

THE STATE OF SOUTH CAROLINA
In the Supreme Court

APPEAL FROM THE ADMINISTRATIVE LAW COURT
Shirley C. Robinson, Administrative Law Judge

Appellate Case No. 2012-213186

RECEIVED

JAN 15 2013

S.C. Supreme Court

Jeffrey D. Allen, on behalf of Jane Doe

Appellant,

v.

South Carolina Public Employee Benefit Authority,
Employee Insurance Program

Respondent.

RECORD ON APPEAL
VOLUME I

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VOLUME I

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**STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT**

SC ADMIN. LAW COURT

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

Docket No. 10-ALJ-30-0710-AP

Appellant,)

vs.)

ORDER

South Carolina Public Employee Benefit
Authority, Employee Insurance Program,)

Respondent.)

For the Appellant: John A. Massalon, Esquire
Matthew D. Hamrick, Esquire
Terry E. Richardson, Esquire

For the Respondent: Theodore D. Willard, Jr., Esquire
Kelly H. Rainsford, Esquire

STATEMENT OF THE CASE

The above-captioned matter is before the Administrative Law Court ("ALC" or "Court") pursuant to S.C. Code Ann. § 1-11-710(C) (2008) and 1-23-600(D) and (E) for an administrative appeal. In this matter, Appellant Jeffrey D. Allen ("Appellant"), on behalf of [REDACTED] seeks review of a decision (the "Decision") by Respondent South Carolina Public Employee Benefit Authority, Employee Insurance Program¹ ("EIP") denying coverage for diabetes education through the Group Health Benefits Plan of the Employees of the State of South Carolina, the Public School Districts, and Participating Entities (the "Plan").

Based upon the record, the parties' briefs, and applicable law, I affirm the final decision of EIP.

BACKGROUND

Appellant is an employee of Dorchester County School District Two and participated in the state insurance benefit program offered through EIP. Appellant and his daughter, [REDACTED] ("Dependent"), have been covered by one of the health plan options offered through EIP since

¹ Effective July 1, 2012, the South Carolina Retirement Systems, a division of the South Carolina Budget and Control Board ("Board"), was transferred from the Board to a newly created agency, the South Carolina Public Employee Benefit Authority pursuant to Act 278 of 2012. The caption of this appeal has been amended accordingly.

2005. Specifically, Appellant and Dependent were covered under the Medical University of South Carolina ("MUSC") Options from September 1, 2005, to December 31, 2006. Beginning January 1, 2007, Appellant and Dependent were covered by the Standard Plan.

Appellant was diagnosed with Type I diabetes in November 2007. On August 5, 2008, Appellant, Appellant's spouse, Dependent's grandparents, and two daycare nurses attended a diabetes management educational session in relation to Dependent's new insulin pump. The total cost of the session was \$560.00. On August 27, 2008, BlueCross BlueShield of South Carolina ("BCBSSC"), the third-party claims administrator for the State Health Plan, sent Appellant an Explanation of Benefits ("EOB") showing the claim was denied. The explanatory note read, "[y]our benefit plan does not cover education and/or training for this condition," in accordance with the terms of the Plan. On February 25, 2009, Appellant's spouse wrote a letter of appeal to BCBSSC.

On April 20, 2009, BCBSSC sent Appellant an adjusted EOB. This EOB had no changes except for an explanatory note: rather than "your benefit plan does not cover education and/or training for this condition," the new EOB indicated that BCBSSC had requested additional medical information from the provider. BCBSSC subsequently received Dependent's medical records from MUSC. After receipt of the medical records, on March 15, 2010, Ashby Jordan, M.D., a board certified pediatrician and the Medical Director and Vice President of Medical Affairs for BCBSSC, reviewed Dependent's file in its entirety. Dr. Jordan noted the services referenced were specifically excluded by the Plan under Article 9, Paragraph O. Dr. Jordan 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. Finally, Dr. Jordan noted that a South Carolina statute, referenced by Appellant's spouse in her appeal document, did not apply to the Plan.

