible Individual who fails to notify his former employer of cessation of eligibility for premium assistance shall pay a penalty of 110 percent of the premium assistance provided for in this paragraph.

ARTICLE 12.

CLAIMS PROCEDURE

12.1 Claim for Payment of Benefits

A. A Covered Person will present an identification card when applying for services covered under this Plan;

B. Written notice of care on which a claim is based must be furnished to the Third Party Claims Processor within 90 days of the beginning of care, or as soon thereafter as is reasonably possible. Upon receipt of the notice, the Third Party Claims Processor will furnish or cause to be furnished to the Covered Person a claim form. If the claim form is not furnished within 15 days after the receipt of the notice by the Third Party Claims Processor the Covered Person will be deemed to have complied with the requirements of this Plan as to proof of loss, if he submits written proof covering the character and extent of the loss within the Plan time fixed for filing proof of loss;

C. A Covered Person must complete or cause to be completed a claim, on forms prescribed by the Plan Administrator or Third Party Claims Processor, and will file it or cause it to be filed, along with all documentation, including medical records, required by the Plan Administrator or Third Party Claims Processor;

D. The claim must be received by the Third Party Claims Processor within 90 days after the beginning of care; however, failure to file the claim within the 90-day period will not prevent payment of benefits if the Covered Person shows that it was not reasonably possible to timely file the claim, provided the claim is filed as soon as is reasonably possible, in no event, except in the absence of legal capacity, later than 12 months following the end of the Benefit Year in which the goods or services were provided;

E. The claim will be deemed written proof of loss and written authorization from the Covered Person to the Third Party Claims Processor to obtain any medical or financial records and documents useful to the Third Party Claims Processor, however, the Third Party Claims Processor is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied to it at the time the claim was processed. Any party who submits medical or financial reports and documents to the Third Party Claims Processor in support of a Covered Person's claim will be deemed to be acting as the agent of the Covered Person.

12.2 Payment of Claims

The Third Party Claims Processor will pay benefits as described in Article 7, Schedule of Benefits, of this Plan directly to Providers who are members in the Provider, Ambulatory Surgical Center or Hospital networks (hereinafter referred to as "participating providers") and any other Providers with whom the Plan Administrator has agreed to make direct payments, automatically, and without any assignment of benefits by the subscriber, when the participating or contracting provider files a health insurance claim form with the Third Party Claims Processor signed by a Covered Person, completed in full, using procedure codes designated by the Third Party Claims Processor for all services rendered.

The right to assign any benefits due and payable hereunder is expressly prohibited except as provided herein. In particular, and without limiting the generality of the foregoing, the Covered Person may not assign any benefits, and the Plan Administrator shall not recognize any assignment of benefits, to: (1) a non-participating provider who was offered and declined membership in the networks; or, (2) a non-participating Provider who did not meet the standards and qualifications for membership in the networks, or (3) a supplier of medical goods, supplies or drugs, unless specifically authorized by the Plan Administrator. Provided, however, the Covered Person may assign benefits to non-participating Providers rendering covered medical services under the Plan who are not within the scope of the networks, or who were not offered and did not decline membership in the networks or as specifically authorized by the Plan Administrator. Failure by the Plan Administrator or the Third Party Claims Processor to reject an assignment of benefits prohibited by this section shall not be construed as a waiver of its rights to enforce this section in the event of subsequent assignments.

A Provider who may accept assignment of benefits shall file a health insurance claim form with the Third Party Claims Processor signed by a Covered Person, completed in full, using procedure codes designated by the Third Party Claims Processor for all services rendered, the Third Party Claims Processor will pay the benefits to the provider. Except as provided above, the Third Party Claims Processor on behalf of the Plan will pay all benefits directly to the Covered Person upon receipt of due proof of loss.

12.3 Allocation and Apportionment of Benefits

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

12.4 Information and Records

As permitted under the Health Insurance Portability and Accountability Act of 1996, the Third Party Claims Processor, as agent of the Plan Administrator, is entitled to obtain such authorization for medical and hospital records as it may reasonably require from any provider of services incident to the administration of the benefits hereunder and the attending Physician's certification as to the Medical Necessity for care or treatment.

12.5 Review of Claims Denied in Whole or Part

If the Third Party Claims Processor, or the Utilization Review Agency or their designee determines that any person who has submitted a claim for the payment or pre-certification of benefits under the Plan is not entitled to receive all or part of the benefits sought, the Third Party Claims Processor, Utilization Review Agency or their designee, shall inform the claimant of such determination and the reasons therefore, with specific reference to pertinent provisions of the Plan. The exclusive remedy for the denial of benefits shall be as provided by statute and by the procedures of the Budget and Control Board.

A. **Reconsideration by Third Party Claims Processor or Utilization Review Agency.** A Covered Person, after receipt of notification of the Third Party Claims Processor's or the Utilization Review Agency's action on his claim, must request a review of any benefits denied in whole or in part within six months of notice of the denial of benefits by the Third Party Claims Processor or the Utilization Review Agency. To request a review of that agency's decision, the Covered Person must write the appropriate agency giving reasons why the claim should be approved. The claimant may also request an expedited reconsideration of the decision denying benefits.

   The Third Party Claims Processor or the Utilization Review Agency shall render its decision within 60 days after the request for review is received, unless medical records are requested, in which case the decision will be rendered no later than 30 days after the requested information is received. If the requested information is not received within 30 days, the decision will be made on the information available at that time. The decision shall be made by one not involved in the original decision to deny benefits or pre-certification. The reconsideration under this section shall be exhausted before any appeal to the Plan Administrator. The Third Party Claims Processor or the Utilization Review Agency will send the Covered Person a written decision stating the specific reasons for its final decision with specific reference to pertinent Plan provisions.

B. **Appeal of Denial of Benefits to Plan Administrator.** After the review provided in 12.5.A, a Covered Person, who is informed that the claim has been denied in whole or in part, or that benefits will not be paid, and who desires review of that determination, may request from the Plan Administrator's director a review of that decision within 90 days after notice of the denial of benefits after reconsideration. The filing of an appeal shall be deemed to be consent for the director or his designee to review all medical records necessary for a determination of the appeal. To hear the appeal, the director may appoint up to five representatives, who are familiar with group health benefits and the State Health Plan and who have not been involved in the denial of benefits in the case under consideration.

   The director, or his designees, may request from the Third Party Claims Processor information reviewed by it, including the pertinent medical records, and may request any additional information from the Third Party Claims Processor, the Utilization Review Agency or the claimant, or from independent medical personnel or other source as in their judgment may be required to make a determination. The

director or his designees shall consider all information submitted, the terms and conditions of the Plan and shall render a decision within 30 days of the receipt of any requested material, providing reasons for the decision and citation of any applicable Plan provisions.

The director, or his designee, shall provide specific reasons for the decision and citation of the pertinent Plan provisions, and may, if the director or his designee agrees with the Third Party Claims Processor or Utilization Review Agency, deny the claim of the Covered Person, and if he agrees with the Covered Person, approve the claim or such portion as is appropriate, provided, however, the director, or his designee, must state in writing the provisions of the Plan justifying the result. The decision of the director, or his designee, on these matters is binding and conclusive, subject to review pursuant to 12.6.

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

12.6 Legal Actions

The exclusive remedy for the denial of benefits shall be as provided in 12.5 and by judicial review of that decision under 1976 S.C. Code Ann § 1-23-380, as amended, as provided by statute. No appeal may be brought until a Covered Person has exhausted the review procedure set forth in 12.5, nor will such action be brought after the expiration of the applicable period for commencing such actions, following the occurrence giving rise to the action. Any construction or interpretation of the Plan, determination of eligibility, or any other decision arising under the Plan, or exercise of judgment or discretion given to the Plan Administrator by the Plan or Planholder, shall be binding and conclusive so long as the decisions of the Plan Administrator or its duly authorized agent are not arbitrary or capricious or in violation of applicable statutes.

12.7 Identification Cards and Booklets

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

12.8 Right to Examine Covered Person

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

12.9 Access to Information

The Plan Administrator will be provided access to all claims data and supporting documents of any person covered under the Plan for purpose of auditing the claims

adjudication procedures. According to the guidelines set forth under the Health Insurance Portability and Accountability Act of 1996, the Plan Administrator agrees to restrict access to all such data and documents to those of the Plan Administrator's employees directly responsible for conduct of the audit, and to assure that the data and documents are handled on a strictly confidential basis.

12.10 Privacy of Protected Health Information

(a) The Plan Administrator and any business associate servicing the Plan will disclose Plan participants' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions for the Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-64). Plan Sponsor shall mean, for the sole purpose of compliance with the mandates of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the South Carolina Budget and Control Board, which established, and maintains, the Group Health Benefits Plan for the Employees of the State of South Carolina, the Public School Districts and Participating Entities.

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

ARTICLE 13.

NOTICE

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

ARTICLE 14.

SUBROGATION RIGHTS

In the event benefits are provided to, or on behalf of, a Covered Person under the terms

of this Plan, the Covered Person agrees as a condition of receiving benefits under the Plan to transfer to the Plan all rights to recover damages in full for such benefits when the injury or illness occurs through the act or omission of another person, firm, corporation, or organization. If, however, a Covered Person receives payment for such medical expenses from another person, firm, corporation, organization or business entity paid by, or on behalf, of the person or entity who allegedly caused the injury or illness, the Covered Person agrees to reimburse the Plan in full for any medical expenses paid by the Plan. The Plan's right of full recovery may be from the third party, any liability or other insurance covering the third party, the insured's own uninsured motorist insurance, underinsured motorist insurance, any medical payments, no fault or malpractice insurance coverages which are paid or payable. The Plan may enforce its reimbursement rights by requiring the Covered Person to cooperate and to assert a claim to any of the foregoing coverages to which the Covered Person may be entitled. The Plan will not pay fees or costs associated with a claim or lawsuit without its express written authorization. The Covered Person shall cooperate with the Planholder and Third Party Claims Processor, if appropriate, on behalf of the Planholder and execute all instruments and do all things necessary to protect and secure the Planholder's right of subrogation. In the event benefits are provided to, or on behalf of, a Covered Person under the terms of this Plan, the Planholder shall be subrogated, at its expense and unless specifically prohibited by law, to the rights of recovery of such Covered Person against any person, firm, corporation, or organization, including such Covered Person's right to uninsured motorists benefits as defined by the South Carolina Motor Vehicle Financial Responsibility Act, as amended, provided, however, that the Planholder shall not be subrogated to such Covered Person's rights to Personal Injury Protection (PIP) benefits as defined by the South Carolina Automobile Reparation Reform Act of 1974, as amended. The Covered Person shall cooperate with the Planholder and Third Party Claims Processor if appropriate, on behalf of the Planholder and execute all instruments and do all things necessary to protect and secure the Planholder's right of subrogation.

ARTICLE 15.

UTILIZATION REVIEW AND MANDATORY CASE MANAGEMENT

SECTION 1

15.1.1 Application

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

benefits for behavioral disorders under the Plan is subject to, and contingent upon, the Covered Person's compliance with the provisions of Section 2 of this Article and the utilization guidelines established by the Behavioral Health Manager.

15.1.2 Pre-Certification of Medical Care

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

A. Any non-emergency admission to a Hospital;

B. Any non-emergency surgical procedure, whether performed in a Hospital, Free Standing Surgical Center, or Ambulatory Surgical Center;

C. Any non-emergency surgical procedure on the foot or knee performed in a Physician's office;

D. Any admission for obstetrical and neonatal (sick newborn) services;

E. Any hospitalization that exceeds the length of stay limitation previously authorized by the Utilization Review Agency;

F. Any admission or re-admission to Extended Benefit Programs, whether or not the benefits payable under this Plan are Primary or Secondary, such as:

1. Hospice program;
2. Skilled Nursing Facility;
3. Home Health Care Program;
4. Alternative Treatment Plan;

G. Any medical services or procedures involving:

1. Inpatient physical therapy;
2. Any second surgical opinion;
3. Any extended care benefits;

H. Any prosthetic appliance or orthopedic brace, crutch or lift attached to such brace, crutch or lift;

I. Any admission, or procedure involving any organ transplant, bone marrow transplant or other stem cell rescue or tissue transplant for which benefits are provided under this Plan;

J. Any purchase or rental of Durable Medical Equipment;

K. High-cost outpatient non-surgical procedures, to be determined at the discretion of the Utilization Review Agency.

15.1.3 Limited Exception to Pre-Certification

Pre-admission certification is not required:

A. For any Hospital admission outside the United States or Canada, which occurs while the Covered Person is in that country for reasons other than obtaining medical services;

B. When the benefits provided under this Plan are secondary to the benefits provided under any other Plan as determined under Article 8, Coordination of Benefits, provided however, that all extended care benefits in 7.10 to 7.13 are subject to Pre-certification under this Article.

15.1.4 Notification of Emergency Admission or Surgical Procedure

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

15.1.5 Concurrent Review of Hospitalization and Individual Case Management

The Hospital stay of any Covered Person shall be monitored by the Utilization Review Agency, which reviews the services and evaluates whether they are appropriate for the diagnosis, and insures that alternative methods of care are considered. Also, the Utilization Review Agency monitors all hospitalizations to identify the most appropriate and cost-effective setting for continued medical care.

15.1.6 Alternative Treatment Plan

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

The Utilization Review Agency after consulting with the treating Physician, and others as appropriate, may recommend an Alternative Treatment Plan in a less intensive care setting. If accepted by the treating Physician, Covered Person and Plan Administrator,

the Utilization Review Agency will assist, as necessary, in implementing the Alternate Treatment Plan. Subject to limitations and exclusions and eligibility requirements, Physician benefits will be paid in accordance with the schedule of benefits, and the medical costs paid by the Covered Person shall be counted towards satisfaction of the out-of-pocket totals under 7.1.A.4 and 7.1.B.4. In addition, services and supplies that are Medically Necessary because of the Alternative Treatment Plan and which would otherwise not be covered under the Plan will be considered as Covered Medical Expenses.

15.1.7 Certification by Utilization Review Agency

A. **Certification and Length of Stay Granted.** The Utilization Review Agency shall reply to the Covered Person, family member, Physician or Hospital within 24 hours. The Utilization Review Agency may certify the procedure or admission and designate a length of stay limitation, if appropriate. The Certification and length of stay limitation constitute a preliminary determination made on the basis of the information then known to the Utilization Review Agency that the procedure or admission and the designated length of stay, are consistent with generally recognized medical standards and procedures, and that, subject to eligibility requirements, other limitations or exclusions, satisfaction of deductibles, and other provisions of the Plan, the procedure or service is eligible for reimbursement under the Plan. The Certification is sent to the Third Party Claims Processor.

B. **Certification or Requested Length of Stay Denied.** If the Utilization Review Agency determines on the information then available that the proposed procedures or services are not within generally recognized medical standards and procedures or the length of stay requested by the health care provider is excessive, the Utilization Review Agency shall inform the Covered Person, family member, as well as the Physician or Hospital and Third Party Claims Processor of that decision. The selection of the course of treatment remains with the patient or Covered Person and the treating Physician. The final decision on whether some or all of a claim will be paid shall be made by the Third Party Claims Processor on the basis of all information known at the time the claim for reimbursement is submitted to the Third Party Claims Processor. The Utilization Review Agency shall reconsider the decision denying Certification only if the Covered Person, treating Physician or Hospital provides new information that may change the result.

15.1.8 Failure to Comply with Utilization Review Requirements

A. **Failure to Obtain Pre-Admission Review.** A patient or Covered Person who does not obtain preadmission review and Pre-certification as required by this Article, in addition to the normal deductible and all other terms and conditions of the selected Plan, shall be subject to the following:

1. A $200 penalty for each admission to a Hospital or Skilled Nursing Facility;
2. The costs incurred during the hospitalization, treatment or extended benefit program shall not be included in those that satisfy the Out-of-

Pocket Limitations of 7.1.A.4 and 7.1.B.4;

3. The costs incurred during the hospitalization, treatment, or extended benefit program shall always be subject to the Coinsurance requirement of the selected plan.

B. Stays in Excess of Length of Stay Limitation. The length of stay limitation is established by the Utilization Review Agency after consultation with the treating Physician, and in light of the information on the Covered Person or patient's condition provided by the Physician, and communicated to the Covered Person, patient, family member, Physician and Hospital. Confinements beyond the length of stay designated by the Utilization Review Agency may be determined to be without Medical Necessity, and reimbursement denied for Room and Board. Other Medically Necessary charges may be covered.

C. Second Opinions may be required by the Utilization Review Agency as a condition to Pre-certification, ongoing certification, or in conjunction with case management or when providing an alternative treatment option. If the opinions are divided, a third opinion may be required, which shall be controlling. The Plan will pay the benefits for the second opinions required by the Utilization Review Agency as provided in 7.15. Second opinions obtained without Certification by the Utilization Review Agency shall be subject to all other terms and conditions of the Plan, including the requirement that they be Medically Necessary, and in addition, if they are Medically Necessary:

1. The costs of a second opinion shall not be included in those costs that satisfy the Out-of-Pocket Limitations of 7.1.A.4 and 7.1.B.4; and

2. The cost of a second opinion shall always be subject to the Coinsurance requirement of the selected Plan.

D. Other Services or Supplies Obtained without Certification from the Utilization Review Agency required by this Plan shall be subject to all the terms, conditions, limitations and exclusions of the Plan, as well as the following:

1. The costs incurred shall not be included in those that satisfy the out-of-pocket limitations of 7.1.A.4 and 7.1.B.4; and

2. The costs incurred shall always be subject to the coinsurance requirement of the selected plan.

E. The Utilization Review Agency may require medical social worker services as a condition of pre-certification of Covered Services. The Plan will pay for the services of a medical social worker as provided in paragraph 7.13.B, at 100 percent of the Reasonable and Customary or Allowable Charge, or the Actual Charge, whichever is less for the purpose of evaluating the patient's needs and identifying other resources, both family and community for which the patient is eligible but are not covered by insurance.

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

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

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

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

15.1.10 Comprehensive Maternity Management

A Covered Person, upon becoming aware of pregnancy, shall notify the Utilization Review Agency. A maternity coordinator providing education and counseling for the mother shall monitor each case. The Covered Person shall be subject to the penalties described in 15.1.8.A for failure to notify the Utilization Review Agency during the first trimester of the pregnancy or refusal to participate in the comprehensive maternity management program. This penalty shall be in addition to that in force for failure to notify the Utilization Review Agency of the hospital admission as described in 15.1.2 and 15.1.4.

SECTION 2

15.2.1 Application

The payment of benefits under the Plan for treatment of Behavioral Health Disorders or

Alcoholism or Drug Abuse is subject to, and contingent upon, the Covered Person's compliance with the following procedures and in accordance with the utilization review procedures established by the Behavioral Health Manager.

15.2.2 Pre-Certification for Covered Behavioral Health Services

The Covered Person, an authorized family member, or Behavioral Health Provider treating the Covered Person shall contact the Behavioral Health Manager at least 24 hours before the Covered Person's receipt of professional, outpatient, or inpatient services for treatment of a Behavioral Health Disorder or Alcoholism or Drug Abuse in the United States or Canada.

15.2.3 Limited Exception to Pre-Certification

Pre-certification is not required:

A. For any Hospital admission outside the United States or Canada, which occurs while the Covered Person is in that country for reasons other than obtaining medical services;

B. When the benefits provided under this Plan are secondary to the benefits provided under any other Plan as determined under Article 8, Coordination of Benefits.

15.2.4 Notification of Psychiatric Emergency

The Behavioral Health Provider, Covered Person, or family member shall notify the Behavioral Health Manager within 24 hours of any emergency admission or any emergency treatment of a Covered Person for a Behavioral Health Disorder or Alcoholism or Drug Abuse. The determination of whether a particular set of facts constitutes an emergency shall be made by the Behavioral Health Manager in conformity with applicable criteria.

15.2.5 Review of Hospitalization and Individual Case Management

The Behavioral Health Manager shall review and determine whether the services provided or to be provided a Covered Person for a Behavioral Health Disorder or Alcoholism or Drug Abuse are Medically Necessary, including but not limited to whether outpatient care, hospitalization, length-of-stay, or diagnostic ancillary services are necessary and appropriate for a Covered Person's condition. Also, the Behavioral Health Manager monitors all hospitalizations to identify the most appropriate and cost-effective setting for continued care.

15.2.6 Alternative Treatment Plan

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

than the one in which the Covered Person is presently receiving medical care. An Alternative Treatment Plan requires the approval of the treating Physician or Behavioral Health Provider, the Plan Administrator and the Covered Person.

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

15.2.7 Certification by Behavioral Health Manager

A. **Certification or Length of Stay Granted.** The Behavioral Health Manager shall reply to the Behavioral Health Provider or Covered Person within 24 hours. The Behavioral Health Manager may certify the procedure or admission and designate a length of stay limitation, if appropriate. The Certification constitutes a preliminary determination made on the basis of the information then known to the Behavioral Health Manager that the determination is consistent with generally recognized medical standards and procedures, and that subject to eligibility requirements, other limitations and exclusions, satisfaction of deductibles and other provisions of the Plan, the procedure or service is eligible for reimbursement under the Plan.

B. **Certification or Length of Stay Denied.** If the Behavioral Health Manager determines, on the information then available, that the proposed procedures or services are not within generally recognized medical standards and procedures or the length of stay requested by the Behavioral Health Provider is excessive, the Behavioral Health Manager shall inform the Behavioral Health Provider and the Covered Person of that decision. The selection of the course of treatment remains with the patient or Covered Person and the treating Behavioral Health Provider. The final decision on whether some or all of a claim will be paid shall be made by the Behavioral Health Manager on the basis of all information known at the time the claim for reimbursement is submitted to the Behavioral Health Manager. The Behavioral Health Manager shall reconsider the decision denying Certification only if the Covered Person or treating Behavioral Health Provider provides new information that may change the result.

15.2.8 Failure to Comply with Utilization Review Requirements

A. **Failure to Obtain Pre-Certification.** A Covered Person who does not obtain Pre-certification as required by this Section, or a Covered Person who requests

services after being informed by the Behavioral Health Provider prior to the rendition of such services that the Behavioral Health Manager has denied Pre-certification of such services, shall be responsible for all the costs incurred during the hospitalization or treatment.

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

C. **Second Opinions.** Second Opinions may be required by the Behavioral Health Manager as a condition of Pre-certification, ongoing certification, or in conjunction with case management. If the opinions are divided, a third opinion may be required, which shall be controlling. The Plan will pay the benefits for the second opinions required by the Behavioral Health Manager as provided in 7.15, subject to all other terms and conditions of the Plan, provided however, that second opinions obtained without Pre-certification by the Behavioral Health Manager are not a Covered Benefit under the Plan.

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

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

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

The Behavioral Health Manager, after consulting with the treating Behavioral Health Provider and reviewing the matter under its internal procedures, may disagree with some medical services recommended or provided by the treating Behavioral Health Provider.

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

ARTICLE 16.

MEDICARE SUPPLEMENTAL PLAN

16.1 Medicare Supplemental Plan

Medicare is the Primary coverage for Retirees eligible for Medicare. To supplement Medicare, the State Health Plan of Benefits also offers a Medicare Supplemental Plan.

A. Enrollment.

Retirees eligible for Medicare, who are enrolled, or eligible to enroll, in the Plan as a Retiree, may enroll in the Medicare Supplemental Plan. The terms, conditions and procedures applicable to enrollment in the Plan as a Retiree under 3.11, are applicable to Retiree enrollment in the Medicare Supplemental Plan. Provided, however, a Retiree enrolled in the Medicare Supplemental Plan may not subsequently enroll in the Standard Plan as Secondary coverage to Medicare.

B. Benefits.

1. **Hospital Admissions.** The Medicare Supplemental Plan will pay the following benefits for covered services received in the United States after Medicare Part A benefits have been paid:

   a) The Medicare Part A hospital Deductible;

   b) The Coinsurance (after Medicare payment) for the 61st through 150th day of hospitalization, up to the Medicare-approved charge;

   c) 100 percent of Medicare-approved charges and reimbursed at the rate approved and paid by Medicare after the 150th day, if Medically Necessary; and,

   d) The Coinsurance for Durable Medical Equipment up to the Medicare-approved charge.

2. **Skilled Nursing Facility.** The Medicare Supplemental Plan will pay the following benefits after Medicare has paid benefits:

a) The Coinsurance (after Medicare payment) for the 21st through the 100th day of confinement in a Skilled Nursing Facility; up to the Medicare-approved charge; and,

b) 100 percent of the Medicare-approved charges and reimbursed at the rate approved and paid by Medicare for confinement after the 100th day in a Skilled Nursing Facility, if Medically Necessary, and if approved by the Utilization Review Agency. The maximum annual benefit per covered person is $6,000.

3. **Physician Charges**. The Medicare Supplemental Plan will pay the following benefits:

a) The Medicare Part B deductible;

b) The Medicare Coinsurance (currently 20 percent or 50 percent for Behavioral Health Disorders) of the Medicare-approved charge for physician's services for surgery, necessary home and office visits, in- hospital visits, and other Physician's services not otherwise excluded by Medicare or this Plan;

c) 20 percent of Medicare approved charges for Physician's services rendered in the outpatient department of a hospital for treatment of accidental injury, medical emergencies, minor surgery and diagnostic services.

4. **Home Health Care**. The Medicare Supplemental Plan will pay the following benefits for Medically Necessary Home Health Care services:

a) The Medicare Part B Deductible;

b) The Coinsurance for any services or costs Medicare does not cover;

c) 20 percent of Medicare approved charges for Durable Medical Equipment;

d) Provided, however, the maximum benefit per Covered Person per Benefit Year is 100 visits or $5,000, whichever occurs first; and further provided that the Medicare Supplemental Plan does not include benefits for services rendered by a person who ordinarily resides in the home, is a member of the family or a member of the family of the spouse of the Covered Person, and further provided that Home Health Care benefits do not include private duty nursing services except as provided in 16.1.B.5, Private Duty Nursing Services, and subject to all the terms and conditions of that section.

5. **Private Duty Nursing Services**. These services are the private services of a registered nurse (RN) or a licensed practical nurse (L.P.N.), which have been certified in writing by a Physician as Medically Necessary. The Medicare Supplemental Plan will pay, subject to an annual $200 Deductible, as follows:

a) 80 percent of Allowable Charges for private duty nursing in a Hospital where no special units are provided; and

b) 80 percent of Allowable Charges for private duty nursing in the Retiree's home;

c) Provided, however, that coverage is limited to no more than three nurses per day, and the maximum annual benefit per Covered Person per Benefit Year is $5,000, up to a maximum lifetime benefit of $25,000;

6. **Prescription Drugs**. Prescription drugs are payable under the terms of Paragraph 7.21 of the Plan.

End of Plan

After you log in, with *My Insurance Manager* you can:

- See how much of your deductible and out-of-pocket limit you have satisfied
- Print an Explanation of Benefits
- Request an ID card
- Ask a question.

To find a network provider, go to the BCBSSC Web site and click on "Find a Doctor or Other Healthcare Provider."

With *My Health Toolkit*, you can:

- Create a Personal Health Record
- Take a Personal Health Assessment
- Find estimates of the cost of treatment.

APPEALS

WHAT IF MY CLAIM OR REQUEST FOR PREAUTHORIZATION IS DENIED?

The Employee Insurance Program (EIP) contracts with claims processors, BlueCross BlueShield of South Carolina, Medco Health Solutions, Inc., and APS Healthcare, Inc., to handle claims for your State Health Plan benefits. You have the right to appeal their decisions.

If all or part of your claim or your request for preauthorization is denied, you will be informed of the decision promptly and told why it was made. If you have questions about the decision, check the information in this book, or call the company that made the decision for an explanation.

If you believe the decision was incorrect, you may ask the company to re-examine its decision. This request should be in writing and should be made within six months after notice of the decision. You (or your physician, on your behalf) may submit any additional information you wish to support this appeal. If you wait too long, the original decision will be considered final, and you will not have any further appeal rights. To begin an appeal, follow the instructions in your denial letter.

If you are still dissatisfied after the decision is re-examined, you may ask EIP to review the matter by making a written request to EIP within 90 days of notice of the denial. If the denial is upheld by EIP, you have 30 days to seek judicial review as provided by S.C. Code Ann. 1-11-710 and 1-23-380.

STATE OF SOUTH CAROLINA)) COUNTY OF CHARLESTON)	IN THE COURT OF COMMON PLEAS FOR THE NINTH JUDICIAL CIRCUIT
Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees, Plaintiffs, v. South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina, Defendants.	Civil Action No.: 2009-CP-10-7404 **CERTIFICATE OF SERVICE**

I, Tracey D. Smith, an employee of the law firm of Montgomery Willard, LLC, attorneys for the Defendants do hereby certify that I have served the below named counsel with copies of *Defendants' Notice of Motion and Motion to Dismiss and For Judgment On The Pleadings and the Affidavit of Robin E. Tester* by mailing copies of same by United States mail, proper postage affixed, return address clearly marked, and addressed as follows:

John A. Massalon, Esquire
Wills & Massalon, LLC
Post Office Box 859
Charleston, South Carolina 29402

Terry E. Richardson, Jr., Esquire
Matthew D. Hamrick, Esquire
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1017 Chuck Dawley Blvd.
Mt. Pleasant, South Carolina 29464

Tracey D. Smith

January 5, 2010
Columbia, South Carolina

STATE OF SOUTH CAROLINA)	IN THE COURT OF COMMON PLEAS
)	FOR THE NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON)	
Jeffrey D. Allen, individually, as guardian) for Jane Doe, a minor, and as representative) of other similarly situated State of South) Carolina employees,)	Civil Action No.: 2009-CP-10-7404
Plaintiffs,)	**DEFENDANTS' MEMORANDUM IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS AND FOR JUDGMENT ON THE PLEADINGS**
v.)	
South Carolina Budget and Control Board) Employee Insurance Program and Blue) Cross and Blue Shield of South Carolina,)	
Defendants.)	

FILED
2010 MAR -3 PM 12: 25
JULIE J. ARMSTRONG
CLERK OF COURT
BY

Defendants, South Carolina Budget and Control Board Employee Insurance Program ("EIP") and BlueCross BlueShield of South Carolina ("BCBSSC"), submit this memorandum in support of their motion to dismiss and for judgment on the pleadings pursuant to S.C.R.C.P. 12 (b) (1), 12 (b) (6) and 12 (c).

I. INTRODUCTION

The Group Health Benefits Plan of the Employees of the State of South Carolina, the Public School Districts, and Participating Entities ("State Health Plan") is a self-funded health plan for state employees, which is administered by the South Carolina Budget and Control Board, Employee Insurance Program ("EIP"). (Affidavit of Robin Tester, ¶ 3). BCBSSC is the claims administrator for the State Health Plan. BCBSSC is not an insurer of the State Health Plan. (Affidavit of Robin Tester, ¶ 4).

Plaintiff, an employee of a South Carolina School District, brings this action to interpret

the State Health Plan, and recover benefits under the State Health Plan for diabetes outpatient, self-management, training and education. Plaintiff alleges that such coverage is mandated by S.C. Code Ann. § 38-71-46.[1] Plaintiff's complaint alleges:

> 5. This is an action for declaratory judgment arising from Defendants' unlawful issuance and administration of the State of South Carolina EIP Standard Plan, a plan of health benefits and insurance offered to all current and retired state employees, including public school district employees, for violation of a SC Code Section 38-71-46, for disgorgement of revenues received as a result of the unlawful issuance and administration, and for declaration to determine the value of unlawfully withheld benefits.
>
> . . .
>
> 11. As the named Plaintiff is an employee of a South Carolina school district, has been enrolled in the EIP Standard Plan, has enrolled his dependent child in said plan who was diagnosed with Diabetes at the age of two years old, and has made multiple claims for his dependent child with a value of approximately One Thousand & 00/100 US Dollars ($1000.00) for diabetes outpatient self-management training and education which were denied by Defendant BCBSSC as administrator to the EIP, his claim, right and privileges are typical of the proposed class.
>
> . . .
>
> 19. Plaintiff seeks, individually and as legal guardian for Jane Doe, and on behalf of all class members, a declaration of the rights of the parties hereto: that Defendants are required to issue and administer all health benefit plans offered through the EIP in compliance with the express mandate of South Carolina Code Section 38-71-46.
>
> 20. Plaintiff seeks an Order of the Court reforming the terms of the health benefit plan provided to all class members effective January 1, 2000 to provide the mandated diabetes coverage.
>
> 21. Plaintiff seeks an Order of the Court requiring the Defendants to disgorge monies received as a result of unlawful denials of the mandatory diabetes coverage, and to pay them to members of the putative class the present value of said unlawfully withheld revenues.

[1] Assuming for the purposes of this motion that S.C. Code § 38-71-46 applies to the State Health Plan, Defendants are entitled to a dismissal of Plaintiff's complaint on the grounds stated herein. However, although not part of the present motion, Defendants do not waive their argument that S.C. Code § 38-71-46 has no application to the State Health Plan.

> 24. The Defendants should be enjoined from the wrongful takings as described above and from further denial of claims for the diabetes outpatient self-management training and education. (Emphasis added).

(Complaint, ¶¶ 5, 11, 19, 20, 21, 24).

As can be seen above, although couched in terms of a purported class action/declaratory judgment action, Plaintiff's complaint is merely one claiming benefits under the State Health Plan. As will be discussed below, actions to resolve claims for benefits under the State Health Plan are exclusively governed by the remedies set forth in S.C. Code Ann. § 1-11-710 (C).

II. DISCUSSION

A. Plaintiff's Causes of Action Are Preempted By S.C. Code Ann. § 1-11-710(C).

A participant and/or beneficiary challenging an award of benefits under State Health Plan is limited to the remedies set forth in S.C. Code Ann. § 1-11-710. § 1-11-710(C) provides as follows:

> Notwithstanding Sections 1-23-310 and 1-23-320 or any other provision of law, claims for benefits under any self-insured plan of insurance offered by the State to state and public school district employees and other eligible individuals must be resolved by procedures established by the board, which shall constitute the exclusive remedy for these claims, subject only to appellate review consistent with standards provided in Section 1-23-380. (Emphasis added).

Id.

Pursuant to the allegations of Plaintiff's complaint, Plaintiff is requesting that the Court interpret the terms of the State Health Plan to include the coverage set out in S.C. Code Ann. § 38-71-46. Plaintiff further alleges that he is entitled to disgorge benefits from the plan for unlawful denials of coverage, and for injunctive relief enjoining "further denial of claims for diabetes Out-patient self-management training and education." Contrary to Plaintiff's arguments,

the interpretation of the State Health Plan and the resolution of claims for benefits under the Plan are exactly the types of remedies contemplated by § 1-11-710(C).

First, the language of the State Health Plan supports EIP's authority to rule on the application of S.C. Code § 38-71-46 to the State Health Plan and the payment of benefits under the Plan. Paragraph 1.3 of the State Health Plan states:

> 1.3 Applicable Law
>
> This Plan is established and will be maintained with the intention of meeting the requirements of all applicable federal and state laws. Any provision of this Plan, which is in conflict with the law of any governmental body or agency that has jurisdiction over this Plan, shall be interpreted to conform to the minimum requirements of such laws. (Emphasis added).

(Exhibit A to Tester Affidavit, p. 1).

This Plan provision is consistent with the enforcement mechanism for S.C. Code § 38-71-46 which is included in S.C. Code § 38-71-80 (2009). § 38-71-80 states:

> Construction of Policy Issued In Violation of this Chapter
>
> A policy issued in violation of this Chapter is held to be valid but must be construed as provided in this Chapter, and when any provisions in the policy is in conflict with any provision of this Chapter, the rights, duties and obligations of the insurer, the policyholder, and the beneficiary are governed by the provisions of the Chapter.

S.C. Code § 38-71-80 (2009).

Second, as can be seen by Exhibit G to Plaintiff's Memorandum In Opposition To Defendant's Motion To Dismiss, during his administrative appeal, Plaintiff, in a letter dated September 30, 2009, made the exact same argument he makes here concerning the application of S.C. Code § 38-71-46 to the State Health Plan. By Plaintiff's own admission, this appeal is still pending. (Plaintiff's Brief, p. 3) (Admitting that there still is a "pending administrative proceeding"); (Exhibit C to Plaintiff's Brief, Affidavit of Christy Ford Allen, ¶ 24 "therefore [I]

believe the appeal is still pending within the Blue Cross administrative process."). Accordingly, by including this issue as part of his administrative appeal, Plaintiff admitted that EIP had the authority to rule on the application of S.C. Code § 38-71-46 to the State Health Plan.

The language of the State Health Plan clearly empowers EIP to take into account applicable state law when resolving benefit claims under the Plan. Because the procedures established by EIP pursuant to § 1-11-710(C) are Plaintiff's exclusive remedy to resolve benefit claims under the Plan, Plaintiff's complaint should be dismissed as a matter of law. Bennett v. South Carolina Dep't of Corrections, 305 S.C. 310, 408 S.E.2d 230 (1991) (statutory requirements proffering administrative remedy and requiring exhaustion before seeking judicial review mandate administrative agency has exclusive right to decide issues before it subject only to appeal for judicial review of its decision).

Plaintiff's attempt to circumvent the statutory requirements of § 1-11-710(C) by alleging a declaratory judgment action is of no avail. It is well settled a court ordinarily will refuse to grant a declaratory judgment where a special statutory remedy has been provided. "Gratuitous interference" in the administrative process should be avoided. Williams Furniture Corp. v. Southern Coatings & Chemical Co., 216 S.C. 1, 7-8, 56 S.E.2d 576, 579 (1949); Smith v. The South Carolina Retirement System, 336 S.C. 505, 520 S.E.2d 339 (Ct. App. 1999). The Court, therefore, should not serve as a substitute for "a tribunal of original jurisdiction in issues that are ripe for litigation by the usual processes." Williams Furniture Corp., at 579; see also Garris v. Governing Bd. of South Carolina Reinsurance Facility, 319 S.C. 388, 390, 461 S.E.2d 819, 821 (1995) ("Declaratory relief will ordinarily be refused where another remedy will be more effective or appropriate under the circumstances," as "relief is not generally available to one who has not exhausted administrative remedies."). In general, judicial review is appropriate only

when appeal is from a final agency order. Id. at 821 (citing S.C. Code Ann. § 1-23-380 (A)). Accordingly, Plaintiff's complaint should be dismissed.

B. **Plaintiff's Complaint Should Be Dismissed Because Plaintiff Failed to Exhaust His Administrative Remedies Under S.C. Code Ann. § 1-11-710(C).**

It is undisputed that Plaintiff failed to exhaust his administrative remedies under the State Health Plan pursuant to S.C. Code Ann. § 1-11-710 (C). (Affidavit of Robin E. Tester ¶¶ 7-10) (Outlining the two-tiered EIP administrative appeals procedure and the fact that Plaintiff never filed a final appeal). Plaintiff even admits that his first level administrative appeal under the State Health Plan is still pending. (Plaintiff's Brief, p. 3) (Admitting that there still is a "pending administrative proceeding"); (Exhibit C to Plaintiff's Brief, Affidavit of Christy Ford Allen, ¶ 24 "therefore [I] believe the appeal is still pending within the Blue Cross administrative process.") Because the exhaustion of administrative remedies is a condition precedent to bringing a claim for benefits under the State Health Plan, Plaintiff's complaint should be dismissed.

§ 1-11-710(C) and the State Health Plan clearly set out the requirement that a Plaintiff must exhaust their administrative remedies prior to bringing an action. The State Health Plan states:

> **12.6 Legal Actions**
> The exclusive remedy for the denial of benefits shall be as provided in 12.5 and by judicial review of that decision under 1976 S.C. Code Ann § 1-23-380, (as amended) as provided by statute. No appeal may be brought until a Covered Person has exhausted the review procedure set forth in 12.5, nor will such action be brought after the expiration of the applicable period for commencing such actions, following the occurrence giving rise to the action. Any construction or interpretation of the Plan, determination of eligibility, or any other decision arising under the Plan, or exercise of judgment or discretion given to the Plan Administrator by the Plan or Planholder, shall be binding and conclusive so long as the decisions of the Plan Administrator or its duly authorized agent are not arbitrary or capricious or in violation of applicable statutes. (Emphasis added).

(Exhibit A to Tester Affidavit, p. 80).

In Unisys Corporation v. The South Carolina Budget and Control Board, 346 S.C. 158, 551 S.E.2d 263 (2001), the Supreme Court interpreted a similar statutory provision requiring exhaustion of administrative remedies and providing exclusive jurisdiction for the administrative appeals process to the State Budget and Control Board. After reviewing the statute, the Court held that because the claimant "is required to exhaust administrative remedies as a matter of law, dismissal under Rule 12(b) (6) for failure to state a claim was proper." Id. at 176, 273 (emphasis added). See also Evans v. State of South Carolina, 344 S.C. 60, 543 S.E.2d 547 (2001) (holding that the circuit court erred by not requiring state retirement program claimants to exhaust administrative remedies before filing lawsuit); Hyde v. South Carolina Department of Mental Health, 314 S.C. 207, 442 S.E.2d 582 (1994) (holding that trial judge abused his discretion by holding that plaintiff did not have to exhaust administrative remedies); Southern Railway Co. v. Order of Railway Conductors of America, 210 S.C. 121, 41 S.E.2d 774 (1947) (holding that exhaustion of administrative remedies precludes court from hearing case when remedies have not been exhausted and statute providing for exhaustion, by its express terms, gives exclusive jurisdiction to administrative agency).

The Supreme Court has held exhaustion of administrative remedies generally is required absent circumstances excusing application of the general rule. Hyde v. S.C. Dep't of Mental Health, 314 S.C. 207, 442 S.E.2d 582 (1994). In Hyde, the Court declared: "[a] trial judge must have a sound basis for excusing the failure to exhaust administrative relief." Id. at 583. The rule of exhaustion is subject to exceptions. See Andrews Bearing Corp. v. Brady, 261 S.C. 533, 201 S.E.2d 241 (1973); Ex parte Allstate Ins. Co., 248 S.C. 550, 151 S.E.2d 849 (1966). "A general exception to the requirement of exhaustion of administrative remedies exists when a party demonstrates that a pursuit of them would be a vain or futile act." Sumter County Council v.

Moore, 300 S.C. 270, 273-74, 387 S.E.2d 455, 458 (1990) (citing 82 Am. Jur. 2d Zoning and Planning § 332 at 903 (1976)). Futility, however, must be demonstrated by a showing comparable to the administrative agency taking "a hard and fast position that [makes] an adverse ruling a certainty." Thetford Properties IV Ltd. Partnership v. U.S. Dep't of Housing and Urban Development, 907 F.2d 445, 450 (4th Cir. 1990); Garris v. Governing Bd. of South Carolina Reinsurance Facility, 319 S.C. 388, 390, 461 S.E.2d 819, 821 (1995) (holding license holder did not meet burden of "showing that a final agency decision [would] not provide an adequate remedy," even where the hearing board had issued a Rule to Show Cause seeking to revoke the license at issue); Stanton v. Town of Pawley's Island, 309 S.C. 126, 128, 420 S.E.2d 502, 503 (1992) (rejecting futility claim by plaintiff denied building permit to rebuild after a hurricane based on Adjustment Board's denial of another owner's identical claim, because "Stanton could not be sure what the Board would rule"). "To allow appellants to avoid the administrative process on their unsupported allegation of futility would allow the futility exception to swallow the exhaustion rule." Thetford Properties, supra.

In the present case, despite Plaintiff's knowledge that his claim for administrative remedies was still pending, Plaintiff failed to plead futility and/or excuse from exhausting administrative remedies.[2] In addition to failing to allege futility, Plaintiff failed to come forward with any evidence of futility. By Plaintiff's own admission, the issue of the application of § 38-71-46 to the State Health Plan, while part of Plaintiff's administrative appeal, has not been ruled in the administrative appeal. Accordingly, Plaintiff cannot prove that EIP has taken "a hard and fast position that [makes] an adverse ruling a certainty." Smith v. The South Carolina Retirement System, 336 S.C. 505, 520 S.E.2d 339 (Ct. App. 1999). At best, Plaintiff's futility argument is

[2] Plaintiff also failed to allege any waiver and/or estoppel on behalf of Defendants.

nothing more than one that Plaintiff is frustrated by an alleged delay in his pending administrative appeal. However, the South Carolina Supreme Court expressly rejected delay as a ground for excuse from exhaustion of administrative remedies in Moore v. Sumter County Council, 300 S.C. 270, 387 S.E.2d 455 (1990) (holding that a party is not excused from administrative remedies because he feels that he will encounter delay, or expense by the agency in acting on his request).

Like the plaintiffs in each of the cases cited, Plaintiff in the current case is attempting to circumvent the statutory requirement that he exhaust his administrative remedies before instituting a lawsuit. However, the exhaustion of administrative remedies requirement is mandatory and cannot be ignored. Accordingly, Plaintiffs' Complaint should be dismissed.

C. The Administrative Law Court Has Exclusive Jurisdiction Over Appeals Concerning Benefits Under The State Health Plan.

Even assuming that Plaintiff did exhaust his administrative remedies under the State Health Plan, which he did not, or that Plaintiff is excused from exhausting his administrative appeals, appeals involving claims under the State Health Plan are under the exclusive jurisdiction of the Administrative Law Court. Accordingly, this Court has no jurisdiction.[3] Pursuant to S.C. Code Ann. § 1-11-710(C), the exclusive remedy available to Plaintiff is the administrative review process provided by the Plan, "subject only to appellate judicial review consistent with the standards provided in Section 1-23-380."

Pursuant to S.C. Code Ann. § 1-23-600 (D), "[a]n administrative law judge also shall preside over all appeals from final decisions of contested cases pursuant to the Administrative

[3] Prior to July 1, 2006, appeals from EIP went directly to the Circuit Court. After July 1, 2006, pursuant to 2006 S.C. Acts 387, appeals from EIP went directly to the Administrative Law Court.

Procedures Act, Article I, Section 22, Constitution of the State of South Carolina, 1895, or another law..."

Because the Administrative Law Court has exclusive jurisdiction over EIP health plan appeals, this Court has no jurisdiction.

D. **Blue Cross Blue Shield of South Carolina Is Not A Proper Party In That It is Not The Insurer of The State Health Plan.**

As can be seen by the affidavit of Robin E. Tester, the State Health Plan is a self-funded health plan for state employees, which is administered by the South Carolina Budget and Control Board, Employee Insurance Program ("EIP"). Blue Cross Blue Shield of South Carolina ("BCBSSC") is the claims administrator for the State Health Plan. BCBSSC is not an insurer of the State Health Plan. Accordingly, BCBSSC is not a proper party.

Plaintiff is not entitled to any relief against BCBSSC in that Plaintiff's exclusive remedy to recover benefits under the State Health Plan is to exhaust his administrative remedies under S.C. Code Ann. § 1-11-710 (C). Additionally, because BCBSSC is not the insurer of the plan, there is no contractual privity between BCBSSC and Plaintiff. Accordingly, there is no contractual duty owed by BCBSSC to pay benefits under the State Health Plan to Plaintiff. Generally, one not in privity of contract with another cannot maintain an action against him in breach of contract, and any damage resulting from the breach of contract between the defendant and a third party is not, as such, recoverable by the plaintiff. Windsor Green Owners Assoc. v. Allied Signal, 362 S.C. 12, 605 S.E.2d 750 (Ct. App. 2004). Because Plaintiff's sole remedy is against the State Health Plan for benefits, not the claim administrator, Plaintiff's causes of action against BCBSSC fail as a matter of law.

E. **Adequate Remedy At Law**

Plaintiff's reformation, disgorgement and injunction allegations fail as a matter of law in that Plaintiff had an adequate remedy at law under S.C. Code Ann. § 1-11-710(C). Where a plaintiff has an adequate remedy at law, equitable relief is not appropriate. Barret v. Miller, 283 S.C. 262, 321 S.E.2d 198 (Ct. App. 1984) (denying a claim for relief based on the equitable doctrine of unjust enrichment where the plaintiff had an adequate remedy at law).

An adequate remedy at law is one which provides the plaintiff with "the full end and justice of the case. It is not enough that there is some remedy at law, but a remedy must be practical, efficient, and prompt as the remedy in equity," such as a contract, tort, or statute. Chisolm v. Pryor, 207 S.C. 54, 35 S.E.2d 21 (1945); Santee Cooper Resort, Inc. v. S.C. Pub. Serv. Comm'n, 298 S.C. 179, 379 S.E.2d 119 (1989) (finding that adequate remedy may be provided by statute); Key Corporate Capital, Inc. v. County of Beaufort, 373 S.C. 55, 644 S.E. 2d 675 (2007) (holding that lower court erred in applying principles of equity where statute provided adequate remedy at law); Scratch Golf Co. v. Dunes West Residential Golf Props., 361 S.C. 117, 603 S.E.2d 905 (2004) (denying equitable relief where a plaintiff failed to establish that it lacked an adequate remedy at law to collect damages in breach of contract and negligence suit against developer). Because Plaintiff has an adequate remedy at law, his equitable causes of action fail as a matter of law.

III. CONCLUSION

For the foregoing reasons, Defendants' motion to dismiss and for judgment on the pleadings should be granted.

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ATTORNEYS FOR DEFENDANTS

March 2, 2010
Columbia, South Carolina

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	IN THE COURT OF COMMON PLEAS FOR THE NINTH JUDICIAL CIRCUIT
Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees, Plaintiffs, v. South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina, Defendants.	Civil Action No.: 2009-CP-10-7404 **CERTIFICATE OF SERVICE**

I, Theodore D. Willard, Jr. of Montgomery Willard, LLC, attorneys for the Defendants do hereby certify that I have served the below named counsel with a copy of *Defendants' Memorandum In Support of Defendants' Motion to Dismiss and For Judgment on The Pleadings* via email and by mailing a copy of same by United States mail, proper postage affixed, return address clearly marked, and addressed as follows:

John A. Massalon, Esquire
Wills & Massalon, LLC
Post Office Box 859
Charleston, South Carolina 29402

Theodore D. Willard, Jr.

March ____, 2010
Columbia, South Carolina

STATE OF SOUTH CAROLINA)	IN THE COURT OF COMMON PLEAS
)	
COUNTY OF CHARLESTON)	CASE NO.: 09-CP-10-7404
Jeffrey D. Allen, individually, as Guardian for Jane Doe, a minor, and as Representative of other similarly situated State of South Carolina employees, Plaintiff, v. South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina, Defendants.	MEMORANDUM IN OPPOSITION TO DEFENDANTS' MOTIONS TO DISMISS

FILED
2010 FEB 26 AM 11:43
JULIE J. ARMSTRONG
CLERK OF COURT
BY

Plaintiff submits this memorandum in opposition to the Motion to Dismiss filed by both Defendants. Defendants have filed motions to dismiss the Complaint on grounds of subject matter jurisdiction, exhaustion, and for failure to state specific claims. Based on the following, the court should deny the Motion to Dismiss and allow this case to proceed

I. BACKGROUND

The Plaintiff, Jeffrey D. Allen is an employee of a local South Carolina school district and an insured/member of the State Health Plan. His daughter, a dependant on that plan, was diagnosed with Type I Diabetes in November 2007 at the age of two (2) years old. This case is about the Defendants' failure to comply with a South Carolina statutory mandate for diabetes coverage and whether this case should be certified as a class action. The Complaint alleges that Defendants have unlawfully denied Plaintiff's and other similarly- situated persons' claims for coverage of diabetes-related education on the grounds that "education is not covered

for diabetes." S.C. Code Ann. section 38-71-46 provides:

Diabetes Mellitus coverage in health insurance policies, diabetes education.

(A) On or after January 1, 2000, *every* health maintenance organization, *individual and group health insurance policy, or contract issued or renewed in this State must provide coverage for* the equipment, supplies, Food and Drug Administration-approved medication indicated for the treatment of diabetes, and *outpatient self-management training and education for the treatment of people with diabetes mellitus*, if medically necessary, and prescribed by a health care professional who is legally authorized to prescribe such items and who demonstrates adherence to minimum standards of care for diabetes mellitus as adopted and published by the Diabetes Initiative of South Carolina.[1] This subsection does not prohibit a health maintenance organization or an individual or a group health insurance policy from providing coverage for medication according to formulary or using network providers. Coverage must not be denied unless the health care professional demonstrates a persistent pattern of failure to adhere to the minimal standards of care and unless the health maintenance organization or insurer has first provided written notice to the health care professional that coverage will be denied if the health care professional fails to adhere to the minimal standards of care.

(B) Services and payment for diabetes education programs shall conform to regulations of the Health Care Financing Administration, US Department of Health and Human Services, pursuant to Section 4105 of the Balanced Budget Act of 1997. Diabetes outpatient self-management training and education shall be provided by a registered or licensed health care professional with certification in diabetes by the National Certification Board of Diabetes Educators, or other accredited program approved by the Diabetes Initiative of South Carolina, or by the Diabetes Control Program of the SC Department of Health and Environmental Control in order to meet the needs of rural communities wherein certified health care professionals providing this service are not available.

(C) Nothing contained in this section may be construed to affect in any way the ability of a managed care plan to credential or re-credential a provider.

(D) For purposes of this section: "*Health insurance policy" means a health benefit plan*, contract, or evidence of coverage providing health insurance coverage as defined in Section 38-71-670(6) and Section 38-71-840(14).

[1] The Diabetes Initiative of South Carolina has adopted the standards promulgated by the American Diabetes Association (ADA). *See* Exhibit A (Affidavit of Daniel Lackland, Executive Director of the Diabetes Initiative of South Carolina).

(emphasis added).

The Complaint alleges that the Plaintiff is insured through the State Health Plan, which is a non-ERISA health benefit plan,[2] and that the State Health Plan is in violation of the diabetes mandate by its failure to provide coverage for diabetes education in accordance with the statutory mandate which has been in effect since 2000. Upon denial of a single claim for diabetes education, Allen attempted to appeal the denial months prior to filing this action, and the details of the status of the pending administrative proceeding are set forth in detail in the Affidavits of Jeffrey Allen and Christy Allen, attached as Exhibits B and C.

The Complaint alleges that over 15,000 State of South Carolina employees have diabetes, and that the exact number of class members affected by the Defendants' unlawful exclusion of coverage for diabetes education is known only to the Defendants and will be ascertained in discovery. Blue Cross is a defendant because Plaintiff has made all claims and/or communicated only with Blue Cross and Blue Shield of South Carolina (hereinafter "Blue Cross"), and has no information regarding the relationship between the State of South Carolina Budget and Control Board Employee Insurance Program (hereinafter "EIP").

The Complaint seeks: (1) class action certification; (2) a declaration that the State of South Carolina benefit plan violates the diabetes mandate; (3) a declaration regarding the future rights of the members of the putative class; (4) reformation of the benefit plan to comply with the mandate; (4) disgorgement and return of all profits and/or monies which should have been paid to putative class, (5) an injunction to stop the Defendants from continuing their unlawful actions

[2] 29 U.S.C.A. § 1003(b)(1) expressly excludes government plans from the broad sweep of ERISA preemption of state laws. *Silvera v. Mutual Life Ins. Co. of New York*, 884 F.2d 423, 425 (9th Cir. 1989). ERISA expressly defines governmental plan as including a plan established by the government of a State or political subdivision 29 U.S.C.A. § 1002 (32).

in the future, and (6) costs and attorneys fees.

II. LEGAL ANALYSIS

A. THIS COURT HAS SUBJECT MATTER JURISDICTION

Defendants cite to S.C. Code Ann. § 1-23-600(D) as the basis of their 12(b)(1) motion. Section 1-23-600(D) is part the statute setting forth hearing procedures before the S.C. Administrative Law Court, and states that an "administrative law judge also shall preside over all appeals from final decisions of contested cases" pursuant to the APA, Art. I, section 22 of the Constitution, or another law, ... It then goes on to except various appeals from specific agencies -- none of which involved the Defendants or issues in this case. This statute does not appear to remove general subject matter jurisdiction from this court, and the undersigned can only surmise that this reference goes to the general defense of exhaustion of administrative remedies.

In *Capital City Ins. Co. v. BP Staff, Inc.*, 674 S.E.2d 524, 529 (S.C. Ct. App. 2009), the Court of Appeals recently addressed this very issue, and explained that exhaustion is a "rule of policy, convenience and discretion, rather than one of law, and is not jurisdictional." And, the failure to exhaust administrative remedies goes to the prematurity of a case, not subject matter jurisdiction. *Id.* In the present case, Allen's declaratory judgment, equitable and injunctive claims are part of the general class of cases which the court of common pleas has jurisdiction to hear. The mere fact that Allen is also engaged in an administrative proceeding regarding a single claim does not divest the circuit court of its power to hear and determine the claims asserted in the Complaint.

Thus, this trial court has subject matter jurisdiction to hear these types of claims, and should not dismiss Allen's complaint pursuant to Rule 12(b)(1), SCRCP.

B. THE COURT SHOULD DENY DEFENDANTS' 12(B)(6) MOTION

Defendants ask this court to dismiss the Complaint pursuant to SCRCP, Rule 12(b)(6) on the grounds of exhaustion and preemption; failure to state a claim for reformation, disgorgement, and injunctive relief; and the failure to state a claim against BCBSSC because it is allegedly not the insurer. A motion pursuant to Rule 12(b)(6) should be denied unless the court finds that, in the light most favorable to the plaintiff, and with every doubt resolved on his behalf, the complaint states no valid claim relief on any theory. *Plyler v. Burns*, 647 S.E.2d 188, 192 (S.C. 2007).

1. *As a Matter of Law, Exhaustion is Not Required*

Defendants often assert in opposition to class action allegations that administrative remedies have not been exhausted arguing that if the remedies were pursued the case might be resolved without the intervention of the court. That argument fails in this case because neither the State Health Plan nor the state statute governing claims within the context of the state benefit plan offer administrative remedies that adequately embrace the issues presented in this putative class action Complaint.

Section 1-11-710(C) of the South Carolina Code provides that "*claims for benefits* under any self-insured plan of insurance offered by the State to state and public school district employees and other eligible individuals must be resolved by procedures established by the board [South Carolina Budget and Control Board], which shall constitute the exclusive remedy

for these claims, subject only to appellate judicial review consistent with the standards provided in Section 1-23-380." S.C. Code Ann. § 1-11-710(C) (emphasis added). Section 1-23-380 entitled "Judicial review upon exhaustion of administrative remedies" "does not limit utilization of or the scope of judicial review *available under other means of review, redress, relief,* or trial de novo provided by law." S.C. Code Ann. § 1-23-380 (A) (Supp. 2009).

In South Carolina, generally, "[w]hen an administrative remedy is available *to determine a question of fact,* one must seek the administrative remedy or be precluded from pursuing relief in the courts." *Stinney v. Sumter School Dist. 17*, 675 S.E2d 760, 763 (S. C. Ct. App. 2009) (citing *Hyde v. Dept. of Mental Health*, 442 S.E.2d 582, 583 (S.C. 1994)) (emphasis added). "A party is not required to exhaust administrative remedies if the issue is one that cannot be ruled upon by the administrative body." *Capital City Ins. Co.*, 674 S.E.2d at 529 (quoting *Charleston Trident Home Builders, Inc. v. Town Council of Town of Summerville*, 632 S.E.2d 864, 867 (S.C. 2006) (citing *Ward v. State*, 538 S.E.2d 245 (S.C. 2000); *see also Stinney*, 675 S.E.2d at 763 (recognizing that inadequacy of the administrative appeal is an exception to the general rule requiring exhaustion).

The claims made in this Complaint are not "claims for benefits" within the meaning of section 1-11-710(C), and continuing with the appeal would not provide Plaintiff with an adequate remedy.[3] The only result possible from the administrative proceeding underway would

[3] With regard to many, if not most insurance claims, the Defendants' exhaustion defense would be applicable. However, a review of several of those cases illustrates how this case is different. For example, in *James v. South Carolina State Budge and Control Board*, 640 S.E.2d 474 (S.C. Ct. App. 2007), the appellate court upheld the circuit court's reversal of the EIP's denial of a claim for a child's cranial molding device as not medically necessary. That case was heard by the EIP, appealed through the Administrative Procedures Act to the Circuit Court, and then the Court of Appeals. In *Grier v. South Carolina Budget and Control Board*, 07-ALJ-30-0139 (2008), the ALJ upheld the reversal of the EIP's denial of a claim for abdominoplasty ("tummy tuck") as not medically necessary. In

not provide the relief sought by Allen and the potential class members. The issues to be determined are not "questions of fact," but are questions of law. The denial of the subject claim states "education is not covered for this condition [diabetes mellitus]," and South Carolina Code Section 38-71-46 states that "[o]n or after January 1, 2000, *every health maintenance organization, individual and group health insurance policy, or contract issued or renewed in this State must provide coverage for . . . outpatient self-management training and education for the treatment of people with diabetes mellitus* . . . ."

If the denial of the subject claim were reversed, Allen would receive coverage for a single $560 diabetes education claim. However, neither the Allen benefit plan nor the putative class members' benefit plans would be reformed to provide the statutorily mandated insurance coverage for diabetes education. Allen prevailing in the administrative process would not require the Defendants to review all denials made in violation of the diabetes mandate since its enactment in 2000. Allen prevailing in the administrative process would not enjoin the Defendants from violating the diabetes mandate in the future, nor force disgorgement of revenues and profits related to the illegal conduct. This is not a case seeking resolution of a claim for benefits.

2. This Court Has The Discretion To Allow This Case To Go Forward At This Time

Whether administrative remedies must, in fact, be exhausted is a matter within the circuit court's sound discretion, and this decision will not be disturbed on appeal short of an abuse of

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Hendley v. South Carolina Budget and Control Board, 481 S.E.2d 159 (S.C. Ct. App. 1996), the court affirmed the lower court's reversal of a decision made by the EIP to deny coverage for a hair prosthesis (or "wig") through interpretation of the language of the benefit plan regarding prostheses. All of these cases involved the agency/administrative review of and interpretation of its own policies and contracts, and single claims for benefits.

discretion. *Hyde*, 442 S.E.2d at 582-83. The purpose of the exhaustion requirement, to allow the agency to render a final decision and set forth its reason for denying the diabetes education claim, would not assist the court in this case. The alleged wrong – violation of the statutory mandate—is not one which the administrative process was designed to address.

> The doctrine of exhaustion of administrative remedies only comes into play when a litigant attempts to invoke the original jurisdiction of a circuit court to adjudicate a claim based on a statutory violation for which the legislature has provided an administrative remedy. A litigant need not exhaust administrative remedies where there are no administrative remedies for the wrongs it assertedly suffered.

Capital City Ins., 674 S.E.2d at 530 (citations omitted). Courts have recognized an exception to the requirement of exhaustion of administrative remedies exists when a party demonstrates that pursuit of them would be a vain or futile act. *See Moore v. Sumter County Council*, 387 S.E.2d 455, 458 (S.C. 1990).

The present case will require the court to determine if the South Carolina Budget and Control Board[4] and BlueCross and Blue Shield of South Carolina, as administrator of the State Health Plan, are required to comply with South Carolina laws regulating insurance. Section 1-23-380 [which is expressly incorporated into section 1-11-710(C)] "does not limit utilization of or the scope of judicial review **available under other means of review, redress, relief,** or trial de novo provided by law." S.C. Code Ann. § 1-23-380 (A) (Supp. 2009). *See Stinney v. Sumter School Dist. 17*, 675 S.E.2d at 764. The Plaintiff's Complaint seeks relief, not under the benefit plan language, but under the South Carolina Declaratory Judgment Act, Rule 23 of the South Carolina Rules of Civil Procedure, and common law principles of equity.

[4] The State Budget and Control Board is a statutorily-created entity made up of the Governor, the State Treasurer, the Comptroller General, the chairman of the Senate Finance Committee, and the chairman of the Ways and Means Committee of the House of Representatives. S.C. Code. Ann. § 1-11-10.

3. Plaintiff Is Excused From Further Administrative Proceedings and That by Their Action, Defendants Have Waived the Assertion of the Defense of Exhaustion

The State of South Carolina provides all eligible employees a copy of the *Insurance Benefit Guide* as published annually by the S.C. State Budget and Control Board Employee Insurance Program. *See* Exhibit B (Affidavit of Jeff Allen ¶ 9), Exhibit D (2009 *Insurance Benefit Guide*)[5]. From the *Guide*, one selects from several benefit plan options—one of which is the State Health Plan administered by Blue Cross. No other documentation is provided directly to employees. *Id.* The 2009 *Guide* booklet contains 236 pages, and the only provision related to any appeal process is as follows:

> The Employee Insurance Program (EIP) contracts with claims processors, BlueCross BlueShield of South Carolina, Medco Health Solutions, Inc., and APS Healthcare, Inc., to handle claims for your State Health Plan benefits. You have the right to appeal their decision.
>
> If all or part of your claim or your request for preauthorization is denied, you will be informed of the decision promptly and told why it was made. If you have questions about the decision, check the information in this book, or call the company that made the decision for an explanation.
>
> **If you believe the decision was incorrect, you may ask the company to re-examine its decision. This request should be in writing and should be made within six months after notice of the decision.** You (or you physician, on your behalf) may submit additional information you wish to support this appeal. If you wait too long, the original decision will be considered final, and you will not have any further appeal right. **To begin an appeal, follow the instructions in your denial letter.**
>
> If you are still dissatisfied after the decision is re-examined, you may ask EIP to review the matter by making a written request to EIP within 90 days of notice of the denial. If the denial is upheld by EIP, you have 30 days to seek judicial review as provided by S.C. Code Ann. 1-11-710 and 1-23-380.

[5] Attached as Exhibit D is the entire State Health Plan Health Insurance, cover page – p. 61, portion of the 2009 Insurance Benefits Guide. The undersigned will bring to the hearing and provide the entire Guide to the court upon request.

Exhibit D (*Guide* at p. 61) (emphasis added). The Affidavits of both Jeff Allen and Christy Allen explain in exhausting detail the attempts made to comply with the only procedures and deadlines set forth in the *Insurance Benefit Guide* and the instructions in the "denial" letters. To summarize, the initial request to reconsider the denial was made to BlueCross within the six (6) months after the denial decision, and the most recent submission to Blue Cross of the requested medical records was made within the 225 day time period stated in the instructions at the bottom of the "ADJUSTMENT" denial letter dated April 20, 2009. To this date, neither Defendant has ever explained its decision to deny, nor provided any response to the Allen appeal. *See* Exhibit C (C. Allen Affidavit ¶¶ 11, 14, 20).

Attached to the Affidavit in support of the Defendants' Motion to Dismiss was a copy of the alleged *Insurance Plan Document*, a 93-page document. Defendants cite to the detailed claims procedure therein to explain the alleged administrative appeal procedures. However, as set forth in the Affidavits of both Plaintiff and his wife: (1) the Defendants do not provide copies of the *Insurance Plan Document* to employees/insureds; (2) Mrs. Allen attempted twice to retrieve a copy of said *Insurance Plan Document* from Defendant EIP prior to the filing of this lawsuit; and (3) the Defendants repeatedly refused to provide a copy of the documents. *See* Exhibits B ¶¶ 10-13 and Exhibit C ¶¶ 23-25. On November 25, 2009, Plaintiff's counsel mailed a formal South Carolina Freedom of Information Act Request for the *Insurance Plan Document* as referenced in the "Insurance Benefits Guide. Defendant and counsel for the Defendant refused, for the third time, to provide a copy of the *Insurance Plan Document*. *See* Exhibit E (Letters).

In light of the effort of the Plaintiff and unexplainable delays and confusion, the Defendants should be deemed to have waived any further reliance on the defense of exhaustion. The Plaintiff and his wife made numerous efforts to navigate the "claims procedure" prior to discovering the statutory mandate for diabetes education coverage. Finally, Plaintiff should not be forced to await a decision from Blue Cross on his appeal so that he can then submit it to the EIP for further review because of a possible statute of limitations deadline. This court has broad discretion in its supervision over the progression and disposition of a circuit court case in the interests of justice and judicial economy. *See Williams v. Bordon's Inc.*, 262 S.E.2d 881, 883 (S.C. 1980). "A party should not be required to 'roll the dice' on whether a collateral administrative proceeding will conclude prior to the running of an applicable statute of limitations in order to preserve a claim properly within the jurisdiction of the circuit court." *Capital City Ins. Co. v. BP Staff, Inc*, 674 S.E.2d 524, 531 (S.C. Ct. App. 2009).

was first diagnosed with Type I diabetes on November 27, 2007 at the age of two, and diabetic education and training was provided during her initial 3-day hospital stay. In reviewing all claims for diabetic education made by Allen, Defendants have denied three other such claims dating back to December 17, 2007. See Exhibit C (C. Allen Aff. ¶ 22). In light of the State of South Carolina board/agency being named as a Defendant, the undersigned made the determination to commence this action within two (2) years of the date of diagnosis, so as not to risk a possible statute of limitation defense related to the two (2) year statute of limitation in the South Carolina Tort Claims Act. Plaintiff should not be prejudiced by a decision to protect himself against all statute of limitations defenses. The court in *Capital City* held that where a party would be harmed by the running of the statute of limitations or otherwise prejudiced if its

claim is dismissed on exhaustion of administrative remedies, and the court has determined that resolution of the administrative proceeding would impact the circuit court case, then the circuit court should properly consider a stay or continuance of the judicial action until the administrative proceedings have concluded. *Id.* at 531.

4. The Complaint States a Claim for Reformation, Disgorgement, and Injunctive Relief

Defendants have moved to dismiss the claims for reformation, disgorgement and injunctive relief on the grounds that the Complaint fails to state a claim for relief. An action to reform an insurance policy is an action in equity. *Elias v. Fireman's Ins. Co. of Newark, New Jersey*, 420 S.E.2d. 504, 505 (S.C. 1992). The Complaint in this case alleges that the State Health Plan, an insurance policy within the express terms of 38-71-46(D), violates the diabetes mandate. The freedom of parties to contract is not absolute, and insurance coverage required by law may not be omitted because statutory provisions relating to an insurance contract are part of the contract. *See Bovain v. Canal Ins.*, 678 S.E.2d 422, 429 (S.C. 2009) (citing *Jordan v. Aetna Cas. & Sur. Co.*, 214 S.E.2d 818, 820 (S.C. 1975). The reformation claims should be permitted to forward at this early stage.

The equitable remedies of restitution and disgorgement require payment of the defendant's ill-gotten gain. *Ellett Brothers, Inc. v. USF&G Co.*, 275 F.3d 384, 388 (4th Cir. 2001) (interpreting South Carolina law). The Plaintiff's class action Complaint sufficiently contains allegations of ill-gotten gain by one or both of the Defendants – that of the retention of monies which should have been paid to the Plaintiff and others similarly situated for claims made for diabetes education. For example, with regard to the named Plaintiff alone, the four

claims he made, which were all denied on the grounds that education is not covered for diabetes total over One Thousand & 00/100 US Dollars ($1,000.00).

The Plaintiff's Complaint seeks an injunction requiring the Defendants stop wrongfully denying diabetes education claims, and provide the statutorily-mandated coverage in the future. Generally, to obtain an injunction, a party must demonstrate irreparable harm, a likelihood of success on the merits, and an inadequate remedy at law. *Roach v. Combined Util. Comm'n*, 351 S.E.2d 168, 170 (S.C. Ct. App. 1986). The allegations of the Plaintiff's Complaint are sufficient to state a claim for injunctive relief. The subject of this Complaint deals with the harm of a large health benefit plan/insurer continuing to deny health benefit claims for diabetes education, which in addition to the financial burden said denials place on the thousands of South Carolinians affected, arguable deters others from seeking those educational services. This is an irreparable harm. The plain and unambiguous language of the diabetes mandate statute is sufficient to support the conclusion that the Plaintiff is likely to be successful on the merits. Lastly, the allegations of the declaratory and equitable claims made in the complaint, as opposed to more typical legal claims, illustrate the inadequacy of a remedy at law. There is no basis on which to dismiss the claim for a permanent injunction as relief in the ultimate outcome of this putative class action at this time, and the Defendants' motion should be denied.

5. The Complaint States a Claim against Blue Cross Blue Shield of South Carolina

Lastly, the Defendants' joint motion seeks to dismiss Blue Cross because is it labeled the third party claims administrator to the State Health Plan. A motion pursuant to Rule 12(b)(6) should be denied unless the court finds that, in the light most favorable to the plaintiff, and with

every doubt resolved on his behalf, the complaint states no valid claim relief on any theory. *Plyler v. Burns*, 647 S.E.2d 188, 192 (S.C. 2007). Looking at the four corners of the Plaintiff's Complaint, it alleges that Defendant Blue Cross was responsible for administering all claims for the State Health Plan, including those made by Plaintiff for diabetes education, and that the only explanation provided to date for the denial of those claims by Blue Cross appears contrary to the plain language of the statutory mandate which is the subject of this action.

"A suit for declaratory judgment is neither legal nor equitable, but is determined by the nature of the underlying issue." *Felts v. Richland County*, 400 S.E.2d 781, 782 (S.C. 1991). "To state a cause of action under the Declaratory Judgment Act, a party must demonstrate a justiciable controversy." *Graham v. State Farm Mut. Auto. Ins. Co.*, 459 S.E.2d 844, 845-46 (1995). A justicable controversy exists when a concrete issue is present, there is a definite assertion of legal rights, and a duty denied by the adverse party. *Id.* The facts pled in the Complaint are sufficient to state a claim for the declaratory and equitable relief demanded.

The Affidavit submitted by the Defendant attempts to define the relationship between the two defendants, however, at this early stage of the litigation, the Plaintiff is entitled to discovery on the details of Blue Cross's role, contractual duties, whether the Defendant Blue Cross has a compensation package or financial interest which is contingent on the approval or denial of certain benefit claims, and whether Plaintiff is a third-party beneficiary to the contract between EIP and Blue Cross.

6. The Motion to Dismiss for Judgment on the Pleadings Pursuant to Rule12(C) Should Be Denied

A Rule 12 (c), like Rule 12(b) (6), motion admits the well-pleaded facts in the Complaint; it does not admit the inferences drawn by the plaintiff from such facts, nor does it admit conclusions of law. *Carolina Winds Owners' Association, Inc. v. Joe Harden Builder, Inc.*, 374 S.E.2d 897, 899 (S.C. Ct. App. 1988) (reversed on other grounds). For the reasons stated above with regard to the sufficiency of the Plaintiff's Complaint to state a claim for declaratory judgment and equitable remedies of reformation, disgorgement, and injunction, this motion should be denied. The Motion and Affidavit submitted by the Defendants in lieu of their filing Answers fail to provide this court with any basis on which to dismiss the Plaintiff's Complaint pursuant to Rule 12(c).

III. CONCLUSION

This case is a putative class action which potentially could affect thousands of South Carolinians employed (current and retired) by the State of South Carolina and its local school districts and municipalities, and involves a disease which according to the State of South Carolina affects 9.6% of the population of this State. The allegations in the Plaintiff's Complaint, taken in the light most favorable to the Plaintiff, are sufficient to withstand these Defendants' Rule 12 motions. The motions should be denied.

John A. Massalon
Wills, Massalon & Allen, LLC
Post Office Box 859
Charleston, South Carolina 29401
(843) 727-1144

-and-

Terry E. Richardson, Jr.
Matthew D. Hamrick
Richardson, Patrick, Westbrook & Brickman, LLC
1017 Chuck Dawley Blvd.
Mt. Pleasant, South Carolina 29464
(843) 727-6500

ATTORNEYS FOR PLAINTIFF

Charleston, SC

February 26, 2010

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on February 26, 2010, a copy of the attached pleading was emailed and placed in an envelope, with first-class postage prepaid, and mailed to:

Theodore D. Willard, Jr.
Montgomery Willard, LLC
Post Office Box 11886
Columbia, South Carolina 29211
(803) 779-3500

Kelly H. Rainsford
State Budget & Control Board
1201 Main Street, Ste. 300
Columbia, South Carolina 29201
(803) 737-0825

ATTORNEYS FOR DEFENDANTS

Faith Trimble
Wills & Massalon, LLC

Exhibit "A"

to Plaintiff's Memorandum in Opposition to Defendant's Motion to Dismiss

STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON

AFFIDAVIT

PERSONALLY appeared before me, Daniel T. Lackland, Dr.PH, who duly sworn, deposes, and states as follows:

1. I am competent to make this Affidavit.
2. I am 18 years of age or older.
3. That the contents of this Affidavit are true, and are made based on personal knowledge.
4. That I am the current Board Chair of the Diabetes Initiative of South Carolina (DSC).
5. The Diabetes Initiative of South Carolina (DSC) was created by legislative action and signed into law by the Governor of South Carolina in July, 1994. The law established a Board of Directors with members appointed by the top officials of key organizations with an interest in diabetes and its complications.
6. The DSC has adopted and publishes the annual standards promulgated by the American Diabetes Association (ADA) as the minimum standards of care for diabetes mellitus, and those standards explain that diabetes self-management education (DSME) is a critical element of care for all people with diabetes and is necessary in order to improve patient outcomes. DSME "is the ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care."



Exhibit "A" to
Plaintiff's Memorandum in
Opposition

FURTHER THIS AFFIANT SAYETH NOT.

Daniel T. Lackland

SWORN to before me this

22 day of Janu 2010.

Notary Public for South Carolina

My Commission Expires: 10-9-19

Exhibit "B"

to Plaintiff's Memorandum in Opposition to Defendant's Motion to Dismiss

STATE OF SOUTH CAROLINA)		IN THE COURT OF COMMON PLEAS
)		
COUNTY OF CHARLESTON)		CASE NO.: 09-CP-10-7404
Jeffrey D. Allen, individually, as Guardian for Jane Doe, a minor, and as Representative of other similarly situated State of South Carolina employees,		
Plaintiff,		AFFIDAVIT OF JEFFREY D. ALLEN IN SUPPORT OF PLAINTIFF'S MEMORANDUM IN OPPOSITION TO MOTION TO DISMISS
v.		
South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina,		
Defendants.		

PERSONALLY appeared before me, Jeffrey D. Allen, who duly sworn, deposes, and states as follows:

1. I am competent to make this Affidavit.
2. I am 18 years of age or older.
3. That the contents of this Affidavit are true, and are made based on my personal knowledge.
4. That I am employed in the district office by the Dorchester County School District No. 2, and am insured through the State Health Plan.
5. That my daughter is a dependant on that insurance plan.
6. That on August 5, 2008, I attended, along with my wife, family caregivers, and two Charleston County School District Nurses who were to be charged with the care of her daughter at school beginning in August 2008, a training session set up by MUSC Pediatric Endocrinology to train her daughter's caregivers, at home and school, how to

operate our daughter's new insulin pump just prescribed by her physician and scheduled to be attached to her body the following week. That training session lasted approximately two hours and was taught by a MUSC diabetic educator.

7. That I first received notice that the claim for the diabetes education services on August 5, 2008 had been denied some time after August 27, 2008 and the denial stated it was based on the grounds that the "benefit plan does not cover education and/or training for this condition."

8. That my wife, Christy Ford Allen, began the appeal process of that denial, but I was not involved in the details of her communications with Blue Cross and MUSC.

9. That I brought home the only insurance documentation I had – the *2009 Insurance Benefits Guide*, attached as Exhibit _ to the Plaintiff's Memorandum in Opposition.

10. That sometime in October 2009, my wife asked me to walk down to the district office benefits administrator and request to see a copy of the *Plan of Benefits Document*.

11. That I did in fact visit the district benefits administrator, but no such document was available.

12. That on October 15, 2009, my wife drafted the attached written request to the Employee Insurance Program for a copy of the *Plan of Benefits Document*.

13. That as of the date of this Affidavit, I had not received any response to my request, and that I first saw a copy of the *Plan of Benefits Document* when Defendants attached it as an attachment to the Defendants' Motion to Dismiss.

FURTHER THIS AFFIANT SAYETH NOT.

Jeffrey D. Allen

SWORN to before me this

24th day of February 2010.

Notary Public for South Carolina

My Commission Expires: 12/19/19

October 15, 2009

Jeffrey D. Allen

South Carolina Budget and Control Board
Employee Insurance Program
1201 Main Street, Suite 300
Columbia, South Carolina 29201

To whom it may concern:

This is a request for a copy of the documents referenced in the 2009 Insurance Benefits Guide entitled State Health Plan "*The Plan of Benefits* (available in your benefits office or through EIP)", see Guide at p. 58, and Benefit Contracts. I am insured under the State Insurance Plan administered by BCBSSC. I attempted to review portions to The Plan of Benefits at the office of my benefits administrator, but she reported that she did not have the document, nor has she ever been provided a copy from the EIP. I do not know what the Plan of Benefits includes, but am requesting that you send me a copy of the provisions related to health insurance coverage/exclusions. I presume that you will provide me with a copy as your office is referenced in the Guide as the entity to contact, and because such would appear subject to State FOIA regulation. I will be glad to pay any reasonable copying charge. If the document is available electronically, I would prefer a digital copy by email over a paper copy.

Sincerely,

Jeffrey D. Allen

Exhibit "C"

to Plaintiff's Memorandum in Opposition to Defendant's Motion to Dismiss

STATE OF SOUTH CAROLINA)) COUNTY OF CHARLESTON)	IN THE COURT OF COMMON PLEAS CASE NO.: 09-CP-10-7404
Jeffrey D. Allen, individually, as Guardian for Jane Doe, a minor, and as Representative of other similarly situated State of South Carolina employees, Plaintiff, v. South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina, Defendants.	AFFIDAVIT OF CHRISTY FORD ALLEN IN SUPPORT OF PLAINTIFF'S MEMORANDUM IN OPPOSITION TO MOTION TO DISMISS

PERSONALLY appeared before me, Christy Ford Allen, who duly sworn, deposes, and states as follows:

1. I am competent to make this Affidavit.
2. I am 18 years of age or older.
3. That the contents of this Affidavit are true, and are made based on my personal knowledge.
4. That I am the wife of the named Plaintiff Jeffrey D. Allen and the mother of , a minor for whom the subject insurance claim was made.
5. That at the time of the filing of this action, I was employed as an attorney at the firm of Wills & Massalon, LLC.
6. I am an approved person to provide and receive HIIPA protected information on Jeffrey D. Allen's health insurance account with BlueCross and Blue Shield of SC, and I generally handle the medical and insurance communications for our daughter, who was

Exhibit "C" to
Plaintiff's Memorandum in
Opposition

diagnosed with Type I diabetes at the age of two (2) in November 2007.

7. That our daughter has been insured through the State of South Carolina employee benefit plan since 2005 as a dependant under my husband's insurance plan.

8. That on August 5, 2008, I attended, along with my husband, family caregivers, and two Charleston County School District nurses who were to be charged with the care of our daughter at school beginning in August 2008, a training session set up by MUSC Pediatric Endocrinology to train our daughter's caregivers, at home and school, how to operate our daughter's new insulin pump prescribed by her physician and scheduled to be attached to her body the following week. That training session lasted approximately two hours and was taught a MUSC diabetic educator.

9. That I first received notice that the claim for the diabetes education services on August 5, 2008 had been denied some time after August 27, 2008 and the denial stated it was based on the grounds that the "benefit plan does not cover education and/or training for this condition." See Exhibit A (First EOB Denial).[1]

10. That the EOB dated August 27, 2008, indicated that in order to request reconsideration of your claim "you may request a review in writing to us within six months of this notice."

11. That I mailed the request for reconsideration attached as Exhibit B on February 25, 2009, within the six (6) month deadline contained in the EOB to the address provided therein.

12. That on April 15, 2009, I received a letter from Blue Cross stating that Blue Cross had received the appeal and it had requested additional medical records from the provider,

1. That upon information and belief, the First EOB Denial was not actually received by the undersigned until sometime in December 2008. It appears to have been mailed to our prior home address despite my having previously attempted to change the address through the Blue Cross website.

and that it would review the claim and determine the benefits as soon as it received the requested records. See Exhibit C.

13. Then, I waited for a response to my appeal.

14. That on April 20, 2009, BlueCross issued an "Adjustment" to the August 27, 2008 EOB, which states the following:

> TO MAKE A DECISION ON THIS CLAIM, **WE HAVE REQUESTED** ADDITIONAL MEDICAL INFORMATION FROM YOUR PROVIDR. IF WE RECEIVE THE INFORMATION WITHIN 45 DAYS, WE WILL REVIEW YOUR CLAIM AND DETERMINE BENEFITS WITHIN 15 DAYS OF RECEIVING THE INFORMATION. IF WE DO NOT RECEIVE THIS INFORMATION WITHIN 45 DAYS YOUR CLAIM WILL BE CONSIDERED DENIED. **IF WE RECEIVE THE INFORMATION AFTER 45 DAYS, BUT WITHIN 225 DAYS, WE WILL REVIEW YOUR CLAIM AS A FIRST LEVEL APPEAL.** PLEASE SEE YOUR PLAN DOCUMENT FOR ADDITIONAL DETAILS REGARDING THE APPEAL PROCESS. (Emphasis added).[2]

15. That on August 14, 2009, I telephoned Blue Cross Blue Shield to inquire into the status of the appeal and was informed that Blue Cross had not received the medical records it had requested directly from MUSC. I asked exactly what medical records Blue Cross wanted, but the Blue Cross representative was unable to specify the records. The Blue Cross representative indicated that I should also have the physician send a statement of medical necessity.

16. That I immediately telephoned MUSC and requested the relevant medical records be forwarded to Blue Cross Blue Shield, and sent the email attached as Exhibit D to my daughter's physician.

[2] The undersigned does not have record of actually receiving this Adjusted EOB dated April 20, 2009, but printed it from the Blue Cross Blue Shield section of the member website in early October 2009.

17. That on August 17, 2009, I mailed the letter attached as Exhibit E to MUSC referencing the pending appeal to Blue Cross in response to the attempt by MUSC to collect the unpaid medical claim.

18. That on September 30, 2009, I telephoned Blue Cross again to inquire about the status of the appeal and spoke with "Gina." When I asked Gina for her full name, she responded she was "the only Gina here." Gina indicated that Blue Cross had never received the MUSC records and stated that Blue Cross had requested the records by way of a letter to MUSC dated April 15, 2009. I asked Gina for a copy of the letter Blue Cross sent to MUSC. Gina put me on hold and when she returned said that she was unable to access the actual letter. Gina then indicated that she could not tell me exactly what records Blue Cross needed but that they were needed to determine whether the claim was based on a preexisting condition. When I explained that was not the basis for denial and could not possibly be the reason, Gina said she had "looked back at her computer" and admitted she was mistaken about the preexisting condition, but that Blue Cross needed "ER records." I explained that my daughter was not seen in the ER that day, and she finally was able to explain Blue Cross needed "outpatient" records. I also asked Gina for the direct fax number of the Blue Cross Blue Shield representative handling the appeal, and told her I would get the records myself and send them via fax.

19. Upon hanging up the telephone, I telephoned MUSC to request all medical records for August 5, 2008, and faxed the attached release form to MUSC the same day. See Exhibit F.

20. I received the relevant medical records within days, and on October 5, 2009, on the 168th day after the April 20, 2009 EOB (well within the 225 days referenced), I faxed the letter

attached as Exhibit G with medical records and other documents to the Blue Cross Blue Shield Appeals office.

21. After my extremely time-consuming and frustrating telephone call with "Gina" at BlueCross, I began to do some research into the issue and discovered the diabetes statutory mandate. I then obtained the *Employee Benefit Guide* and reviewed it for language relating to diabetes education; there is none. At that time, I noticed the reference to the *Plan of Benefits Document*, and began searching for that document.

22. On October 5, 2009, I logged into the southcarolinablues.com website and reviewed other claims made on behalf of our daughter and found several other claims, dating back to December 17, 2007, for diabetes education, which were denied on the basis that education is not covered for diabetes under the State Health Plan. See Exhibit H.

23. On October 7, 2009, I telephoned the South Carolina Employee Insurance Plan (EIP) office in Columbia, spoke to a person, and requested a copy of the *Plan of Benefits Document* which is referenced in the 2009 Insurance Benefits Guide, the only document provided to state employees. I was told the *Plan to Benefits Document* was a very large booklet and that my husband needed to go to his benefits administrator, review the one copy they have as employees are not provided copies, make copies, or that he could request a copy from the EIP and would have to pay copying charge.

24. See the Affidavit of Jeffrey D. Allen regarding his unsuccessful efforts at obtaining a copy of said document from his benefits administrator and the written request mailed October 15, 2009 directly to the Employee Insurance Program requesting a copy of "The Plan of Benefits" referenced at page 58 of the Guide, which has yet to be answered.

25. As of the date of this affidavit, I have never received any response to my letters dated February 25, 2009 or October 5, 2009, and therefore believe the appeal is still pending within the BlueCross administrative process.[3]

FURTHER THIS AFFIANT SAYETH NOT.

Christy Ford Allen

SWORN to before me this

24th day of Feb. 2010.

Notary Public for South Carolina

My Commission Expires: 12/11/2013

[3] On February 3, 2010, the undersigned received a telephone call from Blue Cross offering to enroll into its "wellness program" for diabetes (the telephone caller first was under the mistaken impression that I suffered from asthma). However, after the undersigned disclosed the pendency of this action, the Blue Cross representative called back to disclose that the program was only for persons 5 years or age and older and therefor would not qualify yet.

EXHIBIT "A"

18807

I-20 @ Alpine Road
Columbia, SC 29219

BlueCross BlueShield of South Carolina
An Independent Licensee of the Blue Cross and Blue Shield Association

EXPLANATION OF BENEFITS
THIS IS NOT A BILL

If you have a question about your claim, please call Customer Service at 1-800-868-2520 OR LOCALLY AT 736-1576 MON. - FRI. 8:00 A.M. - 6:00 P.M.

STATE HEALTH PLAN

August 27, 2008

1294077258529!
JEFFREY D ALLEN

SUMMARY INFORMATION

Patient's Name	Relationship to Policyholder	ID No.	Claim No.
	CHILD	ZCS36961363	8E283250-00-00

TOTAL CHARGE FOR YOUR CLAIM	TOTAL AMOUNT WE PAID	WHAT YOU OWE PROVIDER
560.00	.00	[illegible]

[illegible]

DETAIL INFORMATION

Provider	MEDICAL UNIVERSITY			
Network Participation	YES			
Dates of Service	08/05/08			
Type of Service	MEDICAL SERVICES			
Charge	560.00			
Amount Not Covered	560.00 01*			
Covered Expenses	.00			
Deductible	.00			
Copay/Spec Deductible	.00			
Allowed Amount	.00			
Coinsurance	.00			
Amount Paid	.00			

* Please refer to the remarks section.

Suspect claims fraud? Please help by calling our hotline at 1-800-763-0703

THANK YOU FOR ALLOWING US TO SERVE YOU!

www.SouthCarolinaBlues.com

Page 1 of 1

Helpful Definitions (Please check your schedule of benefits in your benefits booklet for details)

Amount Approved for Coordination - the amount we will coordinate with your primary health or dental plan's payment.

Benefit Period - the period of time you must pay any deductibles and coinsurance payments that may apply. Benefits begin once you meet the deductible. If you reach the limit, we pay covered expenses in full for the rest of the benefit period. Deductibles and coinsurance start over with each new benefit period.

Coinsurance - the percentage of the allowed amount you pay as your share of the bill. If your plan pays 80%, then 20% would be your coinsurance.

Copayment - a set fee you pay each time you receive a certain service. Some plans do not have copayments.

Deductible - the amount, if any, that you are responsible for paying before we start paying contract benefits. You do not send this amount to us. We subtract this amount from covered expenses on the claims you and healthcare professionals send to us.

Less Benefit Limitation - the amount that is more than your contract allows for this type of service. Your plan covers these services until you have reached the limit of your benefits.

Network Participation - this column shows whether or not the healthcare professional who provided the service participates in our network. If "YES" this is a network participant. If "NO" this is not a network participant. If "N/A", the issue doesn't apply to your coverage, or this particular claim.

Out-of-pocket-maximum - the highest amount of the covered expenses you will have to pay during a benefit period.

Total Benefit Allowed - the amount we would have paid if another insurance carrier was not involved.

APPEAL OR REVIEW

If you have questions about the disposition of this claim, you may call us at the number listed on the front of this statement. Please refer to your insurance benefit guide for more information. If you would like to request a reconsideration of your claim you may request a review by writing to us within six months of this notice at:

STATE HEALTH PLAN
P. O. BOX 100605
COLUMBIA, S.C. 29260-0605

REMARKS SECTION

THE LIFETIME BENEFITS PAID FOR THIS PERSON TO DATE: 3,907.20

WE PROVIDE ADMINISTRATIVE CLAIMS PAYMENT SERVICES ONLY AND DO NOT ASSUME ANY FINANCIAL RISK OR OBLIGATION WITH RESPECT TO CLAIMS.

