

THE STATE OF SOUTH CAROLINA
In the Supreme Court

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APPEAL FROM THE ADMINISTRATIVE LAW COURT

Shirley C. Robinson, Administrative Law Judge

SC Supreme Court

Appellate Case No. 2012-213186

Jeffrey D. Allen, on behalf of Jane Doe

.....Appellant,

v.

South Carolina Public Employee Benefit Authority,
Employee Insurance Program

Respondent.

RECORD ON APPEAL
VOLUME II

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VOLUME II

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**BEFORE THE STATE BUDGET AND CONTROL BOARD,
EMPLOYEE INSURANCE PROGRAM**

Subscriber: Jeffrey D. Allen)

Dependent: [REDACTED] (Daughter))

Plan: South Carolina Group Health)
Benefits Plan)

FINAL DECISION OF
THE APPEALS COMMITTEE

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, [REDACTED] (Dependent).

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 diabetes⁶ 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 HIPAA [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 2008¹⁵ 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, Heart 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.

- 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 for one 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, 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 to a \$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 in one Plan year Coinsurance of \$2,000 for Covered Medical Expenses, or Coinsurance of \$4,000 for Covered Medical Expenses incurred in one 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 Supplement 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 one 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 one 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 one Plan Year, or Coinsurance of \$4,000 for Covered Medical Expenses have been incurred in one 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 therapist licensed in the appropriate professional discipline;
- 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 Administrator 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 than 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

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 between the ages of 35 through 39; one mammogram every year between the ages of 40 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.

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

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 Smear

The Plan will pay a benefit for one Pap Smear per female subscriber or Dependent ages 18 through 65 per Benefit Year, 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 the following immunizations at the appropriate ages: diphtheria-tetanus-pertussis (DTP); polio; hepatitis B; hemophilus; measles-mumps-rubella (MMR); chickenpox; Pneumococcal Conjugate, and other immunizations 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, non-sedating 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 preferred brand name drug or a \$25 co-payment; (b) the lesser of the allowance established for a non-preferred 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) of 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.

Exhibit D



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- Delivered, August 30, 2010, 10:57 am, CHARLESTON, SC 29401
- Notice Left, August 28, 2010, 1:47 pm, CHARLESTON, SC 29402
- Arrival at Unit, August 28, 2010, 1:46 pm, CHARLESTON, SC 29402

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John A. Massalon, Esq.
Wills, Massalon & Allen, LLC
P.O. Box 859
Charleston, SC 29402

2. Article Number

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PS Form 3811, February 2004

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A. Signature

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[Signature]

☐ Agent

☐ Addressee

B. Received by (Printed Name)

KYNDAL HARRIS 8/30/10

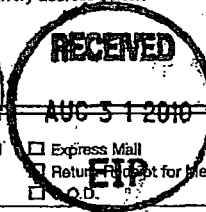
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IF YES, enter delivery address below:

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3. Service Type

☒ Certified Mail

☐ Express Mail

☒ Registered

☐ Return Receipt for Merchandise

☐ Insured Mail

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4. Restricted Delivery? (Extra Fee)

☐ Yes

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- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

John A. Massalon, Esq.
Wills, Massalon & Allen, LLC
P.O. Box 859
Charleston, SC 29402

2. Article Number

(Transfer from service label)

7099 3400 0011 4891 8912

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

COMPLETE THIS SECTION ON DELIVERY

A. Signature

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☐ Agent

☐ Addressee

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State Budget and Control Board

Employee Insurance Program

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SC BUDGET AND CONTROL BOARD

EMPLOYEE INSURANCE PROGRAM

(803) 734-0678
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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: [REDACTED]
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, [REDACTED]. 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

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: [REDACTED] (Daughter))
Plan: South Carolina Group Health)
Benefits Plan)

**FINAL DECISION OF
THE APPEALS COMMITTEE**

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, [REDACTED] (Dependent).

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 diabetes⁶ 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 2008¹⁵ 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, Heart 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.

- 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 for one 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, or Covered Person, who does not obtain Pre-certification from the Utilization Preview 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 to a \$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 in one Plan year Coinsurance of \$2,000 for Covered Medical Expenses, or Coinsurance of \$4,000 for Covered Medical Expenses incurred in one 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 Supplement 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 one 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 one 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 one Plan Year, or Coinsurance of \$4,000 for Covered Medical Expenses have been incurred in one 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 therapist licensed in the appropriate professional discipline;
- 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 Administrator 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 1 st infusion
.....	\$ 50,000 2 nd 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 than 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 between the ages of 35 through 39; one mammogram every year between the ages of 40 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 Smear

The Plan will pay a benefit for one Pap Smear per female subscriber or Dependent ages 18 through 65 per Benefit Year, 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 the following immunizations at the appropriate ages: diphtheria-tetanus-pertussis (DTP); polio; hepatitis B; hemophilus; measles-mumps-rubella (MMR); chickenpox; Pneumococcal Conjugate, and other immunizations 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 preferred brand name drug or a \$25 co-payment; (b) the lesser of the allowance established for a non-preferred 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) of 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.

Sub. Name: Allen, Jeffrey D. SSN: [REDACTED] 1184 BIN:36961363
(Patient Name: Allen, Eva)

Attorney: John Massalon - 843-727-1144, Wills Massalon & Allen LLC

Claims Processor:
BCBS State Claims Unit - AX B10
I-20 at Alpine Road
Columbia, South Carolina 29260

CC Address:
John A. Massalon
134 Meeting Street, Suite 100
Charleston, SC 29401

Type: HA ☒ EE ☐ LTD ☐ LTD(Incap) ☐

Item	Due	Filed	Access	Unix	Comments
Appeal Received		7/1/10	7/2/10	7/2/10	
Need Authorization Y ☐ N ☒		n/a			
Internal Research Completed		7/2/10			
Letter upon Receiving Appeal		7/2/10			
Requested Claim File		7/2/10	7/2/10		
Claim File Received	7/12/10				
ISSUE:	Denial of benefits for diabetes education.				
APPLICABLE PLAN ¶¶	9.O, 9.BB				
LEVEL II STANDARD (basis for prior denial)	education not a covered expense under 9.O and 9.BB.				
Committee Meeting: / /					
ALC Affidavit					
ALC Memo to File					
ALC Pleadings Served					

NOTES/ TELEPHONE LOG

NAME	DATE	INFO	STAFF

Health Appeals Fact Sheet

Date: 8/19/2010

EIP Committee Member	Approved	Denied	Other
Jane Britton			
Nancy Higgins			
Thelma Hopkins			
Chuck Wilson		<i>W</i>	
Laura Smoak			
Patient Name:	[REDACTED]		
Member Name:	Jeffrey D. Allen		
Identification No.:	[REDACTED] 1184		
Third Party Claims Processor:	BCBS: ☒ Medi-Call: ☐ BCBS Dental: ☐ MUSC-Options: ☐ BlueChoice: ☐ Medco: ☐ Cigna: ☐ APS: ☐ Other: ☐		
Issue:	Denial of benefits for diabetes education.		
Claim File Received:	Yes: ☒		
Information Submitted by Claimant:	Yes: ☒ List: Appeal letter Court documents		
Additional Comments:	Subscriber has filed suit in Circuit Court. Case is ongoing, but sub is going through EIP's appeal process as well.		

Health Appeals Fact Sheet

Date: 8/19/2010

EIP Committee Member	Approved	Denied	Other
Jane Britton			
Nancy Higgins		XNA	
Thelma Hopkins			
Chuck Wilson			
Laura Smoak			
Patient Name:	[REDACTED]		
Member Name:	Jeffrey D. Allen		
Identification No.:	[REDACTED] 184		
Third Party Claims Processor:	BCBS: ☒ Medi-Cal: ☐ BCBS Dental: ☐ MUSC-Options: ☐ BlueChoice: ☐ Medco: ☐ Cigna: ☐ APS: ☐ Other: ☐		
Issue:	Denial of benefits for diabetes education.		
Claim File Received:	Yes: ☒		
Information Submitted by Claimant:	Yes: ☒ List: Appeal letter Court documents		
Additional Comments:	Subscriber has filed suit in Circuit Court. Case is ongoing, but sub is going through EIP's appeal process as well.		

Health Appeals Fact Sheet

Date: 8/19/2010

EIP Committee Member	Approved	Denied	Other
Jane Britton			
Nancy Higgins			
Thelma Hopkins		✓	
Chuck Wilson			
Laura Smoak			
Patient Name:	[REDACTED]		
Member Name:	Jeffrey D. Allen		
Identification No.:	[REDACTED] 1184		
Third Party Claims Processor:	BCBS: ☒ Medi-Call: ☐ BCBS Dental: ☐ MUSC-Options: ☐ BlueChoice: ☐ Medco: ☐ Cigna: ☐ APS: ☐ Other: ☐		
Issue:	Denial of benefits for diabetes education		
Claim File Received:	Yes: ☒		
Information Submitted by Claimant:	Yes: ☒ List: Appeal letter Court documents		
Additional Comments:	Subscriber has filed suit in Circuit Court. Case is ongoing, but sub is going through EIP's appeal process as well.		

Health Appeals Fact Sheet

Date: 8/19/2010

EIP Committee Member	Approved	Denied	Other
Jane Britton		✓	JD
Nancy Higgins			
Thelma Hopkins			
Chuck Wilson			
Laura Smoak			

Patient Name:	[REDACTED]
Member Name:	Jeffrey D. Allen
Identification No.:	[REDACTED] 1184
Third Party Claims Processor:	BCBS: ☒ Medi-Call: ☐ BCBS Dental: ☐ MUSC-Options: ☐ BlueChoice: ☐ Medco: ☐ Cigna: ☐ APS: ☐ Other: ☐
Issue:	Denial of benefits for diabetes education.
Claim File Received:	Yes: ☒
Information Submitted by Claimant:	Yes: ☒ List: Appeal letter Court documents
Additional Comments:	Subscriber has filed suit in Circuit Court. Case is ongoing, but sub is going through EIP's appeal process as well.

Health Appeals Fact Sheet

Date: 8/19/2010

EIP Committee Member	Approved	Denied	Other
Jane Britton			
Nancy Higgins			
Thelma Hopkins			
Chuck Wilson			
Laura Smoak		<i>lms</i>	
Patient Name:	[REDACTED]		
Member Name:	Jeffrey D. Allen		
Identification No.:	[REDACTED] 1184		
Third Party Claims Processor:	BCBS: ☒ Medi-Cal: ☐ BCBS Dental: ☐ MUSC-Options: ☐ BlueChoice: ☐ Medco: ☐ Cigna: ☐ APS: ☐ Other: ☐		
Issue:	Denial of benefits for diabetes education.		
Claim File Received:	Yes: ☒		
Information Submitted by Claimant:	Yes: ☒ List: Appeal letter Court documents		
Additional Comments:	Subscriber has filed suit in Circuit Court. Case is ongoing, but sub is going through EIP's appeal process as well.		

sent by email -

10/26/09

#156060
GP

October 15, 2009

Jeffrey D. Allen

Charleston, SC 29414

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
theallenpad@gmail.com
✓ [REDACTED] 1184

RECEIVED

OCT 19 2009

EIP

Lewsky, Michele

From: Lewsky, Michele
Sent: Monday, October 26, 2009 1:18 PM
To: 'theallenpad@gmail.com'
Attachments: 2009 State Health Plan of Benefits.pdf
Good afternoon, Mr. Allen:

Per your request, attached please find a copy of the 2009 State Health Plan of Benefits document.

Sincerely,

Michele Lewsky
Program Manager
Employee Insurance Program
South Carolina Budget and Control Board
Tel. (803)734-2267

This communication, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and/or legally privileged information. If you are not the intended recipient(s), please contact the sender at (803)734-2267, or toll-free at (888)260-9430, and destroy all copies of the original message. Any unauthorized review, use, disclosure, or distribution is prohibited.

3/2/2010

RCS105N1
Mar 1,10

***** EMPLOYEE INSURANCE PROGRAM *****
- Maintain Contact Log -

RCS105M1
1 more >

SSN : [REDACTED] 1184- Name: JEFFREY D ALLEN
Phone : [REDACTED]
CHARLESTON SC 29414

*Reason : CORRESPONDENCE

Start Time : 15:31:51 Group: 5180200
Call Length: 00:01:31 Type: ACTIVE - REGULAR
Call Date : 10/22/2009
CS Rep: GESELE PRICE Dept: INCS
Last Updated by: HPRICG on: 10/22/2009

Notes :

CORR#15666:SUBSCR REQ COPY OF PLAN OF BENE DOC PER JANE BRITTON GIVE TO
MICHELLE LEWSKY TO HANDLE. 4RDED SUBSCR REQ TO MICHELLE

Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10---PF11---PF12---
confm help retrn prev next bkwd frwd left right main
Contact log displayed successfully

RCS105N1
Mar 1,10

***** EMPLOYEE INSURANCE PROGRAM *****
- Maintain Contact Log -

RCS105M1
1 more >

SSN : [REDACTED] 184 Name: JEFFREY D ALLEN
Phone : [REDACTED]
CHARLESTON SC 29414

*Reason : SUPPLIES

Start Time : 13:46:40

Group: 5180200

Call Length: 00:01:14

Type: ACTIVE - REGULAR

Call Date : 10/06/2009

CS Rep: SONJA WALTERS

Dept: INCS

Last Updated by: HNALTS on: 10/06/2009

Notes :

SPOUSE REQ PLAN OF BENEFIT DOCUMENT; ADV CAN PUT REQ IN WRITING TO EIP AND
PAY FOR EACH PAGE OR CAN SEE BA AND REVIEW DOC IN OFFICE

Enter PF1--PF2--PF3--PF4--PF5--PF6--PF7--PF8--PF9--PF10--PF11--PF12---
confm help _ retrn prev next _ bkwd frwd _ left right main
Contact log displayed successfully

2005-07-27 10:53:54

**SOUTH CAROLINA STATE BUDGET AND CONTROL BOARD
EMPLOYEE INSURANCE PROGRAM
ACTIVE NOTICE OF ELECTION (NOE)**

A. ADMINISTRATIVE INFORMATION									
CHECK ONE OF THE FOLLOWING: ☒ New Hire ☐ Transfer ☐ Change	☒ Enrollment ☐ Birth/Adoption ☐ Marriage ☐ Divorce ☐ Death ☐ Other (specify) _____		TYPE OF CHANGE ☐ Address ☐ Ineligible Dependent ☐ Involuntary loss of coverage ☐ Gain of other coverage ☐ Coordination of Benefits (Sed C)		BA USE ONLY Effective Date: <u>9-1-05</u> Group ID #: <u>51302</u> Group Name: <u>DSD2</u> ☐ Permanent Part-time Employee (20 hours)		MONEYPLUS ☒ Yes ☐ No HEALTH SAVINGS ACCOUNT (HSA) ☐ Yes ☐ No (For use with Savings Plan)		
	Date of Occurrence: _____ SSN Change - Incorrect? _____ (attach copy of card) Name Change - Prior _____								
B. ENROLLEE INFORMATION									
1. Social Security Number <u>1184</u>		2. Last Name <u>Allen</u>		3. Suffix	4. First Name <u>Jeffrey</u>		5. M.I. <u>D</u>	6. Date of Birth MM DD YYYY <u>975</u>	
7. Sex ☒ M ☐ F	8. Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed		9. Home Phone # <u>843-571-7030</u>		10. Work Phone #		11. E-mail Address		
12. Mailing Address _____		13. Apt. #	14. City <u>Ches</u>	15. State <u>SC</u>	16. ZIP Code <u>29407</u>	17. County Code <u>10</u>	18. Annual Salary <u>32,674</u>	19. Date of Hire MM DD YYYY <u>8-2-2005</u>	
C. MEDICARE AND OTHER COVERAGE INFORMATION									
LIST BELOW, YOURSELF AND ANY OTHER PERSONS TO BE COVERED WHO ARE ELIGIBLE FOR PART A AND/OR B OF MEDICARE.									
20. NAME		MEDICARE #		ENTITLED DUE TO		EFFECTIVE DATE			
				☐ AGE ☐ DISABILITY		PART A MM/DD/YYYY		PART B MM/DD/YYYY	
				☐ RENAL DISEASE					
				☐ AGE ☐ DISABILITY					
				☐ RENAL DISEASE					
DO YOU OR ANY OF YOUR FAMILY MEMBERS HAVE OTHER GROUP HEALTH COVERAGE? ☐ YES ☐ NO									
DOES THIS COVERAGE INCLUDE PHARMACY BENEFITS? ☐ YES ☐ NO									
21. NAME		INSURANCE COMPANY		POLICYHOLDER DATE OF BIRTH		EFFECTIVE DATE OF POLICY		TERMINATION DATE (IF APPLICABLE)	
IF YOU AND/OR YOUR DEPENDENTS HAVE HAD OTHER COVERAGE WITH ANOTHER CARRIER WITHIN 62 DAYS OF THIS REQUEST, PLEASE ATTACH A COPY OF YOUR CERTIFICATE OF HEALTH COVERAGE (HIPAA). THIS WILL ENSURE PROPER CREDIT FOR ANY PRE-EXISTING CONDITIONS, IF APPLICABLE.									
D. COVERAGE INFORMATION									
22. HEALTH (Refuse or select one plan and one category.)					23. DENTAL (Select One)		24. DENTAL PLUS (Select One)		
☐ Refuse ☐ Standard ☐ Savings (For non-Medicare Employees) ☐ TRICARE Supplement (For Non-Medicare Employees with TRICARE) ☒ HMO <u>Nurse Options</u>					☐ Refuse ☐ Enrollee ☐ Enrollee/Spouse ☐ Enrollee/Child(ren) ☐ Family		☐ Refuse ☐ Enrollee ☐ Enrollee/Spouse ☐ Enrollee/Child ☐ Family		
25. OPTIONAL LIFE (Refuse or enter coverage level.)		25. DEPENDENT LIFE - SPOUSE (Refuse or enter coverage level.)		27. DEPENDENT LIFE - CHILD(REN) (Select One)		28. SUPPLEMENTAL LONG TERM DISABILITY (Select One)			
☐ Refuse ☐ Coverage Level: \$ _____ (Must be in increments of \$10,000)		☐ Refuse ☐ Coverage Level: \$ _____ (Must be in increments of \$10,000)		☒ Refuse ☐ \$10,000		☒ Refuse/Cancel ☐ Plan One - 90 day benefit waiting period ☐ Plan Two - 180 day benefit waiting period			
29. BASIC LIFE/BASIC LTD: Automatically provided with health coverage. If health coverage is refused, benefits are forfeited.									