On March 19, 2010, BCBSSC sent Appellant a letter indicating the Medical Director had denied Appellant's appeal for the reasons stated above. Because the Medical Director did not approve the appeal, the appeal was sent for consideration to the BCBSSC appeals committee. On April 2, 2010, BCBSSC sent Appellant a letter denying Appellant's appeal for additional benefits for the August 5, 2008 educational session. The letter stated the BCBSSC appeals committee concluded that the Plan specifically excluded educational services in Article 9,

Paragraph O, and Article 7 excluded services not specifically covered. BCBSSC also noted that S.C. Code Ann. § 38-71-46 did not apply to the Plan.

On June 30, 2010, Appellant's attorney appealed the denial to the EIP Appeals Committee. On August 24, 2010, EIP wrote Appellant's counsel that the EIP Appeals Committee had denied the request for reimbursement for Dependent's diabetes education. Appellant subsequently appealed this denial to the ALC on September 22, 2010.

ISSUES ON APPEAL

1. Did the EIP err in finding that S.C. Code § 38-71-46 does not apply to the State Health Plan?
2. Did the EIP err in not finding the State Health Plan exclusion for "education programs" void as a matter of law as to diabetes education?
3. Did the EIP err in failing to reform the state health plan to comply with S.C. Code § 38-71-46?
4. Did the EIP err in failing to notify all persons affected by its failure to comply with S.C. Code Ann. § 38-71-46 since said law was first enacted in 2000?
5. Did the EIP err in not disgorging all monies which should have been paid out to participants on claims pursuant to S.C. Code § 38-71-46 for diabetes education?
6. Does the ALC have the authority to certify a class action pursuant to ALC Rule 68 and SCRCP 23?

STANDARD OF REVIEW

Appellate review by this Court of a final EIP decision is governed by the standards set forth in Section 1-23-380 of the South Carolina Code. See S.C. Code Ann. § 1-11-710(C) (2008) (requiring appellate judicial review of decisions of the South Carolina Budget and Control Board to be consistent with the standards provided in Section 1-23-380); S.C. Code Ann. § 1-23-600(E) (Supp. 2011) (directing administrative law judges to conduct appellate review in the same manner as prescribed in Section 1-23-380 for judicial review of a final agency decision). Section 1-23-380 provides that this Court "may not substitute its judgment for the judgment of the agency as to the weight of the evidence on questions of fact." S.C. Code Ann. § 1-23-380(5) (Supp. 2011). However, pursuant to Section 1-23-380(5), this Court:

may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions or decisions are:

- (a) in violation of constitutional or statutory provisions;
- (b) in excess of the statutory authority of the agency;
- (c) made upon unlawful procedure;
- (d) affected by other error of law;
- (e) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or
- (f) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

Id. “‘Substantial evidence’ is not a mere scintilla of evidence nor the evidence viewed blindly from one side of the case, but is evidence which, considering the record as a whole, would allow reasonable minds to reach the conclusion that the administrative agency reached or must have reached in order to justify its action.” Lark v. Bi-Lo, Inc., 276 S.C. 130, 135, 276 S.E.2d 304, 306 (1981) (quoting Law v. Richland County School Dist. No. 1, 270 S.C. 492, 495-96, 243 S.E.2d 192, 193 (1978)). “The findings of the agency are presumed correct and will be set aside only if unsupported by substantial evidence.” Hull v. Spartanburg County Assessor, 372 S.C. 420, 424, 341 S.E.2d 909, 911 (Ct. App. 2007) (quoting Kearse v. State Health and Human Servs. Fin. Comm’n, 318 S.C. 198, 200, 456 S.E.2d 892, 893 (1995)). Accordingly, “[t]he ‘possibility of drawing two inconsistent conclusions from the evidence does not prevent an administrative agency’s finding from being supported by substantial evidence.’” Grant v. S.C. Coastal Council, 319 S.C. 348, 353, 461 S.E.2d 388, 391 (1995) (quoting Palmetto Alliance, Inc. v. S.C. Pub. Serv. Comm., 282 S.C. 430, 432, 319 S.E.2d 695, 696 (1984)).

DISCUSSION

Education Services

The 2008 State Health Plan (the “Plan”), established by the South Carolina Budget and Control Board, provides in pertinent part:

Article 9

Exclusions and Limitations

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

...

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;

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.

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.