01 YOUR BENEFIT PLAN DOES NOT COVER EDUCATION AND/OR TRAINING FOR THIS CONDITION.

EXHIBIT "B"

WILLS & MASSALON, LLC
ATTORNEYS AT LAW
Telephone: (843) 727-1144
Facsimile: (843) 727-7696

COPY

Post Office Box 859
Charleston, South Carolina 29402

134 Meeting Street, Suite 100
Charleston, South Carolina 29401

February 25, 2009

Blue Cross Blue Shield of South Carolina
State Health Plan - Appeal
P.O. Box 100605
Columbia, SC 29260-0605

Re: Appeal and Review / SC State Health Plan
Plan No: ZCS36961363
EOB Claim No: 8E2631250-00-00

To whom it may concern:

My husband and daughter are insured under the South Carolina State Insurance Health Plan. My daughter is three (3) years old and was diagnosed with Type I or Juvenile Diabetes in November 2007. According to your denials and EOB "Diabetic Education" is not a covered service. I am writing to formally appeal that position.

In August 2008, my daughter who requires continuous insulin therapy and monitoring received approval to be placed on an insulin pump. As part of that process, the Medical University of South Carolina provides training for care givers on how to properly operate the insulin pump which is mechanically attached to the body at all times. The following persons attended the training session – my husband and I, our parents who also provide childcare for our daughter, and two nurses from our daughter's school who were to be responsible for operating the pump and monitoring her blood sugar levels during the school day.

This letter is intended to serve as an appeal and objection to the denial of the claim for payment made by MUSC. First, I view this training as a necessary part of insulin pump therapy. My daughter is three (3) years old, and as a result of her young age is obviously not able to teach herself how to use the insulin pump. Those persons responsible for her continuous care must be able to competently operate the pump. I have attached to this letter the EOB, which appears to have been mailed to our old address despite my having changed the address through your website (as evidenced by the attached print out showing the current address). I am also attaching a print-out from your website which indicates the current status information.

Lastly, I also submit this appeal letter to object to the fact that diabetic education is a item

which you indicated is expressly excluded under the policy. I cannot imagine what possible policy, other than one motivated by profit, would support not providing insurance coverage to the education of Type I diabetics about how to better control and manage an intensive, life-long disease which has no cure. While I see no real distinction, does Blue Cross differentiate between its coverage position on education for Type I and Type II diabetes?

Please accept this letter as my appeal of the denial. I will be glad to provide any additional information requested. Thank you for your consideration of this appeal.

Sincerely,

WILLS & MASSALON, LLC

Christy Ford Allen

Enclosures

cc: Deborah Bowlby, M.D.

18807

I-20 @ Alpine Road
Columbia, SC 29219

BlueCross BlueShield of South Carolina
An Independent Licensee of the Blue Cross and Blue Shield Association

EXPLANATION OF BENEFITS
THIS IS NOT A BILL

If you have a question about your claim, please call Customer Service at 1-800-868-2520 OR LOCALLY AT 736-1576 MON. - FRI. 8:00 A.M. - 6:00 P.M.

STATE HEALTH PLAN

###

August 27, 2008

!294077258529!
JEFFREY D ALLEN

38

SUMMARY INFORMATION

Patient's Name	Relationship to Policyholder	ID No.	Claim No.
	CHILD	ZCS36961363	8E2631250-00-00

TOTAL CHARGE FOR YOUR CLAIM:	560.00	TOTAL AMOUNT WE PAID:	.00	WHAT YOU OWE PROVIDER::	560.00

The provider can bill you for this amount if you have not yet paid.

To date, you have satisfied 350.00 of the 350.00 deductible for the benefit period that began 01/01/2008.
This claim contributed .00 toward your out-of-pocket maximum. You have satisfied 3.80 of the 2,000.00 out-of-pocket maximum for this benefit period. We paid a total of 44.40 for this person this benefit period.

DETAIL INFORMATION

Provider	MEDICAL UNIVERSITY			
Network Participation	YES			
Dates of Service	08/05/08			
Type of Service	MEDICAL SERVICES			
Charge	560.00			
Amount Not Covered	560.00 01*			
Covered Expenses	.00			
Deductible	.00			
Copay/Spec Deductible	.00			
Allowed Amount	.00			
Coinsurance	.00			
Amount Paid	.00			

*** Please refer to the remarks section.**

Suspect claims fraud? Please help by calling our hotline at 1-800-763-0703

THANK YOU FOR ALLOWING US TO SERVE YOU!

www.SouthCarolinaBlues.com

Helpful Definitions (Please check your schedule of benefits in your benefits booklet for details)

Amount Approved for Coordination - the amount we will coordinate with your primary health or dental plan's payment.

Benefit Period - the period of time you must pay any deductibles and coinsurance payments that may apply. Benefits begin once you meet the deductible. If you reach the limit, we pay covered expenses in full for the rest of the benefit period. Deductibles and coinsurance start over with each new benefit period.

Coinsurance - the percentage of the allowed amount you pay as your share of the bill. If your plan pays 80%, then 20% would be your coinsurance.

Copayment - a set fee you pay each time you receive a certain service. Some plans do not have copayments.

Deductible - the amount, if any, that you are responsible for paying before we start paying contract benefits. You do not send this amount to us. We subtract this amount from covered expenses on the claims you and healthcare professionals send to us.

Less Benefit Limitation - the amount that is more than your contract allows for this type of service. Your plan covers these services until you have reached the limit of your benefits.

Network Participation - this column shows whether or not the healthcare professional who provided the service participates in our network. If "YES" this is a network participant. If "NO" this is not a network participant. If "N/A", the issue doesn't apply to your coverage, or this particular claim.

Out-of-pocket-maximum - the highest amount of the covered expenses you will have to pay during a benefit period.

Total Benefit Allowed - the amount we would have paid if another insurance carrier was not involved.

APPEAL OR REVIEW

If you have questions about the disposition of this claim, you may call us at the number listed on the front of this statement. Please refer to your insurance benefit guide for more information. If you would like to request a reconsideration of your claim you may request a review by writing to us within six months of this notice at:

STATE HEALTH PLAN
P. O. BOX 100605
COLUMBIA, S.C. 29260-0605

REMARKS SECTION

THE LIFETIME BENEFITS PAID FOR THIS PERSON TO DATE: 3,907.20

WE PROVIDE ADMINISTRATIVE CLAIMS PAYMENT SERVICES ONLY AND DO NOT ASSUME ANY FINANCIAL RISK OR OBLIGATION WITH RESPECT TO CLAIMS.

01 YOUR BENEFIT PLAN DOES NOT COVER EDUCATION AND/OR TRAINING FOR THIS CONDITION.

Claims Status/Explanation of Benefits

Claim Detail

Claim Status:	**FINALIZED/DENIAL**
Member ID:	**ZCS36961363**
Member's Name:	**JEFFREY D ALLEN**
Patient's Name:	
Patient's Date of Birth:	**07/20/2005**
Patient's Gender:	**Female**

Here is the information about the claim you chose. Please click on the "Line Item(s)" button to view the claim's summary.

Claim Number:	**8E26312500000**
Dates of Service:	**08/05/2008 to 08/05/2008**
Charges:	**$560.00**
Was Denied On:	**08/25/2008**
Status Explanation:	**PATIENT'S MEDICAL RECORDS** **FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE**

View Additional Status Information

View your Explanation of Benefits (EOB) *(You will need Adobe Acrobat Reader to view or print items on this page.)*

Modify Your Profile Information

Required fields feature an asterisk (*).

Do we have your most current information?

- If you've added health or dental coverage since you last visited My Insurance Manager, please update this form.
- If you have a spouse or dependents on your health or dental plan and would like to check their claims information online, please add them to your profile.

Please take a minute to complete this form so we can give you access to the information you need.

Please note: This profile is for your Web site My Insurance Manager registration only! Any changes you make here will not carry over to your health plan records. If you need to make changes to your address, phone number or other information that affects your health or dental plan, please Ask Customer Service.

Security

Member ID: **ZCS36961383**

Change your current password here.

To change your Security Question, please choose a Security Question from the list below, then enter your answer. If you lose your Password, we will ask you this question. If you give the right answer, you will be able to reset your Password.

Security Question:*	What is the name of the city where you and your spouse first met?
Security Answer:*	CHARLESTON

General Information

First Name:*	JEFFREY
Middle Initial:	D
Last Name:*	ALLEN
Suffix:	
Gender:	Female ○ Male ●
Address:*	
Address, continued:	
City:*	
State:*	SC
ZIP Code:*	(11111)
Daytime Area Code & Phone Number:	( ) - Extension: (555-555-5555)
Fax:	( ) - (555-555-5555)

Our Ask Customer Service feature allows you to send us a question or comment. If you would like us to respond online, then we need your e-mail address.

E-mail Address:	callen@wills-massalon.com
Confirm E-mail Address:	callen@wills-massalon.com

Coverage

Have you added health or dental coverage since you last accessed My Insurance Manager? Please let us know and we will automatically update your profile so you can access all your claims information.

○ Yes ● No

Dependents

Do you have dependents who are on your insurance plan? Add them to your profile and it will be easy to check their benefits information!

You must list dependents on your dental plan separately from those on your health plan. Just enter the name and birthdate for each person. Choose which plan they belong to — either health or dental — then click on "Add."

EXHIBIT "C"

BlueCross BlueShield
of South Carolina
Columbia, S.C. 29219-0001
An Independent Licensee of the Blue Cross and Blue Shield Association.

Visit My Insurance Manager at www.SouthCarolinaBlues.com

April 15, 2009

Jeffrey Allen

RE: Patient:
Claim Number: 8E26312500001

Dear Mr. Allen:

We received your appeal for the above claim. In order to review this claim accurately, we have asked the health care professional listed below to send additional medical records via our secure fax at (803) 264-4269.

We'll review the claim and determine your benefits as soon as we receive al the medical records we requested.

Please ask your provider whether you need to sign a special form authorizin them to release these records. Thank you for your help.

PROVIDERS: Medical University Hospital

Sincerely,

Rochelle Council
State Business Unit

IKEY: ZCY247451184
MED1 /460/18
¢EOD

74858

I-20 @ Alpine Road
Columbia, SC 29219

***

JEFFREY D ALLEN

BlueCross BlueShield of South Carolina
An Independent Licensee of the Blue Cross and Blue Shield Association

EXPLANATION OF BENEFITS

THIS IS NOT A BILL

If you have a question about your claim, please call Customer Service at 1-800-868-2520 OR LOCALLY AT 736-1576 MON. - FRI. 8:00 A.M. - 6:00 P.M.

This is an ADJUSTMENT to a claim we processed previously.

April 20, 2009

STATE HEALTH PLAN

SUMMARY INFORMATION

Patient's Name	Relationship to Policyholder	ID No.	Claim No.
	CHILD	ZCS36961363	8E2631250-00-01

TOTAL CHARGE FOR YOUR CLAIM:	AMOUNT PREVIOUSLY PAID:	AMOUNT PAID FOR THIS CLAIM:	TOTAL AMOUNT WE PAID:	WHAT YOU OWE PROVIDER:
560.00	.00	.00	.00	.00

The provider can bill you for this amount if you have not yet paid.

To date, you have satisfied 350.00 of the 350.00 deductible for the benefit period that began 01/01/2008.

This claim contributed .00 toward your out-of-pocket maximum. You have satisfied 1,245.36 of the 2,000.00 out-of-pocket maximum for this benefit period. We paid a total of 5,086.94 for this person this benefit period.

DETAIL INFORMATION

Provider	MEDICAL UNIVERSITY			
Network Participation	YES			
Dates of Service	08/05/08			
Type of Service	MEDICAL SERVICES			
Charge	560.00			
Amount Not Covered	560.00 01*			
Covered Expenses	.00			
Deductible	.00			
Copay/Spec Deductible	.00			
Allowed Amount	.00			
Coinsurance	.00			
Amount Paid	.00			

*** Please refer to the remarks section.**

Suspect claims fraud? Please help by calling our hotline at 1-800-763-0703

THANK YOU FOR ALLOWING US TO SERVE YOU!

www.SouthCarolinaBlues.com

Page 1 of 1

Helpful Definitions (Please check your schedule of benefits in your benefits booklet for details)

Amount Approved for Coordination - the amount we will coordinate with your primary health or dental plan's payment.

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Coinsurance - the percentage of the allowed amount you pay as your share of the bill. If your plan pays 80%, then 20% would be your coinsurance.

Copayment - a set fee you pay each time you receive a certain service. Some plans do not have copayments.

Deductible - the amount, if any, that you are responsible for paying before we start paying contract benefits. You do not send this amount to us. We subtract this amount from covered expenses on the claims you and healthcare professionals send to us.

Less Benefit Limitation - the amount that is more than your contract allows for this type of service. Your plan covers these services until you have reached the limit of your benefits.

Network Participation - this column shows whether or not the healthcare professional who provided the service participates in our network. If "YES" this is a network participant. If "NO" this is not a network participant. If "N/A", the issue doesn't apply to your coverage, or this particular claim.

Out-of-pocket-maximum - the highest amount of the covered expenses you will have to pay during a benefit period.

Total Benefit Allowed - the amount we would have paid if another insurance carrier was not involved.

APPEAL OR REVIEW

If you have questions about the disposition of this claim, you may call us at the number listed on the front of this statement. Please refer to your insurance benefit guide for more information. If you would like to request a reconsideration of your claim you may request a review by writing to us within six months of this notice at:

STATE HEALTH PLAN
P. O. BOX 100605
COLUMBIA, S.C. 29260-0605

REMARKS SECTION

THE LIFETIME BENEFITS PAID FOR THIS PERSON TO DATE: 10,144.57

WE PROVIDE ADMINISTRATIVE CLAIMS PAYMENT SERVICES ONLY AND DO NOT ASSUME ANY FINANCIAL RISK OR OBLIGATION WITH RESPECT TO CLAIMS.

01 TO MAKE A DECISION ON THIS CLAIM, WE HAVE REQUESTED ADDITIONAL MEDICAL INFORMATION FROM YOUR PROVIDER. IF WE RECEIVE THE INFORMATIONWITHIN 45 DAYS, WE WILL REVIEW YOUR CLAIM AND DETERMINE BENEFITS WITHIN 15 DAYS OF RECEIVING THE INFORMATION. IF WE DO NOT RECEIVE THIS INFORMATION WITHIN 45 DAYS YOUR CLAIM WILL BE CONSIDERED DENIED.IF WE RECEIVE THE INFORMATION AFTER 45 DAYS, BUT WITHIN 225 DAYS, WE WILL REVIEW YOUR CLAIM AS A FIRST LEVEL APPEAL. PLEASE SEE YOUR PLANDOCUMENT FOR ADDITIONAL DETAILS REGARDING THE APPEAL PROCESS.

EXHIBIT "D"

Christy F. Allen

From: Christy F. Allen
Sent: Friday, August 14, 2009 2:42 PM
To: bowlbyd@musc.com
Cc: walshe@musc.com
Subject: FW: Diabetic Education Insurance Appeal DOS 8/5/08
Attachments: BCBS.pdf

Dr. Bowlby-

In reference to the appeal letter I copied you on below back in February 2009, Blue Cross has just informed me that MUSC has never responded to its request for records on 4/14/09 for the medical records for the date of service of 8/5/08, to include the name and address of the physician who recommended the training, and a statement of medical necessity.

I will call MUSC records directly, but am forwarding this to you as well.

Thank you

Christy Allen

-----Original Message-----
From: Christy Allen [mailto:callen@wills-massalon.com]
Sent: Tuesday, February 24, 2009 8:40 AM
To: bowlbyd@musc.edu
Subject: [redacted] Diabetic Education Insurance Appeal

Dr. Bowlby -

My daughter [redacted] is a patient of yours. She is 3 and got a pump last August. She is insured under the State Health Plan for BC/BS, and I decided to appeal a denial I received for the training session you all provided prior to her getting her pump. While it is not really about the money, it seems to be an absurd policy not to cover "diabetic education." I really am not asking that you do anything, as I can can only imagine the insurance problems you deal with on a daily basis.
However, I was wondering if you have had any experience with this issue.

I am attached the letter I intend to send for your general information.

Thank you

Christy Allen
--

*Christy Ford Allen
Attorney
Wills & Massalon, LLC
PO Box 859
Charleston, SC 29402
(843) 727-1144 telephone
(843) 727-7696 facsimile
*

1

EXHIBIT "E"

WILLS & MASSALON, LLC
ATTORNEYS AT LAW
Telephone: (843) 727-1144
Facsimile: (843) 727-7696

Post Office Box 859
Charleston, South Carolina 29402

134 Meeting Street, Suite 100
Charleston, South Carolina 29401

August 17, 2009

MUSC Hospital Patient Accounting
MSC 819
Charleston, SC 29425

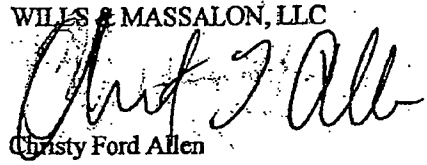
Re: Acct# 241145762
Appeal and Review / SC State Health Plan

To whom it may concern:

Enclosed please find partial payment of the invoice number referenced above. The amount due is currently subject to an appeal to my insurance carrier, which has been delayed due to MUSC's lack of responsiveness to the carrier's requests for information. After my follow up with both the carrier and MUSC last week, I understand the appeal and information is now being reviewed. Attached is the appeal letter dated February 2009. I request that you do not submit this bill to collection as I would prefer to await the decision of my carrier prior to paying it in full.

Sincerely,

WILLS & MASSALON, LLC



Christy Ford Allen

Enclosure

EXHIBIT "F"

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	0775
RECIPIENT ADDRESS	7927292
DESTINATION ID	
ST. TIME	09/30 10:35
TIME USE	00'26
PAGES SENT	1
RESULT	OK

792-7292

MUSC Health

AUTHRELSE

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Page 1 of 1

This form must be completed in its entirety in order to be considered valid.

Patient Name: _____ Date of Birth: 07/20/05

Medical Record Number: _____ Social Security Number: [redacted]

☒ I authorize MUSC Medical Center to disclose/release information to:

☐ I authorize MUSC Medical Center to obtain information from:

Name of Individual / Organization: Christy F. Allen

Street Address: _____ City: _____ State: SC Zip Code: _____

Phone Number: 843-709-0369 Fax Number: 843-727-7696 E-mail Address: callen@wills-masselon.com

The purpose of the disclosure is: ins. denial appeal

The type of information to be disclosed is as follows:

☐ films / images ☐ problem list ☐ medication list ☒ physician orders
☐ radiology reports ☐ consultation reports ☐ physician progress note / visit notes ☐ immunization records
☐ nurses notes ☐ history and physical ☐ discharge summary ☐ laboratory results
☒ entire record
☐ abstract (history and physical, consult, lab, radiology report, pathology, discharge summary, operative report)
☐ other _____

For dates of service: 08/05/08 ("outpatient records")

I understand this information may include reference to psychiatric / psychological care, sexual assault, drug abuse, results of tests for all infectious diseases including HIV / AIDS and / or alcohol abuse.

I authorize the exchange of this information via (check all preferred methods): ☐ mail ☒ fax OR ☒ e-mail ☐ other _____

I understand that I have a right to cancel / revoke this authorization at any time. I understand that if I cancel / revoke this authorization I must do so in writing and present my written cancellation / revocation to the Health Information Services Department (Medical Records). I understand that the cancellation / revocation will not apply to information, which has already been released in response to this authorization, as stated in the Notice of Privacy Practice. Unless otherwise canceled / revoked, this authorization will expire / end one year from this date.

I understand that a reasonable, cost-based fee for copies of protected health information and postage fees will be charged.

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment. I understand I may review and / or copy the information to be disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the possibility of

EXHIBIT "G"

WILLS & MASSALON, LLC
ATTORNEYS AT LAW

134 Meeting Street, Suite 100
Charleston, South Carolina 29401

Telephone: (843) 727-1144
Facsimile: (843) 727-7696

FACSIMILE MEMORANDUM

TO: BCBS Appeals/Medical Records

Fax: 1-803-264-4269

FROM: Christy Allen

RE: Appeal - ZCS 36961363

FILE NO.

DATE: October 5, 2009

Pages : 7

MUSC Health

Medical University of South Carolina
Charleston, SC
843-792-2123

Practice Partner Note

Patient:
Attending:

MRN: 002585257
Date: 8/5/08 3:33 PM
Status: INITIAL

Date: 08/05/08 : 03:33pm
Title: EDUCATION DOCUMENTATION - PEDS ENDO
MEDICAL UNIVERSITY OF SOUTH CAROLINA

3 year female
Learning Needs/Content Taught: Patient's Plan of Care, Medications, Nutrition, Food/Drug Interactions, Health Promotion, Patient Safety, Medical Equipment
Person(s) Taught: Parent, Family Member(grandmothers), school nurse and nursing supervisor, Other,
Readiness to Learn: No barriers
Department: Nursing
Teaching/Learning Method: Written and Verbal, Demonstration
Outcome/Comprehension: Able to state understanding and/or return demonstration
Comments (names of teaching materials used, concerns, etc.): Met with parent's, grandparent's, and school nurses to instruct them on the Medtronic Paradigm insulin pump. They were instructed on troubleshooting hyper/hypoglycemia on the insulin pump, importance of monitoring, ketone testing, and site rotation.
They were instructed on all mechanics of pump therapy and demonstrated good understanding. They were encouraged to practice with the pump with saline until [redacted] is started on the pump next week. school nurse was given a practice pump and NS to review and she will return out pump next week. We discussed school needs and plan.
[redacted] will be started on the pump next week. SS
SIGNED BY SHARON SCHWARZ, R.N. (E17) 08/05/2008 03:39PM

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.

WILLS & MASSALON, LLC
ATTORNEYS AT LAW
Telephone: (843) 727-1144
Facsimile: (843) 727-7696

Post Office Box 859
Charleston, South Carolina 29402

134 Meeting Street, Suite 100
Charleston, South Carolina 29401

September 30, 2009

Blue Cross Blue Shield of South Carolina
State Health Plan - Appeal
P.O. Box 100605
Columbia, SC 29260-0605

Re: Appeal and Review / SC State Health Plan
Plan No: ZCS36961363
EOB Claim No: 8E2631250-00-00/Pending Appeal

To whom it may concern:

This letter is in regard to the pending appeal of the above referenced claim, which has been pending since February 2009. Due to a lack of contact by you or apparent resolution of the appeal, I called BCBS on August 14, 2009 and was informed that you had not received requested medical records, which your telephone representative was unable to specify, from MUSC. I contacted the records department at MUSC that same day and was informed that it had sent the records once and that it would send the records a second time.

On September 30, 2009, I called BCBS again to inquire about the status of this appeal and was informed that you were still waiting on the requested records from MUSC. I was informed that you needed " outpatient ER records" (despite there being no ER involved in the date of service). I have received no direct request by BC/BS, other than what I initiated through my telephone contacts, for the records or even that I complete a HIIPA form.

I have now received the complete set of records from MUSC for the diabetes mellitus insulin pump training session for my daughter who was 3 years old at the time, and enclose these records for your consideration.

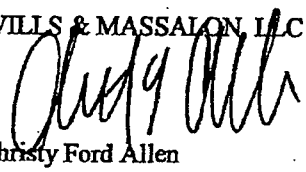
I am also enclosing a copy the South Carolina statute which requires Diabetes Mellitus coverage in health insurance polices. I have highlighted the provision which requires coverage for "outpatient self-management training and education for the treatment of people with diabetes mellitus (or commonly called Type I).

Thank you, and if there is any other information you require in order to resolve this

appeal, please let me know.

Sincerely,

WILLS & MASSALON, LLC



Christy Ford Allen

Enclosures

MUSC Health
Medical University of South Carolina
Charleston, SC
843-792-2123

Practice Partner Note

Patient:
Attending:

MRN: 002585257
Date: 8/5/08 3:41 PM
Status: INITIAL

Record all glucose monitoring and diabetes medications on Pediatric Diabetes Pump Flow Sheet.
6.
Check urine for ketones if blood glucose is greater than 250 mg/dL.
7.
If urine tests positive for ketones, call fellow/attending. Do not use pump to bolus. Chang pump access site and give insulin via syringe injection subcutaneously (use high blood glucose insulin amount for pump).
8.
Exercise guidelines: 30 minutes before exercise begins
A. If blood glucose is less than 150 mg/dL prior to exercise, turn insulin pump off and restart after exercise stops.
B. If blood glucose is greater than 150 mg/dL prior to exercise, leave pump on with 50% basal rate reduction and return to ordered basal rate 30 minutes after exercise stops.
C. If blood glucose is greater than 300 mg/dL or if patient is positive for ketones, do not exercise.
Call Pediatric Endocrinology Fellow or Attending if blood glucose is: less than 70 mg/dL two times in a row, less than 50 mg/dL once, or greater than 240 mg/dL two times in a row; or if urine tests positive for ketones.
Weight: 14.3 kg
Patient/Parent may use home glucose meter, meter strips, lancing device, lancets, new unopened vial of insulin, glucose tabs, glucose gel, and glucagon, and may administer insulin.
Medications:
Insulin Pump
1.
Novolog insulin 100 units per ml for pump - use new vial
2.
Set basal rates at 0.1units per hour
3.
Bolus all meals/snacks one unit insulin for every 30 grams carbohydrate.
4.
For high blood glucose greater than 175 mg/dL before meals or greater than 3 hours after meals from 6 AM to 9 PM, use 1 unit insulin for every 250 mg/dL (sensitivity factor) greater than 175 mg/dL (target).
5.
For high blood glucose greater than 200 mg/dL before meals or greater than 3 hours after meals from 9 PM to 6 AM, use 1 unit insulin for every 280 mg/dL (sensitivity factor) greater than 200 mg/dL (target).

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.

Practice Partner Note

Patient:
Attending:

MRN: 002585257
Date: 8/5/08 3:41 PM
Status: INITIAL

6.
If pump has bolus wizard/calculator option, enter blood glucose reading only when reading is greater than 175 mg/dL from 6 AM to 9 PM or greater than 200 mg/dL from 9 PM to 6 AM (Pump will calculate bolus amount to cover hyperglycemia.)
Glucose tablets: 4 or 5 grams per tab--Administer as directed per hypoglycemia protocol.
Glucose gel: 31 gram tube--Administer as directed per hypoglycemia protocol.
Glucagon 0.5 mg IM (0.5 mg for patients less than 20 kg; 1 mg for patients 20 kg or greater)--
Administer for unconscious hypoglycemia.
Hypoglycemia Protocol
1.
Call physician for 2 consecutive blood glucose levels below 70 mg/dL or 1 blood glucose level below 50 mg/dL.
2.
Give three glucose tabs (4 or 5 grams per tab) or 4 ounces unsweetened juice (15 grams carbohydrate). Recheck blood glucose level in 15 minutes and repeat above treatment until blood glucose is greater than 70 mg/dL.
3.
If patient is unable to chew or drink juice, place 15 grams carbohydrate of glucose gel in patient's cheek (use 1/2 of 31 gram weight tube).
Unconscious Hypoglycemia - If patient is unconscious, give glucagon as ordered above.
Discharge Appointment: Please schedule return appointment (876-0444) with Pediatric Endocrine Diabetes Educator for 2-3 weeks after discharge.
Ordering Physician: Deborah Bowlby, MD pager id 14535
SIGNED BY DEBORAH BOWLBY, MD (ATTENDING) (DB1) 08/06/2008 09:35AM

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.

38-71-840(14).

38-71-46. Diabetes Mellitus coverage in health insurance policies; diabetes education.

ARTICLE 1. GENERAL PROVISIONS

(A) On or after January 1, 2000, every health maintenance organization, individual and group health insurance policy, or contract issued or renewed in this State must provide coverage for the equipment, supplies, Food and Drug Administration-approved medication indicated for the treatment of diabetes, and outpatient self-management training and education for the treatment of people with diabetes mellitus, if medically necessary, and prescribed by a health care professional who is legally authorized to prescribe such items and who demonstrates adherence to minimum standards of care for diabetes mellitus as adopted and published by the Diabetes Initiative of South Carolina. This subsection does not prohibit a health maintenance organization or an individual or a group health insurance policy from providing coverage for medication according to formulary or using network providers. Coverage must not be denied unless the health care professional demonstrates a persistent pattern of failure to adhere to the minimal standards of care and unless the health maintenance organization or insurer has first provided written notice to the health care professional that coverage will be denied if the health care professional fails to adhere to the minimal standards of care.

(B) Services and payment for diabetes education programs shall conform to regulations of the Health Care Financing Administration, US Department of Health and Human Services, pursuant to Section 4105 of the Balanced Budget Act of 1997. Diabetes outpatient self-management training and education shall be provided by a registered or licensed health care professional with certification in diabetes by the National Certification Board of Diabetes Educators, or other accredited program approved by the Diabetes Initiative of South Carolina, or by the Diabetes Control Program of the SC Department of Health and Environmental Control in order to meet the needs of rural communities wherein certified health care professionals providing this service are not available.

(C) Nothing contained in this section may be construed to affect in any way the ability of a managed care plan to credential or re-credential a provider.

(D) For purposes of this section: "Health insurance policy" means a health benefit plan, contract, or evidence of coverage providing health insurance coverage as defined in Section 38-71-670(6) and Section

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	0782
RECIPIENT ADDRESS	18032644269
DESTINATION ID	
ST. TIME	10/05 09:43
TIME USE	01'24
PAGES SENT	7
RESULT	OK

FROM: Christy Allen

RE: Appeal - ZCS 36961363

FILE NO.

DATE: October 5, 2009

Pages: 7

EXHIBIT "H"

06119

I-20 @ Alpine Road
Columbia, SC 29219

BlueCross BlueShield of South Carolina
An Independent Licensee of the Blue Cross and Blue Shield Association

EXPLANATION OF BENEFITS
THIS IS NOT A BILL

If you have a question about your claim, please call Customer Service at 1-800-868-2520 OR LOCALLY AT 736-1576 MON. - FRI. 8:00 A.M. - 6:00 P.M.

###

February 25, 2008

###

!294077258529!
JEFFREY D ALLEN

SUMMARY INFORMATION

Patient's Name	Relationship to Policyholder	ID No.	Claim No.
	CHILD	ZCS36961363	BC4534156-00-00

TOTAL CHARGE FOR YOUR CLAIM:	TOTAL AMOUNT WE PAID:	WHAT YOU OWE PROVIDER:
187.00	39.20 Sent to Provider	147.80 The provider can bill you for this amount if you have not yet paid.

To date, you have satisfied 350.00 of the 350.00 deductible for the benefit period that began 01/01/2007.

This claim contributed 9.80 toward your out-of-pocket maximum. You have satisfied 914.00 of the 2,000.00 out-of-pocket maximum for this benefit period. We paid a total of 3,892.80 for this person this benefit period.

DETAIL INFORMATION

Provider	MEDICAL UNIVERSITY	MEDICAL UNIVERSITY	MEDICAL UNIVERSITY	MEDICAL UNIVERSITY
Network Participation	YES	YES	YES	YES
Dates of Service	12/19/07	12/19/07	12/19/07	12/19/07
Type of Service	OUTPT LAB/PATH	OUTPT LAB/PATH	MEDICAL SERVICES	MEDICAL SERVICES
Charge	60.00	19.00	45.00	63.00
Amount Not Covered	.00	.00	.00	63.00 01*
Covered Expenses	60.00	19.00	45.00	.00
Deductible	.00	.00	.00	.00
Copay/Spec Deductible	60.00	15.00	.00	.00
Allowed Amount	.00	4.00	45.00	.00
Coinsurance	.00	.80	9.00	.00
Amount Paid	.00	3.20	36.00	.00

* Please refer to the remarks section.

Suspect claims fraud? Please help by calling our hotline at 1-800-763-0703

THANK YOU FOR ALLOWING US TO SERVE YOU!

www.SouthCarolinaBlues.com

Helpful Definitions (Please check your schedule of benefits in your benefits booklet for details)

Amount Approved for Coordination - the amount we will coordinate with your primary health or dental plan's payment.

Benefit Period - the period of time you must pay any deductibles and coinsurance payments that may apply. Benefits begin once you meet the deductible. If you reach the limit, we pay covered expenses in full for the rest of the benefit period. Deductibles and coinsurance start over with each new benefit period.

Coinsurance - the percentage of the allowed amount you pay as your share of the bill. If your plan pays 80%, then 20% would be your coinsurance.

Copayment - a set fee you pay each time you receive a certain service. Some plans do not have copayments.

Deductible - the amount, if any, that you are responsible for paying before we start paying contract benefits. You do not send this amount to us. We subtract this amount from covered expenses on the claims you and healthcare professionals send to us.

Less Benefit Limitation - the amount that is more than your contract allows for this type of service. Your plan covers these services until you have reached the limit of your benefits.

Network Participation - this column shows whether or not the healthcare professional who provided the service participates in our network. If "YES" this is a network participant. If "NO" this is not a network participant. If "N/A", the issue doesn't apply to your coverage, or this particular claim.

Out-of-pocket-maximum - the highest amount of the covered expenses you will have to pay during a benefit period.

Total Benefit Allowed - the amount we would have paid if another insurance carrier was not involved.

APPEAL OR REVIEW

If you have questions about the disposition of this claim, you may call us at the number listed on the front of this statement. Please refer to your insurance benefit guide for more information. If you would like to request a reconsideration of your claim you may request a review by writing to us within six months of this notice at:

STATE HEALTH PLAN
P. O. BOX 100605
COLUMBIA, S.C. 29260-0605

REMARKS SECTION

THE LIFETIME BENEFITS PAID FOR THIS PERSON TO DATE: 3,892.80

WE DID NOT PAY BENEFITS ON THIS CLAIM BECAUSE YOU HAVE NOT MET YOUR DEDUCTIBLE YET. ONCE YOU MEET YOUR DEDUCTIBLE WITH FUTURE CLAIMS, WE WILL BEGIN PAYING OUR SHARE OF THE COVERED EXPENSES.

WE PROVIDE ADMINISTRATIVE CLAIMS PAYMENT SERVICES ONLY AND DO NOT ASSUME ANY FINANCIAL RISK OR OBLIGATION WITH RESPECT TO CLAIMS.

01 YOUR BENEFIT PLAN DOES NOT COVER EDUCATION AND/OR TRAINING FOR THIS CONDITION.

17247

I-20 @ Alpine Road
Columbia, SC 29219

BlueCross BlueShield of South Carolina
An Independent Licensee of the Blue Cross and Blue Shield Association

EXPLANATION OF BENEFITS

THIS IS NOT A BILL

If you have a question about your claim, please call Customer Service at 1-800-868-2520 OR LOCALLY AT 736-1576 MON. - FRI. 8:00 A.M. - 6:00 P.M.

STATE HEALTH PLAN

###

April 23, 2008

###

!294077258529!
JEFFREY D ALLEN

3

SUMMARY INFORMATION

Patient's Name	Relationship to Policyholder	ID No.	Claim No.
	CHILD	ZCS36961363	8D0831845-00-00

TOTAL CHARGE FOR YOUR CLAIM:	TOTAL AMOUNT WE PAID:	WHAT YOU OWE PROVIDER:
160.00	.00	160.00
		The provider can bill you for this amount if you have not yet paid.

To date, you have satisfied 319.00 of the 350.00 deductible for the benefit period that began 01/01/2008.

This claim contributed .00 toward your out-of-pocket maximum. You have satisfied .00 of the 2,000.00 out-of-pocket maximum for this benefit period.

DETAIL INFORMATION

Provider	MEDICAL UNIVERSITY	MEDICAL UNIVERSITY	MEDICAL UNIVERSITY	MEDICAL UNIVERSITY
Network Participation	YES	YES	YES	YES
Dates of Service	04/09/08	04/09/08	04/09/08	04/09/08
Type of Service	OUTPT LAB/PATH	OUTPT LAB/PATH	MEDICAL SERVICES	MEDICAL SERVICES
Charge	60.00	19.00	45.00	36.00
Amount Not Covered	.00	.00	.00	36.00 01*
Covered Expenses	60.00	19.00	45.00	.00
Deductible	.00	4.00	45.00	.00
Copay/Spec Deductible	60.00	15.00	.00	.00
Allowed Amount	.00	.00	.00	.00
Coinsurance	.00	.00	.00	.00
Amount Paid	.00	.00	.00	.00

what you owe (bill) if you have not paid

* Please refer to the remarks section.

Suspect claims fraud? Please help by calling our hotline at 1-800-763-0703

THANK YOU FOR ALLOWING US TO SERVE YOU!

www.SouthCarolinaBlues.com

Page 1 of 1

Helpful Definitions (Please check your schedule of benefits in your benefits booklet for details)

Amount Approved for Coordination - the amount we will coordinate with your primary health or dental plan's payment.

Benefit Period - the period of time you must pay any deductibles and coinsurance payments that may apply. Benefits begin once you meet the deductible. If you reach the limit, we pay covered expenses in full for the rest of the benefit period. Deductibles and coinsurance start over with each new benefit period.

Coinsurance - the percentage of the allowed amount you pay as your share of the bill. If your plan pays 80%, then 20% would be your coinsurance.

Copayment - a set fee you pay each time you receive a certain service. Some plans do not have copayments.

Deductible - the amount, if any, that you are responsible for paying before we start paying contract benefits. You do not send this amount to us. We subtract this amount from covered expenses on the claims you and healthcare professionals send to us.

Less Benefit Limitation - the amount that is more than your contract allows for this type of service. Your plan covers these services until you have reached the limit of your benefits.

Network Participation - this column shows whether or not the healthcare professional who provided the service participates in our network. If "YES" this is a network participant. If "NO" this is not a network participant. If "N/A", the issue doesn't apply to your coverage, or this particular claim.

Out-of-pocket-maximum - the highest amount of the covered expenses you will have to pay during a benefit period.

Total Benefit Allowed - the amount we would have paid if another insurance carrier was not involved.

APPEAL OR REVIEW

If you have questions about the disposition of this claim, you may call us at the number listed on the front of this statement. Please refer to your insurance benefit guide for more information. If you would like to request a reconsideration of your claim you may request a review by writing to us within six months of this notice at:

STATE HEALTH PLAN
P. O. BOX 100605
COLUMBIA, S.C. 29260-0605

REMARKS SECTION

THE LIFETIME BENEFITS PAID FOR THIS PERSON TO DATE: 3,892.80

WE PROVIDE ADMINISTRATIVE CLAIMS PAYMENT SERVICES ONLY AND DO NOT ASSUME ANY FINANCIAL RISK OR OBLIGATION WITH RESPECT TO CLAIMS.

01 YOUR BENEFIT PLAN DOES NOT COVER EDUCATION AND/OR TRAINING FOR THIS CONDITION.

83436

I-20 @ Alpine Road
Columbia, SC 29219

BlueCross BlueShield of South Carolina
An Independent Licensee of the Blue Cross and Blue Shield Association

STATE HEALTH PLAN
###

August 25, 2008
###
###

!294077258529!
JEFFREY D ALLEN

EXPLANATION OF BENEFITS

THIS IS NOT A BILL

If you have a question about your claim, please call Customer Service at 1-800-868-2520 OR LOCALLY AT 736-1576 MON. - FRI. 8:00 A.M. - 6:00 P.M.

SUMMARY INFORMATION

Patient's Name	Relationship to Policyholder	ID No.	Claim No.
	CHILD	ZCS36961363	8E3431354-00-00

TOTAL CHARGE FOR YOUR CLAIM:	TOTAL AMOUNT WE PAID:	WHAT YOU OWE PROVIDER:
473.00	.00	441.56
		The provider can bill you for this amount if you have not yet paid.

To date, you have satisfied 350.00 of the 350.00 deductible for the benefit period that began 01/01/2008.
This claim contributed .00 toward your out-of-pocket maximum. You have satisfied 3.60 of the 2,000.00 out-of-pocket maximum for that benefit period. We paid a total of 14.40 for this person this benefit period.

DETAIL INFORMATION

Provider	MEDICAL UNIVERSITY	MEDICAL UNIVERSITY	MEDICAL UNIVERSITY	
Network Participation	YES	YES	YES	
Dates of Service	08/13/08	08/13/08	08/13/08	
Type of Service	OUTPT LAB/PATH	OUTPT LAB/PATH	MEDICAL SERVICES	
Charge	19.00	34.00	420.00	
Amount Not Covered	11.27 01*	20.17 01*	420.00 02*	
Covered Expenses	7.73	13.83	.00	
Deductible	.00	.00	.00	
Copay/Spec Deductible	7.73	13.83	.00	
Allowed Amount	.00	.00	.00	
Coinsurance	.00	.00	.00	
Amount Paid	.00	.00	.00	

* Please refer to the remarks section.

Suspect claims fraud? Please help by calling our hotline at 1-800-763-0703

THANK YOU FOR ALLOWING US TO SERVE YOU!

www.SouthCarolinaBlues.com

Helpful Definitions (Please check your schedule of benefits in your benefits booklet for details)

Amount Approved for Coordination - the amount we will coordinate with your primary health or dental plan's payment.

Benefit Period - the period of time you must pay any deductibles and coinsurance payments that may apply. Benefits begin once you meet the deductible. If you reach the limit, we pay covered expenses in full for the rest of the benefit period. Deductibles and coinsurance start over with each new benefit period.

Coinsurance - the percentage of the allowed amount you pay as your share of the bill. If your plan pays 80%, then 20% would be your coinsurance.

Copayment - a set fee you pay each time you receive a certain service. Some plans do not have copayments.

Deductible - the amount, if any, that you are responsible for paying before we start paying contract benefits. You do not send this amount to us. We subtract this amount from covered expenses on the claims you and healthcare professionals send to us.

Less Benefit Limitation - the amount that is more than your contract allows for this type of service. Your plan covers these services until you have reached the limit of your benefits.

Network Participation - this column shows whether or not the healthcare professional who provided the service participates in our network. If "YES" this is a network participant. If "NO" this is not a network participant. If "N/A", the issue doesn't apply to your coverage, or this particular claim.

Out-of-pocket-maximum - the highest amount of the covered expenses you will have to pay during a benefit period.

Total Benefit Allowed - the amount we would have paid if another insurance carrier was not involved.

APPEAL OR REVIEW

If you have questions about the disposition of this claim, you may call us at the number listed on the front of this statement. Please refer to your insurance benefit guide for more information. If you would like to request a reconsideration of your claim you may request a review by writing to us within six months of this notice at:

STATE HEALTH PLAN
P. O. BOX 100605
COLUMBIA, S.C. 29260-0605

REMARKS SECTION

THE LIFETIME BENEFITS PAID FOR THIS PERSON TO DATE: 3,907.20

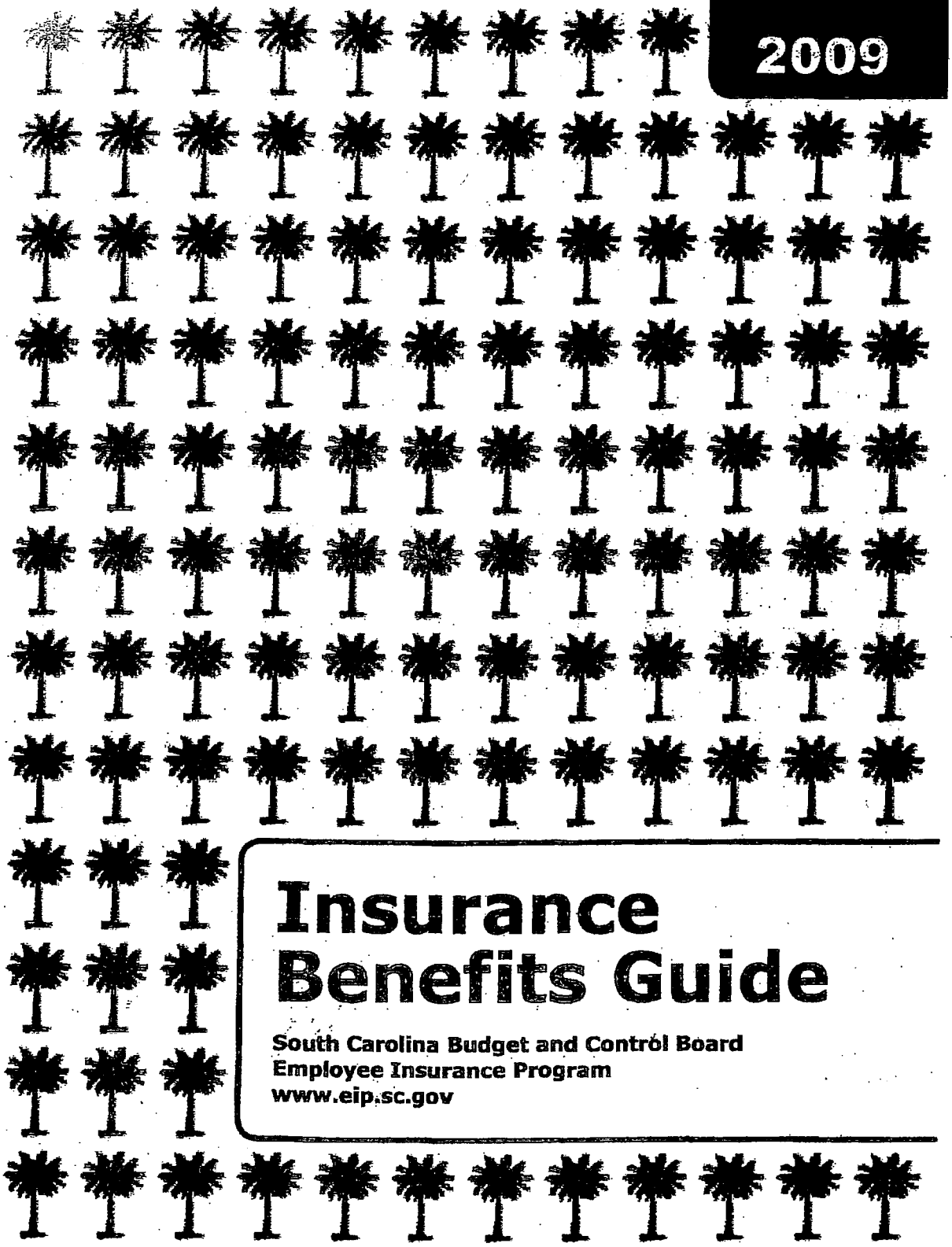
WE PROVIDE ADMINISTRATIVE CLAIMS PAYMENT SERVICES ONLY AND DO NOT ASSUME ANY FINANCIAL RISK OR OBLIGATION WITH RESPECT TO CLAIMS.

01 THIS AMOUNT IS THE DIFFERENCE BETWEEN WHAT THE PROVIDER CHARGED FOR THIS SERVICE AND OUR ALLOWANCE.

02 YOUR BENEFIT PLAN DOES NOT COVER EDUCATION AND/OR TRAINING FOR THIS CONDITION.

Exhibit "D"

to Plaintiff's
Memorandum in Opposition
to Defendant's
Motion to Dismiss



2009

Insurance Benefits Guide

South Carolina Budget and Control Board
Employee Insurance Program
www.eip.sc.gov

Exhibit "D" to Plaintiff's Memorandum in Opposition

Contact Information

APS HEALTHCARE INC.

SHP Mental Health and Substance Abuse

Claims, State of SC
P.O. Box 1307
Rockville, MD 20849
Customer Service: 800-221-8699
Tobacco Treatment: 866-784-8454
Fax: 888-897-8931
www.apshealthcare.com
(password=statesc)

BLUECHOICE HEALTHPLAN OF SOUTH CAROLINA

P.O. Box 6170
AX-435
Columbia, SC 29260-6170
Member Services:
800-868-2528
803-786-8476
www.BlueChoiceSC.com

BLUECROSS BLUESHIELD OF SOUTH CAROLINA (BCBSSC)

SHP Standard Plan, Savings Plan, Medicare Supplemental Plan

P.O. Box 100605
Columbia, SC 29260-0605
Customer Service Center:
800-868-2520
803-736-1576
Fax: 803-264-4204
www.SouthCarolinaBlues.com

Medi-Call

BlueCross BlueShield of SC
AX-330
I-20 Alpine Road
Columbia, SC 29219
800-925-9724
803-699-3337
Fax: 800-264-0183
Rx Card
800-963-TRUE (2583)

Dental Plan, Dental Plus

BlueShield of SC
[illegible]
[illegible] 29202-3300
[illegible] 888-214-6230
[illegible]739
[illegible]naBlues.com

CIGNA HEALTHCARE HMO

P.O. Box 5200
Scranton, PA 18505-5200
Member Services: 800-244-6224
www.cigna.com

EMPLOYEE INSURANCE PROGRAM (EIP)

Street Address:
1201 Main Street, Suite 300
Columbia, SC 29201
Mailing Address:
P.O. Box 11661
Columbia, SC 29211-1661
Customer Service:
803-734-0678 (Greater Columbia area)
888-260-9430 (toll-free outside Columbia area)
Retiree Billing: 803-734-1696
Fax: 803-737-0825
www.eip.sc.gov

FRINGE BENEFITS MANAGEMENT COMPANY (FBMC)

MoneyPlu$

P.O. Box 1878
Tallahassee, FL 32302-1878
3101 Sessions Road
Tallahassee, FL 32303
Customer Service: 800-342-8017
Automated Information: 800-865-FBMC (3262)
Claims Fax: 888-800-5217
Other Fax: 850-425-6220
www.myFBMC.com

THE HARTFORD

Basic Life, Optional Life, Dependent Life

P.O. Box 2999
Hartford, CT 06104-2999
Medical Evidence of Good Health: 800-331-7234
Status of Death Claims: 888-563-1124
Retiree Enrollment /Claims: 888-803-7346, ext. 33666
Conversion: 877-320-0484
Customer Service: 800-523-2233

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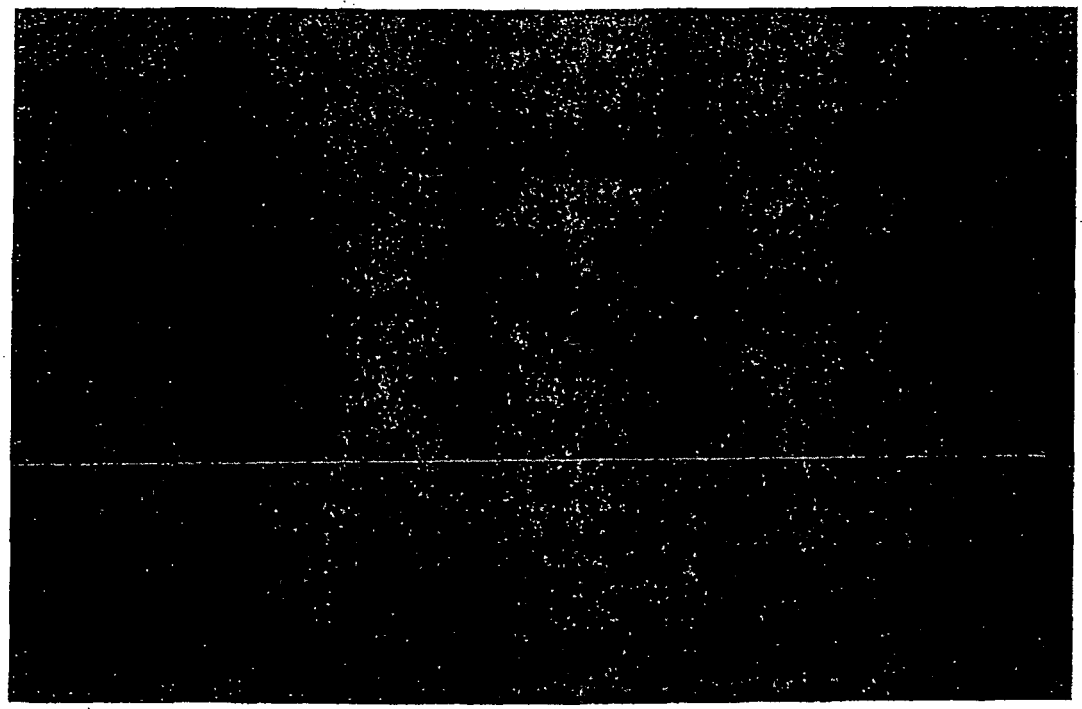
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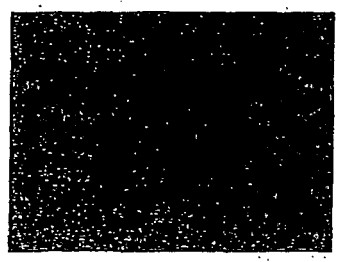
Introduction

We know that your benefits are important to you and to your family. We also know that you lead busy lives and often don't have a chance to read about your insurance until there is a need to use it. For that reason, we continually try to make the *Insurance Benefits Guide* (IBG) easier to understand and use.

The section "What's New for 2009?" highlights major changes in insurance programs offered through the Employee Insurance Program (EIP). There also are some changes in this book.

New symbols have been added to boxes. A box with a book will tell you where to go for more information about a topic. An apple marks information about how to stay healthy or manage diseases.

As always, this guide includes explanations of benefits, premiums and contact information and an overview of the health plans and other programs offered through EIP.



Terms that may be unfamiliar to you are italicized and defined in the text. However, if you have questions, ask your benefits administrator; the third-party administrator, such as BlueCross BlueShield of South Carolina or FBMC; or EIP. The IBG's index has been expanded. Turn to it for help in finding information about specific topics, including definitions of terms.

Remember, only information concerning those programs for which you are eligible and in which you are enrolled applies to you. The word "you," as used in this book, means anyone insured through EIP, you and/or your covered dependents.

We encourage you to review each chapter that applies to you and to discuss your benefits with your family. Charts are included to help you compare plans. Pay close attention to copayments, deductibles, preauthorization requirements and services that may be limited or not covered.

For a more detailed explanation of your benefits, check the appropriate chapter in the IBG. If you still have questions, call your benefits administrator or EIP.

For information about processing and payment of claims, contact the third-party administrator listed on the inside cover of the IBG.

To make the best use of your insurance, please remember:

- **You are responsible for understanding your benefits. Ask questions if you do not understand them.**
- **Coverage and changes are not automatic.**
- **You may make changes in your coverage within 31 days of a qualifying event, such as birth, adoption, marriage or involuntary loss of other coverage. To do so, contact your benefits administrator.**
- **Whether you are covered by the State Health Plan or a Health Maintenance Organization (HMO), some services must be approved by your plan before you receive them. Check preauthorization requirements now so you will be familiar with them when you need services.**

Confidentiality Policies

The South Carolina Budget and Control Board Employee Insurance Program (EIP) is committed to protecting the privacy of your health information. EIP strives continually to ensure its compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, which mandates security and privacy of health information by setting standards for access and distribution of that information.

EIP provides a Notice of Privacy Practices directly to all persons covered under the state insurance program. This brochure outlines the situations in which EIP uses and discloses health information. It also outlines your rights with regard to the information and disclosure. A copy of EIP's Notice of Privacy Practices is on page 215 and on the EIP Web site, www.eip.sc.gov. In addition, the Web site contains links to forms mentioned in the Notice of Privacy Practices.

If you would like for someone, such as your spouse or your parents, to have access to your protected health information – or if they would like for you to have access to theirs – you, as a subscriber or a covered dependent, must complete an Authorized Representative Form. The form is available on EIP's Web site. Choose your category and then select "Forms." Under "Forms," select "Other Forms" then "HIPAA Information" then "Authorized Representative Form."

If you have any questions about HIPAA, please contact:

Privacy Officer
South Carolina Budget and Control Board
1201 Main Street, Suite 300
Columbia, SC 29201
Phone: 803-734-0678
Fax: 803-737-0825
E-mail: privacyofficer@eip.sc.gov

General Information

- **Retirees, survivors and COBRA subscribers,** as well as **active subscribers,** can now update their contact information and beneficiaries and print a copy of their benefits statement year-round on MyBenefits, EIP's online enrollment system. During October, they can also make their own enrollment changes.

For details, see page 24 and www.eip.sc.gov.

State Health Plan

- The State Health Plan now covers certain services related to autism spectrum disorders.

For details, see page 45.

Health Maintenance Organizations

- The HMOs offered through the Employee Insurance Program now cover certain services related to autism spectrum disorders.

For details, see page 66 (BlueChoice HealthPlan) and page 76 (CIGNA HMO).

- **MUSC Options,** a point of service plan offered in the Charleston area, is no longer offered.

Long Term Care

- The Prudential Insurance Company of America has replaced Aetna as the EIP's long term care insurance provider.

For details, see pages 127-134.

MoneyPlu$

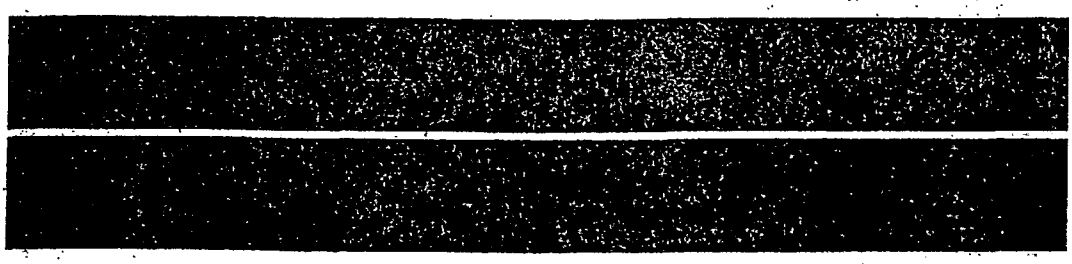
- Eligible Savings Plan subscribers may now open a Health Savings Account online.

For details, see page 153.

Retirement/Disability Retirement

- Employees who began service with an employer participating in the state insurance program on or after May 2, 2008, are covered under new retiree insurance eligibility rules.

For details, see page 163.



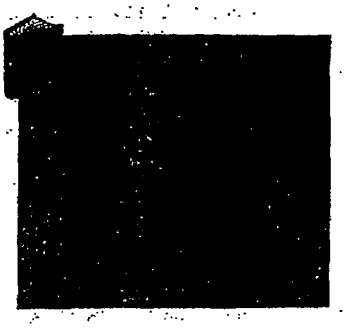
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Your Insurance Benefits:
Help When You Need It Most

Your insurance, offered through the Employee Insurance Program, provides a financial safety net when you are ill or injured. Several health plans are available.

Through the **State Health Plan**, you may enroll in the Standard Plan, the Savings Plan or, if you are a retiree and eligible for Medicare, the Medicare Supplemental Plan.



Health Maintenance Organizations are also offered:

- BlueChoice HealthPlan is available statewide.
- CIGNA HMO is available in all counties **except** Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda.

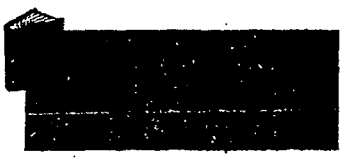
Active employees who enroll in a health plan receive Basic Life Insurance and Basic Long Term Disability Insurance at no charge.

Eligible employees and retirees may also enroll in the State Dental Plan and in Dental Plus. Dental Plus supplements State Dental Plan coverage. It pays a higher amount for the same services covered by the State Dental Plan except orthodontics, which Dental Plus does not cover.

An eligible active employee:

- Is employed by the state, a school district or a participating *local subdivision* and
- Works in a permanent, full-time position and
- Receives compensation from the state, a school district or a participating local subdivision.

Eligible employees also include clerical and administrative employees of the S.C. General Assembly and judges in the state courts. S.C. General Assembly members and elected members of the councils of participating counties or municipalities, who also participate in the S.C. Retirement Systems (SCRS), and permanent, part-time teachers are considered employees for insurance purposes. Members of other governing boards are not eligible for coverage. If you work for more than one *participating group*, please contact your benefits administrator for further information.



A *local subdivision* is any *participating group* other than a state agency, higher education institution or a school district. Examples of local subdivisions include: counties, municipalities, councils on aging, commissions on alcohol and other drug abuse, special purpose districts, community action agencies, disabilities and special needs boards, recreation districts, hospital districts and councils of government. Since 1985, the General Assembly has passed legislation extending voluntary participation in the state insurance benefits program to certain local subdivisions. For a local subdivision to be eligible to participate in the state insurance program, it must fall within one of the categories established by statute (Section 1-11-720 of the 1976 S.C. Code of Laws, as amended).

An eligible dependent spouse is:

- A lawful spouse, or
- A former spouse who is required to be covered by a divorce decree, but not both spouses.

A spouse who is eligible for coverage as an employee of any participating group, including a local subdivision, may not be covered as a dependent in any program. A spouse who is a permanent, part-time teacher may be covered as an employee or as a dependent, but not as both.

An eligible dependent child:

- Must be unmarried and younger than age 19
- Must be principally dependent (more than 50 percent) on the subscriber for maintenance and support
- Must be the natural child, adopted child, stepchild, foster child or child for whom the subscriber has legal custody and
- Must reside in the subscriber's home in a parent-child relationship unless the subscriber has been directed to provide coverage by a court order.

Please note: You may cover an eligible dependent child age 19-24 if he is a full-time student. You may cover an eligible incapacitated child age 19 and older.

If you and your spouse are both eligible for coverage, only one of you can cover your children under any one program. However, one parent can cover the children under health, and the other can cover the children under dental.

Initial Enrollment

If you are an eligible employee or retiree of a *participating group* in South Carolina, you can enroll in a health plan and the dental plan within 31 days of the date you are hired or the date you retire. You can also enroll your eligible dependents. A *participating group* is a state agency, school district, county, municipality or other group that is authorized by statute to participate in, and is participating in, the state insurance plan.

To enroll in a health or dental plan, you must complete the required forms, including a *Notice of Election (NOE)* form. An *NOE* is used to: enroll in benefits; add or drop dependents; or change a subscriber's coverage level, beneficiary, name or address. Coverage is not automatic.

To enroll in Dental Plus, you must be enrolled in the State Dental Plan. You must cover the same family members under both plans.

After you enroll, please check your payroll stub to make sure the correct premiums are deducted. Your health and dental coverage will continue from one year to the next as long as you are a full-time, permanent employee or an eligible retiree. Your coverage begins on the first day of the month if you are *actively at work* on the first working day of the month.

An employee is considered *actively at work* on his employer's scheduled workday if he is performing the regular duties of his occupation. He may be working at his usual work place or at another place, if he is required to travel. An employee is considered actively at work on a paid

vacation day or on one of his employer's normal holidays only if he was actively at work on the last day before the vacation day or holiday.

If you are not actively at work on the first working day of the month, your coverage starts on the first day of the next month. Your enrolled dependents' coverage begins on the same day your coverage begins.

[redacted]

If you enroll in the Standard Plan, Savings Plan or Medicare Supplemental Plan, BlueCross BlueShield of South Carolina will send you insurance cards for you and your covered family members. BlueChoice HealthPlan and CIGNA Healthcare will mail insurance cards to their members. Benefits administrators will provide State Dental Plan subscribers with a card upon which they can write their name and Benefits ID Number. Dental Plus subscribers will receive an insurance card from BlueCross BlueShield of South Carolina.

[redacted]

Benefits Identification Number

The Employee Insurance Program gives each subscriber an eight-digit Benefits Identification Number (BIN). This unique number is used instead of a Social Security Number (SSN) in e-mails and written communication between you and your dependents and EIP. It is designed to make your personal information more secure. When you contact EIP, you may give your SSN or your BIN, and the Customer Service staff will be able to assist you.

The State Health Plan and BlueChoice HealthPlan put your BIN on your identification card. The BIN is also used on Dental Plus cards. CIGNA gives its members another secure number. If you are not enrolled in a program that uses the BIN, EIP will send you your number.

Keep a record of your BIN in a safe place. All subscribers need it to use MyBenefits, EIP's online enrollment system. However, you can also get your BIN through MyBenefits. For more information, see page 24.

[redacted]

Every October, you may make changes in your **health coverage** without regard to special eligibility situations.

- During *annual enrollment,* eligible employees, retirees, survivors and COBRA subscribers may change health plans only. This includes changing to or from the Medicare Supplemental Plan, if you are retired.
- During *open enrollment*, which occurs in odd-numbered years, eligible subscribers may enroll in or drop their own health coverage and add or drop eligible dependents. You may also change **dental coverage.**

Changing Plans or Coverage

You can change to or from the Savings Plan, the Standard Plan, a health maintenance organization (HMO) or the Medicare Supplemental Plan (if you are retired) only during October enrollment periods. There may be exceptions to this rule. Contact your benefits administrator for details if you are an active employee or if you are a retiree, a survivor or COBRA subscriber of a local subdivision. Retirees, survivors and COBRA subscribers of other employers should contact EIP, which is their benefits administrator.

[redacted]

Retirees and survivors and their eligible dependents who are enrolled in a health plan may change to the Medicare Supplemental Plan within 31 days of Medicare eligibility or during annual or open enrollment.

If you are retired and eligible for Medicare, you may not enroll in the Savings Plan. Active employees of any age and retired employees who are not eligible for Medicare may enroll in the Savings Plan.

You can add or drop State Dental Plan and Dental Plus coverage only during open enrollment, which is in October of odd-numbered years, or within 31 days of a special eligibility situation.

Other changes you may make in your insurance coverage are explained in *The Insurance Advantage,* which you receive each September. Changes made during open or annual enrollment become effective the following January 1.

Pre-Existing Condition Exclusions

Most of the health plans offered through EIP exclude coverage for a *pre-existing condition.* This means that if you have a medical condition before coming to the plan, you may have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. The pre-existing exclusion does not apply to pregnancy nor to a child who is enrolled within 31 days of birth; adoption, if the child is younger than age 18; or placement for adoption, if the child is younger than age 18.

This exclusion may last up to 12 months (18 months if you are a late entrant) from your enrollment date. However, you can reduce the length of this exclusion period by the number of days of your prior creditable coverage. Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a *significant break in coverage,* a period of more than 62 days in which you did not have insurance. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you must present to your benefits administrator a creditable coverage letter or a letter on letterhead from your previous employer or insurance company that includes the dates coverage began and ended, the names of all individuals covered and the types of coverage.

The State Dental Plan and Dental Plus do not have pre-existing condition exclusions.

Late Entrants

If you do not enroll within 31 days of the date you begin employment, retire or experience a special eligibility situation, you cannot enroll yourself or your eligible dependents until the next open enrollment period. Open enrollment is held in October of odd-numbered years, and your coverage will take effect the following January 1. As late entrants, you and your dependents will be subject to an 18-month pre-existing condition exclusion period, which may be reduced by prior creditable coverage.

If you decline enrollment for yourself or your eligible dependents (including your spouse), because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents for coverage at a later date if you or your dependents involuntarily lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must complete an NOE within **31 days** of the date your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents in health and/or dental coverage. However, you must complete an NOE within **31 days** of the date of the marriage, birth, adoption or placement for adoption. A salary increase does not create a special eligibility situation.

If you are an active employee and eligible to change your health, dental or Optional Life Insurance coverage due to a special eligibility situation, you also may enroll in or drop the Pretax Group Insurance Premium Feature.

Marriage

If you, as a covered subscriber, wish to add a dependent spouse because you marry, you can do so by completing an NOE within 31 days of the date of your marriage. Coverage becomes effective with the date of marriage. You cannot cover your spouse as a dependent if he is eligible, or becomes eligible, for coverage as an employee or as a retiree of a participating group. If you do not add your spouse within 31 days of the date of marriage, you cannot add him until the next open enrollment period or within 31 days of a special eligibility situation.

Legal Separation

If you and your covered spouse separate, your spouse may remain on your health, dental and Dependent Life/Spouse coverage until the divorce is final.

To drop your spouse when you separate, you must submit a copy of a court order signed by the judge to your benefits administrator. It must state that the divorce is in progress, and it must be attached to an NOE. Your spouse's coverage will end the last day of the month after the date of separation, if you drop your spouse within 31 days of separation. Otherwise coverage will end the first of the month after the date you request it.

If you reconcile with your spouse after you drop health insurance coverage for your spouse, coverage cannot be reinstated until the next open enrollment period or a special eligibility situation. He will then be considered a late entrant. As a late entrant, he will not be eligible for coverage for pre-existing conditions until 18 months after enrollment. If he enrolls due to a special eligibility situation, he will not be eligible for coverage for pre-existing conditions until 12 months after enrollment (which may be reduced by prior creditable coverage). For more information, see page 12.

You may re-enroll your spouse in Dependent Life/Spouse year-round if you submit medical evidence of good health and it is approved by The Hartford. Dental coverage can be reinstated during the next open enrollment period or within 31 days of a special eligibility situation.

Divorce

If you, as a subscriber, divorce, you must drop your spouse from your coverage by completing an NOE and submitting **a complete copy** of the divorce decree within 31 days of the date the divorce decree is signed. Your divorced spouse's coverage ends the last day of the month after the divorce decree is signed. You can continue to cover your eligible dependent children if they live with you and you are financially responsible for them.

You may continue to provide health, dental and Dependent Life coverage for your former spouse only if the Family Court requires that you do so. You must give a complete copy of the Family Court decree or a complete copy of the divorce decree, as well as an NOE, to your benefits administrator, who will send both to EIP. The document must list the programs under which your former spouse must be covered. Retirees of state agencies, higher education institutions and school districts, survivors and COBRA subscribers should notify EIP. Retirees of local subdivisions should notify their benefits administrator.

If you remarry, you can cover your divorced spouse or your current spouse, but you cannot cover both under any EIP program. Dependent spouses who lose coverage due to a qualifying event may be eligible to continue coverage under COBRA. For more information, you must contact your benefits administrator or EIP as soon as possible, but **no later than** within 60 days of the event or from when coverage would have been lost due to the event, whichever is later.

Adding Children

Eligible children may be added by completing an NOE **within 31 days** of the date of birth, gaining legal custody, adoption or placement for adoption. **Children must be listed on your NOE to be covered, even if you already have full family or employee/children coverage. Notification to Medi-Call of the delivery of your baby does not add the baby to your health insurance.**

To add adopted children to your policy, you must submit a copy of the legal adoption documentation from the court, verifying the completed adoption; or a letter of placement from an attorney, adoption agency or the S.C. Department of Social Services (DSS) verifying the adoption is in progress, as well as an NOE. An adopted child will be covered on the date of adoption or when the child has been placed in a subscriber's home, a petition for adoption has been filed and the petitioner has temporary custody of the child.

To verify custody or guardianship of a child, you must submit a copy of the court order or other legal documentation from a placement agency or DSS granting you custody or guardianship of the child or foster child. The documents must verify that you, the subscriber, have guardianship responsibility for the child and not just financial responsibility.

If a court order is issued requiring you to cover your dependent child, you must notify your employer and EIP within 31 days of the date the court order was issued and elect coverage for that child and yourself, if you are not already enrolled.

If you and your spouse are both eligible for coverage, only one of you can cover your children under any one program. However, one parent can cover the children under health, and the other can cover the children under dental. Only one parent can carry Dependent Life coverage for eligible dependent children.

Gaining Other Coverage

If you or your dependents gain other group coverage, you have 31 days to cancel your coverage by completing an NOE and returning it to your benefits office with proof of the other coverage. To document that you have gained coverage, you must present a letter on company letterhead that includes dates of coverage, names of all individuals covered and types of coverage gained.

If you fail to cancel coverage within 31 days, you must wait until the next open enrollment period. For more details, contact your benefits administrator or EIP.

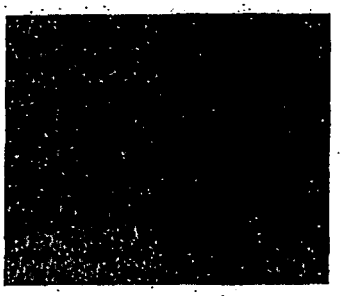
Involuntary Loss of Other Coverage

If you or your dependents are covered under another health or dental plan and you lose that coverage involuntarily because it was discontinued or the covered employee left his job, you have 31 days from the last day of coverage to enroll through EIP. To enroll, you must complete an NOE and return it to your benefits office. To document that you have lost coverage, you must attach a creditable coverage letter or a letter on company letterhead that includes dates of coverage, names of all individuals who lost coverage, the types of coverage and the reason for the loss. Dependents must be listed on the NOE to be covered. Only family members who actually lost coverage may enroll. If you fail to enroll within the 31 days, you must wait until the next open enrollment, which occurs in October of odd-numbered years, or within 31 days of a special eligibility situation.

Full-time Students, Ages 19-24

You may cover your dependent children, ages 19-24, who are full-time students. They must meet these requirements:

- At the beginning of the semester, a student must be enrolled in and attending an accredited high school, vocational/trade school or college or university **full-time**, as defined by the institution he attends. He must remain a full-time student throughout the semester.
- While summer school is not required for maintaining student status, a dependent who enrolls in summer school full-time may become eligible. However, the student will lose eligibility if he does not re-enroll full-time the next semester/quarter.
- Enrollment in adult education night classes and correspondence courses is not considered full-time attendance. Internet courses from the accredited educational institution the student is attending do count toward the hours needed for him to be considered a full-time student.



About 90 days before your dependent's 19th birthday, you will receive a Student Certification letter. To continue coverage, complete and return this letter to your benefits administrator within 31 days of the child's 19th birthday. You must also include a statement on letterhead from the educational institution he is attending that confirms he is a full-time student as of the date of his 19th birthday and gives his dates of enrollment. Evidence of pre-registration is not adequate. If the child's 19th birthday occurs during the summer, return the Student Certification letter with the "Pending Student Certification" block marked to your BA. (Retirees of state agencies, higher education institutions and school districts should return the letter to EIP.) You must submit the letter from the institution verifying that your child is a full-time student by September 30.

If the letter is not returned by September 30, the child will lose eligibility for coverage on October 1. You will be able to add the child to your coverage, again:

- At open enrollment
- Within 31 days of the date he first becomes eligible due to a special eligibility situation
- Within 31 days of the date the child first returns to school full-time.

If your dependent, age 19-24, goes back to school full-time, you may put him back on your health coverage. Within 31 days of eligibility, submit an NOE and a statement on letterhead from the educational institution that verifies your dependent is a full-time student and gives his dates of enrollment. In this case, that would be the date he is again a full-time student.

If your 19-year-old is certified as a full-time student **while he is in high school**, you must notify your benefits administrator within 31 days of the date he leaves high school if he will not be returning to school in the fall.

When your child is covered as a full-time student, his coverage ends the last day of the month in which he graduates, is no longer a full-time student, marries or turns age 25, unless he is covered as an incapacitated dependent.

If a child does not remain a full-time student for the entire semester, his coverage ends the last day of the month in which he becomes ineligible. His 60-day COBRA notification period begins the first day of the month after he becomes ineligible.

If a child remains a full-time student through the semester and does not graduate, EIP will assume the child intends to enroll as a full-time student the next semester. If a child is not a full-time student by September 1, for the fall semester (or by February 1 for the spring semester) his 60-day COBRA notification period will begin on this date. You must notify your benefits office that the child is no longer a full-time student and submit an NOE, dropping him from your coverage. If notification is received within 60 days of when coverage would have been lost due to the event, continuation of insurance under COBRA will be offered. Otherwise, it will not be offered.

EIP conducts periodic audits of the eligibility of covered dependents ages 19-24. If your child is found to be ineligible, his coverage will be canceled, and EIP will seek repayment of any benefits paid for him while he was ineligible.

If a dependent whose eligibility is audited is a graduate of a community or technical college, a four-year college or a university and will return to school when the next term begins, you will be asked to provide EIP with a letter from the school he hopes to attend acknowledging his application or a letter of acceptance from the school he will attend.

Incapacitated Children

You can continue to cover your child, who is age 19 or older, if he is incapacitated and you are financially responsible for him. To cover your dependent child who is incapacitated, he must meet these requirements:

- The child must have been continuously covered by health insurance from the time of incapacitation.
- The child must be unmarried and must remain unmarried to continue eligibility.
- The child must be incapable of self-sustaining employment because of mental illness, retardation or physical disability and must remain principally dependent (more than 50 percent) on the covered employee, retiree, survivor or COBRA subscriber for support and maintenance.

Incapacitation must be established no earlier than 90 days before the child's 19th birthday, but no later than 31 days after the date he is no longer covered as an eligible, full-time student. An Incapacitated Child Certification Form must be completed by the subscriber and the child's physician and then sent to EIP for review. EIP will send the form to Standard Insurance Company for review of the medical information and for compliance with the Plan of Benefits. Additional medical documentation from the child's physician may be required by The Standard. The Standard will forward its recommendation to EIP, which makes the final decision.

If the child became incapacitated while enrolled as a full-time student, you must also include a letter from the school he was attending stating that he was a full-time student up to the date of incapacitation and that he is no longer a full-time student.

Also complete and attach an Authorized Representative Form signed by the incapacitated child. If applicable, you may forward a copy of guardianship papers from the probate court for your incapacitated child. Either of these documents gives EIP permission to discuss or disclose the child's protected health information with the child's Authorized Representative.

As an active employee, you are considered a transfer if you change employment from one participating group to another with no more than a 15 calendar-day break in employment or in insurance coverage.

To avoid a lapse in coverage or delays in processing claims, be sure to tell your benefits administrator that you are transferring to another participating group. **Check with the benefits administrator at your new employer to be sure that your benefits have been transferred.**

As an **academic employee**, you are considered a transfer if you complete a school term and move to another participating academic employer at the beginning of the next school term. Your insurance coverage with the employer you are leaving will remain in effect until you begin work with your new employer, typically September 1. On that date, your new employer will pick up your coverage. If you do not transfer to another participating academic employer, your coverage ends the last day of the month in which you were actively at work.

A transfer is not considered a new hire for insurance purposes. When you transfer, you must remain enrolled in all of the same insurance programs in which you were enrolled at your former employer.

If you are an active employee, you may be eligible to continue your coverage for a limited time if you are on leave without pay, as long as you pay the required premiums. Please contact your benefits administrator about your insurance coverage if you are taking: educational leave, military leave, leave provided under the Family and Medical Leave Act (FMLA), leave because of a disability approved by the Workers' Compensation Benefits Program or disability leave. Leave must be approved by your employer.

If You Are an Active Employee When You or Your Spouse Turns 65

If you are actively working and/or covered under a state health plan for active employees when you turn 65, you may delay enrollment in Part B because your insurance as an active employee remains primary. However, if you are planning to retire within three months of age 65, you should contact the Social Security Administration to learn about your Medicare enrollment options.

When you do retire, you should sign up for Part B within 31 days of retirement. Medicare will then be your primary coverage, and you need Part A and Part B for full coverage. It is strongly advised that you enroll in Medicare Part B coverage. **If you are not enrolled in Part B at retirement, you will be required to pay the portion of your healthcare costs that Part B would have paid.**

If you are an active employee when your spouse turns 65, your spouse should enroll in Medicare Part A but may defer enrollment in Part B until you retire or leave covered employment.

Most Medicare recipients covered by health insurance offered through EIP should not sign up for Medicare Part D, the prescription drug program. Your drug expenses will continue to be covered under your health insurance.

Medicare at Age 65 When You Are Retired

The Social Security Administration should notify you or any dependents of Medicare eligibility approximately 90 days before turning 65 if you are receiving a Social Security check. If you are not notified, contact your local Social Security office immediately. If you are already receiving Social Security benefits when you turn 65, Medicare Part A and Part B will start automatically. It is strongly advised that you enroll in Medicare Part B coverage. **If you are not enrolled in Part B, you will be required to pay the portion of your healthcare costs Part B would have paid.** Even if you have not reached the age to qualify for full Social Security benefits, you should sign up for Medicare within three months of your 65th birthday.

If you are not receiving Social Security benefits when you turn 65 and you wish to wait to receive them until you reach full retirement age, you must contact the Social Security Administration to enroll in Medicare Part A. It is strongly advised that you enroll in Medicare Part B coverage. Medicare becomes your primary health insurance at age 65, regardless of whether you are receiving Social Security benefits.

Most Medicare recipients covered by health insurance offered through EIP should not sign up for Medicare Part D, the prescription drug program. Your drug expenses will continue to be covered under your health insurance.

Medicare Before Age 65

If you or your covered dependent becomes eligible for Medicare before age 65 due to disability or end-stage renal disease (ESRD), the Social Security Administration will notify you. **You must notify EIP within 31 days of Medicare eligibility.** When you notify EIP, please submit a copy of your Medicare card.

If Medicare is your primary insurance, it is strongly advised that **you enroll in Medicare Part B,** which helps cover doctors' services and outpatient hospital care. **If you are not enrolled in Part B, you will be required to pay the portion of your healthcare costs Part B would have paid. Not enrolling in Part B may substantially increase the amount you pay.**

[redacted]

Your coverage will end:

- The last day of the month in which you were actively at work, unless you are transferring to another participating group
- The last day of the month in which you become ineligible for coverage (for example, your working hours are reduced from full-time to part-time)
- The day after your death
- The date the coverage ends for all employees or
- If you do not pay a required premium when it is due. (For example, if you are on leave without pay or on COBRA and are paying the full cost, you must make a monthly payment.)

Dependent coverage will end:

- The date your coverage ends
- The date dependent coverage is no longer offered or
- The last day of the month in which your dependent's eligibility for coverage ends.

If your coverage or your dependent's coverage ends, you may be eligible for continuation of coverage as a retiree, as a survivor or under COBRA. If you are dropping a dependent from your coverage, you must complete a Notice of Election (NOE) form within 31 days of the date the dependent is no longer eligible for coverage.

COBRA

COBRA is short for Consolidated Omnibus Budget Reconciliation Act. It requires that continuation of **group health and/or dental insurance coverage** be offered to you and/or your covered dependents if you are no longer eligible for coverage due to a qualifying event. Qualifying events include:

- The covered employee's working hours are reduced from full-time to part-time
- The covered employee voluntarily quits work, retires, is laid off or is fired (unless the firing is due to gross misconduct)
- The covered employee is separated or divorced from his spouse
- A covered child no longer qualifies as a dependent.

For covered dependents to continue coverage under COBRA, the subscriber or a dependent must notify his benefits office **within 60 days of the qualifying event or the date coverage would have been lost due to the qualifying event,** whichever is later. Otherwise, the individual will lose his rights to COBRA coverage. To begin coverage under COBRA, a COBRA NOE and premiums must be submitted.



The premiums must be paid within 45 days of the date coverage was elected. Your first premium payment must include premiums for the month following the date you lost coverage, the month you elected coverage and the first full month of COBRA coverage.

For example: You lost coverage on June 30 and then elected coverage on August 15. You would be required to pay three premiums: one for the month following the date you lost coverage; one for the month in which you elected coverage; and one for the first full month after you elected coverage.

COBRA coverage becomes effective when the first premium is paid and remains in effect only as long as the premiums are kept up-to-date. EIP is the benefits administrator for COBRA subscribers of state agencies, higher education institutions and school districts. COBRA subscribers from local subdivisions keep the same benefits administrator.

How Medicare Affects COBRA Coverage
If you or your eligible dependent is covered by COBRA and become eligible for Medicare Part A, Part B or both, please notify the Employee Insurance Program. Your COBRA coverage will end.

A subscriber or eligible dependent who is covered by Medicare and then becomes eligible for COBRA can enroll in COBRA for secondary coverage. Medicare will be his primary coverage.

If you need more information about COBRA, contact your benefits office or EIP.

When COBRA Benefits Run Out

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) guarantees that persons who have exhausted COBRA benefits and are not eligible for coverage under another group health plan have access to health insurance coverage without being subject to a pre-existing condition exclusion period. However, certain conditions must be met. In South Carolina, the South Carolina Health Insurance Pool provides this guarantee of health insurance coverage. For information, call 803-788-0500, ext. 46401 (Greater Columbia area) or 800-868-2500, ext. 46401 (toll-free outside the Columbia area).

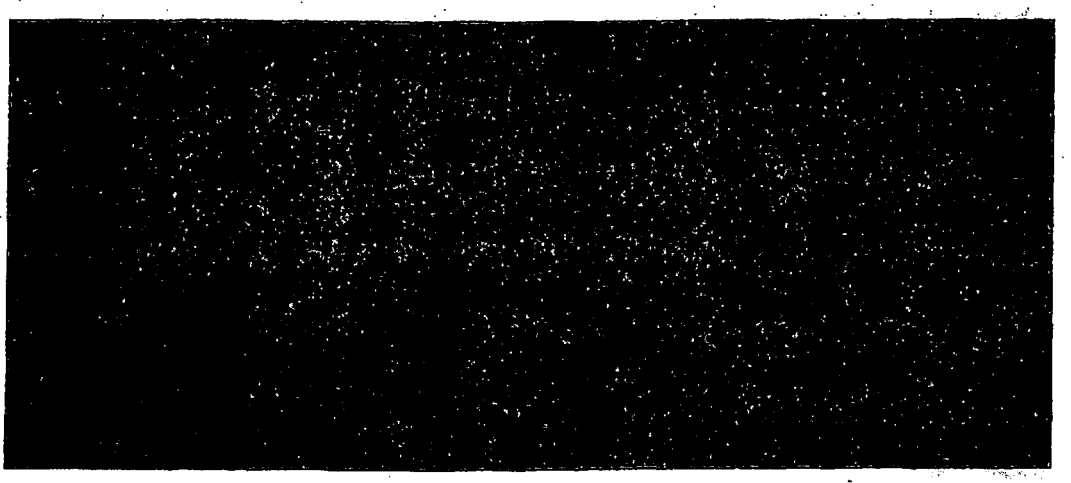
If an active employee or a retiree of a local subdivision dies, a family member should contact the deceased's employer to report the death, to discontinue the employee's health and dental coverage and start survivor coverage for any covered dependents. If a state agency, higher education or school district retiree dies, a family member should contact EIP.

If one of your dependents dies, please contact your benefits administrator. EIP is the benefits administrator for retirees of state agencies, higher education institutions and school districts. Survivor subscribers of local subdivisions keep the same benefits administrator.

Survivors

Spouses and children who are covered as dependents under the State Health Plan or an HMO are eligible as survivors for a one-year waiver of health insurance premiums when a covered employee dies.

Premiums are also waived for qualified survivors of funded retirees of state agencies, higher education institutions and school districts. Participating local subdivisions may elect to, but are not required to, waive the premiums of survivors of retirees. Retirees of a participating local subdivision should check with their benefits administrator to see whether the waiver applies.



After the premium has been waived for a year, a survivor must pay the employee and employer share of the premium to continue coverage. If you and your spouse are both covered employees or retirees at the time of death, your surviving spouse is not eligible for the premium waiver.

If you are a covered spouse or dependent child of a covered employee who was **killed in the line of duty** while working for a participating group, your premium will be waived for the first year after the employee's death. You must submit verification of death in the line of duty. After the one-year waiver, if you are a covered surviving spouse of a state agency or a school district employee you may continue coverage, *at the employer-funded rate*, until you remarry or otherwise become ineligible. If you are a covered surviving dependent child, you may continue coverage at the *employer-funded rate* until you are no longer eligible for coverage as a dependent. Participating local subdivisions may elect to, but are not required to, contribute to your insurance premium, but you may continue coverage, at the full rate, for as long as you are eligible.

State Dental Plan and Dental Plus premiums are not waived. However, survivors may continue dental coverage by paying the full premium.

As a surviving spouse, you can continue coverage until you remarry. If you are a dependent child, you can continue coverage until you are no longer eligible as a dependent. If you are no longer eligible for coverage as a survivor, you may be eligible to continue coverage under COBRA. Contact EIP for details.

As long as a survivor remains covered by either health or dental insurance, he can add the other during open enrollment or within 31 days of a special eligibility situation. If he drops both health and dental insurance, he is no longer eligible as a survivor and cannot re-enroll in coverage, even at open enrollment.

If a surviving spouse becomes an active employee of a participating employer, he can switch to active coverage. When he leaves active employment, he can go back to survivor coverage within 31 days, if he has not remarried.

Workers' Compensation

Insurance offered through EIP is not meant to replace Workers' Compensation and does not affect any requirement for coverage for Workers' Compensation insurance. It is not intended to provide or duplicate benefits for work-related injuries that are within the Workers' Compensation Act. If you need more information, please contact your benefits office or EIP.

Coordination of Benefits

Some families in which one spouse works for a participating employer and the other works for an employer that is not covered through EIP are eligible to enroll in two health plans. While the additional coverage may mean that more of your medical expenses are paid by insurance, you probably pay premiums for both plans. Weigh the advantages and disadvantages carefully before you purchase extra coverage.

Most health plans have a system to determine how claims are handled when a person is covered under more than one insurance plan. This is called "coordination of benefits" (COB). When a subscriber has coverage under more than one plan, he can file a claim for reimbursement from each plan. Third-party administrators, such as BlueCross BlueShield of South Carolina or your HMO, coordinate benefits so that you get the maximum reimbursement allowed. **That amount will never be more than 100 percent of your covered medical, dental or prescription drug expenses.**

There are rules that determine the order in which the plans pay benefits. The plan that pays first is the *primary* plan. The *secondary* plan pays after the primary plan. Here are some examples of how that works:

- The plan that covers a person as an employee is primary to the plan that covers the person as a dependent.
- When both parents cover a dependent child, the plan of the parent whose birthday comes earlier in the year is primary. Other rules may apply in special situations, such as when a child's parents are divorced.
- If you are eligible for Medicare and are covered as an active employee, your State Health Plan or HMO coverage is primary over Medicare. Exceptions may apply in the case of Medicare coverage due to kidney disease. Contact your local Social Security office for details.

For more information about how coordination of benefits works, see the section on your health plan.

Prevention Partners

Prevention Partners, a unit of EIP, is designed to help you and your family lead healthier lives. Its activities, programs and services promote good health through disease prevention, early detection of disease and chronic disease education.

A major initiative of Prevention Partners is the Preventive Worksite Screening. This comprehensive health screening measures cholesterol levels, blood pressure, triglyceride levels, kidney function and red and white blood cell counts. These measurements indicate if an employee is at risk for developing hypertension, diabetes and anemia.

This benefit is available to active and retired employees and their covered spouses whose primary insurance coverage is the Standard Plan, the Savings Plan, BlueChoice HealthPlan or CIGNA HMO for just a $15 copayment. The cost of the Preventive Worksite Screening does not contribute toward a subscriber's annual deductible or out-of-pocket maximum. Individuals are screened at their current or former worksite. To participate, individuals should contact their benefits administrator to find out when their worksite holds its screening.

Chronic Disease Workshops, another major program, give subscribers and their dependents information they need to help them take better care of themselves. Workshops include: Caregivers, Diabetes, Heart Disease, Asthma, Kidney Evaluation, Women's Reproductive Health, Weight Management, Medications, Men's Health, Cholesterol/Lipids and Gastrointestinal Ailments.

Information offered in the programs can be very helpful. For example, 28 people enrolled in a diabetes control program in 2006. The percentage of participants who were controlling their blood pressure increased from 51 percent to 85 percent during the program. The percentage of participants with desirable blood sugar levels increased from 33 percent to 60 percent.

Other Prevention Partners programs include:

- Spring Wellness Walk
- Lifestyle change workshops on weight loss, exercise and lowering risk factors
- Worksite program consultation
- Volunteer Worksite Prevention Partners coordinator network and conferences
- Prevention Partners training workshops

For more information on Prevention Partners, contact your benefits office, your Prevention Partners coordinator or call 888-260-9430. You also can go to the EIP Web site at www.eip.sc.gov. Then click on "Prevention Partners," which is on the left of the home page.

This program offers you discounted vision care services. Participating ophthalmologists and optometrists throughout the state have agreed to charge no more than $60[1] for a routine, comprehensive eye examination. If you are fitted for contact lenses, you may pay more because that can require additional services. Participating providers, who include opticians, have agreed to give a 20-percent[1] discount on all eyewear except disposable contact lenses.

[1]These amounts can change yearly. Contact your benefits office, provider or EIP for the current amounts.

The eye examination should include at least these tests and services:

- Complete eye and medical history review
- Visual acuity far and near, with and without glasses
- Tonometry
- Screening visual fields
- Refraction
- External motility, biomicroscopic and dilated
- Ophthalmoscopic examinations
- Initiation of diagnostic and treatment programs as necessary, including prescription of lenses, medication and other therapy, arranging for special diagnostics or treatment services, consultations, laboratory procedures or radiological services as may be indicated.

Treatment must be within the scope of the license of the provider. Consult your eye care provider for details on any of these services.



You may participate in this program if you are a full-time or part-time employee, retiree, survivor or COBRA participant. Your dependents also are eligible. You do not have to be enrolled in the State Health Plan or a health maintenance organization. It is your responsibility to show your provider some type of employment-related identification to prove you are eligible for the Vision Care Discount Program. If you do not, you may not receive the discount.