EIP Rev. 8/04

2005-07-27 10:53:56

Jeffrey Allen
NAME: [REDACTED] 1184 SSN: [REDACTED] 1184 GROUP #: 51302
PAGE 2
ACTIVE NOE FORM

E. DEPENDENT INFORMATION							
LIST SPOUSE AT ALL TIMES. LIST CHILDREN TO BE COVERED UNDER EITHER HEALTH/DENTAL OR DEPENDENT LIFE PLAN. IF THEY ARE NOT LISTED, THEY WILL NOT BE COVERED. IS YOUR SPOUSE A STATE EMPLOYEE OR EMPLOYED BY A STATE COVERED ENTITY? ☐ Yes ☐ No							
ADD (A) OR DELETE (D)	30. DEPENDENT SSN #	LAST NAME	FIRST NAME	SEX M/F	RELATION	DATE OF BIRTH MM DD YYYY	COMPLETE BELOW IF CHILD IS OVER 18
A	[REDACTED]	Allen	[REDACTED]	F	Daughter	[REDACTED] 05	☐ Full-time Student ☐ Incapacitated ☐ Full-time Student ☐ Incapacitated ☐ Full-time Student ☐ Incapacitated ☐ Full-time Student ☐ Incapacitated
IF FULL-TIME STUDENT WAS CHECKED AND YOU ARE ENROLLING THE DEPENDENT FOR THE FIRST TIME, ATTACH A FULL-TIME CERTIFICATION FROM THE SCHOOL. IF INCAPACITATED WAS CHECKED, ATTACH THE INCAPACITATED CHILD FORM.							
F. BENEFICIARY INFORMATION * REQUIRED FOR BASIC LIFE AND OPTIONAL LIFE							
BASIC LIFE OR OPTIONAL LIFE (Check one or both)	31. LAST NAME	FIRST NAME	SSN #	RELATIONSHIP	DATE OF BIRTH MM DD YYYY	PRIMARY OR CONTINGENT	
☒ BASIC LIFE ☐ OPTIONAL LIFE	Ford-Allen	Christy	[REDACTED] 3751	Wife	[REDACTED] 1973	P	
☐ BASIC LIFE ☐ OPTIONAL LIFE							
☐ BASIC LIFE ☐ OPTIONAL LIFE							
* IF BENEFICIARY IS AN ORGANIZATION OR TRUST, COMPLETE THE FOLLOWING: ORGANIZATION/TRUST ADDRESS _____ IF TRUST, DATE SIGNED _____ UNLESS OTHERWISE PROVIDED HEREIN, IF TWO OR MORE BENEFICIARIES ARE NAMED, THE PROCEEDS SHALL BE PAID IN EQUAL SHARES TO THE NAMED SURVIVORS. CONTINGENT BENEFICIARIES HAVE NO RIGHTS UNLESS ALL PRIMARY BENEFICIARIES HAVE DIED.							
32. CERTIFICATION: I have read this NOE and made the authorizations herein and have selected the coverage noted. I have provided social security numbers and documentation establishing my dependent's eligibility for the plan(s) selected. I understand that I may only cancel my coverage and/or my dependent's coverage during an open enrollment period every two years, unless otherwise provided for in the Plan. Should I refuse health coverage or fail to enroll all eligible dependents in health coverage when first eligible, I and/or all eligible dependents may only enroll during an open enrollment period, unless otherwise provided in the Plan. I also understand that I will be able to add or cancel dental coverage only during the open enrollment period every two years unless otherwise provided in the Plan. I understand and agree that all selected plans will not be effective unless and until the NOE is approved. I understand that the state reserves the right to alter benefits or premiums at any time to preserve the financial stability of the Plan.							
AUTHORIZATION: I hereby authorize my employer to deduct from my salary premiums necessary to pay for all plans selected and verify my salary when necessary for enrollment. I hereby authorize any healthcare provider, prescription drug dispenser and claims administrator to release any information necessary to evaluate, administer and process all claims for any benefits.							
Employee Signature: [Signature]						Date: 6/22/2005	
33. I hereby attest that the employee meets eligibility requirements of plan, proper premiums are being collected, form is complete and accurate, and all required documentation is attached in order to process NOE form.							
Benefits Administrator Signature: [Signature]						Date: 6/22/05	
THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS. THE AGENCY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT IN WHOLE OR IN PART. NO PROMISES OR ASSURANCES, WHETHER WRITTEN OR ORAL, WHICH ARE CONTRARY TO OR INCONSISTENT WITH THE TERMS OF THIS PARAGRAPH CREATE ANY CONTRACT OF EMPLOYMENT.							

EIP Rev. 8/04

08/20/10
13:56:40

SOUTH CAROLINA DIVISION OF INSURANCE & GRANTS SERVICES
EMPLOYEE INSURANCE PROGRAM
SUBSCRIBER INQUIRY - DEPENDENT DATA

HIS204M2
HCLARC

SSN: 247 45 1184 SUBSCR TYPE: ACTIVE - REGULAR EMP GROUP ID: 5180200
NAME: ALLEN JEFFREY D

----- D E P E N D E N T -----
SSN NAME: LAST SUFF FIRST MI DATE OF BIRTH
0876 ALLEN EVA 2005
RELATION: 22C F CHILD NATURAL MEDICARE: REASON:
PART D EFF DATE: END:

ELIGIBILITY: 1 ELIG CHILD PI DATE: DISPLAY MEDICARE (Y/N): N
STATE EMP: N GRP ID: REVIEWED: PRE EXISTING

CURRENT COVERAGE INFORMATION
STATUS EFF DATE END DATE
HEALTH A1 11/01/2008 07/31/2024
DENTAL A1 11/01/2008 07/31/2024
DL/CHILD
DL/SPOUSE
VISION

<PF11> Dependent History <PF10> Wellness Incentive
Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10---PF11---PF12---
HELP AUTH CONT ID OTINS COVR DEPND BENEF INCTV HISTC MAIN

08/20/10
13:56:08

SOUTH CAROLINA DIVISION OF INSURANCE & GRANTS SERVICES
EMPLOYEE INSURANCE PROGRAM
SUBSCRIBER INQUIRY - COVERAGE HISTORY

HIS208M3
HCLARC

SSN: [REDACTED] 1184 SUBSCR TYPE: ACTIVE - REGULAR
NAME: ALLEN JEFFREY D

CURRENT COVERAGE - HEALTH
ST: A1 PLAN BB CAT 3 EFF: 11/01/08 END: GRP: 5180200

PREVIOUS COVERAGE - HEALTH

ENTRY	DATE	ST	PLAN	CAT	RS	EFF DATE	END DATE	GROUP	SUBSCR	PART	TRANS	PROCESSOR
	10/15/08	A1	BB	3	00	09/01/08	11/01/08	H150000	AR		TT	FOSTD1
	07/28/08	A1	BB	3	00	08/01/08	09/01/08	5180200	AR		TT	COPLJ4
	07/23/08	A1	BB	3	00	01/01/07	08/01/08	5180200	AR		TT	HCOPLJ
	11/22/06	A1	HX	3	00	09/01/05	01/01/07	5180200	AR		C3	ATRE14

Enter PF1--PF2--PF3--PF4--PF5--PF6--PF7--PF8--PF9--PF10--PF11--PF12--
HELP CONT UP DOWN MAIN

08/20/10
13:56:58

SOUTH CAROLINA DIVISION OF INSURANCE & GRANTS SERVICES
EMPLOYEE INSURANCE PROGRAM
DEPENDENT COVERAGE HISTORY

HIS204M4
HCLARC

SUBSCRIBER SSN: [REDACTED] 1184

DEP SSN NAME
[REDACTED] 0876 ALLEN

REL: 22C ELIG: 1 PI DATE:

CURRENT - ST: A1 EFF DATE: 11/01/08 END DATE: 07/31/24

PREVIOUS	COVERAGE -	HEALTH
STATUS	EFF DATE	END DATE
A1	09/01/08	11/01/08
A1	08/01/08	09/01/08
A1	01/01/07	08/01/08
A1	09/01/05	01/01/07

Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10---PF11---PF12---
HELP CONT UP DOWN MAIN

*He was hired
8/2/05*

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 ST. COOPER
CHAIRMAN, HOUSE WAYS AND MEANS
COMMITTEE

FRANK W. FUSCO
EXECUTIVE DIRECTOR

July 1, 2010

John A. Massalon, Esquire
Wills, Massalon & Allen, LLC
134 Meeting Street, Suite 100
Charleston, South Carolina 29401

RE: State of South Carolina Group Health Benefits Plan
Subscriber: Jeffrey D. Allen
Patient: [REDACTED] Allen
ID#: XXX-XX-1184

Dear Mr. Massalon:

On July 1, 2010, our office received your appeal of the decision of BlueCross BlueShield of South Carolina, our claims administrator, to deny your claim for diabetes education benefits. The purpose of this letter and enclosure is to provide you with an outline of the appeals process, applicable deadlines, and your rights during this process. Please read this information carefully and completely.

Please understand that we will make every effort to process your appeal as efficiently as possible. If you need any additional information regarding this appeal process, please contact me at (803)734-3569.

Sincerely,

Rachel Robinson
Appeals Coordinator

Enclosure

1201 MAIN STREET, SUITE 300 • COLUMBIA, SOUTH CAROLINA 29201

Sub. Name: Allen, Jeffrey D. SSN: [REDACTED] 1184 BIN:36961363
(Patient Name: Allen, Eva)

Attorney: John Massalon - 843-727-1144, Wills Massalon & Allen LLC

Claims Processor:
BCBS State Claims Unit - AX B10
I-20 at Alpine Road
Columbia, South Carolina 29260

CC Address:
John A. Massalon
134 Meeting Street, Suite 100
Charleston, SC 29401

Type: HA ☒ EE ☐ LTD ☐ LTD(Incap) ☐

Item	Due	Filed	Access	Unix	Comments
Appeal Received		7/1/10	7/2/10	7/2/10	
Need Authorization Y ☐ N ☒		n/a			
Internal Research Completed		7/2/10			
Letter upon Receiving Appeal		7/2/10			
Requested Claim File		7/2/10	7/2/10		
Claim File Received	7/12/10				
ISSUE:	Denial of benefits for diabetes education.				
APPLICABLE PLAN ¶¶	9.O, 9.BB				
LEVEL II STANDARD (basis for prior denial)	education not a covered expense under 9.O and 9.BB.				
Committee Meeting: / /					
ALC Affidavit					
ALC Memo to File					
ALC Pleadings Served					

NOTES/ TELEPHONE LOG

NAME	DATE	INFO	STAFF

Health Appeals Fact Sheet

Date: 8/19/2010

EIP Committee Member	Approved	Denied	Other
Jane Britton			
Nancy Higgins			
Thelma Hopkins			
Chuck Wilson		<i>W</i>	
Laura Smoak			
Patient Name:	[REDACTED]		
Member Name:	Jeffrey D. Allen		
Identification No.:	[REDACTED] 1184		
Third Party Claims Processor:	BCBS: ☒ Medi-Cal: ☐ BCBS Dental: ☐ MUSC-Options: ☐ BlueChoice: ☐ Medco: ☐ Cigna: ☐ APS: ☐ Other: ☐		
Issue:	Denial of benefits for diabetes education.		
Claim File Received:	Yes: ☒		
Information Submitted by Claimant:	Yes: ☒ List: Appeal letter Court documents		
Additional Comments:	Subscriber has filed suit in Circuit Court. Case is ongoing, but sub is going through EIP's appeal process as well.		

Health Appeals Fact Sheet

Date: 8/19/2010

EIP Committee Member	Approved	Denied	Other
Jane Britton			
Nancy Higgins		X NA	
Thelma Hopkins			
Chuck Wilson			
Laura Smoak			

Patient Name:	[REDACTED]
Member Name:	Jeffrey D. Allen
Identification No.:	[REDACTED] 1184
Third Party Claims Processor:	BCBS: ☒ Medi-Call: ☐ BCBS Dental: ☐ MUSC-Options: ☐ BlueChoice: ☐ Medco: ☐ Cigna: ☐ APS: ☐ Other: ☐
Issue:	Denial of benefits for diabetes education.
Claim File Received:	Yes: ☒
Information Submitted by Claimant:	Yes: ☒ List: Appeal letter Court documents
Additional Comments:	Subscriber has filed suit in Circuit Court. Case is ongoing, but sub is going through EIP's appeal process as well.

Health Appeals Fact Sheet

Date: 8/19/2010

EIP Committee Member	Approved	Denied	Other
Jane Britton			
Nancy Higgins			
Thelma Hopkins		✓	
Chuck Wilson			
Laura Smoak			
Patient Name: [REDACTED]			
Member Name: Jeffrey D. Allen			
Identification No.: [REDACTED] 1184			
Third Party Claims Processor: BCBS: ☒ Medi-Cal: ☐ BCBS Dental: ☐ MUSC-Options: ☐ BlueChoice: ☐ Medco: ☐ Cigna: ☐ APS: ☐ Other: ☐			
Issue: Denial of benefits for diabetes education.			
Claim File Received: Yes: ☒			
Information Submitted by Claimant: Yes: ☒ List: Appeal letter Court documents			
Additional Comments: Subscriber has filed suit in Circuit Court. Case is ongoing, but sub is going through EIP's appeal process as well.			

Health Appeals Fact Sheet

Date: 8/19/2010

EIP Committee Member	Approved	Denied	Other
Jane Britton		✓	gfb
Nancy Higgins			
Thelma Hopkins			
Chuck Wilson			
Laura Smoak			
Patient Name:	[REDACTED]		
Member Name:	Jeffrey D. Allen		
Identification No.:	[REDACTED] 1184		
Third Party Claims Processor:	BCBS: ☒ Medi-Call: ☐ BCBS Dental: ☐ MUSC-Options: ☐ BlueChoice: ☐ Medco: ☐ Cigna: ☐ APS: ☐ Other: ☐		
Issue:	Denial of benefits for diabetes education.		
Claim File Received:	Yes: ☒		
Information Submitted by Claimant:	Yes: ☒ List: Appeal letter Court documents		
Additional Comments:	Subscriber has filed suit in Circuit Court. Case is ongoing, but sub is going through EIP's appeal process as well.		