In reviewing the Record on Appeal and in consideration of the applicable law, I conclude there is substantial evidence in the record to support EIP's claims determination that individually-billed diabetes management education was not covered under the terms of the Plan. While the Plan undisputedly covered the insulin pump and accessories, Dependent's separately-billed educational instruction was not included. Article 9, Paragraph O of the State Health Plan excludes educational services, outside of certain situations. Diabetes education, as a stand-alone claim, was not included under EIP's Hospice Program and/or Home Health Care Program and therefore was not covered. Additionally, Paragraph BB of the Plan states those services not enumerated in Article 7, Schedule of Benefits, are not covered; diabetes education was not listed in the Schedule of Benefits. Therefore, no benefits are payable for the educational services received by Appellant, Appellant's spouse, Dependent's grandparents, and two nurses on Dependent's behalf in relation to Dependent's insulin pump on August 5, 2008.

Contracts should be interpreted according to the general rules of construction, and the language is to be understood in its plain, ordinary and popular sense. Universal Underwriters v. Metro. Prop. & Life Ins. Co., 298 S.C. 404, 380 S.E.2d 858 (Ct. App. 1989). Based on the unambiguous language of the Plan applied to the evidence provided, EIP's decision denying Appellant's request for additional benefits was not an abuse of discretion and was supported by

substantial evidence: the services were separately-billed educational services, and as such, those services are excluded under the Plan.

S.C. Code Ann. § 38-71-46

Appellant argues that if the Plan excludes coverage for diabetes education, the Plan should be reformed pursuant to S.C. Code Ann. § 38-71-46 to cover diabetes education. In response, EIP argues that S.C. Code Ann. § 38-71-46 has no application to the Plan because it is a self-funded, non-federal governmental plan that is not subject to regulation by the South Carolina Department of Insurance (the "Department").

The cardinal rule of statutory construction is to give effect to the intent of the legislature. S.C. Coastal Conservation League v. S.C. Dep't of Health and Envtl. Control, 390 S.C. 418, 425, 702 S.E.2d 246, 250 (2010); Hodges v. Rainey, 341 S.C. 79, 85, 533 S.E.2d 578, 581 (2000) (citing Charleston County Sch. Dist. v. State Budget and Control Bd., 313 S.C. 1, 437 S.E.2d 6 (1993)). Legislative intent is first and foremost determined by the language of the statute. State v. Pittman, 373 S.C. 527, 561, 647 S.E.2d 144, 161 (2007) (citing Whitner v. State, 328 S.C. 1, 6, 492 S.E.2d 777, 779 (1997)). "When a statute's terms are clear and unambiguous on their face, there is no room for statutory construction and a court must apply the statute according to its literal meaning." S.C. Coastal Conservation League, 390 S.C. at 425-26, 702 S.E.2d at 250; see, also Sloan v. Hardee, 371 S.C. 495, 498, 640 S.E.2d 457, 459 (2007). "Unless there is something in the statute requiring a different interpretation, the words used in a statute must be given their ordinary meaning." Id., 390 S.C. at 425, 702 S.E.2d at 250. The literal language of a statute should be disregarded only when the result is so plainly absurd that it clearly could not have been the intent of the legislature. Kiriakides v. United Artists Commc'ns, Inc., 312 S.C. 271, 275, 440 S.E.2d 364, 366 (1994) (citing Stackhouse v. Rowland, 86 S.C. 419, 68 S.E. 561 (1910)).

"The legislature is presumed to have fully understood the meaning of the words used in a statute and, unless this meaning is vague or indefinite, intended to use them in their ordinary and common meaning or in their well-defined legal sense." Pee v. AVM, Inc., 344 S.C. 162, 168, 543 S.E.2d 232, 235 (Ct. App. 2001). "Where the legislature chooses not to define a term in the statute, courts should interpret the term in accordance with its usual and customary meaning." Id. at 168, 543 S.E.2d at 235 (citing Adoptive Parents v. Biological Parents, 315 S.C. 535, 543, 446 S.E.2d 404, 409 (1994)). "The true guide to statutory construction is not the phraseology of

an isolated section or provision, but the language of the statute as a whole considered in light of its manifest purpose. Floyd v. Nationwide Mut. Ins. Co., 367 S.C. 253, 260, 626 S.E.2d 6, 10 (2005). "Once the Legislature has made [a] choice, there is no room for the courts to impose a different judgment based upon their notions of public policy." State Farm Bureau Mut. Ins. Co. v. Mumford, 299 S.C. 14, 20, 382 S.E.2d 11, 14 (Ct. App. 1989).