Providers Are Available Statewide

To see the list of participating providers, go to EIP's Web site, www.eip.sc.gov. Click on "Choose Your Category" and then select your category (Active Subscribers, etc.). Next, choose "Online Directories" and then select "Vision Care." You can search for providers by county or by state. This is the most up-to-date list.

If your provider is not listed, you may wish to ask if he gives discounts through the state's Vision Care Discount Program. If your provider would like to be part of the program, he should call EIP. Although EIP lists providers who participate in the program, the state does not recommend any specific eye care provider.

If you do not have access to the Internet, ask your benefits administrator to print a copy of the list for you. You can also request one by writing to EIP at P.O. Box 11661, Columbia, SC 29211, or by calling 803-734-0678 (Greater Columbia area) or 888-260-9430 (toll-free outside the Columbia area).

No Claims to File

The Vision Care Discount Program is a discount program. You do not file claims and will not receive reimbursement for routine eye examinations or eyewear, including contacts. Active employees who have a MoneyPlu$ Medical Spending Account or a limited-use Medical Spending Account can file a reimbursement claim with MoneyPlu$ for vision care expenses.

If you have questions about this program, please contact your benefits office or EIP.

Like many organizations, EIP offers helpful information through the Internet. Two places to find it are *EIP Direct* and the EIP Web site.

EIP Direct is a bimonthly newsletter sent to your benefits administrator, who may send you the information or the newsletter itself. The newsletter gives you information about changes in benefits, answers questions about benefits and tells you about programs that may be of interest to you, such as Prevention Partners chronic disease workshops. *EIP Direct* can be viewed on the EIP Web site, www.eip.sc.gov. Choose "News & Updates" and then "Newsletters."

The Web site is also the place to find other ideas about how to make the best use of your insurance, as well as links to the Web sites of EIP's third-party administrators. When you go to www.eip.sc.gov, you will see a bar across the top of the home page. It has several tabs, including:

- "News and Updates" (includes a tab that takes you to "Newsletters," such as *EIP Direct* and *Avenues*)
- "FAQ" (general information, as well as questions about the Savings Plan and HSAs)
- "Links" (direct access to Web sites of companies that administer EIP programs).

When you select "Choose Your Category," which is on the left, you will see a list of the types of subscribers served by EIP. Most of you are "Active Subscribers," or employees. When you click on your category, you will receive a list of choices. They include "Eligibility," "Forms," "Online Directories" (lists of providers that are part of the plan networks) and "Rates." Click on "Publications" to see a list that includes this guide. You can use the "binoculars" search feature to help you find specific topics in the guide.

"Prevention Partners" is one of the choices listed on the left of our home page. Click on it for ways to improve your health. Under "Education," for example, you will find the Worksite Screening Guide.

"Insurance Managers" provides direct links to the Web sites of the third-party administrators. These sites give you access to your account information, including claim status, verification of authorization for inpatient and outpatient visits and Explanations of Benefits.

If you need assistance or additional information or would like to make a suggestion, click on "Contact Us" to send EIP an e-mail.

MyBenefits — EIP's Online Enrollment System

Access to your benefits information is just a click away with MyBenefits, EIP's online enrollment system. Through MyBenefits, you can update your beneficiaries and contact information and print a copy of your benefits statement anytime you have access to the Internet – 24 hours a day, seven days a week. During the enrollment period each October, you can make your own coverage changes.

The system is convenient and easy to use. To get started with MyBenefits, go to the EIP Web site, www.eip.sc.gov, and select "MyBenefits" on the left side of the screen. If you are a first-time user, you must register. The federal Health Insurance Portability and Accountability Act (HIPAA) requires that insurance programs protect the confidentiality of subscribers' health information. As part of EIP's effort to do so, you need to answer four questions and create a password when you register. After you register, you will be shown a screen listing your password and your answers to the questions. **Print the information, and keep it in a safe place.**

Information about how to use MyBenefits is offered as you work through the program. During enrollment periods, a tutorial will be available, and links to written instructions will accompany each section.

What If I Disagree With A Decision About Eligibility?

This section contains a summary of the eligibility rules for benefits offered through EIP. Eligibility determinations are subject to the provisions of the Plan of Benefits and state law.

If you are dissatisfied after an eligibility determination has been made, you may ask for a review by writing to EIP within 90 days of notice of the decision. If the decision is upheld by EIP, you have 30 days to seek judicial review as provided by S.C. Code Ann. 1-11-710 and 1-23-380.

These lists will help you quickly locate information in the *Insurance Benefits Guide* when you find yourself in a new situation.

Before you retire, review your benefits. You can obtain a copy of your benefits statement from MyBenefits, the online enrollment system. Go to the EIP Web site, www.eip.sc.gov, and click on the "MyBenefits" button. After you log in, click on "Review Benefits."

Eligibility

- Before you set your retirement date, check with your benefits administrator to see if you are eligible to continue your insurance. See page 161.

Funding

- Find out if your employer will pay part of your health insurance premium. See page 162.

Enrollment

- You must complete a Retiree NOE form and an Employment Verification Record within 31 days of your retirement date. See page 164.

Returning to Work

- If you plan to return to work for a participating employer after you retire, see page 166.

Benefits Choices

- **Health** –Your health plan choices as a retiree depend on whether you are eligible for Medicare. To learn what your choices are, see pages 165. For premiums, see pages 200-201.
- Notify your benefits administrator within 31 days of the date you, or a dependent you cover, become eligible for **Medicare. Enroll in Part A and Part B.** In most cases, you should **not** enroll in Part D. For details, see page 168.
- **Dental** –You are eligible for the State Dental Plan and Dental Plus. For benefits information, see page 181. For premiums, see pages 200-201.
- **MoneyPlu$** –Your eligibility ends at retirement. For details, see page 182.
- **Long Term Care** –You can continue, or may be eligible to enroll in, Long Term Care coverage. For details, see page 182.
- **Life Insurance** –You may continue your **Basic Life, Optional Life** and **Dependent Life** insurance. For details, see page 183.
- **Long Term Disability** –Your **Basic Long Term Disability** insurance ends with retirement. You may continue **Supplemental Long Term Disability** coverage under certain circumstances. For details, see page 184.

Your Benefits Administrator in Retirement

- If you worked for a state agency, a higher education institution or a school district, EIP will become your benefits administrator.
- If you worked for a local subdivision, your benefits administrator will remain the same.

It is never easy when a loved one dies. We hope this list will help you during a difficult time.

Contacts

If the deceased was a retiree of a state agency, higher education institution or school district, or one of their covered dependents:

- Notify EIP.

If the deceased was an active employee, a retiree of a local subdivision or one of their covered dependents:

- Notify the subscriber's employer.

When Coverage Ends for the Deceased

- If the deceased was enrolled in health, dental, Long Term Care and/or Long Term Disability coverage, this coverage ends the day after death.

Health and Dental Insurance

Please read the "Survivors" section, beginning on page 19.

- Spouses or children who were covered as dependents under the State Health Plan or an HMO can continue coverage as survivors. They **may also be eligible for a one-year waiver** of health insurance premiums.
- Survivors may continue dental coverage, but **the premium is not waived.**

Life Insurance

A certified, raised-seal death certificate is needed to apply for benefits from The Hartford. See page 102.

- Basic Life insurance, $3,000, is provided to all full-time, active employees enrolled in a health insurance program. See page 93.
- If the deceased was covered by Optional Life insurance, see page 99.
- If the deceased was covered by Dependent Life insurance, see page 107.
- The Beneficiary Assist® Program is free and available to beneficiaries of Basic, Optional and Dependent Life policies. See page 109.
- If the deceased was retired and his last employer before retirement participates in the Retiree Group Life Insurance program, he may be eligible for a benefit based on his retirement-credited service in the S.C. Retirement Systems (SCRS). Contact SCRS for more information.

Supplemental Long Term Disability Insurance

- If the deceased was receiving Supplemental Long Term Disability benefits provided by The Standard, survivor benefits may be payable to the eligible survivor in a lump-sum payment. See page 125.

Long Term Care Insurance

- If the deceased was enrolled in Long Term Care (LTC), his beneficiary may receive a refund of a portion of the premiums paid based on the deceased's age and decreased by any benefits paid under the plan. For information, contact his LTC insurance provider.

MoneyPlu$

- If the deceased had a MoneyPlu$ Health Savings Account, contact NBSC about settling the account. See Article VII of the HSA Custodial Agreement, which is on pages 222-228 and on the EIP Web site under "Publications."
- Medical Spending Accounts (MSAs) and Dependent Care Spending Accounts (DCSAs) end on the date the employee died. See page 157.



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Introduction

What Are My Health Plan Choices?

Your health plan choices include the State Health Plan (the Standard Plan, the Savings Plan and, if you are enrolled in Medicare, the Medicare Supplemental Plan) and two Health Maintenance Organizations (BlueChoice® HealthPlan and CIGNA HMO).

All health plans offered through the Employee Insurance Program (EIP) are self-insured. EIP does not pay premiums to an insurance company. Subscribers' monthly premiums and employers' contributions are placed in a trust account maintained by the state. This account is used to pay claims and administrative expenses. Administrative expenses comprise only about 4 percent of the total program spending.

To learn about eligibility, enrollment and other features that are common to all health plans offered through EIP, see the General Information chapter, which begins on page 7.

CaringBridge®: Communication in a Crisis

CaringBridge® offers free, personalized Web sites that make it easier for you and your dependents to communicate with family and friends in a health crisis. To create a site, go to www.caringbridge.org and follow the directions. Creating a site does not require any technical expertise. Tell your family and friends about your site so they can keep up-to-date.

The State Health Plan

The State Health Plan (SHP) offers active employees the **Standard Plan** and the **Savings Plan.** It is important that you understand how your plan works.

The **Standard Plan** has higher premiums but lower deductibles than the Savings Plan. When one family member meets his deductible, the Standard Plan will begin to pay benefits for him, even if the family deductible has not been met. Under the Standard Plan, when you buy a prescription drug you make a copayment, rather than pay the allowable charge. (The *allowable charge* is the maximum amount a health plan will pay for a covered service or product, such as a drug. Network providers have agreed to accept the allowable charge.) You do not have to meet your deductible to buy prescription drugs for the copayment.

As a **Savings Plan** subscriber you take greater responsibility for your healthcare costs and accept a higher annual deductible. As a result, you save money on premiums. Another advantage is that because the Savings Plan is a tax-qualified, high deductible health plan, you may establish a **Health Savings Account** (HSA) if you have *no other health coverage, including Medicare,* unless it is another high deductible health plan, and you cannot be claimed as a dependent on another person's tax return. Funds in an HSA may be used to pay qualified medical expenses now and in the future.

The *Plan of Benefits* contains a complete description of the plan. Its terms and conditions govern all health benefits offered by the state. To review this document, contact your benefits administrator or EIP.

This brief overview of your medical plan is for comparison only. The *Plan of Benefits* governs all health benefits offered by the state.

	Standard Plan	Savings Plan
Annual Deductible	$350 Individual $700 Family	$3,000 Individual $6,000 Family (If more than one family member is covered, no family member will receive benefits, other than preventive, until the $6,000 annual family deductible is met.)
Per-occurrence Deductibles:		
Emergency Care[1]	$125	None
Outpatient Hospital[2]	$75	None
Physician Office Visit[3]	$10	None
Coinsurance (after deductible is met): Network	20% You Pay 80% Insurance Pays	20% You Pay 80% Insurance Pays
Out-of-network[4]	40% You Pay 60% Insurance Pays	40% You Pay 60% Insurance Pays
Coinsurance maximum: Network	$2,000 Individual $4,000 Family	$2,000 Individual $4,000 Family
Out-of-network[4]	$4,000 Individual $8,000 Family	$4,000 Individual $8,000 Family
Lifetime Maximum	$1,000,000	$1,000,000
Prescription Drug Deductible per Year[4]	No Annual Deductible	**Prescription Drugs** You must use participating pharmacies. You pay the full allowable charge for prescription drugs, and the cost is applied to your annual deductible. After you reach your deductible, you continue to pay the full allowable charge for prescription drugs. However, the plan will reimburse you for 80% of the allowable charge. You pay the remaining 20% coinsurance. Drug costs are applied to your plan's in-network coinsurance maximum: $2,000 – individual; $4,000 – family. After the coinsurance maximum is met, the plan pays 100% of allowable charges.
Retail Copayments for up to a 31-day supply (Participating pharmacies only)[4]	$10 Tier 1 (Generic – lowest cost) $25 Tier 2 (Brand – higher cost) $40 Tier 3 (Brand – highest cost)	
Mail Order and Retail Maintenance Network Copayments for up to a 90-day supply[4]	$25 Tier 1 (Generic – lowest cost) $62 Tier 2 (Brand – higher cost) $100 Tier 3 (Brand – highest cost)	
Prescription Drug Copayment Maximum[4]	$2,500 per person (applies to prescription drugs only)	
Tax-favored Medical Accounts	Medical Spending Account	Health Savings Account Limited-use Medical Spending Account

[1] *Waived if admitted.*
[2] *Waived for dialysis, routine mammograms, routine Pap tests, clinic visits, emergency room, oncology, electro-convulsive therapy, and psychiatric medication management.*
[3] *Waived for routine Pap smear, routine mammograms and well child care.*
[4] *Mental health and substance abuse services and prescription drugs are not covered out of network.*

How SHP Benefits are Paid

EIP contracts with companies, such as BlueCross BlueShield of South Carolina, to process medical claims; APS Healthcare, Inc., to process mental health and substance abuse claims; and Medco Health Solutions, Inc., to process prescription drug claims. Subscribers share the cost of their covered benefits by paying deductibles, coinsurance and copayments for covered services.

Annual Deductible

The annual deductible is the amount of covered medical expenses (including mental health and substance abuse expenses) you must pay each year before the plan begins to pay benefits. The annual deductibles are:

- $350 for individual coverage.
- $700 for family coverage.

If you have Standard Plan individual coverage, once you meet the $350 deductible, the Standard Plan will begin to pay a percentage of your covered medical expenses.

Under the Standard Plan, the family deductible is the same, regardless of how many family members are covered. The $700 family deductible may be met by any combination of two or more family members' covered medical expenses, as long as they total $700. For example, if five people each have $140 in covered expenses, the family deductible has been met, even if no one person has met the $350 individual deductible. However, if only one person has met the $350 individual deductible, only he will begin receiving benefits. No family member may pay more than $350 toward the family deductible.

If the employee and his spouse, who is also covered as an employee or retiree, wish to share the same family deductible, both must select the same health plan.

If you are covered under the Standard Plan, you pay copayments for drugs, up to a maximum of $2,500 per covered family member. Your drug costs do not apply to your deductible.

Per-occurrence Deductibles

A per-occurrence deductible is the amount you must pay before the Standard Plan begins to pay benefits for services in a professional provider's office, emergency room care or outpatient hospital services. You continue to pay per-occurrence deductibles even after you meet your annual deductible and reach your coinsurance maximum. Per-occurrence deductibles do not apply to your annual deductible or to your coinsurance maximum.

The per-occurrence deductible for each visit to a professional provider's office is $10. This deductible is waived for routine Pap tests, routine mammograms and well child care visits. Here is an example of how it works. If the Standard Plan allowed $56 for a physician's visit, you would first pay the $10 per-occurrence deductible.

- If you *have not* met your annual deductible, the remaining $46 would apply toward your annual deductible (you owe $56).
- If you *have* met your annual deductible, the Standard Plan would pay 80 percent of the $46, or $36.80, and you would be responsible for the remaining $9.20, as well as for your $10 per-occurrence deductible (you owe $19.20).

The deductible for each emergency room visit is $125. This deductible is waived if you are admitted to the hospital. The deductible for each outpatient hospital service is $75. This deductible is waived for dialysis.

routine mammograms, routine Pap tests, clinic visits (an office visit at an outpatient facility), and emergency room, oncology, electro-convulsive therapy and psychiatric medication management.

Coinsurance

After your annual deductible has been met, the Standard Plan pays 80 percent of your covered medical, mental health and substance abuse covered expenses if you use network providers. You pay the remaining 20 percent as coinsurance. If you use non-network providers, the plan pays 60 percent of your covered expenses. You pay the remaining 40 percent of the billed charges as coinsurance. This is applied to your coinsurance maximum. Even after you meet your annual deductible under the Standard Plan, you must continue to pay per-occurrence deductibles, and they do not apply to your coinsurance maximum.



If you use a provider outside the State Health Plan network, you must pay any amount above the plan's allowable charge for a covered medical expense. You also will have to pay an additional 20 percent in coinsurance. **Prescription drugs and mental health and substance abuse benefits are paid only if you use a network provider.**

A different coinsurance rate applies for infertility treatments and prescription drugs associated with infertility. See pages 46-47.

Coinsurance Maximum (Out-of-pocket Limit)

The maximum amount in coinsurance you must pay for covered services each year under the Standard Plan is $2,000 for individual coverage or $4,000 for family coverage for network services and $4,000 for individual coverage and $8,000 for family coverage for non-network services. The State Health Plan will then pay 100 percent of the allowable charges. Your payments for non-covered services, prescription drugs, per-occurrence and annual deductibles and penalties for not calling Medi-Call or APS Healthcare do not count toward your coinsurance maximum.

Before the plan will begin paying 100 percent of a covered person's covered prescription drug expenses, the person must pay $2,500 in prescription drug copayments.

Annual Deductible

The annual deductible is the amount of covered medical expenses (including medical, prescription drugs and mental health and substance abuse) you must pay each year before the Savings Plan begins to pay a percentage of your covered medical expenses. The annual deductibles are:

- $3,000 for individual coverage
- $6,000 for family coverage.

There is no individual deductible if more than one family member is covered. The family deductible is not considered met for any covered individual until total covered expenses exceed $6,000. For example, even if one family member has $3,001 in covered medical expenses, he will not begin receiving benefits until his family has $6,000 in covered expenses. However, if the subscriber has $1,000 in expenses, the spouse has $3,001 in expenses and a child has $2,000 in expenses, all family members will begin to receive benefits.

If you are covered under the Savings Plan, you pay the full allowable charge for covered prescription drugs, and the amount is applied to your deductible. After your deductible has been met, you receive reimbursement for 80 percent of your allowable charges. After your coinsurance maximum has been met, you receive reimbursement for 100 percent of your allowable charges.

There are **no** per-occurrence deductibles under the Savings Plan. You pay the full allowable charge for services, and it is applied to your annual deductible.

Coinsurance

After your annual deductible has been met, the Savings Plan pays 80 percent of your covered medical, prescription drug, mental health and substance abuse expenses if you use network providers. You pay the remaining 20 percent as coinsurance.

If you use non-network providers, the plan pays 60 percent of your covered expenses. You pay the remaining 40 percent as coinsurance, and any charge above the plan's allowable charge for a covered medical expense is your responsibility. You will also have to pay the additional 20 percent in coinsurance, a total of 40 percent. See page 38 to learn more about this "out-of-network differential." Prescription drug and mental health and substance abuse benefits will be paid **only** if you use a network provider.

A different coinsurance rate applies for infertility treatments and prescription drugs associated with infertility, see pages 46-47.

Coinsurance Maximum (Out-of-pocket Limit)

The maximum amount in coinsurance you must pay for covered services each year under the Savings Plan is $2,000 for individual coverage or $4,000 for family coverage for network services and $4,000 for individual coverage or $8,000 for family coverage for non-network services. The Savings Plan will then pay 100 percent of the allowable charges. Your payments for non-covered services, annual deductibles and penalties for not calling Medi-Call or APS Healthcare do not count toward your coinsurance maximum.

The maximum amount the State Health Plan will pay for each person for all benefits is $1,000,000. This lifetime maximum includes all payments made for a person while covered under any State Health Plan option, including the Savings, Standard and Medicare Supplemental plans and the Economy Plan, which is no longer offered. It applies regardless of any break in coverage or whether the person is enrolled in one of the plans as a dependent, an employee or a retiree.

All State Health Plan benefits, including prescription drug and mental health benefits, are subject to coordination of benefits (COB). COB is a system to make sure a person covered under more than one insurance plan is not reimbursed more than once for the same expenses. For more information about COB, including how third-party administrators determine which plan pays first, see page 21.

Here are some specific features of coordination of benefits under the Standard Plan and the Savings Plan:

On your Notice of Election (NOE) form, you are asked if you are covered by more than one group insurance plan. Your response is recorded and placed in your file. However, the third-party administrator, BlueCross BlueShield of South Carolina (BCBSSC), may ask you this question every year, by sending you a questionnaire. **Please complete this form and return it to BCBSSC promptly, since claims will not be processed or paid until your information is received.** You can also update this information by calling BCBSSC or by visiting www.SouthCarolinaBlues.com.

This is how the SHP works when it is secondary insurance:

- The SHP will pay the lesser of: 1) what it would pay if it were the primary payer; or 2) the part of the covered charge not paid by the primary payer.
- The SHP's limit on balance billing does not apply. This means if the provider charges more than the plan's allowable charge, you will be responsible for the extra cost.
- You will also be responsible for your deductible, if it has not been satisfied, and for your coinsurance.
- For a medical claim, you or your provider must file the Explanation of Benefits from your primary plan directly with BCBSSC.
- For mental health and substance abuse benefits, you must file the Explanation of Benefits from your primary plan directly with APS Healthcare, Inc.
- For prescription drug benefits, you must present your card for your primary coverage first. Otherwise, the claim will be rejected because the pharmacist's electronic system will indicate that the SHP is secondary coverage. After the pharmacy processes the claim with your primary coverage, you must file a paper claim through Medco for payment of any secondary benefits. Prescription drug claim forms are available on the EIP Web site, www.eip.sc.gov. Choose your category, and then click on "Forms." You may also ask your benefits administrator for the form.

[redacted]

To the extent provided by South Carolina law, the State Health Plan has the right to recover payment in full for benefits provided to a covered person under the terms of the Plan when the injury or illness occurs through the act or omission of another person, firm, corporation or organization. If a covered person receives payment for such medical expenses from another who caused the injury or illness, the covered person agrees to reimburse the Plan in full for any medical expenses paid by the Plan.

[redacted]

The choice is yours. When you are ill or injured, you decide where to go for your care. The SHP is a *preferred provider organization (PPO)*. As such, it has networks of physicians, hospitals, ambulatory surgical centers and mammography testing centers. There are also networks available to subscribers for durable medical equipment, labs, radiology and X-ray, physical therapy, occupational therapy, speech therapy, skilled nursing facilities, long term acute care facilities, hospices and dialysis centers. They have agreed, as part of our networks, to accept the plan's allowable charges for covered medical services as payment in full and will not balance bill you. **Network providers will charge you for your deductibles and coinsurance when the services are provided. They will also file your claims.**

If you use an out-of-network medical provider or your physician sends your laboratory tests to an out-of-network provider, your costs will increase. This applies to your medical benefits. Prescription drug and mental health and substance abuse benefits are only paid if you use a network provider.

How to Find a Medical Network Provider

Paper copies of the SHP provider directory are no longer distributed. There are two ways to view the online directory. On EIP's Web site, www.eip.sc.gov, choose your category and then select "Online Directories." Click on "State Health Plan Doctor/Hospital Finder." You may also go directly to the BCBSSC Web site, www.SouthCarolinaBlues.com. At the site:

- Under "Find a Doctor Or Other Healthcare Provider," choose "South Carolina."
- Choose "Blue Cross and Blue Shield" as the directory. Check to show whether you want to look for a

provider by "Location" or by "Name." Then select a "Healthcare Professional Type" from the menu.
- A menu will enable you to select a city or county, a health plan (State Health Plan) and a specialty.

If you do not have access to the Internet, call BCBSSC at 803-736-1576 (Greater Columbia area) or 800-868-2520 (toll-free outside the Columbia area) to request that a list of SHP providers in your area be mailed to you.

When you need medical care **outside South Carolina**, you have access to doctors and hospitals throughout the United States and around the world through the BlueCard Program and Blue Cross Blue Shield provider networks. If you need mental health or substance abuse care outside South Carolina, call APS Healthcare at 800-221-8699.

Inside the U.S.

With the BlueCard program you can choose the doctors and hospitals that best suit you and your family. Follow these steps for health coverage when you are away from home but within the United States:

1. Always carry your State Health Plan ID card.
2. In an emergency, go directly to the nearest hospital.
3. To find the names and addresses of nearby doctors and hospitals, visit the BlueCard Doctor and Hospital Finder Web site (www.BCBS.com) or call BlueCard *Access* at 800-810-2583.
4. **Call Medi-Call within 48 hours of receiving emergency care.** The toll-free number is on your State Health Plan ID card.
5. When you arrive at the participating doctor's office or hospital, show your identification card. As a BlueCard program member, the doctor will recognize the logo, which will ensure that you will get the highest level of benefits with no balance billing.
6. The provider should file claims with the Blue Cross Blue Shield affiliate in the state where the services were provided.

After you receive care, you should not have to complete any claim forms, nor should you have to pay up front for medical services other than the usual out-of-pocket expenses (deductibles, copayments, coinsurance and non-covered services). You will be mailed an EOB by BCBSSC.

Outside the U.S.

Through the BlueCard Worldwide program, your SHP ID card gives you access to doctors and hospitals in more than 200 countries and territories worldwide and to a broad range of medical services.

To take advantage of the BlueCard Worldwide program, follow these steps:

1. Always carry your SHP ID card.
2. In an emergency, go directly to the nearest hospital.
3. Before your trip:
   - If you have questions, call the phone number on the back of your ID card to check your SHP benefits and for preauthorization, if necessary. (Your healthcare benefits may be different outside the U.S.)
   - Call the BlueCard Worldwide Service Center toll-free at 800-810-2583 or collect at 804-673-1177 to find providers in the area where you will be traveling.
4. During your trip:
   - If you need to locate a doctor or hospital or need medical assistance, call the BlueCard Worldwide Service Center toll-free at 800-810-2583 or collect at 804-673-1177 (24 hours a day, seven days a week).
   - If you are admitted to the hospital, call the BlueCard Worldwide Service Center toll-free at 800-810-2583 or collect at 804-673-1177.
   - The BlueCard Worldwide Service Center will work with the SHP to arrange direct billing with the hospital for your inpatient stay.

- When direct billing is arranged, you are responsible for the out-of-pocket expenses (non-covered services, deductibles, copayments, and coinsurance) you normally pay. The hospital will submit your claim on your behalf.
- Note: If direct billing is not arranged between the hospital and your plan, you will need to pay the bill up front and file a claim.

5. For outpatient care and doctor visits, pay the provider when you receive care and file a claim.
6. To file a claim for services you paid for when you received care or paid to providers that are not part of the BlueCard Worldwide network, complete a BlueCard Worldwide international claim form and send it with the itemized bill(s) to the BlueCard Worldwide Service Center. The claim form is available online at www.BCBS.com. Type "BlueCard claim form" in the "Search" box. You may also call the BlueCard Worldwide Service Center toll-free at 800-810-2583 or collect at 804-673-1177. The address of the service center is on the claim form. BlueCard Worldwide will arrange billing to BCBSSC.

Prescription Drug and Mental Health/Substance Abuse Provider Networks

Because the State Health Plan offers no out-of-network coverage for prescription drugs or mental health/substance abuse care, it is important that you find a participating network provider for these services. The most up-to-date lists of network providers are on Web sites sponsored by Medco Health Solutions, Inc., the prescription drug benefit manager, and APS Healthcare, Inc., the mental health and substance abuse manager. These sites are accessible through the EIP Web site, www.eip.sc.gov. Choose your category and then select "Online Directories." You will see a list of links to provider directories. You can also go there directly:

- To see the list of network pharmacies, go to www.medco.com. Sign in and click on "Locate a pharmacy."
- Mental health and substance abuse providers include: physicians, psychiatrists, health professionals or institutional care providers under agreement to participate in the network administered by APS Healthcare. To see the list, go to the APS Healthcare, Inc., Web site at www.apshealthcare.com. Click on "Information for Members." Then select "State of South Carolina" from the drop-down list under "Employers." Then click on "Online Provider Locator." The access code is "statesc." Finally, click on "Submit." You also may call APS Healthcare toll-free at 800-221-8699 to be directed to a network provider and to receive the required preauthorization.

For more information on your prescription drug benefits, see page 53. For more information on your mental health and substance abuse benefits, see page 57.

If you do not have access to the Internet, paper copies of the provider directories are available from your benefits office or, if you are a retiree, survivor or COBRA participant, from APS.

Remember, there is no out-of-network coverage for **prescription drugs**. For **mental health and substance abuse care**, there is no coverage if you use an out-of-network provider or if you fail to have services preauthorized.

You can use providers who are not part of the network and still receive some coverage for medical care. However, before the State Health Plan will pay 100 percent of allowable charges:

- **Standard Plan and Savings Plan** subscribers must pay a $4,000 individual coinsurance maximum for out-of-network services and an $8,000 family coinsurance maximum for out-of-network services.

Subscribers to both plans may also have to fill out claim forms.

Balance Billing

If you use a provider who is not part of the network, you may be subject to "balance billing." When the

State Health Plan is your primary coverage, network providers are prohibited from billing you for covered services except for copayments, coinsurance and deductibles. However, a non-network provider may choose to bill you for more than the plan's allowable charge for the covered service. The difference between what the non-network provider charges and the allowable charge is called the "balance bill." The balance bill does not contribute toward meeting your annual deductible or coinsurance maximum.

In addition to balance billing, if you choose a provider that does not participate in the State Health Plan or BlueCard network, you will pay 40 percent, instead of the usual 20 percent, in coinsurance. These examples show how it will cost you more money to use a non-network provider:

You have employee-only coverage under the SHP and you have not met your deductible. The non-network provider charges $5,000 for the covered services you receive, but the SHP maximum allowance is $4,000

Standard Plan

Your out-of-pocket costs for services from a **network provider** would have been $1,080.

However, if you had used a non-network provider for the same services:

You pay the $350 Standard Plan deductible. Then $3,650 remains of the Standard Plan responsibility. The plan pays 60 percent of that — $2,190. The remaining $1,460 coinsurance and the $1,000 "balance billing" from the non-network provider are your responsibility. Therefore, $1,460 is applied toward your $4,000 out-of-network coinsurance maximum.

$4,000	SHP allowance	$3,650	Standard Plan responsibility
- 350	Standard Plan deductible for 2009	-2,190	Standard Plan pays
$3,650	Standard Plan responsibility	1,460	You pay as coinsurance
x 60%	Standard Plan coinsurance	1,000	Your balance bill from provider
$2,190	Standard Plan pays	+ 350	Your Standard Plan deductible
		$2,810	**Your out-of-pocket costs for the services of a non-network provid**

Standard Plan subscribers also pay any per-occurrence deductibles (which do not apply toward your annual deductible) both in-network and out-of-network. They are not included in this example.

Savings Plan

Your out-of-pocket costs for the services of a **network provider** would have been $3,200.

However, if you had used a non-network provider for the same services:

You pay the $3,000 Savings Plan deductible. Then $1,000 remains of the Savings Plan responsibility. The plan pays 60 percent of that, or $600. The remaining $400 coinsurance, as well as the $1,000 "balance billing" from the non-network provider, is your responsibility. The $400 in coinsurance is applied to your $4,000 out-of-network coinsurance maximum.

$4,000	SHP allowance	$1,000	Savings Plan responsibility
- 3,000	Savings Plan deductible for 2009	- 600	Savings Plan pays
$1,000	Savings Plan responsibility	400	You pay as coinsurance
x 60%	Savings Plan coinsurance	1,000	Your balance bill from provider
$ 600	Savings Plan pays	+3,000	Your Savings Plan deductible
		$4,400	**Your out-of-pocket costs for the services of a non-network provi**

Some services provided under the State Health Plan require preauthorization before you receive them as a covered benefit. A phone call gets things started. While your healthcare provider may make the call for you, it is your responsibility to see that the call is made.

You can reach Medi-Call by phone from 8:30 a.m. to 5 p.m., Monday through Friday, except holidays. You may fax information to Medi-Call 24 hours a day. However, Medi-Call will not respond until the next business day. If you do fax information to Medi-Call, provide, at a minimum, this information so the review can begin:

- Subscriber's name
- Patient's name
- Subscriber's Benefits ID Number or Social Security Number
- Information about the service requested
- A telephone number where you can be reached during business hours.

Medi-Call numbers are:

- 800-925-9724 (South Carolina, nationwide, Canada)
- 803-699-3337 (Greater Columbia area)
- 803-264-0183 (fax)

Medi-Call promotes high-quality, economical care for you and your covered family members through reviews that assess, plan, implement, coordinate, monitor and evaluate healthcare options and services required to meet an individual's needs. You must contact Medi-Call at least 48 hours or two working days, whichever is greater, before receiving any of these medical services at any hospital in the U.S. or Canada:

- You need any type of inpatient care in a hospital[1]
- Your preauthorized outpatient services result in a hospital admission. (You must call again for the hospital admission.)
- You need outpatient surgery for a septoplasty
- You need outpatient or inpatient surgery for a hysterectomy
- You need sclerotherapy performed in an inpatient, outpatient or office setting
- You need an MRA, MRI, PET or CT Scan
- You will receive a new course of chemotherapy or radiation therapy (one-time notification per course)
- You are admitted to a hospital in an emergency (Your admission must be reported within 48 hours or the next working day after a weekend or holiday admission.)[1]
- You are pregnant **(You must notify MediCall within the first three months of your pregnancy.)**
- You have an emergency admission during pregnancy[2]
- Your baby is born[2]
- Your baby has complications at birth
- You are to be, or have been, admitted to a long-term acute care facility, skilled nursing facility, need home healthcare, hospice care or an alternative treatment plan
- You need durable medical equipment
- You or your covered spouse decides to undergo in vitro fertilization, GIFT, ZIFT or any other infertility procedure
- You or your covered family member needs to be evaluated for a transplant
- You need inpatient rehabilitative services and related outpatient physical, speech or occupational therapy.

A preauthorization request for any procedure that may potentially be considered cosmetic in nature must be received in writing by Medi-Call seven days before surgery. (Procedures in this category include: blepharoplasty, reduction mammoplasty, augmentation mammoplasty, mastopexy, TMJ or other jaw surgery, panniculectomy, abdominoplasty, rhinoplasty or other nose surgery, etc.) Your physician should include photographs if appropriate.

[redacted]

[1]For mental health or substance abuse services, you must call APS Healthcare at 800-221-8699 for preauthorization before a non-emergency admission or within 24 hours of an emergency admission.
[2]Contacting Medi-Call for the delivery of your baby does not add the baby to your health insurance. You must add your child by filing an NOE within 31 days of birth for benefits to be payable.

A determination by Medi-Call that a proposed treatment is within generally recognized medical standards and procedures does not guarantee claim payment. Other conditions, including eligibility requirements, other limitations or exclusions, payment of deductibles and other provisions of the plan must be satisfied before BlueCross BlueShield of South Carolina makes payment. Remember, if you choose a non-network provider, your financial responsibility will be greater.

Are There Penalties for Not Calling?

Yes. If you do not call Medi-Call when required, you will pay a $200 penalty for **each** hospital or skilled nursing facility **admission.** In addition, the coinsurance maximum will not apply. You will continue to pay your coinsurance, no matter how much you pay out-of-pocket. If you do not obtain preauthorization from APS HealthCare, no mental health or substance abuse benefits will be paid.

[redacted]

Regular prenatal care and following your doctor's recommendations can help keep you and your baby healthy. If you are a mother-to-be, **you must participate in the Maternity Management Program.** Medi-Call administers EIP's comprehensive maternity management program, "Coming Attractions." The program monitors expectant mothers throughout pregnancy and manages Neonatal Intensive Care Unit (NICU) infants or other babies with special needs until they are 1 year old. **To preauthorize your pregnancy benefits, you must notify Medi-Call during the first trimester (three months) of your pregnancy.** You do not have to wait until you have seen your physician.

[redacted]

While you can call Medi-Call, you can also notify Medi-Call of your pregnancy and enroll in "Coming Attractions" online through the Personal Health Record's maternity screening program. Go to www.SouthCarolinaBlues.com and log into My Health Toolkit. Then select Personal Health Record.

If you do not notify Medi-Call during the first trimester, or if you refuse to participate in the Maternity Management Program, you will pay a $200 penalty for **each** maternity-related hospital or skilled nursing facility **admission.** This penalty will be in addition to the Medi-Call preauthorization penalty and there will not be a $2,000 limit on the amount of coinsurance you must pay.

You are automatically enrolled in "Coming Attractions" when you preauthorize your pregnancy benefit through Medi-Call. As a participant in the program, you will receive a phone call from a Medi-Call nurse and a packet of information, including a copy of *Caring for Tomorrow's Children – Having a Healthy Baby.*

A Medi-Call maternity nurse will complete a Maternity Health Assessment form when you enroll. This assessment is used to identify potential high-risk factors during your first trimester. If high-risk factors are identified, you will be scheduled for follow-up calls. If no risks are identified, you should call with any changes in your condition. Otherwise, your Medi-Call nurse will send you a reminder card with benefit information during your third trimester, and she will call you after your baby is born.

If you enroll in the program through the Personal Health Record, you can use the online system to correspond with your case manager and receive articles of interest from recognized medical sources.

Also, you can call Medi-Call anytime you have questions. A maternity case management nurse will be there to help you throughout your pregnancy.

Managing a chronic condition can be difficult. However, studies show you can help control your symptoms by making lifestyle changes and by following your doctor's advice. You can also delay, or even prevent, many of the complications of the disease.

The Health Management Program is designed for Standard Plan and Savings Plan subscribers and their covered family members who have diabetes, heart disease or chronic respiratory conditions. BCBSSC selects participants by reviewing medical, pharmacy and laboratory claims. If you are identified as someone who could benefit from it, you are automatically enrolled. You may, however, opt out of the program.

As a participant, you will receive a welcome letter that includes the name of and contact information for your BlueCross health coach. Your coach will be a registered nurse who will help you learn more about your condition and how to manage it. He or she will also help you work with your physician to develop a plan to take charge of your illness, contacting you by phone or through the online Personal Health Record. You can contact your health coach as often as you like with questions or to ask for advice. For more information, call 803-264-3100 (Greater Columbia area) or 800-334-7287 (toll-free outside the Columbia area).

About Your Privacy
In compliance with federal law, your health information will always be kept confidential. Your employer does not receive the results of any surveys you complete. Enrolling will not affect your health benefits now or in the future.

Weight Management Program

The BlueCross Weight Management program is designed to help you achieve weight-loss goals through small changes you can make while still getting on with your life. Food Awareness Training and realistic goal setting are key parts of this program. Program candidates are identified through claims analysis, authorizations, doctor referral or self-referral.

If you think you qualify, but have not received an invitation to participate, call Medi-Call at 803-699-3337 (Greater Columbia area) or 800-925-9724 (South Carolina, the U.S. and Canada). Follow the prompts. As a "Member," press 2. Then press 2, the number for "all other inquiries." When you reach an operator, ask to speak with a coordinator in the Weight Management Program.

Facing a serious illness or injury can be confusing and frustrating. You may not know where to find support or information to help you cope with your illness, and you may not know what treatment options are available. Case management may help.

Three case management programs are available to those enrolled in the State Health Plan. Each program includes teams of specially trained nurses and doctors. The goal of the programs is to assist participants in coordinating, assessing and planning healthcare. They do so by giving each patient control over his healthcare and respecting his right to knowledge, choice, a direct relationship with his physician, privacy and dignity. None of the programs provide medical treatment, and all recognize that, ultimately, decisions about your care are between you and your physician. Each program may involve a home or facility visit to a participant but only with permission.

By working closely with your doctor, using your benefits effectively and using the resources in your community, the case management programs may help you through a difficult time. For more information on any of these programs, call 800-925-9724 and ask to be transferred to the case management supervisor.

BlueCross Medi-Call Case Management Program

This case management program is designed for State Health Plan enrollees who have specific catastrophic or chronic disorders, acute illnesses or serious injuries. The program facilitates continuity of care and support of these patients while managing health plan benefits in a way that promotes high-quality, cost-effective outcomes.

Case managers talk with patients, family members and providers to coordinate services among providers and support the patient through a crisis or chronic disease. Case management intervention may be short- or long-term. Case managers combine standard preauthorization services with innovative approaches for patients who require high levels of medical care and benefits. Case managers can often arrange services or identify community resources available to meet the patient's needs.

The case manager works with the patient and the providers to assess, plan, implement, coordinate, monitor and evaluate ways of meeting a patient's needs, reducing readmissions and enhancing quality of life. Your Medi-Call nurse case manager may visit you at home, with your permission, or in a treatment facility or your physician's office when the treatment team determines it is appropriate.

A Medi-Call nurse stays in touch with the patient, caregivers and providers to assess and re-evaluate the treatment plan and the patient's progress. All communication between BlueCross BlueShield of South Carolina and the patient, family members or providers complies with HIPAA privacy requirements. If a patient refuses medical case management, Medi-Call will continue to preauthorize appropriate treatment.

Alere Complex Care Management Program

Some enrollees are referred to Alere for complex care management. The program is designed to assist the most seriously ill patients. They include those with complex medical conditions, who may have more than one illness or injury, who have critical barriers to their care and who are frequently hospitalized.

The complex care management program provides you with information and support through a local care coordinator, who is a registered nurse. This nurse coordinator can help you identify treatment options; locate supplies and equipment recommended by your doctor; coordinate care with your doctor and the SHP; and research the availability of transportation and lodging for out-of-town treatment. The nurse stays in touch weekly with patients and caregivers to assess and re-evaluate the treatment plan and the patient's progress. This program helps you make informed decisions about your health when you are seriously ill or injured.

Participation is voluntary. You can leave the program at any time, for any reason. Your benefits will not be affected by your participation.

Here is how the program works: BlueCross BlueShield of South Carolina will refer you to Alere if the program may benefit you. You will receive a letter explaining the program, and an Alere representative will contact you. A care coordinator in your area will visit you to discuss ways he can help you and will ask permission to contact your doctor to offer assistance.

An Alere team of specially trained nurses and doctors will review your medical information and treatment plan. (Your medical history and information will always be kept confidential among your caregivers and the Alere team.) Your local care coordinator nurse will be your main contact. You and your doctor, however, will always make the final decision about your treatment. Complex care management does not replace your doctor's care. Always check with your doctor before following any medical advice.

A Medi-Call nurse will act as a liaison with the Alere nurse. This Medi-Call nurse provides information about benefits and networks and completes authorization for medically necessary services that are covered by the plan.

VillageHealth Disease Management Renal Case Management Program

VillageHealth Disease Management provides renal disease management care for select State Health Plan enrollees with end-stage renal disease (ESRD). These nurses visit patients in dialysis centers and in their homes to provide education and outreach that may help prevent acute illnesses and hospitalizations.

Here is how the program works: subscribers with ESRD are referred to VillageHealth by BCBSSC. A South Carolina-based VillageHealth nurse then contacts the individual to confirm that he is a good candidate for renal case management. The nurse, who has many years of ESRD experience, coordinates care across all disciplines and facilitates Medi-Call referrals for patients accepted into the program.

As the link between the patient, providers and dialysis team, the nurse identifies the patient's needs through medical record review and consultations with the patient, family and health care team. Needs may be medical, social, behavioral, emotional and financial. The nurse coordinates services based on the long-term needs of the patient and incorporates these needs into a plan agreed upon by the patient, physician(s), dialysis team and other providers. Your VillageHealth nurse may visit you at home, with your permission, or in the dialysis center when the treatment team determines it is appropriate. He will call you frequently and receive updates from your providers.

A Medi-Call case manager will be the liaison with the VillageHealth nurse. This Medi-Call nurse provides information about the use of benefits and networks and completes authorization for medically necessary services that are covered by the plan.

Personal Health Record

Your Personal Health Record, which is available on the BCBSSC Web site, is safe and secure. Through it, you have access to your health information, including a list of your claims and the prescription drugs you are taking, 24 hours a day, seven days a week. If you participate in the Health Management Program, your health coach can use it to send you messages, assign tasks and provide you with additional information about your condition. To review your record, go to www.SouthCarolinaBlues.com and log into "My Health Toolkit."

Personal Health Assessment

An online Personal Health Assessment (PHA) is available to State Health Plan subscribers who are 18 years and older through the BlueCross BlueShield of South Carolina Web site, www.SouthCarolinaBlues.com. Log on the "Member My Insurance Manager" and then click on the "My HealthCenter" link, which is under "Access Online Programs and Added Values." Select your name from the drop-down menu on the next page and then click on "Personal Health Assessment" to take the survey.

The survey asks questions in nine categories and then provides a wellness score based on your responses. It enables you to evaluate your health and gives suggestions for lifestyle changes.

You can print your PHA results and recommendations, and you will continue to have access to them online. The program is on a secure Web link, and all assessments remain confidential. You can retake the survey each year to measure your progress toward your health goals.

Provider Report Card

BlueCross BlueShield of South Carolina gives you access to a Provider Report Card through its Web site, www.SouthCarolinaBlues.com. With this tool, you can compare hospitals in the same part of the state to determine the number of patients treated, complication rates and how long patients usually stay in the hospital. This information can help you choose a hospital.

Medical Cost Estimator

The cost estimator is available on the BCBSSC Web site, www.SouthCarolinaBlues.com. It can help you determine the cost of a medical service or procedure. This can be useful in budgeting and planning for the cost of certain health conditions. The estimator provides a cost range for an illness, breaks the cost down by type of care (e.g., medical, durable medical equipment, drugs, etc.) and compares costs by setting (e.g., inpatient versus outpatient). The cost estimator can help you plan contributions to a Medical Spending Account or a Health Savings Account.

The Standard Plan and the Savings Plan pay benefits for *medically necessary* treatments of illnesses and injuries. This section is a general description of the plan. The *Plan of Benefits* contains a complete description of the benefits. Its terms and conditions govern all health benefits offered by the state. Contact your benefits administrator or EIP for more information. Some services and treatments require preauthorization by Medi-Call or APS Healthcare. Be sure to read the Medi-Call section beginning on page 39 and the mental health and substance abuse section on page 57 for details.

A *medically necessary* service or supply is:

- Required to identify or treat an illness or injury and
- Prescribed or ordered by a physician and
- Consistent with the covered person's illness, injury or condition and in accordance with proper medical and surgical practices prevailing in the medical specialty or field of medicine at the time provided and
- Required for reasons other than the convenience of the patient. The fact that a service is prescribed by a physician does not necessarily mean that the service is medically necessary.

Alternative Treatment Plans (ATP)

An alternative treatment plan is an individual program to permit treatment in a more cost-effective and less intensive manner. An ATP requires the approval of the treating physician, Medi-Call and the patient. Services and supplies that are authorized by Medi-Call as medically necessary because of the approved alternative treatment plan will be covered.

Ambulance

Ambulance service, to or from a local hospital outpatient department, is covered when used to provide necessary service in connection with an injury or a medical emergency and to or from the nearest hospital providing necessary service in connection with inpatient care. No benefits are payable for ambulance service used for routine, nonemergency transportation, including, but not limited to, travel to a facility for scheduled medical or surgical treatments, such as dialysis or cancer treatment. All claims for ambulance service are subject to medical review.

Ambulatory Surgical Centers

These facilities provide some of the same services offered in the outpatient department of a hospital. Centers in the network accept the State Health Plan allowable charges. You just pay the applicable deductible and coinsurance. Medically necessary services at non-network ambulatory surgical centers are covered, but you may pay more.

Autism Spectrum Disorder Benefits

Effective with the 2009 plan year, Applied Behavior Analysis (ABA) for children diagnosed with an Autism Spectrum Disorder at age 8 or younger will be covered, subject to APS guidelines and preauthorization requirements, for up to a maximum of $50,000 per plan year. A child must be younger than 16 years of age to receive benefits. All services must be approved by APS Healthcare and performed by an in-network ABA provider.

Chiropractic Care

You are covered for specific office-based services from a chiropractor, including 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. Diagnostic X-rays are covered if medically necessary.

Colonoscopies

Routine colonoscopies are covered once every ten years, starting at age 50, even when no symptoms are apparent. The plan also covers diagnostic colonoscopies. All colonoscopies are subject to the plan's deductibles and coinsurance.

Contraceptives

For employees and covered spouses, routine contraceptive prescriptions, including birth control pills and injectables (including, but not limited to, Depo-Provera and Lunelle), filled at a participating pharmacy or through the plan's mail-order pharmacy, are covered as prescription drugs. Birth control implants and injectables, given in a doctor's office, are covered as a medical expense.

Cranial Remodeling Band or Helmet

The plan covers the use of a cranial remodeling band when preauthorization review determines it to be medically necessary for the correction of a child's moderate to severe positional head deformities associated with premature birth, restrictive intrauterine positioning, cervical abnormalities, birth trauma, torticollis or sleeping positions. Remodeling must be initiated between 4 and 12 months of age, following a failed two-month trial of conservative treatment (e.g., repositioning, neck exercises, etc.).

Diabetic Supplies

Insulin is allowed under the prescription drug program or under the medical plan but not under both. (Insulin requires a $25 copayment for each supply of up to 31 days.) Diabetic supplies, including syringes, lancets and test strips, are covered at participating pharmacies through your drug benefit for a $10 copayment, per item, for each supply of up to 31 days. Claims for diabetic durable medical equipment should be filed with BCBSSC.

Doctor Visits

Treatments or consultations for an injury or illness are covered, when they are medically necessary and not associated with a service excluded by the plan. For mental health and substance abuse services to be

covered, you must use a participating provider, and all mental health and substance abuse services must be preauthorized by APS Healthcare. For details on mental health and substance abuse services, see page 57.

Durable Medical Equipment (DME)

Generally, DME must be preauthorized by Medi-Call. Some examples include:

- Any purchase or rental of durable medical equipment
- Any purchase or rental of renal dialysis equipment
- Any purchase or rental of durable medical equipment that has a nontherapeutic use or a potentially non-therapeutic use
- C-Pap or Bi-Pap machines
- Oxygen and equipment for oxygen use outside a hospital setting, whether purchased or rented
- Any prosthetic appliance or orthopedic brace, crutch or lift, attached to the brace, crutch or lift, whether initial or replacement
- Orthopedic shoes.

DME provider networks are available to State Health Plan members. These contracting providers can offer you discounts while providing you with high-quality products and care.

Extended-Role Nurse

Expenses for services received from a licensed, independent extended-role nurse are covered, even if these services are not performed under the immediate direction of a doctor. An extended-role nurse is a nurse practitioner, certified nurse midwife, certified registered nurse anesthetist or a clinical nurse specialist. All services received must be within the scope of the nurse's license and needed because of a service allowed by the plan.

The State Health Plan only recognizes certified nurse midwives as providers for purposes of midwife coverage. A certified nurse midwife (CNM) is an advance-practice registered nurse who is licensed by the State Board of Nursing as a midwife. Lay midwives and certified midwives licensed only by the S.C. Dept. of Health and Environmental Control (DHEC) are not reimbursed.

Home Healthcare

Home healthcare includes part-time nursing care, health aide service or physical, occupational or speech therapy provided by an approved home healthcare agency and given in the subscriber's home. You cannot receive home healthcare and hospital or skilled nursing facility benefits at the same time. These services do not include custodial care or care given by a person who ordinarily lives in the home or is a member of the subscriber's family or the spouse's family. Benefits are limited to $5,000 or 100 visits per year, whichever is less. These services must be preauthorized by Medi-Call.

Hospice Care

The plan will pay benefits for a terminally ill patient's hospice care. The maximum benefit is $6,000 per covered person, including a maximum of $200 for bereavement counseling. These services must be preauthorized by Medi-Call.

Infertility

The plan will pay benefits for the diagnosis and treatment of infertility for enrollees for whom infertility is not a result of a prior tubal ligation or a vasectomy.

The benefits are limited to a lifetime maximum payment of $15,000 for any covered medical expenses and covered prescription drug expenses incurred by the subscriber or the covered spouse whether covered as a dependent or as an employee. Included in the $15,000 maximum are diagnostic tests, prescription drugs and up to six cycles of Intrauterine Insemination (IUI) and/or a maximum of three completed cycles of zygote or gamete intrafallopian transfer (ZIFT or GIFT) or in vitro fertilization (IVF) per lifetime. A cycle reflects the cyclic changes of fertility with the cycle beginning with each new insemination or assisted reproductive technology (ART) transfer or implantation attempt. ART procedures not specifically mentioned are not covered, including but not limited to: tubal embryo transfer (TET), pronuclear stage tubal embryo transfer (PROUST) oocyte donation and intracytoplasmic sperm injection (ICSI).

Benefits are payable at 70 percent of allowable charges. Your share of the expenses does not count toward your coinsurance maximum. All procedures related to infertility must be preauthorized by Medi-Call.

The plan will not provide infertility benefits to a subscriber who has had a tubal ligation. **Prescription drugs for treatment of infertility are subject to a 30 percent coinsurance payment under both the Savings Plan and the Standard Plan.** This expense does not apply to the $2,500, per person, copayment maximum under the Standard Plan. It does apply to the Savings Plan deductible. The 70 percent plan payment for prescription drugs for infertility treatments does apply to both plans' $15,000 maximum lifetime benefit for infertility treatments. Call Medco's Member Services at 800-711-3450 for more information.

Inpatient Hospital Services

Inpatient hospital care, including room and board, is covered. In addition to normal visits by your physician while you are in the hospital, you are covered for one consultation per consulting physician for each inpatient hospital stay. **Inpatient care must be approved by Medi-Call (see page 39).**

Organ Transplants

State Health Plan transplant contracting arrangements include the BlueCross BlueShield Association (BCBSA) national transplant network, Blue Distinction Centers for Transplants (BDCT). All BDCT facilities meet specific criteria that consider provider qualifications, programs and patient outcomes.

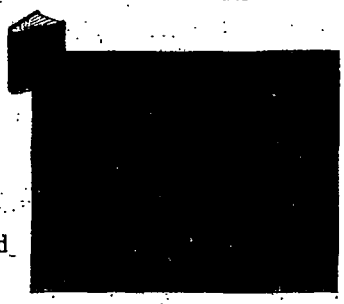
All transplant services must be approved by Medi-Call (see page 39). You must call Medi-Call, even before you or a covered family member is evaluated for a transplant.

Through the BDCT network, SHP enrollees have access to the leading organ transplant facilities in the nation. Contracts are also in effect with local providers for transplant services so that individuals insured by the plan may receive transplants at those facilities. You will save a significant amount of money if you receive your transplant services either at a BDCT network facility or through a local South Carolina network transplant facility. If you receive transplant services at one of these network facilities, you will not be balance billed. You will be responsible only for your deductible, coinsurance and any charges not covered by the plan. In addition, these network facilities will file all claims for you.

Transplant services at nonparticipating facilities will be covered by the plan. However, the SHP will pay only the SHP allowable charges for transplants performed at out-of-network facilities. If you do **not** receive your transplant services at a network facility, you may pay substantially more. In addition to the deductible and coinsurance, subscribers using out-of-network facilities are responsible for any amount over the allowable charges and will pay an additional 20 percent in coinsurance, totaling 40 percent, because they used out-of-network providers. Costs for transplant care can vary by hundreds of thousands of dollars. If you choose care outside the network, you cannot be assured that your costs will not exceed those allowed by the plan. Call Medi-Call for more information.

Outpatient Services

Outpatient services and supplies include:



- Laboratory services
- X-ray and other radiological services
- Emergency room services
- Radiation therapy
- Pathology services
- Outpatient surgery and
- Diagnostic tests (If the diagnosis is psychiatric, only services provided at APS network facilities are covered.)

If you are covered under the Standard Plan and you receive your outpatient services at a hospital, you will be charged a $75 outpatient per-occurrence deductible. You will be charged a $125 per-occurrence deductible for emergency room services. Per-occurrence deductibles do not apply to your annual deductible or your coinsurance maximum. The per-occurrence deductible for emergency room services is waived if you are admitted to the hospital.

Pregnancy and Pediatric Care

Pregnancy benefits are provided to covered female employees or retirees and to covered dependent wives of male employees or retirees. **Dependent children do not have maternity benefits.** Maternity benefits include necessary prenatal and postpartum care, including childbirth, miscarriage and complications related to pregnancy. **You must call Medi-Call within the first three months of your pregnancy to enroll in the Maternity Management Program.** See page 40 for more information.

Under federal law, group health plans generally cannot restrict benefits for the length of any hospital stay in connection with childbirth for the mother or the newborn to fewer than 48 hours following normal, vaginal delivery or fewer than 96 hours following a caesarean section. Neither can they require a provider to obtain authorization from the plan for prescribing a length of stay within the above periods. The attending provider may, however, in consultation with the mother, decide to discharge the mother or newborn earlier.

Pregnancy is not considered a pre-existing condition.

Prescription Drugs

Prescription drugs, including insulin, are covered at a participating pharmacy, subject to plan exclusions and limitations. Drugs in FDA Phase I, II or III testing are not covered. Prescription medications associated with infertility treatments have a different coinsurance rate. Please refer to page 46 for more information.

Nonsedating antihistamines and drugs for treating erectile dysfunction are not covered under the Savings Plan.

Reconstructive Surgery After a Medically Necessary Mastectomy

The plan will cover, as required by the Women's Health and Cancer Rights Act of 1998, mastectomy-related services, including:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and
- Treatment of physical complications in all stages of mastectomy, including lymphedema.

These services apply only in postmastectomy cases. All services must be approved by Medi-Call.

Rehabilitation Care

Rehabilitation care is subject to all terms and conditions of the plan including:

- Preauthorization is required for any inpatient rehabilitation care, regardless of the reason for the admission, and is required for any outpatient rehabilitation therapy that occurs after an inpatient admission for rehabilitation therapy
- The rehabilitation therapy must be performed in the most cost-effective setting appropriate to the condition
- The provider must submit a treatment plan to Medi-Call
- There must be reasonable expectation that sufficient function can be restored for the patient to live at home
- Significant improvement must continue to be made
- An inpatient admission must be to an accredited (JCAHO or CARF) rehabilitation facility.

Rehabilitation benefits are not payable for:

- Vocational rehabilitation intended to teach a patient how to be gainfully employed
- Pulmonary rehabilitation (except in conjunction with a covered and approved lung transplant)
- Behavior therapy, including speech therapy associated with behavior
- Cognitive (mental) retraining
- Community re-entry programs
- Long-term rehabilitation after the acute phase
- Work-hardening programs.

Rehabilitation – Acute
The plan provides limited rehabilitation benefits. Often acute-phase rehabilitation is done in an outpatient setting. In complex cases, the rehabilitation may be done in an acute-care facility and then a sub-acute rehabilitation facility or an outpatient facility. Acute rehabilitation begins soon after the start of the illness or injury and may continue for days, weeks or several months.

Rehabilitation – Long-term
Long-term rehabilitation refers to the point at which further improvement is possible, in theory, but progress is slow and its relationship to formal treatment is unclear. Long-term rehabilitation after the acute phase is generally not covered.

Second Opinions

If Medi-Call advises you to seek a second opinion before a medical procedure, the plan will pay 100 percent of the cost for that opinion. These procedures include surgery as well as treatment (including hospitalization). If APS Healthcare advises you to seek a second opinion before receiving treatment for mental health or substance abuse services, the plan will pay 100 percent of the cost for that opinion.

Skilled Nursing Facility

The plan will pay limited benefits for room and board in a skilled nursing facility for up to 60 days or $6,000, based on a per-day rate, whichever is less. Physician visits are limited to one a day. These services require approval by Medi-Call.

Speech Therapy

The plan covers short-term speech therapy to restore speech or swallowing function that has been lost as a result of disease, trauma, injury or congenital defect (e.g., cleft lip or cleft palate). Speech therapy must be prescribed by a physician and provided by a licensed speech therapist.

Speech therapy requires preauthorization when provided in an inpatient setting or in a home setting. However, claims for speech therapy that are not preauthorized may be verified for medical necessity after the claim is submitted. These expenses are covered only if they are determined to be medically necessary and associated with a service allowed by the plan.

Maintenance therapy begins when the therapeutic goals of a treatment plan have been achieved or when no further functional progress is documented or expected to occur. Maintenance therapy is not covered.

Speech therapy is not covered when associated with any of the following:

- Language delay
- Communication delay
- Developmental delay
- Behavioral disorders
- Cognitive (mental) retraining
- Community re-entry programs or
- Long-term rehabilitation after the acute phase of treatment for the injury or illness.

After a claim is paid, BlueCross BlueShield of South Carolina can still review speech therapy services to determine if the services are a benefit covered by the plan. Please call Customer Service or Medi-Call before beginning the service if you need help in interpreting the list above.

Surgery

Physician charges for medically necessary inpatient surgery, outpatient surgery and use of surgical facilities are covered, if the care is associated with a service allowed by the plan.

Other Covered Expenses

These expenses are covered if they are determined to be medically necessary and associated with a service allowed by the plan:

- Blood and blood plasma, excluding storage fees
- Nursing services (part-time/intermittent)
- Dental treatments or surgery to repair damage from an accident, for up to one year from the date of the accident
- Dental surgery for bony, impacted teeth when supported by X-rays.

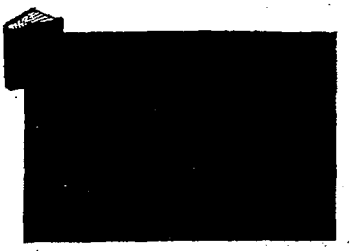
Extended care is covered as an alternative to hospital care **only** if it is approved by Medi-Call.

The Standard Plan and the Savings Plan have benefits that can help make it easier for you and your family to stay healthy. You also are eligible for Prevention Partners programs. By helping prevent potentially expensive health problems and hospital admissions, these benefits help control medical claims costs, saving you and the plan money.

Mammography Program for Women

Routine mammograms are covered at 100 percent as long as you use a participating facility and meet eligibility requirements.

- When you are between the ages 35 and 39, one baseline mammogram (four-view) will be covered.
- If you are age 40 through 74, one routine mammogram (four-view) will be covered every 365 days.



Charges for routine mammograms performed at nonparticipating facilities are not covered, with the exception of procedures performed outside South Carolina. Non-network providers are free to charge you any price for their services, so you may pay more.

A doctor's order is not required for a routine mammogram. However, most centers ask for one, so it is recommended that you get one.

Preventive mammogram benefits are in addition to benefits for diagnostic mammograms. Any charges for additional mammograms are subject to deductibles and coinsurance.

For women, age 40 and older, covered as retirees and enrolled in Medicare, Medicare pays for one screening mammogram every 12 months. The State Health Plan is primary for women covered as active employees, regardless of Medicare eligibility.

Pap Test Program

The plan will pay for a Pap test each year, without any requirement for a deductible or coinsurance, for covered women age 18 through 65. This benefit includes payment for an appropriate-level office visit associated with the Pap test.

Well Child Care

Well Child Care benefits are designed to promote good health and aid in the early detection and prevention of illness in children enrolled in the State Health Plan.

Who is Eligible?

Covered dependent children through age 18 are eligible for Well Child Care check-ups.

How Does it Work?

This benefit covers regular doctor visits and timely immunizations. When services are received from a doctor in the State Health Plan Physician Network, benefits will be paid at 100 percent. **Benefits will not be paid for services from non-network providers.** Some services may not be considered part of Well Child Care. For example, if during a well child visit a fever and sore throat were discovered, the lab work to verify the diagnosis would not be part of the routine visit. These charges would be subject to deductibles and coinsurance, as would any other medical expense.

Checkups

This is the schedule of regular checkups for which the plan pays 100 percent when a network doctor provides the services:

- Younger than 1 year old — five visits
- 1 year old — three visits
- 2 through 18 years old — one visit a year.

Immunizations

This schedule shows routine immunizations for which the plan pays 100 percent when a network doctor provides the services. To ensure that the immunization will be covered, the child must have reached the age at which the schedule says the immunization should be given.

If your covered child has delayed, or missed, receiving immunizations at the recommended times, the plan will pay for "catch-up" immunizations through age 18, for the vaccines listed, and subject to the limitation outlined above. Please contact your State Health Plan pediatrician or call Medi-Call for more information on how to immunize your child properly.

Disease	Recommended Immunization Schedule
Hepatitis B	Birth-2 months 1-4 months 6-18 months 11-12 years if child has not had it before
Polio	2 months 4 months 6-18 months 4-6 years
Diphtheria-Tetanus-Pertussis	2 months 4 months 6 months 15-18 months 4-6 years 11-12 years if child has not had one in last 5 years
Haemophilus (Hib)	2 months 4 months 6 months 12-15 months
Pneumococcal Conjugate (PCV7)	2 months 4 months 6 months 12-15 months
Measles-Mumps-Rubella	12-15 months 4-6 years 11-12 years if child has not already had second dose
Chickenpox	12-18 months 11-12 years if child has not already had disease or vaccine
Influenza	Yearly for children ages 6 months-18 years
Meningococcal	11-12 years
Hepatitis A	12-23 months
Human Papillomavirus (HPV)	11-12 years for females

Natural Blue℠ is a discount program available to State Health Plan subscribers and offered by BCBSSC. The program has a network of licensed acupuncturists, massage therapists and fitness clubs that may be used at lower fees, often as much as a 25 percent discount. Natural Blue℠ also offers discounts on health products, such as vitamins, herbal supplements, books and tapes.

Value Added programs are discounts on products and services that BCBSSC makes available but that are not State Health Plan benefits. Discounts are available on LASIK vision correction, hearing aids, cosmetic dentistry, cosmetic surgery, hair restoration, weight loss, allergy control and children's fitness.

Members may use their Medical Spending Account (MSA) funds tax free for LASIK, contacts, eyeglasses, hearing aids and many other services. For a complete list of qualified medical expenses for MSAs or Health Savings Accounts, go to www.irs.gov/publications/p502.

For more information on Natural Blue or Value Added, log on to the BCBSSC Web site at www.SouthCarolinaBlues.com. Under "Looking for...," select "Discounts & Added Values."

As a participant in the Savings Plan, you are taking greater responsibility for your healthcare. To make that easier, your plan offers extra preventive benefits at no cost. They include:

- A yearly flu immunization for each eligible participant.
- Access to the 24-hour Health at Home® Nurseline, through which registered nurses provide personal, immediate assistance. Subscribers also have access to Healthline Audiotape Library, which includes more than 400 topics. The toll-free number is listed on the back of your health plan ID card and on the cover of the self-care handbook.
- A copy of a self-care handbook, *Health at Home®—Your Complete Guide to Symptoms, Solutions & Self-Care*, and a subscription to the monthly *HealthyLife Wellness Newsletter.*

Physical Exam

Savings Plan participants age 19 and older may receive an annual physical from a network provider in his office that includes:

- A preventive, comprehensive examination
- A complete urinalysis
- An EKG
- A fecal occult blood test
- A general health laboratory panel blood work
- A lipid panel once every five years.

Note: If your network physician sends tests to a non-network physician or lab, the tests will not be covered.

Prescription drugs are a major benefit to you and a major part of the cost of our self-insured health plan. Using generic drugs saves you and the plan money. You also can save money, and receive the same FDA-approved drugs, when you refill prescriptions through Medco by Mail, the mail-order prescription service. **Remember, benefits are paid only for prescriptions filled at network pharmacies or through the mail-order pharmacy.** Prescription drugs, including insulin or other self-injectable drugs (drugs administered at home), are covered subject to plan exclusions and limitations, provided you use a participating pharmacy. Drugs in FDA Phase I, II or III testing are not covered. Prescription drugs associated with infertility treatments have a different coinsurance rate. Please refer to page 46 for more information.

Standard Plan

The prescription drug benefit, administered by Medco Health Solutions, Inc., is easy and convenient to use. With this program, you show your SHP identification card when you purchase your prescriptions from a participating retail pharmacy and pay a copayment of $10 for Tier 1 (generic – lowest cost), $25 for Tier 2 (brand – higher cost) or $40 for Tier 3 (brand – highest cost) for up to a 31-day supply. If the price of your prescription is less than the copayment, you pay the lesser amount.

A *copayment* is a fixed dollar amount a subscriber must pay for a covered expense in addition to what the insurance plan pays. There are no individual exceptions made to the copayment established for a particular prescription drug.

Prescription drug benefits are payable without an annual deductible. There are no claims to file. The prescription drug benefits are the same for the Standard Plan and the Medicare Supplemental Plan.

The prescription drug benefit has a separate annual copayment maximum of $2,500 per person. This means that after you spend $2,500 in prescription drug copayments, the plan will pay 100 percent of your allowable prescription drug charges for the rest of the year.

Drug expenses do not count toward your medical annual deductible, coinsurance maximum or lifetime maximum benefit.

Savings Plan

With this plan, you show your SHP identification card when you purchase your prescriptions from a participating retail pharmacy and pay the full allowable charge for your prescription drugs. There is no copayment.

This cost is transmitted electronically to BCBSSC. If you have not met your annual deductible, the full allowable charge for the drug will be credited to it. If you have met your deductible, you will be reimbursed for 80 percent of the drug's allowable charge. The remaining 20 percent of the cost will be credited to your coinsurance maximum.

Nonsedating antihistamines and drugs for erectile dysfunction are not covered under the Savings Plan.

My Rx Choices

My Rx Choices is an online tool that may help you and your doctor make more economical decisions about your long-term prescriptions. Go to www.medco.com, log in and select "My Rx Choices." You can search for the medications you take, learn what you will pay for them and find out how much you could save by using lower-cost alternatives that are available under your plan. Your options could include generic drugs, less expensive brand-name drugs or use of Medco's mail-order pharmacy, Medco by Mail.

You can ask your doctor to consider Medco's suggestions. If he thinks any of the alternative drugs are appropriate for you, he can write a new prescription.

Depending on the drugs you take and the alternatives available, a Medco pharmacist may be able to contact your doctor on your behalf. *However, no prescription will ever be changed without your doctor's approval, and you will be notified of the change.*

Generic Drugs (Tier 1 – Lowest Cost)

Under both plans, prescription drug choices are divided into three categories: Tier 1 (generic – lowest cost), Tier 2 (brand – higher cost) and Tier 3 (brand – highest cost).

Generic medications may differ in color, size or shape, but the FDA requires that the active ingredients be the chemical equivalent of the brand-name alternative and have the same strength, purity and quality. Prescriptions filled with generic drugs often have lower allowable charges, under the Savings Plan, and lower copayments, under the Standard Plan. Therefore, you get the same health benefits for less.

You may wish to ask your doctor to mark "substitution permitted" on your prescription. If he does not, your pharmacist will have no choice but to give you the brand-name drug, if that is the way the prescription is written.

"Pay-the-Difference" Policy

Under the State Health Plan, there is a "pay-the-difference" policy. This means if you purchase a brand-name drug when an equivalent generic drug is available, the benefit will be limited to that for the generic drug. This policy will apply even if the doctor prescribes the medication as "Dispense as Written" or "Do Not Substitute."

Under the **Standard Plan,** if you purchase a brand-name drug over a generic, you will be charged the generic copayment, PLUS the difference between the allowable charge for the brand name and the generic drug. If the total amount is less than the Tier 2 or Tier 3 (brand-name) copayment, you will pay the brand copayment. Only the copayment for the generic drug will apply toward your copayment maximum.

Under the **Savings Plan,** if you purchase a Tier 2 or Tier 3 (brand-name) drug over a generic, only the allowable charge for the generic drug will apply toward your deductible. After you have met your deductible, only the patient's 20 percent share of the allowable charge for the generic drug will apply toward your coinsurance maximum.

If you are taking a Tier 2 or Tier 3 (brand-name) drug, you may wish to ask your doctor about using a generic drug, if one is available. If appropriate, the doctor may note on the prescription that substitution is permitted.

Tier 2 (Brand – Higher Cost)

These are medications that Medco's Pharmacy and Therapeutics Committee has determined to be safe, effective and available at a lower cost than Tier 3 brand drugs. This list may be updated throughout the year. It is available online at www.medco.com. You may reach the Medco Web site through the EIP Web site by clicking on "Links."

Tier 3 (Brand – Highest Cost)

These medications carry a higher copayment or higher price. Tier 3 contains medication that may be considered preferred or nonpreferred on the formulary, the list of prescription drugs approved by your plan. There are no individual exceptions made to the copayment established for a particular prescription drug.

Compound Prescriptions

A compound prescription is a medication that requires a pharmacist to mix two or more drugs, based on a doctor's prescription, when such a medication is not available from a manufacturer. It is handled the same way any prescription is handled and must be purchased from a participating pharmacy.

Be sure to select a participating pharmacy that will file your compound prescription claim. If the pharmacy does not file for you, you must pay the entire cost of the prescription and then submit a claim to Medco. Information on how to file a claim to Medco is on page 213. Claims must be accompanied by an itemized list of the ingredients for you to be reimbursed. Ask your pharmacist to provide you with this list when you fill your prescription. Please be sure it includes:

- The name of each ingredient
- The valid National Drug Code (NDC) for each ingredient
- The quantity of each ingredient.

This information allows Medco to process your claim based on the actual ingredients in your medication.

When you file your own claim, your reimbursement may be less than what you paid for the drug because it will be limited to the plan's allowable charge minus the copayment for the actual ingredients in the compound prescription.

Some compound medications may be available through Medco by Mail. Please contact Medco to see if they are available before ordering.

Preauthorization

Some medications will be covered by the plan only if they are prescribed for certain uses. These drugs must be authorized in advance, or they will not be covered under the plan. If the prescribed medication must be preauthorized, you or your pharmacist may begin the review process by contacting Medco at 800-711-3450.

You must use a participating pharmacy, and you must show your health plan identification card when purchasing medications. The State Health Plan participates in Rx Selections®, Medco's pharmacy network. Most major pharmacy chains and independent pharmacies participate in this network. A list of network pharmacies is available through the EIP Web site, www.eip.sc.gov (choose your category, then select "Online Directories"), or at www.medco.com. You may also obtain a list of network pharmacies from your benefits administrator.

Retail Maintenance Network

If you are enrolled in the *Standard Plan* or the *Medicare Supplemental Plan*, you may buy 90-day supplies of prescription drugs at mail-order prices at local pharmacies belonging to the Retail Maintenance Network. You will pay the same copayment as you would pay through mail order. This applies only to prescriptions filled for a 63-90 day supply at one of the pharmacies participating in the network. Copayments for prescriptions filled for a 0-62 day supply at these retail pharmacies will remain the same. The copayments will also remain the same at all other network pharmacies. To see a list of the pharmacies, go to the EIP Web site, www.eip.sc.gov, choose your category and select "Online Directories." If you do not have Internet access, ask your benefits administrator to print a copy of the list for you. For more information, call Medco Customer Service at 800-711-3450.

The Standard Plan and the Savings Plan offer mail-order service for 90-day supplies of prescriptions. By using this service, you receive a discount on the same FDA-approved prescription drugs that you would buy at a retail pharmacy.

Mail order is an ideal option for anyone with a recurring prescription, such as birth control medicine, or a chronic condition, such as asthma, high cholesterol or high blood pressure. Some controlled substances may not be available by mail. Please call Medco customer service before submitting your prescription.

Please be sure your physician writes your prescription for a 90-day supply. If it is written for a 31-day supply, you will be charged for a 90-day supply but will be sent a 31-day supply. If you have any questions before you order a 90-day supply of a drug, call Medco at 800-711-3450.

Standard Plan

The copayments for up to a 90-day supply are: Tier 1 (generic) – $25, Tier 2 (brand) – $62, and Tier 3 (brand) – $100. There are no individual exceptions made to the copayment established for a particular prescription drug.

Savings Plan

You pay the full allowable charge when you order prescription drugs through the mail. However, that cost for a 90-day supply will typically be less than you would pay at a retail pharmacy.

How to Order Drugs by Mail

This is how the mail-order service works:

- Ask your physician to write your prescription for a single 31-day supply and for a 90-day supply with refills.
- Fill your prescription for the 31-day supply at a participating retail pharmacy.
- Complete a mail-order prescription form and mail it to Medco. (Forms are available through the EIP Web site, www.eip.sc.gov, under "Forms" or on Medco's Web site: www.medco.com.)
- Your order will be sent to your home, typically within 10-14 business days. Meanwhile, use your prescription from the retail pharmacy.

Once the initial prescription has been entered and filled, you may order refills online or by phone using Medco's toll-free number: 800-711-3450.

If you want to save money by ordering a 90-day supply by mail, be sure to ask your doctor to write a prescription for a **90-day supply with refills**. Under the **Standard Plan**, prescriptions written for a 31-day supply with refills will be filled for a 31-day supply, and you will be charged the same copayment that is charged for a 90-day supply. Under the **Savings Plan**, you can buy less than a 90-day supply.

The State Health Plan coordinates prescription drug benefits, as well as medical benefits. This ensures that if you are covered by more than one health plan, both plans pay their share of the cost of your care. See pages 21 and 34 for more information.

Some prescription drugs are not covered under the plan. See pages 48 and 54 for more information.

For Preauthorization – 800-221-8699

Claims for mental health and substance abuse are subject to the same deductibles, coinsurance and coinsurance maximums as medical claims. There is no limit on the number of provider visits allowed as long as the care is medically necessary. There is not a separate annual and lifetime maximum for mental health and substance abuse benefits.

All services (outpatient office visits, inpatient hospital admissions, etc.) must be preauthorized by APS Healthcare to be covered.

Here is how the mental health and substance abuse program works:

- When you need care inside or outside South Carolina, call APS Healthcare, Inc., the behavioral health manager, at 800-221-8699 to receive preauthorization and to be directed to a network of providers. A *provider* is a physician, psychiatrist, health professional or institutional care provider under agreement to participate in the network administered by APS Healthcare.
- If you need inpatient care, you must call APS Healthcare for preauthorization or within 24 hours of an emergency admission.
- The provider network is open, which means that any eligible provider can participate. You may nominate providers for inclusion in the network. If you do not call APS Healthcare or if you choose to use a non-participating provider, no benefits will be paid.

- To review the network of providers, log on to the EIP Web site at www.eip.sc.gov, then choose your category and select "Online Directories," or go directly to www.apshealthcare.com. Once you are on APS' Web site, click on "Information for Members." Then select "State of South Carolina" from the drop down list under "EMPLOYERS." Click on "Online Provider Locator." At the user login, enter the State Health Plan's access code, which is "statesc" (all lower case). Finally, click on "Submit."
- You will then be able to search the directory by either entering a provider's name or a geographic area. If you would like to view or download the directory, go back to the main South Carolina page and click on "Access the Printable Directory," then enter "statesc."

Paper copies of the provider directory are available from your benefits office or, if you are a retiree, survivor or COBRA subscriber, from APS customer service.

No Claims to File

There are no claims to file. Your network provider is responsible for submitting claims for these services. Remember, no benefits will be paid if you receive care from a provider who is not a member of the network. Your participating mental health and substance abuse provider will be required to conduct periodic medical necessity reviews (similar to Medi-Call). For claims or customer service assistance for mental health and/or substance abuse care, call APS Healthcare at 800-221-8699.

The Free & Clear® Quit For Life™ Program

The research-based Quit For Life Program is available at no charge to State Health Plan subscribers and their covered dependents.

One of the most successful programs of its kind, the Quit For Life Program helps participants stop using cigarettes, cigars, pipes and smokeless tobacco. A professionally trained Quit Coach™ works with each participant to create a personalized quit plan. As part of the 12-month program, participants receive Quit Guides and five telephone calls from a Quit Coach. A participant may call Free & Clear's toll-free support line as often as he wishes. The program also provides free nicotine replacement products (patches, gum or lozenges) if appropriate. Your Quit Coach may also recommend your doctor prescribe a smoking cessation drug, such as bupropion or Chantix, which are available through your prescription drug coverage. The support line is available from 8 a.m. to midnight, seven days a week. If the participant still needs help after the 12-month program ends, he may re-enroll in the program.

To enroll in the Quit For Life Program, call 1-866-QUIT-4-LIFE (1-866-784-8454). After your eligibility is verified, you will be transferred to a Quit Coach for your first call.

APS Helplink™

APS Helplink™ provides tools to help with behavioral health problems, financial and legal issues, child and eldercare concerns and work/life issues. Go to the APS Web site. Follow the instructions above that you use to get to the "Provider Locator," and then click on the "Access APSHelpLink" button. Enter the State Health Plan's "Company Code," which is "statesc."

Services Not Covered by the State Health Plan

There are some medical expenses the State Health Plan does not cover. The *Plan of Benefits* (available in your benefits office or through EIP) contains a complete list of the exclusions. Some expenses that are not covered are charges for:

1. Services or supplies that are not medically necessary

2. Routine procedures not related to the treatment of injury or illness, except for those specifically listed under the Preventive Benefits section
3. Services related to a pre-existing condition in the first 12 months of coverage (or 18 months for late entrants). This may be reduced by any creditable coverage you bring to the plan
4. Routine physical exams, checkups (except Well Child Care and Preventive Benefits according to guidelines), services, surgery (including cosmetic surgery) or supplies that are not medically necessary. (Please note: The Savings Plan covers an annual physical by a network physician for each participant age 19 and older)
5. Eyeglasses
6. Contact lenses, unless medically necessary after cataract surgery and for the treatment of keratoconus, a corneal disease affecting vision
7. Routine eye examinations
8. Refractive surgery, such as radial keratotomy, laser-assisted in situ keratomileusis (LASIK) vision correction, and other procedures to alter the refractive properties of the cornea
9. Hearing aids and examinations for fitting them
10. Dental services, except for removing impacted teeth or treatment within one year of a condition resulting from an accident
11. TMJ splints, braces, guards, etc. (Medically necessary surgery for TMJ is covered if preauthorized by Medi-Call.) TMJ, temporo mandibular joint syndrome, is often characterized by headache, facial pain and jaw tenderness caused by irregularities in the way joints, ligaments and muscles in the jaws work together
12. Custodial care, including sitters and companions or homemakers/caretakers
13. Over-the-counter medicine and contraceptive devices
14. Services related to a vasectomy or tubal ligation performed within one year of enrollment
15. Surgery to reverse a vasectomy or tubal ligation
16. Treatment for infertility resulting from a previous tubal ligation or vasectomy
17. Assisted reproductive technologies (fertility treatment) except as noted on page 46 of this chapter
18. Diet treatments and all weight loss surgery, including, but not limited to: gastric bypass, gastric banding or stapling; intestinal bypass and any related procedures; the reversal of such procedures; and conditions and complications as a result of such procedures or treatment
19. Equipment that has a nontherapeutic use (such as humidifiers, air conditioners, whirlpools, wigs, artificial hair replacement, vacuum cleaners, home and vehicle modifications, fitness supplies, speech augmentation or communication devices, including computers, etc.), regardless of whether the equipment is related to a medical condition or prescribed by a physician
20. Air quality or mold tests
21. Supplies used for participation in athletics (that are not necessary for activities of daily living), including but not limited to, splints or braces
22. Physician charges for medicine, drugs, appliances, supplies, blood and blood derivatives, unless approved by Medi-Call
23. Medical care by a doctor on the same day or during the same hospital stay in which you have surgery, unless a medical specialist is needed for a condition the surgeon could not treat
24. Physician's charges for clinical pathology, defined as services for reading any machine-generated reports or mechanical laboratory tests. Interpretation of these tests is included in the allowance for the lab service
25. Fees for medical records and claims filing
26. Food supplements, including but not limited to formula, enteral nutrition, Boost/Ensure or related supplements
27. Services performed by members of the insured's immediate family
28. Acupuncture
29. Chronic pain management programs
30. Transcutaneous (through the skin) electrical nerve stimulation (TENS), whose primary purpose is the treatment of pain
31. Complications arising from the receipt of noncovered services

32. Psychological tests to determine job, occupational or school placement or for educational purposes; milieu therapy; or to determine learning disability
33. Services or supplies payable by Workers' Compensation, the Veterans Administration or any other governmental or private program (including Employee Assistance Program services)
34. Charges for treatment of illness or injury or complications caused by acts of war or military service, injuries received by participating in a riot, insurrection, felony or any illegal occupation (job)
35. Intentionally self-inflicted injury that does not result from a medical condition or domestic violence
36. Cosmetic goods, procedures or surgery or complications resulting from such procedures or services
37. Nicotine patches used in smoking cessation programs, as well as prescribed drugs used to alleviate the effects of nicotine withdrawal, except as authorized for eligible participants enrolled in the Free & Clear® tobacco cessation program
38. Vocational rehabilitation, pulmonary rehabilitation (except in conjunction with a covered and approved lung transplant), behavior therapy, including speech therapy associated with behavior, cognitive (mental) retraining, community re-entry programs or long-term rehabilitation after the acute phase of treatment for the injury or illness (See Rehabilitation Care on page 49 and Speech Therapy on page 49)
39. Sclerotherapy (treatment of varicose veins), including injections of sclerosing solutions for varicose veins of the leg, unless a prior-approved ligation (tying off of a blood vessel) or stripping procedure has been performed within three years and documentation submitted to Medi-Call with a preauthorization request establishes that some varicosities (twisted veins) remained after the procedure
40. Services performed by service or therapy animals or their handlers.
41. Abortions, except for an abortion performed in accordance with federal Medicaid guidelines
42. Pregnancy of a covered dependent child
43. Speech therapy for the treatment of a language/communication or developmental delay (See page 49)
44. Storage of blood or blood plasma
45. Experimental or investigational surgery or medical procedures, supplies, devices or drugs.
    Any surgical or medical procedures determined by the medical staff of the third-party administrator with appropriate consultation, to be experimental or investigational or not accepted medical practice. Experimental or investigational procedures are those medical or surgical procedures, supplies, devices, or drugs, which at the time provided, or sought to be provided:

    - Are not recognized as conforming to accepted medical practice in the relevant medical specialty or field of medicine; or
    - The procedures, drugs or devices have not received final approval to market from appropriate government bodies; or
    - Are those about which the peer-reviewed medical literature does not permit conclusions concerning their effect on health outcomes; or
    - Are not demonstrated to be as beneficial as established alternatives; or
    - Have not been demonstrated, to a statistically significant level, to improve the net health outcomes; or
    - Are those in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting.

Additional exclusions under the Savings Plan:

- Chiropractic benefits, under the Savings Plan only, are limited to $500 per covered person after the annual deductible is met.
- Nonsedating antihistamines and drugs for treating erectile dysfunction are not covered under the Savings Plan.

The BlueCross BlueShield of South Carolina (BCBSSC) Web site offers a quick, easy way to manage your benefits and learn more about staying healthy. Go directly to the site, www.SouthCarolinaBlues.com, or go to the EIP Web site, www.eip.sc.gov, and click on "Links." Under "State Health Plan," choose "Medical."

After you log in, with *My Insurance Manager* you can:



- See how much of your deductible and out-of-pocket limit you have satisfied
- Print an Explanation of Benefits
- Request an ID card
- Ask a question.

With *My Health Toolkit*, you can:

- Create a Personal Health Record
- Take a Personal Health Assessment
- Find estimates of the cost of treatment.

[redacted]

The Employee Insurance Program (EIP) contracts with claims processors, BlueCross BlueShield of South Carolina, Medco Health Solutions, Inc., and APS Healthcare, Inc., to handle claims for your State Health Plan benefits. You have the right to appeal their decisions.

If all or part of your claim or your request for preauthorization is denied, you will be informed of the decision promptly and told why it was made. If you have questions about the decision, check the information in this book, or call the company that made the decision for an explanation.

If you believe the decision was incorrect, you may ask the company to re-examine its decision. This request should be in writing and should be made within six months after notice of the decision. You (or your physician, on your behalf) may submit any additional information you wish to support this appeal. If you wait too long, the original decision will be considered final, and you will not have any further appeal rights. To begin an appeal, follow the instructions in your denial letter.

If you are still dissatisfied after the decision is re-examined, you may ask EIP to review the matter by making a written request to EIP within 90 days of notice of the denial. If the denial is upheld by EIP, you have 30 days to seek judicial review as provided by S.C. Code Ann. 1-11-710 and 1-23-380.

Exhibit "E"

to Plaintiff's
Memorandum in Opposition
to Defendant's
Motion to Dismiss

WILLS & MASSALON, LLC
ATTORNEYS AT LAW
Telephone: (843) 727-1144
Facsimile: (843) 727-7696

Post Office Box 859
Charleston, South Carolina 29402

134 Meeting Street, Suite 100
Charleston, South Carolina 29401

December 28, 2009

South Carolina Budget and Control Board
Employee Insurance Program
1201 Main Street, Suite 300
Columbia, South Carolina 29201

RE: Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees v. SC Budget & Control Board
Case No.: 09-CP-10-7404
File No.: 595-1

Dear Sir or Madame:

Please allow this letter to serve as a Freedom of Information Act request pursuant to S.C. Code Ann. § 30-4-10 et al. for the following information:

1. A complete copy of the State Health Plan "Plan of Benefits" referenced in the 2009 State Insurance Plan Benefit Guide on page 58.

2. The contract(s) between South Carolina EIP and Blue Cross Blue Shield of South Carolina to administer and/or provide insurance to the State for the State Health Plan effective from January 1, 2000 to present, and any amendments thereto.

With kind regards, I am

Sincerely,

WILLS & MASSALON, LLC

John A. Massalon

cc: Terry E. Richardson, Jr., Esquire
Matthew D. Hamrick, Esquire

Exhibit "E" to
Plaintiff's Memorandum in
Opposition

595-1

MONTGOMERY WILLARD, LLC
ATTORNEYS AND COUNSELORS AT LAW
1002 CALHOUN STREET
COLUMBIA, SOUTH CAROLINA 29201

(803) 779-3500

POST OFFICE BOX 11886
COLUMBIA, SOUTH CAROLINA 29211-1886
FACSIMILE (803)-799-2755
WORLD WIDE WEB HTTP://WWW.MONTGOMERYWILLARD.COM

December 31, 2009

John A. Massalon, Esquire
Wills & Massalon, LLC
PO Box 859
Charleston, SC 29402

Re: Freedom of Information Act Request
Jeffrey Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina Employees v. South Carolina Budget & Control Board Employee Insurance Program and BlueCross BlueShield of South Carolina
Case No. 2009-CP-10-7404

Dear Mr. Massalon:

It is my understanding that you served a request for documents related to the above litigation on the South Carolina Budget and Control Board, Employee Insurance Program pursuant to the South Carolina Freedom of Information Act (FOIA), S.C. Code Ann. § 30-410 et seq. This litigation is currently pending in the South Carolina Court of Common Pleas in the Ninth Judicial Circuit.

FOIA protects from disclosure documents that would not otherwise be discoverable in litigation with the agency. Any discovery sought in ongoing litigation should be pursued through the South Carolina Rules of Civil Procedure. Documents which are not privileged or otherwise exempt from disclosure are available through discovery requests addressed to the attorneys of record in the above case. The attached order from a prior case involving a FOIA request during litigation against the State of South Carolina details the governing law on the matter. As explained in the attached order, "FOIA is not intended as a substitute for discovery and was not enacted to provide procedures for obtaining information during litigation or to benefit private litigants."

If you have any questions, please do not hesitate to contact me.

Sincerely,

Montgomery Willard, LLC

Theodore D. Willard, Jr.

Enclosure

cc: Edwin Evans, Esquire
Kelly Rainsford, Esquire
Lucy Grey McIver, Esquire
Matthew D. Hamrick, Esquire
Terry E. Richardson Jr., Esquire

JL

ORIGINAL

FILED

2003 OCT 30 A 9:36

THOMAS H. COMERFORD
CLERK OF COURT
LEXINGTON SC

STATE OF SOUTH CAROLINA)	IN THE COURT OF COMMON PLEAS
)	
COUNTY OF LEXINGTON)	
Robert E. Lominack,)	2002-CP-32-1890
)	
Plaintiff,)	
-vs-)	ORDER
)	
Donald V. Myers, Solicitor,)	
Eleventh Judicial Circuit,)	
)	
Defendant.)	

This matter came before the Court following the Plaintiff's filing of a complaint seeking declaratory and injunctive relief pursuant to the South Carolina Freedom of Information Act ("FOIA"). Prior to the filing of the complaint, the Plaintiff had sent a letter to the Defendant Donald Myers, Solicitor, Eleventh Judicial Circuit, requesting, pursuant to the FOIA, all materials in the possession of the Solicitor's Office relating to a criminal case where the Plaintiff is representing the Defendant in a post conviction relief action against the Defendant's prior legal counsel. By letter dated May 23, 2002, Defendant Myers denied Plaintiff's FOIA request, indicating that Section 17-27-150(B) provides the procedure for discovery in a capital post-conviction relief case, and that the Plaintiff should use that process rather than trying to circumvent the statute by filing a request for these documents under the FOIA. The Plaintiff then filed this Complaint. The issue before the Court is whether to compel compliance with Plaintiff's FOIA request.