Health Appeals Fact Sheet

Date: 8/19/2010

EIP Committee Member	Approved	Denied	Other
Jane Britton			
Nancy Higgins			
Thelma Hopkins			
Chuck Wilson			
Laura Smoak		<i>lms</i>	
Patient Name:	[REDACTED]		
Member Name:	Jeffrey D. Allen		
Identification No.:	[REDACTED] 1184		
Third Party Claims Processor:	BCBS: ☒ Medi-Call: ☐ BCBS Dental: ☐ MUSC-Options: ☐ BlueChoice: ☐ Medco: ☐ Cigna: ☐ APS: ☐ Other: ☐		
Issue:	Denial of benefits for diabetes education.		
Claim File Received:	Yes: ☒		
Information Submitted by Claimant:	Yes: ☒ List: Appeal letter Court documents		
Additional Comments:	Subscriber has filed suit in Circuit Court. Case is ongoing, but sub is going through EIP's appeal process as well.		

sent by email -
10/26/09

#156060
GP

October 15, 2009

Jeffrey D. Allen

Charleston, SC 29414

South Carolina Budget and Control Board
Employee Insurance Program
1201 Main Street, Suite 300
Columbia, South Carolina 29201

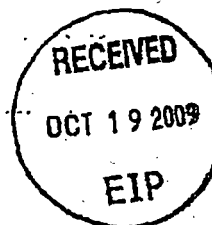
To whom it may concern:

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
theallenpad@gmail.com

✓ [redacted] 1184



RCS105N1
Mar 1,10

***** EMPLOYEE INSURANCE PROGRAM *****
- Maintain Contact Log -

RCS105M1
1 more >

SSN : [REDACTED] 1184 Name: JEFFREY D ALLEN
Phone : [REDACTED]
CHARLESTON SC 29414

*Reason : CORRESPONDENCE

Start Time : 15:31:51 Group: 5180200
Call Length: 00:01:31 Type: ACTIVE - REGULAR
Call Date : 10/22/2009

CS Rep: GESELE PRICE Dept: INCS

Last Updated by: HPRICG on: 10/22/2009

Notes :

CORR#15666:SUBSCR REQ COPY OF PLAN OF BENE DOC PER JANE BRITTON GIVE TO
MICHELLE LEWSKY TO HANDLE. 4RDED SUBSCR REQ TO MICHELLE

Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10---PF11---PF12---
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Contact log displayed successfully

RCS105N1
Mar 1,10

***** EMPLOYEE INSURANCE PROGRAM *****
- Maintain Contact Log -

RCS105M1
1 more >

SSN : [REDACTED] 184 Name: JEFFREY D ALLEN
Phone : [REDACTED]
CHARLESTON SC 29414

*Reason : SUPPLIES

Start Time : 13:46:40
Call Length: 00:01:14
Call Date : 10/06/2009

Group: 5180200
Type: ACTIVE - REGULAR

CS Rep: SONJA WALTERS Dept: INCS

Last Updated by: HWALTS on: 10/06/2009

Notes :

SPOUSE REQ PLAN OF BENEFIT DOCUMENT; ADV CAN PUT REQ IN WRITING TO EIP AND
PAY FOR EACH PAGE OR CAN SEE BA AND REVIEW DOC IN OFFICE

Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10---PF11---PF12---
confm help retrn prev next bkwd frwd left right main
Contact log displayed successfully

2005-07-27 10:53:54

**SOUTH CAROLINA STATE BUDGET AND CONTROL BOARD
EMPLOYEE INSURANCE PROGRAM
ACTIVE NOTICE OF ELECTION (NOE)**

A. ADMINISTRATIVE INFORMATION										
CHECK ONE OF THE FOLLOWING: ☒ New Hire ☐ Transfer ☐ Change	TYPE OF CHANGE ☒ Enrollment ☐ Address ☐ Birth/Adoption ☐ Ineligible Dependent ☐ Marriage ☐ Involuntary loss of coverage ☐ Divorce ☐ Gain of other coverage ☐ Death ☐ Coordination of Benefits (See C) ☐ Other (specify) _____ Date of Occurrence: _____ SSN Change - Incorrect ☐ _____ (attach copy of card) Name Change - Prior _____					BA USE ONLY Effective Date: <u>9-1-05</u> Group ID #: <u>51802</u> Group Name: <u>DSD2</u> ☐ Permanent Part-time Employee (20 hours)		MONEYPLUS ☒ Yes ☐ No HEALTH SAVINGS ACCOUNT (HSA) ☐ Yes ☐ No (For use with Savings Plan)		
B. ENROLLEE INFORMATION										
1. Social Security Number <u>1184</u>		2. Last Name <u>Allen</u>		3. Suffix	4. First Name <u>Jeffrey</u>		5. M.I. <u>D</u>	6. Date of Birth MM DD YYYY <u>978</u>		
7. Sex ☒ M ☐ F	8. Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Separated ☐ Widowed		9. Home Phone # <u>843-571-7030</u>		10. Work Phone #		11. E-mail Address			
12. Mailing Address _____			13. Apt. _____	14. City <u>Chas</u>	15. State <u>SC</u>	16. ZIP Code <u>29407</u>	17. County Code <u>10</u>	18. Annual Salary <u>32,674</u>	19. Date of Hire MM DD YYYY <u>8-2-2005</u>	
C. MEDICARE AND OTHER COVERAGE INFORMATION										
LIST BELOW, YOURSELF AND ANY OTHER PERSONS TO BE COVERED WHO ARE ELIGIBLE FOR PART A AND/OR B OF MEDICARE.										
20. NAME		MEDICARE #		ENTITLED DUE TO		EFFECTIVE DATE				
				☐ AGE ☐ DISABILITY ☐ RENAL DISEASE		PART A MM/DD/YYYY		PART B MM/DD/YYYY		
				☐ AGE ☐ DISABILITY ☐ RENAL DISEASE						
DO YOU OR ANY OF YOUR FAMILY MEMBERS HAVE OTHER GROUP HEALTH COVERAGE? ☐ YES ☐ NO										
DOES THIS COVERAGE INCLUDE PHARMACY BENEFITS? ☐ YES ☐ NO										
21. NAME		INSURANCE COMPANY		POLICYHOLDER DATE OF BIRTH		EFFECTIVE DATE OF POLICY		TERMINATION DATE (IF APPLICABLE)		
IF YOU AND/OR YOUR DEPENDENTS HAVE HAD OTHER COVERAGE WITH ANOTHER CARRIER WITHIN 62 DAYS OF THIS REQUEST, PLEASE ATTACH A COPY OF YOUR CERTIFICATE OF HEALTH COVERAGE (HIPAA). THIS WILL ENSURE PROPER CREDIT FOR ANY PRE-EXISTING CONDITIONS, IF APPLICABLE.										
D. COVERAGE INFORMATION										
22. HEALTH (Refuse or select one plan and one category.)					23. DENTAL (Select One)		24. DENTAL PLUS (Select One)			
Plan ☐ Refuse ☒ Standard ☐ Savings (For non-Medicare Employees) ☐ TRICARE Supplement (For Non-Medicare Employees with TRICARE) ☒ HMO <u>NLSC Options</u> Name _____					Category ☐ Enrollee ☐ Enrollee/Spouse ☒ Enrollee/Child(ren) ☐ Family		☒ Refuse ☐ Enrollee ☐ Enrollee/Spouse ☒ Enrollee/Child ☐ Family		☒ No (Refuse) ☐ Yes	
25. OPTIONAL LIFE (Refuse or enter coverage level.)		26. DEPENDENT LIFE - SPOUSE (Refuse or enter coverage level.)		27. DEPENDENT LIFE - CHILD(REN) (Select One)		28. SUPPLEMENTAL LONG TERM DISABILITY (Select One)				
☒ Refuse ☐ Coverage Level \$ _____ (Must be in increments of \$10,000)		☒ Refuse ☐ Coverage Level \$ _____ (Must be in increments of \$10,000)		☒ Refuse ☐ \$10,000		☒ Refuse/Cancel ☐ Plan One - 90 day benefit waiting period ☐ Plan Two - 180 day benefit waiting period				
29. BASIC LIFE/BASIC LTD: Automatically provided with health coverage. If health coverage is refused, benefits are forfeited.										

EIP Rev. 8/04

2005-07-27 10:53:56

NAME: Jeffrey Allen SSN: [REDACTED] 1184 GROUP #: 51902

PAGE 2
ACTIVE NOE FORM

E. DEPENDENT INFORMATION							
LIST SPOUSE AT ALL TIMES. LIST CHILDREN TO BE COVERED UNDER EITHER HEALTH/DENTAL OR DEPENDENT LIFE PLAN. IF THEY ARE NOT LISTED, THEY WILL NOT BE COVERED. IS YOUR SPOUSE A STATE EMPLOYEE OR EMPLOYED BY A STATE COVERED ENTITY? ☐ Yes ☐ No							
ADD (A) OR DELETE (D)	30. DEPENDENT SSN #	LAST NAME	FIRST NAME	SEX M/F	RELATION	DATE OF BIRTH MM DD YYYY	COMPLETE BELOW IF CHILD IS OVER 19
A	[REDACTED]	Allen	[REDACTED]	F	Daugh	[REDACTED] 05	☐ Full-time Student ☐ Incapacitated ☐ Full-time Student ☐ Incapacitated ☐ Full-time Student ☐ Incapacitated ☐ Full-time Student ☐ Incapacitated
IF FULL-TIME STUDENT WAS CHECKED AND YOU ARE ENROLLING THE DEPENDENT FOR THE FIRST TIME, ATTACH A FULL-TIME CERTIFICATION FROM THE SCHOOL. IF INCAPACITATED WAS CHECKED, ATTACH THE INCAPACITATED CHILD FORM.							
F. BENEFICIARY INFORMATION - REQUIRED FOR BASIC LIFE AND OPTIONAL LIFE							
BASIC LIFE OR OPTIONAL LIFE (Check one or both)	31. LAST NAME	FIRST NAME	SSN #	RELATIONSHIP	DATE OF BIRTH MM DD YYYY	PRIMARY OR CONTINGENT	
☒ BASIC LIFE ☐ OPTIONAL LIFE	Ford-Allen	Christy	[REDACTED] 3751	Wife	[REDACTED] 1973	P	
☐ BASIC LIFE ☐ OPTIONAL LIFE							
☐ BASIC LIFE ☐ OPTIONAL LIFE							
IF BENEFICIARY IS AN ORGANIZATION OR TRUST, COMPLETE THE FOLLOWING:							
ORGANIZATION/TRUST _____							
ADDRESS _____							
IF TRUST, DATE SIGNED _____							
UNLESS OTHERWISE PROVIDED HEREIN, IF TWO OR MORE BENEFICIARIES ARE NAMED, THE PROCEEDS SHALL BE PAID IN EQUAL SHARES TO THE NAMED SURVIVORS. CONTINGENT BENEFICIARIES HAVE NO RIGHTS UNLESS ALL PRIMARY BENEFICIARIES HAVE DIED.							
32. CERTIFICATION: I have read this NOE and made the authorizations herein and have selected the coverage noted. I have provided social security numbers and documentation establishing my dependent's eligibility for the plan(s) selected. I understand that I may only cancel my coverage and/or my dependent's coverage during an open enrollment period every two years, unless otherwise provided for in the Plan. Should I refuse health coverage or fail to enroll all eligible dependents in health coverage when first eligible, I and/or all eligible dependents may only enroll during an open enrollment period, unless otherwise provided in the Plan. I also understand that I will be able to add or cancel dental coverage only during the open enrollment period every two years unless otherwise provided in the Plan. I understand and agree that all selected plans will not be effective unless and until the NOE is approved. I understand that the state reserves the right to alter benefits or premiums at any time to preserve the financial stability of the Plan. AUTHORIZATION: I hereby authorize my employer to deduct from my salary premiums necessary to pay for all plans selected and verify my salary when necessary for enrollment. I hereby authorize any healthcare provider, prescription drug dispenser and claims administrator to release any information necessary to evaluate, administer and process all claims for any benefits. Employee Signature: <u>[Signature]</u> Date: <u>6/22/2005</u> 33. I hereby attest that the employee meets eligibility requirements of plan, proper premiums are being collected, form is complete and accurate, and all required documentation is attached in order to process NOE form. Benefits Administrator Signature: <u>[Signature]</u> Date: <u>6/22/05</u> THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS. THE AGENCY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT IN WHOLE OR IN PART. NO PROMISES OR ASSURANCES, WHETHER WRITTEN OR ORAL, WHICH ARE CONTRARY TO OR INCONSISTENT WITH THE TERMS OF THIS PARAGRAPH CREATE ANY CONTRACT OF EMPLOYMENT.							

EIP Rev. 8/04

08/20/10
13:56:40

SOUTH CAROLINA DIVISION OF INSURANCE & GRANTS SERVICES
EMPLOYEE INSURANCE PROGRAM
SUBSCRIBER INQUIRY DEPENDENT DATA

HIS204M2
HCLARC

SSN: 247 45 1184 SUBSCR TYPE: ACTIVE - REGULAR EMP GROUP ID: 5180200
NAME: ALLEN JEFFREY D

----- D E P E N D E N T -----
SSN: 0876 ALLEN NAME: LAST SUFF FIRST MI DATE OF BIRTH
RELATION: 22C F CHILD NATURAL EVA MEDICARE: 2005
PART D EFF DATE: END:
ELIGIBILITY: 1 ELIG CHILD PI DATE: DISPLAY MEDICARE (Y/N): N
STATE EMP: N GRP ID: REVIEWED:

CURRENT COVERAGE INFORMATION PRE EXISTING
STATUS EFF DATE END DATE END DATE LE:
HEALTH A1 11/01/2008 07/31/2024
DENTAL A1 11/01/2008 07/31/2024
DL/CHILD
DL/SPOUSE
VISION

<PF11> Dependent History <PF10> Wellness Incentive
Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10---PF11---PF12---
HELP AUTH CONT ID OTINS COVR DEPND BENEF INCTV HISTC MAIN

08/20/10
13:56:08

SOUTH CAROLINA DIVISION OF INSURANCE & GRANTS SERVICES
EMPLOYEE INSURANCE PROGRAM
SUBSCRIBER INQUIRY - COVERAGE HISTORY

HIS208M3
HCLARC

SSN: [REDACTED] 1184 SUBSCR TYPE: ACTIVE - REGULAR
NAME: ALLEN JEFFREY D

CURRENT COVERAGE - HEALTH
ST: A1 PLAN BB CAT 3 EFF: 11/01/08 END: GRP: 5180200

PREVIOUS COVERAGE - HEALTH

ENTRY	DATE	ST	PLAN	CAT	RS	EFF DATE	END DATE	GROUP	SUBSCR	PART	TRANS	PROCESSOR
	10/15/08	A1	BB	3	00	09/01/08	11/01/08	H150000	AR		TT	FSTD1
	07/28/08	A1	BB	3	00	08/01/08	09/01/08	5180200	AR		TT	COPLJ4
	07/23/08	A1	BB	3	00	01/01/07	08/01/08	5180200	AR		TT	HCOPLJ
	11/22/06	A1	HX	3	00	09/01/05	01/01/07	5180200	AR		C3	ATRET4

Enter PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10---PF11---PF12---
HELP CONT UP DOWN MAIN

08/20/10
13:56:58

SOUTH CAROLINA DIVISION OF INSURANCE & GRANTS SERVICES
EMPLOYEE INSURANCE PROGRAM
DEPENDENT COVERAGE HISTORY

HIS204M4
HCLARC

SUBSCRIBER SSN: [REDACTED] 1184

DEP SSN [REDACTED] 0876 NAME ALLEN

REL: 220 ELIG: 1 PI DATE: [REDACTED]

CURRENT - ST: A1 EFF DATE: 11/01/08 END DATE: 07/31/24

PREVIOUS	COVERAGE -	HEALTH
STATUS	EFF DATE	END DATE
A1	09/01/08	11/01/08
A1	08/01/08	09/01/08
A1	01/01/07	08/01/08
A1	09/01/05	01/01/07

Enter-PF1---PF2---PF3---PF4---PF5---PF6---PF7---PF8---PF9---PF10---PF11---PF12---
HELP CONT UP DOWN MAIN

*He was hired
8/2/05*

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

July 1, 2010

John A. Massalon, Esquire
Wills, Massalon & Allen, LLC
134 Meeting Street, Suite 100
Charleston, South Carolina 29401

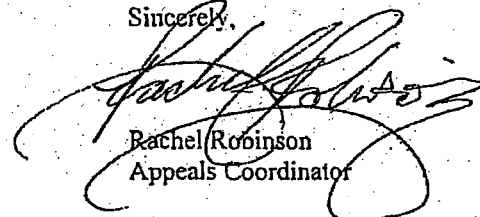
RE: State of South Carolina Group Health Benefits Plan
Subscriber: Jeffrey D. Allen
Patient: [REDACTED] Allen
ID#: XXX-XX-1184

Dear Mr. Massalon:

On July 1, 2010, our office received your appeal of the decision of BlueCross BlueShield of South Carolina, our claims administrator, to deny your claim for diabetes education benefits. The purpose of this letter and enclosure is to provide you with an outline of the appeals process, applicable deadlines, and your rights during this process. Please read this information carefully and completely.