A plain reading of Section 38-71-46 does not indicate that it has any application to the Plan. In fact, Section 38-71-46 does not indicate that it applies to the Plan, EIP, the South Carolina Budget and Control Board, or any combination thereof:

(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.

...

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

S.C. Code Ann. § 38-71-46 (emphasis added).

In order for a "health insurance policy" to be subject to the requirements of Section 38-71-46, it must provide "health insurance coverage." S.C. Code Ann. § 38-71-840(14), which involves group health insurance,² defines health insurance coverage as follows:

(14) "Health insurance coverage" means benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer, except:

- (a) coverage only for accident, or disability income insurance, or any combination of accident and disability income insurance;
- (b) coverage issued as a supplement to liability insurance;
- (c) liability insurance, including general liability insurance and automobile liability insurance;

² Section 38-71-670(6) involves individual policies rather than group coverage and is not applicable to this case.

- (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.
- Id. (emphasis added).

Thus, to qualify as "health insurance coverage" as defined in the statute and to come under the rubric of Section 38-71-46, benefits under a policy or other contract must be provided by a "health insurance issuer." S.C. Code Ann. § 38-71-840(16) defines a "health insurance issuer" as:

(16) "Health insurance issuer" or "issuer" means any entity that provides health insurance coverage in this State. For purposes of this section, "issuer" includes an insurance company, a health maintenance organization, and any other entity providing health insurance coverage which is licensed to engage in the business of insurance in this State and which is subject to state insurance regulation.

Id. (emphasis added).

Because the Plan is not "health insurance coverage" pursuant to S.C. Code Ann. § 38-71-840(14), and because EIP is not licensed to engage in the business of insurance in this State and not a "health insurance issuer" subject to insurance regulation pursuant to S.C. Code Ann. § 38-71-840(16), S.C. Code Ann. § 38-71-46 has no application to the Plan. Moreover, there is an important distinction between a self-funded health plan and a fully-insured health plan, which is not limited to cases governed by the Employee Retirement Income Security Act (ERISA). In the ordinary meaning of the term, "self-insured" plans are those in which a business or other entity

maintains its own fund to cover any loss. The employer, in this case the State, has assumed the risk obligation, and "there is no contract with an insurance company." Black's Law Dictionary 664 (8th ed. abr. 2005).

Additionally, the United States Supreme Court has recognized that self-funded plans generally are not subject to state insurance regulation. See FMC Corporation v. Holliday, 498 U.S. 52 (1990). There is no dispute in this case that the State Health Plan is a self-funded, non-federal, governmental health plan for employees of state agencies, public school districts, and other public entities, administered by EIP; and is not a fully-insured plan. EIP is not licensed to engage in the business of insurance in this State and is not subject to insurance regulation by the SCDOI. Because S.C. Code Ann. § 38-71-46 is a state insurance statute, it has no application to a self-funded health plan.

Appellant next argues that the doctrine of "the enumeration of exclusions from the operation of a statute indicates that the statute should apply to all cases not specifically excluded." However, as concluded above, this doctrine has no applicability to the instant case because Section 38-71-46 is not ambiguous. Hodges v. Rainey, 341 S.C. 79, 85, 533 S.E.2d 578, 582 (2000) ("If a statute's language is plain, unambiguous, and conveys a clear meaning, 'the rules of statutory interpretation are not needed and the court has no right to impose another meaning.'"). Section 38-71-46 only applies to "health insurance coverage" issued by an "insurance issuer" licensed and regulated by the Department. The Plan is not "health insurance coverage," and EIP is not an "insurance issuer." The Plan does not meet the preliminary requirements under Section 38-71-840(16), and therefore, any analysis of the exclusions under Section 38-71-840(16) is irrelevant.

Even if Section 38-71-46 could be construed to be ambiguous, pronouncements by the South Carolina General Assembly indicate that this statute does not apply to the Plan. In a recently amended statute, the Legislature acknowledged the lack of jurisdiction of the Department over EIP:

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.