I find that Section 17-27-150 of the South Carolina Code details the method of discovery in post-conviction relief proceedings. Further, it is well settled case law that the FOIA is not intended as a substitute for discovery and was not enacted to provide procedures for obtaining information during litigation or to benefit private litigants. U.S. v. Murdock, 544F.2d 599 (5th Cir. 1976);

Fruehauf Corp v. Thornton, 507 F.2d 1253 (6th Cir. 1974); N.L.R.B. v. Sears, Roebuck & Co., 421 U.S. 132 (1975).

Therefore, the information sought in this case cannot be obtained under the State Freedom of Information Act and can only be obtained by utilizing the discovery procedure set out by Statute. Plaintiff's request for declaratory and injunctive relief is denied.

AND IT IS SO ORDERED.

Marc H. Westbrook
Resident Judge
Eleventh Judicial Circuit

October 25th, 2002.

5954

STATE OF SOUTH CAROLINA

State Budget and Control Board

EMPLOYEE INSURANCE PROGRAM

MARK SANFORD, CHAIRMAN
GOVERNOR

CONVERSE A. CHELLIS III, CPA
STATE TREASURER

RICHARD ECKSTROM, CPA
COMPTROLLER GENERAL

HUGH K. LEATHERMAN, SR.
CHAIRMAN, SENATE FINANCE COMMITTEE

DANIEL T. COOPER
CHAIRMAN, WAYS AND MEANS COMMITTEE

FRANK W. FUSCO
EXECUTIVE DIRECTOR

1201 MAIN STREET, SUITE 200
COLUMBIA, SOUTH CAROLINA 29201
(803) 734-0678
FAX: (803) 737-0557

January 4, 2010

John A. Massalon, Esquire
Wills & Massalon, LLC
PO Box 859
Charleston, SC 29402

Re: Freedom of Information Act Request
Jeffrey Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina Employees v. South Carolina Budget & Control Board Employee Insurance Program and BlueCross BlueShield of South Carolina
Case No. 2009-CP-10-7404

Dear Mr. Massalon:

The South Carolina Budget and Control Board is in receipt of your request pursuant to the South Carolina Freedom of Information Act (FOIA), S.C. Code Ann. § 30-410 et seq., for documents related to the above-referenced matter, which is pending in the South Carolina Court of Common Pleas in the Ninth Judicial Circuit.

The Act protects from disclosure documents that would not otherwise be discoverable in litigation with the agency. Any discovery sought in ongoing litigation should be pursued through the South Carolina Rules of Civil Procedure. Documents which are not privileged or otherwise exempt from disclosure are available through discovery requests addressed to the attorneys of record in the above case.

If you have any questions, please do not hesitate to contact me.

Sincerely,

Robin E. Tester
Director of Employee Insurance Program

RET/ctqc

cc: Edwin Evans, Esquire
Kelly Rainsford, Esquire
Theodore D. Willard, Jr., Esquire
Lucy Grey McIver, Esquire
Matthew D. Hamrick, Esquire
Terry E. Richardson Jr., Esquire

STATE OF SOUTH CAROLINA)	IN THE COURT OF COMMON PLEAS
)	FOR THE NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON)	
Jeffrey D. Allen, individually, as guardian) for Jane Doe, a minor, and as representative) of other similarly situated State of South) Carolina employees,)	Civil Action No.: 2009-CP-10-7404
Plaintiffs,)	**DEFENDANTS' NOTICE OF MOTION AND MOTION FOR A PROTECTIVE ORDER**
v.)	
South Carolina Budget and Control Board) Employee Insurance Program and Blue) Cross and Blue Shield of South Carolina,)	
Defendants.)	

FILED
2010 JUN -3 PM 4:13
JULIE J. ARMSTRONG
CLERK OF COURT

4 - 9442

TO: John A. Massalon, Esquire, Attorney for Plaintiff:

YOU WILL PLEASE TAKE NOTICE that Defendants, South Carolina Budget and Control Board Employee Insurance Program ("EIP") and Blue Cross Blue Shield of South Carolina ("BCBSSC") by and through their undersigned counsel, will move before the Presiding Judge on the tenth (10^{th}) day after service hereof, or as soon thereafter as the parties might be heard, pursuant to S.C.R.C.P. 26 (c), for a protective order protecting Defendants from having to respond to Plaintiff's discovery pending a determination of Defendants' Motion for Summary Judgment. Copies of Plaintiff's first interrogatories and first request for production to Defendants are attached hereto as Exhibits A-D.

The grounds for this motion are as follows:

1. Defendants' summary judgment motion is potentially dispositive of the entire action;

2. Defendants' summary judgment motion is strictly a matter of law;

3. Plaintiff will not be prejudiced by a stay of discovery; and

4. The discovery sought is voluminous and burdensome covering a span of 10 years, and adjudication of the pending summary judgment motion may obviate the need for the discovery.

This motion is supported by the pleadings, the memorandum in support and the applicable law.

Theodore D. Willard, Jr.
MONTGOMERY WILLARD, LLC
1002 Calhoun Street
Post Office Box 11886
Columbia, South Carolina 29211
Telephone: (803) 779-3500

Kelly H. Rainsford
State Budget & Control Board
1201 Main Street, Ste.300
Columbia, South Carolina
Telephone: (803) 734-2375
Fax: (803) 737-0825

ATTORNEYS FOR DEFENDANTS

June 2, 2010
Columbia, South Carolina

RULE 11 AFFIRMATION

The undersigned affirms that prior to filing this motion, he communicated orally, or in writing with opposing counsel and attempted in good faith to resolve that matter contained in the motion.

Theodore D. Willard, Jr.

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF CHARLESTON	)	CASE NO.: 09-CP-10-7404
	)	
	)	
Jeffrey D. Allen, individually, as Guardian For Jane Doe, a minor, and as Representative Of other similarly situated State of South Carolina employees,	)	
	)	Plaintiff's First Interrogatories To Defendant South Carolina Budget and Control Board Employee Insurance Program
Plaintiff,	)	
v.	)	
	)	
South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina,	)	
	)	
Defendants.	)	

Plaintiff hereby submits the following interrogatories, pursuant to Rules 26 and 33, to Defendant the South Carolina Budget and Control Board Employee Insurance Program (hereinafter referred to as the "EIP").

INTERROGATORIES

1. Give the names and addresses of persons known to the EIP or counsel to be witnesses concerning the facts of this case and indicate whether or not written or recorded statements have been taken from the witnesses and indicate who has possession of such statements.

2. Set forth a list of any prepared documents in possession of the EIP or counsel that relate to the claims or defenses in this case.

3. Set forth the names and addresses of all insurance companies which have liability insurance coverage relating to the claim and set forth the number or numbers of the policies involved and the amount or amounts of liability coverage provided in each policy.

4. List the names and addresses of any expert witnesses whom the EIP proposes to use as a witness at the trial of the case.

5. For each person known to the EIP or counsel to be a witness concerning the facts of the case, set forth either a summary sufficient to inform the Plaintiff of the important facts known to or observed by such witness, or provide a copy of any written or recorded statements taken from such witnesses.

6. If the EIP is improperly identified, give the proper identification and state whether counsel will accept service of an amended summons and pleading reflecting the correct information.

7. State the names and addresses of all persons, both entities and individuals, with authority to make decisions regarding coverage or denials of coverage under the EIP Standard Plan (hereinafter referred to as the "Plan"), including but not limited to making the final determination to allow or disallow a claim for benefits, in each calendar year since January 1, 2000.

8. State the names and addresses of all persons, both entities and individuals, who took part in drafting any portion of the Plan, including any revisions or amendments to the Plan.

9. State whether or not the Plan covers self-management training and education for the treatment or maintenance of *any* medical condition(s), and if so identify the condition(s).

10. For each year since January 1, 2000 state the total (by year) number of individuals who were covered by the Plan, including but not limited to any enrolled dependants.

11. State the reason why Plaintiff's claim was disallowed, including an explanation of any relevant policy provisions or exclusions.

12. If the EIP contends that SC Code § 38-71-46 does not apply to the Plan, please explain why.

13. Identify all statutes, regulations, case law and other authority with the force of law which you contend support your contention that S.C. Code § 38-71-46 does not apply to the Plan.

14. State whether the EIP has ever notified the Diabetes Initiative of South Carolina that the Plan does not cover outpatient self-management training and education for the treatment of people with diabetes mellitus because S.C. Code § 38-71-46 does not apply to the Plan.

15. How and when is the EIP able to identify persons covered under the Plan, including but not limited to enrolled dependants, who have diabetes?

16. Provide the total number of claims, by year, of any type processed under the Plan for each calendar year since January 1, 2000.

17. Provide the total number of claims, by year, of any type which were denied under the Plan for each calendar year since January 1, 2000.

18. State the total number of claims, by year, made under the Plan for diabetes education for each calendar year beginning January 1, 2000.

19. Identify all the different types of individuals, employers, state and local governments which are able to participate in the Plan.

20. Identify any other state law insurance mandates EIP contends do not apply to the Plan, and explain why.

21. Describe the flow of the premium monies from the individual and employer to or through the Plan and/or Blue Cross and Blue Shield of South Carolina (hereinafter referred to as "BCBS").

22. Has any entity other than BCBS served in the same or similar capacity for the EIP since January 1, 2000?

23. Is this action similar in whole or in part to any other lawsuit ever filed against the EIP? If so, provide: (1) a short caption and the full case number of the related action; and (2) a statement of the status of the related action. Counsel should disclose any cases which may be related regardless of whether they are still pending.

24. If you contend that some other person or legal entity is a necessary party to this action, identify such person or entity and describe the basis of your claim that the person or entity is a necessary party.

25. If you contend that some other person or legal entity is, in whole or in part, liable to you or the party asserting a claim against you in this matter, identify such person or entity and describe the basis of said liability.

26. Identify any and all diagnosis or treatment codes related to diabetes.

27. For each year since January 1, 2000 state, by year, the total number of individuals, including but not limited to any enrolled dependants, who were covered by the Plan and who received or were assigned the diagnosis code "250" or a treatment code beginning with "250."

John A. Massalon
Wills Massalon & Allen, LLC
Post Office Box 859
Charleston, SC 29402
(843) 727-1144
-and-
Terry E. Richardson, Jr.
Matthew D. Hamrick
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(843) 727-6500

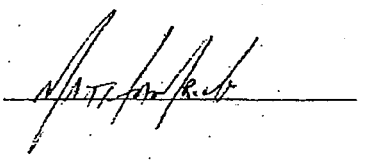
ATTORNEYS FOR PLAINTIFF

CERTIFICATE OF SERVICE

I hereby certify that I have this 10TH day of May, 2010 served the foregoing pleading or paper by depositing a copy of it in the US Mail, first class, postage pre-paid, addressed as follows:

Theodore D. Willard, Jr., Esq.
MONTGOMERY WILLARD, LLC
1002 Calhoun Street
Post Office Box 11886
Columbia, SC 29211

Kelly H. Rainsford, Esq.
State Budget & Control Board
1201 Main Street, Ste. 300
Columbia, SC 29211



STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON Jeffrey D. Allen, individually, as Guardian For Jane Doe, a minor, and as Representative Of other similarly situated State of South Carolina employees, Plaintiff, v. South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina, Defendants.	)	IN THE COURT OF COMMON PLEAS CASE NO.: 09-CP-10-7404 Plaintiff's First Requests for Production to Defendant South Carolina Budget and Control Board Employee Insurance Program

Plaintiff hereby submits the following requests for production, pursuant to Rules 26 and 34, to Defendant the South Carolina Budget and Control Board Employee Insurance Program (hereinafter referred to as the "EIP").

REQUESTS FOR PRODUCTION

1. Any and all documents relating to any contracts between the EIP and Blue Cross and Blue Shield of South Carolina (hereinafter referred to as "BCBS"), including but not limited to any records of payment, from 2000 to present.

2. Any and all documents relating to any contracts between the EIP and/or BCBS and/or any diabetic-supply companies, including but not limited to contracts, lists of services and supplies, and terms of payment (both approved and non-approved for payment) from 2000 to present.

3. Any and all documents relating to any contracts between the EIP and/or BCBS and/or any diabetic-related durable medical equipment companies, including but not limited to

contracts, lists of services, durable medical equipment, and terms of payment (both approved and non-approved for payment) from 2000 to present.

4. Any and all indemnity agreements existing between the EIP and BCBS.

5. A listing of the current members of the South Carolina Budget and Control Board.

6. A listing of the current employees of South Carolina Budget and Control Board whose job responsibilities involve the EIP, including their job descriptions.

7. All versions for each policy year, since January 1, 2000, of the provisions of the Plan, to include the Plan Document and the Summary provided to employees.

8. All written inquiries of any type, including but not limited to claims correspondence and documentation, emails, and any other type of inquiry, made to EIP on or after January 1, 2000, regarding S.C. Code § 38-71-46.

9. Any and all communications made by the EIP, on or after January 1, 2000, regarding S.C. Code § 38-71-46.

10. Any and all communications or documents related to the content of or introduction of the legislation which ultimately resulted in the enactment of S.C. Code 38-71-46.

11. Any and all communications made by the EIP containing information about or in any way relating to any type of wellness plan or wellness coverage for people with diabetes.

12. Any and all documents relating to any limitation of authority of claims adjusters for insurance policies, or reflecting any requirement for prior approval for payment of any claim.

13. Produce any electronic communications or representations, including but not limited to emails, blogs, personal homepages, internet message boards, and social networking sites, relating to or referring to coverage or the absence of coverage under the Plan for outpatient self-management training and education for the treatment of people with diabetes mellitus.

14. Produce any and all non-patient-specific information or data the EIP has used since January 1, 2000 to make predictions about the number of diabetes-related claims that would potentially be made by persons covered under the Plan, including but not limited to enrolled dependants.

15. Produce a chart or other similar document showing the organizational structure of the EIP.

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ATTORNEYS FOR PLAINTIFF

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Kelly H. Rainsford, Esq.
State Budget & Control Board
1201 Main Street, Ste. 300
Columbia, SC 29211

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF CHARLESTON	)	CASE NO.: 09-CP-10-7404
	)	
	)	
Jeffrey D. Allen, individually, as Guardian For Jane Doe, a minor, and as Representative Of other similarly situated State of South Carolina employees,	)	Plaintiff's First Interrogatories To Defendant Blue Cross and Blue Shield of South Carolina
Plaintiff,	)	
v.	)	
	)	
South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina,	)	
Defendants.	)	

Plaintiff hereby submits the following interrogatories, pursuant to Rules 26 and 33, to Defendant Blue Cross and Blue Shield of South Carolina (hereinafter referred to as "BCBS").

INTERROGATORIES

1. Give the names and addresses of persons known to BCBS or counsel to be witnesses concerning the facts of this case and indicate whether or not written or recorded statements have been taken from the witnesses and indicate who has possession of such statements.

2. Set forth a list of any prepared documents in possession of BCBS or counsel that relate to the claims or defenses in this case.

3. Set forth the names and addresses of all insurance companies which have liability insurance coverage relating to the claim and set forth the number or numbers of the policies involved and the amount or amounts of liability coverage provided in each policy.

4. List the names and addresses of any expert witnesses whom BCBS proposes to use as a witness at the trial of the case.

5. For each person known to BCBS or counsel to be a witness concerning the facts of the case, set forth either a summary sufficient to inform the Plaintiff of the important facts known to or observed by such witness, or provide a copy of any written or recorded statements taken from such witnesses.

6. If BCBS is improperly identified, give the proper identification and state whether counsel will accept service of an amended summons and pleading reflecting the correct information.

7. State the names and addresses of all persons, both entities and individuals, with authority to make decisions regarding coverage or denials of coverage under the South Carolina Budget and Control Board Employee Insurance Plan (hereinafter referred to as the "EIP") Standard Plan (hereinafter referred to as the "Plan"), including but not limited to making the final determination to allow or disallow a claim for benefits, in each calendar year since January 1, 2000.

8. State the names and addresses of all persons, both entities and individuals, who took part in drafting any portion of the Plan, including any revisions or amendments to the Plan.

9. State whether or not the Plan covers self-management training and education for the treatment or maintenance of *any* medical condition(s), and if so identify the condition(s).

10. For each year since January 1, 2000 state, by year, the total number of individuals who were covered by the Plan, including but not limited to any enrolled dependants.

11. State the reason why Plaintiff's claim was disallowed, including an explanation of any relevant policy provisions or exclusions.

12. If BCBS contends that SC Code § 38-71-46 does not apply to the Plan, please explain why.

13. Identify all statutes, regulations, case law and other authority with the force of law which you contend support your contention that S.C. Code § 38-71-46 does not apply to the Plan.

14. State whether BCBS has ever notified the Diabetes Initiative of South Carolina that the Plan does not cover outpatient self-management training and education for the treatment of people with diabetes mellitus because S.C. Code § 38-71-46 does not apply to the Plan.

15. State whether or not BCBS covers outpatient self-management training and education under its private health insurance plans (other than the Plan at issue in this case), and identify each plan under which outpatient self-management training and education is covered, and the terms of any such coverage.

16. How and when is BCBS able to identify persons covered under the Plan, including but not limited to enrolled dependants, who have diabetes?

17. Provide the total number of claims, by year, processed under the Plan for each calendar year since January 1, 2000.

18. Provide the total number of claims, by year, which were denied under the Standard Plan for each calendar year since January 1, 2000.

19. State the total number of claims, by year, made for diabetes education for each calendar year beginning January 1, 2000.

20. Set forth the make-up or the formula or method by which BCBS is compensated through its relationship with the EIP, including all years from January 1, 2000 to the present.

21. With regard to any compensation paid to BCBS related in any way to BCBS's services performed for EIP, state whether any portion of the compensation paid to BCBS is based on or related in any way to the number or amount of claims paid or denied.

22. Provide the annual compensation paid to (or revenues collected by) BCBS or any affiliated entities related to the relationship with the EIP.

23. With regard to the annual compensation or revenue referenced in the answer to the preceding Interrogatory, identify for which of the following revenue descriptors compensation or revenue is reported:

- Premiums
- Fee-for-Service
- Risk Revenue
- Net Investment Income Earned
- Net Gain or (Loss) from Agents' or Premium Balances Charged Off
- Other Revenue

24. What percentage of total operating revenue of BCBS is derived from the relationship with the EIP.

25. Does BCBS maintain a separate database of, or have the ability to identify in its databases, diabetes patients, including but not limited to those who have diabetes when they apply for coverage and also those who are diagnosed with diabetes while participants in the Plan?

26. How long has BCBS been serving in its present capacity for the EIP?

27. Is this action similar in whole or in part to any other lawsuit ever filed against BCBS? If so, provide: (1) a short caption and the full case number of the related action; and (2) a statement of the status of the related action. Counsel should disclose any cases which may be related regardless of whether they are still pending.

28. If you contend that some other person or legal entity is a necessary party to this action, identify such person or entity and describe the basis of your claim that the person or entity is a necessary party.

29. If you contend that some other person or legal entity is, in whole or in part, liable to you or the party asserting a claim against you in this matter, identify such person or entity and describe the basis of said liability.

30. Set forth all itemized components of diabetes management, including any educational or nutritional component.

31. For each year since January 1, 2000 state, by year, the total number of individuals, including but not limited to any enrolled dependants, who were covered by the Plan and who received or were assigned the diagnosis code "250" or a treatment code beginning with "250."

32. What type of computer system(s), including the data format(s), does BCBS use with regard to submissions of claims?

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-and-
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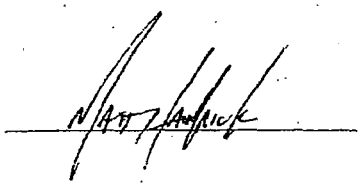
ATTORNEYS FOR PLAINTIFF

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Kelly H. Rainsford, Esq.
State Budget & Control Board
1201 Main Street, Ste. 300
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STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF CHARLESTON	)	CASE NO.: 09-CP-10-7404
	)	
	)	
Jeffrey D. Allen, individually, as Guardian For Jane Doe, a minor, and as Representative Of other similarly situated State of South Carolina employees,	)	
	)	Plaintiff's First Requests for Production to Defendant Blue Cross and Blue Shield of South Carolina
Plaintiff,	)	
v.	)	
	)	
South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina,	)	
	)	
Defendants.	)	
	)	

Plaintiff hereby submits the following requests for production, pursuant to Rules 26 and 34, to Defendant Blue Cross and Blue Shield of South Carolina (hereinafter referred to as BCBS).

REQUESTS FOR PRODUCTION

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2. Any and all documents relating to any contracts between the EIP and/or BCBS and/or any diabetic-supply companies, including but not limited to contracts, lists of services and supplies, and terms of payment (both approved and non-approved for payment) from 2000 to present.

3. Any and all documents relating to any contracts between the EIP and/or BCBS and/or any diabetic-related durable medical equipment companies, including but not limited to

contracts, lists of services, durable medical equipment, and terms of payment (both approved and non-approved for payment) from 2000 to present.

4. Any and all indemnity agreements existing between the EIP and BCBS.

5. A listing of the current employees of BCBS whose job responsibilities involve the EIP, including their job descriptions.

6. All versions for each policy year, since January 1, 2000, of the provisions of the Plan, to include the Plan Document and the Summary provided to employees.

7. All written inquiries of any type, including but not limited to claims correspondence and documentation, emails, and any other type of inquiry, made to BCBS on or after January 1, 2000, regarding S.C. Code § 38-71-46.

8. Any and all communications made by BCBS on or after January 1, 2000, regarding S.C. Code § 38-71-46.

9. Any and all communications or documents related to the content of or introduction of the legislation which ultimately resulted in the enactment of S.C. Code 38-71-46.

10. Any and all communications made by BCBS containing information about or in any way relating to any type of wellness plan or wellness coverage for people with diabetes.

11. Any and all documents relating to any limitation of authority of claims adjusters for insurance policies, or reflecting any requirement for prior approval for payment of any claim.

12. Copies of the annual financial statements, including balance sheets and Profit & Loss Reports, for BCBS for each year beginning January 1, 2000.

13. Training materials, procedure manuals, or other materials used to train employees of BCBS in evaluating claims under the Plan including but not limited to claims for diabetes

related services, and for outpatient self-management training and education for the treatment of people with diabetes mellitus (ICD Code 250).

14. Produce any electronic communications or representations, including but not limited to emails, blogs, personal homepages, internet message boards, and social networking sites, relating to or referring to coverage or the absence of coverage under the Plan for outpatient self-management training and education for the treatment of people with diabetes mellitus.

15. Produce any and all non-patient-specific information or data BCBS has used since January 1, 2000 to make predictions about the number of diabetes-related claims that would potentially be made by persons covered under the Plan, including but not limited to enrolled dependants.

16. Produce a chart or other similar document showing the organizational structure of BCBS.

17. Produce documentation of all BCBSSC claims codes for diabetes (ICD 250)-related services, equipment, drugs, procedures.

18. Produce reimbursement policies for diabetes education and/or nutritional education.

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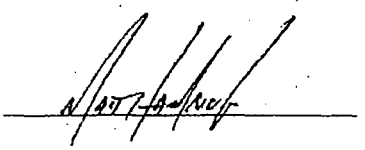
ATTORNEYS FOR PLAINTIFF

CERTIFICATE OF SERVICE

I hereby certify that I have this 6TH day of May, 2010 served the foregoing pleading or paper by depositing a copy of it in the US Mail, first class, postage pre-paid, addressed as follows:

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MONTGOMERY WILLARD, LLC
1002 Calhoun Street
Post Office Box 11886
Columbia, SC 29211

Kelly H. Rainsford, Esq.
State Budget & Control Board
1201 Main Street, Ste. 300
Columbia, SC 29211



STATE OF SOUTH CAROLINA)	IN THE COURT OF COMMON PLEAS
)	FOR THE NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON)	
Jeffrey D. Allen, individually, as guardian)	Civil Action No.: 2009-CP-10-7404
for Jane Doe, a minor, and as representative)	
of other similarly situated State of South)	
Carolina employees,)	**CERTIFICATE OF SERVICE**
Plaintiffs,)	
v.)	
South Carolina Budget and Control Board)	
Employee Insurance Program and Blue)	
Cross and Blue Shield of South Carolina,)	
Defendants.)	

I, Tracey D. Smith, an employee of the law firm of Montgomery Willard, LLC, attorneys for the Defendants do hereby certify that I have served the below named counsel with copies of *Defendants' Notice of Motion and Motion For a Protective Order* by mailing copies of same by United States mail, proper postage affixed, return address clearly marked, and addressed as follows:

John A. Massalon, Esquire
Wills & Massalon, LLC
Post Office Box 859
Charleston, South Carolina 29402

Terry E. Richardson, Jr., Esquire
Richardson, Patrick, Westbrook & Brickman, LLC
1017 Chuck Dawley Blvd.
Mt. Pleasant, South Carolina 29464

Tracey D. Smith

June 2, 2010
Columbia, South Carolina

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees, Plaintiff, vs. South Carolina Budget and Control Board Employee Insurance Program, et al. Defendant.	IN THE COURT OF COMMON PLEAS NINTH JUDICIAL CIRCUIT CASE NO.: 2009-CP-10-7404 **MOTION AND ORDER INFORMATION** **FORM AND COVERSHEET**

Plaintiff's Attorney: John A. Massalon, Bar No. _____ Address: Post Office Box 859, Charleston, SC 29402 Phone: (843) 727-1144Fax (843) 727-7696 E-mail: jmassalon@wills-massalon.comOther: _____	Defendant's Attorney: Theodore D. Willard, Jr., Bar No. _____ Address: Post Office Box 11886, Columbia, SC 29211 Phone: (803) 779-3500 Fax(803) 799-2755 E-mail: tdw@montgomerywillard.com Other: _____

☒ **MOTION HEARING REQUESTED (attach written motion and complete SECTIONS I and III)**
☐ **FORM MOTION, NO HEARING REQUESTED (complete SECTIONS II and III)**
☐ **PROPOSED ORDER/CONSENT ORDER (complete SECTIONS II and III)**

SECTION I: Hearing Information

Nature of Motion: Motion for Summary Judgment
Estimated Time Needed: 30 minutes Court Reporter Needed: ☒YES/☐ NO

SECTION II: Motion/Order Type

☐ Written motion attached
☐ Form Motion/Order

I hereby move for relief or action by the court as set forth in the attached proposed order.

_____ _____
Signature of Attorney for ☐ Plaintiff /☐ Defendant Date submitted

SECTION III: Motion Fee

☒ PAID – AMOUNT: $25.00
☐ EXEMPT: (check reason)
☐ Rule to Show Cause in Child or Spousal Support
☐ Domestic Abuse or Abuse and Neglect
☐ Indigent Status ☐ State Agency v. Indigent Party
☐ Sexually Violent Predator Act ☐ Post-Conviction Relief
☐ Motion for Stay in Bankruptcy
☐ Motion for Publication ☐ Motion for Execution (Rule 69, SCRCP)
☐ Proposed order submitted at request of the court; or, reduced to writing from motion made in open court per judge's instructions
Name of Court Reporter: _____
☐ Other: _____

JUDGE'S SECTION ☐ Motion Fee to be paid upon filing of the attached order. ☐ Other: _____	JUDGE CODE _____ Date: _____

CLERK'S VERIFICATION

Collected by:_____ Date Filed: _____
☐ MOTION FEE COLLECTED: $ _____
☐ CONTESTED – AMOUNT DUE: $ _____

SCCA 233 (11/2003)

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	)	IN THE COURT OF COMMON PLEAS FOR THE NINTH JUDICIAL CIRCUIT
Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees, Plaintiffs, v. South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina, Defendants.	)	Civil Action No.: 2009-CP-10-7404 **DEFENDANTS' NOTICE OF MOTION AND MOTION FOR SUMMARY JUDGMENT**

TO: John A. Massalon, Esquire, Attorney for Plaintiff:

YOU WILL PLEASE TAKE NOTICE that Defendants, South Carolina Budget and Control Board Employee Insurance Program ("EIP") and Blue Cross Blue Shield of South Carolina ("BCBSSC") by and through their undersigned counsel, will move before the Presiding Judge on the tenth (10th) day after service hereof, or as soon thereafter as the parties might be heard, pursuant to S.C.R.C.P. 56, for an order granting Defendants' Summary Judgment as to Plaintiff's Complaint. The grounds for this Motion are that there are no genuine issues of fact relating to Plaintiff's Complaint, and that Defendants are entitled to a judgment as a matter of law. More particularly, Defendants are entitled to summary judgment on the following grounds:

1. S.C. Code Ann. § 38-71-46 does not apply to the State Health Plan;

2. Plaintiff's causes of action are preempted by the remedies set forth in S.C. Code Ann. § 1-11-710 (C);

3. Plaintiff failed to exhaust his administrative remedies under the State Health Plan

pursuant to S.C. Code Ann. § 1-11-710(C) and § 1-23-380; and

4. This matter should be before the Administrative Law Court pursuant to S.C. Code Ann. § 1-23-600 (D), in that any action reviewing a decision under the State Health Plan is subject to the exclusive jurisdiction of the Administrative Law Court.

This motion is supported by the pleadings, any memorandum in support, any supporting affidavits and the applicable law.

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Kelly H. Rainsford
State Budget & Control Board
1201 Main Street, Ste.300
Columbia, South Carolina
Telephone: (803) 734-2375
Fax: (803) 737-0825

ATTORNEYS FOR DEFENDANTS

June 2, 2010
Columbia, South Carolina

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	FOR THE NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON	)	
Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees,	)	Civil Action No.: 2009-CP-10-7404
Plaintiffs,	)	
	)	**AFFIDAVIT OF ROBIN E. TESTER**
v.	)	
South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina,	)	
Defendants.	)	

Personally appeared before me, Robin E. Tester, who, after duly having been sworn, deposes and says:

1. He has personal knowledge of the matters contained herein and is authorized to give this affidavit.

2. He is employed by the State of South Carolina, State Budget and Control Board, Employee Insurance Program ("EIP") as the Director of Employee Insurance Program.

3. The Group Health Benefits Plan of the Employees of the State of South Carolina, the Public School Districts, and Participating Entities ("State Health Plan") is a self-funded, governmental health plan for state employees, which is administered by the South Carolina Budget and Control Board, Employee Insurance Program ("EIP").

4. Blue Cross Blue Shield of South Carolina ("BCBSSC") is the claims administrator for the State Health Plan. BCBSSC is not an insurer of the State Health Plan.

5. Upon information and belief, Jeffrey D. Allen was a participant of the State of South Carolina Health Plan.

6. Plaintiff's complaint alleges that Jeffrey Allen filed a claim for benefits under the State of South Carolina Health Plan for benefits for diabetes outpatient, self-management training and education, which claim Plaintiff alleges was denied.

7. By way of a letter dated September 30, 2009, Plaintiff made a first level of appeal to the Blue Cross Blue Shield of South Carolina Appeals Committee of the denial of his claim for benefits under the State Health Plan, making the exact same argument he makes here concerning the application of S.C. Code § 38-71-46 to the State Health Plan. A true and correct copy of this letter is attached hereto as Exhibit A.

8. On April 2, 2010, The Blue Cross Blue Shield Appeals Committee wrote Plaintiff that it was upholding the denial of Plaintiff's claim in Plaintiff's claim was specifically excluded under the terms of the State Health Plan and that S.C. Code § 38-71-46 did not apply to the State Health Plan. A true and correct copy of this letter is attached hereto as Exhibit B. This letter further gave Plaintiff 90 days from April 2, 2010 to appeal this decision to EIP Health Appeals Committee. The 90 day appeal deadline expires on July 1, 2010.

9. As of the date of this motion, Plaintiff has not yet requested an appeal of the denial of benefits to the EIP Health Appeals Committee as is required under the procedures set out in the State Health Plan. Therefore, Jeffrey D. Allen failed to exhaust his administrative remedies.

10. Pursuant to the terms of the State Health Plan, in order to challenge a denial of benefits, participants and/or beneficiaries are required to exhaust their administrative

remedies by appealing the denial of benefits. A true and correct copy of the applicable State Health Plan is attached hereto as Exhibit C.

11. The State Health Plan states in relevant part:

> **12.5 Review of Claims Denied in Whole or Part**
>
> If the Third Party Claims Processor, or the Utilization Review Agency or their designee determines that any person who has submitted a claim for the payment or pre-certification of benefits under the Plan is not entitled to receive all or part of the benefits sought, the Third Party Claims Processor, Utilization Review Agency or their designee, shall inform the claimant of such determination and the reasons therefore, with specific reference to pertinent provisions of the Plan. The exclusive remedy for the denial of benefits shall be as provided by statute and by the procedures of the Budget and Control Board.(Emphasis added).
>
> A. **Reconsideration by Third Party Claims Processor or Utilization Review Agency.** A Covered Person, after receipt of notification of the Third Party Claims Processor's or the Utilization Review Agency's action on his claim, must request a review of any benefits denied in whole or in part within six months of notice of the denial of benefits by the Third Party Claims Processor or the Utilization Review Agency. To request a review of that agency's decision, the Covered Person must write the appropriate agency giving reasons why the claim should be approved. The claimant may also request an expedited reconsideration of the decision denying benefits.
>
> The Third Party Claims Processor or the Utilization Review Agency shall render its decision within 60 days after the request for review is received, unless medical records are requested, in which case the decision will be rendered no later than 30 days after the requested information is received. If the requested information is not received within 30 days, the decision will be made on the information available at that time. The decision shall be made by one not involved in the original decision to deny benefits or pre-certification. The reconsideration under this section shall be exhausted before any appeal to the Plan Administrator. The Third Party Claims Processor or the Utilization Review Agency will send the Covered Person a written decision stating the specific reasons for its final decision with specific reference to pertinent Plan provisions.
>
> B. **Appeal of Denial of Benefits to Plan Administrator.** After the review provided in 12.5.A, a Covered Person, who is informed that the claim has been denied in whole or in part, or that benefits will not be paid, and who desires review of that determination, may request from the Plan Administrator's director a review of that decision within 90 days after

notice of the denial of benefits after reconsideration. The filing of an appeal shall be deemed to be consent for the director or his designee to review all medical records necessary for a determination of the appeal. To hear the appeal, the director may appoint up to five representatives, who are familiar with group health benefits and the State Health Plan and who have not been involved in the denial of benefits in the case under consideration.

The director, or his designees, may request from the Third Party Claims Processor information reviewed by it, including the pertinent medical records, and may request any additional information from the Third Party Claims Processor, the Utilization Review Agency or the claimant, or from independent medical personnel or other source as in their judgment may be required to make a determination. The director or his designees shall consider all information submitted, the terms and conditions of the Plan and shall render a decision within 30 days of the receipt of any requested material, providing reasons for the decision and citation of any applicable Plan provisions.

The director, or his designee, shall provide specific reasons for the decision and citation of the pertinent Plan provisions, and may, if the director or his designee agrees with the Third Party Claims Processor or Utilization Review Agency, deny the claim of the Covered Person, and if he agrees with the Covered Person, approve the claim or such portion as is appropriate, provided, however, the director, or his designee, must state in writing the provisions of the Plan justifying the result. The decision of the director, or his designee, on these matters is binding and conclusive, subject to review pursuant to 12.6.

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

12.6 Legal Actions

The exclusive remedy for the denial of benefits shall be as provided in 12.5 and by judicial review of that decision under 1976 S.C. Code Ann § 1-23-380, (as amended) as provided by statute. No appeal may be brought until a Covered Person has exhausted the review procedure set forth in 12.5, nor will such action be brought after the expiration of the applicable period for commencing such actions, following the occurrence giving rise to the action. Any construction or interpretation of the Plan, determination of eligibility, or any other decision arising under the Plan, or exercise of judgment or discretion given to the Plan Administrator by the Plan or Planholder, shall be binding and conclusive so long as the decisions of the Plan Administrator or its duly authorized agent are not arbitrary or capricious or in violation of applicable statutes. (Emphasis added).

12. The Insurance Benefits Guide ("IBG") to the State Health Plan additionally informs participants exactly how to pursue appeals under the State Health Plan. A true and correct copy of that portion of the applicable IBG addressing appeals is attached hereto as Exhibit D.

Robin E. Tester

Sworn to before me this
27th day of May, 2010

Notary Public for South Carolina
My Commission Expires: 6-25-2014

WILLS & MASSALON, LLC
ATTORNEYS AT LAW
Telephone: (843) 727-1144
Facsimile: (843) 727-7696

Post Office Box 859
Charleston, South Carolina 29402

134 Meeting Street, Suite 100
Charleston, South Carolina 29401

September 30, 2009

Blue Cross Blue Shield of South Carolina
State Health Plan - Appeal
P.O. Box 100605
Columbia, SC 29260-0605

Re: Appeal and Review / SC State Health Plan
Plan No: ZCS36961363
EOB Claim No: 8E2631250-00-00/Pending Appeal

To whom it may concern:

This letter is in regard to the pending appeal of the above referenced claim, which has been pending since February 2009. Due to a lack of contact by you or apparent resolution of the appeal, I called BCBS on August 14, 2009 and was informed that you had not received requested medical records, which your telephone representative was unable to specify, from MUSC. I contacted the records department at MUSC that same day and was informed that it had sent the records once and that it would send the records a second time.

On September 30, 2009, I called BCBS again to inquire about the status of this appeal and was informed that you were still waiting on the requested records from MUSC. I was informed that you needed " outpatient ER records" (despite there being no ER involved in the date of service). I have received no direct request by BC/BS, other than what I initiated through my telephone contacts, for the records or even that I complete a HIIPA form.

I have now received the complete set of records from MUSC for the diabetes mellitus insulin pump training session for my daughter who was 3 years old at the time, and enclose these records for your consideration.

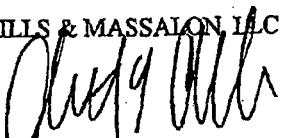
I am also enclosing a copy the South Carolina statute which requires Diabetes Mellitus coverage in health insurance polices. I have highlighted the provision which requires coverage for "outpatient self-management training and education for the treatment of people with diabetes mellitus (or commonly called Type I).

Thank you, and if there is any other information you require in order to resolve this

appeal, please let me know.

Sincerely,

WILLS & MASSALON, LLC



Christy Ford Allen

Enclosures

South Carolina

BlueCross BlueShield of South Carolina
I-20 at Alpine Road
Columbia, SC 29219-0001
803.788.0222

SouthCarolinaBlues.com

April 2, 2010

Jeffrey D. Allen

RE: Patient:
Insured: Jeffrey Allen
ID#: 36961363
Appeal: Claim #8E2631250
Group Plan: State Health Plan

Dear Mr. Allen:

The Appeals Review Committee (Committee) of BlueCross BlueShield of South Carolina (BCBSSC) met on March 25, 2010 to review your appeal of the above referenced claim. This is to notify you of our decision.

In reviewing your appeal, the following information was considered:

A. Letters of appeal dated September 30, 2009 and February 25, 2009 (including a copy of the South Carolina statute, S.C. Code §38-71-46) from Christy F. Allen; and web inquiry dated February 18, 2009;

B. Office notes dated August 5, 2008 from MUSC Health relating to the care and treatment of ; and pre-authorization request from Medtronic MiniMed dated July 9, 2008 for the Insulin Infusion Pump (including the certificate of medical necessity dated July 7, 2008);

C. Copy of the claim dated August 5, 2008 from Medical University Hospital and the related explanations of benefits (EOBs) dated August 27, 2008 and April 20, 2009;

D. Opinion of Ashby Jordan, M.D., Medical Director, BCBSSC dated March 15, 2010;

E. The Group Health Benefits Plan of the Employees of the State of South Carolina, the Public School Districts, and Participating Entities (the "Plan"), Article 9, Sections O and BB; and Article 7.

An Independent Licensee of the
Blue Cross and Blue Shield Association

F. Letter from Brooks Goodman, BCBSSC, to Mr. Allen dated March 19, 2010; and

G. South Carolina Code §38-71-46.

The Committee considered the following relevant provisions of the Plan:

ARTICLE 9. EXCLUSIONS AND LIMITATIONS

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

O. Any medical social services (except for those provided under the Hospice program and Home Health Care Program upon recommendation of the Utilization Review Agency), or vocational, visual, recreational, educational, or milieu therapy. (Emphasis added).

BB. Benefits will not be provided for services or supplies not specifically listed in Article 7, Schedule of Benefits, inclusive.

Based upon our review of the documents identified above, we regret to inform you that no benefits are payable for equipment training or diabetic educational services for the above referenced claim.

According to the Plan, Article 9, Section O, educational services are excluded, and are not covered benefits. Additionally, under Article 9, Section BB, education and training services are excluded because they are not specifically listed as a covered service under Article 7, Covered Medical Expenses. Article 7 does not specifically include diabetes education and training as a covered benefit.

Mr. Goodman's letter dated March 19, 2010, states that the South Carolina statute mandating coverage for diabetes education does not apply to the self-funded State Plan. The Committee agrees with Mr. Goodman, and finds that the statute does not apply to the Plan, and therefore does not apply to this appeal.

We regret that our decision was not favorable. We are sympathetic to 's individual situation; however, we are obligated to review claims consistent with the plain and ordinary meaning of the Plan. In doing so, we are fulfilling our duty as claims administrator to interpret the Plan.

Nothing in this letter should be construed as a waiver of any rights or defenses under the Plan. This determination has been made in good faith and without prejudice under the terms and conditions of the Plan, whether or not specifically mentioned herein.

Your appeal options to BCBSSC are now exhausted. If you wish to further pursue your appeal, you must appeal to the Employee Insurance Program in writing within 90 days of the date of this letter at the following address:

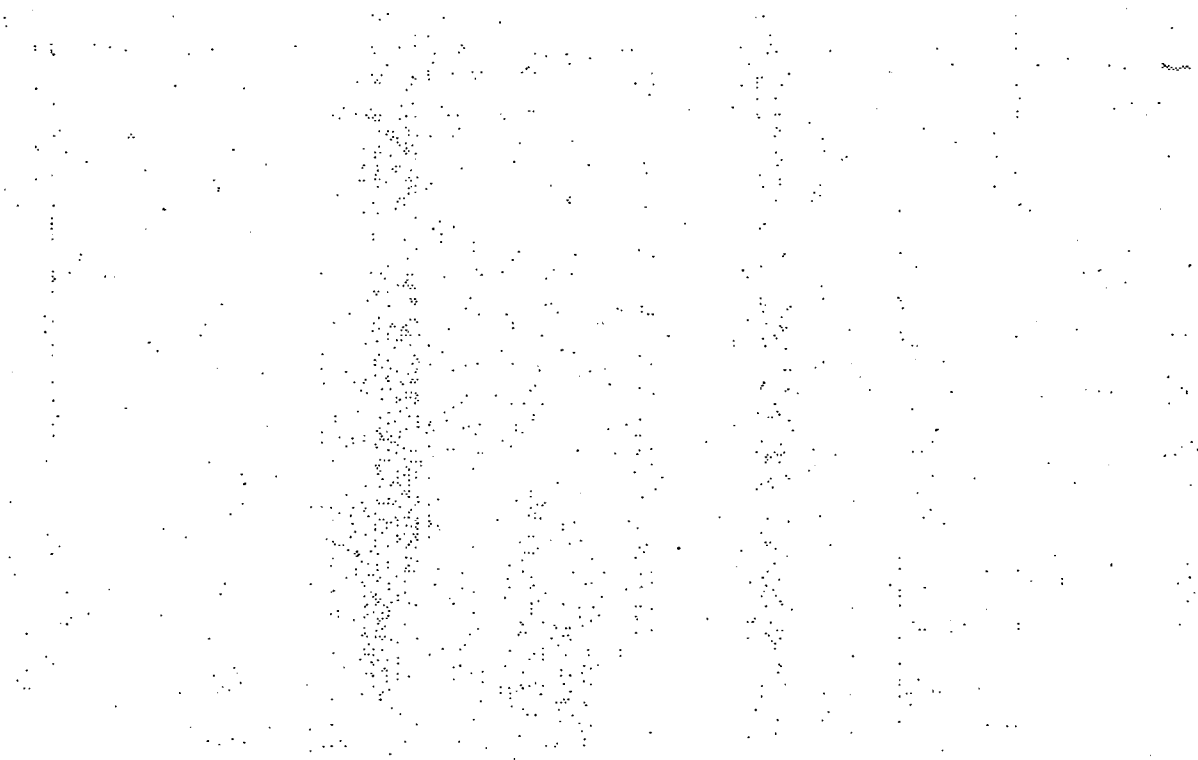
Appeals Coordinator
Employee Insurance Program
Post Office Box 11661
Columbia, South Carolina 29211

Sincerely,

Margie Benson
Appeals Review Committee Coordinator

cc:
Appeals Coordinator
Employee Insurance Program

John A. Massalon, Esq.
Wills & Massalon, LLC
P.O. Box 859
Charleston, SC 29402



ARTICLE 1.

ESTABLISHMENT AND PURPOSE OF PLAN

1.1 Name and Purpose

The name of this Plan is the Group Health Benefits Plan of the Employees of the State of South Carolina, the public school districts, and participating entities (hereinafter "Plan"). The State of South Carolina (hereinafter the State), through the Employee Insurance Program (EIP) has established a self-funded employee welfare benefit plan for the exclusive benefit of the participants and has adopted this Plan. The purpose of this Plan is to provide for the payment of sickness, accident, or other benefits to the participants of this Plan and their eligible dependents.

1.2 Establishment and Effective Date

This Plan is a continuation of and replaces the Health Benefits Plan initially established on July 1, 1972, and this Plan became effective January 1, 2009.

1.3 Applicable Law

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

1.4 Entire Plan

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

1.5 Plan Description

The Plan Administrator shall provide to Employees who are Covered Persons a summary plan description containing the benefits of this Plan and the rights and obligations of Covered Persons under this Plan.

1.6 Changes to Plan

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

1.7 Effect of Changes

All changes to this Plan shall become effective as of a date established by the Plan Administrator EXCEPT that:

A. No increase or reduction in benefits shall be effective with respect to Covered Expenses incurred prior to the date a material change was adopted by the Planholder, regardless of the effective date of the change; and,

B. No change shall become effective with respect to any Covered Person who was hospitalized on the effective date of such change until the date such person ceases to be hospitalized.

1.8 Termination of Plan

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

1.9 Written Notice

Any written notice required by law shall be deemed received by a Covered Employee if sent by regular mail, postage prepaid, to the last address of such Covered Employee on the records of the Plan Administrator.

1.10 Waiver

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

1.11 Clerical Error or Delay

Clerical errors made by EIP, or its agents, on the records of the Plan Administrator, Third Party Claims Processor or Utilization Review Agency, and delays in making entries on such records shall not invalidate coverage that otherwise would be validly in force or cause coverage to be in force or to continue in force which would otherwise be terminated. Upon discovery of any such error or delay, an equitable adjustment will be made not to exceed 12 months contribution by the Employee.

1.12 Workers' Compensation

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

1.13 Gender

The use of masculine pronouns in this Plan shall apply to persons of both sexes unless the context clearly indicates otherwise.

1.14 Headings

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

1.15 Misstatements and Omissions

If any relevant fact has been misstated or omitted, in whole or in part, whether intentional or not, by, or on behalf of, any person on an application, on the Notice of Election Form, or other document, or information submitted or required to be submitted to the Plan Administrator, Third Party Claims Processor or Utilization Review Agency to obtain or retain coverage under this Plan, the true facts shall be used to determine whether coverage is in force and the extent, if any, of such coverage. Upon the discovery of any such misstatement or omission, coverage may be terminated retroactively to the date of the misstatement or omission, and an equitable adjustment of any contributions will be made if this is in order and the Plan Administrator may recover the amount of any claims paid in error due to the misstatement or omission.

1.16 Use of Social Security Numbers on Application

The Plan is required by federal law to obtain the Social Security Account Number of each subscriber and dependent. The Employee's or the Retiree's Social Security Account Number, as well as the Benefits Identification Number (BIN), and address will be used as the identification number and address for the Dependents of the Employee or Retiree.

ARTICLE 2.

DEFINITIONS

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

2.1 Active Employee

A permanent, Full-Time Employee of the State, who receives compensation from a department, agency, board, commission or institution of the state or a public school district or a participating entity.

2.2 Active Employment

The Employee is performing all the regular duties of his occupation at an established business location of the Employer or another location to which he may be required to travel to perform the duties of his employment. An Employee shall be deemed to be engaged in Active Employment on holidays or vacation days established and published

by the Employer if the Employee was engaged in Active Employment on the last preceding regular working day. In no event will an Employee be considered to be in Active Employment if he has not reported for work or if he or his Employer has effectively terminated his employment.

2.3 Provider Billed Charges

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

2.4 Acute Medical Illness

A serious illness requiring immediate medical attention as directed by the Physician; an illness which could result in subsequent death and/or an emergency occurring at a time other than during normal office daytime hours of a licensed Physician.

2.5 Agent for Service of Process

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

2.6 Alcoholism

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

2.7 Alcoholism Treatment Center

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

2.8 Allowable Charge

A Provider's actual charge, or the amount established by the Plan Administrator in the Schedule of Reimbursement Rates for the Physician Network, whichever is less. For charges not included in the Schedule of Reimbursement Rates, the Allowable Charges shall mean an amount measured and determined by comparing it with the charges customarily made for similar services to individuals of similar medical condition in the locality concerned. In the absence of data referred to above, the Third Party Claims Processor, through its medical staff and/or medical consultants, will determine the Allowable Charge based upon comparable or similar services or procedures.

2.9 Alternative Treatment Plan

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

the treating Physician, the Plan Administrator and the patient, and notification of the approved Alternative Treatment Plan to the Third Party Claims Processor.

2.10 Ambulatory Surgical Center

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

A. It is established, equipped and operated in accordance with the applicable laws of the jurisdiction in which it is located primarily for the purpose of performing surgical procedures;

B. It is operated under the supervision of a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is devoting full time to such supervision and permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform such procedure in at least one Hospital, as defined in this Plan, in the area;

C. It requires in all cases, other than those requiring only local infiltration anesthetics, that a licensed anesthesiologist or a certified registered nurse anesthetist administer the anesthetics and remain present throughout the surgical procedure;

D. It provides at least two operating rooms and at least one post-anesthesia recovery room; is equipped to perform diagnostic x-ray and laboratory examinations; and has available, to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to a defibrillator, a tracheotomy set, and a blood bank or other blood supply;

E. It provides the full-time services of one or more registered graduate nurses (R.N.) for patient care in the operating rooms and in the post-anesthesia recovery room;

F. It maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications or require post-operative confinement;

G. It maintains an adequate medical record for each patient, such record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or x-rays, an operative report and a discharge summary.

2.11 Ambulatory Surgical Center Network

A group of ambulatory surgical centers, which have contracted with the Plan Administrator to accept from the State a payment methodology for medical services rendered by the Ambulatory Surgical Center to Covered Persons of the Plan.

2.12 Behavioral Health Disorders

Neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind or other condition that is defined, described or classified as a psychiatric disorder or condition in the latest publication of the American Psychiatric

Association entitled *Diagnostic and Statistical Manual of Mental Disorders*, or other similar authority generally recognized by Behavioral Health Providers, and which is not otherwise excluded by the terms and conditions of this Plan.

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

2.14 Behavioral Health Provider
A Physician, psychiatrist, health professional or any other entity or institutional health care provider under agreement to participate in a Behavioral Health Provider network administered by the Behavioral Health Manager.

2.15 Benefit Year
A period of 12 consecutive months commencing with the first day of January and ending with the last day of December.

2.16 Bodily Injury and Sickness
All bodily injuries sustained by an individual in connection with any one accident. The term "sickness" shall include covered pregnancy, as defined herein, disease, mental illness, and functional nervous disorder.

2.17 Child
An Employee's natural or adopted child, stepchild, foster child or child for whom the Employee has legal custody, and who resides in the Employee's home in a parent-child relationship, or for whom the Employee provides support and maintenance because of a Court order.

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

2.19 Coinsurance
That percentage of the Reasonable and Customary Charges for Covered Medical Expenses, in excess of the individual or family Deductible, that is payable by the Covered Employee under the Plan selected.

2.20 Congenital
Existing and apparent or manifest at, and usually before, birth.

2.21 Co-payment
A fixed amount established by the Plan payable by the Covered Employee for a service.

2.22 Covered Dependent
A Dependent of a Covered Employee, who has met the eligibility requirements and is

enrolled under the Plan and to whom benefits are payable under this Plan.

2.23 Covered Employee

An Employee or Retiree who has met the eligibility requirements and is enrolled under this Plan and to whom benefits are payable under this Plan.

2.24 Covered Hospital Services

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

2.25 Covered Medical Expense

The Market Charge or per diem rate, as determined by the Plan Administrator, for each Diagnosis Related Groups (DRG) category, or for those not included in a DRG category, a Reasonable and Customary expense, or where applicable under this Plan an Allowable Charge, for medical services and supplies Medically Necessary in the diagnosis or treatment of an illness or injury, performed and reimbursed in the least costly setting required by the Covered Person's condition, and which are within the benefits provided in the Plan and not otherwise excluded by any term, condition, limitation or exclusion of this Plan.

2.26 Covered Person

An Employee, Retiree, Surviving Dependent Child/Surviving Spouse, or COBRA enrollee, or a Dependent thereof, who has met the eligibility requirements and is enrolled in this Plan and to whom benefits are payable under this Plan.

2.27 Creditable Coverage

For purposes of applying the Pre-existing Condition exclusion, prior coverage under a group health plan or insurance coverage or health benefits provided by certain state and federal statutes, as described or defined in the Health Insurance Portability and Accountability Act of 1996 and regulations.

2.28 Custodial Care

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

2.29 Customary Charge or Reasonable and Customary Charge

The Market Charge as determined by the Plan Administrator for each DRG category. For other charges not included in a DRG category, the Customary Charge or Reasonable and Customary Charge shall mean an amount measured and determined by comparing it with the charges customarily made for similar services and supplies to

individuals of similar medical condition in the locality concerned. In the absence of data as referred to above, the Third Party Claims Processor will, through its medical staff and/or medical consultants, determine the Reasonable and Customary Charge based upon comparable or similar services or procedures.

2.30 Deductible

The amount indicated in 7.1.A.1, or 7.1.B.1 for the Plan selected during enrollment. In the event that two or more Covered Persons of one Family incur charges for Covered Medical Expenses as a result of injuries received in the same accident, only one Deductible amount will be deductible from the aggregate of all charges for Covered Medical Expenses which are incurred by all such Covered Persons as a result of injuries in the same accident.

2.31 Dependent

Shall mean and include a Covered Employee's:

A. Legally recognized spouse, or former spouse who is required to be covered by either a divorce decree or court order, but not both. Provided, however, that if a spouse is also eligible for coverage or benefits as an Employee of the State, school district or a participating entity, the spouse is eligible for coverage only as an Employee and not as a Dependent. However, a Part-Time Teacher who is the spouse of a Covered Employee may be covered as either an Employee or as a Dependent, but not as both;

B. Unmarried Child under 19 years of age, who is principally dependent (more than fifty percent) upon the Covered Employee for maintenance and support. The Plan Administrator may require the Covered Employee to submit due proof of the Dependent Child relationship with the Covered Employee within 31 days of enrollment, and at such other reasonable times;

C. Unmarried Child, over 19 years of age, who is incapable of self-sustaining employment because of mental illness, retardation or physical handicap and is principally dependent (more than fifty percent) on the Covered Employee for maintenance and support, provided that the Child was covered continuously under the Plan or a Predecessor Plan, prior to the date of incapacitation. The Plan Administrator may require the Covered Employee to submit due proof of such incapacity and dependency satisfactory to the Plan Administrator within 31 days of initial enrollment, upon attaining age 19 and at such other reasonable times, but not more frequently than annually. It shall be the Employee's responsibility to notify the Plan Administrator when the Child is no longer incapacitated;

D. Unmarried Child, over 19 years of age, but under 25 years of age, who is a Full-Time Student as defined in 2.45, and is principally dependent (more than fifty percent) upon the Covered Employee for maintenance and support. The Plan Administrator may require the Covered Employee to submit due proof of such Full-Time Student status and dependency satisfactory to the Plan Administrator within 31 days of enrollment, upon attaining age 19 and at such other reasonable times, but not more frequently than annually. It shall be the Employee's responsibility to

notify the Plan Administrator when the Child is no longer a Full-Time Student.

2.32 Diagnosis Related Groups (hereinafter "DRG")

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

2.33 Drug Abuse

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

2.34 Durable Medical Equipment

Any equipment which:

A. Can withstand repeated use; and

B. Is primarily and customarily used to serve a medical purpose; and

C. Is generally not useful to a person in the absence of illness or injury; and

D. Is appropriate for use in the home.

2.35 Effective Date

Shall mean:

A. With respect to the Plan, the date on which this Plan takes effect;

B. With respect to a Covered Person, the date on which such person is first covered under this Plan.

2.36 Eligible Expense

A Covered Medical Expense as that term is defined in the Plan.

2.37 Employee

A person employed by the State on a permanent and Full-Time basis who works continuously for more than one year, and who receives compensation from a department, agency, board, commission or institution of the State, including clerical and administrative employees of the General Assembly, and judges in the State courts. For purposes of this Plan, the term shall include other Employees that the General Assembly has made eligible for coverage by statute, including Employees of a school district, county, municipality, or other State-Covered Entity that has qualified for and is participating in coverage under the Plan. The members of the South Carolina General Assembly and elected members of the councils of participating counties or

municipalities, whose council members participate in the South Carolina Retirement Systems, and Part-Time Teachers, are also Employees for purposes of the Plan.

2.38 Employer

A department, agency, board, commission or institution of the State, including the General Assembly, the State courts and school districts and participating entities, that hire and provide compensation to an Employee.

2.39 Enrollment Date

For purposes of determining Creditable Coverage and applying the Pre-existing Condition exclusion, (1) for Employees, the hire date; (2) for persons who enroll under the special eligibility situations of paragraphs 3.7 and Late Entrants, the effective date of coverage; and (3) for Retirees, the retirement date.

2.40 Expense Incurred

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

2.41 Extended Role Nurse or Advanced Practice Registered Nurse

An individual who has satisfied the State Board of Nursing's requirements as a nurse practitioner, certified nurse midwife, certified registered nurse anesthetist or clinical nurse specialist, who is functioning in the extended or advanced practice registered nursing role, and who is in independent practice. The Plan only recognizes a certified nurse midwife licensed by the State Board of Nursing as a Provider for purposes of midwife coverage. A lay midwife or a midwife licensed by the Department of Health and Environmental Control (DHEC) is not recognized, or reimbursed, as a Provider, by the Plan.

2.42 Family

A Covered Employee and his Covered Dependents, if any.

2.43 Free Standing Emergency Care Center

An ambulatory facility designed as a place for acute medical treatment. The Free Standing Emergency Care Center includes a specialty facility for industrial accidents and a community based emergency care center provided that they are not designed to house or hospitalize patients after the initial acute treatment. The emergency room of a Hospital is not a Free Standing Emergency Care Center.

2.44 Full-Time

With regard to an Employee shall mean a permanent Employee who works at least 30 hours per week continuously for more than one year. Provided, however, an Employer may exercise a one-time, irrevocable option to elect the definition of Full-Time to mean at least 20 hours per week continuously for more than one year, and to apply this definition, upon notification and acceptance by EIP.

2.45 Full-Time Student

A Dependent Child who has not attained the age of 25 and is enrolled in and attending:

A. High school. Correspondence course participation does not constitute attendance as a Full-Time Student under this section; or

B. An accredited or licensed school, which is commonly recognized as a vocational, technical or trade school, if such scheduled attendance qualifies for Full-Time Student status under the rules of the institution. Correspondence course participation does not constitute attendance as a Full-Time Student under this section; or,

C. A college or university with such enrollment in at least enough regular academic courses to attain the status of a Full-Time Student at the institution. A time period between graduation from high school and college entry, or between college graduation and graduate school entry, shall be included only if such Child has made application for admission beginning with the next regular semester immediately following graduation. Time periods between semesters, such as summer periods shall be included if such Child was attending as a Full-Time Student during the immediately preceding regular semester, quarter or summer school session. Correspondence course participation does not constitute attendance as a Full-Time Student under this section.

Except as provided above, a Child shall cease to be a Dependent eligible for coverage as a Full-Time Student at 12 midnight on the last day of the month after: (1) attaining the age of 25; or (2) notice that the Child ceased being a Full-Time Student by not attending school for any reason other than injury or sickness which prevents the student from attending, provided such Child would otherwise be a Full-Time Student but for such injury or sickness; or (3) failure to provide evidence of Full-Time Student status as required by 2.31.D.

2.46 Health Care Professional

A Physician or other licensed health care provider acting within the scope of the license.

2.47 Home Health Care

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

2.48 Hospice

A private or public agency or organization that administers and provides care for terminally ill patients (1) pursuant to a written treatment plan approved by a Physician and reviewed at least once a month by the Physician, and (2) is licensed or certified as a Hospice or Hospice care agency by the appropriate state regulatory agency, if licensing is required.

2.49 Hospital

A. For other than a psychiatric facility, a short-term acute care (1) general Hospital, (2) children's Hospital, (3) eye, ear, nose and throat Hospital, or (4) maternity Hospital, licensed by the state in which it operates that, for compensation from its patients and on an inpatient basis, is primarily engaged in providing diagnostic and therapeutic facilities for the medical or surgical diagnosis and treatment of injured or sick persons, by or under the supervision of a staff of Physicians duly licensed to practice medicine, and that provides continuous 24 hours-a-day services by licensed, registered, graduate nurses physically present and on duty.

B. A psychiatric facility for the treatment of Behavioral Health Disorders, drug addiction or alcoholism for compensation from their patients and on an inpatient basis, and which is engaged in providing diagnostic and therapeutic care by or under the supervision of a staff of Physicians duly licensed to practice medicine to persons suffering from mental or nervous conditions or drug or alcohol dependency, and which provides continuous 24 hours-a-day services by licensed, registered, graduate nurses physically present and on duty. Such institutions or facilities for Behavioral Health Disorders, or drug addiction or alcoholism, if located in South Carolina must be licensed by the State of South Carolina and if located outside of South Carolina must be approved by the Joint Commission on Accreditation of Hospitals;

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

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

2.50 Hospital or Ambulatory Surgical Center Miscellaneous Charges

The Reasonable and Customary charges, or the Market Charge, where payment is by DRG category, for necessary services, medicines, supplies for diagnosis or treatment of an illness or injury (except services of a Physician and drugs or supplies not consumed or used in the Hospital) while the Covered Person is Hospital confined and a charge is made for Room and Board, or if such services are rendered in connection with a surgical procedure performed on an "outpatient" basis by a Hospital or Ambulatory Surgical Center.

2.51 Hospital Network

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

2.52 Intensive Care Unit

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

A. It is solely for the treatment of patients who require special medical attention because of their medical condition;

B. It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital;

C. It provides a concentration of special life-saving equipment immediately available at all times for the treatment of patients confined within such area;

D. It contains at least two beds for the accommodation of critically ill patients; and

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

2.53 Intermittent

As that term is used in 7.11 Hospice care and 7.13 Home Health Care services, shall mean part-time (less than, or up to, four hours) Skilled Nursing or Home Health care that is provided on a less than daily basis, or if provided on a daily basis (not to exceed eight hours per day), for temporary and definitely fixed periods of time up to 21 days with such extensions for additional fixed and definite periods of time that, at the discretion of the Plan Administrator, may be granted when there are exceptional circumstances and the period of such extension is predictable and fixed. Intermittent care is subject to the requirements of pre-approval by the Utilization Review Agency, and all monetary limitations on such benefits in 7.11 Hospice Care and 7.13 Home Health Care services.

2.54 Late Entrant

A Full-Time Employee, and any Dependent of that Employee, as those terms are defined in the Plan, who did not enroll, or was not enrolled, within 31 days of that person's first date of eligibility for enrollment in a plan of benefits offered by the State, and who subsequently enrolls in the Plan. A Late Entrant is subject to the Preexisting Condition exclusion for 18 months after coverage commences. Provided, however, that any person who qualifies for enrollment under the special eligibility situations of paragraph 3.7, and meets the requirements thereof or who becomes eligible for retirement under the South Carolina Retirement Systems, shall not be considered a Late Entrant if enrolled or re-enrolled in the Plan within the time period provided by the Plan.

2.55 Market

The aggregation of peer group hospitals based on criteria established by the Plan

Administrator.

2.56 Market Charge

The amount determined by the Plan Administrator to be the prevailing charge for a specific DRG category within a specified market.

2.57 Medical Care

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

2.58 Medical Necessity; Medically Necessary or Necessary Service and Supply

A procedure, service or supply that meets all of the following criteria:

A. Is required to identify or treat an existing condition, illness or injury; and

B. Is prescribed or ordered by a Physician; and

C. Is consistent for treatment of the Covered Person's illness, injury, or condition, and is rendered in accordance with recognized, appropriate medical and surgical practices prevailing in the medical specialty or field of medicine at the time rendered; and

D. Is required for reasons other than the convenience of the patient; and

E. Results in measurable, identifiable progress in treating the Covered Person's condition, illness, or injury.

The fact that a service or supply is prescribed by a Physician, or that a Physician asserts that a procedure, service or supply is necessary to avoid the potential onset of a condition or abnormality in the future, does not necessarily mean that such service is Medically Necessary or meets the definition of Medical Necessity in this Plan.

2.59 Obstetrical Care

Services for the prenatal and postpartum care and delivery of one or more fetuses including Cesarean section, miscarriage, or abortion.

2.60 Open Enrollment Period

A period in which eligible Employees and Retirees may enroll or disenroll themselves and/or eligible Dependents in the Program without regard to any special eligibility situations. An Open Enrollment was held in October 2007, for a January 1, 2008, effective date of coverage. An Open Enrollment period will be held in October every two years thereafter. Changes made during the Open Enrollment Period will become effective the following January 1.

2.61 Orthopedic Appliance

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

2.62 Outpatient
A Covered Person who is treated at a Hospital and is not confined for the Room and Board charge.

2.63 Out-of-Pocket Limitation
For Covered Medical and Behavioral Health Expenses, the total of the eligible coinsurance payable by the Covered Employee in one Plan Year for individual or family Covered Medical and Behavioral Health Expenses, in excess of the individual or family Deductible, before the Plan provides coverage for 100 percent of the Reasonable and Customary Charges for Covered Medical Expenses and Behavioral Health Expenses; for covered prescription drug expenses, shall mean the total of the eligible co-payments payable by a Covered Person in one Plan Year for covered prescription drug expenses before the Plan provides coverage for 100 percent of the Allowable Charges for covered prescription drug expenses.

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

2.65 Part-Time Teacher
A teacher employed by a school district, the South Carolina Department of Corrections, or the South Carolina Department of Juvenile Justice, on a permanent and part-time basis working at least 15, but no more than 29, hours a week continuously for more than one year.

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

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

2.68 Physician Network
Those health care providers who have contracted with the Plan Administrator or Third Party Claims Processor to accept from the State a standard payment methodology for their services rendered to Employees, Retirees and their Dependents.

2.69 Plan
This Group Health Benefits Plan for the Employees of the State of South Carolina, the Public School Districts and Participating Entities. The Plan is composed of the Savings

Plan, the Standard Plan and the Medicare Supplemental Plan.

2.70 Planholder

The State of South Carolina, which provides the health plan for its Full-Time Employees, Retirees and others by statute through the Employee Insurance Program acting on behalf of the State Budget and Control Board.

2.71 Plan Administrator

The Employee Insurance Program of the State Budget and Control Board.

2.72 Plan Year

The 12-month period of time beginning January 1 and ending December 31, 2009.

2.73 Predecessor Plan

(1) The Employee Health Benefit Plan of the State that was in effect immediately before the effective date of this Plan or (2), prior coverage in which a Covered Person was enrolled immediately prior to enrollment in this Plan, which qualifies as Creditable Coverage, pursuant to the Health Insurance Portability and Accountability Act of 1996.

2.74 Pre-Certification or Certification

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

2.75 Pre-existing Condition

Any medical condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended by, or received from, a licensed health care provider or practitioner in the six months preceding the Covered Person's Enrollment Date under the Plan. Benefits for a pre-existing condition are payable only for treatment rendered 12 months after the Enrollment Date of a Covered Person, or 18 months after the Enrollment Date for a Late Entrant; provided, however, that Creditable Coverage without a break in coverage of greater than 62 days prior to the Enrollment Date is applied toward the waiting period for services related to a pre-existing condition to be payable. Pregnancy does not constitute a pre-existing condition.

2.76 Prescription Drug Program

The network of pharmacies that have agreed to accept a standard payment methodology for prescription drugs, provide drug utilization review of the appropriateness of the medication and its use, provide a drug formulary consisting of Tier 2 drugs obtainable at lower cost, and the Pharmacy Benefits Manager which processes drug claims and coordinates the activities of the Prescription Drug Program.

2.77 Professional Ambulance

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

2.78 Program

The Medical Benefits program provided for the Employees of the State of South Carolina, the Public School Districts, and Participating Entities, including the Plan, and participating Health Maintenance Organization (HMO) plans. Covered Employees shall have the option annually, during the month of October, of changing plans offered as part of the Program. Changes made during the October enrollment period become effective the following January 1.

2.79 Prosthetic Appliance

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

2.80 Provider

A Physician, Extended Role Nurse, Advanced Practice Registered Nurse, Behavioral Health Provider or Hospital as those terms are defined in this Plan.

2.81 Allowed Amount

The Market Charge as determined by the Plan Administrator for each DRG category. For other charges not included in a DRG category, the Customary or Reasonable and Customary Charge shall mean an amount measured and determined by comparing it with the charges customarily made for similar services and supplies to individuals of similar medical condition in the locality concerned. In the absence of data as referred to above, the Third Party Claims Processor will, through its medical staff and/or medical consultants, determine the Reasonable and Customary Charge based upon comparable or similar services or procedures.

2.82 Retiree

An Employee who is retired under the terms and conditions of the State Retirement Systems and meets one or more of the following eligibility requirements in order to participate in the State's Plan of Benefits. For employees who were hired before May 2, 2008, an eligible retiree shall be defined as:

A. A person covered by the Plan who terminates employment with at least 20 years of earned service credit with a State-Covered Entity before eligibility for retirement under a State retirement system is eligible for the Plan effective with the date of retirement under a State retirement system, if the last five years are consecutive and in a Full-Time, permanent position with a State-Covered Entity. Provided, however, that a person covered by the Plan who terminated employment with at least 18 years earned service credit with a State-Covered Entity before eligibility for retirement under a State retirement system prior to 1990 is eligible for the Plan effective on the date of retirement, if this person returns to a State-Covered Entity and is covered by the Plan and completes at least two consecutive years in a full-time permanent position prior to the date of retirement.

B. A member of the General Assembly, who leaves office or retires with at least eight years of credited service in the General Assembly Retirement System, is eligible to

participate in the Plan by paying the full premium costs as determined by the State Budget and Control Board.

C. Former municipal and county council members, who have served on council for at least 12 years and were covered under the State's plans at the time of termination from council, are eligible to continue the state insurance benefits by paying full premium costs, provided the county or municipal council elects to allow this coverage for former members.

D. An Active Employee covered by the Plan and retiring with 10 or more years of State-Covered Entity service credited under a State retirement system is eligible for state-paid premiums, if the last five years of service are consecutive and in a Full-Time permanent position with a State-Covered Entity. Special conditions apply to the following:

1. A person covered by the Plan, who has attained the age of 55, has at least 25 years of credited service under a State-Covered Entity and elects early retirement must pay the full premium costs as determined by the State Budget and Control Board until the earlier of attaining age 60 or the date the person would have 28 years' creditable service if early retirement had not occurred.

2. A person covered by the Plan, who has at least 25 years credited service under a State-Covered Entity, and who purchases up to three years of additional service credit under the "Special Monthly Contributor Provision" and retires, shall pay the full premium costs as determined by the State Budget and Control Board for the service credit purchased.

E. A person covered by the Plan who retires with at least five years of service with a State-Covered Entity credited under a State retirement system is eligible to participate in the Plan by paying the full premium costs as determined by the State Budget and Control Board, provided the last five years are consecutive and in a Full-Time permanent position with a State-Covered Entity.

F. All Employees of State-Covered Entities whose most recent hire date was before July 1, 1984, who were or would have been eligible for the Plan upon completion of five years of service are exempt from the provisions of this section and are eligible for the Plan, effective on the date of their retirement, provided the last five years are consecutive and in a Full-Time permanent position with a State-Covered Entity.

G. Those Retirees, who by the terms of their retirement, are covered by the Plan but are not receiving any State contribution to their premium for health insurance.

For employees hired on or after May 2, 2008, an eligible retiree shall be defined as:

A. An active employee covered by the Plan, who retires with at least five (5) years of earned retirement service credit under a State retirement system with a State-Covered Entity, is eligible to participate as a retiree in the Plan if the last five (5)

years of the person's covered employment were consecutive and in a full-time permanent position.

B. A person covered by the Plan who terminates employment before the person's date of retirement with at least twenty (20) years of earned retirement service credit under a State retirement system with a State-Covered Entity is eligible to participate as a retiree in the Plan on the person's date of retirement under a State retirement system, if the last five (5) years of the person's covered employment before termination were consecutive and in a full-time permanent position.

C. A retired state employee or a retired employee of a public school district who retires under a State retirement system and who is eligible for Plan coverage under the provisions of item (A) or (B) of this section, is eligible for trust fund paid premiums as follows:

(a) If the retiree's earned service credit in a State retirement system is five (5) or more years but fewer than fifteen (15) years with a State-Covered Entity, then the retiree shall pay the full premium for the Plan.

(b) If the retiree's earned service credit in a State retirement system is more than fifteen (15) years, but fewer than twenty-five (25) years with a State-Covered Entity, then the retiree is eligible for fifty percent trust fund paid premiums and the retiree shall pay the remainder of the premium cost.

(c) If the retiree's earned service credit in a State retirement system is twenty-five (25) or more years with a State-Covered Entity, then the retiree is eligible for trust fund paid premiums and the retiree is responsible for the entire employee premium.

D. If a retiree under a State retirement system was employed by an entity that participates in the Plan pursuant to the provisions of Section 1-11-720 and is eligible to participate in the Plan as a retiree pursuant to the provisions of item (A) or (B) of this section, then the retiree's employer, at its discretion, may elect to pay all or a portion of the premium for the retiree's Plan.

E. Those Retirees, who by the terms of their retirement, are covered by the Plan but are not receiving any state contribution to their premium for health insurance.

2.83 Room and Board

Room, board, general duty nursing, and any other services, supplies, or items regularly furnished by the Hospital and included in the total charge as a condition of occupancy of the class of accommodations occupied, including blood. Room and board does not include professional services of Physicians or intensive nursing care by whatever name called.

2.84 Schedule of Reimbursement Rates

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

2.85 Second Opinion

A second opinion shall mean and consist of the Covered Person obtaining a second opinion from a qualified Physician regarding the Medical Necessity of a recommended, elective, non-emergency surgical procedure, medical procedure or treatment or hospitalization for treatment of mental illness or chemical dependency prior to undergoing or continuing the treatment, hospitalization or procedure.

2.86 Semi-Private Room

A Hospital room containing two or more patient beds.

2.87 Significant Break in Creditable Coverage

For purposes of applying the Pre-existing Condition limitation, a period of 63 consecutive days during which the individual does not have any Creditable Coverage, except that neither a waiting period, nor an affiliation period, is taken into account in determining a Significant Break in Creditable Coverage.

2.88 Skilled Nursing Care

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

2.89 Skilled Nursing Facility

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

A. Maintains permanent and full-time facilities for bed care of resident patients; and

B. Has available at all times the services of a Physician; and

C. Has a registered nurse (R.N.) or Physician on full-time duty in charge of patient care, and one or more registered nurses (R.N.) or licensed practical nurses (L.P.N.) on duty at all times; and

D. Maintains a daily medical record for each patient; and

E. Is primarily engaged in providing continuous skilled nursing care for sick or injured persons during the convalescent stage of their illness or injuries and is not, other than incidentally, a rest home or a home for custodial care or for the aged; and

F. Is operating lawfully as a nursing home in the jurisdiction where it is located; in no event, however, shall such term include an institution or facility primarily engaged in the care or treatment of substance abuse or Alcoholism.

2.90 State-Covered Entity

Any State agency, public school district, or any other entity granted by statute the right to

participate in the Plan and participating in the Plan.

2.91 Subscriber

An Active or Retired Employee, Surviving Dependent Child/Surviving Spouse or COBRA enrollee of a State-Covered Entity.

2.92 Surgery

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

2.93 Surviving Dependent Child

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

2.94 Surviving Spouse

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

2.95 Third Party Claims Processor

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

2.96 Transplant Network

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

2.97 Utilization Review Agency

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

ARTICLE 3.

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

3.1 Eligibility

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

A. All Full-Time Employees, as defined in 2.37 and 2.44, and their Dependents, as defined in 2.31, provided however, that a spouse or a child of a Covered Employee who is also an Employee may be covered only as an Employee and not as a Dependent.

B. All Full-Time Employees who are on leave without pay status or disabled but not retired status, and their Dependents, as defined in 2.31, for up to one year. The Employer may apply to the Plan Administrator to extend leave without pay status for an Employee beyond one year with demonstration of extraordinary circumstances. The Plan Administrator shall have the sole discretion to determine if leave without pay status may be extended beyond one year;

C. All Retirees, as defined in 2.82, and their Dependents, as defined in 2.31;

D. The Surviving Spouse, as defined in 2.94, and Covered Dependent Child, as defined in 2.31, of a deceased Covered Employee, as defined in 2.23 and 2.93;

E. All Employees and Dependents eligible for coverage as the result of COBRA in Article 11;

F. All Part-Time Teachers, as defined in 2.65, and their Dependents, as defined in 2.31, provided however, that a Part-Time Teacher who is the Spouse of a Covered Employee who is an Employee may be covered as either an Employee or as a Dependent, but not as both.

3.2 Employee Enrollment

To enroll under this Plan, each eligible Employee must complete within 31 days of his eligibility for coverage: (1) a Notice of Election, and (2) any other forms required by the Plan Administrator. If the Employee fails to complete such timely Notice of Election, payroll deduction authorization form, and other required forms within 31 days following the Employee's eligibility date, and such Employee is not eligible for coverage under 3.7,

Special Eligibility Situations, such Employee may be enrolled for coverage only during such Open Enrollment Periods as may be established by the Plan Administrator.

3.3 Commencement of Employee Coverage

Employee coverage under this Plan shall commence as follows:

A. Each Employee in Active Employment, who did not elect coverage under this Plan or a State approved Health Maintenance Organization (HMO) plan when first eligible and subsequently elects coverage under this Plan as a Late Entrant by filing a timely Notice of Election form during an Open Enrollment Period and satisfying the other conditions, shall be covered under this Plan on the subsequent January 1, provided that the Employee is on Active Employment on the first working day of that month. Otherwise, coverage commences on the first day of the following month;

B. Each new Employee, who becomes eligible for coverage after the Effective Date of this Plan, and who has elected coverage by filing a timely Notice of Election, shall be covered under this Plan (1) on the first day of the month that the Employee commences Active Employment provided that the Employee commences Active Employment on the first calendar day of that month; or (2) on the first day of the following month provided that the Employee commences Active Employment on any day other than the first calendar day and the first working day of the month. Otherwise, if the Employee commences Active Employment on the first working day of the month, other than the first calendar day of the month, the Employee may choose to commence coverage under this Plan on either the first day of that month or the first day of the following month.

For purposes of this paragraph, the first working day of the month is the first day that is not a Saturday, Sunday, or holiday. The first working day of the month is not an Employer-specific first working day.

3.4 Eligibility for Dependent Coverage

Each Employee, who has one or more Dependents on the date he becomes eligible for coverage, shall be eligible to enroll for Dependent Coverage on such date. Each Employee without a Dependent on the date he becomes eligible for coverage shall be eligible to enroll each Dependent for coverage on the date he acquires a Dependent, provided in both cases the Employee has met the requirements of 3.5 below.

3.5 Dependent Enrollment

To obtain Dependent Coverage under this Plan, each eligible Employee must: (1) be covered under this Plan, (2) file a timely Notice of Election form selecting Dependent Coverage for eligible Dependents and (3) agree in writing to make any required contributions toward the cost of the Dependents' coverage prior to his eligibility date. If the Employee acquires a Dependent as defined herein after the Effective Date of his coverage, the Employee has 31 days from the date the Dependent was acquired to enroll the Dependents in this Plan. If the Employee fails to notify the Plan Administrator within the 31-day period of time, the Dependent may be enrolled for coverage only

during such Open Enrollment periods under such conditions as may be established by the Plan Administrator.

3.6 Commencement for Dependent Coverage

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

3.7 Special Eligibility Situations

A. The spouse of an Employee, who was covered as an Employee under another employer's health plan, and any Dependent covered under the spouse's plan including the Employee, who subsequently loses coverage because that employer canceled its present group insurance, the employer canceled its contribution to its group insurance, or the spouse of the employee left such employment, is eligible for coverage under this Plan commencing on the date of loss of coverage, provided that a satisfactory statement of the circumstances surrounding the loss of coverage accompanies the revised Notice of Election.

B. An Employee, and any Dependent of an Employee, who loses coverage as a Dependent under another employer's health plan as the result of separation or divorce or other similar involuntary loss of coverage, is eligible for coverage under this Plan commencing on the date of loss of coverage provided that a satisfactory statement of the circumstances surrounding the loss of coverage accompanies the Notice of Election.

C. Coverage under the special eligibility situations in Paragraph A and B above commences upon the date of loss of the earlier coverage, and those eligible under Paragraph A and B are not considered Late Entrants, provided that such persons comply with the requirements of sections 3.2 and 3.5 within 31 days of the loss of coverage.

D. An Employee, and any Dependent of an Employee, who was called to active duty with the National Guard or a Reserve unit, or who was mobilized and who dropped coverage under this Plan or under an HMO offered by the State as an alternative to this Plan, upon discharge or release from active duty and resumption of employment with an eligible Employer, may re-enroll in this Plan. The time period for exclusions based upon pre-existing condition commences upon the original date of employment, and not the date of re-employment.

E. Notwithstanding any other provisions, an Employee may enroll for coverage for the Employee and all eligible Dependents provided that (1) the Employee is eligible for coverage under the Plan but is not currently enrolled; (2) the Employee declined coverage under the Plan when it was offered previously; (3) another individual (a spouse or child) has become a Dependent of the Employee through marriage, birth, adoption or placement for adoption; and (4) the request for enrollment is made within 31 days of the events described in (3) above. Coverage for the

Employee and any Dependent enrolled under this paragraph shall commence on the day of the qualifying event.

3.8 Termination of Employee's Coverage

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

A. Termination of the Employee's employment;

B. The date the Employee ceases to qualify as an Employee;

C. The date the Employee ceases to be in a class of Employees eligible for coverage;

D. Sixty days from the date that the Employee's contribution for coverage is due;

E. The date coverage is discontinued with respect to the class of Employees to which such Employee belongs;

F. The date this Plan is terminated with respect to all Employees;

G. Provided, however, that when an Employee requests the termination of coverage during the Open Enrollment period, coverage will terminate at midnight the following December 31st;

H. Provided, however, that coverage of an Employee ceases on the day following the date of death of the Employee.

3.9 Termination of Dependent's Coverage

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

A. The date the Employee ceases to be in a class of Employees eligible for Dependent coverage under this Plan;

B. The date all Dependent coverage under this Plan terminates;

C. Sixty days from the date that the Employee's contribution for coverage is due;

D. The date that any particular Dependent ceases to be a Dependent of the Employee as defined in 2.31. The existing coverage of any Surviving Dependent Child will not be affected by the remarriage of the Surviving Spouse;

E. The 31st day after the date of birth of a newborn, unless the Employee has enrolled the newborn as required by paragraph 3.5, or under such conditions as established by the Planholder;

F. Provided, however, that when an Employee requests the termination of dependent coverage during the Open Enrollment period, coverage will terminate at midnight the following December 31st;

G. Provided, however, that coverage of a Dependent ceases on the day following the date of death of the Dependent or the Employee, however after death of the Employee, coverage of the Dependent may continue under Article 10, Continuation of Coverage, or Article 11 COBRA.

3.10 Effect of Divorce or Annulment on Dependent Eligibility

A former Dependent Child of an Employee or Retiree, whose coverage terminated upon the Child's marriage, shall again be eligible for coverage upon the Child's divorce or annulment, if the conditions of paragraph 2.31 B, C, or D are met.

3.11 Retiree Enrollment

A. An Employee, who is covered under this Plan or an HMO approved by the State as an alternative to this Plan, at the time he elects retirement, may elect coverage under this Plan as a Retiree by completing within 31 days of eligibility for coverage: (1) Notice of Election, and (2) any other forms required by the Plan Administrator. If the Employee fails to complete such Notice of Election, retirement check authorization form, and other required forms within 31 days following the Employee's eligibility date, such Employee may be enrolled for coverage only during such Open Enrollment periods as may be established by the Plan Administrator.

B. An Employee, who is not covered by this Plan or an HMO approved by the State as an alternative to this Plan, at the time he elects retirement, may enroll as a Retiree by completing within 31 days of eligibility for coverage as a Retiree: (1) Notice of Election, and (2) any other forms required by the Plan Administrator. If the Employee fails to complete such Notice of Election, retirement check deduction authorization form, and other required forms within 31 days following the Employee's eligibility date, such Employee may be enrolled for coverage only during such Open Enrollment periods as may be established by the Plan Administrator.

C. Medicare Supplemental Plan Open Enrollment was held in October 2007 for an effective date of coverage on January 1, 2008. An Open Enrollment period will be held every two years thereafter. During the enrollment period, the eligible Retiree may change from or to the Medicare Supplemental coverage. Coverage changes will become effective the following January 1.

3.12 Enrollment of Dependents of the Retiree

A. A Dependent of an Employee, who is covered under this Plan or an HMO approved by the State as an alternative to this Plan, at the time the Employee elects retirement, and any Dependent acquired after retirement, may be covered

as the Dependent of a Retiree under this Plan provided that the Employee/ Retiree completes within 31 days of eligibility for coverage as a Retiree, or the date the Dependent was acquired after retirement: (1) Notice of Election, and (2) any other forms required by the Plan Administrator. If the Employee fails to complete such Notice of Election and other required forms within 31 days following the Employee's eligibility date, the Dependent may be enrolled for coverage only during such Open Enrollment periods as may be established by the Plan Administrator.

B. A Dependent of an Employee, who is not covered by this Plan or an HMO approved by the State as an alternative to this Plan, at the time the Employee elects retirement, may be enrolled as the Dependent of a Retiree by completing within 31 days of the Employee's eligibility for coverage as a Retiree: (1) Notice of Election, and (2) any other forms required by the Plan Administrator. If the Employee fails to complete such Notice of Election, retirement check deduction authorization form, and other required forms within 31 days following the Employee's eligibility date, the Dependent may be enrolled for coverage only during such Open Enrollment periods as may be established by the Plan Administrator.

C. A Medicare Supplemental Plan Open Enrollment was held in October 2007 for an effective date of coverage on January 1, 2008. An Open Enrollment period will be held every two years thereafter. During the enrollment period, the eligible Retiree may change from or to the Medicare Supplemental coverage. Coverage changes will become effective the following January 1.

3.13 Open Enrollment

An Open Enrollment Period was held in October 2007 for an effective date of coverage on January 1, 2008. An Open Enrollment Period will be held during the month of October every two years thereafter. During the Open Enrollment Period, the eligible subscriber is given an opportunity to add or drop themselves or eligible dependents to or from coverage. Changes made during the Open Enrollment Period will become effective the following January 1. No other coverage changes may be made until the next Open Enrollment Period except in situations described in paragraph 3.7, Special Eligibility Situations, or the following:

1. Dependent Children:

A. May be added within 31 days of birth, adoption or legal custody;

B. May be added within 31 days of when they are no longer covered under other group insurance because the employer discontinued such insurance, the employer canceled its contribution to its group insurance, or the parent lost coverage due to employment termination, and provided that proof of loss of coverage is supplied;

C. May be added within 31 days of when they are acquired by marriage, so long as they are living in a parent-child relationship with the Employee or Retiree;

D. Must be dropped when dependency ends at age 19, unless approved as an incapacitated dependent, or unless proof of Full-Time Student status is provided for dependents age 19 through 24;

E. Must be dropped at age 25 and older (regardless of whether a Full-Time Student) unless approved as an incapacitated dependent;

F. Must be dropped upon marriage of the Dependent, upon full-time employment of the Dependent, or when the Dependent is no longer principally dependent (more than fifty percent); upon the Employee or Retiree.

G. May be dropped within 31 days of acquisition of other group coverage, provided proof of such coverage is established.

2. Dependent Spouse:

A. May be added within 31 days of marriage; or

B. May be added within 31 days of loss of coverage because such group insurance was discontinued by the employer, the employer canceled its contribution to its group insurance, or employment was terminated, and provided that proof of loss of coverage is supplied;

C. Must be dropped from Dependent status when they are eligible to enroll as a State Employee or Retiree;

D. May be dropped within 31 days of when they are divorced or legally separated; or

E. May be dropped within 31 days of acquisition of other group coverage, provided proof of such coverage is established.

3. A Covered Employee or Retiree may select coverage under the Plan or a Participating HMO within the Program annually during the month of October.

3.14 Commencement of Coverage for Retiree and Dependents

Retirees and Dependents, who are Covered Persons under this Plan or an HMO approved by the State as an alternative to this Plan, at the time of the retirement of the Employee, and who are re-enrolled as Covered Persons at the time of retirement, remain covered under this Plan. Retirees and Dependents, who are not Covered Persons under this Plan or an HMO approved by the State as an alternative to this Plan, at the time of the retirement of the Employee, and who are enrolled in this Plan at the time of retirement, shall be covered on the first day of the month following the approval of the application for enrollment as a Retiree or Dependent under this Plan. A Dependent who is acquired after retirement, and enrolled within 31 days of the date the Dependent is acquired, shall be covered from the date the Dependent was acquired. A Retiree, not otherwise eligible for coverage as a Retiree, who is approved for disability benefits through the South Carolina Retirement Systems (SCRS), shall have the

coverage under the Plan commence no earlier than the first day of the month following SCRS' approval of the disability.

3.15 Termination of Retiree's Coverage

Except as provided in Article 10, Continuation of Coverage, or Article 11, COBRA, the coverage of a Retiree shall cease as of midnight on the last day of the month following:

A. The date the Retiree ceases to be in a class of Retirees eligible for coverage under this Plan;

B. The date the Retiree ceases to be in a class eligible for coverage;

C. Sixty days from the date the Retiree fails to make the required contribution for coverage;

D. The date coverage is discontinued with respect to the class of Retiree to which such Retiree belongs;

E. The date this Plan is terminated with respect to all Retirees;

F. Provided, however, that when a retiree requests the termination of coverage during the Open Enrollment period, coverage will terminate at midnight the following December 31st.

G. Provided, however, that coverage of a Retiree ceases on the day following the date of death of the Retiree.

3.16 Termination of Coverage of Dependent of Retiree

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

A. The date the Retiree ceases to be in a class of Employees eligible for Dependent coverage under this Plan;
B. The date all Dependent coverage under this Plan terminates;

C. Sixty days from the date that the Retiree's contribution for coverage is due;

D. The date that any particular Dependent ceases to be a Dependent of the Employee as defined in 2.31. The existing coverage of any Surviving Dependent Child will not be affected by the remarriage of the Surviving Spouse;

E. Provided, however, that when an Retiree requests the termination of dependent coverage during the Open Enrollment period, coverage will terminate at midnight the following December 31st;

F. Provided, however, that coverage of a Dependent ceases on the day following the date of death of the Dependent or the Retiree. However, after death of the Retiree,

coverage of the Dependent may continue under Article 10, Continuation of Coverage, or Article 11, COBRA.

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

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

ARTICLE 4.

PAYMENT OR REIMBURSEMENT OF MEDICAL EXPENSES

4.1 Payment for Medical Care

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

4.2 Changes to Plan

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

ARTICLE 5.

CONTRIBUTIONS

5.1 Employee Contribution

To be covered under this Plan, each eligible Active Employee or Retiree shall contribute the amount determined by the State for each Plan Year for the benefit plan the Employee selects, commencing with the pay period in which coverage starts under this Plan. Each eligible Employee or Retiree, who elects to have his Dependents covered under this Plan, shall contribute the amount determined for each Plan Year by the State for the benefit plan the Employee selects commencing with the pay period in which such Dependents' coverage starts. The Plan Administrator reserves the right at any time to alter, amend, change, supplement, revoke or reduce the benefits under this Plan or increase or decrease the premiums charged under this Plan.