Please understand that we will make every effort to process your appeal as efficiently as possible. If you need any additional information regarding this appeal process, please contact me at (803)734-3569.

Sincerely,



Rachel Robinson
Appeals Coordinator

Enclosure

1201 MAIN STREET, SUITE 300 • COLUMBIA, SOUTH CAROLINA 29201

APPEALS PROCESS

HEALTH APPEALS COMMITTEE

Who will review your claim?

Your claim will be reviewed by the Health Appeals Committee, which is composed of five individuals appointed by the Director of the Employee Insurance Program ("EIP"). These Committee members are familiar with the South Carolina Group Health Benefits Plan ("Plan") and have not been involved in the prior decisions to deny benefits for your claim.

Will there be an opportunity to meet with the Committee?

Typically, the Committee will not meet with the claimant. Any decision to conduct a conference or other non-adversarial proceeding is within the Committee's sole discretion. The Committee instead conducts an independent evaluation of all written documentation submitted prior to its meeting. At the meeting, the Committee discusses the information and the applicable Plan language and ultimately makes a decision regarding the claim.

What will the Committee review?

The Committee will review:

- The relevant Plan language;
- The file the claims administrator used in making its decision (we have requested a copy);
- Any relevant, reliable information maintained by or accessible to EIP; and
- Any additional information you submit.

If you have any additional information you believe is relevant to your claim, please submit it in writing within thirty (30) days of the date of this letter to:

Appeals Coordinator
Employee Insurance Program
1201 Main Street, Suite 300
Columbia, South Carolina 29201

We may provide this additional information to the claims administrator for review prior to the Committee's review. If you need additional time to submit information, please contact the Appeals Coordinator at (803)734-3569. If you choose not to submit additional information within this timeframe, the Committee will proceed with your appeal based on the documentation received from the claims administrator. Once the Committee begins its review of your appeal, you will not be allowed to submit additional documentation and your claim will be decided based on the record before the Committee at that time.

What are your rights during this process?

As explained above, you have the right to submit within thirty (30) days of this letter any written information you want the Committee to consider when reviewing your claim.

You have the right to review your claim file. If you wish to review your claim file, you may send a written request for a copy of your file to the Appeals Coordinator at the address listed above. The Appeals Coordinator will coordinate the production of your file with the claims administrator. You may be required to sign an additional authorization form and pay a reasonable fee for the claims administrator to produce your claim file.

You have the right to be represented by an attorney during the appeals process.

You have the right to request an expedited review. Please understand that due to the high volume of appeals processed by our office, this request is granted rarely and only for urgent circumstances.

How will you be notified of the Committee's decision?

After the Committee makes its decision, you will receive a written explanation of the Committee's decision. The written determination will explain the specific reasons for the Committee's decision and will include the applicable Plan provisions relied upon by the Committee. The Committee will make every effort to provide you a written determination within thirty (30) days of the Committee's decision.

What if your claim is denied by the Committee?

If the Committee denies your claim in whole or in part, you will have thirty (30) days to seek appellate review in the Administrative Law Court.

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

July 1, 2010

Mary Adams

State Claims Unit, AX B10

BlueCross BlueShield of South Carolina

I-20 East at Alpine Road

Columbia, South Carolina 29260

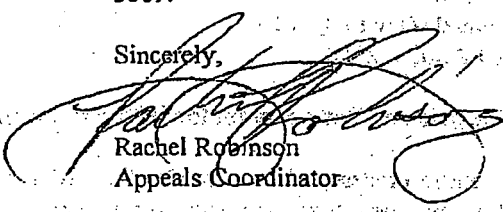
Re: *State of South Carolina Group Health Benefits Plan*
Subscriber: Jeffrey D. Allen
Patient: [redacted] Allen
ID#: XXX-XX-1184
ZCS 36961363

Dear Mary:

The Employee Insurance Program will be moving forward with Mr. Allen's request for an appeal regarding BlueCross Blue Shield of South Carolina's ("BCBSSC") denial of his claim for diabetes education benefits. Please forward to us all documentation considered by BCBSSC in adjudicating this claim within ten (10) days of your receipt of this letter.

If you have any questions or need further information, please contact me at (803) 734-3569.

Sincerely,


Rachel Robinson
Appeals Coordinator

/rr

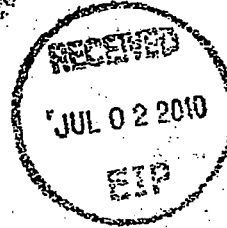
1201 MAIN STREET, SUITE 300 • COLUMBIA, SOUTH CAROLINA 29201

WMA

WILLS MASSALON & ALLEN LLC

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.

under the law.

Thank you.

With kind regards, I am

Sincerely,

WILLS MASSALON & ALLEN, LLC

Jaith Irick, 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

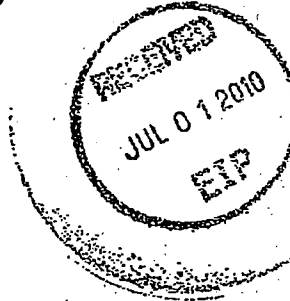
WMA

WILLS MASSALON & ALLEN LLC

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
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under the law.

Thank you.

With kind regards, I am

Sincerely,

WILLS MASSALON & ALLEN, LLC

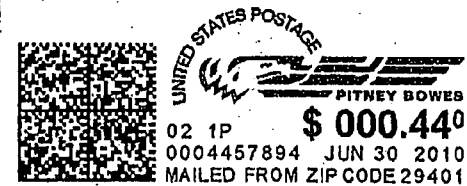
Saith Irink, Paralegal
for John A. Massalon

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

WILLS & MASSALON, LLC
ATTORNEYS AT LAW

PO Box 859
CHARLESTON, SOUTH CAROLINA 29402



595-1
Kelly H. Rainsford, Esquire
State Budget & Control Board
1201 Main Street, Ste. 300
Columbia, South Carolina 29201

29201+3230



360

242



South Carolina.

Blue Cross Blue Shield of South Carolina
1-20 at Alpine Road
Columbia, SC 29219-0001
803.788.0222

SouthCarolinaBlues.com

March 19, 2010

Jeffrey Allen

Charleston, South Carolina 29414-6577

RE: Patient: [REDACTED] Allen
ID#: ZCS: 36961363
Date(s) of Service: August 5, 2008

Dear Mr. Allen:

We received an appeal of the date of service for [REDACTED] Allen listed above, which was updated by a fax received from Christy Allen, which included requested medical records. Our medical director has reviewed the appeal documents including the medical records and upheld the denial on the grounds that (1) the services referenced in the appeal are specifically excluded in the Plan of Benefits, Article 9, paragraph O; in addition Article 9, paragraph BB applies as there is no mention of this service in the Benefits section of the Plan; and (2) the statute referenced in the appeal documents does not apply to the State Health Plan.

Because the medical director has upheld the denial of the above referenced service, the appeal file will now be sent to the Appeals Review Committee. When we have completed this review, we will notify you in writing.

If you have questions about this matter, please call me at (803) 264-2886.

Sincerely,

Brooks Goodman, Senior Director
State Operations, AX-B10
Phone: 803-264-2886
Fax: 803-870-8483
Brooks.goodman@bcbssc.com

cc: John A. Massalon, Esq. ✓
Wills & Massalon, LLC
P.O. Box 859
Charleston, SC 29402

RECEIVED

MAR 23 2010

Wills & Massalon



South Carolina

April 2, 2010

BlueCross BlueShield of South Carolina
1-20 at Alpine Road
Columbia, SC 29219-0001
803.788.0222

SouthCarolinaBlues.com

395-1
PED

Jeffrey D. Allen

Charleston, South Carolina 29414

RE: Patient: [REDACTED] Allen
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 [REDACTED] Allen; 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.

RECEIVED

APR 06 2010

Wills & Massalon

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.

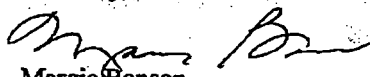
We regret that our decision was not favorable. We are sympathetic to Eva Allen's individual situation; however, we are obligated to review claims consistent with the plain and ordinary meaning of the Plan. In doing so, we are fulfilling our duty as claims administrator to interpret the Plan.

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

STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

COURT OF COMMON PLEAS

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.

CASE NO: 2009-CP-10-7404

SUMMONS

BY

JULIE J. ARMSTRONG
CLERK OF COURT

2009 NOV 25 AM 10:56

FILED

TO SOUTH CAROLINA BUDGET AND CONTROL BOARD EMPLOYEE INSURANCE
PROGRAM:

YOU ARE HEREBY SUMMONED and required to Answer the Complaint in this
action, a copy of which is herewith served upon you, and to serve a copy of your Answer to said
Complaint on the below subscribed attorney at his office at 134 Meeting Street, Suite 100,
Charleston, South Carolina 29401 within thirty (30) days after the service hereof, exclusive of
the day of such service; and if you fail to Answer the Complaint within the time aforesaid,
Plaintiff in this action will apply to the Court for the relief demanded in the Complaint and will
seek a default judgment against you.

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;)

COMPLAINT

v.)

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

Defendants.)

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).*

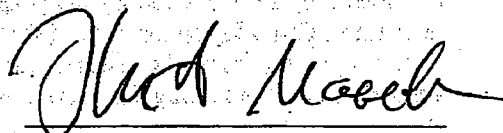
(emphasis added).

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
WILS & 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

STATE OF SOUTH CAROLINA

COUNTY OF CHARLESTON

IN THE COURT OF COMMON PLEAS

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 COVERSHEET

Plaintiff(s)

vs.

2009-CP - 10- 7404

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

Defendant(s)

(Please Print)

Submitted By: John A. Massalon

Wills & Massalon, LLC

Address: 134 Meeting Street, Suite 100

Charleston, South Carolina 29401

SC Bar #: 10279

Telephone #: 843-727-1144

Fax #: 843-727-7696

Other:

E-mail: jmassalon@wills-massalon.com

NOTE: The cover sheet and information contained herein neither replaces nor supplements the filing and service of pleadings or other papers as required by law. This form is required for the use of the Clerk of Court for the purpose of docketing. It must be filled out completely, signed, and dated. A copy of this cover sheet must be served on the defendant(s) along with the Summons and Complaint.

DOCKETING INFORMATION (Check all that apply)

*If Action Is Judgment/Settlement do not complete

- ☐ JURY TRIAL demanded in complaint. ☒ NON-JURY TRIAL demanded in complaint.
☐ This case is subject to ARBITRATION pursuant to the Court Annexed Alternative Dispute Resolution Rules.
☐ This case is subject to MEDIATION pursuant to the Court Annexed Alternative Dispute Resolution Rules.
☐ This case is exempt from ADR. (Proof of ADR/Exemption Attached)

NATURE OF ACTION (Check One Box Below)

- Contracts**
☐ Constructions (100)
☐ Debt Collection (110)
☐ Employment (120)
☐ General (130)
☐ Breach of Contract (140)
☐ Other (199)

- Torts - Professional Malpractice**
☐ Dental Malpractice (200)
☐ Legal Malpractice (210)
☐ Medical Malpractice (220)
Previous Notice of Intent Case #
20 -CP-
☐ Notice/ File Med Mal (230)
☐ Other (299)

- Torts - Personal Injury**
☐ Assault/Slander/Libel (300)
☐ Conversion (310)
☐ Motor Vehicle Accident (320)
☐ Premises Liability (330)
☐ Products Liability (340)
☐ Personal Injury (350)
☐ Wrongful Death (360)
☐ Other (399)

- Real Property**
☐ Claim & Delivery (400)
☐ Condemnation (410)
☐ Foreclosure (420)
☐ Mechanic's Lien (430)
☐ Partition (440)
☐ Possession (450)
☐ Building Code Violation (460)
☐ Other (499)

- Inmate Petitions**
☐ PCR (500)
☐ Mandamus (520)
☐ Habeas Corpus (530)
☐ Other (599)

- Judgments/Settlements**
☐ Death Settlement (700)
☐ Foreign Judgment (710)
☐ Magistrate's Judgment (720)
☐ Minor Settlement (730)
☐ Transcript Judgment (740)
☐ Lis Pendens (750)
☐ Transfer of Structured
Settlement Payment Rights
Application (760)
☐ Other (799)

- Administrative Law/Relief**
☐ Reinstate Driver's License (800)
☐ Judicial Review (810)
☐ Relief (820)
☐ Permanent Injunction (830)
☐ Forfeiture-Petition (840)
☐ Forfeiture-Consent Order (850)
☐ Other (899)

- Appeals**
☐ Arbitration (900)
☐ Magistrate-Civil (910)
☐ Magistrate-Criminal (920)
☐ Municipal (930)
☐ Probate Court (940)
☐ SCDOT (950)
☐ Worker's Comp (960)
☐ Zoning Board (970)
☐ Administrative Law Judge (980)
☐ Public Service Commission (990)
☐ Employment Security Comm (991)
☐ Other (999)

- Special/Complex /Other**
☐ Environmental (600)
☐ Automobile Arb. (610)
☐ Medical (620)
☒ Other (699)
☐ Pharmaceuticals (630)
☐ Unfair Trade Practices (640)
☐ Out-of State Depositions (650)
☐ Sexual Predator (510)

Class Action-
Declaratory
Judgment

SCCA / 234 (07/09)

Page 1 of 3

Submitting Party Signature:

Michael A. [Signature]

Date: November 25, 2009

Note: Frivolous civil proceedings may be subject to sanctions pursuant to SCRCP, Rule 11, and the South Carolina Frivolous Civil Proceedings Sanctions Act, S.C. Code Ann. §15-36-10 et. seq.

MANDATED ADR COUNTIES
Allendale, Anderson, Beaufort, Colleton, Florence, Greenville,
Hampton, Horry, Jasper, Lexington, Pickens (Family Court Only), and Richland

SUPREME COURT RULES REQUIRE THE SUBMISSION OF ALL CIVIL CASES TO AN ALTERNATIVE DISPUTE RESOLUTION PROCESS, UNLESS OTHERWISE EXEMPT.

You are required to take the following action(s):

1. The parties shall select a neutral and file a "Proof of ADR" form on or by the 210th day of the filing of this action. If the parties have not selected a neutral within 210 days, the Clerk of Court shall then appoint a primary and secondary mediator from the current roster on a rotating basis from among those mediators agreeing to accept cases in the county in which the action has been filed.
2. The initial ADR conference must be held within 300 days after the filing of the action.
3. Pre-suit medical malpractice mediations required by S.C. Code §15-79-125 shall be held not later than 120 days after all defendants are served with the "Notice of Intent to File Suit" or as the court directs. (Medical malpractice mediation is mandatory statewide.)
4. Cases are exempt from ADR only upon the following grounds:
 - a. Special proceeding, or actions seeking extraordinary relief such as mandamus, habeas corpus, or prohibition;
 - b. Requests for temporary relief;
 - c. Appeals
 - d. Post-Conviction relief matters;
 - e. Contempt of Court proceedings;
 - f. Forfeiture proceedings brought by governmental entities;
 - g. Mortgage foreclosures; and
 - h. Cases that have been previously subjected to an ADR conference, unless otherwise required by Rule 3 or by statute.
5. In cases not subject to ADR, the Chief Judge for Administrative Purposes, upon the motion of the court or of any party, may order a case to mediation.
6. Motion of a party to be exempt from payment of neutral fees due to indigency should be filed with the Court within ten (10) days after the ADR conference has been concluded.

**Please Note: You must comply with the Supreme Court Rules regarding ADR.
Failure to do so may affect your case or may result in sanctions.**

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 Notice of Motion and
Motion for Class Certification

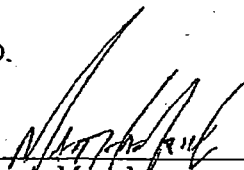
TO: Theodore D. Willard, Jr., Esq. and Kelly H. Rainsford, Esq., counsel for
Defendants.

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, certifying
a plaintiffs' class in the above-captioned lawsuit.

Plaintiff hereby moves for an order certifying a plaintiffs' class in the above-captioned
lawsuit on the grounds that: (1) the class is so numerous that joinder of all members is
impracticable, (2) there are questions of law or fact common to the class, (3) the claims of the
representative parties are typical of the claims of the class, (4) the representative party will fairly
and adequately protect the interests of the class, and (5) to the extent non-injunctive or non-
declaratory relief is requested with respect to the class as a whole, the amount in controversy
exceeds one hundred dollars for each member of the class.