2005 Act No. 76, § 3, codified as S.C. Code Ann. § 1-11-780 (Supp. 2010) (emphasis added). The remainder of the Act created Section 38-71-290, separately and distinctly from the portion of legislation addressing EIP. See 2005 Act No. 76, § 1. The Legislature was aware that it needed to name EIP outside of a general insurance statute in Title 38, Chapter 71, if it intended EIP to comply with the contents of that statute.

Further, the Legislature passed a series of health insurance coverage mandates in Title 38, Chapter 71, Article 1. With the exception of Section 38-71-280, regarding autism spectrum disorder, none of these laws or their preceding bills mentioned EIP, the Plan, or the Budget and Control Board. In 2007, the Legislature passed Section 38-7-280, mandating coverage for autism spectrum disorder care. In this statute, the Legislature specifically stated that it applied to EIP: “It includes the State Health Plan . . . ‘State Health Plan’ means the employee and retiree insurance program provided for in Article 5, Chapter 11, Title 1.” S.C. Code Ann. § 38-71-280(A)(4)-(5). The statute made specific reference to EIP’s governing Code sections, again underscoring the General Assembly’s understanding that EIP is governed differently. Accordingly, the Legislature deliberately referenced the Plan and EIP’s enabling statutes to make the Legislature’s intent clear that Section 38-71-280 applied to EIP.

Amidst this series of legislation, the bill that would become Section 38-71-46 and mandate the provision of diabetes mellitus coverage by health insurers was introduced and passed in 1999, one session and one year before Section 1-11-760 (repealed 2005) would explicitly require EIP to provide mental health coverage. The original diabetes health insurance coverage legislation had no references to EIP in its text. See 1999 S.C. Act No. 98, codified at S.C. Code Ann. § 38-71-46. Notably, Section 38-71-46 was subsequently amended in the same session in which Section 1-11-760 (repealed 2005) became law. See 2000 S.C. Act No. 348 (amending coverage mandates for diabetes mellitus); 2000 S.C. Act No. 341 (mandating EIP provide mental health coverage). The Legislature was aware at the time Section 38-71-46 was amended in 2000 that for the statute to apply to EIP, EIP needed to be identified in the statute. However, the Legislature chose not to do so, and Section 38-71-46 makes no mention of its application to the Plan, unlike the contemporaneously and subsequently passed legislation. By Appellant’s own admission, “the court should take judicial notice that the members of the South Carolina General Assembly have the option of participating in the State Health Plan themselves, and therefore knowledge of its existence cannot be minimized.”

The Legislature made it very clear when mandates otherwise restricted to health insurers were to apply to the Plan. When EIP was to be included, the Legislature either: (1) amended EIP's governing statutes in Title 1, Chapter 11, Article 5; (2) made a direct reference to those statutes in its legislation; or (3) at a minimum, identified EIP by name in its legislation. The Legislature was aware EIP was not governed by the Department and specifically stated this fact in 2005 legislation. The Legislature also acknowledged that EIP was not governed by the mandates in Title 38, Chapter 71, Article 1, unless a specific intent to do so was stated in the statute. Finally, Section 38-71-46 itself was passed contemporaneously with other legislation specifically indicating application to EIP; yet Section 38-71-46 remained silent regarding EIP and the Plan. If the Legislature had intended Section 38-71-46 to apply to EIP, it would have indicated that in the statute itself or associated legislation.

Appellant also argues finding Section 38-71-46 does not apply to the Plan means the Plan is devoid of regulation. I disagree. First, the State Health Plan was created by the Legislature, and the Legislature acknowledges the existence of the Plan on a regular basis. For example, the Plan is included annually in the state budget provisos, which would not take place with a regular insurance plan. Second, the Plan is specifically regulated by S.C. Code Title 1, Chapter 11, Article 5, and those parts of Title 38, Chapter 71 that specifically refer to the Plan. Third, in addition to state regulation, federal laws and regulations, although not ERISA, also govern the Plan through the U.S. Department of Health and Human Services.³ Accordingly, Appellant's argument that the Plan is without regulation is incorrect.