5.2 Contribution of Entire Premium

To be covered under this Plan, the following persons eligible for coverage shall contribute the full amount of the premium determined for each Plan Year by the State for the type of coverage selected, commencing with the period in which the person elects coverage In the categories listed below. These individuals are not eligible to receive any State contribution for health insurance:

A. Full-Time Employees who elect leave-without-pay status;

B. A Surviving Spouse (excluding a Spouse who is a State Employee) and eligible Dependents of a deceased Active or Retired Employee who elect coverage under Article 10, Continuation of Coverage, provided, however:

1. The full premium for coverage for the Surviving Spouse (who is not a State Employee) and/or Dependent of a deceased Active or Retired Employee, who elected coverage under the Savings Plan, the Standard Plan or the Medicare Supplemental Plan and for which there was a State contribution to the premium is waived for one year after the Active or Retired Employee's death; and

2. Provided, however, that following the one-year waiver, the premium for coverage for the Surviving Spouse and/or Dependent of a deceased Active or Retired Employee who was killed in the line of duty after December 31, 2001, and while working for a State-Covered Entity; for whom there was a state contribution to the premium, may contribute the amount determined under 5.1 as long as eligible.

C. Those electing to extend coverage as provided in Article 11 under COBRA;

D. Those hired on or after July 1, 1984, and who retired with five years, but less than 10 years, active service;

E. Those Retirees who, by the terms of their retirement, are covered by the Plan but are not receiving any State contribution to their premium for health insurance.

ARTICLE 6.

DUTIES AND RESPONSIBILITIES

6.1 Planholder Duties

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

A. The appointment or removal of the Plan Administrator, Third Party Claims Processor, Utilization Review Agency and other entities or their delegates that implement the Plan;

B. The design of this Plan, including the right to amend this Plan and any other document relating to this Plan;

C. The qualification of this Plan under the applicable law;

D. The formation and maintenance of the funding policy of this Plan;

E. The amendment and termination of this Plan;

F. The determination of the amount of participant contributions under this Plan;

G. The exercise of all functions provided in this Plan, or as may be necessary to the operation of this Plan, except such functions as are assigned to others pursuant to this Plan.

6.2 Plan Administrator Duties

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

A. To administer this Plan according to its terms and to be accountable to the State with regard to the administration of this Plan;

B. To construe and interpret this Plan in a nondiscriminatory manner; to decide all questions of eligibility; and to determine all questions arising in the administration and application of this Plan;

C. To determine the types of benefits allowable under this Plan;

D. To be responsible for the reporting and disclosure requirements imposed upon administrators under applicable law;

E. To receive from the State and from Employee participants and Dependents such information as shall be necessary for the proper administration of this Plan, and to furnish the State, upon request, such reports with respect to the administration of this Plan as are reasonable and appropriate;

F. To receive, review and keep on file (as it deems convenient or proper) reports of the financial condition, and of the receipts and disbursements;

G. To maintain all records of this Plan;

H. To review as necessary, all claims for benefits under this Plan;

I. To determine the manner and time of payment of benefits under this Plan;

J. To apprise the State as to the amounts and timing of disbursements for payment of benefits and expenses under this Plan;

K. To prescribe procedures to be followed by participants and dependents in filing claims for benefits under this Plan;

L. To furnish the State such reports with respect to the processing and payment of claims under this Plan as are reasonable and appropriate;

M. To do all other acts or things as may be necessary for the proper administration of this Plan.

6.3 Duties and Powers of Third Party Claims Processor

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

A. To act under the direction and control of the Plan Administrator;

B. To receive, review and verify and investigate as necessary, all claims for benefits under this Plan;

C. To determine the amounts, manner and item of payment of benefits under this Plan;

D. To apprise the Plan Administrator as to the amounts and dates of disbursements for payment of benefits and expenses under this Plan;

E. To receive from the State, the Plan Administrator, the Utilization Review Agency and participants and Dependents such information as shall be necessary for the proper processing and payment of claims under this Plan;

F. To furnish the Plan Administrator, upon request, such reports with respect to the processing and payment of claims under this Plan as are reasonable and appropriate;

G. To maintain records relating to claims for benefits, processing of claims, and payment or denial or claims for benefits;

H. To administer contracts between the Plan Administrator and providers as a part of a provider network;

I. Any other related duties.

6.4 Duties and Powers of Utilization Review Agency

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

A. To act under the direction and control of the Plan Administrator;

B. To receive, review and verify and investigate and monitor as necessary, all requests for pre-certification required under the Plan including, but not limited to, non-emergency Hospital admissions, surgical procedures, length of stay limitations, and extended care benefits provided under this Plan; and to conduct and monitor and undertake a concurrent review of hospitalizations and conduct individual case management as necessary and all other utilization review activity required by this Plan;

C. To apprise the Plan Administrator and Third Party Claims Processor, if applicable, as to the Utilization Review Agency's determination as to Pre-certification, extended care benefits, concurrent review of hospitalization, case management, maternity management, behavioral health case management and other utilization review activities as may affect the amounts and timing of the payment of benefits under this Plan;

D. To receive from the State, the Plan Administrator, the Third Party Claims Processor and participants and dependents such information as shall be necessary for the proper processing and administration of the utilization review activities under the Plan;

E. To furnish the State and the Plan Administrator upon request, and Third Party Claims Processor, if applicable, such reports with respect to the utilization review activities under this Plan as are reasonable and appropriate;

F. To maintain records relating to pre-certification, extended care benefits, concurrent review of hospitalization, case management and other utilization review and case management activities required by the Plan;

G. To perform DRG validation audits and administer out-of-state policy as related to the Plan's Hospital Network;

H. To do such other acts as may be necessary, or as requested by the Plan Administrator, or required by the contract between the Plan Administrator and the Utilization Review Agency to properly handle the administration of the utilization review activities under this Plan.

ARTICLE 7.

SCHEDULE OF BENEFITS

7.1 Covered Medical Expenses

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

A. Savings Plan

1. Deductible. The annual individual Deductible shall be $3,000, and a Covered Person shall pay annually the first $3,000 of Covered Medical Expenses incurred in one Plan year before becoming eligible for Plan benefits. There is no individual Deductible if more than one family member is covered. The annual Family Deductible shall be $6,000. The annual Family Deductible is not considered satisfied for any Covered Person until the Family's total Covered Medical Expenses exceed $6,000. Payment of Deductible amounts, by any two or more Family members, totaling $6,000 of Covered Medical Expenses for that Plan year, shall satisfy the Deductible for all Covered Persons in that Family. In order for the Employee, and his employed spouse, who is also covered as an Employee, to share the same plan family deductible, both spouses must select the Savings Plan.

2. Coinsurance. After the individual or Family Deductible has been paid during the Plan year, the Savings Plan will pay 80 percent of the Covered Person's Covered Medical Expenses in excess of the deductible, provided, however, the Plan will pay 60 percent of the Covered Person's Covered

Medical Expenses if a Covered Person uses a Provider that is not participating in the Plan's Physician or Hospital Networks.

3. Penalty. A patient, who is a Covered Person, who does not obtain Pre-certification from the Utilization Preview Agency as required by Article 15, shall, in addition to the normal Deductible, and all other terms and conditions of the selected Plan, be subject to a $200 penalty for each admission to a Hospital or Skilled Nursing Facility. No amount of a penalty incurred by a Covered Person shall be applied or counted towards the coinsurance amount required to be paid.

4. Out-of-Pocket Limitation. For care delivered within the Plan's networks, after the annual Deductible has been paid and a Covered Person has incurred in the Plan year Coinsurance of $2,000 for Covered Medical Expenses, or Coinsurance of $4,000 for Covered Medical Expenses incurred in the Plan year by any combination of family members, the Plan will pay 100 percent of the allowable cost of the Covered Person's Covered Medical Expenses, up to the Benefit Maximum for each Covered Person, for the rest of the Plan year. Provided, however, for a Covered Person using a Physician or Hospital that is not participating in the Plan's networks, the Out-of Pocket Limitation is Coinsurance of $4,000 for Covered Medical Expenses in one Plan Year, or Coinsurance of $8,000 for Covered Medical Expenses incurred in one Plan Year by any combination of Family members, after which the Plan will pay 100 percent of Covered Medical Expenses up to the Benefit Maximum for each Covered Person for the rest of the Plan Year. Provided further, that: (1) the penalty in paragraph 3 above, or (2) Covered Medical Expenses incurred because of a failure to notify or follow utilization review procedures required by Article 15, are not included in those expenses used to satisfy the Out-of-Pocket Limitation, and provided further, that the Covered Medical Expenses incurred for such treatment or during such admission are always subject to Coinsurance.

5. Eligible Expense Limitations. The payments for Covered Medical Expenses that may satisfy the Deductible and Out-of-Pocket Limitations provisions of 7.1.A.1 and 7.1.A.4 are those incurred by one or more Covered Family members enrolled in the Savings Plan. Deductible and Coinsurance amounts made under the Medicare Supplemental Plan or the Standard Plan may not be used to satisfy the requirements of 7.1.A.1 and 7.1.A.4.

B. Standard Plan

1. Deductible. The annual individual Deductible shall be $350, and a Covered Person shall pay annually the first $350 of Covered Medical Expenses incurred in the Plan Year before becoming eligible for Plan benefits. The annual Family Deductible shall be $700. Payment of Deductible amounts by any two or more Family members totaling $700 of Covered Medical Expenses for that Plan Year shall satisfy the Deductible for all Covered Persons in that Family. In the event that two or more Covered Persons of one Family incur charges for Covered Medical Expenses as a result of injuries received in the same accident, only one Deductible will be deducted from the aggregate of all

charges for Covered Medical Expenses which are incurred by all such Covered Persons as a result of injuries in the same accident. In order for the Employee, and his employed spouse covered as an Employee, to share the same plan family deductible, both spouses must select the same plan.

2. **Coinsurance.** After the individual or family deductible has been paid for the Plan year, the Standard Plan will pay 80 percent of the Covered Person's Covered Medical Expenses in excess of the deductible, provided, however, the Plan will pay 60 percent of the Covered Person's Covered Medical Expenses if a Covered Person uses a Provider that is not participating in the Plan's Physician or Hospital Networks.

3. **Penalty.** A patient or Covered Person who does not obtain Pre-certification from the Utilization Review Agency as required by Article 15, in addition to the normal Deductible, and all other terms and conditions of the selected Plan, shall be subject an additional $200 penalty for each admission to a Hospital or Skilled Nursing Facility.

4. **Out-of-Pocket Limitation.** For care delivered within the Plan's Networks, after the annual Deductible has been paid and a Covered Person has incurred Coinsurance of $2,000 for Covered Medical Expenses in the Plan Year, or Coinsurance of $4,000 for Covered Medical Expenses have been incurred in the Plan Year by any combination of Family members; the Plan will pay 100 percent of Covered Medical Expenses up to the Benefit Maximum for each Covered Person for the rest of the Plan Year. Provided, however, for a Covered Person using a Physician or Hospital that is not participating in the Plan's networks, the Out-of-Pocket Limitation is Coinsurance of $4,000 for Covered Medical Expenses in one Plan Year, or Coinsurance of $8,000 for Covered Medical Expenses incurred in one Plan Year by any combination of Family members, after which the Plan will pay 100 percent of Covered Medical Expenses up to the Benefit Maximum for each Covered Person for the rest of the Plan Year. Provided further, that:

(1) the penalty in paragraph 3 above, or

(2) Covered Medical Expenses incurred because of a failure to notify or follow utilization review procedures required by Article 15, are not included in those expenses used to satisfy the Out-of-Pocket Limitation, and provided further, that the Covered Medical Expenses incurred for such treatment or during such admission are always subject to Coinsurance.

5. **Eligible Expense Limitations.** The payments for Covered Medical Expenses that may satisfy the Deductible and Out-of-Pocket Limitations provisions of 7.1.B.1 and 7.1.B.4 are those incurred by one or more Covered Family members under the Standard Plan, so long as all members of the Family are enrolled in the same Plan. Deductible and Coinsurance amounts paid under the Medicare Supplemental Plan or Savings Plan may not be used to satisfy the provisions of 7.1.B.1 and 7.1.B.4.

6. **Per Occurrence Deductibles** In addition to the Deductible referenced

in Section 7.1.B.1, separate per occurrence deductibles will be applied under the Standard Plan, in the following circumstances:

a. $125 per Emergency Room visit, to be waived if the patient is admitted to the hospital.

b. $75 per Outpatient Hospital visit, to be waived for Emergency Room services, physical therapy services, speech therapy services, occupational therapy services, oncology services, dialysis, routine mammograms, routine pap tests, clinic visits (an office visit at an outpatient facility), electric-convulsive therapy and psychiatric medication management.

c. $10 per office visit Deductible, to be waived for routine Pap smears, routine mammograms and well child care visits.

Per Occurrence Deductibles are not included in those expenses used to satisfy the Out-of-Pocket Limitation of 7.1.B.4.

7.2 Benefit Maximum

All payments made under this Plan, and any successor plan, for services or supplies provided to, or on behalf of, a Covered Person shall be included to determine if the amounts paid reach or exceed the maximum benefit, regardless of whether the payments were for medical services or supplies received by the Covered Person as a Dependent, Employee or Retiree, and regardless of any break in coverage.

The maximum amount payable for all benefits is $1,000,000 for each Covered Person.

7.3 Covered Medical Expense

Shall mean the Market Charge or per diem rate as determined by the Plan Administrator for each DRG category, or for those not included in a DRG category, a Reasonable and Customary or, if applicable, an Allowable Charge, for medical services and supplies that are Medically Necessary in the diagnosis or treatment of an illness or injury, and not otherwise excluded by any term, condition, limitation or exclusion of the Plan, and which are within the benefits provided in the Plan and are performed and reimbursed in the least costly setting required by the Covered Person's condition, including the following:

A. Charges made by a Physician, or Behavioral Health Provider, as those terms are defined in this Plan, except as they may be limited by any provision of the Plan, but not to exceed an Allowable Charge or the applicable amount in the Schedule of Reimbursement Rates as defined in this Plan or the Actual Charges, whichever is less.

The benefits for services rendered by a chiropractor are for the detection and correction by manual or mechanical means (including x-rays incidental thereto) of structural imbalance, distortion or subluxation in the human body, for the removal of nerve interference where such interference is the result of, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column. The patient

must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition. Spinal axis aches, sprains, nerve pains, and functional disabilities of the spine are considered to provide therapeutic grounds for chiropractic treatment. Most other non-spinal diseases and pathological disorders do not provide therapeutic grounds for chiropractic treatment. Examples of these types of diseases and disorders are rheumatoid arthritis, muscular dystrophy, multiple sclerosis, pneumonia, and emphysema. In the Savings Plan, the maximum amount payable for chiropractic benefits for the Plan year is $500 for each Covered Person after the annual deductible has been paid.

The benefits for services of a podiatrist, acting within the scope of his license, are payable only to the extent that benefits under this Plan will not exceed benefits that would have been paid to an M.D. or D.O. for treatment of the given condition, except that no payment is provided when the services consist of, either in whole or in part, the removal of corns, callosities, hypertrophy or hyperplasia of the skin or any subcutaneous tissues; or the cutting, trimming, or other partial removal of toenails;

B. Blood transfusions, including cost of blood and blood plasma, either inpatient or outpatient, but excluding blood and blood products replaced by donors and related storage fees;

C. Licensed registered nurse (R.N.) charges for nursing care in a Hospital where no special care units are provided;

D. Nursing care charges for services provided in the home by a licensed registered nurse (R.N.) if Medically Necessary, or by licensed practical nurses, if appropriate, provided in the home by a home health agency certified by the State of South Carolina, subject to Pre-certification by the Utilization Review Agency;

E. Rental cost, up to the purchase price, of Durable Medical Equipment required for temporary therapeutic use by an individual Covered Person for a specific condition when such equipment is ordinarily used under the direction of a Physician and if certified by the Utilization Review Agency. If such equipment is not available for rent, the monthly payments toward the purchase of the equipment may be approved by the Plan. Equipment, including Durable Medical Equipment, which has a non-therapeutic use, purchased or requested by the Subscriber with or without a prescription including but not limited to home and vehicle modifications, an air conditioner, air filter or air filtration system, wigs, hairpiece, or any other artificial device or procedure to replace scalp hair, dehumidifier, home whirlpool, exercise equipment, ace bandages, tennis shoe supports, knee braces, bandages and gauze and similar equipment, are not Covered Medical Expenses;

F. Medical supplies, limited to the following:

1. Syringes, and related supplies, for conditions such as diabetes;

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

Provided, however, that supplies and equipment which have non-therapeutic uses are not Covered Medical Expenses;

G. Professional ambulance service used locally to or from a Hospital outpatient department providing the necessary service in connection with accidental injury or medical emergency and to or from the nearest Hospital providing the necessary service in connection with inpatient care. No benefits are payable for ambulance service used for routine, non-emergency transport, including, but not limited to, transportation to a facility for scheduled medical or surgical treatments;

H. Prosthetic Appliances necessary for the correction of conditions caused by trauma or disease and that restore a function to the body. The Plan will provide benefits for the replacement of those prosthetic appliances that assist the body to function when the replacement is Medically Necessary and required by wear to the appliance, or growth of the Covered Person, provided, however, that charges for Prosthetic Appliances that have non-therapeutic uses, including a wig or hairpiece, are not a Covered Medical Expense, and further provided that the Plan will provide benefits for the initial breast prosthesis, and a subsequent replacement thereof;

I. Oxygen and rental of equipment for its administration outside a Hospital, with rental payments not to exceed the equipment's purchase price;

J. Orthopedic braces, crutches, lifts attached to braces, and orthopedic shoes, which are Medically Necessary and required by a specific diagnosis and limited to one pair of shoes at six months intervals, provided, however, that charges for supplies or shoes that have non-therapeutic uses are not a Covered Medical Expense;

K. Occupational and physical therapy services when provided by a licensed Occupational Therapist or Physical Therapist;

L. Treatment of Behavioral Health Disorders in the outpatient department of a Hospital or outside of a Hospital, and outpatient treatment for alcoholism and drug abuse at those facilities designated by the South Carolina Commission on Alcohol and Drug Abuse and with which the Behavioral Health Manager has a written agreement and in accordance with such agreement, limited to the benefits specified in section 7.8 and subject to Pre-certification by the Behavioral Health Manager;

M. Inpatient treatment of Behavioral Health Disorders and alcoholism and drug abuse, up to the benefits specified in Section 7.8 in a Hospital or in those State Institutions with which the Behavioral Health Manager has a written agreement and in

accordance with such agreement;

N. Speech Therapy:

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

The speech therapy benefit is provided for acute phase treatment only, in accordance with the therapeutic goals of a written treatment plan. Maintenance speech therapy is not covered. Benefits are provided only to the extent that documented, functional progress is occurring to achieve the therapeutic goals of a written treatment plan.

Speech therapy requires pre-certification by the Utilization Review Agency when provided in an inpatient setting or a home setting. Notwithstanding the pre-certification requirement, any claim for speech therapy services may be reviewed by the Third Party Claims Processor for Medically Necessary treatment after the claim is submitted.

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

A. Services rendered for the treatment of delays in speech development in young children unless the speech delay is due to a specific non-chronic disease, brain injury, or congenital defect (e.g., cleft palate, cleft lip, etc.).

B. Speech therapy for dysfunctions that are self-correcting, such as natural dysfluency or developmental articulation errors in young children.

C. Speech therapy for verbal apraxia or stuttering/stammering unless due to a specific disease or brain injury.

D. Speech therapy associated with any of the following conditions:
1. Psychosocial speech delay
2. Behavioral disorders
3. Attention disorders
4. Conceptual handicap
5. Mental retardation

O. Dental care and treatments, dental surgery or dental applications, limited to:

1. Allowable Charges for Physician services for excision or extraction of bony impacted teeth, when supported by dental x-rays;

2. Hospital services for excision or extraction of three or more bony impacted teeth, when supported by dental X-rays, and in connection with dental services, if the procedure is of such complexity as to require hospitalization or if hospitalization is required to ensure proper medical management, control or treatment of a non-dental physical condition, when Pre-certification has been obtained from the Utilization Review Agency;

3. Allowable Charges involving natural and artificial teeth, dentures, bridges, etc., made necessary by accidental bodily injury occurring while a Covered Person is continuously covered, limited to care completed within one year of such accident, and while the Covered Person remains continuously covered under this Plan;

P. Subject to the general provisions of the Plan, major human organ transplant procedures are eligible for benefits under the Plan as specified below:

1. Specified human major organ transplant procedures are Covered Medical Expenses of this Plan when such procedures conform to the following circumstances:

a. Covered procedures are liver, lung (single or double), heart, heart/lung, kidney, intestinal and pancreas transplants;
b. In order for benefits to be available for the above major organ transplant procedures listed in paragraph A, pre-approval in writing must be obtained from the Utilization Review Agency;
c. Covered Medical Expenses resulting from, or directly related to, the completion of one of the above organ transplant procedures are subject to the Deductible amount and Coinsurance specified in the Plan; and
d. The transplant procedure is performed by a member of the Transplant Network; and
e. The organ transplant is the only treatment for the illness or injury that has an equivalent or better prognosis than an alternative form of treatment;

2. Allogeneic or syngeneic bone marrow transplants or other forms of stem cell rescue (with or without high dose chemotherapy and/or radiation) are available for benefits under the following conditions:

a. There are no other recognized treatments that provide the Covered Person with an equivalent or better prognosis; and,
b. Bone marrow transplantation is the Covered Person's only reasonable opportunity to survive; and,
c. The Utilization Review Agency and the Third Party Claims Processor recommend that the Covered Person is an acceptable candidate for the treatment; and,
d. The bone marrow transplant is performed by a member of the Transplant Network that has accepted the Covered Person as a candidate for the transplant using generally accepted standards for the procedure;

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

a. There are no other recognized treatments that provide the Covered Person with an equivalent or better prognosis; and,
b. The autologous bone marrow transplantation or peripheral stem cell rescue with high dose chemotherapy is the Covered Person's

only reasonable opportunity to survive; and,

c. Both the Utilization Review Agency and the Third Party Claims Processor recommend that the Covered Person is an acceptable candidate for the treatment; and,

d. The bone marrow transplant is performed by a member of the Transplant Network that has accepted the Covered Person as a candidate for the transplant using generally accepted standards for the procedure;

4. Provided, however, the Plan will pay benefits for a major human organ transplant listed in paragraph 1-3 above performed in a Hospital that is not a member of the Transplant Network only if all of the following additional conditions are met:

a. The Covered Person is otherwise eligible for a transplant and has been approved by the URA for the transplant; and

b. The Covered Person has been accepted as a candidate for the transplant by a facility that used generally accepted standards for the procedure;

c. The benefits for the transplants, including patient workup, pre-transplant care, organ acquisition, the transplant and post-transplant care are limited to the lesser of actual charges or:

i) liver $115,000
ii) lung ..... $115,000 - single
As determined by the Utilization Review Agency - double
iii) heart ..... $ 85,000
iv) kidney ..... $ 42,000
v) pancreas ..... $ 57,000
vi) kidney and pancreas ..... $ 90,000
vii) allogeneic bone marrow .....$110,000 - match
.....$135,000 - mismatch- related
.....$145,000 - match- unrelated
viii) autologous bone marrow .....$ 75,000
ix) peripheral stem cell ..... $ 65,000
x) tandem bone marrow or
tandem peripheral stem
cell procedures ..... $ 65,000 1st infusion
..... $ 50,000 2nd infusion

xi) intestinal transplant.....$500,000
xii) multiple transplants .....
As determined by the Utilization Review Agency

5. The following transplants of tissue (rather than whole major organs) are eligible for benefits under this Plan when Medically Necessary. Such procedures are subject to all the provisions of this Plan, and prior approval in writing must be obtained from the Utilization Review Agency:

a. Blood transfusions;

b. Autologous parathyroid transplants;

c. Corneal transplants;

d. Bone and cartilage grafting; and

e. Skin grafting.

No other tissue transplant procedures are covered unless it can be determined that: (1) there are no other recognized treatments that provide the Covered Person with a better prognosis for the illness or injury; and, (2) the tissue transplant is the only treatment for the illness or injury that has an equivalent or better prognosis that an alternative form of treatment; and, (3) both the Utilization Review Agency and the Third Party Claims Processor, and the facility performing the procedure using generally recognized standards, recommend that the Covered Person is an acceptable candidate for treatment;

6. All medical costs incurred in the identification of a donor, including surgical, storage and transportation expenses incurred and directly related to the donation of an organ used in a covered organ transplant procedure for liver, lung (single or double) heart, heart/lung, kidney, pancreas, kidney/ pancreas, intestinal, and bone marrow transplants are subject to a maximum payment hereunder of $10,000 for each such procedure completed;

7. Transportation expenses to and from the site of a covered organ transplant procedure for liver, heart, heart/lung, kidney, intestinal, bone marrow or pancreas are covered for the Covered Person who is the transplant recipient and one other individual. If the recipient is a minor, transportation costs are covered for two other individuals accompanying the recipient. All reasonable and necessary lodging and meals expenses are covered, up to a daily maximum of $150 per individual accompanying the recipient. The aggregate sum of transportation, lodging and meal expenses under this provision shall not exceed $10,000 for expenses incurred within five days immediately prior to, and one year immediately following, a covered organ transplant procedure. These transportation expenses are specifically for transportation of the Covered Person and/or a family member to the site of the transplantation. This benefit is not available for transportation expenses related to evaluation of a Covered Person for an organ transplant procedure.

7.4 Hospital or Ambulatory Surgical Center Expense Benefits

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

A. **Ambulatory Surgical Center and Hospitals in Networks - Fixed Rate DRG or Per Diem.** The Plan will pay to a Hospital in the Hospital Network, or an Ambulatory Surgical Center in that Network, compensation calculated from the applicable fixed rate DRG or per diem rate provided in the agreement between the Planholder and the Network Hospital, or Ambulatory Surgical Center as full payment for the Plan's share of the inpatient, Medically Necessary, Covered Services rendered to a Covered Person by the Hospital or Ambulatory Surgical Center. The Subscriber payment to the Hospital or Ambulatory Surgical Center shall be limited to appropriate deductible or coinsurance calculated from the lesser of (1) the fixed rate DRG or per diem rate established in the Agreement, or, (2) the Hospital's or Ambulatory Surgical Center's actual charges. The Subscriber is responsible for any other charges for goods or services that are not Medically Necessary or not covered by the Plan that were incurred with the specific consent of the Covered Person.

B. **In-State Non-Network Hospital or Ambulatory Surgical Center - Fixed Rate DRG or Per Diem.** The Plan will pay to an In-State Hospital or Ambulatory Surgical Center compensation calculated from the lesser of (1) the applicable fixed rate DRG or per diem rate established for Network Hospitals, or Network Ambulatory Surgical Centers, or, (2) the Hospital's or Ambulatory Surgical Center's actual charges, as full payment of the Plan's share of Medically Necessary, Covered Services rendered to a Covered Person by the Hospital or Ambulatory Surgical Center.

C. **Charges by DRG or Per Diem**

1. **Hospital Room and Board** - In all cases not payable as provided in paragraph A and B above, the Plan will pay the lesser of the actual charges or the Market Charge for the semi-private room, board and general nursing care, and the lesser of the actual charges or the Market Charge for the newborn Child delivered from the Covered Person. When Medically Necessary, the Plan will pay the lesser of the actual charge or the Market Charge of an Intensive Care Unit. No benefit is provided for a bed accommodation "reserved" for a Covered Person in an intensive care facility.

2. **Other Hospital Charges for Covered Services** - The Plan will pay the lesser of the actual charges or the Market Charges for necessary services, medicines, blood, or blood plasma not replaced, and supplies for diagnosis or treatment of the illness or injury, for which the Covered Person is confined (except services of a Physician, dentist, special nursing in any form, or drugs or supplies not consumed or used in the Hospital) and not exceeding the overall Plan maximum, provided:

a) The Covered Person is in the Hospital, confined as a bed patient; or

b) The Covered Person has surgery performed in the Hospital; or

c) The Covered Person received necessary emergency treatment as a

result of an accident, acute emergency illness or incurred expenses for emergency Professional Ambulance service to the Hospital for illness or injury; or

d) The Covered Person incurred expenses for pre-admission diagnostic X-ray and laboratory services; or

e) The Covered Person incurred expenses for administration of anesthesia. This does not include any charge made by the operating Physician, or his assistant, or any charges made for infiltration anesthesia.

3. **Other Ambulatory Surgical Center charges for Covered Services** -The Plan will pay the lesser of actual charges or the Market Charges for necessary services, medicines, blood, or blood plasma not replaced, and supplies for diagnoses or treatment of the illness or injury for which the Covered Person receives on the day of services at the Ambulatory Surgical Center (except services of a Physician, dentist, special nursing in any form, or drugs or supplies not consumed in the Ambulatory Surgical Center) and not exceeding the Plan maximum provided:

a) The Covered Person has outpatient surgery performed in the Ambulatory Surgical Center; or

b) The Covered Person incurred expenses for the administration of anesthesia. This does not include any charge made by the operating Physician, his assistant or any charges made for infiltration anesthesia.

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

7.5 Medical Surgical Benefits

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

A. **Surgical Service**, which consists of operative or cutting procedures, or the treatment of fractures or dislocations; such service includes the usual, necessary and related preoperative and postoperative care, when performed by a Physician, subject to the following:

1. If two or more operations or procedures are performed at the same time, through the same surgical opening or by the same surgical approach, the total amount covered for such operations or procedures will be the Allowable Charge for the major procedure only;

2. If two or more operations or procedures are performed at the same time, through different surgical openings or by different surgical approaches, the total amount covered will be the Allowable Charge for the operation or procedure bearing the highest allowance, plus one-half of Allowable Charge for all other operations or procedures performed;

3. If an operation consists of the excision of multiple skin lesions, the total amount covered will be the Allowable Charge for the procedure bearing the highest allowance, 50 percent for the procedure bearing the second and third highest Allowable Charges, 25 percent for the procedures bearing the fourth through the eighth highest Allowance Charges, and 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 allowance, and 50 percent of the charge for each subsequent procedure;

4. If an operation or procedure is performed in two or more steps or stages, coverage for the entire operation or procedure will be limited to the Allowable Charge set forth for such operation or procedure;

5. If two or more Physicians perform operations or procedures in conjunction with one another, other than as an assistant at surgery or anesthesiologist, the Allowable Charge subject to the above paragraphs, will be coverage for the services of only one Physician or will be prorated between them by the Plan when so requested by the Physician in charge of the case;

6. Certain surgical procedures, which are normally exploratory in nature, are designated as "Independent Procedures" by the Plan, and the Allowable Charge is payable when such procedure is performed as a separate and single entity; however, when an Independent Procedure is performed as an integral part of another Surgical Service, the total amount covered will be the Allowable Charge for the major procedure only;

7. Medically Necessary surgical correction of disorders of the temporo mandibular joint will be covered by the Plan when there is documentation that there is anatomical derangement of the joint and there is significant symptomatology. Such disorders include displacement of the joint meniscus and/or other joint structures coupled with significant locking, clicking, popping and pain sufficient to interfere with the patient's ability to speak, masticate food and otherwise carry on normal oral functions. Pre-approval for these procedures is required and the total amount covered will be the Allowable Charge for the procedure performed. Except as provided in this provision, however, services or supplies for temporo mandibular joint conditions are not covered under the Plan. See 9.1.MM.

8. Medically Necessary surgical correction of skeletal malrelationships or deformities of the jaws that cause documented chronic, persistent pain or debilitating loss of function and have required treatment or medication, are covered by the Plan. The presence of a documented congenital anomaly alone does not establish Medical Necessity. Prior approval by the Utilization Review Agency is required.

B. **Surgical Assistant Service,** which consists of the Medically Necessary service of one Physician who actively assists the operating surgeon when a covered surgical service is performed in a Hospital, and when such surgical assistant service is not available by an intern, resident or house Physician. The Plan will cover charges equal to 20 percent of the Allowable Charge for the surgical service, not to exceed the Physician's actual charge;

C. **Anesthesia Service,** which consists of services rendered by a Physician or a certified registered nurse anesthetist, other than the attending surgeon or his assistant, and includes the administration of spinal or rectal anesthesia, or the administration of a drug or other anesthetic agent by injection or inhalation, except by local infiltration, the purpose and effect of which administration is the obtaining of muscular relaxation, loss of sensation, or loss of consciousness. Additional benefits will not be provided for preoperative anesthesia consultation;

D. **In-Hospital Medical Service,** which consists of a Physician's visit or visits to a Covered Person who is a registered bed patient in a Hospital or Skilled Nursing Facility for treatment of a condition other than that for which surgical service or obstetrical service is required, as follows:

1. In-Hospital medical benefits will be provided based on the actual expense incurred but not to exceed the Allowable Charges;
2. In-Hospital medical benefits primarily for treatment of mental or nervous conditions, acute and chronic alcoholism, or drug addiction will be provided for each Covered Person subject to limitations of Section 7.8;
3. In-house medical benefits in a Skilled Nursing Facility will be provided for the visits of a Physician, limited to one visit per day, not to exceed 60 visits;
4. When two or more Physicians render in-Hospital medical visits at the same time, payment for such services will be made only to one Physician;
5. Concurrent Medical/Surgical Care benefits for in-Hospital medical services, in addition to benefits for surgical service, will be provided only: (a) when the condition for which in-Hospital medical services requires medical care not related to surgical or obstetrical service and does not constitute a part of the usual, necessary and related preoperative or post-operative care, but requires supplemental skills not possessed by the attending surgeon or his assistant, (b) when a Physician, other than a surgeon, admits a Covered Person to the Hospital for medical treatment and it later develops that surgery becomes necessary, such benefits to cease on the date of surgery, or (c) when the surgical procedure performed is designated by the Administrator as a "warranted diagnostic procedure" or as a "minor surgical procedure";
6. When the same Physician renders different levels of care on the same day, benefits will only be provided for the highest level of care;

E. **Intensive Medical Care Service,** which consists of medical care rendered by the attending Physician to a Covered Person who is eligible for in-Hospital medical service or Medical Care in the Outpatient department of a Hospital immediately

prior to an admission, and who is confined with a serious disease or injury requiring additional time and study over and above the usual in-Hospital medical service;

F. **Consultation Service,** which consists of services of a consulting Physician, requested by the attending Physician and rendered during an admission. This service is limited to one consultation per consulting Physician for each continuous period of disability and includes discussion with the attending Physician and/or family, and a written expression of opinion by the consultant based on examination of the patient. Consultation service does not include radiological consultations and staff consultations required by institutional rules and regulations, nor when primary care of the patient is transferred to the Physician providing consultation service;

G. **Obstetrical Care** shall refer to services for the prenatal and postpartum care and delivery of one or more fetuses, including Cesarean section, miscarriage, or abortion, as well as in-Hospital medical service for conditions related directly to pregnancy, limited to the Allowable Charge for the delivery only;

H. **Pediatric Medical Care,** which consists of the initial inpatient examination of the newborn when such care is given by a Physician other than the delivering Physician or the Physician who administered anesthesia during delivery;

I. **Radiation Therapy Service,** which consists of the use of x-ray, radium, or radioactive isotopes in the treatment of disease, when ordered by the attending Physician. Benefits for radiation therapy service are provided only when a Physician performs the service;

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

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

7.6 Outpatient Diagnostic Services

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

A. Diagnostic X-ray examinations for the diagnosis of an illness or injury;

B. Clinical laboratory and tissue diagnostic examinations and medical diagnostic

procedures for the diagnosis of an illness or injury, provided, however, that the Physician charges for any machine generated tests are not a Covered Medical Expense under this Plan.

7.7 Human Organ Transplants

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

A. When both the transplant recipient and the donor are Covered Persons, benefits will be provided for both;

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

C. When the transplant recipient is not a Covered Person and the donor is, the donor will receive benefits to the extent that such benefits are not provided by any coverage available to the recipient of the organ or tissue transplant procedure. This includes, but is not limited to, other insurance coverage, other Blue Cross or Blue Shield coverage, any government program, or any employee welfare benefit plan. Benefits will not be provided to a non-eligible transplant recipient.

7.8 Behavioral Health Disorders

Subject to all the terms and conditions of the Plan, and including the requirements herein, the Plan will pay covered expenses for inpatient, outpatient, or Partial Hospitalization Programs rendered by a Behavioral Health Provider for Behavioral Health Disorders and Alcoholism and Drug Abuse. All care must be in accord with the utilization guidelines established by the Behavioral Health Manager and, for specified levels of care, pre-authorized by the Behavioral Health Manager.

7.9 Extended Care Programs

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

7.10 Skilled Nursing Facility

Subject to all the terms, conditions, limitations and exclusions of the Plan including the limitation on Physician visits under 7.5.D.3. and the requirement that all admissions and readmissions to a Skilled Nursing Facility be Pre-certified by the Case Management

Agency, the Plan will pay the Covered Medical Expense for room and board and a skilled nursing level of treatment in such facility for 60 days, or up to $6,000 in any Benefit Year, whichever is less. Refer to 16.1, B.2.(a) and (b) for the Medicare Supplemental Plan benefits concerning Skilled Nursing Facility.

7.11 Hospice Care

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

A. The Covered Person is diagnosed as having a terminal illness with a life expectancy of six months or less;

B. Admission into the Hospice program is certified by the Utilization Review Agency and the care is monitored by it;

C. The services are provided by a Hospice care agency or by others who are not its employees but who are supervised or coordinated by the Hospice care agency;

D. The services are provided pursuant to a written treatment plan approved by a Physician and reviewed by the Physician at least once a month;

E. The expenses incurred are Covered Hospice Expenses which are defined as services provided by a Hospice care agency, or provided under the supervision or coordination of the Hospice care agency by others who are not its employees, in an inpatient Hospice setting or a private residence, for:

1. Medical social services provided under the direction of a Physician including:

a) Assessment of the Covered Person's home and family situation and that person's social, emotional and medical needs;

b) Identification of community resources available to the Covered Person;

c) Assisting the Covered Person to obtain community resources to meet the Covered Person's needs;

d) Psychological and dietary counseling;

e) Consultation and case management services by a Physician;

f) Physical or occupational therapy;

g) Medical supplies, drugs, medicines prescribed by a Physician.

2. Hospice services provided for a Covered Person in a private home are subject to the following:

a. Part-time or Intermittent (less than or up to four hours per day, if provided on a less-than-daily basis, or if provided on a daily basis not to exceed eight hours per day, for temporary and definitely fixed periods of time up to 21 days, with such extensions for additional fixed and definite periods of time that, in the discretion of the Plan Administrator, may be granted when there are exceptional circumstances and the period of such extension is predictable and fixed) nursing care provided by a registered nurse or licensed practical nurse;

b. Part-time or Intermittent (less than or up to four hours per day, if provided on a less-than-daily basis, or if provided on a daily basis not to exceed eight hours per day, for temporary and definitely fixed periods of time up to 21 days, with such extensions for additional fixed and definite periods of time that, in the discretion of the Plan Administrator, may be granted when there are exceptional circumstances and the period of such extension is predictable and fixed) home health aid services which consist mainly of caring for the Covered Person;

F. Limitations and Exclusions

1. The maximum benefit payable under the Plan for Hospice care services is $6,000 per person including bereavement counseling not to exceed $200.

2. Benefits are not payable for:

a) Funeral expenses;

b) Financial or legal counseling, including estate planning or the drafting of a will;

c) Pastoral counseling;

d) Homemaker or caretaker services which are not solely related to the care of the Covered Person, or transportation, housecleaning or maintenance of the Covered Person's dwelling;

e) Sitter or companion services for either the ill Covered Person or other members of his family;

f) Respite care, which is care furnished during a period when the Covered Person's family or usual caretaker cannot, or will not, attend to the Covered Person's needs.

7.12 Alternative Treatment Plan

A. **Allowable Charge.** For purposes of this section only an Allowable Charge includes: (1) all costs otherwise allowed under this Plan; (2) all other costs for

medical goods and services that are essential to the implementation and maintenance of the Alternative Treatment Plan even if not otherwise covered under the Plan, provided that the Utilization Review Agency has Pre-certified that the particular medical goods or services are essential to the implementation and maintenance of the Alternative Treatment Plan.

B. **Limitation.** The Alternative Treatment Plan is subject to:

1. The Plan Deductible, and Plan maximums;
2. And, in addition, the Allowable Charges for the Alternative Treatment Plan, as defined in this section, may not exceed those payable for comparable treatment or services in an acute care facility or a Skilled Nursing Facility.

7.13 Home Health Care Services

Subject to all the terms and conditions of the Plan, including the Deductible and Coinsurance requirement, and the requirement that these services are Pre-certified by the Utilization Review Agency, and including other conditions and limitations herein, the Plan will provide benefits for the Reasonable and Customary Charges for the following Medically Necessary services and supplies provided a Covered Person in the home:

A. Covered Medical Expenses for purposes of this section shall be limited to:

1. Part-time or Intermittent (less than or up to four hours per day, if provided on a less-than-daily basis, or if provided on a daily basis, not to exceed eight hours per day, for temporary and definitely fixed periods of time of up to 21 days, with allowances for extensions and exceptional circumstances where the need for care in excess of 21 days is finite and predictable) nursing care by a registered nurse (R.N.), or by a licensed practical nurse (L.P.N.) where appropriate;

2. Part-time or Intermittent (less than or up to four hours per day, if provided on a less-than-daily basis, or if provided on a daily basis, not to exceed eight hours per day, for temporary and definitely fixed periods of time of up to 21 days, with allowances for extensions and exceptional circumstances where the need for care in excess of 21 days is finite and predictable) home health aide services which consist primarily of caring for the individual; and

3. Physical, occupational or speech therapy provided by the home health care agency;

4. Medical drugs, supplies and medicines prescribed by a Physician and required for the care rendered by the nurse or physical, occupational or speech therapist, but only to the extent that the medical drugs, supplies, durable medical equipment and medicines are otherwise covered under this Plan.

B. The payment of benefits for Home Health Care is subject to the following additional requirements, in addition to all other limitations and exclusions of the Plan:

1. That the Home Health Care benefits, if provided, would permit the

Covered Person to remain in a less intensive care facility, or at home, than would otherwise be required without these benefits;

2. The annual maximum benefit for professional services only, is the lesser of $5,000 or 100 visits. A visit shall consist of up to four hours, whether consecutive or non-consecutive, within any 24-hour period, incurred by a registered nurse or a licensed practical nurse to provide nursing care, by a therapist to provide physical, occupational or speech therapy, or by a home health care aide to provide services within the scope of the license; and

3. Covered Medical Expenses under this section shall not include:

   a) Any service or supply rendered by a person who ordinarily resides in the home of the Covered Person, or is a member of the family, or of the family of the spouse of the Covered Person; or

   b) any transportation services;

4. The Plan will provide benefits for Medical Social Worker Services if authorized and required by the Utilization Review Agency under section 15.1.8.E at 100 percent of the Reasonable and Customary or Allowable Charge, or the Actual Charge, whichever is less.

7.14 Mammography Testing

The Plan will provide benefits for routine mammography testing for Active female Employees, female Retirees, and female Dependents of Employees or Retirees from ages 35 through 74 enrolled in the Savings Plan or the Standard Plan or the Medicare Supplemental Plan and without regard to the Plan Deductible, Coinsurance or need for a referral by a Physician, subject to the following terms and conditions:

A. Benefits under this section are limited to one mammogram for a Covered female every year between the ages of 35 through the age of 74;

B. Benefits under this section are payable only for routine four view mammograms which are defined as elective procedures undertaken without the need for a Physician's referral or presence of symptoms, and performed only at facilities specified by the Plan Administrator;

C. Benefits under this section are in addition to benefits for diagnostic mammography otherwise available under this Plan. The Plan will pay the same benefit to the participating facility as it does for routine mammograms. Any charges above that amount and/or additional mammograms are subject to the other terms, conditions, limitations and exclusions of this Plan including the Deductible, Coinsurance and requirement of a Physician referral;

D. Approved charges for diagnostic mammograms performed at non-participating facilities will be subject to the Plan Deductible and Coinsurance, up to the Out-of-pocket Maximum.

7.15 Required Second Opinion

The plan will provide benefits for a Second Opinion required to be obtained by the Utilization Review Agency under 15.1.8.C at 100 percent of the Reasonable and Customary Charge or Allowable Charge, or the actual charge, whichever is less.

7.16 Pap Test

The Plan will pay a benefit for one Pap Test per female subscriber or Dependent ages 18 through 65 per Benefit Year, including an appropriate-level office visit associated with the Pap Test, without any requirement for a Deductible or Coinsurance.

7.17 Rehabilitation Care

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

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

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

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

A. Pre-certification is required for any inpatient rehabilitation care, regardless of the reason for the admission, and is required for any outpatient rehabilitation therapy that occurs subsequent to an inpatient admission for rehabilitation therapy;

B. The rehabilitation therapy must be performed in the most cost-effective setting as required by the Covered Person's condition;

C. The Provider must submit and have approved by the Utilization Review Agency a treatment plan with the proposed treatment, the expected result and the length of the treatment required to reach that result;

D. There must be reasonable expectation that sufficient function can be restored for the patient to live outside the institutional setting;

E. Continued rehabilitation therapy is dependent upon documentation that progress is continuing to be made, and only so long as there is a significant improvement in the capabilities of the patient;

F. An inpatient admission must be to a rehabilitation facility under the same licensure as a short term general hospital accredited by the Joint Commission on Accreditation of Hospitals (JCAH), or if to a freestanding rehabilitation facility, one accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF);

G. Rehabilitation benefits are not payable for vocational rehabilitation intended to teach a patient how to be gainfully employed; or pulmonary rehabilitation, except in conjunction with a covered and approved lung transplant; or long term rehabilitation after the acute phase, including cognitive retraining and community re-entry programs.

7.18 Infertility Treatment

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

A. The benefits are limited to a lifetime maximum payment of $15,000 for any Covered Medical Expenses and Covered Prescription Drug Expenses incurred by either the Subscriber or the Covered Spouse whether covered as a Dependent or as an Employee. Included in the $15,000 maximum are up to six (6) cycles of Intrauterine Insemination (IUI) and/or a maximum total of three completed cycles of zygote or gamete intrafallopian transfer (ZIFT or GIFT), or In Vitro Fertilization (IVF), is allowed. A cycle reflects the cyclic changes of fertility with the cycle beginning with each new insemination or assisted reproductive technology (ART) transfer or implantation attempt. ART procedures not specifically referenced in this policy are not covered, including, but not limited to: tubal embryo transfer (TET), pronuclear stage tubal embryo transfer (PROUST), Oocyte donation, and Intracytoplasmic sperm injection (ICSI). Benefits paid for infertility treatments after January 1, 1990, will be considered in computing the lifetime maximum benefit; and,

B. The benefits for infertility treatment are always subject to Coinsurance at a rate of 30 percent of the Covered Medical Expenses or Covered Prescription Drug Expenses regardless of the Plan selected; and

C. Coinsurance paid by the Covered Person for the infertility services cannot be used to satisfy the Out-of-pocket Limitation in 7.1.A.4 and 7.1.B.4 or in paragraph 7.21;

D. All IVF procedures must receive prior approval from the Utilization Review Agency;

E. No benefits are payable for infertility treatments to a Covered Person who has received a tubal ligation, whether or not surgically reversed.

7.19 Well Care

A. The Plan will provide benefits for routine Well Child Care visits and immunizations for Covered Persons through age 18 enrolled in the Savings Plan, Standard Plan or Medicare Supplemental Plan and without regard to the Plan Deductible or Coinsurance, subject to the following terms and conditions:

1. Benefits for routine visits are limited to five visits for a Child under age one; three visits for a Child age one; one visit per year for Children age two through 18 years of age.

2. Benefits are provided for all immunizations at the appropriate ages recommended by the American Academy of Pediatrics for children through age 18;

B. The Plan will provide benefits for one routine annual physical for covered persons age 18 and older enrolled in the Savings Plan, and without regard to the Plan Deductible or Coinsurance. Benefits are provided for one annual influenza immunization.

C. Benefits under this section are payable only for services rendered by the participating providers in the State Health Plan Physician Network in accordance with guidelines established by the Plan Administrator.

7.20 Preventive Screenings for Employees at Worksite

The Plan will provide benefits, for Covered Employees and their Covered Spouses, for a routine worksite screening that includes procedures recommended by the United States Preventive Services Task Force, consisting of a health risk appraisal, blood lipid profile, blood chemistry profile, hemogram, blood pressure measurement, height and weight measurement, and counseling on identified individual health risk factors. The screening is limited to one occurrence per year, is provided only at the Employee's worksite, and is subject to the ability of the Plan Administrator and the Provider to schedule a screening session at the worksite. The screening is provided without regard to the Plan Deductible and Coinsurance, but is subject to a Co-payment determined by the Plan Administrator. Worksite screening benefits are payable only for a) Covered Employees who are actively at work, and their Covered Spouses and b) Covered Retirees for whom the Plan is Primary, and their Covered Spouses.

7.21 Covered Prescription Drug Expenses

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

Provided, however, that there is no coverage for:

A. any medicines or drugs which are in the Food and Drug Administration phases I, II, or III testing, whether or not prescribed by a Physician;

B. prescription drugs or medicines obtained by or for the Covered Person in violation of the utilization review and management standards established by the Pharmacy Benefits Manager under the Prescription Drug Program.

C. prescription drugs or medicines purchased at pharmacies not participating in the State Pharmacy Network; provided, however, out-of-network drug benefits may be allowable only in specific geographic areas in which the Plan Administrator has determined that there is no access to a participating pharmacy.

D. in the Savings Plan, nonsedating antihistamine medications or drugs to treat erectile dysfunction.

For Covered Persons enrolled in the Standard Plan, the expenses described in this paragraph are not Covered Medical Expenses for purposes of Paragraphs 7.1.B and 7.2 of the Plan of Benefits. In the Standard Plan, the Covered Person shall pay for up to a 31-day supply of a drug (a) the lesser of the allowance established for a Tier 2 brand name drug or a $25 co-payment; (b) the lesser of the allowance established for a Tier 3 brand name drug or a $40 co-payment; or (c) the lesser of the allowance established for a generic drug or a $10 co-payment. Provided, however, that if a generic equivalent is available, payment for a brand name drug is limited to what is payable for the generic equivalent. Covered Persons may obtain up to a maximum of a 90-day supply of medication, provided, however, a separate co-payment is required for each additional 31-day supply of medication received at retail. There is an annual out-of-pocket maximum for prescription drugs of $2,500 per person.

A voluntary mail service prescription drug benefit is available at a pharmacy established by the Pharmacy Benefits Manager. In the Standard Plan, patient co-payments at the mail service pharmacy for a 90-day supply of covered medication are established at an amount equal to 2.50 times (rounded down to the nearest dollar) the retail co-payment for a 31-day supply.

For Covered Persons enrolled in the Savings Plan, the expenses described in this paragraph are Covered Medical Expenses for purposes of Paragraphs 7.1.A and 7.2 of the Plan of Benefits. In the Savings Plan, the Covered Person shall pay for up to a maximum of a 90-day supply of a drug, the allowance established for a brand name or generic drug. Provided, however, that if a generic equivalent is available, payment (or amount to be applied to the deductible) for a brand name drug is limited to what is payable for the generic equivalent.

7.22 Cranial Band

The Plan covers the use of a cranial remodeling band when pre-certification review determines it to be Medically Necessary for the correction of a child's moderate to severe positional head deformities associated with premature birth, restrictive intrauterine positioning, cervical abnormalities, birth trauma, torticollis and sleeping positions. Remodeling must be initiated between 4 and 12 months of age, following a failed two-month trial of conservative treatment (e.g., repositioning, neck exercises).

7.23 Colonoscopy

The Plan will provide benefits for one routine colonoscopy screening for colorectal cancer every 10 years for a Covered Person, beginning at age 50. Benefits under this section are subject to the Plan Deductible and Coinsurance.

7.24 Autism Spectrum Disorders

The Plan shall cover behavior therapy related to autism spectrum disorder pursuant to Act 65 of 2007, as enacted by the South Carolina General Assembly. All services are subject to the guidelines formulated by the Behavioral Health Manager and must be approved by the Behavioral Health Manager.

ARTICLE 8.

COORDINATION OF BENEFITS

8.1 Definitions for this Article

A. **Plan.** For purposes of this Article means any program which provides benefits or services for or by reason of medical care or treatment including:

1. Any group insurance and group subscriber contracts;

2. Any uninsured arrangements of group coverage;

3. Any group coverage through health maintenance organizations (HMOs) and other prepayment, group practice and individual practice plans;

4. Any group hospital indemnity plans to the extent that the benefits exceed $100 per day;

5. Any medical benefits coverage in group and individual automobile "no fault" and traditional automobile "fault" type contracts;

6. Any coverage under a governmental plan, or coverage required to be provided by law, but does not include a State Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the Social Security Act, as amended);

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

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

B. **Dependent.** With respect to this Article, any person included in the definition of Dependent in 2.31 herein and, with respect to any other Plan, any person who qualifies as a dependent under such Plan.

C. **Primary Plan.** A Plan whose benefits must be determined without taking the existence of another Plan into consideration. There may be more than one Primary

Plan. The provisions of paragraph 8.2 determine whether a Plan is Primary or Secondary.

D. **Secondary Plan.** A Plan that is not a Primary Plan. When this Plan is a Secondary Plan its benefits are determined after those of the other Plan's and may be reduced because of the other Plan's benefits. The provisions of paragraph 8.2 determine whether a Plan is Primary or Secondary.

8.2 Order of Determination of Benefits

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

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

A. **Coverage as a Non-Dependent or Dependent.** The benefits of a Plan, which covers the person as an employee, member or subscriber (that is other than as a Dependent), are determined before those of the Plan that covers the person as a Dependent.

B. **Dependent Child - Parents Not Separated or Divorced.** Except as provided in paragraph C below, when this Plan and another Plan cover the same child as a Dependent of different persons called parents:

1. The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

2. If both parents have the same birthday, the benefits of the Plan that covered a parent longer are determined before those of the Plan that covered the other parent for a shorter period of time;

3. Provided, however, that if the other Plan does not have the rule described in B(1) above (the birthday rule) but has the gender rule so that the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

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

1. First, the plan of the parent with custody of the child;

2. Second, the plan of the spouse of the parent with custody of the child;

3. Third, the plan of the parent who does not have custody of the child;

4. Provided, however, that if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The plan of the other parent shall be the Secondary Plan;

5. Provided further, that if the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules in paragraph B above.

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

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

1. First, the benefits of a plan covering the person as an employee, member or subscriber (or as that person's dependent);

2. Second, the benefits under the continuation coverage.

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

Note: The Consolidated Omnibus Budget Reconciliation Act of 1987 (COBRA) originally provided that coverage under a new group health plan caused the COBRA coverage to end. An amendment passed as part of H.R. 3299 (1989) allows the COBRA coverage to continue if the other group plan contains any pre-existing condition limitation. In this instance, two policies will cover an individual, and the COBRA coverage will be the Secondary Payor.

8.3 Effect of Order of Determination of Benefits on this Plan

A. This Plan is Primary. When the order of determination rules of this Plan establish that this Plan is the Primary Plan, the benefits provided by this Plan shall be determined without consideration of the benefits of any other Plan.

B. This Plan is Secondary. When the order of determination of benefits rules of this Plan determines that this Plan is the Secondary Plan, the benefits of this Plan will be reduced when the sum of: (1) the benefits that would be payable for the Covered Medical Expense under this Plan in the absence of this COB provision; and (2) the benefits that would be payable for the Covered Medical Expenses under the other plans, in the absence of provision with a purpose like that of this COB provision, whether or not claim is made, exceeds the Allowable Charge for the Covered Medical Expense. In that case, the benefits of this Plan will be reduced so that they, and the benefits payable under the other plans, do not total more than the Allowable Charge for the Covered Medical Expense. In no event will the total benefits paid by this Plan exceed the total benefits that would have been paid by this Plan if this Plan had been Primary. When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

8.4 Right to Receive and Release Information

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

8.5 Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this Article have been made under any other Plan, the Third Party Claims Processor will have the right to pay over to any organization making such other payments any amounts it determines to be warranted in order to satisfy the intent of this Article, and amounts so paid will be deemed to be benefits paid under this Plan, and to the extent of such payments for Covered Medical Expenses, the Plan will be fully discharged from liability. The term "payments" includes providing benefits in the form of services, in which case the term "payment made" means the reasonable cash value of the benefits provided in the form of services.

8.6 Right of Recovery

Whenever payments have been made under this Plan by the Third Party Claims Processor with respect to Covered Medical Expenses in a total amount in excess of the amount necessary to satisfy the purposes of this Article, the Third Party Claims Processor will be entitled to recover on behalf of the Plan such excess amounts from a Covered Person or any group insurer, Plan, or other person or organization contractually obligated to such Covered Person with respect to such Covered Medical Expenses. The employee, for himself, or on behalf of, his Dependents will, upon request, execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to this Plan or any other plan.

8.7 Medicare

A. This Plan will provide Primary coverage for Active Employees, age 65 and over, and their Dependents who have elected to enroll in Medicare and who are also enrolled in this Plan. Medicare is Secondary for a Covered Person during the first 30 months in which the Covered Person is eligible for Medicare solely because of permanent kidney failure, and thereafter, Medicare is Primary and the Plan is Secondary. Federal law prohibits active Employees, who elect Medicare as their Primary coverage, from enrolling in the Plan as a supplement.

B. This Plan is Primary and Medicare is Secondary for an Active Employee or Dependent of an Active Employee under age 65 and eligible for Medicare by reason of disability, other than end stage renal disease.

C. For Retired Employees and their Dependents eligible for Medicare, the benefits paid under this Plan will be determined in the following manner:

1. Benefits available under this Plan less benefits paid or payable under Parts A and B of Medicare.

2. When Medicare is Primary and this Plan is Secondary, benefits will be coordinated with both Parts A and B of Medicare, whether or not the Covered Person is actually receiving both Parts A and B of Medicare.

3. Retirees who return to Active Employment, again, are eligible for the Plan. Federal law prohibits active Employees who elect Medicare as their Primary coverage from enrolling in the Plan as a supplement.

ARTICLE 9

EXCLUSIONS AND LIMITATIONS

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

A. Any service or charge for service which is not Medically Necessary as defined in paragraph 2.58; any service or charge for service which is performed in a more costly setting than that required by a Covered Person's condition, in which case benefits will be limited to the benefits due had the services been performed in the least costly setting required by the Covered Person's condition;

B. Any service or charge for service to the extent a Covered Person is entitled to payment or benefits (whether or not any such payment or benefits have been applied for or paid) pursuant to any law (now existing or as may be amended) of the United States, (except Medicaid) or any state or political subdivision thereof. Without limiting the generality of the foregoing, this exclusion applies to benefits provided by, or payable under, Workers' Compensation Laws, the Veterans Administration, or any state or federal hospital for which hospital services the Covered Person is not legally obligated to pay. This exclusion applies if the Covered Person receives any benefits or payments in whole or in part, and it applies to any settlement or other agreement, including any settlement of "doubtful and disputed" claims, or "clincher" agreements, or any other agreement regardless of how characterized, and even if the document or release specifically excludes payment for medical expenses;

C. Any service or charge for service to the extent a Covered Person is entitled to payment or benefits under state or federal programs of health care, excluding Medicare and amendments thereto, but only to the extent that benefits are provided or reimbursement is paid or payable hereunder;

D. Illness contracted or injury sustained as a result of declared or undeclared war or any act of war, or while in the military service;

E. Any charges for services commencing prior to the Covered Person's coverage hereunder or rendered after the termination of coverage, except as provided in Article 10, Continuation of Coverage, or Article 11, COBRA, of this Plan. This exclusion also applies to all hospital charges incurred during a continuous hospital stay when the admission occurred before, and the discharge occurred after, the effective date of coverage, and there is pre-existing coverage for that admission. Physician charges are payable from the date of commencement of coverage;

F. Services or charges incurred for acupuncture;

G. Any surgical or medical procedures determined by the medical staff of the Third Party Claims Processor with appropriate consultation, to be experimental or investigational or not accepted medical practice. Experimental or investigational procedures are those medical or surgical procedures, supplies, devices, or drugs, which at the time provided, or sought to be provided:

1. Are not recognized as conforming to accepted medical practice in the relevant medical specialty or field of medicine; or

2. The procedures, drugs or devices have not received final approval to Market from appropriate government bodies; or

3. Are those about which the peer-reviewed medical literature does not permit conclusions concerning their effect on health outcomes; or

4. Are not demonstrated to be as beneficial as established alternatives; or

5. Have not been demonstrated, to a statistically significant level, to improve the net health outcomes; or

6. Are those in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting;

H. Services, supplies or charges for premarital, pre-employment, or routine physical examinations, when no injury or illness is present, and except as provided in 7.19, well care and immunizations;

I. Admissions or portions thereof for: (1) sanitarium care or rest cures, (2) physical or occupational therapy, or (3) Custodial Care;

J. Hospital and Physicians services and prescription drugs related to procedures or goods that have primarily cosmetic effects including but not limited to cosmetic surgery, or the complications resulting there from. Cosmetic goods, procedures or surgery shall mean all goods, procedures, and surgical procedures performed to improve appearance or to correct a deformity without restoring a bodily function. In the instances of the following and other procedures which might be considered "cosmetic"— e.g., rhinoplasty (nose), mentoplasty (chin), rhytidoplasty (face lift), glabellar rhytidoplasty, surgical planing (dermabrasion), blepharoplasty (eyelid), mammoplasty (suspension or augmentation), superficial chemosurgery (acid peel of the face) and rhytidectomy (abdomen, legs, hips, or buttocks including lipectomy or adipectomy)—benefits may only be provided when the malappearance or deformity was caused by physical trauma, surgery, or congenital anomaly (as opposed to familial characteristics or aging phenomenon) occurring after the Covered Person's Effective Date of coverage under this Plan; provided, however, that surgery to correct a cleft palette, or for restoration required because of burn injuries, or other similar procedures performed in stages or after certain growth has been attained, are not excluded because the physical trauma, surgery or

congenital anomaly (as opposed to familial characteristics or aging phenomenon), occurred after the Covered Person's Effective Date of Coverage under this Plan or a Predecessor Plan;

K. Hospital and Physician services for dental procedures, including those related to tooth structures, extractions, gingival tissue, alveolar process, dental X-rays, or other procedures of dental origin, which are principally for the preserving of teeth or the preparation of the mouth for dentures, except as specified under 7.3.O.

L. Physician's charges for medicine, drugs, appliances, supplies, blood and blood derivatives, unless these items are Covered Medical Expenses under the Plan, and then only to the extent that the charges do not exceed the usual charge for such items from other providers;

M. Eyeglasses, contact lenses, hearing aids and examination for the prescription or fitting thereof and any hospital or Physician's charges related to refractive surgery such as radial keratotomy, keratomileusis, or lamellar keratoplasty and any other procedure the purpose of which is to alter the refractive properties of the cornea, except for the treatment of keratoconus;

N. Travel, whether or not recommended by a Physician, unless related to a human organ transplant specified under 7.3.P.6;

O. Any medical social services (except for those provided under the Hospice program and Home Health Care Program upon recommendation of the Utilization Review Agency) or vocational, visual, recreational, educational, or milieu therapy;

P. Diet treatments, and all weight loss surgery, including, but not limited to the following: gastric bypass or stapling; intestinal bypass and any related procedures; the reversal of such procedures; and conditions and complications as a result of such procedures or treatment.

Q. Any service or supply rendered by a member of the Covered Person's immediate family (parent, child, spouse, grandparent or in-law);

R. Room and Board charges for elective non-emergency Hospital admissions for certain surgical procedures that can safely be performed on an outpatient basis. Benefits will be provided when Pre-certification of coverage is requested and it is determined that the Covered Person's medical condition warrants hospitalization. If Pre-certification is not obtained and upon subsequent review, it is determined that the admission was Medically Necessary, Room and Board benefits will be provided, subject to the Deductible and Co-payment requirements in 7.1.A and B and 15.8.1 and 15.2.8.

S. Charges for chronic pain management programs or any program developed by centers with multidisciplinary staffs intended to provide the interventions necessary to allow the patient to develop pain coping skills and freedom from dependence on analgesic medications;

T. With respect to a Dependent Child, for charges which are the result of the Dependent Child's pregnancy, or complications from the Dependent Child's pregnancy or childbirth;

U. Any services, supplies or charges for, or in connection with, a vasectomy or tubal ligation performed within one year of enrollment, or any procedure or surgery designed to reverse a prior vasectomy or tubal ligation;

V. Assisted reproductive technologies, except as provided in 7.18.A;

W. Physician charges for clinical pathology defined as services for reading any machine-generated reports on mechanical laboratory tests;

X. Any psychological tests to determine job or occupational placement, school placement or other educational purposes or milieu therapy or to determine learning disability or behavior disorder;

Y. Transcutaneous electrical nerve stimulation whose primary purpose is the treatment of pain;

Note: This exclusion does not include muscle stimulation units when they are used to strengthen specific muscles when electrical stimulation is more effective than resistance exercise programs. (e.g., quadriceps, shoulder, paraspinal muscle groups weakened or atrophied by disease, injury or surgery).

Z. Any services or supplies for Pre-existing Conditions, as that term is defined in the Plan. Benefits for a Pre-existing Condition are payable only for treatment rendered 12 months after a Covered Person's Enrollment Date, or 18 months after a Late Entrant's Enrollment Date. Notwithstanding any other provision of the Plan, the Pre-existing Condition exclusion shall not apply to a newborn child, an adopted child under age 18, or a child under age 18 who has been placed for adoption as a Dependent of an Employee or Retiree who is covered under this Plan, or under any other Creditable Coverage, within 31 days of the first date such person was eligible for such coverage.

Notwithstanding any other provision of this Plan, any period during which benefits for a Pre-existing Condition as described herein, would be excluded shall be reduced by the length of an individual's Creditable Coverage, which is calculated by determining all days during which the individual had one or more types of Creditable Coverage, without regard to specific benefits included in coverage. However, days of Creditable Coverage that occurred before a Significant Break in Coverage shall not be counted for the purpose of reducing any period of exclusion.

AA. When a patient in a Hospital receives only a Skilled Nursing level of care, benefits for inpatient Hospital Care are limited to the average daily statewide per diem rate, plus additional medical services rendered, as determined by the Third Party Claims Processor paid to Skilled Nursing Facilities, and benefits for related Physician services are limited to one visit per week up to the maximum benefits provided in

7.10;

BB. Benefits will not be provided for services or supplies not specifically listed in Article 7, Schedule of Benefits, inclusive;

CC. Services or supplies received as a result of any intentionally self-inflicted injury (or injuries resulting from attempted suicide) that does not result from a medical condition or domestic violence;

DD. Benefits will be limited to the extent a Covered Person proves entitlement to any benefits under the Plan by filing or causing to be filed a claim and documentation in support of the claim;

EE. Equipment, including durable medical equipment, which has a non-therapeutic use, purchased or requested by the Subscriber with or without a prescription including but not limited to home and vehicle modifications, an air conditioner, air filter or air filtration system, speech augmentation or communication devices, including computers, dehumidifier, home whirlpool, exercise equipment, ace bandages, wigs, hairpieces, or any other artificial device or procedure to replace scalp hair, foot orthotics or ankle or knee braces whose primary or sole purpose is to allow participation in athletics but are not documented to be Medically Necessary, bandages and gauze and similar equipment, are not Covered Medical Expenses;

FF. Over-the-counter medicine;

GG. Fees for medical records and/or claims filing;

HH. Any service, supply or charge for which the Employee, Retiree or Dependent is not legally obligated to pay, as well as any deductible, coinsurance or charges, or parts thereof, which a Hospital or Health Care Provider waives on an other than isolated case by case basis;

II. Additional benefits will not be provided for preoperative anesthesia consultation;

JJ. When the same Physician renders different levels of care on the same day, benefits will only be provided for the highest level of care;

KK. Any medical service, supply or charge, which is prescribed or ordered by a Physician because an anatomical variation causes psychological problems;

LL. Any service or supply related to dysfunctional conditions of the muscles of mastication, or derangement of the temporo mandibular joint (TMJ), including office visits, splints, braces, guards, etc. Provided however, this exclusion shall not apply to the Medically Necessary surgical correction of disorders of the temporo mandibular joint that meet the conditions of 7.5.A.7;

MM. Any service or supply related to orthognathic surgery or skeletal malrelationships or deformities of the jaws. Provided, however, this exclusion shall not apply to

Medically Necessary surgical correction as provided in 7.5.A.8.;

NN. Schlerotherapy, including injections of sclerosing solutions for varicose veins of the leg, unless prior approved ligation or stripping procedure has been performed within three years and documentation establishes that some varicosities remained after the prior procedure.

Benefits will not be provided for varicose vein surgery performed for cosmetic purposes. The treatment of visible subcuticular veins (i.e. spider angiomas, telangiectasis) less than 2 mm in size is considered to be cosmetic in nature and therefore is not a covered benefit.

OO. Services or charges incurred for, or in connection with, transexuality, gender reassignment or related procedures;

PP. Food supplements, even if the supplements are ordered or prescribed by a Physician;

QQ. Services and supplies rendered after death including, but not limited to, transportation and autopsies;

RR. Smoking cessation or deterrence products, with the exception of provisions established under the Prescription Drug Program, or as authorized by the Behavioral Health Manager for eligible participants in its tobacco cessation p program;

SS. Services performed by service or therapy animals or their handlers.

TT. Abortion, except for an abortion performed in accordance with federal Medicaid guidelines;

UU. Any services or charges related to Employee Assistance Programs.

VV. Complications arising from Covered Person's receipt of either hospital services, medical services, medical supplies or other treatments that are not considered Covered Hospital Services or Covered Medical Expenses, including complications arising from a Covered Person's use of discount services.

WW. In the Savings Plan, non-sedating antihistamine medications or prescription drugs to treat erectile dysfunction are not a covered benefit.

ARTICLE 10.

CONTINUATION OF COVERAGE

10.1 Incapacitated Dependent Child

The coverage of a Dependent Child under this Plan will not be terminated upon the attainment of the limiting age specified in the Plan while the Child is, and continues to be both (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap, and (b) principally dependent (more than 50%) upon the Subscriber for support and maintenance, so long as continued provided proof of such incapacity and dependency is furnished to the Plan Administrator by the Employee within 31 days of such Child's attainment of the limiting age of 19, and at such other reasonable times, but not more than annually, and provided further, that coverage remains in force for the Employee.

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

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

10.3 Surviving Spouse and/or Dependent Children

The Covered Surviving Spouse and/or Covered Dependent Children of a deceased Active or Retired Employee, including any Child born after the death of the Employee but before the remarriage of the Surviving Spouse, shall be eligible to continue the coverage; provided they pay the entire premium without any contribution by the Employer or State, provided however:

A. The premium due from a Covered Surviving Spouse (who is not a State Employee) and/or Covered Dependent Children of a deceased Active or Retired Employee (whose surviving parent is not an Active or Retired Employee) and for which there was a State contribution to the Employee/Retiree premium shall be waived for one year from the date of the Employee's or Retiree's death.

   After one year, the Surviving Spouse and Dependent Children shall be eligible to continue the coverage, provided that they pay the entire premium for such coverage without any contribution by the Employer or State; provided, however the Surviving Spouse and/or Dependent may pay the premium at the employer-funded rate as long as eligible if the deceased Active or Retired Employee was killed in the line of duty after December 31, 2001, and while working for State-Covered Entity;

B. The coverage of a Surviving Spouse provided under this section shall terminate upon remarriage but, in no event shall any Surviving Spouse or Dependent who feloniously and intentionally kills the Active or Retired Employee be entitled to any premium waiver;

C. The existing coverage of any Dependent Children will not be effected by the remarriage of the Surviving Spouse, but such coverage is subject to all the terms, conditions, limitations and exclusions of the Plan, including the requirement that coverage ceases on the date that a Covered Dependent no longer meets the definition of a Dependent.

ARTICLE 11.

COBRA

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

COBRA requires that a Covered Person who would otherwise lose coverage as a result of a "qualifying event" as defined in that act, is entitled to elect to temporarily extend health coverage under this Plan. The coverage will be identical to the coverage provided to the Covered Employee before the qualifying event and identical to the coverage provided similarly situated Employees to whom a qualifying event has not occurred.

11.2 Qualifying Event

A qualifying event is any one of the following:

A. Termination of the Employee's employment (other than for gross misconduct) or reduction of hours worked so as to render the Employee ineligible for coverage;

B. The death of the Employee;

C. Divorce or legal separation of the Employee from his spouse;

D. A Dependent Child ceasing to qualify as an eligible Dependent under the Plan;

E. Entitlement to Medicare by the Covered Employee.

11.3 Qualified Beneficiary

A qualified beneficiary is any individual who, on the day before the qualifying event for

the Employee, is a beneficiary under the plan and is any of the following:

A. The Employee whose employment was terminated (other than for gross misconduct) or work hours were reduced so as to render the Employee ineligible for coverage;

B. The Spouse of the Employee; or

C. The Dependent Child of the Employee, including a child who is born to or placed for adoption with the Employee during the period of continuation coverage.

11.4 Notice by Employee, Spouse or Dependent

In cases of divorce or legal separation of the Employee from his spouse or a Dependent ceasing to qualify as an eligible Dependent under the Plan, the Employee or eligible Dependent is responsible for notifying the benefits office of the Employer or the Plan Administrator within 60 days after the later of (a) the date of the qualifying event, or (b) the date the Dependent would lose coverage on account of the qualifying event. If the Plan Administrator is not notified within 60 days of the happening of either event, the Dependent will not be given the opportunity to continue coverage. Provided further, that an Employee or Dependent who is determined to be disabled under Title II or XVI of the Social Security Act, either before the qualifying event or during the first 60 days of COBRA coverage, must provide notice of the determination of disability before the end of the first 18 months of coverage to be eligible for up to 29 months of continuation coverage, and must also notify the Plan Administrator within 30 days of any determination that the Employee or Dependent is no longer disabled.

11.5 Notice By Plan Administrator

The Plan Administrator or employing entity shall provide written notice, as required by statute, to the Covered Employee and his spouse (if any) when commencing coverage of the right to continue health and dental coverage, and to any Qualified Beneficiary within 14 days of the termination or reduction of hours or other qualifying event for which the Plan Administrator must notify the Employee. Notice to the Spouse is deemed notice to any Covered Dependent of the Employee residing with such spouse at the time of notification.

11.6 Election of Coverage

Continued coverage is not automatic. Coverage must be elected within 60 days of the later of the following:

1. The date coverage ceases because of the "qualifying event;"

2. The date the Qualified Beneficiary is sent notice of the right to elect continuation coverage.

11.7 Premium Required

Except as provided below, the Qualified Beneficiary will be required to pay a premium calculated as provided by law for the continued coverage and have the option to make

these payments in monthly installments. The eligible Qualified Beneficiary will have 45 days from the date of election to pay the first premium, which shall include the period when coverage commenced, regardless of the date that the first premium is due. Subsequent premiums are subject to a grace period of 30 days.

11.8 Length of Coverage

The maximum period for continued coverage for a "qualifying event" involving termination of employment or a reduction in hours is 18 months. Provided, however, that an Qualified Beneficiary, who is determined to be disabled under Title II or XVI of the Social Security Act, either before the qualifying event or during the first 60 days of COBRA coverage, is entitled to 29 months of continuation coverage, but only if the Qualified Beneficiary has provided notice of the determination of disability before the end of 18 months of coverage. If a second qualifying event occurs within this 18- (or 29-) month period, the coverage for any affected Dependent who was a Covered Person under the Plan at the time of the first qualifying event, and, at the time of the second qualifying event, may be extended up to 36 months from the first qualifying event. For all other qualifying events, the maximum period of coverage is 36 months.

Coverage under this section may end sooner than the periods listed in the preceding paragraph, and will occur on the date of the earliest of any of the following:

A. The date the State ceases to provide any group health plan to any Employee;

B. The date, including any grace period provided herein, the Employee or eligible Dependent fails to make any required payment;

C. The first date after the date of election in which the Qualified Beneficiary is covered under any other group health plan which does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary. Provided, however, that an Employee who, on the date of the qualifying event, is covered by a plan (including Medicare), other than this Plan, remains eligible for COBRA coverage under this Plan;

D. The date the Employee or eligible Dependent already enrolled for COBRA coverage becomes entitled to Medicare.

11.9 Order of Determination of Benefits

If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of determination:

1. First, the benefits of a plan covering the person as an employee, member or subscriber (or as the person's Dependent); and

2. Second, the benefits under the continuation coverage.

11.10 Premium Assistance for COBRA Benefits pursuant to the

American Recovery and Reinvestment Act of 2009

Notwithstanding any other paragraph in this Plan, an Assistance Eligible Individual shall be treated as having paid the full amount of his COBRA premium if such individual pays (or anyone else other than the individual's employer pays on his behalf) 35 percent of the amount of the COBRA premium.

A. Assistance Eligible Individual is any Qualified Beneficiary if:

1. At any time during the period of September 1, 2008, through December 31, 2009, such Qualified Beneficiary is eligible for COBRA continuation coverage;

2. Such Qualified Beneficiary elects such coverage; and

3. The qualifying event with respect to the COBRA continuation coverage consists of the involuntary termination of the Employee's employment and occurred during the period of September 1, 2008, through December 31, 2009.

B. An Assistance Eligible Individual may, not later than 90 days after the date of notice, elect to enroll in coverage under a plan offered by EIP that is different than coverage under the plan in which the Assistance Eligible Individual was enrolled at the time the qualifying event occurred, provided the premium for such different coverage does not exceed the premium for coverage in which the Individual was enrolled at the time the qualifying event occurred.

C. An individual who does not have an election of COBRA continuation coverage in effect on February 17, 2009, but who would be an Assistance Eligible Individual if such election were so in effect, such individual may elect the COBRA continuation coverage during the period beginning February 17, 2009, and ending 60 days after the date of notice to such individual, provided such coverage shall commence March 1, 2009, and shall not extend beyond the period of COBRA continuation coverage that would have been required if the coverage had been elected. With respect to this election, the period beginning on the date of the qualifying event and ending with February 28, 2009, shall be disregarded for purposes of determining pre-existing conditions.

D. Eligibility for premium assistance shall cease on the earlier of:

1. The first date that the Assistance Eligible Individual is eligible for coverage under any other group health plan or Medicare; or

2. The earliest of:

a. The date that is 9 months after the first day of the first month that the individual receives premium assistance;

b. The date following the expiration of the maximum period of

continuation coverage; or

c. The date following the expiration of the period of continuation coverage allowed under 11.10.C.

E. Any Assistance Eligible Individual who fails to notify his former employer of cessation of eligibility for premium assistance shall pay a penalty of 110 percent of the premium assistance provided for in this paragraph.

ARTICLE 12.

CLAIMS PROCEDURE

12.1 Claim for Payment of Benefits

A. A Covered Person will present an identification card when applying for services covered under this Plan;

B. Written notice of care on which a claim is based must be furnished to the Third Party Claims Processor within 90 days of the beginning of care, or as soon thereafter as is reasonably possible. Upon receipt of the notice, the Third Party Claims Processor will furnish or cause to be furnished to the Covered Person a claim form. If the claim form is not furnished within 15 days after the receipt of the notice by the Third Party Claims Processor the Covered Person will be deemed to have complied with the requirements of this Plan as to proof of loss, if he submits written proof covering the character and extent of the loss within the Plan time fixed for filing proof of loss;

C. A Covered Person must complete or cause to be completed a claim, on forms prescribed by the Plan Administrator or Third Party Claims Processor, and will file it or cause it to be filed, along with all documentation, including medical records, required by the Plan Administrator or Third Party Claims Processor;

D. The claim must be received by the Third Party Claims Processor within 90 days after the beginning of care; however, failure to file the claim within the 90-day period will not prevent payment of benefits if the Covered Person shows that it was not reasonably possible to timely file the claim, provided the claim is filed as soon as is reasonably possible, in no event, except in the absence of legal capacity, later than 12 months following the end of the Benefit Year in which the goods or services were provided;

E. The claim will be deemed written proof of loss and written authorization from the Covered Person to the Third Party Claims Processor to obtain any medical or financial records and documents useful to the Third Party Claims Processor, however, the Third Party Claims Processor is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied to it at the time the claim was processed. Any party who submits medical or financial reports and documents to the Third Party Claims Processor in support of a Covered Person's claim will be deemed to be acting as the agent of the Covered Person.

12.2 Payment of Claims

The Third Party Claims Processor will pay benefits as described in Article 7, Schedule of Benefits, of this Plan directly to Providers who are members in the Provider, Ambulatory Surgical Center or Hospital networks (hereinafter referred to as "participating providers") and any other Providers with whom the Plan Administrator has agreed to make direct payments, automatically, and without any assignment of benefits by the subscriber, when the participating or contracting provider files a health insurance claim form with the Third Party Claims Processor signed by a Covered Person, completed in full, using procedure codes designated by the Third Party Claims Processor for all services rendered.

The right to assign any benefits due and payable hereunder is expressly prohibited except as provided herein. In particular, and without limiting the generality of the foregoing, the Covered Person may not assign any benefits, and the Plan Administrator shall not recognize any assignment of benefits, to: (1) a non-participating provider who was offered and declined membership in the networks; or, (2) a non-participating Provider who did not meet the standards and qualifications for membership in the networks, or (3) a supplier of medical goods, supplies or drugs, unless specifically authorized by the Plan Administrator. Provided, however, the Covered Person may assign benefits to non-participating Providers rendering covered medical services under the Plan who are not within the scope of the networks, or who were not offered and did not decline membership in the networks or as specifically authorized by the Plan Administrator. Failure by the Plan Administrator or the Third Party Claims Processor to reject an assignment of benefits prohibited by this section shall not be construed as a waiver of its rights to enforce this section in the event of subsequent assignments.

A Provider who may accept assignment of benefits shall file a health insurance claim form with the Third Party Claims Processor signed by a Covered Person, completed in full, using procedure codes designated by the Third Party Claims Processor for all services rendered, the Third Party Claims Processor will pay the benefits to the provider. Except as provided above, the Third Party Claims Processor on behalf of the Plan will pay all benefits directly to the Covered Person upon receipt of due proof of loss.

12.3 Allocation and Apportionment of Benefits

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

12.4 Information and Records

As permitted under the Health Insurance Portability and Accountability Act of 1996, the Third Party Claims Processor, as agent of the Plan Administrator, is entitled to obtain such authorization for medical and hospital records as it may reasonably require from any provider of services incident to the administration of the benefits hereunder and the attending Physician's certification as to the Medical Necessity for care or treatment.

12.5 Review of Claims Denied in Whole or Part

If the Third Party Claims Processor, or the Utilization Review Agency or their designee determines that any person who has submitted a claim for the payment or pre-certification of benefits under the Plan is not entitled to receive all or part of the benefits sought, the Third Party Claims Processor, Utilization Review Agency or their designee, shall inform the claimant of such determination and the reasons therefore, with specific reference to pertinent provisions of the Plan. The exclusive remedy for the denial of benefits shall be as provided by statute and by the procedures of the Budget and Control Board.

A. **Reconsideration by Third Party Claims Processor or Utilization Review Agency.** A Covered Person, after receipt of notification of the Third Party Claims Processor's or the Utilization Review Agency's action on his claim, must request a review of any benefits denied in whole or in part within six months of notice of the denial of benefits by the Third Party Claims Processor or the Utilization Review Agency. To request a review of that agency's decision, the Covered Person must write the appropriate agency giving reasons why the claim should be approved. The claimant may also request an expedited reconsideration of the decision denying benefits.

   The Third Party Claims Processor or the Utilization Review Agency shall render its decision within 60 days after the request for review is received, unless medical records are requested, in which case the decision will be rendered no later than 30 days after the requested information is received. If the requested information is not received within 30 days, the decision will be made on the information available at that time. The decision shall be made by one not involved in the original decision to deny benefits or pre-certification. The reconsideration under this section shall be exhausted before any appeal to the Plan Administrator. The Third Party Claims Processor or the Utilization Review Agency will send the Covered Person a written decision stating the specific reasons for its final decision with specific reference to pertinent Plan provisions.

B. **Appeal of Denial of Benefits to Plan Administrator.** After the review provided in 12.5.A, a Covered Person, who is informed that the claim has been denied in whole or in part, or that benefits will not be paid, and who desires review of that determination, may request from the Plan Administrator's director a review of that decision within 90 days after notice of the denial of benefits after reconsideration. The filing of an appeal shall be deemed to be consent for the director or his designee to review all medical records necessary for a determination of the appeal. To hear the appeal, the director may appoint up to five representatives, who are familiar with group health benefits and the State Health Plan and who have not been involved in the denial of benefits in the case under consideration.

   The director, or his designees, may request from the Third Party Claims Processor information reviewed by it, including the pertinent medical records, and may request any additional information from the Third Party Claims Processor, the Utilization Review Agency or the claimant, or from independent medical personnel or other source as in their judgment may be required to make a determination. The

director or his designees shall consider all information submitted, the terms and conditions of the Plan and shall render a decision within 30 days of the receipt of any requested material, providing reasons for the decision and citation of any applicable Plan provisions.

The director, or his designee, shall provide specific reasons for the decision and citation of the pertinent Plan provisions, and may, if the director or his designee agrees with the Third Party Claims Processor or Utilization Review Agency, deny the claim of the Covered Person, and if he agrees with the Covered Person, approve the claim or such portion as is appropriate, provided, however, the director, or his designee, must state in writing the provisions of the Plan justifying the result. The decision of the director, or his designee, on these matters is binding and conclusive, subject to review pursuant to 12.6.

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

12.6 Legal Actions

The exclusive remedy for the denial of benefits shall be as provided in 12.5 and by judicial review of that decision under 1976 S.C. Code Ann § 1-23-380, as amended, as provided by statute. No appeal may be brought until a Covered Person has exhausted the review procedure set forth in 12.5, nor will such action be brought after the expiration of the applicable period for commencing such actions, following the occurrence giving rise to the action. Any construction or interpretation of the Plan, determination of eligibility, or any other decision arising under the Plan, or exercise of judgment or discretion given to the Plan Administrator by the Plan or Planholder, shall be binding and conclusive so long as the decisions of the Plan Administrator or its duly authorized agent are not arbitrary or capricious or in violation of applicable statutes.

12.7 Identification Cards and Booklets

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

12.8 Right to Examine Covered Person

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

12.9 Access to Information

The Plan Administrator will be provided access to all claims data and supporting documents of any person covered under the Plan for purpose of auditing the claims

adjudication procedures. According to the guidelines set forth under the Health Insurance Portability and Accountability Act of 1996, the Plan Administrator agrees to restrict access to all such data and documents to those of the Plan Administrator's employees directly responsible for conduct of the audit, and to assure that the data and documents are handled on a strictly confidential basis.

12.10 Privacy of Protected Health Information

(a) The Plan Administrator and any business associate servicing the Plan will disclose Plan participants' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions for the Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-64). Plan Sponsor shall mean, for the sole purpose of compliance with the mandates of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the South Carolina Budget and Control Board, which established, and maintains, the Group Health Benefits Plan for the Employees of the State of South Carolina, the Public School Districts and Participating Entities.

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

ARTICLE 13.

NOTICE

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

ARTICLE 14.

SUBROGATION RIGHTS

In the event benefits are provided to, or on behalf of, a Covered Person under the terms

of this Plan, the Covered Person agrees as a condition of receiving benefits under the Plan to transfer to the Plan all rights to recover damages in full for such benefits when the injury or illness occurs through the act or omission of another person, firm, corporation, or organization. If, however, a Covered Person receives payment for such medical expenses from another person, firm, corporation, organization or business entity paid by, or on behalf, of the person or entity who allegedly caused the injury or illness, the Covered Person agrees to reimburse the Plan in full for any medical expenses paid by the Plan. The Plan's right of full recovery may be from the third party, any liability or other insurance covering the third party, the insured's own uninsured motorist insurance, underinsured motorist insurance, any medical payments, no fault or malpractice insurance coverages which are paid or payable. The Plan may enforce its reimbursement rights by requiring the Covered Person to cooperate and to assert a claim to any of the foregoing coverages to which the Covered Person may be entitled. The Plan will not pay fees or costs associated with a claim or lawsuit without its express written authorization. The Covered Person shall cooperate with the Planholder and Third Party Claims Processor, if appropriate, on behalf of the Planholder and execute all instruments and do all things necessary to protect and secure the Planholder's right of subrogation. In the event benefits are provided to, or on behalf of, a Covered Person under the terms of this Plan, the Planholder shall be subrogated, at its expense and unless specifically prohibited by law, to the rights of recovery of such Covered Person against any person, firm, corporation, or organization, including such Covered Person's right to uninsured motorists benefits as defined by the South Carolina Motor Vehicle Financial Responsibility Act, as amended, provided, however, that the Planholder shall not be subrogated to such Covered Person's rights to Personal Injury Protection (PIP) benefits as defined by the South Carolina Automobile Reparation Reform Act of 1974, as amended. The Covered Person shall cooperate with the Planholder and Third Party Claims Processor if appropriate, on behalf of the Planholder and execute all instruments and do all things necessary to protect and secure the Planholder's right of subrogation.

ARTICLE 15.

UTILIZATION REVIEW AND MANDATORY CASE MANAGEMENT

SECTION 1

15.1.1 Application

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

benefits for behavioral disorders under the Plan is subject to, and contingent upon, the Covered Person's compliance with the provisions of Section 2 of this Article and the utilization guidelines established by the Behavioral Health Manager.

15.1.2 Pre-Certification of Medical Care

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

A. Any non-emergency admission to a Hospital;

B. Any non-emergency surgical procedure, whether performed in a Hospital, Free Standing Surgical Center, or Ambulatory Surgical Center;

C. Any non-emergency surgical procedure on the foot or knee performed in a Physician's office;

D. Any admission for obstetrical and neonatal (sick newborn) services;

E. Any hospitalization that exceeds the length of stay limitation previously authorized by the Utilization Review Agency;

F. Any admission or re-admission to Extended Benefit Programs, whether or not the benefits payable under this Plan are Primary or Secondary, such as:

   1. Hospice program;

   2. Skilled Nursing Facility;

   3. Home Health Care Program;

   4. Alternative Treatment Plan;

G. Any medical services or procedures involving:

   1. Inpatient physical therapy;

   2. Any second surgical opinion;

   3. Any extended care benefits;

H. Any prosthetic appliance or orthopedic brace, crutch or lift attached to such brace, crutch or lift;

I. Any admission, or procedure involving any organ transplant, bone marrow transplant or other stem cell rescue or tissue transplant for which benefits are provided under this Plan;

J. Any purchase or rental of Durable Medical Equipment;

K. High-cost outpatient non-surgical procedures, to be determined at the discretion of the Utilization Review Agency.

15.1.3 Limited Exception to Pre-Certification

Pre-admission certification is not required:

A. For any Hospital admission outside the United States or Canada, which occurs while the Covered Person is in that country for reasons other than obtaining medical services;

B. When the benefits provided under this Plan are secondary to the benefits provided under any other Plan as determined under Article 8, Coordination of Benefits, provided however, that all extended care benefits in 7.10 to 7.13 are subject to Pre-certification under this Article.

15.1.4 Notification of Emergency Admission or Surgical Procedure

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

15.1.5 Concurrent Review of Hospitalization and Individual Case Management

The Hospital stay of any Covered Person shall be monitored by the Utilization Review Agency, which reviews the services and evaluates whether they are appropriate for the diagnosis, and insures that alternative methods of care are considered. Also, the Utilization Review Agency monitors all hospitalizations to identify the most appropriate and cost-effective setting for continued medical care.

15.1.6 Alternative Treatment Plan

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

The Utilization Review Agency after consulting with the treating Physician, and others as appropriate, may recommend an Alternative Treatment Plan in a less intensive care setting. If accepted by the treating Physician, Covered Person and Plan Administrator,

the Utilization Review Agency will assist, as necessary, in implementing the Alternate Treatment Plan. Subject to limitations and exclusions and eligibility requirements, Physician benefits will be paid in accordance with the schedule of benefits, and the medical costs paid by the Covered Person shall be counted towards satisfaction of the out-of-pocket totals under 7.1.A.4 and 7.1.B.4. In addition, services and supplies that are Medically Necessary because of the Alternative Treatment Plan and which would otherwise not be covered under the Plan will be considered as Covered Medical Expenses.

15.1.7 Certification by Utilization Review Agency

A. **Certification and Length of Stay Granted.** The Utilization Review Agency shall reply to the Covered Person, family member, Physician or Hospital within 24 hours. The Utilization Review Agency may certify the procedure or admission and designate a length of stay limitation, if appropriate. The Certification and length of stay limitation constitute a preliminary determination made on the basis of the information then known to the Utilization Review Agency that the procedure or admission and the designated length of stay, are consistent with generally recognized medical standards and procedures, and that, subject to eligibility requirements, other limitations or exclusions, satisfaction of deductibles, and other provisions of the Plan, the procedure or service is eligible for reimbursement under the Plan. The Certification is sent to the Third Party Claims Processor.