This motion will be supported with the responses to discovery requests, depositions,
affidavits, and memoranda of law on file with the Court as of the date of the hearing on this
motion.

PLEASE BE PRESENT TO DEFEND IF SO MINDED.


John A. Massalon
Wills Massalon & Allen, LLC
Post Office Box 855

RECEIVED
JUN 04 2010

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

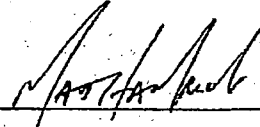
ATTORNEYS FOR PLAINTIFF

CERTIFICATE OF SERVICE

I hereby certify that I have this 3rd day of JUNE, 2010 served the foregoing pleading or paper by depositing a copy of it in the US Mail, first class, postage prepaid, 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



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

2

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 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

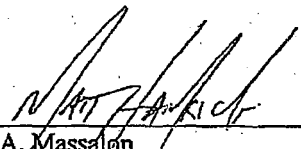
TO: Theodore D. Willard, Jr., Esq. and Kelly H. Rainsford, Esq., counsel for
Defendants.

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.

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

RECEIVED

JUN 21 2010.

Wills & Massalon

(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 prepaid, 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

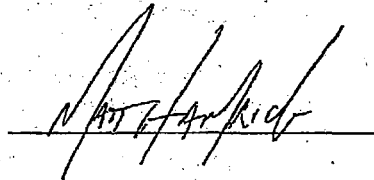


EXHIBIT A

ROUTING: D028028 MARY ADAMS
FOLDID: PVT09072K920

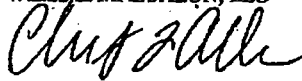
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03/17/10 11:58:19 PAGE 002 OF 006

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.

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ROUTING: D028028 MARY ADAMS
FOLDID: PVT09072K920

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1-20 @ Alpine Road
Columbia, SC 29219

18807



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 738-1578

MON - FRI 8:00 A.M. - 8:00 P.M.

STATE HEALTH PLAN

August 27, 2008

12940772585291

JEFFREY D ALLEN

CHARLESTON SC 29407-7258

SUMMARY INFORMATION

Patient's Name	Relationship to Policyholder	ID No.	Claim No.
ALLEN	CHILD	22-336961563	023811250-00-00
TOTAL CHARGES FOR YOUR CLAIM	TOTAL AMOUNT WE PAID	WHAT YOU OWE	
\$60.00	\$60.00	\$60.00	
To date, you have satisfied \$60.00 of the \$60.00 payment for the current period (see page 1 of 1).			
This claim is subject to a \$0.00 deductible. You have satisfied \$0.00 of the \$0.00 deductible.			
Out-of-pocket maximum for this benefit period: \$4,200. For this period, this benefit is paid.			

DETAIL INFORMATION

Provider	MEDICAL UNIVERSITY		
Network Participation	YES		
Dates of Service	08/05/08		
Type of Service	MEDICAL SERVICES		
Charge	\$60.00		
Amount Not Covered	\$60.00 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

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09072K920

ROUTING: D028028 MARY ADAMS
FOLDID: PVT09072K920

DEPT/CC 460 EMPID 7846
03/17/10 11:58:19 PAGE 004 OF 006

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.

Coinurance - 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. 29280-0605

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.

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ROUTING: D028028 MARY ADAMS
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Member Claim Status Summary

Page 1 of 1

Claims Status/Explanation of Benefits

Claim Detail

Claim Status: FINALIZED/DENIAL
Member ID: ZC838661363
Member's Name: JEFFREY D ALLEN
Patient's Name: JEFFREY D ALLEN
Patient's Date of Birth: 08/25/2005
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: BE28312500000
Dates of Service: 08/05/2008 to 08/05/2008
Charge: \$580.00

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.)

[Claims List](#) [Review Claims](#) [Next Claim](#) [Line Item\(s\)](#) [View Summary](#) [Ask Customer Service](#)

https://www3.bcbss.com/func/status/member_claim_status_summary.jsp

2/18/2009

09072K920

My Insurance Manager for Members

Page 1 of 2

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: ZC336961363

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? [ask](#)
Security Answer:* CHARLESTON

General Information

First Name:* JEFFREY

Middle Initial: D

Last Name:* ALLEN

Suffix:

Gender: Female ☐ Male ☒

Address:* [REDACTED]

Address, continued:

City:* Charleston

State:* SC

ZIP Code:* 29414 (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."

<https://www3.bcbssc.com/func/ModifyProfile.js>

09061E644

2/18/2009

09072K920

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

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 HIPA 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.

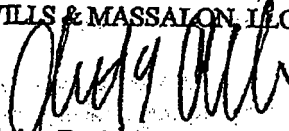
I am also enclosing a copy the South Carolina statute which requires Diabetes Mellitus coverage in health insurance policies. I have highlighted the provision which requires coverage for "outpatient self-management training and education for the treatment of people with diabetes mellitus (or commonly 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

MEDICAL AFFAIRS REVIEW COORDINATOR'S RESPONSE

②

Patient Name: M Allen
Patient ID: 1184 002
Claim number(s): 8E26312500000
Date(s) of service: 08/05/2008
Effective Date: 01/01/2007
Issue: Denial of Diabetic Education.

State Health Plan

Member's mother, Christy Ford Allen, is appealing for payment of G0108 (S1942) (8 dut's):
Diabetes outpatient self-management training services, individual, per 30 minutes- denied U0568:
Your benefit plan does not cover education/training services for this condition. Please refer to the
exclusions section of your benefit booklet for more details. These services are being billed by
Medical University Hospital. The diagnosis filed is 250.01: Diabetes mellitus without mention of
complication, type I {juvenile type}, not stated as uncontrolled.

Mothers 1st appeal letter, dated 2/25/09, on the letter head of Wills & Massalon, LLC, Attorneys at Law, states, "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 point 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..." Signed: Christy Ford Allen.

The claim was submitted to PSMM for review and records were ordered on 4/15/09. The records ordered were not received.

Mothers second appeal letter, dated 9/30/09, on the letter head of Wills & Massalon, LLC, Attorneys at Law, states, "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

MEDICAL AFFAIRS REVIEW COORDINATOR'S RESPONSE

Patient Name: [REDACTED] M Allen State Health Plan
Patient ID: [REDACTED] 1184 002
Claim number(s): 8E26312500000
Date(s) of service: 08/05/2008
Effective Date: 01/01/2007
Issue: Denial of Diabetic Education.

(continued) 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 HIPAA 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 of the South Carolina statute which requires Diabetes Mellitus coverage in health insurance policies. 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)..." Signed: Christy Ford Allen.

Member's mother also included the following statute for review "38-71-46: Title 38- Insurance Chapter 71. Accident and Health Insurance:

SECTION 38-71-46. 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

MEDICAL AFFAIRS REVIEW COORDINATOR'S RESPONSE

Patient Name: M Allen
Patient ID: 1184 002
Claim number(s): 8E26312500000
Date(s) of service: 08/05/2008
Effective Date: 01/01/2007
Issue: Denial of Diabetic Education.

State Health Plan

(continued) 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."

Clinical documentation submitted with the precert request for the Minimed insulin pump documents the following:

1/2/08: MUSC. Pediatric Endocrinology. HPI: 2 yr 5 month old female. Followed for Type I DM. Dx 6 wks ago after being admitted to PICU in DKA. DKA resolved without complications. Transitioned to SQ insulin and discharged home after teaching. Has done well. No severe hypoglycemic episodes. Sporadic elevated blood sugars mostly in afternoons and evenings. Target range in AM. 200-300 range in afternoon and evening. Current regimen is Lantus 2 units each evening. Novolog for carbohydrate coverage: 20-30g: 1 1/2 units. 31-45g 2 units. 46-60g: 2 1/2 units and sliding scale. Takes approximately 2 units with each meal and has a morning and afternoon snack below 10g of carbs which she does not take coverage. Total daily dose is 8 units per day. Checking blood sugars 5-6 x daily and rotating sites over arms, abdomen and buttock. Eating well. No nausea, vomiting or diarrhea. Active, especially at daycare program. No polyuria or polydipsia. PMH: Full term gestation without complication. Hx of RAD with upper respiratory infections. FH: Maternal great grandmother with adult onset diabetes. SH: Lives with parents. Attends daycare program. PE: HR: 123, BP 85/62, Ht: 89.8, Wt: 13.3 kg's. BMI: 16.49. Bruising over abdomen from injection sites. Lab: A1c 8.8% 12/07. Impression: 2yr 5 month old w/ Type I DM. Persistently having elevated blood sugars throughout the afternoon and evening. Morning fasting blood sugars are within target range. Discussed switching her Lantus to the morning to help improve daytime BS. Will adjust sliding scale to treat blood sugars 200-349 range with 1/2 unit Novolog and > 350 1 unit Novolog. Continue current carb coverage. Mom to call w/ persistently elevated or low blood sugars.

3/11/08: Phone consult for glycemia. Mom called concerned about high blood glucose at 9:30 am snack and 11:30am and using correction at snacks and meals. Was then having hypoglycemia in afternoon. Discussed only using correction @ lunch. Not at 9:30 am snack. Will cover snacks/meals with 1.25 ratio. Concerned when blood glucose is > 200's post prandial. Explained that at this age we do not want to correct unless it has been 3 hours since meal/snack. Pens leak with such a small dose. Syringes work better. Will ask school to use syringes as well as using them at home.

4/9/08: MUSC - Pediatric Endocrinology. Follow up visit. Blood sugars more in target range. No severe hypoglycemia episodes. Checking blood sugars 6-8 times per day with sporadic high and low blood sugars. Most are in target range. Lab: A1c 7.8% 4/9/08. Impression: 2 yr 8 month old female w/ Type I DM. Improved A1c over past 3 months. Plan to continue current insulin.

MEDICAL AFFAIRS REVIEW COORDINATOR'S RESPONSE

Patient Name: M Allen State Health Plan
Patient ID: 1184 002
Claim number(s): 8E26312500000
Date(s) of service: 08/05/2008
Effective Date: 01/01/2007
Issue: Denial of Diabetic Education.

(continued) regimen. Discussed insulin pump management and gave education maternal on various pumps. Mother to make appointment with Sharon Schwarz to discuss insulin pumps in more detail and consider trying a saline insulin pump.

Patient's Medtronic Minimed insulin pump was MD approved under TNAV certification # 0819123215998. Submitted documentation for the Minimed pump is in the file for review.

8/5/08: Education documentation- Peds Endo. 3 yr old female. Learning needs/Content taught: Patient's plan of care, medications nutrition, food/drug interaction, 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: Met with parents, grandparent's, and school nurses to instruct them on the Medtronic Paradigm insulin pump. They were instructed on trouble shooting hyper/hypoglycemia on the insulin pump, importance of monitoring, ketone testing and site rotation. Instructed on all mechanics of pump therapy and demonstrated good understanding. Encouraged to practice with pump w/ saline until is started on the pump next week. School nurse given a practice pump and NS to review and she will return pump next week. Discussed school needs and plan. To be started on pump next week. Signed: Sharon Schwarz, RN.

Also included in the file are the MD guidelines/orders for the insulin pump. It appears the records submitted are incomplete. Appears only pages 2 and 3 were submitted. Please see file for the submitted documentation.

A copy of the 2009 State Health Plan Contract and South Carolina statute 38-71-46 are in the file for review.

Please advise if the Diabetic Education Services rendered on 8/5/08 are payable under this members contract.

Shelly M Jackson, RN
Medical Affairs Review Coordinator
3/15/2010

Shelly M Jackson
3/15/2010

MEDICAL DIRECTOR RESPONSE

3/15/2010 The services referenced in this appeal are specifically excluded in the plan Article 9 paragraph 0. Exclusion BB in Article 9 also applies as there is no mention of this service in the Benefit section of the plan.

The statute referenced in the appeal document does not apply to the State Health plan
Page 4 of 4
Shelly M Jackson MD
V.P. Medical Affairs

MEDICAL AFFAIRS DETERMINATION

Page 1

RE: 8E26312500000
CLAIM ADJUDICATION: UPHOLD DENIAL OF G0108 (8 DUT'S) AS NOT COVERED
BY THE CONTRACT.

MEDICAL DIRECTOR RESPONSE: 3/15/2010: THE SERVICES REFERENCED IN
THIS APPEAL ARE SPECIFICALLY EXCLUDED IN THE PLAN ARTICLE 9 PARAGRAPH O.
EXCLUSION BB IN ARTICLE 9 ALSO APPLIES AS THERE IS NO MENTION OF THIS
SERVICE IN THE BENEFITS SECTION OF THE PLAN. THE STATUTE REFERENCED IN
THE APPEAL DOCUMENT DOES NOT APPLY TO THE STATE HEALTH PLAN.
ASHBY M JORDAN SR, MD. V.P. MEDICAL AFFAIRS.

SUPPORTING INFORMATION: PER DIRECTION FROM MEDICAL AFFAIRS.
PLEASE REFER TO THE MEDICAL AFFAIRS REVIEW COORDINATOR'S RESPONSE
FORM FOR COMPLETE REVIEW INFORMATION.

DISPOSITION: FILE TO BE COMPLETED PER PSMM DEPARTMENT PROCESSES.

PLEASE SEND A LETTER TO THE APPROPRIATE PARTIES INFORMING THEM
OF THIS DECISION.

OR0514 Added: 03/17/10 08:05 D025531.

F1=Help F3=End F5= F7= F9= F11=
F2= F4= F6= F8=Fnd F10= F12=

MEDICAL AFFAIRS DETERMINATION

RE: 8E26312500000

Page 2

IMAGE: MED247451184

**SHELLY M JACKSON, RN:
MEDICAL AFFAIRS REVIEW COORDINATOR
3/17/2010**

**F1=Help
F2=**

**F3=End
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**F11=
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RM85M15
RM85P015

- RMSS - DEPT: CLAIM DETAIL HISTORY

03/17 11:28

CLAIM NO: 8E26312500000

SUBS ID: 1184

PAYMENT==> PRE: POST: X COMPLAINT: W1 PPC IND: 1 EFF DATE: 00/00/00

PATIENT==> ID: 002 NAME: MALLIN

PRIM PROV==> ID: 571098556007 NAME: MEDICAL UNIVERSITY HOSPITAL
NPI: 1659435840

PRIM DEFER=> CODE: U0568 DESC: YOUR BENEFIT PLAN DOES NOT COVER EDUCATION

DATES==> CORP: 08/13/08 CRIT: 09/27/08 RECVD: 03/11/10

FROM==> NAME: MARY ADAMS APPEAL TYPE: N EXT: 3139
DEPT: STG GRP #: 002133600

TECHNICIAN NAME: SHELLY JACKSON REVIEWER NAME: SHELLY JACKSON

HCMS STATUS: DMAP2 DESC: STATE APPEAL DECISION; SEE NOTEPAD.