Class Action

Appellant next argues that the ALC has the authority to permit this matter to proceed as a class action and allow class action relief. In light of the Court's disposition of this case, it is not necessary to address this issue. Futch v. McAllister Towing of Georgetown, Inc., 335 S.C. 598, 518 S.E.2d 591 (1999); Whiteside v. Cherokee County Sch. Dist. No. One, 311 S.C. 335, 428 S.E.2d 886 (1003) (appellate court need not address remaining issues when disposition of prior issue is dispositive).

³ As a self-funded, nonfederal governmental plan, the State Health Plan is subject to the Public Health Service Act, 42 U.S.C. § 201 *et seq.*, which includes such well-known federal laws as HIPAA and COBRA, and was amended significantly by the recent health care reform act. *See e.g.*, Centers for Medicare & Medicaid Servs., Regulations & Guidance, Self-funded Nonfederal Governmental Plans, <https://www.cms.gov/SelfFundedNonFedGovPlan/>.

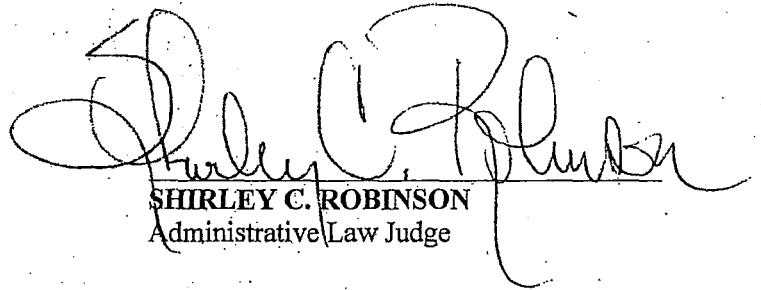
Accordingly, the Court concludes that there is substantial evidence in the record to support EIP's decision. Further, there is nothing in the Record on Appeal to suggest that EIP abused its discretion in this matter.

ORDER

For the reasons set forth above,

IT IS HEREBY ORDERED that the final decision of EIP, concluding that 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, is **AFFIRMED.**

AND IT IS SO ORDERED.


SHIRLEY C. ROBINSON
Administrative Law Judge

August 13th, 2012
Columbia, South Carolina

CERTIFICATE OF SERVICE
This is to certify that the undersigned has this date served this order in the above entitled action upon all parties to this cause by depositing a copy hereof, in the United States mail, postage paid, or in the Interegacy Mail Service addressed to the party(ies) or their attorney(s).
This: 13 day of August 2012
By: Jeckel J. Henderson
Judicial Law Clerk

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Shirley C. Robinson, Administrative Law Judge

Case No. 10-ALJ-30-0710-AP

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

v.

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

NOTICE OF APPEAL

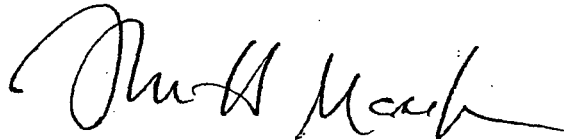
Jeffrey D. Allen appeals the decision of the Honorable Shirley C. Robinson dated August
13, 2012. Appellant received a copy of this decision on August 15, 2012.

September 12, 2012

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SC Court of Appeals



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.....Appellant,

v.

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

PROOF OF SERVICE

I certify that I have served the Appellant's Notice of Appeal on Respondent Agency by
depositing a copy of it in the United States Mail, postage prepaid, on September 12, 2012,
addressed to its attorneys of record, Theodore D. Willard, Jr., Montgomery Willard, LLC, P.O.
Box 11886, Columbia, SC, 29211 and Kelly H. Rainsford, State Budget & Control Board, 1201
Main Street, Suite 300, Columbia, SC 29201.

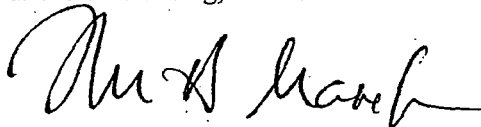
I certify that I have served the Appellant's Notice of Appeal on the Administrative Law
Court by depositing a copy of it in the United States Mail, postage prepaid, on September 12,
2012, addressed to The Honorable Shirley C. Robinson, Administrative Law Judge, South
Carolina Administrative Law Court, Edgar A. Brown Building, 1205 Pendleton Street, Suite 224,
Columbia, SC 29201.

September 12, 2012

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State of South Carolina



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STATE OF SOUTH CAROLINA
In the Administrative Law Court

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

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

v.