B. **Certification or Requested Length of Stay Denied.** If the Utilization Review Agency determines on the information then available that the proposed procedures or services are not within generally recognized medical standards and procedures or the length of stay requested by the health care provider is excessive, the Utilization Review Agency shall inform the Covered Person, family member, as well as the Physician or Hospital and Third Party Claims Processor of that decision. The selection of the course of treatment remains with the patient or Covered Person and the treating Physician. The final decision on whether some or all of a claim will be paid shall be made by the Third Party Claims Processor on the basis of all information known at the time the claim for reimbursement is submitted to the Third Party Claims Processor. The Utilization Review Agency shall reconsider the decision denying Certification only if the Covered Person, treating Physician or Hospital provides new information that may change the result.

15.1.8 Failure to Comply with Utilization Review Requirements

A. **Failure to Obtain Pre-Admission Review.** A patient or Covered Person who does not obtain preadmission review and Pre-certification as required by this Article, in addition to the normal deductible and all other terms and conditions of the selected Plan, shall be subject to the following:

1. A $200 penalty for each admission to a Hospital or Skilled Nursing Facility;
2. The costs incurred during the hospitalization, treatment or extended benefit program shall not be included in those that satisfy the Out-of-

Pocket Limitations of 7.1.A.4 and 7.1.B.4;

3. The costs incurred during the hospitalization, treatment, or extended benefit program shall always be subject to the Coinsurance requirement of the selected plan.

B. **Stays in Excess of Length of Stay Limitation.** The length of stay limitation is established by the Utilization Review Agency after consultation with the treating Physician, and in light of the information on the Covered Person or patient's condition provided by the Physician, and communicated to the Covered Person, patient, family member, Physician and Hospital. Confinements beyond the length of stay designated by the Utilization Review Agency may be determined to be without Medical Necessity, and reimbursement denied for Room and Board. Other Medically Necessary charges may be covered.

C. **Second Opinions** may be required by the Utilization Review Agency as a condition to Pre-certification, ongoing certification, or in conjunction with case management or when providing an alternative treatment option. If the opinions are divided, a third opinion may be required, which shall be controlling. The Plan will pay the benefits for the second opinions required by the Utilization Review Agency as provided in 7.15. Second opinions obtained without Certification by the Utilization Review Agency shall be subject to all other terms and conditions of the Plan, including the requirement that they be Medically Necessary, and in addition, if they are Medically Necessary:

1. The costs of a second opinion shall not be included in those costs that satisfy the Out-of-Pocket Limitations of 7.1.A.4 and 7.1.B.4; and

2. The cost of a second opinion shall always be subject to the Coinsurance requirement of the selected Plan.

D. **Other Services or Supplies Obtained without Certification** from the Utilization Review Agency required by this Plan shall be subject to all the terms, conditions, limitations and exclusions of the Plan, as well as the following:

1. The costs incurred shall not be included in those that satisfy the out-of-pocket limitations of 7.1.A.4 and 7.1.B.4; and

2. The costs incurred shall always be subject to the coinsurance requirement of the selected plan.

E. The Utilization Review Agency may require medical social worker services as a condition of pre-certification of Covered Services. The Plan will pay for the services of a medical social worker as provided in paragraph 7.13.B, at 100 percent of the Reasonable and Customary or Allowable Charge, or the Actual Charge, whichever is less for the purpose of evaluating the patient's needs and identifying other resources, both family and community for which the patient is eligible but are not covered by insurance.

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

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

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

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

15.1.10 Comprehensive Maternity Management

A Covered Person, upon becoming aware of pregnancy, shall notify the Utilization Review Agency. A maternity coordinator providing education and counseling for the mother shall monitor each case. The Covered Person shall be subject to the penalties described in 15.1.8.A for failure to notify the Utilization Review Agency during the first trimester of the pregnancy or refusal to participate in the comprehensive maternity management program. This penalty shall be in addition to that in force for failure to notify the Utilization Review Agency of the hospital admission as described in 15.1.2 and 15.1.4.

SECTION 2

15.2.1 Application

The payment of benefits under the Plan for treatment of Behavioral Health Disorders or

Alcoholism or Drug Abuse is subject to, and contingent upon, the Covered Person's compliance with the following procedures and in accordance with the utilization review procedures established by the Behavioral Health Manager.

15.2.2 Pre-Certification for Covered Behavioral Health Services

The Covered Person, an authorized family member, or Behavioral Health Provider treating the Covered Person shall contact the Behavioral Health Manager at least 24 hours before the Covered Person's receipt of professional, outpatient, or inpatient services for treatment of a Behavioral Health Disorder or Alcoholism or Drug Abuse in the United States or Canada.

15.2.3 Limited Exception to Pre-Certification

Pre-certification is not required:

A. For any Hospital admission outside the United States or Canada, which occurs while the Covered Person is in that country for reasons other than obtaining medical services;

B. When the benefits provided under this Plan are secondary to the benefits provided under any other Plan as determined under Article 8, Coordination of Benefits.

15.2.4 Notification of Psychiatric Emergency

The Behavioral Health Provider, Covered Person, or family member shall notify the Behavioral Health Manager within 24 hours of any emergency admission or any emergency treatment of a Covered Person for a Behavioral Health Disorder or Alcoholism or Drug Abuse. The determination of whether a particular set of facts constitutes an emergency shall be made by the Behavioral Health Manager in conformity with applicable criteria.

15.2.5 Review of Hospitalization and Individual Case Management

The Behavioral Health Manager shall review and determine whether the services provided or to be provided a Covered Person for a Behavioral Health Disorder or Alcoholism or Drug Abuse are Medically Necessary, including but not limited to whether outpatient care, hospitalization, length-of-stay, or diagnostic ancillary services are necessary and appropriate for a Covered Person's condition. Also, the Behavioral Health Manager monitors all hospitalizations to identify the most appropriate and cost-effective setting for continued care.

15.2.6 Alternative Treatment Plan

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

than the one in which the Covered Person is presently receiving medical care. An Alternative Treatment Plan requires the approval of the treating Physician or Behavioral Health Provider, the Plan Administrator and the Covered Person.

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

15.2.7 Certification by Behavioral Health Manager

A. **Certification or Length of Stay Granted.** The Behavioral Health Manager shall reply to the Behavioral Health Provider or Covered Person within 24 hours. The Behavioral Health Manager may certify the procedure or admission and designate a length of stay limitation, if appropriate. The Certification constitutes a preliminary determination made on the basis of the information then known to the Behavioral Health Manager that the determination is consistent with generally recognized medical standards and procedures, and that subject to eligibility requirements, other limitations and exclusions, satisfaction of deductibles and other provisions of the Plan, the procedure or service is eligible for reimbursement under the Plan.

B. **Certification or Length of Stay Denied.** If the Behavioral Health Manager determines, on the information then available, that the proposed procedures or services are not within generally recognized medical standards and procedures or the length of stay requested by the Behavioral Health Provider is excessive, the Behavioral Health Manager shall inform the Behavioral Health Provider and the Covered Person of that decision. The selection of the course of treatment remains with the patient or Covered Person and the treating Behavioral Health Provider. The final decision on whether some or all of a claim will be paid shall be made by the Behavioral Health Manager on the basis of all information known at the time the claim for reimbursement is submitted to the Behavioral Health Manager. The Behavioral Health Manager shall reconsider the decision denying Certification only if the Covered Person or treating Behavioral Health Provider provides new information that may change the result.

15.2.8 Failure to Comply with Utilization Review Requirements

A. **Failure to Obtain Pre-Certification.** A Covered Person who does not obtain Pre-certification as required by this Section, or a Covered Person who requests

services after being informed by the Behavioral Health Provider prior to the rendition of such services that the Behavioral Health Manager has denied Pre-certification of such services, shall be responsible for all the costs incurred during the hospitalization or treatment.

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

C. **Second Opinions.** Second Opinions may be required by the Behavioral Health Manager as a condition of Pre-certification, ongoing certification, or in conjunction with case management. If the opinions are divided, a third opinion may be required, which shall be controlling. The Plan will pay the benefits for the second opinions required by the Behavioral Health Manager as provided in 7.15, subject to all other terms and conditions of the Plan, provided however, that second opinions obtained without Pre-certification by the Behavioral Health Manager are not a Covered Benefit under the Plan.

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

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

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

The Behavioral Health Manager, after consulting with the treating Behavioral Health Provider and reviewing the matter under its internal procedures, may disagree with some medical services recommended or provided by the treating Behavioral Health Provider.

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

ARTICLE 16.

MEDICARE SUPPLEMENTAL PLAN

16.1 Medicare Supplemental Plan

Medicare is the Primary coverage for Retirees eligible for Medicare. To supplement Medicare, the State Health Plan of Benefits also offers a Medicare Supplemental Plan.

A. Enrollment.

Retirees eligible for Medicare, who are enrolled, or eligible to enroll, in the Plan as a Retiree, may enroll in the Medicare Supplemental Plan. The terms, conditions and procedures applicable to enrollment in the Plan as a Retiree under 3.11, are applicable to Retiree enrollment in the Medicare Supplemental Plan. Provided, however, a Retiree enrolled in the Medicare Supplemental Plan may not subsequently enroll in the Standard Plan as Secondary coverage to Medicare.

B. Benefits.

1. **Hospital Admissions.** The Medicare Supplemental Plan will pay the following benefits for covered services received in the United States after Medicare Part A benefits have been paid:

   a) The Medicare Part A hospital Deductible;

   b) The Coinsurance (after Medicare payment) for the 61st through 150th day of hospitalization, up to the Medicare-approved charge;

   c) 100 percent of Medicare-approved charges and reimbursed at the rate approved and paid by Medicare after the 150th day, if Medically Necessary; and,

   d) The Coinsurance for Durable Medical Equipment up to the Medicare-approved charge.

2. **Skilled Nursing Facility.** The Medicare Supplemental Plan will pay the following benefits after Medicare has paid benefits:

a) The Coinsurance (after Medicare payment) for the 21st through the 100th day of confinement in a Skilled Nursing Facility, up to the Medicare-approved charge; and,

b) 100 percent of the Medicare-approved charges and reimbursed at the rate approved and paid by Medicare for confinement after the 100th day in a Skilled Nursing Facility, if Medically Necessary, and if approved by the Utilization Review Agency. The maximum annual benefit per covered person is $6,000.

3. **Physician Charges.** The Medicare Supplemental Plan will pay the following benefits:

a) The Medicare Part B deductible;

b) The Medicare Coinsurance (currently 20 percent or 50 percent for Behavioral Health Disorders) of the Medicare-approved charge for physician's services for surgery, necessary home and office visits, in- hospital visits, and other Physician's services not otherwise excluded by Medicare or this Plan;

c) 20 percent of Medicare approved charges for Physician's services rendered in the outpatient department of a hospital for treatment of accidental injury, medical emergencies, minor surgery and diagnostic services.

4. **Home Health Care.** The Medicare Supplemental Plan will pay the following benefits for Medically Necessary Home Health Care services:

a) The Medicare Part B Deductible;

b) The Coinsurance for any services or costs Medicare does not cover;

c) 20 percent of Medicare approved charges for Durable Medical Equipment;

d) Provided, however, the maximum benefit per Covered Person per Benefit Year is 100 visits or $5,000, whichever occurs first; and further provided that the Medicare Supplemental Plan does not include benefits for services rendered by a person who ordinarily resides in the home, is a member of the family or a member of the family of the spouse of the Covered Person, and further provided that Home Health Care benefits do not include private duty nursing services except as provided in 16.1.B.5, Private Duty Nursing Services, and subject to all the terms and conditions of that section.

5. **Private Duty Nursing Services.** These services are the private services of a registered nurse (RN) or a licensed practical nurse (L.P.N.), which have been certified in writing by a Physician as Medically Necessary. The Medicare Supplemental Plan will pay, subject to an annual $200 Deductible, as follows:

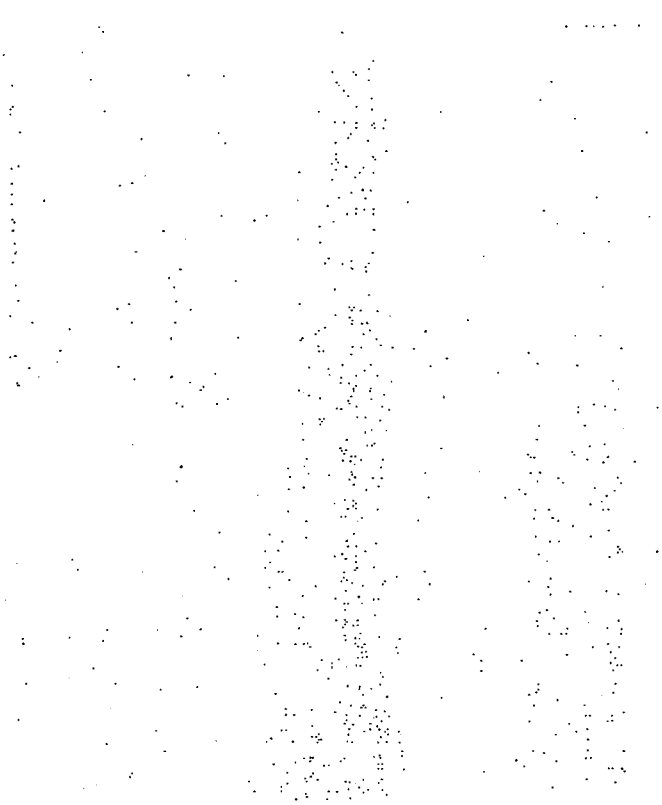
a) 80 percent of Allowable Charges for private duty nursing in a Hospital where no special units are provided; and

b) 80 percent of Allowable Charges for private duty nursing in the Retiree's home;

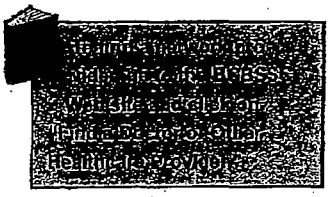
c) Provided, however, that coverage is limited to no more than three nurses per day, and the maximum annual benefit per Covered Person per Benefit Year is $5,000, up to a maximum lifetime benefit of $25,000;.

6. **Prescription Drugs.** Prescription drugs are payable under the terms of Paragraph 7.21 of the Plan.

End of Plan



After you log in, with *My Insurance Manager* you can:



- See how much of your deductible and out-of-pocket limit you have satisfied
- Print an Explanation of Benefits
- Request an ID card
- Ask a question.

With *My Health Toolkit*, you can:

- Create a Personal Health Record
- Take a Personal Health Assessment
- Find estimates of the cost of treatment.

APPEALS

WHAT IF MY CLAIM OR REQUEST FOR PREAUTHORIZATION IS DENIED?

The Employee Insurance Program (EIP) contracts with claims processors, BlueCross BlueShield of South Carolina, Medco Health Solutions, Inc., and APS Healthcare, Inc., to handle claims for your State Health Plan benefits. You have the right to appeal their decisions.

If all or part of your claim or your request for preauthorization is denied, you will be informed of the decision promptly and told why it was made. If you have questions about the decision, check the information in this book, or call the company that made the decision for an explanation.

If you believe the decision was incorrect, you may ask the company to re-examine its decision. This request should be in writing and should be made within six months after notice of the decision. You (or your physician, on your behalf) may submit any additional information you wish to support this appeal. If you wait too long, the original decision will be considered final, and you will not have any further appeal rights. To begin an appeal, follow the instructions in your denial letter.

If you are still dissatisfied after the decision is re-examined, you may ask EIP to review the matter by making a written request to EIP within 90 days of notice of the denial. If the denial is upheld by EIP, you have 30 days to seek judicial review as provided by S.C. Code Ann. 1-11-710 and 1-23-380.

STATE OF SOUTH CAROLINA)) COUNTY OF CHARLESTON)	IN THE COURT OF COMMON PLEAS FOR THE NINTH JUDICIAL CIRCUIT
Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees, Plaintiffs, v. South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina, Defendants.	Civil Action No.: 2009-CP-10-7404 **CERTIFICATE OF SERVICE**

I, Tracey D. Smith, an employee of the law firm of Montgomery Willard, LLC, attorneys for the Defendants do hereby certify that I have served the below named counsel with copies of *Defendants' Notice of Motion and Motion For Summary Judgment and Affidavit of Robin E. Tester* by mailing copies of same by United States mail, proper postage affixed, return address clearly marked, and addressed as follows:

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Tracey D. Smith

June 2, 2010
Columbia, South Carolina

STATE OF SOUTH CAROLINA)	IN THE COURT OF COMMON PLEAS
)	FOR THE NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON)	
Jeffrey D. Allen, individually, as guardian) for Jane Doe, a minor, and as representative) of other similarly situated State of South) Carolina employees,)	Civil Action No.: 2009-CP-10-7404
Plaintiffs,)	**MEMORANDUM IN SUPPORT OF DEFENDANTS' MOTION FOR A PROTECTIVE ORDER**
v.)	
South Carolina Budget and Control Board) Employee Insurance Program and Blue) Cross and Blue Shield of South Carolina,)	
Defendants.)	

FILED
2010 AUG 26 AM 10:40
JULIE J. ARMSTRONG
CLERK OF COURT
BY

I. BACKGROUND

Plaintiff, a participant in the State Health Plan, brings this purported class action alleging causes of action for declaratory judgment, disgorgement of benefits, reformation of contract and injunctive relief. Plaintiff alleges that coverage for diabetes outpatient, self-management, training and education is mandated by S.C. Code Ann. § 38-71-46. Defendants moved for summary judgment on the grounds that: (1) the administrative remedies under S.C. Code Ann. § 1-11-710 (c) are Plaintiff's exclusive remedy, subject only to appeal to the South Carolina Administrative Law Court pursuant to S.C. Code Ann.§ 1-23-600 (D); and (2) S.C. Code Ann. § 38-71-46 does not apply to the State Health Plan.

On May 6, 2010, Plaintiff served both Defendants with interrogatories and requests for production. Copies of these interrogatories and requests for production are attached to Defendants' motion as Exhibits A-D. As can be seen by the discovery attached to Defendants' motion, Plaintiff's discovery requests are voluminous and request over ten years of information

back to January 1, 2000. Even Plaintiff anticipates that this information will be quite burdensome in that Plaintiff's complaint alleges, "...the denial records are voluminous and the review of thousands of documents is anticipated..." (Complaint ¶16).

Defendants moved for summary judgment on the ultimate issues in the case, (1) whether the administrative remedies under S.C. Code Ann. § 1-11-710 (c) are Plaintiff's exclusive remedy, subject only to appeal to the South Carolina Administrative Law Court pursuant to S.C. Code Ann.§ 1-23-600 (D); and (2) whether or not S.C. Code Ann. § 38-71-46 applies to the State Health Plan.[1] If Plaintiff is required to pursue an administrative appeal at the Administrative Law Court, Plaintiff will not be entitled to conduct any discovery. Accordingly, Plaintiff's discovery will be moot. Likewise, if S.C. Code Ann. § 38-71-46 does not apply to the State Health Plan, Plaintiff's Complaint fails and Plaintiff's discovery also will be rendered moot. Accordingly, Defendants move the Court for a protective order protecting Defendants from having to respond to Plaintiff's discovery pending a determination of Defendants' Motion for Summary Judgment.

II. DISCUSSION

A. Discovery Should Be Stayed Pending a Determination of Defendants' Motion For Summary Judgment.

Defendants are entitled to a protective order staying Plaintiff's discovery pending a determination of Defendant's Motion for Summary Judgment. Pursuant to S.C.R.C.P. 26 (c), a party may move for a protective order "for good cause shown ... to protect a party or person from annoyance...oppression, or undue burden by expense, including one or more of the following: (1) that discovery not be had; (2) that the discovery may be had only on specified

[1] Plaintiff admits that the application of S.C. Code Ann. § 38-71-46 is a "relatively narrow question of law." (Complaint ¶ 15).

terms and conditions...." The Court may control the timing and sequence of discovery pursuant to S.C.R.C.P. 26 (d).

An order under Rule 26(c) to stay discovery pending determination of a dispositive motion is an appropriate exercise of a court's discretion. See Thigpen v. United States, 800 F.2d 393, 396-97 (4th Cir.1986) ("Nor did the court err by granting the government's motion under Fed.R.Civ.P. 26(c) to stay discovery pending disposition of the 12(b)(1) motion.... Trial courts ... are given wide discretion to control this discovery process...."), overruled on other grounds, Sheridan v. United States, 487 U.S. 392, 108 S. Ct. 2449, 101 L. Ed. 2d 352 (1988); Tilley v. United States, 270 F. Supp. 2d 731, 734 (M.D.N.C. 2003), affirmed, 85 Fed. Appx. 333 (4th Cir. 2004), cert denied, 543 U.S. 819, 125 S. Ct. 64, 160 L. Ed. 2d 27 (2004); Simpson v. Specialty Retail Concepts, Inc., 121 F.R.D. 261, 263 (M.D.N.C.1988); Chavous v. D.C. Fin. Responsibility & Mgmt. Assistance Auth., 201 F.R.D. 1, 3 (D.D.C. 2001); see Fed.R.Civ.P. 26(c).

Courts often stay discovery pending the outcome of dispositive motions that will terminate the case. See e.g., Johnson v. New York Univ. of Education, 205 F.R.D. 433 (S.D. N.Y. 2002); Yongo v. Nationwide Affinity Ins. Co. of America, 2008 U.S. Dist. LEXIS 14684, 2008 WL 516744, *2 (E.D.N.C. February 25, 2008) (staying discovery pending motion to dismiss); Bellamy v. Ford Motor Co., No. 3:07-CV-00287, 2007 U.S. Dist. LEXIS 66093 (W.D.N.C. Sept. 5, 2007), aff'd, 286 Fed. Appx. 13 (4th Cir. 2008) (same); Graham v. Stansberry, No. 5:07-CV-3015, 2008 U.S. Dist. LEXIS 64067 (E.D.N.C. Aug. 19, 2008) (staying discovery pending dispositive motion).

A stay of discovery until the determination of a dispositive motion is appropriate when (1) the issue raised is strictly one of law, (2) the motion, if successful, would be dispositive of the

entire action, (3) the issue is one that cannot be cured by amending the pleadings, and (4) there is no showing of any prejudice if the Court were to stay discovery. United States v. County of Naussau, 188 F.R.D. 187 (E.D. N.Y. 1999).

In the current case, the issues raised by Defendants' Motion for Summary Judgment are strictly ones of law. Whether the administrative remedies under S.C. Code Ann. § 1-11-710 (c) are Plaintiff's exclusive remedy, subject only to appeal to the South Carolina Administrative Law Court pursuant to S.C. Code Ann.§ 1-23-600 (D) is a matter of law. Also, as Plaintiff admits, the application of S.C. Code Ann. § 38-71-46 to the State Health Plan is a "relatively narrow question of law." (Complaint ¶ 15). Additionally, Defendants' motion, if successful, would be dispositive of the entire case resulting in the dismissal Plaintiff's entire complaint. Also, the issues involved cannot be cured by amending the pleadings. A stay of discovery would not prejudice Plaintiff in that the ultimate issue in the case would be decided at the front end of the litigation without either party wasting time on voluminous, burdensome and costly discovery. Finally, the discovery sought is voluminous and burdensome, covering a span of 10 years, and adjudication of the pending summary judgment motion may obviate the need for the discovery.

III. CONCLUSION

Because Defendants' summary judgment is potentially dispositive of the entire action; Defendants' summary judgment is strictly a matter of law, the discovery sought is voluminous and burdensome covering a span of 10 years, and adjudication of the pending summary judgment motion may obviate the need for the discovery, Defendants' Motion for a Protective Order should be granted, staying Plaintiff's first interrogatories and first requests to produce until a determination can be made as to Defendants' Motion for Summary Judgment.

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August 24, 2010
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STATE OF SOUTH CAROLINA)	IN THE COURT OF COMMON PLEAS
)	FOR THE NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON)	
Jeffrey D. Allen, individually, as guardian)	Civil Action No.: 2009-CP-10-7404
for Jane Doe, a minor, and as representative)	
of other similarly situated State of South)	
Carolina employees,)	
)	**CERTIFICATE OF SERVICE**
Plaintiffs,)	
)	
v.)	
)	
South Carolina Budget and Control Board)	
Employee Insurance Program and Blue)	
Cross and Blue Shield of South Carolina,)	
)	
Defendants.)	
)	

I, Theodore D. Willard, Jr., of the law firm of Montgomery Willard, LLC, attorneys for the Defendants do hereby certify that I have served the below named counsel with a copy of *Defendants' Memorandum In Support For A Protective Order* by mailing a copy of same by United States mail, proper postage affixed, return address clearly marked, and addressed as follows:

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Theodore D. Willard, Jr.

August 24, 2010
Columbia, South Carolina

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Paul M. Burch, Circuit Court Judge

Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees,.....Appellant,

v.

South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina.....Respondent.

RECORD ON APPEAL

2009-CP-10-7404

VOLUME 2

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STATE OF SOUTH CAROLINA)	IN THE COURT OF COMMON PLEAS
)	FOR THE NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON)	
Jeffrey D. Allen, individually, as guardian) for Jane Doe, a minor, and as representative) of other similarly situated State of South) Carolina employees,)	Civil Action No.: 2009-CP-10-7404
Plaintiffs,)	**MEMORANDUM IN SUPPORT OF DEFENDANTS' MOTION FOR SUMMARY JUDGMENT**
v.)	
South Carolina Budget and Control Board) Employee Insurance Program and Blue) Cross and Blue Shield of South Carolina,)	
Defendants.)	

FILED
2010 AUG 26 AM 10:39
JULIE J. ARMSTRONG
CLERK OF COURT
BY _____

I. BACKGROUND

The Group Health Benefits Plan of the Employees of the State of South Carolina, the Public School Districts, and Participating Entities ("State Health Plan") is a self-funded, governmental health plan, which is administered by the South Carolina Budget and Control Board, Employee Insurance Program ("EIP"). (Affidavit of Robin Tester, ¶ 3). BCBSSC is the claims administrator for the State Health Plan. BCBSSC is not an insurer of the State Health Plan. (Affidavit of Robin Tester, ¶ 4).

Plaintiff, an employee of a South Carolina School District, brings this purported class action against the State Health Plan and BCBSSC alleging causes of action for declaratory judgment, disgorgement of benefits, reformation of contract and for injunctive relief. Plaintiff alleges that coverage for diabetes outpatient self-management training and education is mandated by S.C. Code Ann. § 38-71-46. Plaintiff's Complaint alleges:

> 5. This is an action for declaratory judgment arising from Defendants' unlawful issuance and administration of the State of South Carolina EIP Standard

Plan, a plan of health benefits and insurance offered to all current and retired state employees, including public school district employees, for violation of a SC Code Section 38-71-46, for disgorgement of revenues received as a result of the unlawful issuance and administration, and for declaration to determine the value of unlawfully withheld benefits.

. . .

11. As the named Plaintiff is an employee of a South Carolina school district, has been enrolled in the EIP Standard Plan, has enrolled his dependent child in said plan who was diagnosed with Diabetes at the age of two years old, and has made multiple claims for his dependent child with a value of approximately One Thousand & 00/100 US Dollars ($1000.00) for diabetes outpatient self-management training and education which were denied by Defendant BCBSSC as administrator to the EIP, his claim, right and privileges are typical of the proposed class.

. . .

19. Plaintiff seeks, individually and as legal guardian for Jane Doe, and on behalf of all class members, a declaration of the rights of the parties hereto: that Defendants are required to issue and administer all health benefit plans offered through the EIP in compliance with the express mandate of South Carolina Code Section 38-71-46.

20. Plaintiff seeks an Order of the Court reforming the terms of the health benefit plan provided to all class members effective January 1, 2000 to provide the mandated diabetes coverage.

21. Plaintiff seeks an Order of the Court requiring the Defendants to disgorge monies received as a result of unlawful denials of the mandatory diabetes coverage, and to pay them to members of the putative class the present value of said unlawfully withheld revenues.

. . .

24. The Defendants should be enjoined from the wrongful takings as described above and from further denial of claims for the diabetes outpatient self-management training and education.

Defendants move for summary judgment on the following grounds: (1) the administrative remedies under S.C. Code Ann. § 1-11-710 (c) are Plaintiff's exclusive remedy, subject only to appeal to the South Carolina Administrative Law Court pursuant to S.C. Code Ann.§ 1-23-600

(D); and (2) S.C. Code Ann. § 38-71-46 does not apply to the State Health Plan.

II. STANDARD FOR SUMMARY JUDGMENT

The purpose of summary judgment is to "expedite the disposition of cases which do not require the services of a fact finder." Dawkins v. Fields, 354 S.C. 58, 69, 580 S.E.2d 433, 438 (2003) (quoting George v. Fabri, 345 S.C. 440, 452, 548 S.E.2d 868, 874 (2001)); Rumpf v. Massachusetts Mut. Life Ins. Co., 357 S.C. 386, 593 S.E.2d 183 (Ct. App. 2004). When plain, palpable, and indisputable facts exist on which reasonable minds cannot differ, summary judgment should be granted. Pye v. Aycock, 325 S.C. 426, 480 S.E.2d 455 (Ct. App. 1997).

III. DISCUSSION

A. The Administrative Remedies Under S.C. Code Ann. § 1-11-710(C) Are Plaintiff's Exclusive Remedy, Subject Only To Appeal To The South Carolina Administrative Law Court Pursuant To S.C. Code Ann. § 1-23-600 (D).

A participant and/or beneficiary challenging an award of benefits under State Health Plan is limited to the remedies set forth in S.C. Code Ann. § 1-11-710. § 1-11-710(C) provides as follows:

> Notwithstanding Sections 1-23-310 and 1-23-320 or any other provision of law, claims for benefits under any self-insured plan of insurance offered by the State to state and public school district employees and other eligible individuals must be resolved by procedures established by the board, which shall constitute the exclusive remedy for these claims, subject only to appellate review consistent with standards provided in Section 1-23-380. (Emphasis added).

Id.

Pursuant to the allegations of Plaintiff's Complaint, Plaintiff is requesting that the Court interpret the terms of the State Health Plan to include the coverage set out in S.C. Code Ann. § 38-71-46. Plaintiff further alleges that he is entitled to disgorge benefits from the plan for unlawful denials of coverage, and for injunctive relief enjoining "further denial of claims for

diabetes out-patient self-management training and education." (Complaint ¶24). The interpretation of the State Health Plan and the resolution of claims for benefits under the Plan are exactly the types of remedies contemplated by § 1-11-710(C).

Interestingly, while the current action was pending, Plaintiff also was availing himself of his administrative remedies under § 1-11-710(C). On September 30, 2009, Plaintiff made a first level appeal to the Blue Cross Blue Shield of South Carolina Appeals Committee regarding the denial of his claim for benefits under the State Health Plan, making the exact same argument he makes here concerning the application of S.C. Code Ann. § 38-71-46 to the State Health Plan. (Affidavit of Robin E. Tester ¶7, Exhibit A). By including this issue as part of his administrative appeal, Plaintiff recognized that EIP had the authority to rule on the application of S.C. Code Ann. § 38-71-46 to the State Health Plan.

On April 2, 2010, The Blue Cross Blue Shield Appeals Committee wrote Plaintiff that it was upholding the denial of Plaintiff's claim because Plaintiff's claim was specifically excluded under the terms of the State Health Plan and S.C. Code Ann. § 38-71-46 did not apply to the State Health Plan. (Affidavit of Robin Tester ¶8, Exhibit B). This letter further gave Plaintiff 90 days from April 2, 2010 to appeal this decision to EIP Health Appeal's Committee.

On June 30, 2010, Plaintiff appealed the denial of his claim to the EIP Health Appeal's Committee. A true correct copy of this letter is attached hereto as Exhibit A. As can be seen from the contents of this letter, Plaintiff appealed the issue of the applicability of S.C. Code Ann. § 38-71-46 to the State Health Plan to the EIP Health Appeal's Committee.

By letter dated August 24, 2010, the EIP Health Appeal's Committee wrote Plaintiff that it was denying his claim for benefits in that S.C. Code Ann. § 38-71-46 did not apply to the State Health Plan. This letter also informed Plaintiff that his next level of appeal was to the South

Carolina Administrative Law Court. A true and correct copy of this letter is attached hereto as Exhibit B.

Appeals involving claims under the State Health Plan are under the exclusive jurisdiction of the Administrative Law Court. Accordingly, this matter should be before the Administrative Law Court.[1] Pursuant to S.C. Code Ann. § 1-11-710(C), the exclusive remedy available to Plaintiff is the administrative review process provided by the Plan, "subject only to appellate judicial review consistent with the standards provided in Section 1-23-380."

S.C. Code Ann. § 1-23-380 provides that "[A] party who has exhausted all administrative remedies available within the agency and who is aggrieved by a final decision in a contested case is entitled to judicial review under this article [the Administrative Procedures Act]." Pursuant to S.C. Code Ann. § 1-23-600 (D), "[a]n administrative law judge also shall preside over all appeals from final decisions of contested cases pursuant to The Administrative Procedures Act...or another law."

Plaintiff argues that based on Drummond v. State of South Carolina, 378 S.C. 362, 662 S.E.2d 587 (2008), the Administrative Law Court cannot rule on whether or not S.C. Code Ann. § 38-71-46 applies to the State Health Plan. However, Drummond stands for the proposition that the Administrative Law Court cannot rule on the validity of a statute in that the Administrative Law Court is a part of the executive branch. The Administrative Law Court is charged with following the law "as written." Video Gaming Consultants, Inc. v. South Carolina Dept. of Revenue, 342 S.C. 34, 535 S.E.2d 642 (2000) ("ALJs are an agency of the executive branch of government and must follow the law as written until its constitutionality is judicially determined;

[1] Prior to July 1, 2006, appeals from EIP went directly to the Circuit Court. After July 1, 2006, pursuant to 2006 S.C. Acts 387, appeals from EIP went directly to the Administrative Law Court.

ALJs have no authority to pass upon the constitutionality of a statute or regulation."). Here, no one is challenging the validity of S.C. Code Ann. § 38-71-46, merely that S.C. Code Ann. § 38-71-46 does not apply to the State Health Plan. Therefore, rule set forth in Drummond has no application to the present case.

The language of the State Health Plan clearly empowers EIP to take into account applicable state law when resolving benefit claims under the Plan. Because the procedures established by EIP pursuant to § 1-11-710(C) are Plaintiff's exclusive remedy to resolve benefit claims under the plan, subject only to appeal to the South Carolina Administrative Law Court, Defendants' Motion for Summary Judgment should be granted dismissing Plaintiff's Complaint as a matter of law.

B. **S.C. Code Ann. § 38-71-46 Has No Application To The State Health Plan In That The State Health Plan Is A Self-Funded, Governmental Plan Not Subject To State Insurance Regulation.**

S.C. Code Ann. § 38-71-46 has no application to the State Health Plan in that the State Health Plan is a self-funded, governmental plan that is not subject to regulation by the South Carolina Department of Insurance ("SCDOI"). The primary rule of statutory interpretation is to ascertain and effectuate the intent of the Legislature. See Auto Owners Ins. Co. v. Rollison, 378 S.C. 600, 609, 663 S.E.2d 484, 488 (2008). "The primary rule of statutory construction requires that legislative intent prevail if it can reasonably be discovered in the language used construed in light of the intended purpose. Sections which are part of the same general statutory law of the state should be construed together and each given effect if it can be done by any reasonable construction." Glover v. Suitt Const. Co., 318 S.C. 465, 469, 458 S.E.2d 535, 537 (1995). "It is proper to consider the title or caption of an act in aid of construction to show the intent of the legislature." Lindsay v. Southern Farm Bureau Cas. Ins. Co., 258 S.C. 272, 277,188 S.E.2d 374,

376 (1972). But, "they may not be construed to limit the plain meaning of the text." Gamer v. Houck, 312 S.C. 481, 486, 435 S.E.2d 847, 849 (1993).

S.C. Code Ann. § 38-71-46, the statute that Plaintiff alleges applies to the State Health Plan, makes no mention that it applies to the State Health Plan, EIP and/or the South Carolina Budget and Control Board. S.C. Code Ann. § 38-71-46 states:

> (A) On or after January 1, 2000, every health maintenance organization, individual and group health insurance policy, or contract issued or renewed in this State must provide coverage for equipment, supplies, Food and Drug Administration-approved medication indicated for the treatment of diabetes, and outpatient self-management training and education for treatment of people with diabetes mellitus, if medically necessary, and prescribed by a health care professional who is legally authorized to prescribe such items and who demonstrates adherence to minimum standards of care for diabetes mellitus as adopted and published by the Diabetes Initiative of South Carolina.
>
> . . .
>
> (D) For purposes of this section: "Health insurance policy" means a health benefit plan, contract, or evidence of coverage providing health insurance coverage as defined in Section 38-71-670 (6)[2] and Section 38-71-840 (14). (Emphasis added).

Id.

S.C. Code Ann. §38-71-840 (14), which involves group health insurance, defines health insurance coverage as:

> (14) "Health insurance coverage" means benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer, except:
>
> (a) coverage only for accident, or disability income insurance, or any combination of accident and disability income insurance;
>
> (b) coverage issued as a supplement to liability insurance;

[2] S.C. Code Ann. §38-71-670 (6) contains the identical language as S.C. Code Ann. §38-71-840 (14) and applies to individual policies.

(c) liability insurance, including general liability insurance and automobile liability insurance;

(d) workers' compensation or similar insurance;

(e) automobile medical payment insurance;

(f) credit-only insurance;

(g) coverage for on-site medical clinics;

(h) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(i) if offered separately;

(i) limited scope dental or vision benefits;

(ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these;

(iii) other similar, limited benefits as are specified in regulations;

(j) if offered as independent, noncoordinated benefits;

(i) coverage only for a specified disease or illness;

(ii) hospital indemnity or other fixed indemnity insurance;

(k) if offered as a separate insurance policy;

(i) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

(ii) coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code; and

(iii) similar supplemental coverage under a group health plan. (Emphasis added).

Id.

S.C. Code Ann. §38-71-340 (16) defines a "health insurance issuer" as:

(16) "Health insurance issuer" or "issuer" means any entity that provides health insurance coverage in this State. For purposes of this section, "issuer" includes an insurance company, a health maintenance organization, and any other entity providing health insurance coverage which is licensed to engage in the business of insurance in this State and which is subject to state insurance regulation. (Emphasis added).

Id.

The State Health Plan is a self-funded, governmental health plan for state employees, administered by the South Carolina Budget and Control Board, Employee Insurance Program

("EIP"). (Affidavit of Robin E. Tester ¶ 3). The State Health Plan is not a fully insured plan. EIP is not licensed to engage in the business of insurance in this State and is not subject to insurance regulation by the SCDOI. S.C. Code Ann. §1-11-780 (Supp. 2009) ("The State Employee Insurance Program...is not under the jurisdiction of the South Carolina Department of Insurance.").

The State Health Plan is not "health insurance coverage" pursuant to S.C. Code Ann. §38-71-840 (14), and EIP is not a "health insurance issuer" pursuant to S.C. Code Ann. §38-71-840 (16) in that EIP is not licensed to engage in the business of insurance in this State and is not subject to insurance regulation. Therefore, S.C. Code Ann. § 38-71-46 has no application to the State Health Plan and/or EIP.

This conclusion is further supported by the legislative history of Title 1, Chapter 11 and Title 38, Chapter 71. The Legislature explicitly recognized the lack of jurisdiction of the SCDOI over EIP in South Carolina Code Ann. § 1-11-780 (Supp. 2009). That statute reads in its entirety:

> The State Employee Insurance Program shall continue to provide mental health parity in the same manner and with the same management practices as included in the plan beginning in 2002[3], and is not under the jurisdiction of the Department of Insurance. The continuation by the State Employee Insurance Program of providing mental health parity in accordance with the plan set forth in 2002 constitutes compliance with this act. (Emphasis added).

Id.

In the 1990s and into the 2000s, the Legislature passed a series of health insurance

[3] The prior coverage beginning in 2002 that is referenced in this statute is from repealed § 1-11-760 (repealed 2005), which also pertained to mental health coverage mandates for EIP. See S.C. Code Ann. § 1-11-760 (repealed 2005). The former statute took effect in 2002 with a built-in repeal date effective in 2005. See 2000 S.C. Act No. 341, § 4, codified at S.C. Code Ann. § 1-11-760 (repealed 2005). The former law also specifically defined what entity it applied to: "State Health Insurance Plan means health insurance plans offered or administered by the State Budget and Control Board." S.C. Code Ann. § 1-11-760 (repealed 2005). This statute explicitly set out requirements for mental health coverage by EIP, and by EIP only, as former § 1-11-760 clearly was located in Title 1, Chapter 11, Article 5.

coverage mandates in Title 38, Chapter 71, Article 1.[4] With the exception of § 38-71-280, regarding autism spectrum disorder, none of these laws or their preceding bills mentioned EIP, the State Health Plan, or the Budget and Control Board.

In 2007, the Legislature passed § 38-71-280, mandating coverage for autism spectrum disorder care.[5] In § 38-71-280 the Legislature specifically stated that it desired the statute apply to EIP: "It includes the State Health Plan. ... 'State Health Plan' means the employee and retiree insurance program provided for in Article 5, Chapter 11, Title 1." S.C. Code Ann § 38-71-280(A)(4)-(5). Although not in Title 1, Chapter 11, Article 5, the statute made specific reference to EIP's governing Code sections. Accordingly, the Legislature deliberately referenced EIP's enabling statutes to make the Legislature's intent clear that § 38-71-280 applied to EIP.

The bill that would become § 38-71-46 was introduced and passed in 1999, one session and one year before § 1-11-760 (repealed 2005) with no references to EIP in its text. See 1999 S.C. Act No. 98 (codified at S.C. Code Ann. § 38-71-46). It is important to note that § 38-71-46 was amended in the same session in which § 1-11-760 (repealed 2005) became law. See 2000 S.C. Act No. 348 (amending coverage mandates for diabetes mellitus); 2000 S.C. Act No. 341 (mandating EIP provide mental health coverage). The Legislature was clearly aware at the time § 38-71-46 was amended that for the statute to apply to EIP, EIP needed to be identified in the

[4] Chronologically, these statutes requiring coverage were: § 38-71-240, for cleft lip and palate care (1993 S.C. Act No. 129, § 1); § 38-71-143, for children placed for adoption (1994 S.C. Act No. 481, § 2); § 38-71-135, for postpartum care for mothers and newborns (1996 S.C. Act No. 335, § 1, amended by 1997 S.C. Act No. 5, § 4); § 38-71-125, for mastectomies and related treatment (1998 S.C. Act No. 329, § 3); § 38-71-130, for breast reconstruction following mastectomy (1998 S.C. Act No. 329, § 4); § 38-71-145, for mammograms, pap smears, and prostate cancer examinations (1998 S.C. Act No. 329, § 5); § 38-71-215, for dermatology referrals (1998 S.C. Act No. 353, § 1); § 38-71-46, for diabetes mellitus care, with attendant education and equipment (1999 S.C. Act No. 98, § 5, amended by 2000 Act No. 348, § 1); and § 38-71-280, autism spectrum disorder care (2007 S.C. Act No. 65, § 1).

[5] Notably, § 38-71-280 followed § 1-11-780 in time.

statute. However, the Legislature chose not to do so and § 38-71-46 made no mention of its application to the State Health Plan.

The Legislature made it very clear when health insurance mandates were to apply to the State Health Plan. When EIP was to be included, the legislature either: (1) amended EIP's governing statutes in Title 1, Chapter 11, Article 5; (2) made a direct reference to those statutes in its legislation; or (3) at a minimum, identified EIP by name. The Legislature was aware that EIP was not governed by the SCDOI and specifically stated this fact in 2005 legislation. The Legislature also acknowledged that EIP was not governed by the mandates in Title 38, Chapter 71, Article 1, unless a specific intent to do so was stated in the statute. Finally, § 38-71-46 itself was passed contemporaneously with other legislation that specifically indicated that those statutes applied to EIP; yet § 38-71-46 remained silent in this regard. If the Legislature had intended section § 38-71-46 to apply to EIP, it would have indicated that in the statute itself.

IV. CONCLUSION

For the foregoing reasons, Defendants' Motion for Summary Judgment should be granted and Plaintiffs' complaint should be dismissed as a matter of law.

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Post Office Box 11886
Columbia, South Carolina 29211
Telephone: (803) 779-3500

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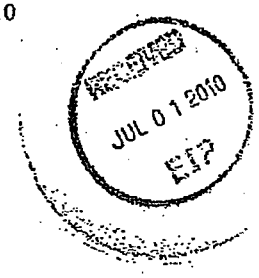
ATTORNEYS FOR DEFENDANTS

August 24, 2010
Columbia, South Carolina

WMA
WILL[illegible]

134 Meeting Street, Suite 100 • Charleston, SC 29401 • Post Office Box 859 • Charleston, SC 29402
Phone: 843-727-1144 • Fax: 843-727-7696 • www.wmalawfirm.net

June 30, 2010



VIA FEDERAL EXPRESS- OVERNIGHT
Appeal Coordinator
Employee Insurance Program
Post Office Box 11661
Columbia, South Carolina 29211
1201 Main Street, Suite 300
Columbia, South Carolina 29201

RE: Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees v. SC Budget & Control Board
Case No.: 09-CP-10-7404
File No.: 595-1

Dear Sir or Madame:

Please allow this letter with attachments to serve as the 90 day written notice of appeal to the EIP from the April 2, 2010 letter authored by BCBSC. As you already know the Plaintiffs have brought a putative class action lawsuit against the SCEIP and BCBSSC as it relates to the applicability of S.C. Code Ann. § 38-71-46 to the State Plan. The legal and factual basis for these claims are set forth in detail in the attached pleadings in the civil action pending in Charleston County Court of Common Pleas, and are hereby incorporated into this appeal letter.

Specifically, I am including the following documents most of which are on file and public record with the Charleston County Court of Common Pleas Clerk of Court:

1. Summons & Complaint
2. Plaintiffs' Memo. in Opp. to Def's Motions to Dismiss
3. Appeal Letter- Goodman, Sr. Director of BCBS dated March 19, 2010
4. Letter from App. Review Committee BCBS dated April 4, 2010
5. Plaintiffs' Motion for Class Certification
6. Plaintiffs' Motion to Compel & Motion to Stay Decision on Def's Motion for Summary Judgment

It is interesting to note that throughout this entire process, which includes the EIP and BCBSSC's Motion to Dismiss, Answer, Motion for Summary Judgment and both underlying administrative decisions to date, neither BCBSSC nor EIP has ever provided any explanation for its legal conclusion that section 38-71-46 does not apply to the State Plan. As our pleadings indicate, we believe that it does in fact apply and intend to continue to pursue this matter to the full extent of the law. Nothing in this letter should be construed as a waiver of any rights or defenses

EX A

under the law.

Thank you.

With kind regards, I am

Sincerely,

WILLS MASSALON & ALLEN, LLC

Faith Frink, Paralegal
for John A. Massalon

Enclosures

cc: (w/out enclosures)
Mr. Jeffrey D. Allen
Terry E. Richardson, Jr., Esquire
Matthew D. Hamrick, Esquire
Theodore D. Willard, Jr., Esquire
Kelly H. Rainsford, Esquire

MARK SANFORD, CHAIRMAN
GOVERNOR

CONVERSE A. CHELLIS, III, CPA
STATE TREASURER

RICHARD ECKSTROM, CPA
COMPTROLLER GENERAL

SC BUDGET AND CONTROL BOARD

EMPLOYEE INSURANCE PROGRAM

(803) 734-0678
FAX: (803) 737-0557

HUGH K. LEATHERMAN, SR.
CHAIRMAN, SENATE FINANCE
COMMITTEE

DANIEL T. COOPER
CHAIRMAN, HOUSE WAYS AND MEANS
COMMITTEE

FRANK W. FUSCO
EXECUTIVE DIRECTOR

August 24, 2010

John A. Massalon, Esquire
Wills Massalon & Allen, LLC
PO Box 859
Charleston, South Carolina 29402

RE: State of South Carolina Group Health Benefits Plan
Subscriber: Jeffrey D. Allen
Patient:
ID#: xxx-xx-1184

Dear Mr. Massalon:

Thank you for your letter to the Employee Insurance Program on behalf of your client, Jeffrey D. Allen, in which you appealed the decision of BlueCross Blue Shield of South Carolina (BCBSSC) to deny the request to cover a claim for diabetes educational training relating to Mr. Allen's daughter. Your client's appeal was considered by the Health Appeals Committee, which consists of five members who have not been involved in any prior decisions to deny this claim. The Committee fully considered the appeal by reviewing the claim file along with the relevant provisions of the State Health Plan (Plan). After the review, the Committee determined that no benefit was payable for the diabetes education training. The Committee's full decision is enclosed for your information.

This determination has been made in good faith under the terms and conditions of the Plan and relevant statutes. Nothing in the decision should be construed as a waiver of any rights or defenses under the Plan or state law, whether or not specifically mentioned in the decision.

Your client's right to appeal through the Employee Insurance Program has been exhausted. In accordance with instruction from the Administrative Law Court (ALC), the next level of appeal is to the ALC in its appellate jurisdiction pursuant to S.C. Code Ann. § 1-23-600(D). The contact information for the ALC is:

1201 MAIN STREET, SUITE 300 • COLUMBIA, SOUTH CAROLINA 29201

EX B

Administrative Law Court
1205 Pendleton Street, Suite 224
Columbia, South Carolina 29201

An appeal is commenced by filing a notice of appeal with the ALC within 30 days of receipt of this letter. If you need any further information regarding your client's appeal, please contact the ALC at (803)734-0550.

If you choose to appeal to the ALC, please note the following address for serving the Employee Insurance Program:

Stephen R. Van Camp, Director
Employee Insurance Program
South Carolina Budget and Control Board
1201 Main Street, Suite 300
Columbia, South Carolina 29201

Thank you for allowing the Employee Insurance Program the opportunity to review your client's claim. Best wishes to your client for good health now and in the future.

Sincerely,

Stephen R. Van Camp
Director, Employee Insurance Program

SRV/ctqc

Enclosure

cc: Theodore Willard, Esquire
Brooks Goodman, BCBSSC
Margie Benson, BCBSSC

BEFORE THE STATE BUDGET AND CONTROL BOARD,
EMPLOYEE INSURANCE PROGRAM

Subscriber: Jeffrey D. Allen	)	
	)	
Dependent: er)	)	FINAL DECISION OF
	)	THE APPEALS COMMITTEE
Plan: South Carolina Group Health Benefits Plan	)	
	)	
	)	

This matter is before the Health Appeals Committee of the Employee Insurance Program (EIP) pursuant to the appeal of John A. Massalon, Esquire, on behalf of his clients Jeffrey Allen (Claimant) and Christie Ford Allen (Claimant's spouse).[1] Claimant is appealing the decision of BlueCross BlueShield of South Carolina (BCBSSC)[2] to deny reimbursement for diabetes education pertaining to his minor daughter, it).

Findings of Fact

The Appeals Committee carefully considered all evidence contained in the file, including but not limited to Claimant's letters with exhibits, information provided by BCBSSC, and information maintained by EIP. After taking into account the credibility of the evidence, the Appeals Committee made the following findings.

As an employee of Dorchester County School District Two, Claimant participates in the South Carolina Group Health Benefits Plan (Plan or State Health Plan). Claimant and Dependent have been covered by one of the health insurance options offered through EIP since 2005.[3] Dependent was born July 20, 2005. Claimant was hired at Dorchester County effective August 2, 2005, with a benefits effective date of September 1, 2005. Claimant and Dependent were covered under MUSC Options from September 1, 2005, to December 31, 2006. Beginning

[1] Claimant's spouse is a partner at the law firm Wills Massalon & Allen, LLC, (formerly known as Wills & Massalon, LLC, until it was given the present name in February 2010) where Claimant's attorney is also a partner. She is not a named plaintiff or counsel of record but, as noted below, handled all the correspondence and research regarding Dependent's coverage until the putative class action lawsuit was filed in November 2009.

[2] BCBSSC is the third-party claims administrator for the South Carolina Group Health Benefits Plan, which is self-insured. As such, BCBSSC processes and pays the claims for the Plan under the Plan's rules and with the Plan's money. Although the Plan is administered by BCBSSC, it is not a BCBSSC plan.

[3] EIP offers several health insurance options. The South Carolina Group Health Benefits Plan consists of the Standard Plan (a preferred provider organization or PPO), the Savings Plan (a high deductible health plan), and the Medicare Supplemental Plan. EIP also offers two health maintenance organization (HMO) options: BlueChoice HealthPlan and CIGNA. EIP offered a third HMO, called MUSC Options, until December 31, 2008. MUSC Options was a region-specific HMO available only in the Charleston area and administered by BlueChoice HealthPlan.

January 1, 2007, Claimant and Dependent have been covered by the Standard Plan.[4] Claimant's spouse has never been covered under Claimant's health insurance coverage.[5]

Dependent was diagnosed with Type I diabetes[6] in November 2007. On August 5, 2008, Claimant, Claimant's spouse, Dependent's grandparents, and two daycare nurses attended a diabetes management educational session in relation to Dependent's new insulin pump for a total cost of $560.00. On August 27, 2008, BCBSSC sent Claimant an Explanation of Benefits (EOB) showing the claim was denied. The explanatory note read, "Your benefit plan does not cover education and/or training for this condition." The EOB indicated Claimant had the right to request reconsideration of the claim in writing within six months of the EOB.

On February 25, 2009, Claimant's spouse wrote a letter of appeal to BCBSSC.[7] Claimant's spouse stated Claimant and Dependent were "insured under the South Carolina State Insurance Health Plan." Claimant's spouse indicated Dependent was three years old and had been diagnosed with Type I diabetes in November 2007. In August 2008, Dependent had been approved for an insulin pump because Dependent needed continuous insulin therapy. Claimant's spouse stated the Medical University of South Carolina (MUSC) provides training for caregivers on how to properly operate the insulin pump. Claimant's spouse indicated she, Claimant, their parents (Dependent's grandparents), and two nurses from Dependent's daycare attended the training on August 5, 2008.

Claimant's spouse stated she was objecting to the claim denial as a necessary part of insulin pump therapy. She pointed out Dependent was three years old "and as a result of her young age is obviously not able to teach herself how to use the insulin pump." Claimant's spouse also stated the EOB had been mailed to her family's old address even though she had changed it through the website. She then concluded,

> Lastly, I also submit this appeal letter to object to the fact that diabetic education is a [sic] item which you indicated is expressly excluded under the policy. I cannot imagine what possible policy, other than one motivated by profit, would support not providing insurance coverage to the education of Type I diabetics about how to better control and manage an intensive, life-long disease which has no cure. While I see no real distinction, does Blue Cross differentiate between its coverage position on education for Type I and Type II diabetes?

---

[4] Claimant was covered as an active employee at College of Charleston for August and September 2008, after which he transferred back to Dorchester County with no interruption or change in coverage.

[5] Claimant's spouse was covered as an active employee by the Standard Plan for six months in 1998 but has not been covered since.

[6] Type I diabetes is usually diagnosed in childhood and used to be known as juvenile diabetes. In Type I diabetes, the body makes little or no insulin and daily injections of insulin are needed. The exact cause is unknown, though genetics, viruses, and autoimmune problems are suspected to play a role. Type I diabetes can come on suddenly and the symptoms can be severe. Those with Type I diabetes often need injections of insulin one to four times daily, and in more acute cases a continuous insulin pump can be attached to the body for continuous insulin delivery. (Type II diabetes, in which the pancreas does not make enough insulin to regulate blood glucose levels, is far more common than Type I; its frequent causes include obesity, lack of exercise, and age). *See* The U.S. Nat'l Library of Med. & the Nat'l Insts. of Health, A.D.A.M. Medical Encyclopedia, *Diabetes* (2009), available at http://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

[7] The letter was on Wills & Massalon's letterhead.

Claimant's spouse included copies of the EOB, and a copy of a screen capture showing she had updated Claimant's address on the BCBSSC website.

On April 20, 2009, BCBSSC sent Claimant an adjusted EOB. It had no changes except for the explanatory note. Rather than "Your benefit plan does not cover education and/or training for this condition," the new EOB indicated BCBSSC had requested additional medical information from the provider. The updated note explained if the information was received within 45 days, they would review their claim and make the decision within 15 days of receipt. It then stated if the information was not received, the claim would be considered denied. Finally, if the information was received after 45 days but under 225, the appeal would move forward.

On September 30, 2009, Claimant's spouse wrote a letter to BCBSSC in follow-up. She indicated her appeal had been pending since February 2009. Claimant's spouse stated she had called BCBSSC on August 14, 2009, and was informed the reason for the lack of resolution was BCBSSC had not received Dependent's requested medical records, which BCBSSC had been unable to describe with particularity. Claimant's spouse stated she then called MUSC, who stated they had sent the records but agreed to send them to BCBSSC again. She noted this was well within the 225 days in the April 20, 2009, letter. Claimant's spouse stated she called BCBSSC again on September 30, 2009, to inquire about the status of the appeal. She said BCBSSC told her they were awaiting "outpatient ER records." Claimant's spouse then stated she had not received any direct request for records "or even that I complete a HIIPA [sic] form." Claimant enclosed the records with the letter. Claimant's spouse then stated, "I am also enclosing a copy [of] the South Carolina statute which requires Diabetes Mellitus coverage in health insurance policies."[8] She highlighted the provision requiring coverage for outpatient self-management training and education for the treatment of people with diabetes mellitus.

Dependent's records began with a letter dated July 9, 2008, with a pre-authorization request for Dependent's insulin pump from the manufacturer, Medtronic. The items listed on Medtronic's request were an insulin pump with accompanying equipment, for a total of $5,142.95.[9] The records also included hemoglobin measurements glucose logs reflecting Dependent's condition, a certificate of medical necessity completed by Dependent's physician for the manufacturer, and Dependent's office visits with endocrinologist Deborah Bowlby, M.D., at MUSC.

Dependent's earliest submitted visit note was from January 2, 2008. The treating physician indicated Dependent had been diagnosed with Type I diabetes six weeks prior after being admitted to the emergency room with diabetic ketoacidosis.[10] Dependent was taking

[8] S.C. Code Ann. § 38-71-46. The statute is reproduced in the next section.

[9] This claim, 8E4953594000, was paid on an actual-amount-billed of $4,988.40, with the total paid by the Plan at $3,990.72, the normal rate of 80%.

[10] Diabetic ketoacidosis refers to the buildup of ketones in the body. It is a complication of diabetes occurring when the body cannot use blood glucose for fuel because the body has little or no insulin and the body begins using fat instead. Byproducts of fat breakdown, called ketones, build up in the body; in high levels, ketones are poisonous. The liver then produces glucose to try to combat the problem and blood glucose levels rise, often to over 300, when the buildup occurs because the body cannot pull in the glucose without enough insulin.

insulin injections at each meal plus two snack times, with her care providers also checking her glucose levels an average of five to six times per day, "rotating sites over arms, abdomen, and buttock." Dependent was having elevated blood sugars in the afternoon and evening despite this care. Dr. Bowlby stated overall Dependent seemed to be doing okay, adjusted Dependent's insulin, and scheduled follow-up in three months.

A telephone note dated March 11, 2008, indicated Claimant's spouse called the MUSC endocrinology office. She was "concerned with high blood glucose at 9:30 am snack and 11:30 am and was using correction at snacks and meals and was then having hypoglycemia in the afternoon." The responding nurse stated they discussed only using correction at lunch and not the 9:30 snack. Claimant's spouse was concerned when Dependent's glucose was spiking after meals. The responding nurse explained correction was not advised unless it had been three hours since Dependent had a meal or snack. The nurse also noted Claimant's spouse felt the cartridge-based insulin pens leaked with such a small dose of insulin and that the syringes worked better, and she had asked the daycare and those caring for Dependent at home to use the syringes as well. The nurse noted, "Dr. Walsh spoke with mother in great detail regarding above."

Dependent returned to Dr. Bowlby on April 9, 2008. Dr. Bowlby observed Dependent was doing better, with Claimant's spouse reporting Dependent's blood sugars had been more in target range since Dependent's previous visit. Claimant's spouse was feeling better about dealing with elevated or low blood sugars, and Dependent had not had any severe hypoglycemic blood sugar episodes. Dr. Bowles noted Dependent was doing better and recommended an insulin pump, scheduling follow-up with a nurse, Sharon Schwartz, R.N., C.D.E.,[11] to discuss the option of an insulin pump.

A visit note from the August 5, 2008, educational session was also included. Nurse Schwarz indicated the content taught included Dependent's care plan, medications, nutrition, food/drug interactions, health promotion, patient safety, and medical equipment. Nurse Schwarz noted Dependent's parents, grandparents, and daycare nurses were "instructed on the Medtronic Paradigm insulin pump. They were instructed on troubleshooting hyper/hypoglycemia on the insulin pump, importance of monitoring, ketone testing, and site rotation." They were encouraged to practice with saline for a week; the nurse also noted one of the daycare nurses was given a practice pump and saline to practice and would return the pump the following week. A list of instructions was also given, including monitoring for ketones if the blood sugar was elevated, insulin input amounts, and safe glucose levels.

On October 15, 2009, Claimant e-mailed a request for a copy of the Plan of benefits to EIP. EIP e-mailed a copy of the Plan document to Claimant's provided gmail account.

Diabetic ketoacidosis may lead to a diagnosis of Type I diabetes because it is often the first symptom that causes a person to see a doctor. It can also be the result of increased insulin needs in someone already diagnosed with Type I diabetes. Infection, trauma, heart attack, or surgery can lead to diabetic ketoacidosis in such cases. Missing doses of insulin can also lead to ketoacidosis in people with diabetes. (People with Type II diabetes can develop ketoacidosis but it is rare and usually triggered by a severe illness). *See* A.D.A.M. Medical Encyclopedia, *Diabetic Ketoacidosis* (2009), available at http://www.nlm.nih.gov/medlineplus/ency/article/000320.htm.

[11] Certified Diabetes Educator.

On November 25, 2009, Claimant filed a putative class action suit against the South Carolina Budget and Control Board, EIP, and BCBSSC in the circuit court of the Ninth Judicial Circuit in Charleston, alleging a violation of S.C. Code Ann. § 38-71-46. In response, EIP filed a motion to dismiss, based in part because Claimant had not exhausted the administrative appeals process through EIP and the Administrative Law Court (ALC). Claimant filed a memorandum in opposition to EIP's motions to dismiss on February 26, 2010.

In an affidavit dated February 24, 2010, Claimant stated Claimant's spouse had handled all the appeal activities up to that point. Claimant stated he had gone to the district office, at his wife's direction, in October 2009 to seek a copy of the Plan of Benefits but was told the document was not available. Claimant stated Claimant's spouse had then e-mailed EIP to obtain a copy but they had received no response.

On the same day, Claimant's spouse completed an affidavit. She stated the same things noted above in Claimant's affidavit. She also included recounts of her August 14, 2009, phone call with BCBSSC, the September 30, 2009, phone call with BCBSSC, and stated she had faxed the records on October 5, 2009. Claimant's spouse stated she had obtained and reviewed the *Employee Benefit Guide*[12] after speaking to BCBSSC on September 30, 2009. She stated she noticed the references to the Plan of Benefits Document at the time, which she then attempted to obtain. Claimant's spouse stated she telephoned EIP on October 7, 2009, and was told to have Claimant get a copy at work because the document was large, or else he would have to pay the copying fee. Claimant's spouse stated she had not received a response to her letters dated February 25, 2009, or October 5, 2009, and therefore believed the appeal was still pending within the BCBSSC administrative process. She noted in a footnote a BCBSSC representative had called, offering to enroll Dependent in a diabetes wellness program.[13] Claimant's spouse stated "after [I] disclosed the pendency of this action, the Blue Cross representative called back to disclose that the program was only for persons 5 years of age and older and therefore Eva would not qualify yet."[14]

Copies of e-mails to Dependent's doctor, the medical records and correspondence noted above, and a copy of the entire 2009 IBG were also included with Claimant's memorandum in opposition to dismiss.

On March 15, 2010, Ashby Jordan, M.D., the medical director and vice president of medical affairs for BCBSSC, reviewed Dependent's file in its entirety. He noted the services referenced were specifically excluded in the Standard Plan under Article 9, Paragraph O. Dr. Jordan also stated Exclusion BB in Article 9 also applied, as there was no mention of these services in the Article 7, Schedule of Benefits section of the Plan. He noted the statute referenced in the appeal document does not apply to the State Health Plan.

On March 19, 2010, Brooks Goodman, senior director for state operations at BCBSSC, sent Claimant a letter indicating the medical director had denied Claimant's appeal for the

[12] The Committee understood this to mean the *Insurance Benefits Guide* (IBG), a summary booklet of benefits sent to subscribers annually.
[13] Claimant's spouse stated the BCBSSC representative initially thought Dependent suffered from asthma.
[14] Dependent turned five in July 2010.

reasons stated above. Because the medical director had not approved the appeal, it would be considered by the BCBSSC appeals committee.

On April 2, 2010, BCBSSC sent Claimant a letter denying Claimant's appeal for additional benefits for the August 5, 2008, educational session. The letter indicated it had reviewed Claimant's spouse's letters from February 25, 2009, and September 30, 2009; a web inquiry dated February 18, 2009; Dependent's medical records, noted above; the claim with EOBs dated August 27, 2008, and April 20, 2009; Dr. Jordan's medical review from March 15, 2010; Article 7 and Article 9, Sections O and BB of the 2008 Plan; the letter from Brooks Goodman on March 19, 2010; and S.C. Code Ann. § 38-71-46. The letter stated the BCBSSC appeals committee observed the Plan specifically excluded educational services in Article 9, and Article 7 excluded services not specifically covered. It also noted § 38-71-46 did not apply to the self-funded State Health Plan. The letter then stated the appeals process through BCBSSC was exhausted, and Claimant had 90 days to appeal in writing to EIP.

On June 30, 2010, Claimant's attorney appealed the denial in the April 2, 2010, to EIP on Claimant's behalf. Claimant's attorney captioned the letter as though it were part of the Claimant's lawsuit. Claimant's attorney noted, "As you already know the Plaintiffs have brought a putative class action lawsuit against the SCEIP [sic] and BCBSSC as it relates to the applicability of S.C. Code Ann. § 38-71-46 to the State Plan." He stated the pleadings were incorporated by reference into the appeals letter, and he enclosed copies of the lawsuit summons and complaint; the memorandum in opposition to EIP's motion to dismiss; Mr. Goodman's denial letter of March 19, 2010; the BCBSSC denial letter dated April 4, 2010; Claimant's motion for class certification; and Claimant's motion to compel and motion to stay decision on EIP's motion for summary judgment. Claimant's attorney noted that throughout the putative class action proceeding, "neither BCBSSC nor EIP has ever provided any explanation for its legal conclusion that section 38-71-46 does not apply to the State Plan." He stated he believed it did apply and intended to pursue the issue to the full extent of the law.

Relevant Statutory, Plan and Policy Provisions

The Appeals Committee considered the relevant statutes in the South Carolina Code of Laws, established by the General Assembly of the State of South Carolina. The statutes read in pertinent part:

> ***Section 38-71-46***
> *(A) On or after January 1, 2000, every health maintenance organization, individual and group health insurance policy, or contract issued or renewed in this State must provide coverage for the equipment, supplies, Food and Drug Administration-approved medication indicated for the treatment of diabetes, and outpatient self-management training and education for the treatment of people with diabetes mellitus, if medically necessary, and prescribed by a health care professional who is legally authorized to prescribe such items and who demonstrates adherence to minimum standards of care for diabetes mellitus as adopted and published by the Diabetes Initiative of South Carolina. This subsection does not prohibit a health maintenance organization or an individual*

or a group health insurance policy from providing coverage for medication according to formulary or using network providers. Coverage must not be denied unless the health care professional demonstrates a persistent pattern of failure to adhere to the minimal standards of care and unless the health maintenance organization or insurer has first provided written notice to the health care professional that coverage will be denied if the health care professional fails to adhere to the minimal standards of care.

(B) Services and payment for diabetes education programs shall conform to regulations of the Health Care Financing Administration, US Department of Health and Human Services, pursuant to Section 4105 of the Balanced Budget Act of 1997. Diabetes outpatient self-management training and education shall be provided by a registered or licensed health care professional with certification in diabetes by the National Certification Board of Diabetes Educators, or other accredited program approved by the Diabetes Initiative of South Carolina, or by the Diabetes Control Program of the SC Department of Health and Environmental Control in order to meet the needs of rural communities wherein certified health care professionals providing this service are not available.

(C) Nothing contained in this section may be construed to affect in any way the ability of a managed care plan to credential or re-credential a provider.

(D) For purposes of this section: "Health insurance policy" means a health benefit plan, contract, or evidence of coverage providing health insurance coverage as defined in Section 38-71-670(6) and Section 38-71-840(14).

Section 38-71-670
As used in this subarticle: . . .
(6) "Health insurance coverage" means benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer, except:
a) coverage only for accident or disability income insurance or any combination of these;
(b) coverage issued as a supplement to liability insurance;
(c) liability insurance, including general liability insurance and automobile liability insurance;
(d) workers' compensation or similar insurance;
(e) automobile medical payment insurance;
(f) credit-only insurance;
(g) coverage for on-site medical clinics;
(h) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;
(i) if offered separately:

(i) limited scope dental or vision benefits;

(ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these;

(iii) other similar, limited benefits as are specified in regulations;

(j) if offered as independent, noncoordinated benefits:

(i) coverage only for a specified disease or illness;

(ii) hospital indemnity or other fixed indemnity insurance;

(k) if offered as a separate insurance policy:

(i) Medicare supplemental health insurance, as defined under Section 1882(g)(1) of the Social Security Act;

(ii) coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code; and

(iii) similar supplemental coverage under a group health plan.

Section 38-71-840

As used in this subarticle: . . .

(14) "Health insurance coverage" means benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer, except:

(a) coverage only for accident, or disability income insurance, or any combination of accident and disability income insurance;

(b) coverage issued as a supplement to liability insurance;

(c) liability insurance, including general liability insurance and automobile liability insurance;

(d) workers' compensation or similar insurance;

(e) automobile medical payment insurance;

(f) credit-only insurance;

(g) coverage for on-site medical clinics;

(h) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(i) if offered separately:

(i) limited scope dental or vision benefits;

(ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these;

(iii) other similar, limited benefits as are specified in regulations;

(j) if offered as independent, noncoordinated benefits:

(i) coverage only for a specified disease or illness;

(ii) hospital indemnity or other fixed indemnity insurance;

(k) if offered as a separate insurance policy:

(i) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

(ii) coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code; and

(iii) similar supplemental coverage under a group health plan.

The Appeals Committee also considered the 2008[15] State Health Plan (Plan), established by the South Carolina Budget and Control Board for state employees and retirees.

Article 7
Schedule of Benefits
[see attached]

Article 9
Exclusions and Limitations

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

. . .

O. Any medical social services (except for those provided under the Hospice program and Home Health Care Program upon recommendation of the Utilization Review Agency) or vocational, visual, recreational, educational, or milieu therapy;

. . .

BB. Benefits will not be provided for services or supplies not specifically listed in Article 7, Schedule of Benefits, inclusive;

The Committee also considered pertinent parts of the 2008 IBG:

General Information

. . . .

Prevention Partners

Prevention Partners, a unit of the Employee Insurance Program, is designed to help you and your family lead healthier lives. Its activities, programs and services promote good health through disease prevention, early detection of disease and chronic disease education.

. . . .

Chronic Disease Workshops, another major program, give subscribers and their dependents information they need to help them take better care of themselves. Workshops include: Caregivers, Diabetes, Heath Disease, Asthma, Kidney Evaluation, Women's Reproductive Health, Weight Management, Medications, Men's Health, Cholesterol/Lipids and Gastrointestinal Ailments.[16]

State Health Plan

Doctor Visits

Treatments or consultations for an injury or illness are covered, as long as they are medically necessary and not associated with a service excluded by the plan.

[15] Because the claim was incurred in 2008, the Plan provisions from the 2008 Plan would apply. However, the provisions relevant to this claim and appeal were substantially the same in the 2009 Plan.
[16] P. 20.

For mental health and substance abuse services to be covered, you must use a participating provider, and all mental health and substance abuse services must be preauthorized by APS Healthcare. For details on mental health and substance abuse services, see page 58.[17]

Exclusions

Services Not Covered by the State Health Plan

There are some medical expenses the State Health Plan does not cover. The Plan of Benefits document (available in your benefits office or through EIP) contains a complete list of the exclusions.[18]

BlueChoice HealthPlan

. . . .

Covered Services

. . . .

Doctor Visits

Charges from your PCP for office visits, including routine examinations, vision and hearing screenings, preventive care, injections, immunizations, well-child care and health education, are covered. Charges from specialists for treatment or consultation are also covered.[19]

MUSC Options

. . . .

Covered Services

. . . .

Doctor Visits

Charges from your PCP for office visits, including routine examinations, vision and hearing screenings, preventive care, injections, immunizations, well-child care and health education, are covered. Charges from specialists for treatment or consultation are also covered.[20]

Determination of Appeals Committee

The Appeals Committee considered all of the evidence in Claimant's file. The Committee then applied all of the reliable and probative evidence to the relevant provisions of the Plan.

The Committee first noted the apparent confusion about the nature of the relationship between EIP and BCBSSC. The South Carolina Budget and Control Board is a state agency charged, in part, with providing a self-insured, non-federal governmental group health benefits plan to employees of the state, public school districts, and other participating entities listed in §

[17] P. 46.
[18] P. 59
[19] P. 66
[20] P. 83

1-11-720.[21] The Board is required to "make available to active and retired employees of this State and its public school districts and their eligible dependents group health, dental, life, accidental death and dismemberment, and disability insurance plans and benefits in an equitable manner and of maximum benefit to those covered within the available resources." The available resources consist of employee contributions, employer contributions (i.e., public funds), and investment income on those contributions. The Board provides coverage to approximately 400,000 lives in South Carolina, and the Plan rules are developed with the purpose of providing affordable quality coverage to all those covered.

EIP is the part of the Budget and Control Board that is responsible for administering the State Health Plan as well as other benefit programs offered to public employees. BCBSSC is a third party claims processor procured by EIP to provide medical reviews, claims processing, and claims payment services for the State Health Plan. With that in mind, the Committee considered the terms of the 2008 Plan applicable to this appeal.

Article 9, Paragraph O of the 2008 Plan excludes educational services, outside of certain programmatically-offered situations. Paragraph BB states those services not enumerated in Article 7 are not covered; diabetes education, as a stand-alone claim, is not covered. Therefore, no more benefits are payable for the educational services received by Claimant, Claimant's spouse, Dependent's grandparents, and two nurses on Dependent's behalf in relation to Dependent's insulin pump on August 5, 2008, under the terms of the Plan. The Plan covered the insulin pump and accessories without issue, but the group's separately-billed educational instruction is not included.

The Committee also observed that, in the Standard Plan, while those diabetes educational services are not covered as a stand-alone claim, wellness and educational programs for chronic diseases including diabetes are available if pursued through EIP's Prevention Partners and other available BCBSSC programs. The Committee noted Claimant's spouse made no mention of having pursued these other avenues, except to state in a footnote someone from BCBSSC had called her regarding one such program.

The Committee also noted other health insurance coverage options were available to Dependent and Claimant which would have covered the in-office, separately-billed educational services they sought. While differences in coverage do exist among the Standard Plan and the HMO options and every subscriber must weigh these options while selecting coverage, if Claimant and his family had decided office-setting, independently-billed educational services were a priority, they could have remained covered under the MUSC Options plan or selected BlueChoice HealthPlan when changing coverage at the beginning of the 2008 Plan year. However, Claimant selected different health insurance coverage for himself and Dependent, and he selected an option that does not cover the desired educational services outside of the wellness programs described above.

Lastly, the Committee noted the repeated assertions regarding S.C. Code Ann. § 38-71-46 and Claimant's attorney's assertion no one has explained why it does not apply to the State Health Plan. While the Committee noted the alternative methods for obtaining diabetes

[21] S.C. Code Ann. § 1-11-710(A).

education noted above, the Committee also observed the Department of Insurance and the General Assembly historically have acknowledged the Department has no jurisdiction over EIP.[22] EIP is not a health insurance issuer under the Code. In the areas in which the General Assembly has wanted to include EIP in the Accident and Health Insurance provisions of Title 38, Chapter 31, it has specifically said so. Therefore, because § 38-71-46 does not refer to EIP or the State Health Plan, it does not apply to the State Health Plan.

The Committee hopes the best for Dependent's well-being in the future. While the particularities regarding Dependent's young age and the severity of her disease are compelling, the Committee must make decisions within the terms of the Plan. The Plan does not cover educational services as a separately billed claim. Therefore, no further benefits are payable for the August 5, 2008, educational session.

Conclusion

Based on all of the evidence in the record, the Committee concluded no benefits are payable for the $560.00 claim filed for diabetes educational training on August 5, 2008, for Dependent's family and caregivers in conjunction with her covered insulin pump.

[22] See, e.g., S.C. Code Ann. § 1-11-780:

> *The State Employee Insurance Program shall continue to provide mental health parity in the same manner and with the same management practices as included in the plan beginning in 2002, and is not under the jurisdiction of the Department of Insurance. The continuation by the State Employee Insurance Program of providing mental health parity in accordance with the plan set forth in 2002 constitutes compliance with this act.*

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	FOR THE NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON	)	
Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees,	)	Civil Action No.: 2009-CP-10-7404
Plaintiffs,	)	**CERTIFICATE OF SERVICE**
v.	)	
South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina,	)	
Defendants.	)	

I, Theodore D. Willard, Jr., of the law firm of Montgomery Willard, LLC, attorneys for the Defendants do hereby certify that I have served the below named counsel with a copy of *Defendants' Memorandum In Support of Motion For Summary Judgment* by mailing a copy of same by United States mail, proper postage affixed, return address clearly marked, and addressed as follows:

John A. Massalon, Esquire
Wills & Massalon, LLC
Post Office Box 859
Charleston, South Carolina 29402

Terry E. Richardson, Jr., Esquire
Richardson, Patrick, Westbrook & Brickman, LLC
1017 Chuck Dawley Blvd.
Mt. Pleasant, South Carolina 29464

Theodore D. Willard, Jr.

August 24, 2010
Columbia, South Carolina

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF CHARLESTON	)	CASE NO.: 09-CP-10-7404
	)	
Jeffrey D. Allen, individually, as Guardian For Jane Doe, a minor, and as Representative Of other similarly situated State of South Carolina employees,	)	Plaintiff's Notice of Motion and Motion to Compel Responses to Plaintiff's First Interrogatories and First Requests for Production and Motion to Stay Decision on Defendant's Motion for Summary Judgment
Plaintiff,	)	
v.	)	
South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina,	)	
Defendants.	)	

FILED
2010 JUN 18 PM 2:39
JULIE J. ARMSTRONG
CLERK OF COURT

TO: Theodore D. Willard, Jr., Esq. and Kelly H. Rainsford, Esq., counsel for Defendants.

PLEASE TAKE NOTICE that Plaintiff, by and through his undersigned attorneys, will move the Court for an order, on the date set by the Court for the hearing of this matter, upon Plaintiff's motion herein, compelling the Defendants to answer Plaintiff's First Interrogatories and First Requests for Production (served May 6, 2010, and attached hereto as Exhibits "A," "B," "C," and "D") in the above-captioned lawsuit.

10 - 1035

Also, as Defendants have moved for (1) a protective order to allow Defendants not to answer Plaintiff's First Interrogatories and Requests for Production, and (2) summary judgment prior to any discovery, Plaintiff hereby moves for a stay of decision on Defendants' Motion for Summary Judgment until after the Court has determined whether Defendants should be required to respond to Plaintiff's First Interrogatories and Requests for Production.

Counsel for Plaintiff and counsel for Defendants have consulted orally in a good faith attempt to resolve the matter contained in the foregoing motions.

PLEASE BE PRESENT TO DEFEND IF SO MINDED.

John A. Massalon
Wills Massalon & Allen, LLC
Post Office Box 859
Charleston, SC 29402

(843) 727-1144
-and-
Terry E. Richardson, Jr.
Matthew D. Hamrick
Richardson, Patrick, Westbrook & Brickman, LLC
1017 Chuck Dawley Blvd.
Mt. Pleasant, SC 29464
(843) 727-6500

ATTORNEYS FOR PLAINTIFF

CERTIFICATE OF SERVICE

I hereby certify that I have this 17 day of June, 2010 served the foregoing pleading or paper by depositing a copy of it in the US Mail, first class, postage pre-paid, addressed as follows:

Theodore D. Willard, Jr., Esq.
MONTGOMERY WILLARD, LLC
1002 Calhoun Street
Post Office Box 11886
Columbia, SC 29211

Kelly H. Rainsford, Esq.
State Budget & Control Board
1201 Main Street, Ste. 300
Columbia, SC 29211

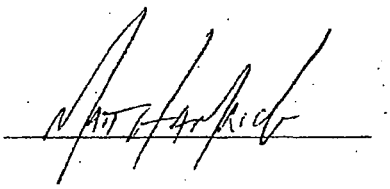


EXHIBIT A

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF CHARLESTON	)	CASE NO.: 09-CP-10-7404
	)	
	)	
Jeffrey D. Allen, individually, as Guardian For Jane Doe, a minor, and as Representative Of other similarly situated State of South Carolina employees,	)	
	)	Plaintiff's First Interrogatories To Defendant South Carolina Budget and Control Board Employee Insurance Program
Plaintiff,	)	
v.	)	
	)	
South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina,	)	
	)	
Defendants.	)	

Plaintiff hereby submits the following interrogatories, pursuant to Rules 26 and 33, to Defendant the South Carolina Budget and Control Board Employee Insurance Program (hereinafter referred to as the "EIP").

INTERROGATORIES

1. Give the names and addresses of persons known to the EIP or counsel to be witnesses concerning the facts of this case and indicate whether or not written or recorded statements have been taken from the witnesses and indicate who has possession of such statements.

2. Set forth a list of any prepared documents in possession of the EIP or counsel that relate to the claims or defenses in this case.

3. Set forth the names and addresses of all insurance companies which have liability insurance coverage relating to the claim and set forth the number or numbers of the policies involved and the amount or amounts of liability coverage provided in each policy.

4. List the names and addresses of any expert witnesses whom the EIP proposes to use as a witness at the trial of the case.

5. For each person known to the EIP or counsel to be a witness concerning the facts of the case, set forth either a summary sufficient to inform the Plaintiff of the important facts known to or observed by such witness, or provide a copy of any written or recorded statements taken from such witnesses.

6. If the EIP is improperly identified, give the proper identification and state whether counsel will accept service of an amended summons and pleading reflecting the correct information.

7. State the names and addresses of all persons, both entities and individuals, with authority to make decisions regarding coverage or denials of coverage under the EIP Standard Plan (hereinafter referred to as the "Plan"), including but not limited to making the final determination to allow or disallow a claim for benefits, in each calendar year since January 1, 2000.

8. State the names and addresses of all persons, both entities and individuals, who took part in drafting any portion of the Plan, including any revisions or amendments to the Plan.

9. State whether or not the Plan covers self-management training and education for the treatment or maintenance of *any* medical condition(s), and if so identify the condition(s).

10. For each year since January 1, 2000 state the total (by year) number of individuals who were covered by the Plan, including but not limited to any enrolled dependants.

11. State the reason why Plaintiff's claim was disallowed, including an explanation of any relevant policy provisions or exclusions.

12. If the EIP contends that SC Code § 38-71-46 does not apply to the Plan, please explain why.

13. Identify all statutes, regulations, case law and other authority with the force of law which you contend support your contention that S.C. Code § 38-71-46 does not apply to the Plan.

14. State whether the EIP has ever notified the Diabetes Initiative of South Carolina that the Plan does not cover outpatient self-management training and education for the treatment of people with diabetes mellitus because S.C. Code § 38-71-46 does not apply to the Plan.

15. How and when is the EIP able to identify persons covered under the Plan, including but not limited to enrolled dependants, who have diabetes?

16. Provide the total number of claims, by year, of any type processed under the Plan for each calendar year since January 1, 2000.

17. Provide the total number of claims, by year, of any type which were denied under the Plan for each calendar year since January 1, 2000.

18. State the total number of claims, by year, made under the Plan for diabetes education for each calendar year beginning January 1, 2000.

19. Identify all the different types of individuals, employers, state and local governments which are able to participate in the Plan.

20. Identify any other state law insurance mandates EIP contends do not apply to the Plan, and explain why.

21. Describe the flow of the premium monies from the individual and employer to or through the Plan and/or Blue Cross and Blue Shield of South Carolina (hereinafter referred to as "BCBS").

22. Has any entity other than BCBS served in the same or similar capacity for the EIP since January 1, 2000?

23. Is this action similar in whole or in part to any other lawsuit ever filed against the EIP? If so, provide: (1) a short caption and the full case number of the related action; and (2) a statement of the status of the related action. Counsel should disclose any cases which may be related regardless of whether they are still pending.

24. If you contend that some other person or legal entity is a necessary party to this action, identify such person or entity and describe the basis of your claim that the person or entity is a necessary party.

25. If you contend that some other person or legal entity is, in whole or in part, liable to you or the party asserting a claim against you in this matter, identify such person or entity and describe the basis of said liability.

26. Identify any and all diagnosis or treatment codes related to diabetes.

27. For each year since January 1, 2000 state, by year, the total number of individuals, including but not limited to any enrolled dependants, who were covered by the Plan and who received or were assigned the diagnosis code "250" or a treatment code beginning with "250."

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Mt. Pleasant, SC 29464
(843) 727-6500

ATTORNEYS FOR PLAINTIFF

CERTIFICATE OF SERVICE

I hereby certify that I have this 10th day of May, 2010 served the foregoing pleading or paper by depositing a copy of it in the US Mail, first class, postage pre-paid, addressed as follows:

Theodore D. Willard, Jr., Esq.
MONTGOMERY WILLARD, LLC
1002 Calhoun Street
Post Office Box 11886
Columbia, SC 29211

Kelly H. Rainsford, Esq.
State Budget & Control Board
1201 Main Street, Ste. 300
Columbia, SC 29211

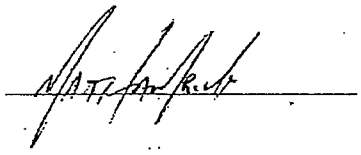


EXHIBIT B

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF CHARLESTON	)	CASE NO.: 09-CP-10-7404
	)	
	)	
Jeffrey D. Allen, individually, as Guardian For Jane Doe, a minor, and as Representative Of other similarly situated State of South Carolina employees,	)	Plaintiff's First Requests for Production to Defendant South Carolina Budget and Control Board Employee Insurance Program
Plaintiff,	)	
v.	)	
	)	
South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina,	)	
	)	
Defendants.	)	

Plaintiff hereby submits the following requests for production, pursuant to Rules 26 and 34, to Defendant the South Carolina Budget and Control Board Employee Insurance Program (hereinafter referred to as the "EIP").

REQUESTS FOR PRODUCTION

1. Any and all documents relating to any contracts between the EIP and Blue Cross and Blue Shield of South Carolina (hereinafter referred to as "BCBS"), including but not limited to any records of payment, from 2000 to present.

2. Any and all documents relating to any contracts between the EIP and/or BCBS and/or any diabetic-supply companies, including but not limited to contracts, lists of services and supplies, and terms of payment (both approved and non-approved for payment) from 2000 to present.

3. Any and all documents relating to any contracts between the EIP and/or BCBS and/or any diabetic-related durable medical equipment companies, including but not limited to

contracts, lists of services, durable medical equipment, and terms of payment (both approved and non-approved for payment) from 2000 to present.

4. Any and all indemnity agreements existing between the EIP and BCBS.

5. A listing of the current members of the South Carolina Budget and Control Board.

6. A listing of the current employees of South Carolina Budget and Control Board whose job responsibilities involve the EIP, including their job descriptions.

7. All versions for each policy year, since January 1, 2000, of the provisions of the Plan, to include the Plan Document and the Summary provided to employees.

8. All written inquiries of any type, including but not limited to claims correspondence and documentation, emails, and any other type of inquiry, made to EIP on or after January 1, 2000, regarding S.C. Code § 38-71-46.

9. Any and all communications made by the EIP, on or after January 1, 2000, regarding S.C. Code § 38-71-46.

10. Any and all communications or documents related to the content of or introduction of the legislation which ultimately resulted in the enactment of S.C. Code 38-71-46.

11. Any and all communications made by the EIP containing information about or in any way relating to any type of wellness plan or wellness coverage for people with diabetes.

12. Any and all documents relating to any limitation of authority of claims adjusters for insurance policies, or reflecting any requirement for prior approval for payment of any claim.

13. Produce any electronic communications or representations, including but not limited to emails, blogs, personal homepages, internet message boards, and social networking sites, relating to or referring to coverage or the absence of coverage under the Plan for outpatient self-management training and education for the treatment of people with diabetes mellitus.

14. Produce any and all non-patient-specific information or data the EIP has used since January 1, 2000 to make predictions about the number of diabetes-related claims that would potentially be made by persons covered under the Plan, including but not limited to enrolled dependants.

15. Produce a chart or other similar document showing the organizational structure of the EIP.

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ATTORNEYS FOR PLAINTIFF

CERTIFICATE OF SERVICE

I hereby certify that I have this 10TH day of May, 2010 served the foregoing pleading or paper by depositing a copy of it in the US Mail, first class, postage pre-paid, addressed as follows:

Theodore D. Willard, Jr., Esq.
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Post Office Box 11886
Columbia, SC 29211

Kelly H. Rainsford, Esq.
State Budget & Control Board
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Columbia, SC 29211

EXHIBIT C

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF CHARLESTON	)	CASE NO.: 09-CP-10-7404
	)	
	)	
Jeffrey D. Allen, individually, as Guardian For Jane Doe, a minor, and as Representative Of other similarly situated State of South Carolina employees,	)	Plaintiff's First Interrogatories To Defendant Blue Cross and Blue Shield of South Carolina
Plaintiff,	)	
v.	)	
	)	
South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina,	)	
	)	
Defendants.	)	

Plaintiff hereby submits the following interrogatories, pursuant to Rules 26 and 33, to Defendant Blue Cross and Blue Shield of South Carolina (hereinafter referred to as "BCBS").

INTERROGATORIES

1. Give the names and addresses of persons known to BCBS or counsel to be witnesses concerning the facts of this case and indicate whether or not written or recorded statements have been taken from the witnesses and indicate who has possession of such statements.

2. Set forth a list of any prepared documents in possession of BCBS or counsel that relate to the claims or defenses in this case.

3. Set forth the names and addresses of all insurance companies which have liability insurance coverage relating to the claim and set forth the number or numbers of the policies involved and the amount or amounts of liability coverage provided in each policy.

4. List the names and addresses of any expert witnesses whom BCBS proposes to use as a witness at the trial of the case.

5. For each person known to BCBS or counsel to be a witness concerning the facts of the case, set forth either a summary sufficient to inform the Plaintiff of the important facts known to or observed by such witness, or provide a copy of any written or recorded statements taken from such witnesses.

6. If BCBS is improperly identified, give the proper identification and state whether counsel will accept service of an amended summons and pleading reflecting the correct information.

7. State the names and addresses of all persons, both entities and individuals, with authority to make decisions regarding coverage or denials of coverage under the South Carolina Budget and Control Board Employee Insurance Plan (hereinafter referred to as the "EIP") Standard Plan (hereinafter referred to as the "Plan"), including but not limited to making the final determination to allow or disallow a claim for benefits, in each calendar year since January 1, 2000.

8. State the names and addresses of all persons, both entities and individuals, who took part in drafting any portion of the Plan, including any revisions or amendments to the Plan.

9. State whether or not the Plan covers self-management training and education for the treatment or maintenance of *any* medical condition(s), and if so identify the condition(s).

10. For each year since January 1, 2000 state, by year, the total number of individuals who were covered by the Plan, including but not limited to any enrolled dependants.

11. State the reason why Plaintiff's claim was disallowed, including an explanation of any relevant policy provisions or exclusions.

12. If BCBS contends that SC Code § 38-71-46 does not apply to the Plan, please explain why.

13. Identify all statutes, regulations, case law and other authority with the force of law which you contend support your contention that S.C. Code § 38-71-46 does not apply to the Plan.