EESM

F3=RETRN F12=EXIT F21=PVDR-SON F22=DETR-SON F23=NOTES CLEAR=EXIT

RM74M30
RM74P300

RMH - CLAIM DISPLAY

(3)

03/10 10:47
RPN: 001

ALPHA PREFIX: ZCS SUBSCRIBER ID: 1184 ID CARD: ZCS 36961363
CLAIM NO: 8E26312500001 BATCH: B5409105 OPERATOR ID: STATUS: U PROCE
RECEIVED: 08/13/2008 ENTERED: 04/15/2009 PROCESSED: 04/15/2009 PLAN: 885
DOS FROM: 08/05/2008 TO: 08/05/2008 SOURCE: 1 CLAIM KEYED
KEY: B102008 BENEFIT TYPE: 07 NETWORK BENEFITS ACTION REQUEST:
GROUP: 002133600 DORCHESTER SCHOOL DIST
PROVIDER: MEDICAL UNIVERSITY H PROVIDER #: 571098556007 NPI: 1659435840
IMAGE NUMBER: HCMS REVD MED REC NO: 002585257730013
ITS TYPE: SCCF:
ADJ REASON: 01 THIS REPRESENTS AN ADJUST REASON CODE: J2 GENERATED CLAIM FROM
CVG MKT: PPO CUSTM MEDICARE LIC: PROCESSED: BY MQ
PATIENT NAME: M ALLEN PAT ID: 002
PATIENT IS: FEMALE DEPENDNT DATE OF BIRTH: 2005 MEMBER NUMBER: 002
PAY TO CURRENT: PROVIDER PREVIOUS:

----- STATUS INFO -----

PRIMARY STATUS: UPWRK TO MAKE A DECISION ON THIS LINE OF BUSINESS: HEALTH LIN
STATUS CODE:

OVERRIDE CODE: FERCD

NUMBER OF LINES: 1 CHARGES: 560.00 MM PAID: 0.00

CUST SVC	ITS/BASIC	PAYMENT	ADD DATA	MEDC/COB	INTEREST	EOB
NTWK REIMB	DRG	CLM STAT	GROUP	CLM SUMM	CLM MENU	LINE SUMM

RM80M21
RM80D210

- RMHI - A M M S SUMMARY HISTORY
PATIENT BENEFIT PERIOD

03/10 10:47 PAGE: 3

SUBSCRIBER ID: 1184 PAT-ID: 002 PLAN: 885 LOB: H 0161
PATIENT NAME FIRST: MI: M LAST: ALLEN
BENEFIT PERIOD: 01/01/08 TYPE: 07 PRIORITY IND: 01
RULE: SC006 NO DESCRIPTION ON FILE

>> SELECT		0161
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DED MET :	350.00	350.00
DED COVR:	0.00	0.00
OOP :	1,245.36	1,245.36
OOP COVR:	0.00	0.00

>> SELECT
BT/BAB :
DED MET :
DED COVR:
OOP :
OOP COVR:

EESM

E=DETL F2=LIF F4=RULE F5=REFSH F6=SUBPRD F7=PREV F8=NXTBP F9=FAM F10=BPKG

MEDICAL UNIVERSITY HOSPIT		MEDICAL UNIVERSITY HOSPITAL AU		54 PAT CHIL #	241145762	131
169 ASHLEY AVENUE		P O BOX 931854		00258925773001		
CHARLESTON	SC 294035836	ATLANTA	GA 311931854	5 FED. TAX NO.	571098556	
(843) 792-3349 (918) 481-4275				08-05-2008	08-05-2008	
PATIENT NAME		PATIENT ADDRESS				
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74858

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.

This is an **ADJUSTMENT** to
a claim we processed previously



JEFFREY D ALLEN
CHARLESTON SC 29414-6577

April 20, 2009

STATE HEALTH PLAN

SUMMARY INFORMATION

ALLEN	Patient's Name	Relationship to Policyholder CHILD	ID No. ZCS36961363	Claim No. 8E2631250-00-01
TOTAL CHARGE FOR YOUR CLAIM: 560.00	AMOUNT PREVIOUSLY PAID: .00	AMOUNT PAID FOR THIS CLAIM: .00	TOTAL AMOUNT WE PAID: .00	WHAT YOU OWE PROVIDER: .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 1,245.35 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.

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: 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 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.

18807

1-20 @ 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

JEFFREY D ALLEN
CHARLESTON SC 29407-7258

SUMMARY INFORMATION

Patient's Name ALLEN		Relationship to Policyholder CHILD		ID No. ZCS36961363	Claim No. 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 [3.69] of the [2,000.00] out-of-pocket maximum for this benefit period. We paid a total of [14.40] 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

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.



Medtronic
MINIMED

FAX COVER SHEET

18000 Devonshire Street
Northridge, CA. 91325

Date: Wednesday, July 09, 2008 2:06:52 PM

Fax: 803-264-0183

To: Carol Leper

Phone:

From: Demrest, Kathi

Fax:

Number of pages including cover 12

Phone: (+1-818) 576-4745

sheet:

NOTES: At your request, we are faxing the following materials to you. The materials may contain personal health information. We urge you to handle this information as required by applicable law. If you need to change the fax number for future transmissions, please notify your Medtronic Representative.

CONFIDENTIALITY NOTE: The information contained in this facsimile message may be legally privileged and confidential information intended only for the use of the individual or entity named above. We believe the individual named to be a representative of said entity. If the reader of this message is not the intended recipient, or is not an employee of the entity named, you are hereby notified that any use, dissemination, distribution or copying of this information is strictly prohibited and may result in violations of federal or state law. If you have received this telecopy in error, please notify us immediately by calling the telephone number above and destroy the original message. Thank You.

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Fax Cover Sheet

Date: July 9, 2008
To: BCBS of South Carolina
Attn: PRIOR AUTHORIZATION
From: Kathi Demrest/Insulin Pump Specialist
Subject/Patient: M Allen
Policy#: ZCS36961363
Group#: STATESC

Comments:

Please see the attached pre-approval request for the above-mentioned patient. Attached you will find the price listing for the Medtronic MiniMed insulin pump and supplies as well as a prescription from the patient's ordering physician.

Please process this request as soon as possible. If there are any questions, or if any additional information is required, please contact me at 800 646 4633 4544.

Sincerely,

Kathi Demrest
Insulin Pump Specialist

of pages (including Fax Cover Sheet):

Return Fax: 818 576 6616

Receiver Fax: 803-264-0183

Please call me to confirm receipt of this fax transmittal



Request for Pre-Authorization

July 9, 2008

Patient: [REDACTED] Allen
Date of Birth: [REDACTED]/2005
Policy #: ZCS36961363
Policy Holder: Jeffrey D Allen

Dear Insurance Carrier:

We are requesting that the above mentioned patient, [REDACTED] Allen, be approved for the purchase of a Medtronic MiniMed Insulin Infusion Pump and the necessary supplies. These items, prices, and HCPC codes are listed as follows with the supplies listed in quarterly quantities:

Qty.	Description	Price	HCPCS
1.000	PUMP MMT-722NAS PRDGM INS SK EN	4670.00	E0784
1.000	LINK HMS-02124701 ULTRA KIT X22 2L US	0.00	E0607
4.000	RSVR MMT-332A 10PK PRDGM 3CC 14L	98.40	A4232
4.000	INFST MMT-397 QCKSTPRDGM 23IN9M	349.60	A4230
1.000	LANCET DEVICE MMT-395 QCKSRTR M4 13L	24.95	E1399

This patient has Type Insulin Dependent Diabetes, diagnosis code . Included with this request is a copy of the prescribing physicians letter of medical necessity and information regarding the Medtronic MiniMed Insulin Infusion Pump. Please review this attached information on the above mentioned patient in order to determine if the Medtronic MiniMed Insulin Pump and supplies will be approved as medically necessary.

Please contact me at 800 646 4633 4544 as soon as this is approved as medically necessary or if any additional information is required. Thank you for your prompt attention to this matter.

Sincerely,

Kathi Demrest
Insulin Pump Specialist

JUL-09-2008 14:27 From: PEDS AMBULATORYCARE 843 876 1253
Medtronic Inc

7/8/2008 10:43:11 AM

PAGE

To: Medtronic Inc

P.2/11

2/002 Fax Server

BLUE CROSS BLUE SHIELD OF SOUTH CAROLINA

INSULIN PUMP PRECERTIFICATION for MEDICAL NECESSITY

Date: 7/8/08

PATIENT NAME: ALLEN

SUB ID: ZCS34961363

PATIENT ADDRESS:

CHARLESTON, SC 29412

PATIENT
TELEPHONE:

Daytime 843-571-7830

Evening

AGE: 2

GENDER: M ☒ F

INSULIN PUMP Request must include:

- ☐ THIS FORM Completed and signed by prescribing physician
☐ BLOOD SUGAR LOG documenting at least QID home blood glucose monitoring for the most recent 12 months
☐ Two (2) most recent PHYSICIAN NOTES related to diabetes care & rationale for prescribing insulin pump

TYPE INFUSION PUMP PRESCRIBED: Medtronic Minimed Insulin Pump and Supplies

INITIAL START-UP PUMP TRAINING

Location: Dr's office

DATE OF DIAGNOSIS Month Year

DATE OF DIAGNOSIS

Month

11/27/2007

Year

DIABETES TYPE

☒ Type 1

☐ Type 2

☐ Pregnant - Type 1

Insulin Dependent

Insulin Requiring

BDC

Current Height:

43.2cm

Current Weight:

14.3kg

Hemoglobin A1C / Glycated Hemoglobin

7.9

7.9

C-Peptide Level (if available)

0.2

0.2

1. LANTUS

3 UNITS

DAILY

2. NOVOLOG

1:25 RATIO

MEALS/SNACKS

(4-6x day)

☒ Self monitor blood glucose

(SMBG) 6-8 x per day

☐ Diet management

☐ Exercise routine

☒ Carbohydrate counting

☐ Smoking cessation

☐ Other:

☒ Blood sugar goal range:

80 to 180

☒ Widely fluctuating blood sugars

☐ Hypoglycemia unawareness

☐ Nephropathy

☐ Persistent hyperglycemia

☐ Dawn phenomenon

☐ Gastroparesis

☐ DKA

☐ Retinopathy

☐ Post renal transplant

☐ Frequent hypoglycemia

☐ Neuropathy

☐ Pregnant or planning

☒ Demonstrates compliance with current diabetes treatment regimen

☒ Intellectually, physically & psychologically capable OR has a competent care partner available

☒ Desires better glycemic control

☒ Understands carbohydrate counting

DEBORAH BOWUS
PHYSICIAN NAME (Please Print)

PHYSICIAN SIGNATURE

ALLEN
Patient ID: 2585257
Date of Birth: Not Specified

Date Range: 5/29/2008 - 6/11/2008
Omitted Events, Ins Carb Excr Meds HbA1c Exam Ket Note Gen Alm

Logbook Report

Date	Pre (mg/dL)	Breakfast	Post (mg/dL)	Lunch	Post (mg/dL)
6/11/2008			07:24A 63		
6/10/2008			09:42A 231		12:06P 190 02:15P 63 02:42P 133
6/9/2008			07:34A 158 09:31A 302	11:27A 114	
6/8/2008			07:01A 73 07:15A 86 09:52A 391	11:29A 176	
6/7/2008	06:55A 117		09:54A 317	11:00A 168	12:01P 75 01:04P 67 02:14P 284 02:48P 68 12:22P 67
6/6/2008			07:25A 229	10:21A 268	12:36P 106 12:10P 87
6/5/2008			07:09A 100	10:24A 81	12:28P 74
6/4/2008				10:43A 175	
6/3/2008			07:10A 195 09:55A 254	11:43A 235	
6/2/2008			07:38A 222 09:43A 226		12:43P 65 12:54P 69
6/1/2008			07:38A 181	11:42A 308	
5/31/2008					
5/30/2008	06:29A 82				
5/29/2008			07:23A 256		

Insulin reported here does not include any basal insulin.

6/11/2008 10:53 AM, Page 1 Of 2
CoPilot Health Management System

JUL-02-2008 09:35 From: PEDS AMBULATORYCORE 843 876 1253
Medtronic Inc 7/9/2008 2:07:11 PM PAGE 0/012 FAX DRIVER
TailMedtronic Inc P.9/17

ALLEN
Patient ID: 2585257
Date of Birth: Not Specified

Date Range: 5/23/2005 - 6/11/2008
Omitted Events: Ins Carbs Exer Meds HbA1c Lab Exam Ket Note Cgm Alim

Logbook Report

G	Pre (mg/dL)	Dinner		G	Bed & Sleep	
		G	Post (mg/dL)		Bed (mg/dL)	Sleep (mg/dL)
	06:00P 98				10:19P 101	
	03:41P 242		07:18P 107			12:07A 122
	03:43P 270		08:42P 257			12:16A 80
			08:54P 98			02:24A 106
	03:05P 94		07:52P 243		10:54P 154	11:54P 113
	04:03P 114		07:54P 80			02:08A 175
	05:51P 444					
	05:52P 81					
	03:32P 94		09:00P 400		09:27P 412	12:21A 195
	05:55P 276				10:06P 293	02:56A 140
	03:33P 104		05:58P 187		09:37P 124	
	03:32P 82					
	04:00P 183					
	03:37P 274		06:19P 289			
	03:55P 227		06:11P 189			
			08:08P 167			
	05:07P 94				10:21P 206	
					09:40P 84	02:07A 214
	03:32P 367		08:24P 120			11:40P 152

Insulin reported here does not include any basal insulin.

JUL-02-2008 09:35 From: PEDS AMBULATORY CARE 843 876 1253

TailMedtronic Inc

P-10/17

Medtronic Inc

11/2/2008 2:01:11 PM

FINAL

C:\DATA

11/2/2008 2:01:11 PM

10069E268

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411

fax 818-576-6616

07/02/2008 11:00 FAX 818 576 6488

MEDTRONIC MINIMED

Q002

Order # 100478588

CERTIFICATE OF MEDICAL NECESSITY

Doc ID: 00007000

New Pump ☒Upgrade Pump ☐Pump Supplies ☒Diabetic Supplies ☒Is this a Pediatric Model Pump? ☐Is this a Pediatric Model Pump? ☐REAL TIME Starter Kit ☒Replacement Transmitter ☐Continuous REAL Time ☐Sensors ☒

Pump Supplies ☒

- Infusion sets
- Pump cartridges/tubing
- Related supplies
- IV pump & electrode, tape, replacement (infusion)

Diabetic Supplies ☒

- Glucose Meter
- Test strips
- Lancets
- Related supplies (control solution, alcohol swabs, insulin syringes, glucose tabs)

PATIENT INFORMATION

Patient Name: <u>Jeff Allen</u>	Sex: <u>Male</u>	DOB: <u>05-76</u>	DOB: <u>2003</u>
Address: <u>100478588</u>		Phone (day): <u>843-671-7030</u>	
City/State/Zip: <u>Charleston, SC 29412</u>		Phone (home): <u></u>	
Subscriber Name: <u>Jeffrey D Allen (Please send copy of his card)</u>		Subscriber Name: <u>(Please send copy of his card)</u>	
Primary Insurance: <u>BOBS of South Carolina</u>		Secondary Insurance: <u></u>	
Group # <u>STATESG</u>	Policy # <u>ZCS3681265</u>	Group # <u></u>	Policy # <u></u>
Insurance Phone # <u>800-444-4311</u>		Insurance Phone # <u></u>	
Employer: <u></u>			

STATEMENT OF MEDICAL NECESSITY

Insulin shots/day in last 6 months: 5 to 7

Glucose check/day: NOT IN USE

HA1c: 8.0 Date: 06/1/2008

Current Diagnosis and Diabetes Complications:

250.00 ☐ 250.01 ☐ 250.02 ☐ 250.03 ☒ Additional diagnosis:

Insulin Reaction Notes:

Additional Notes:

Has the member completed a diabetes education program? Yes ☒ No ☐

Has the member been on a program of multiple daily injections of insulin with frequent self-adjustments of insulin dose for at least 6 months prior to the initiation of the insulin pump? Yes ☒ No ☐

I certify that the above patient demonstrates one or more of the following (Please check all that apply):

- ☒ A. Hemoglobin A1c level is 7.0% or 1% over upper range of normal
- ☒ B. History of severe glycemic excursions (commonly associated with brittle diabetes, hypophosphatemia, uremia, ketoacidosis, nocturnal hypoglycemia, extreme insulin sensitivity and/or very low insulin requirements)
- ☒ C. Wide fluctuations in preprandial BG levels (e.g., levels commonly exceed 100 mg/dl)
- ☒ D. Diets prearranged with BG levels often exceed 200 mg/dl
- ☒ E. Day-to-day variations in work schedule, insulin dose and/or activity level which confound the degree of regulation required to self-manage diabetes with multiple insulin injections
- ☐ F. History of hypoglycemic control failure during pregnancy
- ☐ G. Suboptimal glycemic and metabolic control after renal transplantation
- ☐ H. Poor glycemic control evidenced by CGM testing

Is this a replacement pump? ☐ Replacement transmitter? ☐ Please provide reason:

SUPPORTING CRITERIA (Please check all that apply):

☐ Member has been hospitalized or required paramedical treatment for low blood sugar

☒ Member has demonstrated ability to self-monitor blood glucose levels > 4x/day (Patient)

☒ Member is motivated to achieve and maintain improved glycemic control (Patient)

PHYSICIAN INFORMATION

Physician: <u>Shantay Webb</u>	Office Contact:
Hospital/Clinic: <u>Charleston</u>	Phone # <u>843-782-0517</u>
Address: <u>88 Jonathan Lucas Ct</u>	Fax # <u>843-782-0511</u>
CITY/STATE/ZIP: <u>CHARLESTON, SC 29425</u>	Home # <u>770-666-1470</u>

This document serves as a Prescription and Statement of Medical Necessity for the above referenced patient for a Medtronic Minimed Insulin Infusion Pump and/or any items designated above.

I certify that I am the physician identified in the above section, and I certify that the medical necessity information contained in this document is true, accurate and complete, to the best of my knowledge, and I understand that any alteration, omission, or misstatement of material fact in this section may subject me to civil or criminal liability.