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

BRIEF OF APPELLANT

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STATEMENT OF ISSUES ON APPEAL

1. Did the EIP err in finding that the S.C. Code § 38-71-46 does not apply to the state health plan?
2. Did the EIP err in not finding the state health plan exclusion for “education programs” void as a matter of law as to diabetes education?
3. Did the EIP err in failing to reform the state health plan to comply with S.C. Code § 38-71-46?
4. Did the EIP err in failing to notify all persons affected by its failure to comply with S.C. Code § 38-71-46 since said law was first enacted in 2000?
5. Did the EIP err in not disgorging all monies which should have been paid out to participants on claims pursuant to S.C. Code § 38-71-46 for diabetes education?
6. Does the ALC have the authority to certify a class action pursuant SCALC Rule 68 and SCRCP 23?

STATEMENT OF THE CASE

The Appellant, Jeffrey D. Allen is an employee of a local South Carolina school district and an insured/member of the State Health Plan. His daughter, [REDACTED] a dependant on that plan, was diagnosed with type 1 diabetes¹ in November 2007 at the age of two (2) years old. (R.101). This appeal is about the Respondent's failure to comply with a South Carolina statutory mandate for diabetes coverage and whether this matter should be certified as a class action. Appellant alleges that Respondent has unlawfully denied Appellant's and other similarly-situated persons' claims for coverage of diabetes-related education on the grounds that its benefit plan provides that "education is not covered for diabetes." S.C. Code Ann. section 38-71-46 provides:

Diabetes Mellitus coverage in health insurance policies, diabetes education.

(A) On or after January 1, 2000, *every health maintenance organization, individual and group health insurance policy, or contract issued or renewed in this State must provide coverage for the equipment, supplies, Food and Drug Administration-approved medication indicated for the treatment of diabetes, and outpatient self-management training and education for the treatment of people with diabetes mellitus, if medically necessary, and*

¹ Type 1 diabetes is an autoimmune disease in which the body's immune system attacks and destroys the insulin-producing cells of the pancreas. Its causes are not yet entirely known. It causes dependence on injected or pumped insulin for life, and carries the constant threat of devastating complications. To stay alive, people with type 1 diabetes must take multiple insulin injections daily or continually infuse insulin through a pump. They must also test their blood sugar by pricking their fingers for blood six or more times a day. While trying to balance insulin doses with their food intake and daily activities, people with this form of diabetes still must always be prepared for serious hypoglycemic (low blood sugar) and hyperglycemic (high blood sugar) reactions, both of which can be life-limiting and life threatening. Each year, more than 15,000 children - 40 per day - are diagnosed with type 1 diabetes in the U.S.

http://www.jdrf.org/index.cfm?fuseaction=home.viewPage&page_id=14AF69BC-BE51-42DA-B1B41955029FBC7F (December 28, 2010)

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).

The denial of benefits arose from an education session attended at MUSC on August 5, 2008.

That day, [REDACTED]'s family and other caregivers, including two Charleston County School District nurses who were to be charged with her the care in school beginning in August 2008, a training session set up by MUSC Pediatric Endocrinology to train those caregivers, at home and school, how to operate an insulin pump prescribed by Allen's physician and scheduled to

be attached to her body the following week. (R. 377). That training session lasted approximately two hours and was taught by a MUSC diabetic educator. Id.

The claim submitted to the State Health Plan was denied on August 27, 2008 on the grounds that the “benefit plan does not cover education and/or training for this condition.” (R. 267-68). On February 25, 2009, Appellant submitted a written request for reconsideration to Blue Cross Blue Shield. (R. 386-91). Having received no response, Appellant wrote again on September 30, 2009 and inquired as to why the claim was denied and why S.C. Code § 38-71-46 did not mandate payment of the claim. (R. 405-09). On November 25, 2009, (two years less two days from Eva Allen’s date of diagnosis), Appellant filed a putative class action complaint seeking declaratory judgment, reformation, disgorgement, injunctive relief, and attorneys fees in the Ninth Circuit Court of Common Pleas against the State of South Carolina and Blue Cross Blue Shield of South Carolina. (R. 338-49). At the time of that court filing, Respondent had yet to respond to Appellant’s request for reconsideration.