14. State whether BCBS has ever notified the Diabetes Initiative of South Carolina that the Plan does not cover outpatient self-management training and education for the treatment of people with diabetes mellitus because S.C. Code § 38-71-46 does not apply to the Plan.

15. State whether or not BCBS covers outpatient self-management training and education under its private health insurance plans (other than the Plan at issue in this case), and identify each plan under which outpatient self-management training and education is covered, and the terms of any such coverage.

16. How and when is BCBS able to identify persons covered under the Plan, including but not limited to enrolled dependants, who have diabetes?

17. Provide the total number of claims, by year, processed under the Plan for each calendar year since January 1, 2000.

18. Provide the total number of claims, by year, which were denied under the Standard Plan for each calendar year since January 1, 2000.

19. State the total number of claims, by year, made for diabetes education for each calendar year beginning January 1, 2000.

20. Set forth the make-up or the formula or method by which BCBS is compensated through its relationship with the EIP, including all years from January 1, 2000 to the present.

21. With regard to any compensation paid to BCBS related in any way to BCBS's services performed for EIP, state whether any portion of the compensation paid to BCBS is based on or related in any way to the number or amount of claims paid or denied.

22. Provide the annual compensation paid to (or revenues collected by) BCBS or any affiliated entities related to the relationship with the EIP.

23. With regard to the annual compensation or revenue referenced in the answer to the preceding Interrogatory, identify for which of the following revenue descriptors compensation or revenue is reported:

- Premiums
- Fee-for-Service
- Risk Revenue
- Net Investment Income Earned
- Net Gain or (Loss) from Agents' or Premium Balances Charged Off
- Other Revenue

24. What percentage of total operating revenue of BCBS is derived from the relationship with the EIP.

25. Does BCBS maintain a separate database of, or have the ability to identify in its databases, diabetes patients, including but not limited to those who have diabetes when they apply for coverage and also those who are diagnosed with diabetes while participants in the Plan?

26. How long has BCBS been serving in its present capacity for the EIP?

27. Is this action similar in whole or in part to any other lawsuit ever filed against BCBS? If so, provide: (1) a short caption and the full case number of the related action; and (2) a statement of the status of the related action. Counsel should disclose any cases which may be related regardless of whether they are still pending.

28. If you contend that some other person or legal entity is a necessary party to this action, identify such person or entity and describe the basis of your claim that the person or entity is a necessary party.

29. If you contend that some other person or legal entity is, in whole or in part, liable to you or the party asserting a claim against you in this matter, identify such person or entity and describe the basis of said liability.

30. Set forth all itemized components of diabetes management, including any educational or nutritional component.

31. For each year since January 1, 2000 state, by year, the total number of individuals, including but not limited to any enrolled dependants, who were covered by the Plan and who received or were assigned the diagnosis code "250" or a treatment code beginning with "250."

32. What type of computer system(s), including the data format(s), does BCBS use with regard to submissions of claims?

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-and-
Terry E. Richardson, Jr.
Matthew D. Hamrick
Richardson, Patrick, Westbrook & Brickman, LLC
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Mt. Pleasant, SC 29464
(843) 727-6500

ATTORNEYS FOR PLAINTIFF

CERTIFICATE OF SERVICE

I hereby certify that I have this 6TH day of May, 2010 served the foregoing pleading or paper by depositing a copy of it in the US Mail, first class, postage pre-paid, addressed as follows:

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1002 Calhoun Street
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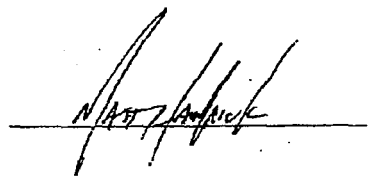


EXHIBIT D

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF CHARLESTON	)	CASE NO.: 09-CP-10-7404
	)	
	)	
Jeffrey D. Allen, individually, as Guardian For Jane Doe, a minor, and as Representative Of other similarly situated State of South Carolina employees,	)	Plaintiff's First Requests for Production to Defendant Blue Cross and Blue Shield of South Carolina
Plaintiff,	)	
v.	)	
	)	
South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina,	)	
	)	
Defendants.	)	
	)	

Plaintiff hereby submits the following requests for production, pursuant to Rules 26 and 34, to Defendant Blue Cross and Blue Shield of South Carolina (hereinafter referred to as BCBS).

REQUESTS FOR PRODUCTION

1. Any and all documents relating to any contracts between the State of South Carolina Budget and Control Board Employee Insurance Program (hereinafter referred to as the "EIP") and BCBS, including but not limited to any records of payment, from 2000 to present.

2. Any and all documents relating to any contracts between the EIP and/or BCBS and/or any diabetic-supply companies, including but not limited to contracts, lists of services and supplies, and terms of payment (both approved and non-approved for payment) from 2000 to present.

3. Any and all documents relating to any contracts between the EIP and/or BCBS and/or any diabetic-related durable medical equipment companies, including but not limited to

contracts, lists of services, durable medical equipment, and terms of payment (both approved and non-approved for payment) from 2000 to present.

4. Any and all indemnity agreements existing between the EIP and BCBS.

5. A listing of the current employees of BCBS whose job responsibilities involve the EIP, including their job descriptions.

6. All versions for each policy year, since January 1, 2000, of the provisions of the Plan, to include the Plan Document and the Summary provided to employees.

7. All written inquiries of any type, including but not limited to claims correspondence and documentation, emails, and any other type of inquiry, made to BCBS on or after January 1, 2000, regarding S.C. Code § 38-71-46.

8. Any and all communications made by BCBS on or after January 1, 2000, regarding S.C. Code § 38-71-46.

9. Any and all communications or documents related to the content of or introduction of the legislation which ultimately resulted in the enactment of S.C. Code 38-71-46.

10. Any and all communications made by BCBS containing information about or in any way relating to any type of wellness plan or wellness coverage for people with diabetes.

11. Any and all documents relating to any limitation of authority of claims adjusters for insurance policies, or reflecting any requirement for prior approval for payment of any claim.

12. Copies of the annual financial statements, including balance sheets and Profit & Loss Reports, for BCBS for each year beginning January 1, 2000.

13. Training materials, procedure manuals, or other materials used to train employees of BCBS in evaluating claims under the Plan including but not limited to claims for diabetes

related services, and for outpatient self-management training and education for the treatment of people with diabetes mellitus (ICD Code 250).

14. Produce any electronic communications or representations, including but not limited to emails, blogs, personal homepages, internet message boards, and social networking sites, relating to or referring to coverage or the absence of coverage under the Plan for outpatient self-management training and education for the treatment of people with diabetes mellitus.

15. Produce any and all non-patient-specific information or data BCBS has used since January 1, 2000 to make predictions about the number of diabetes-related claims that would potentially be made by persons covered under the Plan, including but not limited to enrolled dependants.

16. Produce a chart or other similar document showing the organizational structure of BCBS.

17. Produce documentation of all BCBSSC claims codes for diabetes (ICD 250)-related services, equipment, drugs, procedures.

18. Produce reimbursement policies for diabetes education and/or nutritional education.

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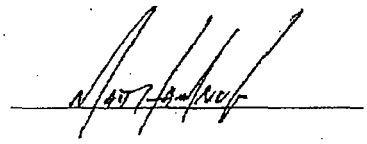
ATTORNEYS FOR PLAINTIFF

CERTIFICATE OF SERVICE

I hereby certify that I have this 6TH day of May, 2010 served the foregoing pleading or paper by depositing a copy of it in the US Mail, first class, postage pre-paid, addressed as follows:

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Kelly H. Rainsford, Esq.
State Budget & Control Board
1201 Main Street, Ste. 300
Columbia, SC 29211



STATE OF SOUTH CAROLINA)	IN THE COURT OF COMMON PLEAS
)	
COUNTY OF CHARLESTON)	CASE NO.: 09-CP-10-7404
)	
)	Plaintiff's Memorandum in Support of
Jeffrey D. Allen, individually, as Guardian)	Motion to Compel Responses to
For Jane Doe, a minor, and as Representative)	Plaintiff's First Interrogatories
Of other similarly situated State of)	and First Requests for Production, in
South Carolina employees,)	Support of Motion to Stay Decision on
)	Defendants' Motion for Summary
Plaintiff,)	Judgment or, in the Alternative,
v.)	Denial of Defendants' Motion for
)	Summary Judgment, and in Opposition to
South Carolina Budget and Control Board)	Defendants' Motion for Protective
Employee Insurance Program and Blue)	Order
Cross and Blue Shield of South Carolina,)	
)	
Defendants.)	
)	

FILED
CHARLESTON COUNTY
2010 APR 21 P 3:16

INTRODUCTION

Plaintiff, Jeffrey D. Allen, by and through his undersigned attorneys, submits this memorandum in support of his motion to compel responses to his first interrogatories and requests for production, in support of his motion to stay decision on Defendants' motion for summary judgment or, in the alternative, denial of Defendants' motion for summary judgment, and in opposition to Defendants' motion for protective order.

BACKGROUND AND PERTINENT PROCEDURAL HISTORY

The Plaintiff, Jeffrey D. Allen, is an employee of a local South Carolina school district and an insured/ member of the State Health Plan. His daughter, . a dependant covered by that health insurance plan, was diagnosed with Type I Diabetes in November 2007 at the age of two (2) years old. This case is about the Defendants' failure to comply with a South Carolina statutory mandate for coverage of outpatient diabetes training and education, S.C. Code Ann. § 38-71-46 (discussed further below), and whether this case should be certified as a class action.

The Complaint alleges that Defendants have unlawfully denied Plaintiff's and other similarly- situated persons' claims for coverage of diabetes-related education on the grounds that, as set forth in Defendant Blue Cross and Blue Shield of South Carolina's denials of Plaintiff's claims for coverage, the "benefit plan does not cover education and/or training for this condition [diabetes]."

The Defendants have asserted that the above-referenced statutory mandate for coverage of outpatient diabetes education and training does not apply to the State Health Plan, without any explanation or reasoning whatsoever and in direct contradiction to the plain and unambiguous language of the statute.

The Defendants initially moved to dismiss this case, and for judgment on the pleadings, arguing that Plaintiff had failed to exhaust his administrative remedies and that Defendant Blue Cross and Blue Shield of South Carolina is merely the administrator and not the insurer under the State Health Plan. *See* Defendants' Memorandum in Support of Defendants' Motion to Dismiss and for Judgment on the Pleadings.

In response to Defendants' Motion to Dismiss and for Judgment on the Pleadings, Plaintiff submitted a thorough memorandum in opposition and detailed affidavits. *See* Memorandum in Opposition to Defendants' Motion to Dismiss, and exhibits/affidavits attached thereto, all of which are incorporated here in opposition to Defendants' current motion for summary judgment.

A hearing was held before the Honorable Markley Dennis on March 4, 2010 on Defendants' motions to dismiss and for judgment on the pleadings, and Judge Dennis denied the motions. *See* March 8, 2010 and March 10, 2010 Orders, respectively, denying motion to dismiss and denying motion for judgment on the pleadings.

Thereafter, on May 6, 2010 Plaintiff served interrogatories and requests for production upon Defendants. Defendants have refused to respond to Plaintiff's written discovery requests, and instead filed the motion for protective order (to allow Defendants not to respond to Plaintiff's discovery requests) and the motion for summary judgment currently pending before the Court.

Defendants' motion for summary judgment repeats the same grounds regarding the exhaustion of administrative remedies as Defendants' previously-denied motion to dismiss and for judgment on the pleadings, plus the additional ground, without any explanation or reasoning whatsoever, that the above-referenced mandate for coverage of outpatient diabetes education and training does not apply to the State Health Plan.

Thereafter, Plaintiff filed his motion to compel responses to his written discovery requests, and motion to stay decision on Defendants' motion for summary judgment, currently pending before the Court.

Defendants' motion for protective order should be denied and discovery in this case should be allowed to proceed. Defendants' motion for summary judgment should either be stayed until the parties have had a full opportunity to conduct discovery, or, alternatively, should be denied because no discovery has taken place in this case, Defendants' unexplained and unreasoned assertion that the above-referenced statutory mandate does not apply to the State Insurance Plan is completely without basis and in direct contradiction to the plain and unambiguous language of the statute and is a novel question, and the application of the law to the facts is in dispute.

In addition to Plaintiff's Memorandum in Opposition to Defendants' Motion to Dismiss, and the exhibits/affidavits attached thereto, all of which are incorporated here in opposition to

Defendants' current motion for summary judgment, Plaintiff also submits the Affidavit of Matthew D. Hamrick, counsel for Plaintiff, pursuant to Rule 56(f), SCRCP (attached hereto as Exhibit "A").

THE STATUTORY MANDATE FOR COVERAGE OF DIABETES EDUCATION

S.C. Code Ann. § 38-71-46 provides:

Diabetes Mellitus coverage in health insurance policies, diabetes education.

(A) On or after January 1, 2000, *every* health maintenance organization, ***individual and group health insurance policy, or contract issued or renewed in this State must provide coverage for*** the equipment, supplies, Food and Drug Administration-approved medication indicated for the treatment of diabetes, and ***outpatient self-management training and education for the treatment of people with diabetes mellitus***, if medically necessary, and prescribed by a health care professional who is legally authorized to prescribe such items and who demonstrates adherence to minimum standards of care for diabetes mellitus as adopted and published by the Diabetes Initiative of South Carolina. This subsection does not prohibit a health maintenance organization or an individual or a group health insurance policy from providing coverage for medication according to formulary or using network providers. Coverage must not be denied unless the health care professional demonstrates a persistent pattern of failure to adhere to the minimal standards of care and unless the health maintenance organization or insurer has first provided written notice to the health care professional that coverage will be denied if the health care professional fails to adhere to the minimal standards of care.

(B) Services and payment for diabetes education programs shall conform to regulations of the Health Care Financing Administration, US Department of Health and Human Services, pursuant to Section 4105 of the Balanced Budget Act of 1997. Diabetes outpatient self-management training and education shall be provided by a registered or licensed health care professional with certification in diabetes by the National Certification Board of Diabetes Educators, or other accredited program approved by the Diabetes Initiative of South Carolina, or by the Diabetes Control Program of the SC Department of Health and Environmental Control in order to meet the needs of rural communities wherein certified health care professionals providing this service are not available.

(C) Nothing contained in this section may be construed to affect in any way the ability of a managed care plan to credential or re-credential a provider.

(D) For purposes of this section: "***Health insurance policy" means a health benefit plan***, contract, or evidence of coverage providing health insurance

coverage as defined in Section 38-71-670(6) and Section 38-71-840(14).

S.C. Code Ann. § 38-71-46 (emphasis added).

As noted above, the mandate statute states that "Health insurance policy" means a health benefit plan, contract, or evidence of coverage providing health insurance coverage as defined in Section 38-71-670(6) and Section 38-71-840(14). S.C. Code § 38-71-670(6) defines "Health insurance coverage" as follows:

> (6) "Health insurance coverage" means benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer, except:
>
> (a) coverage only for accident or disability income insurance or any combination of these;
>
> (b) coverage issued as a supplement to liability insurance;
>
> (c) liability insurance, including general liability insurance and automobile liability insurance;
>
> (d) workers' compensation or similar insurance;
>
> (e) automobile medical payment insurance;
>
> (f) credit-only insurance;
>
> (g) coverage for on-site medical clinics;
>
> (h) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;
>
> (i) if offered separately:
>
> (i) limited scope dental or vision benefits;
>
> (ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these;

(iii) other similar, limited benefits as are specified in regulations;

(j) if offered as independent, noncoordinated benefits:

(i) coverage only for a specified disease or illness;

(ii) hospital indemnity or other fixed indemnity insurance;

(k) if offered as a separate insurance policy:

(i) Medicare supplemental health insurance, as defined under Section 1882(g)(1) of the Social Security Act;

(ii) coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code; and

(iii) similar supplemental coverage under a group health plan.

S.C. Code § 38-71-670(6). Similarly, S.C. Code § 38-71-840(14) is nearly identical and defines "Health insurance coverage" as follows:

(14) "Health insurance coverage" means benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer, except:

(a) coverage only for accident, or disability income insurance, or any combination of accident and disability income insurance;

(b) coverage issued as a supplement to liability insurance;

(c) liability insurance, including general liability insurance and automobile liability insurance;

(d) workers' compensation or similar insurance;

(e) automobile medical payment insurance;

(f) credit-only insurance;

(g) coverage for on-site medical clinics;

(h) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(i) if offered separately:

(i) limited scope dental or vision benefits;

(ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these;

(iii) other similar, limited benefits as are specified in regulations;

(j) if offered as independent, noncoordinated benefits:

(i) coverage only for a specified disease or illness;

(ii) hospital indemnity or other fixed indemnity insurance;

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(i) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

(ii) coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code; and

(iii) similar supplemental coverage under a group health plan.

S.C. Code § 38-71-840(14). The State Health Plan obviously meets these statutory definitions of "health insurance coverage" and is not included within any of the enumerated exceptions. Therefore, the State Health Plan is a "Health insurance policy" for purposes of the statutory mandate of S.C. Code Ann. § 38-71-46. *See Riverwoods, LLC v. County of Charleston*, 349 S.C. 378, 384, 563 S.E.2d 651, 655 (2002) (" The canon of construction ' *expressio unius est exclusio alterius* ' or ' *inclusio unius est exclusio alterius* ' holds that 'to express or include one thing implies the exclusion of another, or of the alternative. The enumeration of exclusions from the operation of a statute indicates that the statute should apply to all cases not specifically excluded. Exceptions strengthen the force of the general law and enumeration weakens it as to things not

expressed.' ") (citations omitted); *W. Va. Pulp & Paper Co. v. Riddock*, 225 S.C. 283, 288, 82 S.E.2d 189, 190 (1954) (" The inclusion in the statute of certain specified exclusions leaves the inference that the Legislature intended no other exclusions from the exemption.").

The Defendants have asserted that the above-referenced statutory mandate for coverage of outpatient diabetes education and training does not apply to the State Health Plan, without any explanation or reasoning whatsoever and in direct contradiction to the plain and unambiguous language of the statute. The statutory mandate should be held to apply to the State Health Plan. "The cardinal rule of statutory construction is to ascertain and effectuate the intent of the legislature." *Hardee v. McDowell*, 381 S.C. 445, 453, 673 S.E.2d 813, 817 (2009) (internal quotation omitted). Under the plain meaning rule, the court is not permitted to change the meaning of a clear and unambiguous statute. *Hodges v. Rainey*, 341 S.C. 79, 85, 533 S.E.2d 578, 581 (2000). Where the statute's language is plain, unambiguous, and conveys a clear, definite meaning, the court may not impose a different meaning and need not employ rules of statutory interpretation. *Gay v. Ariail*, 381 S.C. 341, 345, 673 S.E.2d 418, 420 (2009).

DEFENDANTS' MOTIONS FOR A PROTECTIVE ORDER AND SUMMARY JUDGMENT SHOULD BE DENIED, AND DISCOVERY SHOULD BE ALLOWED TO PROCEED

The Defendants' motions for a protective order (that they be permitted to not respond to Plaintiff's written discovery requests) and for summary judgment should be denied. Discovery should be allowed to proceed. At the very least, a decision on the motion for summary judgment should be stayed until the parties have had a full opportunity to conduct discovery. The Court of Appeals of South Carolina has explained that:

> summary judgment is a "drastic remedy" which should be cautiously invoked so no person will be improperly deprived of a trial of the disputed factual issues. *Cunningham v. Helping Hands, Inc.*, 352 S.C. 485, 575 S.E.2d 549 (2003); *Lanham v. Blue Cross & Blue Shield*, 349 S.C. 356, 563 S.E.2d 331 (2002); *Conner v. City of Forest Acres*, 348 S.C. 454, 560 S.E.2d 606 (2002); *Redwend*

> *Ltd. P'ship v. Edwards,* 354 S.C. 459, 581 S.E.2d 496 (Ct.App.2003); *Baril v. Aiken Reg'l Med. Ctrs.,* 352 S.C. 271, 573 S.E.2d 830 (Ct.App.2002); *Trivelas v. South Carolina Dep't of Transp.,* 348 S.C. 125, 558 S.E.2d 271 (Ct.App.2001); *Murray v. Holnam, Inc.,* 344 S.C. 129, 542 S.E.2d 743 (Ct.App.2001); *McNair v. Rainsford,* 330 S.C. 332, 499 S.E.2d 488 (Ct.App.1998). Because summary judgment is a drastic remedy, it **must not be granted until the opposing party has had a "full and fair opportunity to complete discovery."** *Dawkins v. Fields,* 354 S.C. 58, 69, 580 S.E.2d 433, 439 (2003); *Lanham,* 349 S.C. at 363, 563 S.E.2d at 334; *Doe v. Batson,* 345 S.C. 316, 322, 548 S.E.2d 854, 857 (2001); *Baird v. Charleston County,* 333 S.C. 519, 529, 511 S.E.2d 69, 74 (1999); *Baughman v. American Tel. & Tel. Co.,* 306 S.C. 101, 112, 410 S.E.2d 537, 543 (1991).

Schmidt v. Courtney, 357 S.C. 310, 592 S.E.2d 326, 331 (Ct. App. 2003) (emphasis added). The court in *Schmidt* went on to explain:

> Summary judgment is not appropriate where further inquiry into the facts of the case is desirable to clarify the application of the law. *Lanham,* 349 S.C. at 362, 563 S.E.2d at 333; *Moriarty v. Garden Sanctuary Church of God,* 341 S.C. 320, 534 S.E.2d 672 (2000); *Mosteller v. County of Lexington,* 336 S.C. 360, 520 S.E.2d 620 (1999); *Redwend Ltd. P'ship,* 354 S.C. at 468, 581 S.E.2d at 501; *Baril,* 352 S.C. at 280, 573 S.E.2d at 835; *Trivelas,* 348 S.C. at 130, 558 S.E.2d at 273; *Hall v. Fedor,* 349 S.C. 169, 561 S.E.2d 654 (Ct.App.2002); *Hedgepath v. American Tel. & Tel. Co.,* 348 S.C. 340, 559 S.E.2d 327 (Ct.App.2001); *Bayle v. South Carolina Dep't of Transp.,* 344 S.C. 115, 542 S.E.2d 736 (Ct.App.2001); *Vermeer Carolina's, Inc. v. Wood/Chuck Chipper Corp.,* 336 S.C. 53, 518 S.E.2d 301 (Ct.App.1999); *Middleborough Horizontal Prop. Regime Council v. Montedison,* 320 S.C. 470, 465 S.E.2d 765 (Ct.App.1995). "Summary judgment is inappropriate when further development of the facts is desirable to clarify the application of the law." *Lee v. Kelley,* 298 S.C. 155, 158, 378 S.E.2d 616, 617 (Ct.App.1989). Even when there is no dispute as to evidentiary facts, but only as to the conclusions or inferences to be drawn from them, summary judgment should be denied. *Redwend Ltd. P'ship,* 354 S.C. at 468, 581 S.E.2d at 501; *Baril,* 352 S.C. at 280, 573 S.E.2d at 835; *Hall,* 349 S.C. at 173-74, 561 S.E.2d at 656; *Glasscock, Inc. v. United States Fid. & Guar. Co.,* 348 S.C. 76, 557 S.E.2d 689 (Ct.App.2001); *Stewart v. State Farm Mut. Auto. Ins. Co.,* 341 S.C. 143, 533 S.E.2d 597 (Ct.App.2000); *see alsoLaurens Emergency Med. Specialists v. M.S. Bailey & Sons Bankers,* 355 S.C. 104, 584 S.E.2d 375 (2003) (noting that summary judgment should not be granted even when there is no dispute as to evidentiary facts, if there is dispute as to conclusions to be drawn therefrom).

Schmidt v. Courtney, 357 S.C. 310, 592 S.E.2d 326, 331 (Ct. App. 2003). The Court of Appeals held that summary judgment should have been denied in the *Schmidt* case because the question

of law in that case was a novel one, and the application of the law to the facts was in dispute. As in the *Schmidt* case, the question of law in this case (whether the above-referenced statutory mandate applies to the State Health Plan) is a novel question, and the application of the statute to the facts of this case is in dispute. Additionally, further inquiry into the facts is necessary to clarify the application of the law. Therefore, summary judgment is inappropriate and should be denied, as should Defendants' motion for a protective order allowing them not to answer Plaintiff's discovery requests. At a minimum, the decision on Defendants' motion for summary judgment should be stayed until the parties have had a full opportunity to conduct discovery.

PLAINTIFF IS NOT REQUIRED TO EXHAUST ADMINISTRATIVE REMEDIES

The issue of exhaustion of administrative remedies, which Defendants assert is a basis for summary judgment, was fully briefed and argued pursuant to Defendants' motion to dismiss and for judgment on the pleadings, which, as mentioned above, were denied. Defendant is now attempting a second bite at the apple by again asserting the issue of exhaustion of administrative remedies as a purported basis for summary judgment. Plaintiff incorporates by reference Plaintiff's Memorandum in Opposition to Defendants' Motion to Dismiss, and the exhibits/affidavits attached thereto, in opposition to this purported basis for summary judgment. Additionally, Plaintiff respectfully directs the Court's attention to *Drummond v. State of South Carolina*, 378 S.C. 362, 662 S.E.2d 587 (2008), wherein the court recently affirmed that the Administrative Law Court and judges formerly known as ALJs "are an agency of the executive branch of government" and cannot rule on the validity of a statute or regulation. While this case is not a direct challenge of the constitutionality of the subject statutory coverage mandate, the South Carolina Budget and Control Board is a state agency and it has promulgated its "decision" that its State Health Plan does not provide coverage for diabetic education. It is the validity of

that state agency's decision which is being challenged in this case. In *Drummond*, the court held that although the appellant was not challenging the constitutionality of the regulation, he was challenging its validity under state law. Because the Administrative Law Court is part of the executive branch, as stated in *Video Gaming Consultants, Inc. v. South Carolina Dep't of Revenue*, 342 S.C. 34, 38, 535 S.E.2d 642, 644 (2000), it has no authority to rule on the validity of the regulation.

CONCLUSION

For the reasons discussed above, Plaintiff respectfully requests that the Court issue an order as follows:

1. Granting Plaintiff's motion to compel Defendants to fully respond to Plaintiff's first interrogatories and requests for production;
2. Denying Defendant's motion for a protective order; and
3. Denying Defendant's motion for summary judgment, or, alternatively, staying the decision on Defendant's motion for summary judgment until the parties have had a full and fair opportunity to complete discovery.

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ATTORNEYS FOR PLAINTIFF

11

CERTIFICATE OF SERVICE

I hereby certify that I have this 23RD day of AUGUST, 2010 served the foregoing pleading or paper by depositing a copy of it in the US Mail, first class, postage pre-paid, addressed as follows, and also by email transmission as follows:

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MATT [illegible]

FILED
2010 AUG 24 P 3:15
JULIE J. ARMSTRONG
CLERK OF COURT

EXHIBIT A

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF CHARLESTON	)	CASE NO.: 09-CP-10-7404
Jeffrey D. Allen, individually, as Guardian For Jane Doe, a minor, and as Representative Of other similarly situated State of South Carolina employees,	)	
Plaintiff,	)	AFFIDAVIT OF
v.	)	MATTHEW D. HAMRICK, ESQ.
South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina,	)	
Defendants.	)	

APPEARED BEFORE ME Matthew D. Hamrick, Esq., who, after being first duly sworn, deposed and said the following:

1. My name is Matthew D. Hamrick. I am over the age of eighteen (18) years. I am a citizen and resident of South Carolina, and I am one of the attorneys of record for the Plaintiff in the above-captioned lawsuit.

2. My statements herein are made upon my oath, are based upon my own personal knowledge, are true and correct, and I make them voluntarily and under penalty of perjury.

3. I make this affidavit pursuant to Rule 56(f), SCRCP in opposition to Defendants' motion for summary judgment.

4. This case is about the Defendants' failure to comply with a South Carolina statutory mandate for coverage of outpatient diabetes training and education, S.C. Code Ann. § 38-71-46, to an insured covered by the State Health Plan and whether this case should be certified as a class action.

5. Defendant Blue Cross and Blue Shield of South Carolina has asserted, in its denials of Plaintiff's claims for coverage, that the "benefit plan does not cover education and/or training for this condition [diabetes]."

6. The question of whether S.C. Code Ann. § 38-71-46 applies to the State Health Plan appears to be a novel question of law. Plaintiff's counsel has not found any case or other authority on this particular question.

7. On May 6, 2010 Plaintiff served interrogatories and requests for production upon Defendants. Defendants have refused to respond to Plaintiff's written discovery requests, and instead filed the motion for protective order (to allow Defendants not to respond to Plaintiff's discovery requests) and motion for summary judgment currently pending before the Court.

8. It is necessary for Plaintiff to have a full and fair opportunity to conduct discovery in this case, beginning with Plaintiff's first interrogatories and requests for production, so that Plaintiff can discover additional factual evidence to offer in opposition to Defendants' motion for summary judgment.

9. In their motion for summary judgment, Defendants have asserted that S.C. Code Ann. § 38-71-46 does not apply to the State Health Plan, but Defendants have not given any explanation or reason for this assertion.

10. In Plaintiff's first interrogatories to Defendant the South Carolina Budget and Control Board Employee Insurance Program, Plaintiff inquired, among other things:

> . . . .
>
> 9. State whether or not the Plan covers self-management training and education for the treatment or maintenance of *any* medical condition(s), and if so identify the condition(s).
>
> . . . .
>
> 11. State the reason why Plaintiff's claim was disallowed, including an explanation of any relevant policy provisions or exclusions.
> 12. If the EIP contends that SC Code § 38-71-46 does not apply to the Plan, please explain why.
> 13. Identify all statutes, regulations, case law and other authority with the force of law which you contend support your contention that S.C. Code § 38-71-46 does not apply to the Plan.
> 14. State whether the EIP has ever notified the Diabetes Initiative of South Carolina that the Plan does not cover outpatient self-management training and education for the treatment of people with diabetes mellitus because S.C. Code § 38-71-46 does not apply to the Plan.
>
> . . . .
>
> 23. Is this action similar in whole or in part to any other lawsuit ever filed against the EIP? If so, provide: (1) a short caption and the full case number of the related action; and (2) a statement of the status of the related action. Counsel should disclose any cases which may be related regardless of whether they are still pending.

11. In Plaintiff's first requests for production to the South Carolina Budget and Control Board Employee Insurance Program, Plaintiff requests, among other things:

. . . .

7. All versions for each policy year, since January 1, 2000, of the provisions of the Plan, to include the Plan Document and the Summary provided to employees.
8. All written inquiries of any type, including but not limited to claims correspondence and documentation, emails, and any other type of inquiry, made to EIP on or after January 1, 2000, regarding S.C. Code § 38-71-46.
9. Any and all communications made by the EIP, on or after January 1, 2000, regarding S.C. Code § 38-71-46.
10. Any and all communications or documents related to the content of or introduction of the legislation which ultimately resulted in the enactment of S.C. Code 38-71-46.
11. Any and all communications made by the EIP containing information about or in any way relating to any type of wellness plan or wellness coverage for people with diabetes.

. . . .

13. Produce any electronic communications or representations, including but not limited to emails, blogs, personal homepages, internet message boards, and social networking sites, relating to or referring to coverage or the absence of coverage under the Plan for outpatient self-management training and education for the treatment of people with diabetes mellitus.

12. In Plaintiff's first interrogatories and requests for production to Defendant Blue Cross and Blue Shield of South Carolina Plaintiff made inquiries and requests similar or essentially identical to those listed above.

13. The Defendants' answers and responses to all of the above-listed interrogatories and requests for production are necessary and would be highly relevant to the Defendants' assertion as a basis for summary judgment that S.C. Code Ann. § 38-71-46 does not apply to the State Health Plan.

FURTHER AFFIANT SAYETH NAUGHT.

Matthew D. Hamrick (SC Bar #: 16853)

Sworn to before me this 23rd day of August, 2010.

Julia N Murray
Notary Public for South Carolina
My commission expires: 6/4/17

STATE OF SOUTH CAROLINA)	IN THE COURT OF COMMON PLEAS
)	
COUNTY OF CHARLESTON)	CASE NO.: 09-CP-10-7404
)	
)	
Jeffrey D. Allen, individually, as Guardian)	
For Jane Doe, a minor, and as Representative)	
Of other similarly situated State of)	
South Carolina employees,)	
)	
Plaintiff,)	NOTICE OF AND MOTION TO ALTER
v.)	OR AMEND PURSAUNT TO SCRCP,
)	RULE 59(e)
South Carolina Budget and Control Board)	
Employee Insurance Program and Blue)	
Cross and Blue Shield of South Carolina,)	
)	
Defendants.)	

FILED
2010 NOV -8 PM 4:06
JULIE J. ARMSTRONG
CLERK OF COURT
BY _____

10-19244

PLEASE TAKE NOTICE that Plaintiffs, by and through his undersigned counsel, will move before the Hon. Paul M. Burch, Judge of the Charleston County Court of Common Pleas, at the Charleston County Courthouse, Charleston, South Carolina ten (10) days from the filing of this motion, for an order altering or amending the summary judgment order entered in this case pursuant to SCRCP, Rule 59(e). Said entry of judgment was received by the undersigned on October 27, 2010. The grounds for this motion are fully explained in the memorandum filed herewith, and are based on the South Carolina Rules of Civil Procedure, any other applicable law, any memorandum of law filed prior to the hearing, and argument of counsel at a hearing on this matter.

PLEASE BE PRESENT TO DEFEND IF SO MINDED.

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-and-
Terry E. Richardson, Jr.
Matthew D. Hamrick
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ATTORNEYS FOR PLAINTIFF

CERTIFICATE OF SERVICE

I hereby certify that I have this 8th day of November, 2010 served the foregoing pleading or paper by depositing a copy of it in the US Mail, first class, postage pre-paid, addressed as follows, and also by email transmission as follows:

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Faith Frink

STATE OF SOUTH CAROLINA)	IN THE COURT OF COMMON PLEAS
)	
COUNTY OF CHARLESTON)	CASE NO.: 09-CP-10-7404
)	
)	
Jeffrey D. Allen, individually, as Guardian)	
For Jane Doe, a minor, and as Representative)	
Of other similarly situated State of)	
South Carolina employees,)	
)	
Plaintiff,)	MEMORANDUM IN SUPPPORT OF
v.)	MOTION TO ALTER OR AMEND
)	PURSUANT TO SCRCP, RULE 59(e)
South Carolina Budget and Control Board)	
Employee Insurance Program and Blue)	
Cross and Blue Shield of South Carolina,)	
)	
Defendants.)	

FILED
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JULIE J. ARMSTRONG
CLERK OF COURT
BY

This memorandum in submitted in support of the Motion to Alter of Amend filed herewith. This motion to alter or amend the court's order granting summary judgment is based on the court's failure to rule on the following matters raised by the Plaintiff:

1. The court's order fails to discuss why it is not exercising its discretion to stay the civil action pending the outcome of the administrative case. This court has broad discretion in its supervision over the progression and disposition of a circuit court case in the interests of justice and judicial economy. *See Williams v. Bordon's Inc.*, 262 S.E.2d 881, 883 (S.C. 1980). "A party should not be required to 'roll the dice' on whether a collateral administrative proceeding will conclude prior to the running of an applicable statute of limitations in order to preserve a claim properly within the jurisdiction of the circuit court." *Capital City Ins. Co. v. BP Staff, Inc*, 674 S.E.2d 524, 531 (S.C. Ct. App. 2009).

was first diagnosed with Type I diabetes on November 27, 2007 at the age of two, and diabetic education and training was provided during her initial 3-day hospital stay. In

reviewing all claims for diabetic education made by Allen, Defendants have denied three other such claims dating back to December 17, 2007. In light of the State of South Carolina board/agency being named as a Defendant, the undersigned made the determination to commence this action within two (2) years of the date of diagnosis, so as not to risk a possible statute of limitation defense related to the two (2) year statute of limitation in the South Carolina Tort Claims Act. Plaintiff should not be prejudiced by a decision to protect himself against all statute of limitations defenses, particularly when there is no guidance in the law of whether the Administrative Law Court has the power to grant the relief requested by the Plaintiffs, and that legal issue has not been ruled upon by this court.

While the parties to this case were awaiting the court's ruling in this matter, the South Carolina Court of Appeals issued an opinion in *South Carolina Dept. of Consumer Affairs v. Foreclosure Specialists, Inc.* Op. No. 4749 (S.C. Ct. App. Filed Sept. 29, 2010). That case is instructive because, although addressing a different statutory scheme -- the Consumer Credit Counseling Act, the court found that, under the more general Administrative Law Court statutes, also relied upon by the Defendants in this case, that the ALC did not in fact have the power to grant the Dept. a refund of fees collected in violation of the Act, and that any action for such relief should have been brought in circuit court. While not substantively on point, the case illustrates that risk and difficulty of predicting where the lines fall between the jurisdiction of the ALC and the circuit court.

The court in *Capital City* held that where a party would be harmed by the running of the statute of limitations or otherwise prejudiced if its claim is dismissed on exhaustion of administrative remedies, and the court has determined that resolution of the administrative proceeding would impact the circuit court case, then the circuit court should properly consider a

stay or continuance of the judicial action until the administrative proceedings have concluded. *Id.* at 531. While the outcome of the administrative proceeding could moot this case; another possible outcome is that the ALC (or South Carolina Court of Appeals) determines it does not have the power to grant the relief requested and that the plaintiffs should be in circuit court. This is the classic *catch-22* for a plaintiff, and this court should vacate its order granting summary judgment and enter an order staying this circuit case could pending the final outcome of the administrative proceeding.

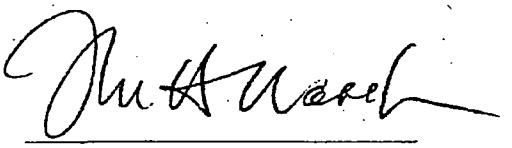
2. The court's order does not address the differences between what is "pending" in the administrative process and the claims made in this Complaint. The claims in this Complaint are not "claims for benefits" within the meaning of section 1-11-710(C), and continuing with the administrative appeal would not provide Plaintiff with an adequate remedy. The only result possible from the administrative proceeding underway would not provide the relief sought by Allen and the potential class members.

If the denial of the subject claim were reversed, Allen would receive coverage for a single $560 diabetes education claim. However, neither the Allen benefit plan nor the putative class members' benefit plans would necessarily be reformed to provide the statutorily mandated insurance coverage for diabetes education. Allen prevailing in the administrative process would not require the Defendants to review all denials made in violation of the diabetes mandate since its enactment in 2000. Allen prevailing in the administrative process would not enjoin the Defendants from violating the diabetes mandate in the future, nor force disgorgement of revenues and profits related to the illegal conduct.

Generally, "[w]hen an administrative remedy is available *to determine a question of fact,* one must seek the administrative remedy or be precluded from pursuing relief in the courts."

Stinney v. Sumter School Dist. 17, 675 S.E2d 760, 763 (S. C. Ct. App. 2009) (citing *Hyde v. Dept. of Mental Health*, 442 S.E.2d 582, 583 (S.C. 1994)) (emphasis added). "A party is not required to exhaust administrative remedies if the issue is one that cannot be ruled upon by the administrative body." *Capital City Ins. Co. v. BP Staff, Inc*, 674 S.E.2d 524, 529 (S.C. Ct. App. 2009) quoting *Charleston Trident Home Builders, Inc. v. Town Council of Town of Summerville*, 632 S.E.2d 864, 867 (S.C. 2006) (citing *Ward v. State*, 538 S.E.2d 245 (S.C. 2000); *see also Stinney*, 675 S.E.2d at 763 (recognizing that inadequacy of the administrative appeal is an exception to the general rule requiring exhaustion).

The purpose of the exhaustion requirement, to allow the agency to render a final decision and set forth its reason for denying the diabetes education claim, would not assist the court in this case. The alleged wrong – violation of the statutory mandate as to an entire class of persons—is not one which the administrative process was designed to address.



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ATTORNEYS FOR PLAINTIFF

CERTIFICATE OF SERVICE

I hereby certify that I have this 8th day of November, 2010 served the foregoing pleading or paper by depositing a copy of it in the US Mail, first class, postage pre-paid, addressed as follows, and also by email transmission as follows:

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Faith Funk

FILED
2010 NOV -8 PM 4:06
JULIE J. ARMSTRONG
CLERK OF COURT
BY _____

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	)	IN THE COURT OF COMMON PLEAS FOR THE NINTH JUDICIAL CIRCUIT
Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees, Plaintiffs, v. South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina, Defendants.	)	Civil Action No.: 2009-CP-10-7404 **DEFENDANTS' RESPONSE TO PLAINTIFF'S RULE 59(e) MOTION TO ALTER OR AMEND JUDGMENT**

FILED
2010 NOV 17 AM 11:33
JULIE J. ARMSTRONG
CLERK OF COURT

Defendants, South Carolina Budget and Control Board Employee Insurance Program ("EIP") and Blue Cross and Blue Shield of South Carolina ("BCBSSC"), Respond to Plaintiff's SCRCP 59(e) Motion To Alter or Amend Judgment as follows:

I. DISCUSSION

A. Plaintiff's Rule 59(e) Motion Fails In That Plaintiff Cannot Use Rule 59(e) To Raise Issues He Could have Raised Prior To Judgment.

Plaintiff's Rule 59(e) motion fails as a matter of law in that Plaintiff is attempting to use Rule 59(e) to present issues that he failed to present prior to judgment. "A party cannot use Rule 59(e) to present to the court an issue the party could have raised prior to judgment, but did not." C.A.H. v. L.H., 315 S.C. 389, 434 S.E.2d 268 (1993). Here, Plaintiff argues that a stay of the case pending a resolution of the administrative appeal was more appropriate than a dismissal. However, Plaintiff never raised this issue prior to entry of judgment in favor of Defendant. Accordingly, Plaintiff's Rule 59(e) motion fails with respect to this issue. Even assuming,

arguendo, that the Plaintiff did assert this position prior to judgment, his argument would fail as discussed fully in I. B.

B. Dismissal Was Proper In That The Administrative Remedies Under S.C. Code Ann. § 1-11-710 (C) Were Plaintiff's Exclusive Remedy, Subject Only To Appellate Review To The South Carolina Administrative Law Court ("ALC") Pursuant To S.C. Code Ann. § 1-23-600 (D).

Even assuming that Plaintiff properly preserved the issue, Plaintiff's argument that this action should be stayed rather than dismissed "pending resolution of a collateral administrative proceeding" is misplaced in that the administrative proceeding was not collateral, but, in fact, was Plaintiff's exclusive remedy as a matter of law. A participant and/or beneficiary challenging an award of benefits under the State Health Plan is limited to the remedies set forth in S.C. Code Ann. § 1-11-710(C), which provides as follows:

> Notwithstanding Sections 1-23-310 and 1-23-320 or any other provision of law, claims for benefits under any self-insured plan of insurance offered by the State to state and public school district employees and other eligible individuals must be resolved by procedures established by the board, which shall constitute the exclusive remedy for these claims, subject only to appellate review consistent with standards provided in Section 1-23-380.

Id. (Emphasis added).

Pursuant to the allegations of Plaintiff's Complaint, Plaintiff is requesting the Court interpret the terms of the State Health Plan to include the coverage set out in S.C. Code Ann. § 38-71-46. Plaintiff further alleges he is entitled to disgorge benefits from the plan for unlawful denials of coverage and for injunctive relief enjoining "further denial of claims for diabetes out-patient self-management training and education." (Complaint ¶24). The interpretation of the State Health Plan and the resolution of claims for benefits under the Plan are exactly the types of remedies contemplated by § 1-11-710(C).[1]

[1] Paragraph 1.3 of the State Health Plan states:

In Unisys v. The S.C. Budget and control Board, 346 S.C. 158, 551 S.E.2d 263 (2001), the South Carolina Supreme Court upheld the dismissal of the plaintiff's complaint on the grounds that exhausting plaintiff's administrative remedies under the S.C. procurement Code was the exclusive remedy. The Court went on to hold that the term "exclusive remedy" indicates "exclusivity of jurisdiction." Id. at 269. The Court also found that "because a statute waiving the State's immunity must be strictly construed, the State can be sued only in the manner and upon the terms and conditions prescribed by the statute." Id. at 266. Finally, the Court held that dismissal was an appropriate remedy. The Court stated:

> Since Unisys is required to exhaust its administrative remedies as a matter of law, dismissal under Rule 12(b)(6) for failure to state a claim was proper. Further, because an action was pending pursuant to the Procurement Code as required when this action was brought, dismissal was also proper under Rule 12(b)(8). See Southern Ry. Co. v. Order of Ry. Conductors, 210 S.C. 121, 41 S.E.2d 774 (1947) (exhaustion of remedies will preclude original resort to courts where statute by express terms gives exclusive jurisdiction to administrative agency).

Id. at 273.

Contrary to Plaintiff's argument, Capital City Insurance Company v. B.P. Staff, Inc., 382 S.C. 92, 674 S.E.2d 524 (Ct. App. 2009) does not stand for the blanket proposition that a stay is more appropriate than a dismissal. In fact, the Court of Appeals in Capital City, relying on the holding in Unisys, acknowledged that:

> The South Carolina Supreme Court has instructed that dismissal may be proper under Rule 12 (b)(6) SCRCP where the opposing party is required to exhaust administrative remedies as a matter of law, but failed to do so. See Unisys Corp. v. S.C. Budget & Control Bd., 346 S.C. 158, 176, 551 S.E.2d 263, 273 (2001)

> 1.3 Applicable Law
>
> This Plan is established and will be maintained with the intention of meeting the requirements of all applicable federal and state laws. Any provision of this Plan, which is in conflict with the law of any governmental body or agency that has jurisdiction over this Plan, shall be interpreted to conform to the minimum requirements of such laws.

(Affidavit of Robin E. Tester, Exhibit C, p.1) (Emphasis added).

> (stating that exhaustion of remedies precludes original resort to courts where an administrative agency is granted exclusive jurisdiction by the express terms of a statute). Thus, we must determine whether exhaustion of administrative remedies was required as a matter of law; if not, we next determine whether the court abused its discretion in dismissing the case until exhaustion of the administrative process is complete in order to assist in the disposition of the circuit court proceeding.

Capital City, at 529.

Simply put, the rule relied upon by Plaintiff that an action should be stayed rather than dismissed, does not apply where the administrative agency has exclusive jurisdiction to consider the complaint initially brought in the court. U.S. v. Michigan National Corp., 419 U.S. 1, N. 2 (1974); Pan American World Airways v. U.S., 371 U.S. 296 (1963). In the present case, because a participant and/or beneficiary challenging an award of benefits under the State Health Plan is limited to the administrative remedies set forth in S.C. Code Ann. § 1-11-710(C), dismissal was appropriate.

Finally, Plaintiff's argument that he should not be forced to "roll the dice" with respect to the statute of limitations has no application. Plaintiff's administrative remedies under S.C. Code Ann. § 1-11-710 (C) were Plaintiff's exclusive remedy, subject only to appellate review to the ALC under S.C. Code Ann. § 1-23-600 (D). It is undisputed that Plaintiff timely availed himself of these remedies. Because Plaintiff appealed to the ALC on a timely basis, Plaintiff was not threatened by the statute of limitations. Accordingly, Plaintiff will suffer no prejudice as a result of the dismissal.

C. Plaintiff's Complaint Is A Claim For Benefits Under The State Health Plan.

Plaintiff's argument that his complaint is not a claim for benefits under the State Health Plan is incorrect and is not supported by the allegations of his pleadings. Plaintiff's Complaint alleges:

5. This is an action for declaratory judgment arising from Defendants' unlawful issuance and administration of the State of South Carolina EIP Standard Plan, a plan of health benefits and insurance offered to all current and retired state employees, including public school district employees, for violation of a SC Code Section 38-71-46, for disgorgement of revenues received as a result of the unlawful issuance and administration, and for declaration to determine the value of unlawfully withheld benefits.

. . .

11. As the named Plaintiff is an employee of a South Carolina school district, has been enrolled in the EIP Standard Plan, has enrolled his dependent child in said plan who was diagnosed with Diabetes at the age of two years old, and has made multiple claims for his dependent child with a value of approximately One Thousand & 00/100 US Dollars ($1000.00) for diabetes outpatient self-management training and education which were denied by Defendant BCBSSC as administrator to the EIP, his claim, right and privileges are typical of the proposed class.

. . .

19. Plaintiff seeks, individually and as legal guardian for Jane Doe, and on behalf of all class members, a declaration of the rights of the parties hereto: that Defendants are required to issue and administer all health benefit plans offered through the EIP in compliance with the express mandate of South Carolina Code Section 38-71-46.

20. Plaintiff seeks an Order of the Court reforming the terms of the health benefit plan provided to all class members effective January 1, 2000 to provide the mandated diabetes coverage.

21. Plaintiff seeks an Order of the Court requiring the Defendants to disgorge monies received as a result of unlawful denials of the mandatory diabetes coverage, and to pay them to members of the putative class the present value of said unlawfully withheld revenues.

. . .

24. The Defendants should be enjoined from the wrongful takings as described above and from further denial of claims for the diabetes outpatient self-management training and education.

(Plaintiff's Complaint).

As the Court correctly found in its order,

> Pursuant to the allegations of Plaintiff's Complaint, Plaintiff is requesting the Court interpret the terms of the State Health Plan to include the coverage set out in S.C. Code Ann. § 38-71-46. Plaintiff further alleges he is entitled to disgorge benefits from the plan for unlawful denials of coverage and for injunctive relief enjoining "further denial of claims for diabetes out-patient self-management training and education." (Complaint ¶24). The interpretation of the State Health Plan and the resolution of claims for benefits under the Plan are exactly the types of remedies contemplated by § 1-11-710(C).

(Order at 4 -5).

Plaintiff's attempt to circumvent the statutory requirements of § 1-11-710(C) by alleging a purported class action and/or a declaratory judgment action is of no avail. The administrative remedies under S.C. Code Ann. § 1-11-710 (C) were Plaintiff's exclusive remedy, subject only to appellate review to the ALC pursuant to S.C. Code Ann. § 1-23-600 (D). Accordingly, all of Plaintiff's causes of action are preempted by S.C. Code Ann. § 1-11-710 (C). As was previously stated: "because a statute waiving the State's immunity must be strictly construed, the State can be sued only in the manner and upon the terms and conditions prescribed by the statute." Unisys, at 266.

Additionally, it is well settled a court ordinarily will refuse to grant a declaratory judgment where a special statutory remedy has been provided. "Gratuitous interference" in the administrative process should be avoided. Williams Furniture Corp. v. Southern Coatings & Chemical Co., 216 S.C. 1, 7-8, 56 S.E.2d 576, 579 (1949); Smith v. The South Carolina Retirement System, 336 S.C. 505, 520 S.E.2d 339 (Ct. App. 1999). The Court, therefore, should not serve as a substitute for "a tribunal of original jurisdiction in issues that are ripe for litigation by the usual processes." Williams Furniture Corp., at 579; see also Garris v. Governing Bd. of South Carolina Reinsurance Facility, 319 S.C. 388, 390, 461 S.E.2d 819, 821 (1995) ("Declaratory relief will ordinarily be refused where another remedy will be more effective or appropriate under the circumstances," as "relief is not generally available to one who has not

exhausted administrative remedies."). In general, judicial review is appropriate only when appeal is from a final agency order. Id. at 821 (citing S.C. Code Ann. § 1-23-380 (A)). Accordingly, Plaintiff's complaint was properly dismissed.

II. CONCLUSION

For the foregoing reasons, Plaintiff's SCRCP 59 (e) Motion To Alter or Amend Judgment should be denied.

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ATTORNEYS FOR DEFENDANTS

November 16, 2010
Columbia, South Carolina

STATE OF SOUTH CAROLINA)	IN THE COURT OF COMMON PLEAS
)	FOR THE NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON)	
Jeffrey D. Allen, individually, as guardian) for Jane Doe, a minor, and as representative) of other similarly situated State of South) Carolina employees,)	Civil Action No.: 2009-CP-10-7404
)	**CERTIFICATE OF SERVICE**
Plaintiffs,)	
)	
v.)	
)	
South Carolina Budget and Control Board) Employee Insurance Program and Blue) Cross and Blue Shield of South Carolina,)	
)	
Defendants.)	

FILED
2010 NOV 17 AM 11:33
JULIE J. ARMSTRONG
CLERK OF COURT

I, Tracey D. Smith, an employee of the law firm of Montgomery Willard, LLC, attorneys for the Defendants do hereby certify that I have served the below named counsel with copies of *Defendants' Response to Plaintiff's Rule 59(e) Motion to Alter or Amend Judgment* by mailing copies of same by United States mail, proper postage affixed, return address clearly marked, and addressed as follows:

John A. Massalon, Esquire
Willls Massalon & Allen LLC
Post Office Box 859
Charleston, South Carolina 29402

Tracey D. Smith

November 16, 2010
Columbia, South Carolina

STATE OF SOUTH CAROLINA)	IN THE COURT OF COMMON PLEAS
)	
COUNTY OF CHARLESTON)	CASE NO:: 09-CP-10-7404
)	
)	
Jeffrey D. Allen, individually, as Guardian)	
For Jane Doe, a minor, and as Representative)	
Of other similarly situated State of)	
South Carolina employees,)	
)	
Plaintiff,)	PLAINTIFF'S REPLY TO
v.)	DEFENDANTS' OPPOSITION TO
)	MOTION TO ALTER OR AMEND
South Carolina Budget and Control Board)	PURSUANT TO SCRCP, RULE 59(e)
Employee Insurance Program and Blue)	
Cross and Blue Shield of South Carolina,)	
)	
Defendants.)	

FILED
2010 NOV 29 PM 1:55
JULIE J. ARMSTRONG
CLERK OF COURT

As one basis for their opposition to Plaintiff's Motion to Alter of Amend the court's order granting summary judgment, Defendants assert that the Plaintiff's request that the court stay this case pending the administrative appeal action was not raised during the briefing and argument before this court and as such was not the proper subject of a motion to alter or amend. However, Plaintiff did, in fact, raise the issue and possibility of a stay in briefing on the motions heard and ruled upon by this court, and therefore such request is proper under SCRCP, Rule 59(e).

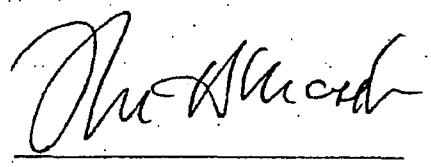
The issue of exhaustion was first raised by the Defendants in a motion to dismiss and denied by Judge M. Dennis, and then, while refusing to conduct any discovery, Defendants filed the subject motion raising that identical ground. Page 10 of "Plaintiff's Memorandum in Support of Motion to Compel Responses to Plaintiff's First Interrogatories and First Requests for Production, in Support of Motion to Stay Decision on Defendants' Motion for Summary Judgment or, in the Alternative, Denial of Defendants' Motion for Summary Judgment, and in Opposition to Defendants' Motion for Protective Order" stated:

> The issue of exhaustion of administrative remedies, which Defendants assert is a basis for summary judgment, was fully briefed and argued pursuant to Defendants' motion to dismiss and for judgment on the pleadings, which, as mentioned above, were denied. Defendant is now attempting a second bite at the apple by again asserting the issue of exhaustion of administrative remedies as a purported basis for summary judgment. Plaintiff incorporates by reference Plaintiff's Memorandum in Opposition to Defendants' Motion to Dismiss, and the exhibits/affidavits attached thereto, in opposition to this purported basis for summary judgment.

Said Memorandum in Opposition to Defendants' Motion to Dismiss raised and briefed the South Carolina Court of Appeals' decision in *Capital City Ins. Co. v. BP Staff, Inc.*, 674 S.E.2d 524, 529 (S.C. Ct. App. 2009), where the court held that where a party would be harmed by the running of the statute of limitations or otherwise prejudiced if its claim is dismissed on exhaustion of administrative remedies, and the court has determined that resolution of the administrative proceeding would impact the circuit court case, then the circuit court should properly consider a stay or continuance of the judicial action until the administrative proceedings have concluded. *Id.* at 531. (See Exhibit A, Plaintiff's Memorandum in Opposition to Defendants' Motion to Dismiss at pp. 11-12). This issue was raised at both the Defendant's motion to dismiss and motions for summary judgment, and has been sufficiently preserved for inclusion into this request to alter or amend.

Based on this Reply and Motion to Alter or Amend and Memorandum in Support, Plaintiff's request that the court alter or amend its judgment.

Respectfully submitted,



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ATTORNEYS FOR PLAINTIFF

EXHIBIT "A"

In light of the effort of the Plaintiff and unexplainable delays and confusion, the Defendants should be deemed to have waived any further reliance on the defense of exhaustion. The Plaintiff and his wife made numerous efforts to navigate the "claims procedure" prior to discovering the statutory mandate for diabetes education coverage. Finally, Plaintiff should not be forced to await a decision from Blue Cross on his appeal so that he can then submit it to the EIP for further review because of a possible statute of limitations deadline. This court has broad discretion in its supervision over the progression and disposition of a circuit court case in the interests of justice and judicial economy. *See Williams v. Bordon's Inc.*, 262 S.E.2d 881, 883 (S.C. 1980). "A party should not be required to 'roll the dice' on whether a collateral administrative proceeding will conclude prior to the running of an applicable statute of limitations in order to preserve a claim properly within the jurisdiction of the circuit court." *Capital City Ins. Co. v. BP Staff, Inc*, 674 S.E.2d 524, 531 (S.C. Ct. App. 2009).

was first diagnosed with Type I diabetes on November 27, 2007 at the age of two, and diabetic education and training was provided during her initial 3-day hospital stay. In reviewing all claims for diabetic education made by Allen, Defendants have denied three other such claims dating back to December 17, 2007. See Exhibit C (C. Allen Aff. ¶ 22). In light of the State of South Carolina board/agency being named as a Defendant, the undersigned made the determination to commence this action within two (2) years of the date of diagnosis, so as not to risk a possible statute of limitation defense related to the two (2) year statute of limitation in the South Carolina Tort Claims Act. Plaintiff should not be prejudiced by a decision to protect himself against all statute of limitations defenses. The court in *Capital City* held that where a party would be harmed by the running of the statute of limitations or otherwise prejudiced if its

claim is dismissed on exhaustion of administrative remedies, and the court has determined that resolution of the administrative proceeding would impact the circuit court case, then the circuit court should properly consider a stay or continuance of the judicial action until the administrative proceedings have concluded. *Id.* at 531.

4. The Complaint States a Claim for Reformation, Disgorgement, and Injunctive Relief

Defendants have moved to dismiss the claims for reformation, disgorgement and injunctive relief on the grounds that the Complaint fails to state a claim for relief. An action to reform an insurance policy is an action in equity. *Elias v. Fireman's Ins. Co. of Newark, New Jersey*, 420 S.E.2d. 504, 505 (S.C. 1992). The Complaint in this case alleges that the State Health Plan, an insurance policy within the express terms of 38-71-46(D), violates the diabetes mandate. The freedom of parties to contract is not absolute, and insurance coverage required by law may not be omitted because statutory provisions relating to an insurance contract are part of the contract. *See Bovain v. Canal Ins.*, 678 S.E.2d 422, 429 (S.C. 2009) (citing *Jordan v. Aetna Cas. & Sur. Co.*, 214 S.E.2d 818, 820 (S.C. 1975). The reformation claims should be permitted to forward at this early stage.

The equitable remedies of restitution and disgorgement require payment of the defendant's ill-gotten gain. *Ellett Brothers, Inc. v. USF&G Co.*, 275 F.3d 384, 388 (4th Cir. 2001) (interpreting South Carolina law). The Plaintiff's class action Complaint sufficiently contains allegations of ill-gotten gain by one or both of the Defendants – that of the retention of monies which should have been paid to the Plaintiff and others similarly situated for claims made for diabetes education. For example, with regard to the named Plaintiff alone, the four

CERTIFICATE OF SERVICE

I hereby certify that I have this 23rd day of November, 2010 served the foregoing pleading or paper by depositing a copy of it in the US Mail, first class, postage pre-paid, addressed as follows, and also by email transmission as follows:

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Faith Funk

STATE OF SOUTH CAROLINA	)	
	)	COURT OF COMMON PLEAS
COUNTY OF CHARLESTON	)	
Jeffrey D. Allen, as guardian ad litem for Jane Doe,	)	
Plaintiff,	)	
vs.	)	Case No. 09-CP-10-7404
South Carolina Budget & Control Board Insurance Program, and Blue Cross-Blue Shield of S.C.	)	
Defendant.	)	

TRANSCRIPT OF HEARING

The within Hearing was held in the above-captioned action on March 4, 2010, before The Honorable R. Markley Dennis, Jr. in Courtroom 4B of the Charleston County Courthouse, 100 Broad Street, Charleston, South Carolina; attended by Counsel, as follows:

APPEARANCES:

John Massalon, Esq.
Appearing for Plaintiff

Theodore Williard, Esq.
Kelly H. Rainsford, Esq.
S.C. Budget & Control Board
Appearing for Defendant

DEBORAH GARRISON
Circuit Court Reporter - 9th Judicial Circuit
Post Office Box 901
Johns Island, South Carolina 29457
dGarrison@sccourts.org

MARCH 4, 2010 2:00 P.M.

THE COURT: Good afternoon, ladies and gentlemen. If you would, please, identify yourself and the parties that you are representing, please.

MR. MASSALON: Good afternoon. I'm John Massalon, Your Honor. I'm here for the plaintiffs.

THE COURT: Thank you.

MR. WILLARD: Ted Willard and Kelly Rainsford on behalf of the defendants.

THE COURT: Thank you. This is a Motion to dismiss, is that correct?

MR. WILLARD: Yes, sir.

THE COURT: I'll be happy to hear from you.

MR. WILLARD: Your Honor, may it please the Court, this case involves a claim for benefits from the South Carolina State Health Insurance Plan. That plan is a self-insured plan and is administered by the South Carolina Budget and Control Board, a fully insurance program.

The claims administrator for that

plan is Blue Cross-Blue Shield. Your Honor, we're moving to dismiss on the grounds that, one, plaintiff's causes of action are prohibited by South Carolina Code 1-11-17(c).

And that Code Section, Your Honor, I've handed up a copy and provided the plaintiffs a copy -- states, (reading): "Notwithstanding ..." -- and it cites two Code Sections, " ...or any other provision of law has claims for benefits under any self-insured plan of insurance offered by the state to state and public school district employees and other eligible individuals must be resolved by procedures established by the Board, but shall constitute the exclusive remedy for these claims, subject only to appellate judicial review consistent with the standards provided in Section 1-23-3(a)."

Your Honor, if we examine the allegations in plaintiff's Complaint -- and I will point Your Honor to, for instance, allegations in Paragraph 5 of the Complaint where the plaintiff states, "This is an action for a declaratory judgment arising from the defendants' unlawful issuance and

administration of the State of South Carolina to the standard plan, a plan of health benefits and insurance offered to all current and retired state employees, including public school district employees, in violation of South Carolina Code Section 38-71-46."

Your Honor, I've provided you a copy of that statute. That is an insurance statute for disgorgement of revenue received as an unlawful issuance and administration and for declaration to determine the value of any unlawful withheld benefits.

We turn, Your Honor, to Paragraph 11 of the Complaint. It sets out the standing the plaintiff has. "As the main plaintiff who is an employee of a South Carolina school district, he has been enrolled in the EIP standard plan and enrolled his dependent child in the said plan who was diagnosed with diabetes at the age of two years old and has made multiple claims for his dependent child for the value of approximately a thousand dollars for diabetes out-patient treatment and for training and education, which were denied by Defendant Blue Cross-Blue Shield, as

administrator, to the EIP whose claim is typical of those of its proposed clients.

Plaintiff goes on to allege, Your Honor, in Paragraph 19 asking for a declaration of the rights of the parties herein. The defendants are required to issue and administer all health plan documents and PIP in compliance with that Code Section.

Paragraph 20 goes on to seek an Order reforming the terms of the health benefit plan provided by its members to provide the mandated diabetes coverage.

Paragraph 21 ---

THE COURT: You don't need to go through all that on the record, please. I have it. It's in the record for purposes of review. *Why am I not entitled to this benefit based on this Section,* is what you're saying.

I mean, it's a declaratory judgment. It's not asking for anything other than somebody to look at the statute. And I assume the justiciable controversy, in theory, could be all the things that may have to be brought under the Administrative Procedures Act. But, clearly, you're not saying that the agency has

to declare law? How does an agency have a right to do that?

MR. WILLARD: And, Your Honor, if I may, in Paragraph 21 they ask for -

THE COURT: Let's don't talk about the Complaint. Let's talk about how a declaratory judgment action has to first be brought and determined by an agency. What authority does an agency have to declare law?

MR. WILLARD: Your Honor, the agency can determine law.

THE COURT: In making applications, yes, under the Act. But I don't think they have the right to review the law and then make a determination from a legal perspective, do they?

MR. WILLARD: Absolutely, Your Honor.

THE COURT: What case says that?

MR. WILLARD: Your Honor, the case is ---

THE COURT: I'll need to look at that.

MR. WILLARD: Yes, sir. It talks about what a state agency cannot do is

interpret constitutionality. That it cannot do because of another act.

I call your attention, Your Honor, to the case of *Smith v. South Carolina Retirement System.* I believe I've handed that up.

THE COURT: Do you know what the cite is on that?

MR. WILLARD: It's 520 S.E.2d 339.

THE COURT: Thank you.

MR. WILLARD: Your Honor, that case -- is a case involving an action against the South Carolina Retirement System for a declaratory judgment, and a constructive trust of benefits under a requirement. This is a Court of Appeals case.

THE COURT: Uh-hum.

MR. WILLARD: Held that the plaintiffs had to exhaust administrative remedies under the South Carolina Retirement System. And it says "a Court should ordinarily refuse to grant a declaratory judgment where special statutory remedies have been provided." So that's an example.

If you read these cases about when a DJ action is appropriate and when it is not, an agency can interpret the law.

Here, if you read the provision of the state health plan, the applicable law is incorporated under the terms of the plan.

And, Your Honor, I believe in Paragraph 1.3 of the plan that I've handed up, it clearly states that. If you'll look at the enforcement provision of the Insurance Code that applies to the insurance statute that they say applies, it says, "those terms are incorporated into the plan." The plan has language that matches the code, that the terms and is considered a part of the plan.

Here, statutorily -- PIP Budget and Control Board is charged with interpretation of the plan and the payment of benefits. The allegations the plaintiff makes are disgorgement of benefits -- clearly alleged.

Can a state agency interpret the law? Absolutely, Your Honor. What a state agency cannot do is interpret the constitutionality of the law.

THE COURT: Okay.

MR. WILLARD: And, Your Honor, on that basis we feel that we are entitled for the action to be dismissed.

THE COURT: All right.

MR. WILLARD: Your Honor, there's a further argument concerning the -- what I would say the exhaustion of administrative benefits. In this case there's no allegation by the Plaintiff that the administrative remedies have been exhausted.

The Plaintiff did submit an affidavit contending that there's still a pending administrative review. Your Honor, concerning -- taking the facts in the light most favorable to the plaintiff, there's still a pending administrative appeal. One of the grounds, Your Honor, mentioned in that appeal by the plaintiffs is the application of this statute to the state health plan. So that has not been decided in this appeal.

Your Honor, as a part of the administrative appeal, there is a two-level layer of internal appeals. This is only at the first level. The second level goes to the state EIP. Then after that, Your Honor, the

case is appealed to the ALJ who has exclusive jurisdiction over the appeal.

Now, the next part of the argument is, Your Honor, assuming that they did have the exhaustion of administrative appeals, we're in the wrong Court. And that statute was amended in 2006.

THE COURT: Okay.

MR. WILLARD: Finally, Your Honor, not to burden the Court too much but there are some additional grounds.

One is they sued Blue Cross-Blue Shield. Blue Cross-Blue Shield is the claims administrator. There's no privity of contract. This contract has been alleged with Blue Cross. Blue Cross-Blue Shield is not the insurer.

THE COURT: You're getting into the area now of in the motion to dismiss that I don't think I can go. Thank you. I thank you. Let me hear from Mr. Massalon. I don't want to hear any more about issues that are outside the pleadings.

MR. WILLARD: One issue that is absolutely within the pleadings ---

THE COURT: Okay.

MR. WILLARD: The plaintiff has alleged three technical causes of action, injunction, reformation and, I believe, disgorgement. Your Honor, the plaintiffs have not plead an essential element to an equitable cause of action, no active remedy at law. So based on that, Your Honor, that would be our position.

THE COURT: Thank you. Mr. Massalon.

MR. MASSALON: Thank you, Your Honor. We submitted our memo ahead of the hearing and it I'm prepared to recite some of the facts.

THE COURT: You can. All the materials filed, of course, in conjunction with the motion are incorporated fully for the purposes of review. And I assume that all this has been submitted -- has been filed with the Court as well?

MR. MASSALON: Yes, sir. So I will go straight to the legal issues and throw in a few facts here and there.

THE COURT: Thank you.

MR. MASSALON: First of all, Your Honor, on the argument that the suit must be dismissed because it's just a claim for benefits, this case is not just a claim for benefits. My opposing counsel cited several sections of the Complaint. But what we've alleged in this lawsuit is basically this. The policy that was issued to my client contained an exclusion for diabetes-related incidents. There is a state statute that we cited in our brief that mandates that this policy include that. And so what we're seeking in this lawsuit is not benefits under the policy. We are seeking a declaration that the policy violates state law and seeking reformation of the policy to be conformed in accordance with state law. We've alleged class action claims that not just this policy but all the ones like it would be reformed in accordance with state law. And we are also seeking a declaration that the monies that have been wrongfully withheld or not paid as benefits must be restored.

Those aren't claims for benefits under the policy, Judge. What we're looking for

here is something that we cannot get in the agency process. Because regardless of what the *Smith* case says and these other cases say, what we cannot get by going back to Blue Cross-Blue Shield or going through the administrative process is somebody telling us, "you're right, this policy doesn't comply with state law. We're going to rewrite an all new policy." We believe that under the law, this is the only place that we can get that remedy. The first point, Your Honor, is ---

THE COURT: Why?

MR. MASSALON: Because, Your Honor, the remedies provided under the Administrative Procedure Act in the cases pertaining to exhaustion, I believe, fairly read really deal with issues of policy interpretation. And an example might be if this claim was submitted and denied as not being medically necessary. That's really kind of a facts-and-circumstances determination. And exhaustion would really deal with whether there's a prima facie decision under the policy. And in those circumstances I think, fairly read, you could go back to the people

that made the decision and ask them to take another look at it in light of some additional facts.

What we're alleging in this case is this policy violates the law.

THE COURT: I understand that. But wouldn't that be something an Administrative Law Judge should hear?

MR. MASSALON: We don't think so, Your Honor, because we haven't been able to come up with any authority that vests the Administrative Law Judge with jurisdiction to rewrite policies under these circumstances. We believe this Court, under the declaratory judgment act ---

THE COURT: But if your argument is that it violates the law, assuming counsel's argument that the agency has the right to interpret and apply the law, they could make a finding that yes, it does or no, it doesn't. That frames the issue, does it not?

MR. MASSALON: I guess what I would say, Your Honor, is it's possibly. Here's where I part company with Mr. Willard. The argument he's essentially making is that

Court has got exclusive jurisdiction over it. So there's a change, and we've cited it on appeal in *Capital City*. It was recently decided. And it says exactly the opposite. It says that this is not an adoption of jurisdiction. It's adoption of policy. And that's where I think Mr. Willard's wrong and we're correct. He's saying it's the only place you can go. We are saying, and based on the *Capital City* case which I think is on all fours with these issues, that this is not jurisdictional. It is discretionary. It's a matter of policy. And it's really a doctrine that's designed to promote efficiency and have these cases resolved quickly and as efficiently as possible and by the people who know the most about them.

So I think if you read that case, what it says is that we don't have to go there. We can come here.

THE COURT: I see.

MR. MASSALON: Now, on the exhaustion requirement, Your Honor, I've got three main points about that particular issue. First of all, as far as whether exhaustion is

mandated -- the other thing the *Capital City* case says is it's a discretionary matter and you are supposed to look at this and exercise your discretion about whether going back to the people who had denied this benefit so far is an additional appropriate thing to do, and should not require us to do it.

The second thing is if you look at the facts of this case, Your Honor, my clients have gone above and beyond what anybody should be expected to do in an attempt to get these issues resolved. And I won't rehash all the facts to you, but simply give you a sense of what they've done.

THE COURT: Well, with all due respect, that's really more for another day, because this one is really technical. It's based on the pleadings, as I understand the motion. So all these things -- just as I stopped Mr. Willard -- I really don't need to hear that part of it. The issue is whether or not on the pleadings, on its face, does it withstand scrutiny of the Court?

Now, if I do deny it and there's another motion to dismiss based on some other

grounds, now we're getting into an area where I probably need to be consider that, or a judge should.

MR. MASSALON: Thank you. I'll skip that for now.

The other issue that I'd like to raise with you is the issue that we think is material and say that even if you disagree with me and agree that exhaustion is required, we don't have to exhaust it.

Again, without going into the facts of it, I think that under this circumstance, the reason - and there's a case cited where it's been decided, and the Court found well, if you don't even attempt and just say it's going to be hard or difficult for them to do it.

But what we've got here, Your Honor, is a situation where we've been trying to get this resolved as we've alleged in the Complaint for over a year. And you heard Mr. Willard say it - we have no response. And so he argues on the fact that we haven't told him no means that we haven't exhausted it.

But the point I'd like to make, Your Honor, is the fact that we've been waiting over a year for an answer is proof positive that we're doing what he wants us to do and it's getting us nowhere. Because otherwise they could never answer any prevent anybody from suing, just by not giving the answer.

THE COURT: Okay.

MR. MASSALON: Finally, Your Honor, on the issue of the other defendant, and I'll just touch on it briefly, I think that -- again, because this is a motion to dismiss and we're entitled to an inference that we can prove what we allege and all inferences that flow from that, we've alleged plenty to keep Blue Cross-Blue Shield in, mostly because somebody, and we don't know who yet because we haven't gotten into discovery, made the determination to deny the claim. We allege that it violates state law. And this is the claims administrator, which is Blue Cross-Blue Shield and the other defendant which actually issued the policy. Again, taking the facts in the light most favorable to us, we've alleged enough against them to

entitle us to get a declaratory judgment based on the proof of the facts. And also the same is true for the equitable causes of action that we've alleged. Again, on the motion to dismiss, in the light most favorable to us we believe we've alleged sufficient facts here to make our causes of action. And again, what I think Mr. Willard urges the Court to do is to anticipate defenses in our pleadings. Again, I don't think in a well-plead Complaint we're required to not only plead the elements of our causes of action, but also we anticipate defenses that are going to be raised and allege facts that would respond to them. Thank you.

THE COURT: Hold on just one second. Ladies and gentlemen, we've got a jury that's reached a verdict. And we're going to recess this for a minute so I can get those people in and out. I'll be happy to hear from you in response, Mr. Willard, when we come back. Thank you. I'm sorry to hold y'all up.

(RECESS)

THE COURT: Thank you very much.

Mr. Willard, I'll be happy to hear from you

MR. WILLARD: Yes, Your Honor. One thing, Your Honor, I have handed up the case of *Unisys v. South Carolina Budget and Control Board.*

THE COURT: Yes, sir.

MR. WILLARD: And that is a case concerning the exclusivity of a remedy.

THE COURT: Yes.

MR. WILLARD: Your Honor, the language under the South Carolina Code regarding exclusivity is very similar to the language here. The exclusion remedy for claims and benefits from the state health plan is governed by that.

Your Honor, if we just keep in mind two things, futility has not been plead. Certainly, there's some arguments concerning futility. But the test of futility is very high. In fact, it has to be such that an agency authority made up its mind. And that is simply not the case here, because the issue has not been determined.

THE COURT: My question is what's a person to do if they've tried to find out an

answer and can't get one? What are you supposed to do? Why isn't that futility?

MR. WILLARD: Your Honor, our Courts determine futility.

THE COURT: I'm asking you a question. Assuming everything you've said is correct, and they're trying to do something and find out something and can't get an answer, why they should be held ---

MR. WILLARD: They're at round one.

THE COURT: I don't know where they are.

MR. WILLARD: Stage two is the second internal step, and they go to the next step.

THE COURT: But my question is round one is dead in the water, from what I'm hearing.

MR. WILLARD: That's what they're alleging.

THE COURT: Well, that's what you said too.

MR. WILLARD: There is intentional dealing.

THE COURT: I understand that.

MR. WILLARD: And the thing is, this issue was made part of that opinion. And we've got some determination here.

THE COURT: I understand that. But don't you think somebody's entitled to have an answer to when it's coming? I mean you can't sit there and tell them, "Well, let's just wait around."

MR. WILLARD: I understand, Your Honor.

THE COURT: I tell you what I'm going to do because I, really - that concerns me. I hear what you're saying. And I really don't have any problem, at least at this juncture, thinking through this process and coming up with a conclusion that really the ultimate determination to get - the ultimate determination of this case obviously isn't going to be in a lower court. It's going to be in the Court in Columbia.

And what route is the quickest way and the best way and the proper way to get there, I think, is through the administrative law judge now that it's in direct appeal, which it should have been. I'm delighted they

changed that, because that's the way it needs to go. And I think this issue ultimately will get there once they rule.

But the problem we have is these - it's like they're holding these people hostage. Because you say we're the only way you can go, but we haven't decided and we don't know when we're going to decide. That's what I'm hearing. And so that's the problem I have.

So the motion to dismiss based on the pleadings is denied, given all the circumstances in this case.

MR. WILLARD: Thank you, Your Honor.

THE COURT: Thank you. But, obviously, there may be another day when we hear motions for summary judgment and dismiss it because it's not -- it's a matter of law and doesn't belong in here. But that's when we can get to some other things outside the pleadings, which is where is this process. And I can't do that right now. That's my problem. Okay.

MR. WILLARD: Judge, would you like me to submit an Order?

THE COURT: I'm going to do a form order that just simply says motion to dismiss on the pleadings is denied. So it will be clearly on the pleadings which doesn't prejudice you from filing a subsequent motion for summary judgment. Thank you.

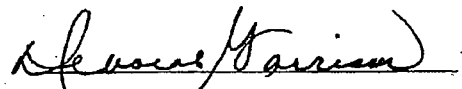
Thank you very much.

(HEARING CONCLUDED)

CERTIFICATE OF REPORTER

I, the undersigned, Deborah Garrison, official court reporter for the 9th Judicial Circuit of the State of South Carolina, do hereby certify that the foregoing is a true, accurate and complete transcript of the hearing held before The Honorable R. Markley Dennis, Jr., on March 4, 2010;

I further certify that I am neither kin nor counsel to any of the parties and have no interest in the outcome of this action.



Deborah Garrison
Circuit Court Reporter
9th Judicial Circuit

Charleston, South Carolina
February 6, 2011

received
2-15-11 MH

STATE OF SOUTH CAROLINA)
IN THE COURT OF COMMON PLEAS
COUNTY OF CHARLESTON)

JEFFREY ALLEN,

PLAINTIFF,

-vs-

THE S C BUDGET AND CONTROL BOARD, ET AL,

DEFENDANTS.

Original

2009-CP-10-7404

JUDICIAL (NONJURY) PROCEEDINGS HELD BEFORE

THE HONORABLE PAUL BURCH;

COMMENCING AT THE HOUR OF 12:04 PM, ON THE 26TH DAY OF AUGUST, 2010, AT THE CHARLESTON COUNTY COURTHOUSE, 15TH JUDICIAL DISTRICT, CIRCUIT COURT, CHARLESTON, SOUTH CAROLINA.

REPORTED BY: H. EUGENE BUCKNER, CVR

ORIGINAL

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Index of Testimony

NO SWORN TESTIMONY WAS OFFERED IN THESE PROCEEDINGS.

Index of Exhibits

NO EXHIBITS WERE MARKED BY THE COURT REPORTER FOR THIS HEARING

CLERK:

Jeffrey Allen versus South Carolina Budget and Control.

UNIDENTIFIED SPEAKER:

Your Honor, may I approach?

THE COURT:

(Nods in the affirmative.)

MR. WILLARD:

Those are some briefs and authorities I will be referring to.

THE COURT:

All right.

MR. WILLARD:

May it please The Court, Your Honor; Bo Willard, for the Defendants, the State Health Plan and Blue Cross Blue Shield.

Your Honor, this is Defendant's Motion of Summary Judgment.

Uh -- There are two rifle-shot legal issues in this case, Your Honor.

And, Your Honor, this case will be in English (laughs) unlike Dutch in the previous hearing.

Your Honor, the first issue -- and again, this is the State Health Plan.

And, Your Honor, the State Health

Plan is a self-funded health plan for by the State of South Carolina.

And it's not an insured plan.

The claim administrator of the self -- excuse me -- of the State's health plan is Blue Cross Blue Shield.

Blue Cross Blue Shield is not the insurer of the plan.

In this case Your Honor, the Plaintiff alleges in the Complaint that:

He was an employee with the School District of South Carolina covered by the State's Health Plan.

And that he made a claim of benefits for his daughter for diabetic education and training, out-patient, that should have been covered by the State Health Plan.

And that claim was denied.

Plaintiff, then, alleges that:

Pursuant to 38 71 46, that should -- a -- which is a coverage mandate, that that coverage should have been covered by the State's Health Plan.

He asks that the State's Health Plan -- first for a Declaratory Judgment Action that this claim be paid.

He asks for reformation of the State's Health Plan.

And he asks for disgorgement of benefits from the State's Health Plan, which he alleges were wrongfully denied.

Now, Your Honor, the problem with Plaintiff's Complaint -- I'd ask you to turn to Tab 2 of the information I handed up.

Pursuant to section 111 710 C, claims for benefits under any self-insured plan of insurance offered by the State to State and public school district employees must be resolved by procedures established by The Court, which shall constitute the exclusive remedy for these claims, subject only to appellate review pursuant to the standards provided in 123 380.

123 380 is The Administrative Procedures Act.

So, Your Honor, what we have is that:

By statute, the Plaintiff's exclusive remedy is his administrative remedies under the APA, subject to appeal -- and as I'll talk about later -- to the Administrative Law Court.

So, again, Your Honor, we're in the wrong court.

Plaintiff needs to be before the

Administrative Law Court.

And interesting, the Plaintiff, while he filed this action, was going through the administrative process.

I call your attention to Tab 1, which is a Final Denial Order by the South Carolina Budget and Control Board, which denied the Plaintiff's claim.

And if you'll notice, Your Honor, the first page refers the Plaintiff to his appellate rights to the Administrative Law Court

So, again, this exact issue, that has been brought in this case, was a Section 38 71 46, a finding for the State's Health Plan, was ruled on by the Budget and Control Board and denied.

Now, Plaintiff's exclusive remedy by statute is an appeal to the Administrative Law Court, not the Circuit Court.

I'd ask Your Honor look at Tab 3, which is Section 120 3 380 that says:

A party who has exhausted all administrative remedies within an agency is entitled to have his case for judicial review.

If you look at Tab 4, Section 123 600 (b) says that:

An Administrative Law Judge shall

preside over all appeals from final decisions of contested cases pursuant to The Administrative Procedures Act or another law.

So again, Your Honor, by statute, the exclusive remedy the Plaintiff has, and which he has in fight gone through the administrative process, is through the ALC, not the Circuit Court.

Now according to Spike's -- uh -- case in his briefing, Drummond versus State of South Carolina.

And that case is located at Tab 5.

And Drummond stands for the position that:

The Administrative Law Court is an executive body and may not rule on the validity or constitutionality of a statute.

And that's exactly right. They can't.

That is not the issue here.

The validity of the statute is not at issue. It is whether or not the statute applies to the State's Health Plan.

And again, there's another case at Tab 6, Video Gaming Consultants, that again expands on the authority of the ALJ.

And in fact, it says:

The ALJ must follow the law as written and can't challenge the constitutionality.

So again, Your Honor, this claim for benefits, that is brought in Circuit Court, needs to be before the ALJ.

So, Your Honor, that's ground number one of our motion -- uh -- that:

The Plaintiff is in the wrong court.

He needs to go to the ALJ, which has exclusive jurisdiction over appeals of denials.

Your Honor, issue number two really goes to the ultimate issue in this case.

And that is:

Does the Section 38 71 46 even apply to the State's Health Plan?

Again, Your Honor, the State's Health Plan is not a fully insured plan. It is a self-funded plan.

If the Plaintiff's claim is paid by state money, again, no insurance companies are involved.

Section 38 71 46 says that:

After January 1st, 2000, any health insurance policy sold or reviewed in this state, has to cover diabetes self-management and education.

If you look at Section D -- and

again, Your Honor, this is a Tab 7.

It talks about defining what is health insurance?

For purposes of this section, health insurance means -- and it goes down -- as it is defined -- and it gives two code sections.

Section 38 71 676 involves individual insurance. So that would not, certainly, apply.

On Section 38 71 840 14, which is group insurance:

If we look at that Section, which is at Tab 14 -- or excuse me -- Tab 8 of the materials, it defines what health insurance coverage is.

It means benefits consisting of medical care provided directly, through insurance reimbursement or otherwise, and including items and services paid for as medical care under any office, hospital, or medical service policy or certificate, top civil, medical and service plan contract, or health maintenance organization contract, offered by a self-issuer.

And again, Your Honor, you have to look up:

What is a health issuer?

You turn to Tab 9:

A health issue is defined -- and it

goes on to say -- for purposes of the section, issuer includes an insurance company, a health maintenance organization, and any other entity providing health insurance coverage which is licensed to engage in the business of insurance in the state, and which is subject to state insurance regulation.

Now, Your Honor, the State's Health Plan is not subject to state insurance regulation.

And in fact, at Tab 10, there is a statute that specifically says:

The state employee insurance program is not under the jurisdiction of the South Carolina Department of Insurance.

So, Your Honor, because the State's Health Plan is a -- not a health insurance issuer, and therefore, it is not health insurance, this code section has no application.

If you were to look at these mandated coded, Your Honor?

For instance, if you look at Tab 10, 1 11 78 does apply to the State's Health Plan and it is in Title 1, Chapter 11, where the State's Health Plan mandates are included.

Now, there were several mandates during this period of time that talked about the coverages

that insurance policies had to offer.

They are silent as to apply to the State's Health Plan with the exception -- if you look at -- uh -- Tab 11.

Tab 11 was a health mandate in Title 38 that specifically says:

It applies to the State's Health Plan.

So, Your Honor, the code section at issue here, 38 71 46, is silence on its application of the State's Health Plan.

So again, Your Honor, the State's Health Plan is self-funded. It is not insurance.

Your Honor, that's our second ground.

The statute that the Plaintiff hangs his hat on simply does not apply to the State's Health Plan.

Thank Your Honor.

THE COURT:

Council?

MR. HAMRICK:

Thank Your Honor.

Matt Hamrick, from Richardson, Patrick, Westbrook and Brickman -- uh -- along with -- uh -- Christy Ford Allen.

Uh -- Wills, Massalon, and Allen, is

our co-counsel in this case, Your Honor.

Uh -- Several points to address in response to counsel's argument:

Uh -- But first of all, Your Honor, if I may, just give you a little bit of background on the procedural history of this case, because I believe it's important -- uh -- to understand where we are today.

Your Honor -- uh -- this case began when Jeffrey Allen -- uh -- who is a school district employee -- uh -- brought a claim, all the way back in December of 2007, Your Honor -- uh -- for education related to diabetic -- uh -- treatment -- uh -- for his daughter, who was two years old -- uh -- in November of 2007, just before he made his claim, when she was diagnosed with type I diabetes.

The claim was denied.

And follow-up claims and -- uh -- procedure began. That's what this all started.

And every time, Your Honor, Blue Cross Blue Shield issued a -- uh -- Explanation of Benefits and said on the bottom of the form, simply, that:

Your coverage does not include coverage for this -- for this diabetes education; no explanation.

So, that process did begin, long ago.

In fact, it's been over two and a half years, Your Honor.

And the letter that Defense Counsel referenced, which is at Tab 1, if you'll notice, Your Honor, it was issued two days ago, the same day that Counsel served us his brief -- uh -- pursuant to this hearing.

The is the very first time, Your Honor, two days ago, after two and a half -- over two and a half years -- that anyone has ever explained why they say that:

The mandate for the education doesn't apply to the State Health Plan; two days ago, Your Honor.

Before that, never had an explanation.

And I'll get back to that in a moment, but -- about the explanation, and why is so tortured -- and such a tortured reading of the -- uh -- statute.

But first of all, let me just also point out to Your Honor, that:

This case was filed -- this lawsuit -- in November of 2009, November 25th.

Out of -- Out of an abundance of caution -- because the administrative procedure -- that process has been lollygagging, and delayed through no fault of the Plaintiff.

And there's -- there's plenty in the record, because we've already had a motion about the exhaustion requirement, Your Honor, after we filed the lawsuit, because the statute of limitations was potentially coming up and the administrative process was going along, but slowly.

The Defendant moved to dismiss the case on the grounds that the statute of limit -- I mean, I'm sorry exhaustion of administrative remedies had not been done -- uh -- and also that Blue Cross was an improper party.

Judge Dennis -- uh -- in this very courtroom, I believe, back in March, heard those motions and them; the same exact exhaustion motion that we heard today.

After that, the Defendant answered. And we then served our initial discovery requests.

May 5th, we served discovery; Interrogatories, Requests for Production to both client -- uh -- both Defendants.

Instead of answering our initial discovery, the Defendant filed a Motion for Summary Judgment and a Protect Order motion to be allowed not to answer any of the discovery in the case; and just have the case -- uh -- Dismissed on Summary Judgment.

So what is pending before Your Honor

today, is:

The Defendant's Motion for Summary Judgment.

Their motion that they not have to answer discovery.

And then, we filed a motion to compel discovery. Uh -- So it's our motion to have our discovery answered.

And we also filed a motion, Your Honor, that the Summary Judgment decision be stayed -- uh -- until it's determined whether or not we get discovery in the case, or not.

However, after understanding, now, their argument about Summary Judgment:

In the alternative, Your Honor, we would ask you to go ahead and on Summary Judgment, if Your Honor is so inclined.

And it should be denied.

And here's why:

I'd like to come back to the exhaustion argument, because, again, we've already argued that.

It was dismissed.

And there's nothing new there, except for one thing. I will point this out now.

Back when that motion was heard in May, Your Honor, again, the administrative process was going on.

The Allen's were back and forth with Blue Cross Blue Shield -- uh -- and not getting any explanation for why it was denied; why the mandate doesn't apply to the insurance coverage.

And the Defense made the -- the -- We made the argument of two titles.

One of our arguments on the exhaustion issue is:

It was futile to try to do this in the administrative process.

And Defendant -- uh -- objected or they -- they disagreed with that; and said:

It's not futile because the Agency has not made a hard and fast -- taken a hard and fast position -- uh -- which makes an adverse ruling appropriate.

Well, the futility has now been borne out. Two day's it was borne out.

Because, finally, as this motion was coming up for a hearing, the Agency, the Budget and Control Board Insurance Program -- uh -- Committee or Board -- uh -- went ahead and -- and reviewed the case; and then, as I said, two days ago issued a letter that:

Uh -- If I may submit, probably not coincidentally, tracks the language of Defendant's brief to Your Honor on their Motion for Summary Judgment, and was issued on the same day.

But in any event, the futility argument has now been borne out.

They've ruled that:

This mandate does not apply to the Plaintiff.

And the other argument for exhaustion, I'd like for us to come back and to touch on, because they are the same as have already been argued.

But, Your Honor, on a Motion for Summary Judgment on a case where there is a novel question of law -- and this is a novel question of law -- I submit that:

If there were any cases, or any other authorities out there, to determine whether this diabetes education mandate applies to the employee's insurance claims, we would have heard about it.

We haven't found it.

Defense obviously hasn't found it.

It's a novel issue.

And, there's abundant case law; we cite it in our brief -- uh -- in particular the Schmidt

versus Courtney case -- uh -- and -- uh -- and the cases cited therein, which, Your Honor, states that:

A Motion for Summary Judgment should not be granted when the issue is a novel issue.

This is certainly a novel issue.

And Motion for Summary Judgment also should not be granted, Your Honor, when -- uh -- when discovery has not even begun.

I mean, the cases say:

When the parties haven't had a full and fair opportunity to complete discovery.

We haven't even had the opportunity to start discovery, other than our serving discovery.

Uh -- The Defense won't answer.

And discovery is important, Your Honor.

We -- We need the discovery so we can understand how to apply this law to the facts.

And then, now, based on the new arguments about that the -- the -- not only the mandate doesn't apply to the insurance plan, but none of the insurance regulations apply to insurance plan, we've got to do discovery on that.