Signature: [Signature]Date: 7/7/2008P. 5
P. 2/2

To: Medtronic Inc

8437920548

JUL-04-2008 12:03 PM PEDIATRIC ENDOCRINOLOGY

843 876 1253

10069E268

-294-

Progress Notes

Page: 1

Name: ALLEN [REDACTED]

Date Printed: 07/01/08
ID: 2585257 SEX: F AGE: 2

04/09/08 : 03:15pm
PEDI ENDOCRINE F/U Visit
LOCATION: RUTLEDGE TOWER
MEDICAL UNIVERSITY OF SOUTH CAROLINA
3V7-DB1

MEDICAL UNIVERSITY OF SOUTH CAROLINA
DIVISION OF PEDIATRIC ENDOCRINOLOGY
96 Jonathan Lucas St. PO BOX 250608
Charleston, SC 29425
Phone (843) 792-6807 Fax (843) 792-0540

REFERRING PROVIDER: GOFDECKE MD, AIMEE
PRIMARY PROVIDER: GOFDECKE MD, AIMEE

RE: [REDACTED] ALLEN

CHARLESTON, SC 29414
DOB [REDACTED] 05 MRN: 2585257

HPI: [REDACTED] is a 2 6/12 year old female who is followed by Pediatric Endocrinology for T1DM. [REDACTED] was last seen by me on 1/2/08. She is accompanied by her Mother today. [REDACTED] has been well since her last visit. Mother reports her blood sugars have been more in target range than her previous visit and she is feeling better about dealing with elevated or low blood sugars. [REDACTED] has not had any severe hypoglycemia episodes. She brings her glucometer today. She is checking her blood sugar 6-8 times per day with sporadic high and low blood sugars although most of her blood sugars are in target range. [REDACTED] is taking Lantus 2.5 U each am, Novolog ICR 1.25 and sliding scale as >250 1/2 unit, >350 1 unit. Her total daily dose is about 6-8 units each day (0.5 units/kg/day). [REDACTED] continues to eat well including 2 snacks each day. She is very active.

PAST MEDICAL HISTORY: Unchanged see previous note

FAMILY HISTORY: Unchanged see previous note. Maternal family history of Chron's Disease, gallstones. Maternal Grandmother status post partial thyroidectomy

SOCIAL HISTORY: [REDACTED] lives with her parents. She attends a school program.

REVIEW OF SYSTEMS: Except as noted above an extensive review of systems was unremarkable. In particular, there were no symptoms suggestive of CNS, ear, nose, throat, cardiac, pulmonary, gastrointestinal, GU, musculoskeletal, dermatologic, hematologic, or other endocrine disorders.

PHYSICAL EXAM

Height: 92.5 cm, Height %: 56.89 Height: 0.17 SD
Weight: 14.3 kg Weight %: 59.59 Weight: 0.24 SD
BMI: 16.71 kg/m2
Growth Velocity: 10.06 cm/yr

General: well-nourished well developed, nondysmorphic Caucasian female in no distress.

Head: Normal size, shape and symmetry

HEENT: Normocephalic, atraumatic. PERI A EOM: No exophthalmos or lid lag. Hearing grossly normal. Nares patent without lesions. Dentition is age-appropriate.

Neck: Supple with normal mobility, trachea midline, thyroid not palpable.

Cardiovascular: RRR, no murmurs

GU/Abdomen: Abdomen is soft and free of mass and organomegaly

Nervous System: Gait normal, muscle strength normal. Coordination is grossly intact.

Skin: Warm and dry no abnormal pigmentation, café au lait spots, acanthosis, hair growth or lesions

Musculoskeletal: No joint swelling, tenderness, redness, or deformity. Muscle tone and mass are normal

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P.13/17

To: Medtronic Inc

JUL-02-2008 09:35 From: PEDI ENDOCRINOLOGY 843 876 1253

10069E268

295

Progress Notes

Page: 2

Name: ALLEN, [REDACTED]

Date Printed: 07/01/08

ID: 2585257 SEX: F AGE: 2

Extremities: No edema or varicosities with full range of motion.

LAB REVIEW

4/9/08 A1C 7.0% RBS 150

1/2/08 A1C 9.0% RBS 297

12/19/07 A1C 8.8%

11/27/07 TSH 0.44 FT4 0.9 ICA-512 <0.8 ICA IgG 1.13 CAD-65 96.37 Insulin Ab 5.7 C-peptide 0.2 A1C 8.0%

DIAGNOSIS/IMPRESSION [REDACTED] is a 2 8/12 year old female with T1DM. She is doing well with an improved A1C over the past three months. Will plan to continue her current insulin regimen as described above. Discussed with Mother insulin pump management and gave educational material on various insulin pumps. Mother to make appointment with Sharon Schwarz to discuss insulin pumps in more detail and consider trying a saline insulin pump with [REDACTED].

FOLLOW-UP: 3 months

Dr. Deborah Bowly, MD was present in the clinic and participated in the care of this patient.

Rx: NOVOLOG VIAL, Rel. 5

Extended sig exists; see Medication List.

SIGNED BY ELIZABETH WALSH, MD (3V7) 02-30/2008 03:50PM

CO-SIGNED BY DEBORAH BOWLY, MD (001) 07/10/2008 01:41PM

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P.14/17

To: Medtronic Inc

JUL-02-2008 09:36 From: PEDS AMBULATORYCARE 843 876 1253

10089E268

-296-

Progress Notes

Page: 1

Name: ALLEN, [REDACTED]

Date Printed: 07/01/08

ID: 2585257 SEX: F AGE: 2

03/11/08 : 11:21am
DIABETES PHONE RESPONSE - PEDIATRICS
MEDICAL UNIVERSITY OF SOUTH CAROLINA

CALL RETURNED AT 11:20am

REASON FOR CALL:
INSULIN ADJUSTMENT
Insulin Type: Lantus 3units
Adjusted from: Units at
Adjusted to: Units/Ratio at

Reason for adjustment: glycemia

Patient instructed to monitor blood sugar at least QID and to call with reading if they have any pattern of hyper/hypoglycemia.

Special Instructions: Mom called concerned about high blood glucose at 9:30am snack and 11:30am and was using correction at snacks and meals and was then having hypoglycemia in afternoon. We discussed only using correction at lunch not 9:30am snack. They will cover snacks/meals with 1.25 ratio. They are very concerned when blood glucose is > 200's post prandial. We explained that at this age we do not want to correct unless it has been 3 hours since meal/snack. She verbalized understanding. As well mom feels that the pens leak with such a small dose of insulin and that the syringes work better. She will ask the school to use syringes as well as using them at home. Dr. Walsh spoke with mother in great detail regarding above.

INSTRUCTIONS GIVEN: to call back as needed with any further hypoglycemia/hyperglycemia.

SIGNED BY SHARON SCHWARZ, R.N. (17) 03/11/2008 11:33AM

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JUL-02-2008 09:36 From: PEDS AMBULATORYCARE 843 876 1253 To: Medtronic Inc P.15/17

10069E268

Progress Notes

Page: 1

Name: ALLEN, [REDACTED]

Date Printed: 07/01/08
ID: 2585257 SEX: F AGE: 2

01/02/08 01:00pm
PEDS ENDOCRINE F/U Visit
LOCATION: RUTLEDGE TOWER
MEDICAL UNIVERSITY OF SOUTH CAROLINA
3V7 DB1

MEDICAL UNIVERSITY OF SOUTH CAROLINA
DIVISION OF PEDIATRIC ENDOCRINOLOGY
96 Jonathan Lucas St PO BOX 250808
Charleston, SC 29425
Phone (843) 792-6807 Fax (843) 792-0548

REFERRING PROVIDER: GOFDECKE MD, AIMEE A 1243 SAVANNAH HWY CHARLESTON, SC 29407
PRIMARY PROVIDER: GOFDECKE MD, AIMEE A 1243 SAVANNAH HWY CHARLESTON, SC 29407

RE: EVA ALLEN

[REDACTED]
CHARLESTON, SC 29407
DOB: [REDACTED] /05 MRN 2585257

HPI: [REDACTED] is a 2 5/12 year old female who is followed by Pediatric Endocrinology for type one diabetes mellitus. [REDACTED] is accompanied by her Mother today. [REDACTED] was recently diagnosed 6 weeks ago after being admitted to the PICU in DKA. Her DKA resolved without complications and she was transitioned to subcutaneous insulin and discharged home after teaching in a couple of days. She has done well since her discharge home without any severe hypoglycemic episodes. She has sporadic elevated blood sugars mostly in the afternoons and evenings. She brings her glucometer and log book today which show blood sugar in target range in the morning and in the 200-300 range in the afternoon and evening. Eva's current insulin regimen is Lantus 2 U each evening, Novolog Insulin for carbohydrate coverage: 20-30g: 1 1/2u, 31-45g: 2u, 46-60g: 2 1/2u and sliding scale: >250 1/2u, >305 1u. She takes approximately 2u with each meal and has a morning and afternoon snack below 10 g of carbohydrates for which she does not take coverage. Her total daily dose is 8 units per day (0.6 u/kg/day). They are checking blood sugars about 5-6 times per day and rotating sites over arms, abdomen, and buttock. [REDACTED] is eating very well without nausea, vomiting, diarrhea. She does not have constipation, skin, or hair changes. She is very active, especially when at her daycare program. Mom reports she does not have polyuria or polydipsia.

PAST MEDICAL HISTORY: Eva is the product of a full term gestation without complications. She has not been previously hospitalized or had any surgeries. She has a history of reactive airway disease with upper respiratory infections.

FAMILY HISTORY: Mother is 5'4", Father is 5'10", both healthy. Maternal family history of Chron's Disease, gallstones. Maternal Grandmother status post partial thyroidectomy. Maternal Great Grandmother with adult onset diabetes. Paternal family member with Multiple Sclerosis.

SOCIAL HISTORY: [REDACTED] lives with her parents. She attends a daycare program.

REVIEW OF SYSTEMS: Except as noted above an extensive review of systems was unremarkable. In particular, there were no symptoms suggestive of CNS, ear, nose, throat, cardiac, pulmonary, gastrointestinal, GU, musculoskeletal, dermatologic, hematologic, or other endocrine disorders.

PHYSICAL EXAM

HR 123 BP 85/62

Height: 89.8 cm Height % 54.53 Height Z: 1.50

Weight: 13.3kg Weight % 42.36 Weight Z: -0.00

BMI 16.49

General: well-nourished well-developed, nondysmorphic Caucasian female in no distress.

Head: Normal size, shape and symmetry.

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P.16-17

To: Medtronic Inc

JUL-02-2008 09:37 From: PEDS AMBULATORYCARE 843 876 1253

10069E268

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Progress Notes

Page: 2

Name: ALLEN, [REDACTED]

Date Printed: 07/01/08

ID: 2585257 SEX: F AGE: 2

HEENT: Normocephalic, atraumatic. Conjunctiva normal. PERRLA, EOML. No exophthalmos or lid lag. Funduscopy exam

normal. Hearing normal. Nares patent without lesion. Dentition is age-appropriate.

Neck: Supple with normal mobility, trachea midline, thyroid not palpable.

Cardiovascular: PMI normally placed. RRR, no murmurs, gallops, or other abnormal sound.

GI/Abdomen: Abdomen is soft and free of mass and organomegaly.

Genitourinary: External genitalia are normal. Tanner stage 1.

Nervous System: Gait normal, muscle strength normal. Coordination is grossly intact.

Skin: Warm and dry, no abnormal pigmentation, café au lait spots, acanthosis, hair growth or lesions. Bruising over abdomen from injection sites.

Musculoskeletal: No joint swelling, tenderness, redness, or deformity. Muscle tone and mass are normal.

Extremities: No edema or varicosities with full range of motion.

LAB REVIEW

1/2/08 A1C 9.0% RBS 297

12/19/07 A1C 8.8%

11/27/07 TSH 0.44 FT4 0.9 ICA-512 <0.8 ICA IgG 1:16 GAD-65 98.37 Insulin Ab 5.7 C-peptide 0.2 A1C 8.0%

DIAGNOSIS/IMPRESSION: [REDACTED] is a 2 5/12 year old female with type one diabetes mellitus. She is doing fairly well although persistently having elevated blood sugars throughout the afternoon and evening. Her morning fasting blood sugars are within target range. We discussed switching her Lantus to the morning to help improve daytime BS. We will adjust her sliding scale to treat blood sugars 200-349 with 1/2 unit Novolog and >350 1 unit Novolog. We will continue her current carbohydrate coverage. Mom to call with persistently elevated or low blood sugars.

FOLLOW-UP: 3 months with nutrition follow-up

Dr. Deborah Bowlby, MD pager id 14535 was present in the clinic and participated in the care of this patient.

Rx: NOVOLOG PENFILLS, 1 box Ref. 5

Extended sig exactly; see Medication List

Rx: NOVOFINE 30 as directed, 100=1 BOX, Ref. 6

Extended sig exactly; see Medication List

SIGNED BY ELIZABETH WALSH, MD (3V7) 01/01/2008 10:23AM

CO-SIGNED BY DEBORAH BOWLBY MD (DR*) 01/01/2008 02:53PM

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JUL-02-2008 09:37 From: PEDS AMBULATORYCARE 843 876 1253

10069E268

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Medical University of South Carolina

Charleston, SC

843-792-2123

Practice Partner Note

Patient: ALLEN, [REDACTED]

MRN: 002585[REDACTED]

Attending:

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

[REDACTED] ALLEN

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 [REDACTED]

Outcome/Comprehension: Able to state understanding and/or return demonstration

Comments (names of teaching materials used, concerns, etc.): Met with Eva's

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. [REDACTED] 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

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2000/4/0004

108605268

10/05/2009 09:44 FAX 843 727 7696



Medical University of South Carolina

Charleston, SC

843-792-2123

Practice Partner Note

Patient: ALLEN, [REDACTED]

MRN: 002585257

Attending:

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. Change 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 0.1 units 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).

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1008508257

10/05/2009 09:44 FAX 843 727 7698

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Medical University of South Carolina
Charleston, SC
843-792-2123

Practice Partner Note

Patient: ALLEN, [REDACTED]

MRN: 002585257

Attending:

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

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2000/90007

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10/05/2009 09:44 FAX 843 727 7896

CHAPTER 71. ACCIDENT AND HEALTH INSURANCE

38-71-46. 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

5

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), mamimoplasty (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 palate, 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.
- 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 program;

SS. Any services or charges related to animals trained to aid the physically challenged;

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.

- 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 for one 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, 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 to a \$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 in one Plan year Coinsurance of \$2,000 for Covered Medical Expenses, or Coinsurance of \$4,000 for Covered Medical Expenses incurred in one 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 Supplement 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 one 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 one 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 one Plan Year, or Coinsurance of \$4,000 for Covered Medical Expenses have been incurred in one 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 therapist licensed in the appropriate professional discipline;
- 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 Administrator 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



Blue Cross BlueShield
of South Carolina
Columbia, S.C. 29219-0001

An independent licensee of the Blue Cross and Blue Shield Association.

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(6)

April 7, 2009

Jeffrey Allen

Charleston, SC 29414-6577

RE: Patient: Allen
ID #: ZCY247451184
Claim Number: 8E263125000

Dear Mr. Allen:

I have received your letter of appeal dated February 25, 2009. Please allow us up to 60 days to thoroughly complete our review and respond to you in writing. In the meantime, if you have any questions or concerns about this matter, please call me at 1-800-868-2520.

Thank you for allowing us to serve you.

Sincerely,

Rochelle Council
State Health Plan Service Center

APP16 /460/18
IKEY: ZCY247451184
EOD



**BlueCross BlueShield
of South Carolina**

Columbia, S.C. 29219-0001

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April 15, 2009

[REDACTED] Allen

Charleston, SC 29414-6577 [REDACTED]

RE: Patient: [REDACTED]
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 us 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 all the medical records we requested.

Please ask your provider whether you need to sign a special form authorizing 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
OEOD



South Carolina

BlueCross BlueShield of South Carolina
1-20 at Alpine Road
Columbia, SC 29219-0001
803.788.0222

SouthCarolinaBlues.com

March 19, 2010

Jeffrey Allen
[REDACTED]

Charleston, South Carolina 29414-6577
[REDACTED]

RE: Patient: [REDACTED] Allen
ID#: ZCS: 36961363
Date(s) of Service: August 5, 2008

Dear Mr. Allen:

We received an appeal of the date of service for [REDACTED] Allen listed above, which was updated by a fax received from Christy Allen, which included requested medical records. Our medical director has reviewed the appeal documents including the medical records and upheld the denial on the grounds that (1) the services referenced in the appeal are specifically excluded in the Plan of Benefits, Article 9, paragraph O; in addition Article 9, paragraph BB applies as there is no mention of this service in the Benefits section of the Plan; and (2) the statute referenced in the appeal documents does not apply to the State Health Plan.

Because the medical director has upheld the denial of the above referenced service, the appeal file will now be sent to the Appeals Review Committee. When we have completed this review, we will notify you in writing.

If you have questions about this matter, please call me at (803) 264-2886.

Sincerely,

Brooks Goodman, Senior Director
State Operations, AX-B10
Phone: 803-264-2886
Fax: 803-870-8483
Brooks.goodman@bcbssc.com

cc: John A. Massalon, Esq.
Wills & Massalon, LLC
P.O. Box 859
Charleston, SC 29402



South Carolina

April 2, 2010

BlueCross BlueShield of South Carolina
1-20 at Alpine Road
Columbia, SC 29219-0001
803.788.0222

SouthCarolinaBlues.com

Jeffrey D. Allen

Charleston, South Carolina 29414

RE: Patient: [REDACTED] Allen
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 [REDACTED] Allen; 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.

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.

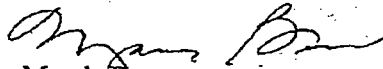
We regret that our decision was not favorable. We are sympathetic to Allen's individual situation; however, we are obligated to review claims consistent with the plain and ordinary meaning of the Plan. In doing so, we are fulfilling our duty as claims administrator to interpret the Plan.

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

ASHBY MINER JORDAN, SR., M.D.
404 Oakbrook Drive
Columbia, South Carolina 29223
Telephone: (803) 788-1166

CURRICULUM VITAE

WORK EXPERIENCE

December 1986 - to Present	<u>Vice President - Medical Affairs/Corporate Medical Director</u> Blue Cross Blue Shield of South Carolina I-20 at Alpine Road Columbia, South Carolina 29219 Telephone: (803) 264-3873
May 1983 - October 1986	<u>Vice President - Medical Affairs</u> CIGNA Healthplan of South Florida, Inc. Fort Lauderdale, Florida
February 1980 - April 1983	<u>Chief of Staff</u> Paradise Valley Health Care Center CIGNA Healthplan of Arizona Phoenix, Arizona
October 1978 - February 1980	<u>Staff Pediatrician</u> Arizona Health Plan (CIGNA Healthplan of Arizona) Phoenix, Arizona
November 1975 - October 1978	<u>Private Practice</u> Pollock & Arnall, M.D., P.a. Ft. Myers, Florida

EDUCATION

September 1957 - June 1961	University of Florida Gainesville, Florida Degree: Bachelor of Science
September 1961 - June 1965	Emory University School of Medicine Atlanta, Georgia Degree: Doctor of Medicine

MILITARY SERVICE

June 1966 - March 1968	U.S. Air Force McGuire Air Force Base, New Jersey Flight Surgeon
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Ashby M. Jordan, Sr., M.D.

MILITARY SERVICE (continued)

March 1968 - March 1969	Phu Cat Air Base Republic of Viet Nam Flight Surgeon
July 1971 - August 1975	USAF Regional Hospital Eglin Air Force Base, Florida Chief of Pediatric Services

INTERNSHIP

July 1965 - June 1966	Cincinnati General Hospital Cincinnati, Ohio Straight Pediatrics
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RESIDENCY TRAINING

July 1969 - June 1970	Active Duty - U.S. Air Force Grady Memorial Hospital Atlanta, Georgia Resident Pediatrics
July 1970 - July 1971	Henrietta Egleston Hospital for Children Atlanta, Georgia Chief Resident

BOARD CERTIFICATION

July 1, 1982	Diplomate, American Board of Pediatrics Certification #15387
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LICENSURE

Georgia	#10976 - 1965
South Carolina	#13695 - 1987

**ORGANIZATIONAL
AFFILIATION**

American Academy of Pediatrics
American College of Physician Executives
South Carolina Medical Association

**ACADEMIC
APPOINTMENTS**

Clinical Associate Professor
Department of Family Medicine and Community Health
University of South Carolina
School of Medicine
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,)

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.)

FILED
2010 JUN -3 PM 4:22
JULIE J. ARMSTRONG
CLERK OF COURT

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.

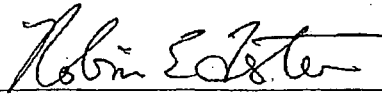
The director, or his designee, shall provide specific reasons for the decision and citation of the pertinent Plan provisions, and may, if the director or his designee agrees with the Third Party Claims Processor or Utilization Review Agency, deny the claim of the Covered Person, and if he agrees with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

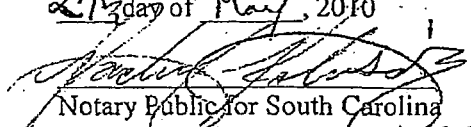
The exclusive remedy for the denial of benefits shall be as provided in 12.5 and by judicial review of that decision under 1976 S.C. Code Ann § 1-23-380, (as amended) as provided by statute. No appeal may be brought until a Covered Person has exhausted the review procedure set forth in 12.5, nor will 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
20th day of May, 2010



Notary Public for South Carolina
My Commission Expires: 6-25-2014

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

DOCKET NO. 10-ALJ-30-0710-AP

Jeffrey D. Allen, on behalf of Eva Allen.....Appellant,

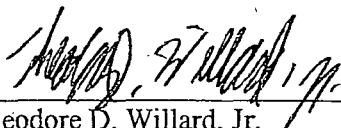
vs.

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

CERTIFICATE OF SERVICE

I certify that I have served the Record on Appeal on Jeffrey D. Allen by depositing one copy of it in the United States Mail, postage prepaid on November 17, 2010, addressed to his attorney of record, Matthew D. Hamrick, 1017 Chuck Dawley Blvd., Post Office Box 1007, Mt. Pleasant, South Carolina 29465.

November 17, 2010



Theodore D. Willard, Jr.
MONTGOMERY WILLARD, LLC
1002 Calhoun Street
Post Office Box 11886
Columbia, South Carolina 29211-1886
Telephone: (803) 779-3500
ATTORNEY FOR THE RESPONDENT

**STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT**

DOCKET NO. 10-ALJ-30-0710-AP

Jeffrey D. Allen, on behalf of [REDACTED] Appellant,

vs.

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

SUPPLEMENTAL RECORD ON APPEAL

Theodore D. Willard, Jr.
MONTGOMERY WILLARD, LLC
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Kelly H. Rainsford
STATE BUDGET & CONTROL BOARD
1201 Main Street, Suite 300
Columbia, South Carolina 29201-3230
Telephone: (803) 734-2375
Fax: (803) 737-0825
ATTORNEYS FOR THE RESPONDENT

Matthew D. Hamrick
**RICHARDSON, PATRICK, WESTBROOK &
BRICKMAN, LLC**
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Post Office Box 1007
Mt. Pleasant, South Carolina 29465
Telephone: (843) 727-6500
E-Mail: MHamrick@RPWB.com
ATTORNEY FOR THE APPELLANT

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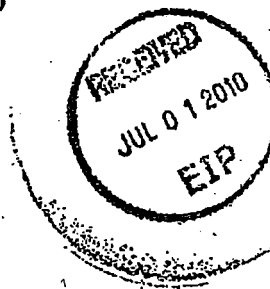
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134 Meeting Street, Suite 100 • Charleston, SC 29401 • Post Office Box 859 • Charleston, SC 29402
Phone: 843-727-1144 • Fax: 843-727-7696 • www.wmalawfirm.net

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 BCBS. As you already know the Plaintiffs have brought a putative class action lawsuit against the SCEIP and BCBS 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 BCBS's Motion to Dismiss, Answer, Motion for Summary Judgment and both underlying administrative decisions to date, neither BCBS 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.

under the law.

Thank you.

With kind regards, I am

Sincerely,

WILLS MASSALON & ALLEN, LLC

Smith Irick, Paralegal
for John A. Massalon

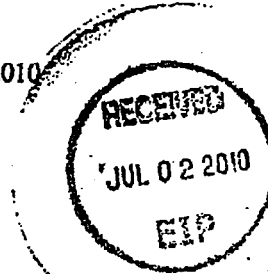
Enclosures

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



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
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under the law.

Thank you.

With kind regards, I am

Sincerely,

WILLS MASSALON & ALLEN, LLC

Smith Irick, 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

WILLS & MASSALON, LLC

ATTORNEYS AT LAW

PO Box 859
CHARLESTON, SOUTH CAROLINA 29402



595-1
Kelly H. Rainsford, Esquire
State Budget & Control Board
1201 Main Street, Ste. 300
Columbia, South Carolina 29201

29201+3230



RP:CT:CL 70-00-0107

STATE OF SOUTH CAROLINA

)

COURT OF COMMON PLEAS

COUNTY OF CHARLESTON

)

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,

)

CASE NO: 2009-CP-10-7404

)

)

)

Plaintiffs,

)

)

v.

)

)

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

)

)

)

)

Defendants.

)

SUMMONS

BY

JULIE J. ARMSTRONG
CLERK OF COURT

2009 NOV 25 AM 10:56

FILED

TO SOUTH CAROLINA BUDGET AND CONTROL BOARD EMPLOYEE INSURANCE
PROGRAM:

YOU ARE HEREBY SUMMONED and required to Answer the Complaint in this
action, a copy of which is herewith served upon you, and to serve a copy of your Answer to said
Complaint on the below subscribed attorney at his office at 134 Meeting Street, Suite 100,
Charleston, South Carolina 29401 within thirty (30) days after the service hereof, exclusive of
the day of such service; and if you fail to Answer the Complaint within the time aforesaid,
Plaintiff in this action will apply to the Court for the relief demanded in the Complaint and will
seek a default judgment against you.

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

87

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

FILED

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).

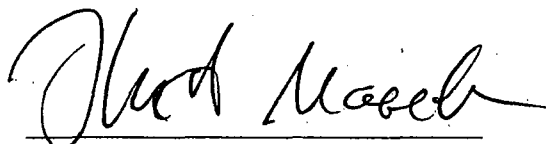
(emphasis added).

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

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(s))

vs.)

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

Defendant(s))

(Please Print)

Submitted By: John A. Massalon

Wills & Massalon, LLC

Address: 134 Meeting Street, Suite 100

Charleston, South Carolina 29401

SC Bar #: 10279

Telephone #: 843-727-1144

Fax #: 843-727-7696

Other:

E-mail: jmassalon@wills-massalon.com

2009-CP - 10- 7404

NOTE: The cover sheet and information contained herein neither replaces nor supplements the filing and service of pleadings or other papers as required by law. This form is required for the use of the Clerk of Court for the purpose of docketing. It must be filled out completely, signed, and dated. A copy of this cover sheet must be served on the defendant(s) along with the Summons and Complaint.

DOCKETING INFORMATION (Check all that apply)

**If Action is Judgment/Settlement do not complete*

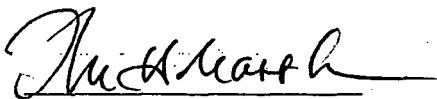
- ☐ JURY TRIAL demanded in complaint. ☒ NON-JURY TRIAL demanded in complaint.
☐ This case is subject to ARBITRATION pursuant to the Court Annexed Alternative Dispute Resolution Rules.
☐ This case is subject to MEDIATION pursuant to the Court Annexed Alternative Dispute Resolution Rules.
☐ This case is exempt from ADR. (Proof of ADR/Exemption Attached)

NATURE OF ACTION (Check One Box Below)

- | | | | |
|---|---|---|--|
| Contracts | Torts - Professional Malpractice | Torts - Personal Injury | Real Property |
| ☐ Constructions (100) | ☐ Dental Malpractice (200) | ☐ Assault/Slander/Libel (300) | ☐ Claim & Delivery (400) |
| ☐ Debt Collection (110) | ☐ Legal Malpractice (210) | ☐ Conversion (310) | ☐ Condemnation (410) |
| ☐ Employment (120) | ☐ Medical Malpractice (220) | ☐ Motor Vehicle Accident (320) | ☐ Foreclosure (420) |
| ☐ General (130) | ☐ Previous Notice of Intent Case # | ☐ Premises Liability (330) | ☐ Mechanic's Lien (430) |
| ☐ Breach of Contract (140) | 20 -CP- | ☐ Products Liability (340) | ☐ Partition (440) |
| ☐ Other (199) | ☐ Notice/ File Med Mal (230) | ☐ Personal Injury (350) | ☐ Possession (450) |
| | ☐ Other (299) | ☐ Wrongful Death (360) | ☐ Building Code Violation (460) |
| | | ☐ Other (399) | ☐ Other (499) |
| Inmate Petitions | Judgments/Settlements | Administrative Law/Relief | Appeals |
| ☐ PCR (500) | ☐ Death Settlement (700) | ☐ Reinstate Driver's License (800) | ☐ Arbitration (900) |
| ☐ Mandamus (520) | ☐ Foreign Judgment (710) | ☐ Judicial Review (810) | ☐ Magistrate-Civil (910) |
| ☐ Habeas Corpus (530) | ☐ Magistrate's Judgment (720) | ☐ Relief (820) | ☐ Magistrate-Criminal (920) |
| ☐ Other (599) | ☐ Minor Settlement (730) | ☐ Permanent Injunction (830) | ☐ Municipal (930) |
| | ☐ Transcript Judgment (740) | ☐ Forfeiture-Petition (840) | ☐ Probate Court (940) |
| | ☐ Lis Pendens (750) | ☐ Forfeiture-Consent Order (850) | ☐ SCDOT (950) |
| | ☐ Transfer of Structured Settlement Payment Rights Application (760) | ☐ Other (899) | ☐ Worker's Comp (960) |
| | ☐ Other (799) | | ☐ Zoning Board (970) |
| Special/Complex/Other | | | ☐ Administrative Law Judge (980) |
| ☐ Environmental (600) | ☐ Pharmaceuticals (630) | | ☐ Public Service Commission (990) |
| ☐ Automobile Arb. (610) | ☐ Unfair Trade Practices (640) | | ☐ Employment Security Comm (991) |
| ☐ Medical (620) | ☐ Out-of State Depositions (650) | | ☐ Other (999) |
| ☒ Other (699) | ☐ Sexual Predator (510) | | |

Class Action-
Declaratory
Judgment

Submitting Party Signature:



Date: November 25, 2009

Note: Frivolous civil proceedings may be subject to sanctions pursuant to SCRCP, Rule 11, and the South Carolina Frivolous Civil Proceedings Sanctions Act, S.C. Code Ann. §15-36-10 et. seq.

FAMILY MANDATED ADR COUNTIES ONLY
Allendale, Anderson, Beaufort, Colleton, Florence, Greenville,
Hampton, Horry, Jasper, Lexington, Pickens (Family Court Only), and Richland

SUPREME COURT RULES REQUIRE THE SUBMISSION OF ALL CIVIL CASES TO AN ALTERNATIVE DISPUTE RESOLUTION PROCESS, UNLESS OTHERWISE EXEMPT.

You are required to take the following action(s):

1. The parties shall select a neutral and file a "Proof of ADR" form on or by the 210th day of the filing of this action. If the parties have not selected a neutral within 210 days, the Clerk of Court shall then appoint a primary and secondary mediator from the current roster on a rotating basis from among those mediators agreeing to accept cases in the county in which the action has been filed.
2. The initial ADR conference must be held within 300 days after the filing of the action.
3. Pre-suit medical malpractice mediations required by S.C. Code §15-79-125 shall be held not later than 120 days after all defendants are served with the "Notice of Intent to File Suit" or as the court directs. (Medical malpractice mediation is mandatory statewide.)
4. Cases are exempt from ADR only upon the following grounds:
 - a. Special proceeding, or actions seeking extraordinary relief such as mandamus, habeas corpus, or prohibition;
 - b. Requests for temporary relief;
 - c. Appeals
 - d. Post Conviction relief matters;
 - e. Contempt of Court proceedings;
 - f. Forfeiture proceedings brought by governmental entities;
 - g. Mortgage foreclosures; and
 - h. Cases that have been previously subjected to an ADR conference, unless otherwise required by Rule 3 or by statute.
5. In cases not subject to ADR, the Chief Judge for Administrative Purposes, upon the motion of the court or of any party, may order a case to mediation.
6. Motion of a party to be exempt from payment of neutral fees due to indigency should be filed with the Court within ten (10) days after the ADR conference has been concluded.

**Please Note: You must comply with the Supreme Court Rules regarding ADR.
Failure to do so may affect your case or may result in sanctions.**