Uh -- And that's another reason the motion should not be granted.

But, on the actual question of whether or not, as -- as Counsel put it -- the ultimate issue:

Does this diabetes education mandate apply?

Your Honor, it was -- it was gone over fairly quickly. And I'm not going to belabor it, but I just want you to understand:

Defendant's argument, how they get to this short-hearing proposition that:

The South Carolina Insurance Regulation under Title 38 and the Department of Insurance do not apply to the over 400,000 South Carolina citizens that are insured under these state plans.

That's how many people have this type of insurance, Your Honor.

And the Defense wants to now say that -- that:

The regulations in our state for insurance is on what -- for all those peoples insurance.

But let me say for sure how they get there, Your Honor, and it's -- it's extremely tortured -- uh -- reading of the statute.

Your Honor, was cited to -- uh -- Section 38 71 46, which is the Mandate Statute, which says:

Every -- and I'm going to paraphrase, because some of it doesn't apply.

You can read it for -- for yourself, Your Honor, but -- but:

Every health maintenance organization, individual, group health insurance policy, or contract issued or renewed in the state, must provide coverage for equipment -- and it goes on.

And it says also:

Out-patient self-management training and education for the treatment of people with diabetes mellitus.

And then it goes on.

And it says:

Health insurance policy means: A health benefit plan, contract, or evidence of coverage providing health insurance as defined in the section that Counsel -- uh -- for the Defense cited, 38 71 840, Sub 14, which applies to these three plans.

Your Honor, that -- that code section says:

Health insurance means:

Benefits consisting of medical care provided directly through insurance reimbursement.

I believe this, Your Honor, is the

Tab -- 9 -- uh -- or rather 8 -- of what Counsel handed up.

Health insurance coverage means:

Benefits consisting of medical care provided directly, comma, through insurance or reimbursement, comma, or otherwise; and including items or services paid for, or medical care, under any hospital or medical service policy or a certificate, comma, hospital or medical service plan contract, comma, or health maintenance organization contract offered by the health insurance issuer.

All right.

Now, first of all:

That first part of the statute, the definition of what health insurance coverage is -- and if I might just pause, Your Honor?

It -- Every time I -- I think about the Defense argument, it just amazes me that, ultimately, your argument is that:

The Plaintiff's health insurance policy is not health insurance coverage; all right.

But in any event, the very last part of that first part of the health insurance coverage definition says:

Comma, or health maintenance organization contract offered by a health insurance issuer.

And -- And they -- they then go -- all right -- they then go to the health insurance issuer -- uh -- definition.

But, before I go there, I just want Your Honor to -- to see that:

This is not a health maintenance organization contractor we're talking about.

The plan that Mr. -- uh -- Allen has is not an HMO-type insurance contract.

So, it may be that that part of the statute's definition does not even apply, the part that says:

Or health maintenance organization contract offered by a health insurance issuer.

It's not -- It's not an HMO policy.

But in any event, then it lists several exceptions.

A through -- A through J -- K -- through K, and subsections of K:

Exceptions to that definition of health insurance coverage.

And this plan is not in it; in any of the exceptions.

The employee insurance plan is not within any of the enumerated exceptions to that definition

of health insurance coverage.

And, as Your Honor, I'm sure, is well aware:

The doctrine of expressio unius est exclusio alterius -- and I'm sorry about my Latin -- but if there are exceptions to a statute, and something is not included in the exceptions, then that means the Statute doesn't apply -- the exceptions don't apply to it.

There -- There is no exception for this employee insurance plan.

But in any event, Your Honor, that's where the mandate statute direction for how to figure out if the mandate statute applies -- what insurance policies the mandate statute applies to.

But that's where it stops.

All it says is:

Look to the definition of health insurance coverage that I just spent a great deal of time going over; and that's all it says.

It doesn't say:

And then, go and look up the definition in Title 38 for health insurance issuer, which again, is related in this sentence to an HMO-type policy.

But even if it did apply to this type of policy, here's what the Defendants then do:

Then, they wanted to go over to a different part of Title 38, that has a definition for health insurance issuer, 38 71 840.

And that definition, Your Honor, after very broadly saying that:

A health insurance issuer or issuer in any entity that provides health insurance coverage in this state is a health insurance issuer.

And then, you go on to:

For the purposes of the section, issuer includes -- and very broad -- insurance company -- uh -- health maintenance organization, and any other entity providing health insurance coverage which is licensed to engage the business of insurance in this state and which is subject to state insurance regulation.

Because of the last part of that definition -- a definition that is not even mentioned in the mandate statute, or the definition that the mandate statute says to go and see, they come up with the argument that:

The EIP -- the insurance -- The Employee Insurance Plan and the -- the State Budget and Control Board Insurance Program is not a health insurance issuer.

It doesn't say that anywhere in Title 38, dealing with insurance.

It doesn't say that anywhere in the Mandate Statute for this type of diabetes education.

It doesn't say that -- doesn't even say that where they say to go and see that that's the case.

They then cited Your Honor to a totally different code section -- a totally different title of the code -- Title 1 -- 1 dash 11 780, and thus what they say is -- in their brief -- uh -- explicit recognition of the lack of application of -- of these insurance regulations, including the mandates for this policy.

1 11 780, Your Honor, which is in -- what they handed up at Tab 10, if Your Honor looks, the title of it is "Mental Health Insurance."

They cite you a mental health insurance statute that has nothing to do with diabetes or diabetes education, or anything close to anything this case is about.

And that is the silver of their argument.

And where we get full-circle, if you take their argument to its logical conclusion, Your Honor, is that:

Because this mental health statute says that:

The employee insurance program -- and

it goes on -- and then they want you to just skip to the end, that says:

It's not under the jurisdiction of Department of Insurance.

They made the extraordinary argument then, that:

Therefore, not only does this diabetes mandate education statute not apply, none of the insurance regulations in our state apply for 400 -- over 400,000 people's health insurance, Your Honor, for any type of insurance that they get through the state.

And that just can't be so.

And if -- if The Court's reading of the statute -- they make -- they try to make a point that:

You've got to read -- uh -- the same general -- uh -- the statutory law -- you know -- to -- to harmonize it, and all that.

It's not even the same general statutory law.

They have to jump to a totally different title of the code to get there.

And it's a novel question.

And it's really fairly extraordinary, Your Honor, I mean, that -- that that is what -- It really boggles my mind to think that:

If you carry that to its logical conclusion, that there is no regulation of these over 400,000 people's insurance in the state, except for by the Budget and Control Board, which is an agency of the state.

So anyway, that brings again, Your Honor, to the exhaustion -- uh -- Although, real quick, Your Honor, also in the definition of insurer in Title 38 -- uh -- which is now at 38 120:

It does not exclude the employee insurance program.

Uh -- The insurance licensing law at 38 510:

There's no exclusion for it.

It doesn't even mention any of this stuff that the Defendant is arguing, that it's not -- uh -- regulated by the regulations in Title 38 and the Department of Insurance.

But in any event, Your Honor, this case cannot be decided in the Administrative Law Court.

And -- And here's why.

And, of course, that's the process that -- where it began -- because they made an insurance claim that was denied.

And they did an appeal.

And it's gone for two and a half

years or more.

But in any event, Your Honor, this case is a class-action case.

Uh -- That can't be heard in the Administrative Law Court.

It's a case for -- They want to try to make this just a simple old claim for coverage.

But it's also -- It's a case about enforcement of the Defendant's profits on -- both Defendant's profits -- uh -- for denying these claims -- uh -- in violation of -- uh -- the mandate.

It's a case providing an injunction going forward, that they not deny them anymore.

And -- And those -- those are not appropriate, Your Honor for an Administrative Law Court -- uh -- action.

Even though the Plaintiff has -- you know -- gone through that process in abundance of caution -- uh -- and as the cases that we've cited, Your Honor, say:

That is appropriate.

Uh -- The Capital City case that is cited in our -- uh -- that was cited in our brief when this exhaustion argument was already denied by a judge then -- says that:

Uh -- It's not a jurisdictional

issue.

That the exhaustion requirement is about -- uh -- policy -- convenient discretion -- uh -- that goes to the prematurity of the case.

It's not subject matter jurisdiction that's being decided on exhaustion -- uh -- question.

And Your Honor, in the Drummond case, Counsel for Defendant -- uh -- with all due respect, misunderstands our -- our citing of the Drummond case.

The Drummond case says that:

Administrative Law Judges can not pass upon the validity of the statute or regulations.

And I understand the Defense -- uh -- thinks that only went to this mandate statute; that the ALJ -- We -- We're not saying they the ALJ can't pass on the validity of the mandate statute.

But what we've got is:

The Budget and Control Board Employee Insurance Program has now issued a rule -- two days ago -- but still -- have now issued a rule -- a policy -- a regulation that:

The mandate statute does not apply.

In fact, that none of Title 38, or the Department of Insurance Regulations apply to these.

For the first time that we know of,

they've made that argument.

But the Administrative Law Judge can't pass on the validity of that policy -- of that regulation.

Uh -- So, it's not appropriate to be heard in the Administrative Law Court.

I've gone on for a long time, Your Honor.

I'd be happy to answer any questions; but that's our argument.

We'd ask you to:

Deny the Motion for Summary Judgment.

Uh -- And deny the Motion for a Protective Order, so we can get some discovery, and get on with this case.

Thank Your Honor.

MR. WILLARD:

Your Honor, just -- just briefly.

That is not a regulation.

That is merely a decision by the state health insurance plan that was denied.

The exclusive remedy is appeal to the ALJ.

The Plaintiff and purposely availed themselves of that procedure; and in fact, went through the

process.

Certainly an Administrative Law Judge can determine whether not that statute applies.

One other issue I'd like to address is this argument that -- uh -- we're saying:

Nothing in Title 38 applies to the state contract.

If the legislature intended it to apply, mandates for coverage, they'd put them in Title 1, like we pointed out in Section 10.

And there have been incidences in Title 38 where it does say it applies to the State's Health Plan; and it specifically says -- I'm looking at Tab 11:

It applies to the State's Health Plan, and it defines it:

As provided for in Article 5, Chapter 11, Title I.

So again, Your Honor, this is a clear -- two clear questions of law.

One is:

What court should the Plaintiff be in?

They purposely availed themselves of the administrative process; and the statute says:

Their exclusive remedy.

Now, there is -- there were allegations of class-action and things of that nature.

But again, no class has been certified.

Right now, we have one case with one Plaintiff with a claim that they admit was denied under the State's Health Plan.

And again:

Claims under the State's Health Plan: The exclusive remedy is with the ALJ.

With respect to this -- this argument about discovery.

Your Honor, no amount of discovery in the world is going to change this with anything other than a statutory interpretation case.

And in fact, the Plaintiff even asked Your Honor to go ahead and move on it.

So, Your Honor, either the ALJ will move it, or we'll get a ruling here.

That's a strict -- straight question of law; both those issues.

Your Honor, there is no need for discovery.

There's no need to drag this out to tie up more time and money, particularly in this budget

year, with class-action discovery that's not needed to clear up this question.

Thank Your Honor.

MR. HAMRICK:

Just briefly, Your Honor; very briefly, I promise.

Uh -- Counsel mention of the -- uh -- class-action allegations, in fact, reminds me that our motion for class certification was actually filed months ago.

We filed it because Judge Dennis had just had a bench bar meeting and told us that it was taking -- you know -- 4 and 5 months to get a motion heard.

So we went ahead and filed it.

Really, at the beginning of the case, it really is not ripe to be heard, Your Honor.

We'd ask that it either be continued to another motion -- uh -- another motion day -- uh -- or just postponed in some way until we get some discovery.

You know, obviously we cannot have a class-action motion -- uh -- heard without considerable discovery. And we haven't even begun to get any.

Uh -- Your Honor, the -- you know -- when we hear that:

We don't want to drag this out.

It's a little difficult to hear, because, as I've said several times, the administrative process has been drug out for over two and a half years.

And until two days ago, there was no good explanation -- there's still no good explanation, but it was no explanation at all until then.

And just briefly, the argument that:

If the legislature had wanted to say that the mandate applies to the employee plan, it could have.

And Counsel points to a statute regarding autism that -- uh -- in Title 1 that -- that does -- in Title 1 that does specifically -- uh -- say it applies to the -- uh -- to the employee insurance plan.

Your Honor, that statute was passed in 2007.

And Counsel makes the argument in their brief that -- you know:

The legislature knew, as shown by that statue, that it had to specifically say -- uh -- that the mandate applies to employee insurance plan, when it has to.

But it -- the -- the (not understandable word) mandate was passed in 2000.

But it doesn't work.

You can't -- It's not -- It's not that -- uh -- they passed the diabetes mandate after they'd already passed the mandate where they specifically said:

It applies to the employee insurance plan.

It was the other way around -- uh -- and that was the 38 71 280. And that was an autism -- uh -- mandates about autism coverage.

In any event, Your Honor -- uh -- we'd ask that:

You deny the Motion for Summary Judgment.

Allow us to proceed.

And allow us to get discovery.

Thank you, Your Honor.

THE COURT:

All right.

I need proposed orders within 10 days on this. And let me take a look at it.

And those other matters are continued.

MR. HAMRICK:

Thank Your Honor.

MR. WILLARD:

Thank Your Honor.

THE COURT:

Thank you.

WHEREUPON: There being nothing further in this particular matter, this hearing was closed at 12:42 PM, August, 26, 2010.

CERTIFICATE

I, the undersigned, H. Eugene Buckner, CVR, Official Court Reporter at Large in and for the State of South Carolina, do hereby certify that the foregoing proceeding was taken on the 26th day of August, 2010;

That the within judicial proceedings are, to the best of my ability, an accurate and verbatim transcription of the hearing;

I further certify that I'm neither Counsel nor Solicitor to any of the parties in said suit, nor interested in the event of the cause.

IN WITNESS WHEREOF, I've hereunto set my hand and seal this 14th day of February, 2011.

H. Eugene Buckner

H. EUGENE BUCKNER, CVR
OFFICIAL COURT REPORTER AT LARGE
15TH JUDICIAL DISTRICT
STATE OF South Carolina

CERTIFICATE OF COUNSEL

The undersigned hereby certifies that the Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

___ day of _____, 20___

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

Paul M. Burch, Circuit Court Judge

Circuit Court Case No. 2009-CP-10-7404
S.C. Court of Appeals Case No. 2011183026

Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees,

Appellant,

v.

South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina,

Respondent.

BRIEF OF APPELLANT

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STATEMENT OF ISSUES ON APPEAL

1. Did the trial court err in declining to exercise its discretion to stay decision on Respondents' motion for summary judgment?

2. Did the trial court err in granting Respondents' motion for summary judgment and dismissing Appellant's Complaint with prejudice on the basis that Appellant was required to exhaust administrative remedies?

STATEMENT OF THE CASE

Appellant, Jeffrey D. Allen (referred to herein as "Appellant") is an employee of a local South Carolina school district and an insured/member of the State Health Plan (referred to herein as the "Plan"). His daughter (referred to herein as "Jane Doe"), a dependant covered by the Plan, was diagnosed with Type I Diabetes on November 27, 2007 at the age of two (2) years old. Appellant submitted claims under the Plan for coverage of the cost of outpatient diabetes training and education, but Blue Cross and Blue Shield of South Carolina and the South Carolina Budget and Control Board Employee Insurance Program (referred to herein as "Respondents") denied the claims on the purported basis that the Plan does not include coverage for education or training for diabetes.

Appellant commenced the instant lawsuit on November 25, 2009, alleging, *inter alia*, that the Respondents' denial of the claim violated the statutory mandate for

outpatient diabetes training and education contained in S.C. Code Ann. § 38-71-46[1], and that the case should be certified as a class action. (R. pp. 16-22).

Respondents initially moved to dismiss this case, and for judgment on the pleadings, arguing that Appellant had failed to exhaust his administrative remedies and that Blue Cross and Blue Shield of South Carolina is merely the administrator and not the insurer under the Plan, and Appellant opposed the motion. (R. pp. 35-135); (R. pp. 136-148); (R. pp. 149-293). A hearing was held before the Honorable Markley Dennis on March 4, 2010 and Judge Dennis denied Respondents' motions to dismiss and for

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[1] S.C. Code Ann. § 38-71-46 provides (with emphasis added):

Diabetes Mellitus coverage in health insurance policies, diabetes education.
(A) On or after January 1, 2000, *every* health maintenance organization, ***individual and group health insurance policy, or contract issued or renewed in this State must provide coverage for*** the equipment, supplies, Food and Drug Administration-approved medication indicated for the treatment of diabetes, and ***outpatient self-management training and education for the treatment of people with diabetes mellitus***, if medically necessary, and prescribed by a health care professional who is legally authorized to prescribe such items and who demonstrates adherence to minimum standards of care for diabetes mellitus as adopted and published by the Diabetes Initiative of South Carolina. This subsection does not prohibit a health maintenance organization or an individual or a group health insurance policy from providing coverage for medication according to formulary or using network providers. Coverage must not be denied unless the health care professional demonstrates a persistent pattern of failure to adhere to the minimal standards of care and unless the health maintenance organization or insurer has first provided written notice to the health care professional that coverage will be denied if the health care professional fails to adhere to the minimal standards of care.

(B) Services and payment for diabetes education programs shall conform to regulations of the Health Care Financing Administration, US Department of Health and Human Services, pursuant to Section 4105 of the Balanced Budget Act of 1997. Diabetes outpatient self-management training and education shall be provided by a registered or licensed health care professional with certification in diabetes by the National Certification Board of Diabetes Educators, or other accredited program approved by the Diabetes Initiative of South Carolina, or by the Diabetes Control Program of the SC Department of Health and Environmental Control in order to meet the needs of rural communities wherein certified health care professionals providing this service are not available.

(C) Nothing contained in this section may be construed to affect in any way the ability of a managed care plan to credential or re-credential a provider.

(D) For purposes of this section: ***"Health insurance policy" means a health benefit plan***, contract, or evidence of coverage providing health insurance coverage as defined in Section 38-71-670(6) and Section 38-71-840(14).

judgment on the pleadings. (R. pp. 529-553); (R. p. 14); (R. p. 15). Thereafter, on March 19, 2010 Respondents served an Answer. (R. pp. 24-34)

Thereafter, on May 6, 2010 Appellant served interrogatories and requests for production upon Respondents. Respondents did not provide responses to Appellant's discovery requests. Instead, Respondents filed a motion for protective order (to allow Respondents not to respond to Appellant's discovery requests) and a motion for summary judgment. (R. pp. 294-320); (R. pp. 432-437); (R. pp. 321-431); (R. pp. 439-467).

Appellant filed a motion to compel discovery responses and a motion to stay decision on Respondents' motion for summary judgment. (R. pp. 468-491); (R. pp. 492-507). A hearing was held on August 26, 2010 before the Honorable Paul M. Burch and thereafter, by Order dated October 12, 2010, Judge Burch denied Appellant's motions to compel discovery responses and to stay decision on Respondents' motion for summary judgment, and granted Respondents' motion for summary judgment and dismissed Appellant's Complaint with prejudice. (R. pp. 554-592); (R. pp. 4-13).

Appellant filed a motion to alter, amend, or reconsider Judge Burch's October 12, 2010 Order, and Judge Burch, after considering the parties' briefing on the motion, denied the motion by Order dated November 23, 2010. (R. pp. 508-509); (R. pp. 510-514); (R. pp. 515-522); (R. pp. 523-528); (R. pp. 2-3). Appellant received written notice of the entry of the November 23, 2010 order on December 8, 2010. Judge Burch's grant of summary judgment was based solely on the issue of exhaustion of administrative remedies and did not consider whether S.C. Code Ann. § 38-71-46 applies to the Plan. (R. pp. 4-13). Appellant served a Notice of Appeal on January 7, 2011.

Prior to and throughout the time the instant lawsuit has been pending, Appellant has also appealed the denial of his claim for outpatient diabetes training and education through the administrative process for doing so, first to Blue Cross and Blue Shield of South Carolina, then to the South Carolina Budget and Control Board Employee Insurance Program, and then ultimately by submitting a Request for Contested Case Hearing on September 22, 2010 to the South Carolina Administrative Law Court (referred to herein as the "ALC"). The administrative appeal in the ALC is still pending.

ARGUMENT

1. *The Trial Court Erred in Declining to Exercise its Discretion to Stay Decision on Respondents' Motion for Summary Judgment.*

Appellant requested that Judge Burch either deny Respondents' motion for summary judgment or exercise his discretion to stay decision on the motion for summary judgment while the administrative appeal of Appellant's claim was still pending and to give the parties an opportunity to conduct discovery. Judge Burch declined to do so, and instead granted Respondents' motion for summary judgment and dismissed Appellant's Complaint with prejudice. Judge Burch should have stayed decision on Respondents' motion for summary judgment.

Jane Doe was first diagnosed with Type I diabetes on November 27, 2007 at the age of two (2) years old, and diabetic education and training was provided during her initial three-day hospital stay. Respondents have repeatedly denied Appellant's claims for coverage of the costs of diabetes education and training (four claims since December 17, 2007, totaling over $1,000). However, despite Appellant's numerous requests for an explanation of the denial of the claims and after nearly three (3) years of frustration and compliance with the administrative claims process, the South Carolina Budget and

Control Board Employee Insurance Program on August 24, 2010 finally issued its denial of the claims and explained for the first time its assertion that S.C. Code Ann. § 38-71-46 does not apply to the Plan. As noted above, Appellant has appealed that agency decision to the ALC and the appeal is still pending.

In light of the State of South Carolina board/agency being named as a Defendant in the instant lawsuit, Appellant and his undersigned attorneys made the decision to commence the suit within two (2) years of the date of the diagnosis, so as not to risk a possible statute of limitations defense related to the two (2) year statute of limitations in the South Carolina Tort Claims Act, if applicable. It was proper for Appellant to file the instant lawsuit while his administrative appeals were still pending because, as stated by this Court, "[a] party should not be required to 'roll the dice' on whether a collateral administrative proceeding will conclude prior to the running of an applicable statute of limitations in order to preserve a claim properly within the jurisdiction of the circuit court." *Capital City Ins. Co. v. BP Staff, Inc.*, 674 S.E.2d 524, 531 (S.C. Ct. App. 2009).

The court in *Capital City* held that where a party would be harmed by the running of the statute of limitations or otherwise prejudiced if its claim is dismissed for failure to exhaust administrative remedies, and the court has determined that resolution of the administrative proceeding would impact the circuit court case, then the circuit court should properly consider a stay or continuance of the judicial action until the administrative proceedings have concluded. *Id.* at 531. While the outcome of the administrative proceeding could moot the instant lawsuit, another possible outcome is that the ALC (or possibly this Court) determines the ALC does not have the power to grant the relief requested and that the issues should be decided by the circuit court. This

is the classic *catch-22* for a plaintiff, and for this reason Judge Burch should have exercised his discretion to stay decision on Respondents' motion for summary judgment while the administrative appeal of Appellant's claim was still pending, and given the parties an opportunity to conduct discovery.

Judge Burch had broad discretion in his supervision over the progression and disposition of the instant case in the interests of justice and judicial economy. *See Williams v. Bordon's Inc.*, 262 S.E.2d 881, 883 (S.C. 1980). Judge Burch should have exercised his discretion and stayed decision on Respondents' motion for summary judgment instead of granting the motion for summary judgment and dismissing Appellant's Complaint with prejudice. Appellant should not be prejudiced by his decision to protect himself (and all putative class members) against a possible statute of limitations defense, particularly when there is no guidance in the law of whether the ALC has the power to grant the relief requested in the instant lawsuit, including: (1) certification of a class; (2) a declaration that the Plan violates S.C. Code Ann. § 38-71-46; (3) a declaration of the future rights of the putative class members with regard to claims for diabetes education and training under the Plan; (4) reformation of the Plan to comply with S.C. Code Ann. § 38-71-46; (5) an injunction to stop the Respondents from continuing their unlawful actions in the future; (6) disgorgement and return of all profits and/or monies which should have been paid to the putative class members; and (7) costs and attorneys' fees.

While the parties to this case were awaiting Judge Burch's ruling in this matter, this Court issued an opinion in *South Carolina Dept. of Consumer Affairs v. Foreclosure Specialists, Inc.* Op. No. 4749 (S.C. Ct. App. Filed Sept. 29, 2010). That case is

instructive because, although addressing a different statutory scheme -- the Consumer Credit Counseling Act, this Court found that, under the more general Administrative Law Court statutes, also relied upon by Respondents in this case, the ALC did not in fact have the power to grant the Department of Consumer Affairs a refund of fees collected in violation of the Consumer Credit Counseling Act, and that any action for such relief should have been brought in circuit court. While not substantively on point, the case illustrates the risk and difficulty of predicting where the lines fall between the jurisdiction of the ALC and the circuit court.

The proper course would have been for Judge Burch to stay decision on Respondents' motion for summary judgment pending the final outcome of Appellant's administrative claim and to give the parties an opportunity to conduct discovery instead of granting the motion for summary judgment and dismissing Appellant's Complaint with prejudice.

2. *The Trial Court Erred in Granting Respondents' Motion for Summary Judgment and Dismissing Appellant's Complaint with Prejudice on the Basis that Appellant was Required to Exhaust Administrative Remedies.*

Judge Burch granted Respondents' motion for summary judgment on the basis that the administrative remedies under S.C. Code Ann. § 1-11-710(C) were Appellant's exclusive remedy. However, Judge Burch did not address the differences between what is "pending" in the administrative process and the causes of action asserted in the instant lawsuit. The causes of action asserted in the instant lawsuit are not "claims for benefits" within the meaning of section 1-11-710(C), and continuing with the administrative appeal would not provide Appellant with an adequate remedy.

With regard to many, if not most, insurance claims, the Respondents' exhaustion defense would be applicable. However, a review of several of those cases illustrates how this case is different. For example, in *James v. South Carolina Budget and Control Board,* 640 S.E.2d 474 (S.C. Ct. App. 2007), this Court upheld the circuit court's reversal of the Budget and Control Board's denial of a claim for a child's cranial molding device as not medically necessary. That case was heard by the Budget and Control Board, appealed through the Administrative Procedures Act to the circuit court, and then to this Court. In *Grier v. South Carolina Budget and Control Board,* 07-ALJ-30-0139 (2008), the ALC upheld reversal of the Budget and Control Board's denial of a claim for abdominoplasty ("tummy tuck") as not medically necessary. In *Hendley v. South Carolina Budget and Control Board,* 481 S.E.2d 159 (S.C. Ct. App. 1996) this Court affirmed the lower court's reversal of a decision made by the Budget and Control Board to deny coverage for a hair prosthesis (or "wig") through interpretation of the language of the benefit plan regarding prosthesis. All of these cases involved the agency/administrative review of and interpretation of its own policies and contracts, and single claims for benefits. In contrast, in the instant lawsuit Appellant seeks: (1) certification of a class; (2) a declaration that the Plan violates S.C. Code Ann. § 38-71-46; (3) a declaration of the future rights of the putative class members with regard to claims for diabetes education and training under the Plan; (4) reformation of the Plan to comply with S.C. Code Ann. § 38-71-46; (5) an injunction to stop the Respondents from continuing their unlawful actions in the future; (6) disgorgement and return of all profits and/or monies which should have been paid to the putative class members; and (7) costs and attorneys' fees. The potential result in favor of Appellant from the pending

administrative proceeding would not provide the relief sought by Appellant and the putative class members in the instant lawsuit.

Section 1-11-710(C) provides that "*claims for benefits* under any self-insured plan of insurance offered by the State to state and public school district employees and other eligible individuals must be resolved by procedures established by the board [South Carolina Budget and Control Board], which shall constitute the exclusive remedy for these claims, subject only to appellate judicial review consistent with the standards provided in Section 1-23-380." S.C. Code Ann. § 1-11-710(C) (emphasis added). Section 1-23-380 entitled "Judicial Review Upon Exhaustion of Administrative Remedies" "does not limit utilization of or the scope of judicial review *available under other means of review, redress, relief,* or trial de novo provided by law." S.C. Code Ann. § 1-23-380(A) (Supp. 2009) (emphasis added).

If the denial of Appellant's claims for diabetes education and training benefits is reversed in the ALC, then presumably Appellant would receive coverage only for his diabetes education claims. However, neither the Appellant's benefit plan nor the putative class members' benefit plans would necessarily be reformed to provide the statutorily mandated insurance coverage for diabetes education. Appellant's prevailing in the administrative process would not require Respondents to review all denials made in violation of the diabetes education mandate statute since its enactment in 2000. Appellant's prevailing in the administrative process would not enjoin Respondents from violating the diabetes mandate in the future, nor force disgorgement of revenues and profits related to the illegal conduct.

Generally, "[w]hen an administrative remedy is available *to determine a question of fact,* one must seek the administrative remedy or be precluded from pursuing relief in the courts." *Stinney v. Sumter School Dist. 17*, 675 S.E.2d 760, 763 (S.C. Ct. App. 2009) (citing *Hyde v. Dept. of Mental Health*, 442 S.E.2d 582, 583 (S.C. 1994)) (emphasis added). "A party is not required to exhaust administrative remedies if the issue is one that cannot be ruled upon by the administrative body." *Capital City Ins. Co. v. BP Staff, Inc*, 674 S.E.2d 524, 529 (S.C. Ct. App. 2009) quoting *Charleston Trident Home Builders, Inc. v. Town Council of Town of Summerville*, 632 S.E.2d 864, 867 (S.C. 2006) (citing *Ward v. State*, 538 S.E.2d 245 (S.C. 2000)); *see also Stinney*, 675 S.E.2d at 763 (recognizing that inadequacy of the administrative appeal is an exception to the general rule requiring exhaustion).

The purpose of the exhaustion requirement, to allow the agency to render a final decision and set forth its reason for denying the diabetes education claim, would not assist the Court in this case. The alleged wrong – violation of the statutory mandate as to an entire class of persons—is not one which the administrative process was designed to address. To limit Appellant to the administrative process would be to require him to pursue a vain and futile act. Courts have recognized an exception to the requirement of exhaustion of administrative remedies exists when a party demonstrates that pursuit of them would be a vain or futile act. *See Moore v. Sumter County Council*, 387 S.E.2d 455, 458 (S.C. 1990).

In *Capital City Ins. Co. v. BP Staff, Inc.*, 674 S.E.2d 524, 529 (S.C. Ct. App. 2009), this Court recently addressed the exhaustion of administrative remedies issue, and explained that exhaustion is a "rule of policy, convenience and discretion, rather than one

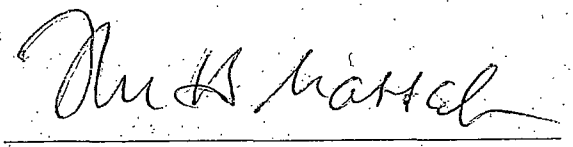
of law, and is not jurisdictional." And, the failure to exhaust administrative remedies goes to the prematurity of a case, not subject matter jurisdiction. *Id.* In the instant case, Appellant's declaratory judgment, equitable and injunctive claims are part of the general class of cases which the court of common pleas has jurisdiction to hear. The mere fact that Appellant was also engaged in an administrative proceeding regarding a single claim for benefits did not divest the circuit court of its power to hear and determine the claims asserted in Appellant's Complaint. Thus, the trial court had subject matter jurisdiction to hear Appellant's claims, should not have dismissed Appellant's Complaint, and especially not with prejudice.

Additionally, Appellant respectfully directs the Court's attention to *Drummond v. State of South Carolina*, 378 S.C. 362, 662 S.E.2d 587 (2008), wherein the South Carolina Supreme Court recently affirmed that the ALC and its administrative law judges "are an agency of the executive branch of government" and cannot rule on the validity of a statute or regulation. While the instant case is not a direct challenge of the constitutionality of the subject statutory coverage mandate, the South Carolina Budget and Control Board is a state agency and it has promulgated its "decision" that the Plan does not provide coverage for diabetic education. It is the validity of that state agency's decision which is being challenged in this case. In *Drummond*, the court held that although the appellant was not challenging the constitutionality of the regulation, he was challenging its validity under state law. Because the ALC is part of the executive branch, as stated in *Video Gaming Consultants, Inc. v. South Carolina Dep't of Revenue*, 342 S.C. 34, 38, 535 S.E.2d 642, 644 (2000), it has no authority to rule on the validity of the regulation.

CONCLUSION

For the reasons discussed herein, Appellant respectfully requests that the Court reverse the trial court's grant of summary judgment in favor of Respondents.

Respectfully submitted,



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Paul M. Burch, Circuit Court Judge

Circuit Court Case No. 2009-CP-10-7404
S.C. Court of Appeals Case No. 2011183026

Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees or retirees,.....Appellant,

v.

South Carolina Budget and Control Board,
Employee Insurance Program.....Respondent.

CERTIFICATE OF COUNSEL

The undersigned certified that the Final Brief complies with Rule 211(b), SCACR.

August 31, 2011

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

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v.

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Employee Insurance Program.....Respondent.

PROOF OF SERVICE

I certify that I have served the Final Brief and Final Reply of Appellant on Respondent of record by depositing a copy of it in the United States Mail, postage prepaid, on September 1, 2011, addressed to their attorneys of record, Theodore D. Willard, Jr., Montgomery Willard, LLC, P.O. Box 11886, Columbia, SC, 29211 and Kelly H. Rainsford, State Budget & Control Board, 1201 Main Street, Suite 300, Columbia, SC 29201.

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v.

South Carolina Budget and Control Board
Employee Insurance Program and BlueCross and
BlueShield of South Carolina,.....Respondents.

FINAL BRIEF OF RESPONDENTS

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STATEMENT OF ISSUES ON APPEAL

I. DID THE TRIAL COURT ABUSE ITS DISCRETION IN FAILING TO STAY A DECISION ON RESPONDENTS' MOTION FOR SUMMARY JUDGMENT?

A. DID APPELLANT PROPERLY PRESERVE HIS ARGUMENT THAT THE TRIAL COURT ABUSED ITS DISCRETION IN FAILING TO STAY A DECISION ON RESPONDENTS' MOTION FOR SUMMARY JUDGMENT PENDING A DECISION ON APPELLANT'S ADMINISTRATIVE APPEAL TO THE SOUTH CAROLINA ADMINISTRATIVE LAW COURT WHEN APPELLANT FAILED TO RAISE THIS ISSUE PRIOR TO JUDGMENT?

B. DID THE TRIAL COURT ABUSE ITS DISCRETION IN FAILING TO STAY A DECISION ON RESPONDENTS' MOTION FOR SUMMARY JUDGMENT PENDING COMPLETION OF DISCOVERY?

C. DID THE TRIAL COURT ABUSE ITS DISCRETION BY DISMISSING APPELLANT'S CASE ON THE GROUNDS THAT S.C. CODE ANN. § 1-11-710(C) WAS APPELLANT'S EXCLUSIVE REMEDY, RATHER THAN STAYING A DECISION ON RESPONDENTS' MOTION FOR SUMMARY JUDGMENT?

II. DID THE TRIAL COURT ERR IN GRANTING RESPONDENTS' MOTION FOR SUMMARY JUDGMENT ON THE GROUNDS THAT S.C. CODE ANN. § 1-11-710(C) WAS APPELLANT'S EXCLUSIVE REMEDY, SUBJECT ONLY TO APPELLATE REVIEW BY THE SOUTH CAROLINA ADMINISTRATIVE LAW COURT PURSUANT TO S.C. CODE ANN. § 1-23-600(D)?

STATEMENT OF THE CASE

On November 25, 2009, Appellant Jeffrey D. Allen, an employee of a South Carolina School District, brought a purported class action against the Group Health Benefits Plan of the Employees of the State of South Carolina, the Public School Districts, and Participating Entities ("State Health Plan") and BlueCross BlueShield of South Carolina ("BCBSSC"), alleging that S.C. Code Ann. § 38-71-46 mandated coverage under the State Health Plan for diabetes outpatient self-management training and education. (R. pp. 16-22). Appellant alleged causes of action for declaratory judgment to interpret the terms of the State Health Plan, disgorgement of benefits under the State Health Plan, reformation of the State Health Plan, and for injunctive relief.

Respondents answered the complaint, denying Appellant's allegations and alleging multiple affirmative defenses, including but not limited to failure to state a claim; preemption by the exclusive statutory remedies contained in S.C. Code Ann. §1-11-710(C); failure to exhaust administrative remedies; and lack of jurisdiction. (R. pp. 24-34).

On June 2, 2010, Respondents moved for summary judgment on the grounds S.C. Code Ann. § 38-71-46 did not apply to the State Health Plan; Appellant's causes of action were preempted by the exclusive statutory remedies set forth in S.C. Code Ann. § 1-11-710(C); Appellant failed to exhaust his administrative remedies under the State Health Plan pursuant to S.C. Code Ann. § 1-11-710(C) and § 1-23-380; and this matter should be before the Administrative Law Court ("ALC") pursuant to S.C. Code Ann. § 1-23-600(D), in that any action reviewing a decision under the State Health Plan is subject to the exclusive jurisdiction of the ALC. (R. pp. 321-431, 439-467).

Respondents further moved for a protective order staying Appellant's discovery pending a determination of Respondent's motion for summary judgment. (R. pp. 294-318, 432-436). Appellant moved to stay Respondents' motion for summary judgment pending the completion of discovery and to compel responses to Plaintiff's discovery. (R. pp. 468-507).

A hearing was held on the parties' outstanding motions on August 26, 2010, before the Honorable Paul M. Burch. By order dated October 12, 2010, the Court denied Appellant's motion to stay and compel and granted Respondents' motion for summary judgment and for a protective order. (R. pp. 4-13).

On November 8, 2010, Appellant filed a motion to alter or amend the trial court's October 12, 2010 order pursuant to SCRCP 59(e). (R. pp. 508-509). Both parties submitted supporting memoranda. (R. pp. 510-528). By order filed November 29, 2010, the trial court denied Appellant's motion to alter or amend judgment. (R. p. 2).

Appellant received written notice of the entry of the November 29, 2010 order on December 8, 2010. Appellant served his notice of appeal on January 7, 2011.

STATEMENT OF FACTS

The issue in this case is whether a participant in the State Health Plan can obtain benefits under the plan without availing himself of the statutorily required administrative remedies. The State Health Plan is a self-funded, non-federal governmental health plan administered by the South Carolina Budget and Control Board Employee Insurance Program ("EIP") on behalf of the State of South Carolina. (R. p. 323). BlueCross BlueShield of South Carolina ("BCBSSC') is the third-party claims administrator for the State Health Plan. BCBSSC is not an insurer of the State Health Plan. (R. p. 323).

Appellant alleged S.C. Code Ann. § 38-71-46 mandated coverage under the State Health Plan for diabetes outpatient self-management training and education. Appellant alleged causes of action for declaratory judgment to interpret the terms of the State Health Plan, disgorgement of benefits under the State Health Plan, reformation of the State Health Plan and for injunctive relief. Appellant's complaint alleged:

> 5. This is an action for declaratory judgment arising from Defendants' unlawful issuance and administration of the State of South Carolina EIP Standard Plan, a plan of health benefits and insurance offered to all current and retired state employees, including public school district employees, for violation of a SC Code Section 38-71-46, for disgorgement of revenues received as a result of the unlawful issuance and administration, and for declaration to determine the value of unlawfully withheld benefits.
>
> . . .
>
> 11. As the named Plaintiff is an employee of a South Carolina school district, has been enrolled in the EIP Standard Plan, has enrolled his dependent child in said plan who was diagnosed with Diabetes at the age of two years old, and has made multiple claims for his dependent child with a value of approximately One Thousand & 00/100 US Dollars ($1000.00) for diabetes outpatient self-management training and education which were denied by Defendant BCBSSC as administrator to the EIP, his claim, right and privileges are typical of the proposed class.

. . .

19. Plaintiff seeks, individually and as legal guardian for Jane Doe, and on behalf of all class members, a declaration of the rights of the parties hereto: that Defendants are required to issue and administer all health benefit plans offered through the EIP in compliance with the express mandate of South Carolina Code Section 38-71-46.

20. Plaintiff seeks an Order of the Court reforming the terms of the health benefit plan provided to all class members effective January 1, 2000 to provide the mandated diabetes coverage.

21. Plaintiff seeks an Order of the Court requiring the Defendants to disgorge monies received as a result of unlawful denials of the mandatory diabetes coverage, and to pay them to members of the putative class the present value of said unlawfully withheld revenues.

. . .

24. The Defendants should be enjoined from the wrongful takings as described above and from further denial of claims for the diabetes outpatient self-management training and education.

(R. pp. 16-22).

It is undisputed that prior to filing the current action, and while the current action was pending at the lower court, Appellant continued to avail himself of his administrative remedies under § 1-11-710(C). On September 30, 2009, Appellant made a first level appeal to the BCBSSC Appeals Committee regarding the denial of his claim for benefits under the State Health Plan, arguing that S.C. Code Ann. § 38-71-46 applied to the State Health Plan. (R. pp. 324, 329-330).

On April 2, 2010, the BCBSSC Appeals Committee sent a letter informing Appellant it was upholding the denial of Appellant's claim because the terms of the State Health Plan specifically excluded the requested services. BCBSSC also stated S.C. Code Ann. § 38-71-46 did not apply to the State Health Plan. (R. pp. 324, 332-334). This letter further gave Appellant 90 days from April 2, 2010, to appeal this decision to the EIP

Health Appeals Committee.

On June 30, 2010, Appellant appealed the denial of his claim to the EIP Health Appeals Committee. (R. pp. 451-452). As the contents of this letter reflect, Appellant's appeal to the EIP Health Appeals Committee included the issue of the applicability of S.C. Code Ann. § 38-71-46 to the State Health Plan.

On August 24, 2010, the EIP Health Appeals Committee denied Appellant's claim for benefits via letter and noted S.C. Code Ann. § 38-71-46 did not apply to the State Health Plan. This letter also informed Appellant his next level of appeal was to the ALC. (R. pp. 453-466).

On September 22, 2010, Appellant filed an administrative appeal with the ALC. As of the date of this brief, Appellant's administrative appeal is still pending in the ALC.

ARGUMENTS

I. THE TRIAL COURT DID NOT ABUSE ITS DISCRETION BY FAILING TO STAY A DECISION ON RESPONDENTS' MOTION FOR SUMMARY JUDGMENT.

Granting a motion for stay of proceedings rests entirely within the discretion of the trial judge. Spartanburg v. Belk's Dep't Store, 199 S.C. 458, 20 S.E.2d 157 (1942).

A. APPELLANT FAILED TO RAISE THE ISSUE PRIOR TO JUDGMENT.

Appellant's argument—that the trial court abused its discretion in failing to stay a decision on Respondents' motion for summary judgment, pending a decision on Appellant's administrative appeal in the ALC—fails because Appellant neglected to make this argument until after judgment was entered. (R. pp. 468-469, 492-507). Appellant did not argue that the trial court should stay the matter to allow the exhaustion of Appellant's administrative appeal until Appellant made his motion to alter or amend judgment pursuant to SCRCP 59(e). "A party cannot use Rule 59(e) to present to the court an issue the party could have raised prior to judgment, but did not." C.A.H. v. L.H., 315 S.C. 389, 392, 434 S.E.2d 268, 270 (1993) (citing Hickman v. Hickman, 301 S.C. 455, 392 S.E.2d 481 (Ct. App. 1990)). Because Appellant never raised this issue prior to entry of judgment in favor of Respondents, Appellant's argument fails. Even assuming arguendo that the Appellant did assert this position prior to judgment, his argument fails on its merits, as discussed fully below.

B. THE TRIAL COURT DID NOT ABUSE ITS DISCRETION IN FAILING TO STAY A DECISION ON RESPONDENTS' MOTION FOR SUMMARY JUDGMENT PENDING THE COMPLETION OF DISCOVERY.

While Appellant did argue prior to judgment that the trial court should have stayed a decision on Respondent's motion for summary judgment to allow Appellant to

conduct discovery, Appellant's brief makes only makes two conclusory references to such a stay on pages 7 and 9, and it does so with no argument or citation of authority. "South Carolina law clearly states that short, conclusory statements made without supporting authority are deemed abandoned on appeal and therefore not presented for review." Glasscock, Inc. v. U.S. Fid. & Guar. Co., 348 S.C. 76, 81, 557 S.E.2d 689, 691 (Ct. App. 2001). "An issue is also deemed abandoned if the argument in the brief is merely conclusory." State v. Colf, 332 S.C. 313, 322, 504 S.E.2d 360, 364 (Ct. App. 1998), aff'd as modified, 337 S.C. 622, 525 S.E.2d 246 (2000). Accordingly, Appellant's argument for stay of the summary judgment decision to allow for discovery is waived.

Even assuming Appellant's argument for a stay is not waived, Appellant purposely availed himself of the State Health Plan's administrative remedies. Therefore, the trial court was left to decide the purely legal issue of whether Appellant's exclusive remedy was an appeal to the ALC. The issue of interpretation of a statute is a question of law for the court. Catawba Indian Tribe of S.C. v. State, 372 S.C. 519, 524, 642 S.E.2d 751, 753 (2007). While Plaintiff's counsel did submit a Rule 56(f) affidavit, that affidavit failed to identify any evidence Plaintiff expected to discover that would be relevant to whether the administrative remedies under S.C. Code Ann. § 1-11-710(C) were Plaintiff's exclusive remedy, subject only to appellate review to the ALC pursuant to S.C. Code Ann. § 1-23-600(D). When plain, palpable, and indisputable facts exist on which reasonable minds cannot differ, summary judgment should be granted. Pye v. Aycock, 325 S.C. 426, 480 S.E.2d 455 (Ct. App. 1997). Because development of the facts was not needed to interpret the statute at issue, the trial court did not abuse its discretion in failing to stay a decision on Respondents' summary judgment motion until the completion of

discovery.

C. THE TRIAL COURT DID NOT ABUSE ITS DISCRETION BY DISMISSING APPELLANT'S CASE ON THE GROUNDS THAT S.C. CODE ANN. § 1-11-710(C) WAS APPELLANT'S EXCLUSIVE REMEDY, RATHER THAN STAYING A DECISION ON RESPONDENTS' MOTION FOR SUMMARY JUDGMENT

Even assuming that Appellant properly preserved and/or did not waive the stay issue, Appellant's argument—that this action should be stayed rather than dismissed, pending resolution of an administrative proceeding—is misplaced because the administrative proceeding was Appellant's exclusive remedy as a matter of law. A participant and/or beneficiary challenging an award of benefits under the State Health Plan is limited to the remedies set forth in S.C. Code Ann. § 1-11-710(C), which provides as follows:

> Notwithstanding Sections 1-23-310 and 1-23-320 or any other provision of law, claims for benefits under any self-insured plan of insurance offered by the State to state and public school district employees and other eligible individuals must be resolved by procedures established by the board, which shall constitute the exclusive remedy for these claims, subject only to appellate review consistent with standards provided in Section 1-23-380.

Id. (emphasis added).

Pursuant to the allegations of Appellant's Complaint, Appellant requested the court interpret the terms of the State Health Plan to include the coverage set out in S.C. Code Ann. § 38-71-46. Appellant further alleged he was entitled to disgorge benefits from the plan for unlawful denials of coverage and for injunctive relief enjoining "further denial of claims for diabetes out-patient self-management training and education." (R. pp. 20-22). The interpretation of the State Health Plan and the resolution of claims for benefits under the Plan are exactly the types of remedies contemplated by § 1-11-

710(C).[1]

In Unisys Corp. v. S.C. Budget & Control Bd., 346 S.C. 158, 551 S.E.2d 263 (2001), the South Carolina Supreme Court upheld the dismissal of the plaintiff's complaint because it found exhausting administrative remedies under the S.C. Procurement Code constituted the plaintiff's exclusive remedy. The Court went on to hold the term "exclusive remedy" indicates "exclusivity of jurisdiction." Id. at 170, 551 S.E.2d at 270. The Court also found "because a statute waiving the State's immunity must be strictly construed, the State can be sued only in the manner and upon the terms and conditions prescribed by the statute." Id., 551 S.E.2d at 270. Finally, the Court held dismissal was appropriate. The Court stated:

> Since Unisys is required to exhaust its administrative remedies as a matter of law, dismissal under Rule 12(b)(6) for failure to state a claim was proper. Further, because an action was pending pursuant to the Procurement Code as required when this action was brought, dismissal was also proper under Rule 12(b)(8) [another action is pending between the same parties for the same claim]. See Southern Ry. Co. v. Order of Ry. Conductors, 210 S.C. 121, 41 S.E.2d 774 (1947) (exhaustion of remedies will preclude original resort to courts where statute by express terms gives exclusive jurisdiction to administrative agency).

Id. at 176–77, 551 S.E.2d at 273.

Contrary to Appellant's argument, Capital City Insurance Company v. B.P. Staff, 382 S.C. 92, 674 S.E.2d 524 (Ct. App. 2009), does not stand for the blanket proposition

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[1] Paragraph 1.3 of the State Health Plan states:

> 1.3 Applicable Law
> This Plan is established and will be maintained with the intention of meeting the requirements of all applicable federal and state laws. Any provision of this Plan, which is in conflict with the law of any governmental body or agency that has jurisdiction over this Plan, shall be interpreted to conform to the minimum requirements of such laws.

(Emphasis added) (R. p. 336).

that a stay is more appropriate than a dismissal. In fact, the South Carolina Court of Appeals in Capital City, relying on the holding in Unisys, acknowledged that:

> The South Carolina Supreme Court has instructed that dismissal may be proper under Rule 12(b)(6) SCRCP where the opposing party is required to exhaust administrative remedies as a matter of law, but failed to do so. See Unisys Corp. v. S.C. Budget & Control Bd., 346 S.C. 158, 176, 551 S.E.2d 263, 273 (2001) (stating that exhaustion of remedies precludes original resort to courts where an administrative agency is granted exclusive jurisdiction by the express terms of a statute). Thus, we must determine whether exhaustion of administrative remedies was required as a matter of law; if not, we next determine whether the court abused its discretion in dismissing the case until exhaustion of the administrative process is complete in order to assist in the disposition of the circuit court proceeding.

Capital City at 529.

The rule Appellant relied upon—that an action should be stayed rather than dismissed—does not apply where the administrative agency has exclusive jurisdiction to consider the complaint initially brought in the court. U.S. v. Mich. Nat'l Corp., 419 U.S. 1, n.2 (1974); Pan Am. World Airways v. U.S., 371 U.S. 296 (1963). In the present case, dismissal was appropriate because a participant and/or beneficiary challenging an award of benefits under the State Health Plan was limited to the administrative remedies set forth in S.C. Code Ann. § 1-11-710(C).

Not just this

Appellant's reliance on South Carolina Department of Consumer Affairs v. Foreclosure Specialists, 390 S.C. 182, 700 S.E.2d 468 (Ct. App. 2010) is misplaced. Foreclosure Specialists is easily distinguished from the present case in part because, as Appellant concedes, Foreclosure Specialists involved a statutory scheme with a different set of enumerated remedies. The South Carolina Consumer Credit Counseling Act allowed plaintiffs seeking relief to bring two types of actions: an "administrative action" in the ALC, and a "civil action" in circuit court. S.C. Code Ann. § § 37-6-108(A); 37-6-

113(C). The Court of Appeals held:

> [t]here is nothing in the 2005 amendments that changes the procedure that a civil action has to be brought in circuit court. Because the relief sought by the Department in this action is available in a civil action pursuant to Section 37-6-113(A), and because a civil action must still be brought in circuit court, the ALC was correct in ruling that it did not have the power to grant the relief [to recover actual damages and excess charges paid by consumers].

Foreclosure Specialists, 390 S.C. at 186, 700 S.E.2d at 470. Unlike the Consumer Credit Counseling Act, which specifically allowed a civil action, the administrative remedies under S.C. Code Ann. § 1-11-710(C) were Appellant's exclusive remedy to challenge a claim for benefits under the State Health Plan, subject only to appellate review to the ALC pursuant to S.C. Code Ann. § 1-23-600 (D).

Finally, Appellant's argument that he should not be forced to "roll the dice" with respect to the statute of limitations has no application. Appellant timely availed himself of these remedies. Because Appellant appealed to the ALC on a timely basis, Appellant was not threatened by the expiration of the statute of limitations. Accordingly, Appellant suffered no prejudice as a result of the dismissal.[2]

II. THE TRIAL COURT PROPERLY GRANTED SUMMARY JUDGMENT BECAUSE THE ADMINISTRATIVE REMEDIES UNDER S.C. CODE ANN. § 1-11-710 (C) WERE APPELLANT'S EXCLUSIVE REMEDIES, SUBJECT ONLY TO APPELLATE REVIEW BY THE ADMINISTRATIVE LAW COURT PURSUANT TO S.C. CODE ANN. § 1-23-600(D).

Appellant's argument that summary judgment was improperly granted because his complaint was not a claim for benefits under the State Health Plan was incorrect and was not supported by the allegations of his pleadings. Appellant's complaint alleges:

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[2] Appellant's argument that he is protecting the claims of putative class members also fails in that the putative class members would also be required to exhaust their individual administrative remedies under S.C. Code Ann. § 1-11-710(C).

5. This is an action for declaratory judgment arising from Defendants' unlawful issuance and administration of the State of South Carolina EIP Standard Plan, a plan of health benefits and insurance offered to all current and retired state employees, including public school district employees, for violation of a SC Code Section 38-71-46, for disgorgement of revenues received as a result of the unlawful issuance and administration, and for declaration to determine the value of unlawfully withheld benefits.

. . .

12. As the named Plaintiff is an employee of a South Carolina school district, has been enrolled in the EIP Standard Plan, has enrolled his dependent child in said plan who was diagnosed with Diabetes at the age of two years old, and has made multiple claims for his dependent child with a value of approximately One Thousand & 00/100 US Dollars ($1000.00) for diabetes outpatient self-management training and education which were denied by Defendant BCBSSC as administrator to the EIP, his claim, right and privileges are typical of the proposed class.

. . .

22. Plaintiff seeks, individually and as legal guardian for Jane Doe, and on behalf of all class members, a declaration of the rights of the parties hereto: that Defendants are required to issue and administer all health benefit plans offered through the EIP in compliance with the express mandate of South Carolina Code Section 38-71-46.

23. Plaintiff seeks an Order of the Court reforming the terms of the health benefit plan provided to all class members effective January 1, 2000 to provide the mandated diabetes coverage.

24. Plaintiff seeks an Order of the Court requiring the Defendants to disgorge monies received as a result of unlawful denials of the mandatory diabetes coverage, and to pay them to members of the putative class the present value of said unlawfully withheld revenues.

. . .

24. The Defendants should be enjoined from the wrongful takings as described above and from further denial of claims for the diabetes outpatient self-management training and education.

(R. pp. 16-22).

As the Court correctly found in its order,

> Pursuant to the allegations of Plaintiff's Complaint, Plaintiff is requesting the Court interpret the terms of the State Health Plan to include the coverage set out in S.C. Code Ann. § 38-71-46. Plaintiff further alleges he is entitled to disgorge benefits from the plan for unlawful denials of coverage and for injunctive relief enjoining "further denial of claims for diabetes out-patient self-management training and education." (Complaint ¶24). The interpretation of the State Health Plan and the resolution of claims for benefits under the Plan are exactly the types of remedies contemplated by § 1-11-710(C).

(R. pp. 7-8).

Appellant's attempt to circumvent the statutory requirements of § 1-11-710(C) by alleging a purported class action and/or a declaratory judgment action is of no avail. The administrative remedies under S.C. Code Ann. § 1-11-710 (C) were Appellant's, and any putative class members', exclusive remedy, subject only to appellate review to the ALC pursuant to S.C. Code Ann. § 1-23-600 (D). See Unisys Corp. v. S.C. Budget & Control Bd., 346 S.C. 158, 176, 551 S.E.2d 263, 273 (2001) (stating that exhaustion of remedies precludes original resort to courts where an administrative agency is granted exclusive jurisdiction by the express terms of a statute). Accordingly, all of Appellant's causes of action were preempted by S.C. Code Ann. § 1-11-710(C). "Because a statute waiving the State's immunity must be strictly construed, the State can be sued only in the manner and upon the terms and conditions prescribed by the statute." Unisys, 346 S.C. at 170, 551 S.E.2d at 270 (citing S.C. Const. art. X, § 10 ("The General Assembly may direct, by law, in what manner claims against the State may be established and adjusted"[3])).

A court ordinarily will refuse to grant a declaratory judgment where a special statutory remedy has been provided. "Gratuitous interference" in the administrative process should be avoided. Williams Furniture Corp. v. Southern Coatings & Chem. Co.,

[3] The provisions of this section are identical to S.C. Const. art. XVII, § 2, meaning this sentence appears twice in the South Carolina Constitution.

216 S.C. 1, 7-8, 56 S.E.2d 576, 579 (1949); Smith v. S.C. Ret. Sys., 336 S.C. 505, 520 S.E.2d 339 (Ct. App. 1999). The Court, therefore, should not serve as a substitute for "a tribunal of original jurisdiction in issues that are ripe for litigation by the usual processes." Williams Furniture Corp., 216 S.C. at 8, 56 S.E.2d at 579; see also Garris v. Governing Bd. of S.C. Reinsurance Facility, 319 S.C. 388, 390, 461 S.E.2d 819, 821 (1995) ("Declaratory relief will ordinarily be refused where another remedy will be more effective or appropriate under the circumstances," as "relief is not generally available to one who has not exhausted administrative remedies."). In general, judicial review is appropriate only when appeal is from a final agency order. Id. at 821 (citing S.C. Code Ann. § 1-23-380(A)). Accordingly, the trial court properly granted Respondents' motion for summary judgment.

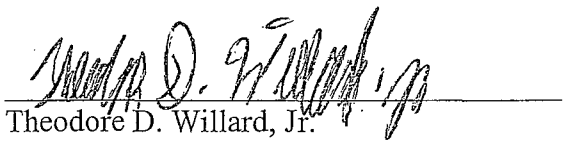
Appellant's argument that it was futile for Appellant to exhaust his administrative remedies is misplaced. Undeniably, Plaintiff purposely availed himself of the administrative remedies under the State Health Plan and fully exhausted the internal appeals process. Because Appellant exhausted the Plan's administrative remedies and filed an appeal with the ALC, any futility argument was waived and/or mooted. Simply put, Appellant still has a viable remedy by virtue of his administrative appeal to the ALC, which has exclusive jurisdiction over such actions.

Appellant also argues that based on Drummond v. State of South Carolina, 378 S.C. 362, 662 S.E.2d 587 (2008), the ALC cannot rule on whether or not S.C. Code Ann. § 38-71-46 applies to the State Health Plan. However, Drummond stands for the proposition that the ALC cannot rule on the validity of a statute because the ALC is a part of the executive branch. The ALC is charged with following the law "as written." Video

Gaming Consultants, Inc. v. S.C. Dep't of Revenue, 342 S.C. 34, 535 S.E.2d 642 (2000) ("ALJs are an agency of the executive branch of government and must follow the law as written until its constitutionality is judicially determined; ALJs have no authority to pass upon the constitutionality of a statute or regulation." (emphasis added)). Appellant argues that the final EIP Health Appeals Committee decision dated August 24, 2010, was a "regulation," the validity of which cannot be challenged by the ALC. However, the August 24, 2010, decision was not a regulation but merely a decision by the EIP Health Appeals Committee regarding a claim for benefits, which was precisely the type of decision the ALC is authorized to hear in its appellate capacity. In the current case, no one was challenging the validity of S.C. Code Ann. § 38-71-46; rather, the challenge was whether S.C. Code Ann. § 38-71-46 did not apply to the State Health Plan. Therefore, the trial court correctly held that the rule set forth in Drummond has no application to the present case.

CONCLUSION

For the foregoing reasons, this Court should affirm the judgment of the circuit court.



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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

Paul M. Burch, Circuit Court Judge

Case No. 2009-CP-10-7404

Jeffrey D. Allen, individually, as guardian for
Jane Doe, a minor, and as representative of other
Similarly situated State of South Carolina employees,.....Appellant.

vs.

South Carolina Budget and Control Board,
Employee Insurance Program and BlueCross and
BlueShield of South Carolina,.....Respondents.

CERTIFICATE OF COUNSEL

The undersigned certified that this Final Brief complies with Rule 211(b), SCACR.

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Employee Insurance Program and BlueCross and
BlueShield of South Carolina,.....Respondents.

PROOF OF SERVICE

I certify that I have served the Respondents' Final Brief on Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees by depositing a copy of it in the United States mail, postage prepaid on August 30, 2011, address to his attorneys of record John A. Massalon, Esquire, Post Office Box 859, Charleston, South Carolina 29402; and Thomas P. Grissette, Jr., Esquire, 1037 Chuck Dawley Blvd., Building A, Mt. Pleasant, South Carolina 29464.

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Circuit Court Case No. 2009-CP-10-7404
S.C. Court of Appeals Case No. 2011183026

Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees, Appellant,

v.

South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina, Respondents.

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ARGUMENT

A. THE LOWER COURT SHOULD HAVE DENIED THE MOTION FOR SUMMARY JUDMENT BECAUSE AS A MATTER OF LAW, EXHAUSTION IS NOT APPLICABLE TO THE CLAIMS MADE IN THE CIRCUIT COURT CASE

Appellant first takes this opportunity to refer the court to a recent decision of the South Carolina Supreme Court, which has just come to the attention of Appellant's counsel, reversing a case cited in Appellant's Brief, Stinney v. Sumter School District 17, 382 S.C. 352, 675 S.E.2d 760 (Ct. App. 2009). Stinney v. Sumter School District 17, 391 S.C. 547, 707 S.E.2d 397 (2011). In that decision, the Supreme Court explained, in *dicta*, that when a litigant invokes the original jurisdiction of the circuit court to adjudicate a claim for which "an administrative remedy is not available for the injury suffered, the doctrine of exhaustion is not applicable." Id. at 551, n.1, 675 S.E.2d at 399, n.1.

Allen's Complaint invoked the original jurisdiction of the circuit court, and includes claims for which "administrative remedies" are not available. This civil action was filed as a class action seeking declaratory and injunctive remedies, it does not seek a refund for "claims for benefits" – the statutory violation for which the legislature has provided the administrative remedy relied upon by Respondents. (R. pp. 16-23). Section 1-11-710(C) of the South Carolina Code provides that "*claims for benefits* under any self-insured plan of insurance offered by the State to state and public school district employees and other eligible individuals must be resolved by procedures established by the board [South Carolina Budget and Control Board], which shall constitute the exclusive remedy for these claims, subject only to appellate judicial review consistent with the standards provided in Section 1-23-380." S.C. Code Ann. § 1-11-710(C) (emphasis added). Section 1-23-380 entitled "[j]udicial review upon exhaustion of

administrative remedies" "does not limit utilization of or the scope of judicial review *available under other means of review, redress, relief,* or trial de novo provided by law." S.C. Code Ann. § 1-23-380 (A) (Supp. 2009).

As referenced in Stinney, this does not mean that any litigant in an administrative process can bring a separate suit to collaterally attack the findings of the administrative bodies. "Res judicata still applies in the administrative setting, and such determinations *may* bar subsequent litigation." Id. (citing Earle v. Aycock, 276 S.C. 471, 475, 279 S.E.2d 614, 616 (1981) (administrative decision can have preclusive effect in collateral litigation)) (emphasis added). However, in this case, the administrative process, prior to ever reaching even the ALC, took so long that Allen was faced with a potential statute of limitations defense should he await the conclusion of the administrative process. The health insurance claim which serves as the origin of the merits of this case was first denied by Blue Cross Blue Shield on August 28, 2008. (R. pp. 176, 182-83). Allen complied with the deadlines imposed by Blue Cross at this first stage of the internal appeal process, and had not even received a decision on the very first level request for reconsideration of the initial denial by the time of the filing of the civil action Complaint in late November 2009 – approximately two years from the date of the first claim for diabetes education by Jane Doe. (R. pp. 175-80).

In response to the Complaint, EIP filed a Motion to Dismiss and Allen opposed said motion in a Memorandum in Opposition and supporting Affidavits regarding the ongoing administrative process on February 26, 2010. (R. pp. 35-135) (R. pp. 149-293). Further, at the time of that February 26, 2010 filing, Blue Cross had yet to issue a decision on the very first level of the "administrative process." (R. p. 180). It was not

until two days before the August 26, 2010 hearing on the EIP's second attempt to dismiss this case -- its Motion for Summary Judgment, the grant of which is the basis of this appeal-- that the EIP, for the very first time, explained why it contended that the diabetes mandate statute did not apply to the State Health Plan. (R. pp. 571-72) (R., pp. 453-466, 465-66).[1]

As explained in Stinney, a final decision by this court on appeal from the ALC in the parallel administrative case that the EIP is not bound to follow the diabetes insurance mandate, S.C. Code Ann. § 38-71-46, *may* have preclusive effect on this civil action. However, should the EIP's determination that, as a matter of law, it is not subject to the diabetes insurance mandate ultimately be rejected, that conclusion of law would greatly impact this case for class and injunctive relief. And, because exhaustion is not applicable to the claims made in this civil action, the doctrine of exhaustion is not applicable. The lower court's order granting summary judgment and dismissing this case *with prejudice* should be reversed.

---

[1] By letter dated August 24, 2010, the EIP Appeals Committee wrote Appellant that it was denying his claim and again stated summarily that S.C. Code § 38-71-46 did not apply to the State Health Plan. (R. p. 465-66). The underlying basis for the conclusion that the diabetes coverage mandate did not apply to the State Health Plan was explained (for the first time) as follows:

> Lastly, the Committee noted the repeated assertions regarding S.C. Code 38-71-46 and Claimant's attorney's assertion that no one has explained why it does not apply to the State Health Plan. While the Committee noted the alternative methods for obtaining diabetes education noted above, the Committee also observed the Department of Insurance and the General Assembly *historically have acknowledged* the Department [of Insurance] has no jurisdiction over EIP. EIP is not a health insurance issuer under the Code. In the areas on which the General Assembly has wanted to include EIP in the Accident and Health Insurance provisions of Title 38, Chapter 31, it has specifically said so. Therefore, because 38-71-46 does not refer to EIP or the State Health Plan, it does not apply to the State Health Plan.

(emphasis added). (R. p. 466, n.22). That explanation contains a single footnote which references S.C. Code Ann. §1-11-780 -- a statute addressing "mental health coverage" – presumably as the legal authority for the proposition that the South Carolina Department of Insurance has no jurisdiction over the South Carolina State Budget and Control Board's Employee Insurance Program .

B. WHETHER THE TRIAL COURT SHOULD HAVE ISSUED A STAY ORDER PENDING THE OUTCOME OF THE ADMINISTRATIVE CASE IS PRESERVED FOR APPEAL.

Contrary to the argument by Respondents, the record reflects that the Appellant raised the propriety of a stay prior to entry of judgment in the lower court. A "party must file [a Rule 59(e), SCRCP] motion when an issue or argument has been raised, but not ruled on, in order to preserve it for appellate review." Elam v. South Carolina Dep't of Transp., 361 S.C. 9, 24, 602 S.E.2d 772, 780 (2004). Because Appellant raised this issue and reference to a stay was omitted from the lower court's summary judgment order, including it in the Motion to Alter or Amend pursuant to SCRCP, Rule 59(e) was proper and necessary. (R. pp. 4-13, 508-09). The Rule 59(e) motion was denied, and therefore that issue was raised and ruled upon. (R. pp.2-3).

Some procedural history of the motions made before the lower court is relevant to the discussion of this issue. The EIP filed a Motion to Dismiss and for Judgment on the Pleadings in lieu of Answering the Allen Complaint filed on November 25, 2009. (R. pp.35-135). Said motion was based on grounds of failure to exhaust administrative remedies. Allen filed Affidavits and a Memorandum in Opposition to the Motion to Dismiss. (R. pp. 149-293). The motion was heard on March 4, 2010 by the Hon. Markley Dennis, and the court issued an Order denying the Motion. (R. pp. 14-15). The EIP filed its Answer, and in response to Allen's serving written discovery requests, the EIP filed a Motion for Protective Order and Motion for Summary Judgment, without providing any responses to discovery. (R. pp. 294-320) (R. pp. 321-431). In response, Allen filed a Motion to Compel and a Motion to Stay Decision on Motion for Summary Judgment pending discovery, and filed memoranda in support of its motions and in

opposition to the EIP's motion for protective order and for summary judgment. (R. pp. 468-507). Practically, there had been no change or progression of the civil action between the filing of first Motion to Dismiss and the Motion for Summary Judgment, the grant of which is now on appeal.

As nothing had changed in the case, Allen did not copy his legal argument from the earlier filed memorandum in opposition to the EIP's motion to dismiss on the identical issue, and expressly referenced the arguments made in opposition to the EIP's assertion of requirement to exhaust administrative remedies. (R. p. 501). Specifically, the memorandum stated:

> The issue of exhaustion of administrative remedies, which Defendants assert is a basis for summary judgment, was fully briefed and argued pursuant to Defendants' motion to dismiss and for judgment on the pleadings, which, as mentioned above, were denied. Defendant is now attempting a second bite at the apple by again asserting the issue of exhaustion of administrative remedies as a purported basis for summary judgment. Plaintiff incorporates by reference Plaintiff's Memorandum in Opposition to Defendants' Motion to Dismiss, and the exhibits/affidavits attached thereto, in opposition to this purported basis for summary judgment.

Id. That brief relied on and discussed in detail the South Carolina Court of Appeals' decision in Capital City Ins. Co. v. BP Staff, Inc., 382 S.C. 92, 674 S.E.2d 524 (S.C. Ct. App. 2009), wherein this Court held that where a party would be harmed by the running of the statute of limitations or otherwise prejudiced if its claim is dismissed on exhaustion of administrative remedies, and the court has determined that resolution of the administrative proceeding would impact the circuit court case, then the circuit court should properly consider a stay or continuance of the judicial action until the administrative proceedings have concluded. Id. at 531. (R. pp. 152-56).

At the hearing on August 26, 2010, Judge Burch heard arguments on the pending motions and subsequently issued an order granting summary judgment to the EIP and dismissing this case *with prejudice* based on a finding that Allen is required to exhaust administrative remedies. (R. pp. 4-13). Judge Burch's Order omitted any reference to consideration of staying the circuit court case until the administrative action was concluded. Id. As a result of that omission, Allen filed a Motion to Alter or Amend and argued that the court's order failed to discuss why it is not exercising its discretion to stay the civil action pending the outcome of the administrative case. (R. pp. 508-14). That Motion to Alter or Amend was denied. (R. pp. 2-3). The Respondent's argument that this issue is not preserved for review is without support.

EIP cites to the case of State v. Colf, 332 S.C. 313, 504 S.E.2d 360 (Ct. App. 1998) for the proposition that the briefing accorded the discussion of staying the case pending the outcome of administrative remedies was conclusory, and therefore did not rise to the level of "raised" before the lower court. That case, however, is distinguishable from the case at bar, and did not involve the standards for issue preservation. The issue in Colf was whether the appellate brief contained sufficient argument to preserve that issue for decision. "The purpose of Rule 59(e), SCRCP, to alter or amend the judgment[,] is to request the trial judge to 'reconsider matters properly encompassed in a decision on the merits.' "Arnold v. State, 309 S.C. 157, 172, 420 S.E.2d 834, 842 (1992) (quoting Budinich v. Becton Dickinson and Co., 486 U.S. 196, 200, 108 S.Ct. 1717, 100 L.Ed.2d 178 (1988)). It is undisputed that the Allen administrative proceeding was made known and ongoing at the time of the hearing before Judge Burch, and what the circuit

court should do with the circuit court case in light of that pending administrative action was encompassed in the merits of all issues raised before the circuit court.

C. THE LOWER COURT SHOULD HAVE STAYED THE CASE PENDING THE OUTCOME OF THE ADMINISTRATIVE PROCEEDING

The circuit court has broad discretion in its supervision over the progression and disposition of a circuit court case in the interests of justice and judicial economy. See Williams v. Bordon's Inc., 274 S.C. 275, 279, 262 S.E.2d 881, 883 (1980). "A party should not be required to 'roll the dice' on whether a collateral administrative proceeding will conclude prior to the running of an applicable statute of limitations in order to preserve a claim properly within the jurisdiction of the circuit court." Capital City Ins. Co., 382 S.C. at 105, 674 S.E.2d at 531.

Jane Doe was first diagnosed with Type I diabetes on November 27, 2007 at the age of two, and diabetic education and training was provided during her initial 3-day hospital stay. (R. pp. 175-76). In reviewing all claims for diabetic education made by Allen, Defendants have denied three other such claims dating back to December 17, 2007. (R. p. 179). In light of the State of South Carolina board/agency being named as a Defendant, the undersigned made the determination to commence this action within two (2) years of the date of diagnosis, so as not to risk missing the two-year statute of limitations often applicable to claims against the State or State agencies. Allen should not be prejudiced by a decision to protect himself against all statute of limitations defenses, particularly when there is no guidance in the law of whether the Administrative

Law Court has the power to grant the relief requested by the Plaintiffs, and the key legal question at issue has not been ruled upon by any court.[2]

In South Carolina Dept. of Consumer Affairs v. Foreclosure Specialists, Inc., 390 S.C. 182, 700 S.E.2d 468 (Ct. App. 2010), the court held that the ALC did not in fact have the power to grant the Dept. a refund of fees collected in violation of the Consumer Credit Counseling Act, and that any action for such relief should have been brought in circuit court. While admittedly addressing a different statutory scheme -- the Consumer Credit Counseling Act, the case illustrates the risk and difficulty of predicting where the lines fall between the jurisdiction of the ALC and the circuit court. The scope and meaning of the statute on which the EIP relies, S.C. Code Ann. § 1-11-710(C) has never been addressed by any published opinion, and both the applicability of that statute and the diabetes mandate statute are novel issues of law.

The court in Capital City held that where a party would be harmed by the running of the statute of limitations or otherwise prejudiced if its claim is dismissed on exhaustion of administrative remedies, and the court has determined that resolution of the administrative proceeding would impact the circuit court case, then the circuit court should properly consider a stay or continuance of the judicial action until the administrative proceedings have concluded. Id. at 531. While the outcome of the administrative proceeding could moot this case; another possible outcome is that the ALC (or the South Carolina Court of Appeals) determines the ALC does not have the

[2] Despite Allen commencing both the civil action and administrative action in late 2009 and early 2010, respectively, to date no court has made any ruling on the substantive question of law at issue in this case -- the applicability of the South Carolina diabetes mandate to the State Health Plan. Two circuit court judges have been presented with the issue, and both made procedural rulings which avoided the necessity of ruling on the question of law. Briefing is completed on the substantive issue also pending the ALC, but no decision has been rendered as of the date of this Reply.

jurisdiction to award the relief requested and that the plaintiffs should, instead, be in circuit court. This is the classic *catch-22* for a plaintiff, and this court should reverse the order granting summary judgment and remand the case to the circuit court to enter an order staying the case pending the final outcome of the administrative proceeding (including all appeals).

CONCLUSION

Based on the foregoing, the lower court's order should be reversed.

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August 31, 2011

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

Paul M. Burch, Circuit Court Judge

Circuit Court Case No. 2009-CP-10-7404
S.C. Court of Appeals Case No. 2011183026

Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees or retirees,.....Appellant,

v.

South Carolina Budget and Control Board,
Employee Insurance Program.....Respondent.

CERTIFICATE OF COUNSEL

The undersigned certified that the Final Reply complies with Rule 211(b), SCACR.

August 31, 2011

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Employee Insurance Program.....Respondent.

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I certify that I have served the Final Brief and Final Reply of Appellant on Respondent of record by depositing a copy of it in the United States Mail, postage prepaid, on September 1, 2011, addressed to their attorneys of record, Theodore D. Willard, Jr., Montgomery Willard, LLC, P.O. Box 11886, Columbia, SC, 29211 and Kelly H. Rainsford, State Budget & Control Board, 1201 Main Street, Suite 300, Columbia, SC 29201.

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THIS OPINION HAS NO PRECEDENTIAL VALUE. IT SHOULD NOT BE CITED OR RELIED ON AS PRECEDENT IN ANY PROCEEDING EXCEPT AS PROVIDED BY RULE 268(d)(2), SCACR.

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees, Appellant,

v.

South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina, Respondents.

Appellate Case No. 2011-183026

Appeal From Charleston County
Paul M. Burch, Circuit Court Judge

Unpublished Opinion No. 2012-UP-433
Heard May 9, 2012 – Filed July 18, 2012

AFFIRMED

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Theodore DuBose Willard, Jr., of Montgomery Willard, LLC, of Columbia, for Respondent Blue Cross and Blue Shield of South Carolina; Kelly Hunter Rainsford, of

Columbia, for Respondent South Carolina Budget and Control Board Employee Insurance Program.

PER CURIAM: Jeffrey Allen appeals the circuit court's grant of summary judgment in favor of the South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina. He argues the circuit court erred in finding he was required to exhaust his administrative remedies before pursuing a claim in circuit court. He also contends the circuit court erred in not staying the circuit court litigation pending the resolution of the matter in the Administrative Law Court. We affirm pursuant to Rule 220(b)(1), SCACR, and the following authorities:

As to the issue of staying the circuit court proceedings: *Tallent v. S.C. Dep't of Transp.*, 363 S.C. 160, 165, 609 S.E.2d 544, 546 (Ct. App. 2005) ("A party cannot use a motion to reconsider, alter[,] or amend a judgment to present an issue that could have been raised prior to the judgment but was not."), *rev'd sub nom. on other grounds, Hardin v. S.C. Dep't of Transp.*, 371 S.C. 598, 641 S.E.2d 437 (2007); *MailSource, LLC v. M.A. Bailey & Assocs., Inc.*, 356 S.C. 370, 374, 588 S.E.2d 639, 641 (Ct. App. 2003) ("A party cannot raise an issue for the first time in a Rule 59(e), SCRCP motion which could have been raised at trial.").

As to whether the circuit court erred in requiring Allen to exhaust his administrative remedies: *Smith v. S.C. Ret. Sys.*, 336 S.C. 505, 523, 520 S.E.2d 339, 349 (Ct. App. 1999) ("The question of whether exhaustion of administrative remedies is required is a matter within the sound discretion of the trial court that will not be disturbed on appeal absent an abuse of that discretion."); *id.* ("An abuse of discretion occurs where the trial court is controlled by an error of law or where the [c]ourt's order is based on factual conclusions without evidentiary support."); *id.* at 527, 520 S.E.2d at 351 ("[A] court ordinarily will refuse to grant a declaratory judgment where a special statutory remedy has been provided."); *id.* ("'Gratuitous interference' in the administrative process should be avoided." (quoting *Williams Furniture Corp. v. S. Coatings & Chem. Co.*, 216 S.C. 1, 7-8, 56 S.E.2d 576, 579 (1949))); S.C. Code Ann. § 1-11-710(C) (2005) (stating "claims for benefits under any self-insured plan of insurance offered by the State to state and public school district employees and other eligible individuals must be resolved by procedures established by the board, which shall constitute the exclusive remedy for these claims . . .").

AFFIRMED.

PIEPER, KONDUROS, and GEATHERS, JJ., concur.

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

Paul M. Burch, Circuit Court Judge

Circuit Court Case No. 2009-CP-10-7404
S.C. Court of Appeals Case No. 2011183026

Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees, Appellant,

v.

South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina, Respondent.

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PETITION FOR REHEARING EN BANC

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STATEMENT OF ISSUES

1. This is a matter of exceptional importance as it impacts public employees in South Carolina and their access to judicial determination on the applicability of a diabetes statutory mandate to the state insurance plan.
2. In affirming the grant of summary judgment with prejudice against the Appellant, this Court's opinion failed to address the differences between the claims alleged in this civil action with those subject to the Administrative Law Court proceeding ("ALC") (which has been pending and fully briefed and

awaiting action by the ALJ for eighteen (18) months), and therefore whether the differences in those claims render the exhaustion requirement in S.C. Code Ann. § 1-11-710(C) inapplicable to this civil action.

ARGUMENT

1. *This is matter of exceptional importance as it impacts public employees in South Carolina and their access to judicial determination on the applicability of a diabetes statutory mandate to the state insurance plan.*

Due to the delays Appellant has experienced within the administrative process, this Court should have reversed the grant of summary judgment, and at a minimum, remanded the case for entry of a stay pending the outcome of the Administrative Law Court action. "Protecting against abusive delay *is* an interest of justice." *Martel v. Clair*, 132 S.Ct. 1276, 1286 (2012). The SC General Assembly mandated insurance coverage related to diabetes, a condition which affects nearly 10% of South Carolinians (R. pp. 17-18). Respondents unilaterally choose to ignore the legistlative mandate and do not provide the insurance coverage required. The ultimate question in this matter is whether the Respondents can overrule the SC General Assembly.

Appellant, Jeffrey D. Allen (referred to herein as "Appellant") is an employee of a local South Carolina school district and an insured/member of the State Health Plan (referred to herein as the "Plan"). (R. p. 170). His daughter (referred to herein as "Jane Doe"), a dependant covered by the Plan, was diagnosed with Type I Diabetes on November 27, 2007 at the age of two (2) years old. (R. pp. 175-76). Appellant submitted claims under the Plan for coverage of the cost of outpatient diabetes training and education in 2007 and in 2008, but Blue Cross and Blue Shield of South Carolina and the

South Carolina Budget and Control Board Employee Insurance Program (referred to herein as "Respondents") denied the claims on the basis that the Plan does not include coverage for education or training for diabetes. (R. pp. 175-80).

After attempting to proceed with the agency appeals process for some time and after getting no explanation of the denial, Appellant commenced the instant lawsuit on November 25, 2009, alleging, *inter alia*, that the Respondents' denial of the claim violated the statutory mandate for outpatient diabetes training and education contained in S.C. Code Ann. § 38-71-46[1], and that the case should be certified as a class action. (R. pp. 16-22).

---

[1] S.C. Code Ann. § 38-71-46 provides (with emphasis added):

> **Diabetes Mellitus coverage in health insurance policies, diabetes education.**
> (A) On or after January 1, 2000, *every* health maintenance organization, ***individual and group health insurance policy, or contract issued or renewed in this State must provide coverage for*** the equipment, supplies, Food and Drug Administration-approved medication indicated for the treatment of diabetes, and ***outpatient self-management training and education for the treatment of people with diabetes mellitus***, if medically necessary, and prescribed by a health care professional who is legally authorized to prescribe such items and who demonstrates adherence to minimum standards of care for diabetes mellitus as adopted and published by the Diabetes Initiative of South Carolina. This subsection does not prohibit a health maintenance organization or an individual or a group health insurance policy from providing coverage for medication according to formulary or using network providers. Coverage must not be denied unless the health care professional demonstrates a persistent pattern of failure to adhere to the minimal standards of care and unless the health maintenance organization or insurer has first provided written notice to the health care professional that coverage will be denied if the health care professional fails to adhere to the minimal standards of care.
>
> (B) Services and payment for diabetes education programs shall conform to regulations of the Health Care Financing Administration, US Department of Health and Human Services, pursuant to Section 4105 of the Balanced Budget Act of 1997. Diabetes outpatient self-management training and education shall be provided by a registered or licensed health care professional with certification in diabetes by the National Certification Board of Diabetes Educators, or other accredited program approved by the Diabetes Initiative of South Carolina, or by the Diabetes Control Program of the SC Department of Health and Environmental Control in order to meet the needs of rural communities wherein certified health care professionals providing this service are not available.
>
> (C) Nothing contained in this section may be construed to affect in any way the ability of a managed care plan to credential or re-credential a provider.

In response to receiving written discovery from Appellant and in lieu of answering it, Respondents filed a motion for summary judgment. (R. pp. 294-320); (R. pp. 432-37); (R. pp. 321-431); (R. pp. 439-67). Appellant filed a motion to compel discovery responses, a motion to stay decision on Respondents' motion for summary judgment. (R. pp. 468-91); (R. pp. 492-507), and opposed the motion for summary judgment. On the eve of the circuit court hearing in August 2010, for the very first time, the SC Budget and Control Board Employee Insurance Program issued its decision attempting to explain why S.C. Code Ann. § 38-71-46 did not apply to the State Insurance Plan. (R.pp. 453-66). By this time, it had been over two (2) years since the date of Apellant's last claim denial, and over 18 months since Appellant had begun to navigate the internal agency appeals process prior to even being able to submit the appeal to the Administrative Law Court.

In the circuit court, the hearing was held on August 26, 2010, and the trial court denied Appellant's motions and granted Respondents' motion for summary judgment dismissing Appellant's Complaint with prejudice. (R. pp. 554-92); (R. pp. 4-13). This appeal was taken.

Respondents delayed this matter by taking eighteen (18) months from the Appellant's first objection to explain their position on why the diabetes mandate did not apply to them, and Appellant has now waited an additional eighteen (18) months for the ALC to set this matter for hearing or decide it. (Briefing there was fully complete as of March 3, 2011, and as of the date of this Petition, August 2, 2012, the ALC had not set a hearing nor issued its decision.)

(D) For purposes of this section: "***Health insurance policy" means a health benefit plan***, contract, or evidence of coverage providing health insurance coverage as defined in Section 38-71-670(6) and Section 38-71-840(14).

"A party should not be required to 'roll the dice' on whether a collateral administrative proceeding will conclude prior to the running of an applicable statute of limitations in order to preserve a claim properly within the jurisdiction of the circuit court." *Capital City Ins. Co. v. BP Staff, Inc.*, 674 S.E.2d 524, 531 (S.C. Ct. App. 2009). The court in *Capital City* held that where a party would be harmed by the running of the statute of limitations or otherwise prejudiced if its claim is dismissed for failure to exhaust administrative remedies, and the court has determined that resolution of the administrative proceeding would impact the circuit court case, then the circuit court should properly consider a stay or continuance of the judicial action until the administrative proceedings have concluded. *Id.* While the outcome of the administrative proceeding could moot the instant lawsuit, another possible outcome is that the ALC (or possibly this Court on appeal from the ALC) determines the ALC does not have the power to grant the relief requested and that the issues should be decided by the circuit court. This is the classic *catch-22* for a plaintiff, and for this reason this Court should rehear this matter and reverse the grant of summary judgment. Appellant should not be prejudiced by his decision to protect himself (and all putative class members) against a possible statute of limitations defense, particularly when there is no guidance in the law of whether the ALC has the power to grant the relief requested in the instant lawsuit, including: (1) certification of a class; (2) a declaration that the Plan violates S.C. Code Ann. § 38-71-46; (3) a declaration of the future rights of the putative class members with regard to claims for diabetes education and training under the Plan; (4) reformation of the Plan to comply with S.C. Code Ann. § 38-71-46; (5) an injunction to stop the Respondents from continuing their unlawful actions in the future; (6) disgorgement and

return of all profits and/or monies which should have been paid to the putative class members; and (7) costs and attorneys' fees.

2. *In affirming the grant of summary judgment with prejudice against the Appellant, this Court's opinion failed to address the differences between the claims alleged in this civil action with those subject to the Administrative Law Court proceeding (which has been pending and fully briefed and awaiting action by the ALJ for eighteen (18) months), and therefore whether the differences in those claims render the exhaustion requirement in S.C. Code Ann. § 1-11-710(C) inapplicable to this civil action.*

This Court's opinion did not address the differences between what is subject to the administrative process and the causes of action asserted in the instant lawsuit. The causes of action asserted in the instant lawsuit are not "claims for benefits" within the meaning of section 1-11-710(C), and continuing with the administrative appeal would not provide Appellant with an adequate remedy.

In the instant lawsuit Appellant seeks: (1) certification of a class; (2) a declaration that the Plan violates S.C. Code Ann. § 38-71-46; (3) a declaration of the future rights of the putative class members with regard to claims for diabetes education and training under the Plan; (4) reformation of the Plan to comply with S.C. Code Ann. § 38-71-46; (5) an injunction to stop the Respondents from continuing their unlawful actions in the future; (6) disgorgement and return of all profits and/or monies which should have been paid to the putative class members; and (7) costs and attorneys' fees. (R. p. 22). The potential result in favor of Appellant from the pending administrative proceeding would not provide the relief sought by Appellant and the putative class members in the instant lawsuit.

Section 1-11-710(C) provides that "*claims for benefits* under any self-insured plan of insurance offered by the State to state and public school district employees and other

eligible individuals must be resolved by procedures established by the board [South Carolina Budget and Control Board], which shall constitute the exclusive remedy for these claims, subject only to appellate judicial review consistent with the standards provided in Section 1-23-380." S.C. Code Ann. § 1-11-710(C) (emphasis added). Section 1-23-380 entitled "Judicial Review Upon Exhaustion of Administrative Remedies" "does not limit utilization of or the scope of judicial review *available under other means of review, redress, relief,* or trial de novo provided by law." S.C. Code Ann. § 1-23-380(A) (Supp. 2009) (emphasis added).

If the denial of Appellant's claims for diabetes education and training benefits is reversed in the ALC, then presumably Appellant would receive coverage only for his diabetes education claims. However, neither the Appellant's benefit plan nor the putative class members' benefit plans would necessarily be reformed to provide the statutorily mandated insurance coverage for diabetes education. Appellant's prevailing in the administrative process would not require Respondents to review all denials made in violation of the diabetes education mandate statute since its enactment in 2000. Appellant's prevailing in the administrative process would not enjoin Respondents from violating the diabetes mandate in the future, nor force disgorgement of revenues and profits related to the illegal conduct.

"A party is not required to exhaust administrative remedies if the issue is one that cannot be ruled upon by the administrative body." *Capital City Ins. Co. v. BP Staff, Inc*, 674 S.E.2d 524, 529 (S.C. Ct. App. 2009) quoting *Charleston Trident Home Builders, Inc. v. Town Council of Town of Summerville*, 632 S.E.2d 864, 867 (S.C. 2006) (citing *Ward v. State*, 538 S.E.2d 245 (S.C. 2000)); *see also Stinney*, 675 S.E.2d at 763

(recognizing that inadequacy of the administrative appeal is an exception to the general rule requiring exhaustion). The purpose of the exhaustion requirement, to allow the agency to render a final decision and set forth its reason for denying the diabetes education claim, would not assist the Court in this case. The alleged wrong – violation of the statutory mandate as to an entire class of persons—is not one which the administrative process was designed to address.

CONCLUSION

For the reasons discussed herein, Appellant respectfully requests that the Court rehear this matter en banc.

Respectfully submitted,

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

Paul M. Burch, Circuit Court Judge

Circuit Court Case No. 2009-CP-10-7404
S.C. Court of Appeals Case No. 2011183026

Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees or retirees,.....Appellant,

v.

South Carolina Budget and Control Board,
Employee Insurance Program.....Respondent.

PROOF OF SERVICE

I certify that I have served the Appellant's Petition for Rehearing en Banc on Respondent of record by depositing a copy of it in the United States Mail, postage prepaid, on August 2, 2012, addressed to their attorneys of record, Theodore D. Willard, Jr., Montgomery Willard, LLC, P.O. Box 11886, Columbia, SC, 29211 and Kelly H. Rainsford, State Budget & Control Board, 1201 Main Street, Suite 300, Columbia, SC 29201.

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August 1, 2012

VIA OVERNIGHT MAIL
The Honorable Jeanette Barber
Clerk
South Carolina Court of Appeals
1015 Sumter Street
PO Box 11629
Columbia, SC 29211

RE: Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees v. SC Budget & Control Board
SC Court of Appeals Case No.: 2011183026
Circuit Court Case No.: 09-CP-10-7404
File No.: 595-1

Dear Ms. Barber:

With regard to the above referenced matter, enclosed please find the original and six (6) copies of the Petition for Rehearing en Banc of Appellant, Certificate of Service, and filing fee in the amount of $25.00. By copy of this letter to all counsel of record, I am serving them with a copy of the same. If you have any questions, please do not hesitate to give me a call.

With kind regards, I am

Sincerely,

WILLS MASSALON & ALLEN LLC

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SC Court of Appeals

Enclosures

cc: Terry E. Richardson, Jr., Esquire
Theodore D. Willard, Jr., Esquire
Kelly H. Rainsford, Esquire

The South Carolina Court of Appeals

Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees, Appellant,

v.

South Carolina Budget and Control Board Employee Insurance Program and Blue Cross and Blue Shield of South Carolina, Respondents

Appellate Case No. 2011-183026

ORDER

After careful consideration of the petition for rehearing, the Court is unable to discover that any material fact or principle of law has been either overlooked or disregarded, and hence, there is no basis for granting a rehearing. Accordingly, the petition for rehearing is denied.

Daniel F. Pieper J.

J.

John D. Dalton J.

Columbia, South Carolina

cc:
John A. Massalon
Theodore DuBose Willard, Jr.
Kelly Hunter Rainsford

FILED
19 September 2013