The State Health Plan provides that it is “established and will be maintained with the intention of meeting the requirements of all applicable federal and state laws. Any provision of the Plan, which is in conflict with the law of any governmental body or agency that has jurisdiction over this Plan, shall be interpreted to conform to the minimum requirements of such law.” (R. 4).

On March 23, 2010, over one year after Appellant’s initial objection and three weeks after the first hearing in the circuit court case which resulted in a denial of the Respondent’s motions to dismiss, Blue Cross Blue Shield first issued its decision dated March 19, 2010 to

uphold the original denial dated August 27, 2008, and indicated that the appeal file would be sent to the Blue Cross Blue Shield Appeals Review Committee. (R. 243). Two weeks later, on April 2, 2010, the Blue Cross Blue Shield Appeals Committee issued a denial of the appeal on the basis that education is expressly excluded under the State Health Plan and concluded, without explanation, that S.C. Code Ann. § 38-71-46 did not apply to the State Health Plan. (R.244-46). On June 30, 2010, Appellant appealed the denial to the EIP's Appeals Committee, (R. 240-41), by sending as the basis for appeal a copy of the pleadings as filed in the then- concurrently pending case in the Court of Common Pleas. (R. 333-503)

By letter dated August 24, 2010, the EIP Appeals Committee wrote Appellant that it was denying his claim and again stated that S.C. Code § 38-71-46 did not apply to the State Health Plan. (R. 98-111). The underlying basis for the conclusion that the diabetes coverage mandate did not apply to the State Health Plan was explained (for the first time) as follows:

Lastly, the Committee noted the repeated assertions regarding S.C. Code 38-71-46 and Claimant's attorney's assertion that no one has explained why it does not apply to the State Health Plan. While the Committee noted the alternative methods for obtaining diabetes education noted above, the Committee also observed the Department of Insurance and the General Assembly *historically have acknowledged* the Department [of Insurance] has no jurisdiction over EIP. EIP is not a health insurance issuer under the Code. In the areas on which the General Assembly has wanted to include EIP in the Accident and Health Insurance provisions of Title 38, Chapter 31, it has specifically said so. Therefore, because 38-71-46 does not refer to EIP or the State Health Plan, it does not apply to the State Health Plan.

(R. 111). That explanation contains a single footnote which referenced S.C. Code Ann. § 11-780 -- a statute addressing mental health coverage -- presumably as the legal justification for the proposition that the South Carolina Department of Insurance has no jurisdiction over the South Carolina State Budget and Control Board's Employee Insurance Program -- an

insurance program which admittedly insures over 400,000 South Carolinians. The only support for this underlying legal conclusion appears on the Medical Affairs Review Coordinator's Response in long-hand dated March 15, 2010 and signed by Ashby M. Jordan, MD, V.P. Medical Affairs wherein she writes "the statute referenced in the appeal document does not apply to the State Health Plan." (R. 277).

Curiously, in its decision, the EIP also makes very general reference to "alternative methods for obtaining diabetes education," in particular a program entitled "Prevention Partners" and MUSC Options, a separate HMO option for State employee insurance. (R.110). These references, however, do not form the basis for the decision and are, at best, irrelevant, and at worst an attempt to further obfuscate the issue. Prevention Partners is described by the EIP's Insurance Benefit Guide to include services such as preventive worksite screenings for prevention and early detection of chronic disease, spring wellness walk, lifestyle change workshops, worksite program consultation, and volunteer worksite prevention partners. (R. 446-447). Clearly, this program is aimed at adults suffering from chronic and preventable diseases, such as heart disease and Type 2 Diabetes. The EIP did not and cannot contend that the educational service prescribed by [REDACTED]'s physician to assist her caregivers with the operation of her insulin pump would have been paid for or covered by said program. Further, contrary to the EIP's conclusion that Appellant made no mention of this program, Appellant was contacted, during this legal challenge, presumably about the Prevention Partners' "wellness program" and then told that [REDACTED] was not old enough to participate and that their records indicated (incorrectly) the chronic condition she suffered from was asthma. (R. 381). Respondent also referenced in its decision the Appellant

could have chosen plans other than the State Health Plan – BlueChoice HMO or MUSC Options as his insurance plan, and that education is covered under those plans. (R. 110). However, Respondent fails to recognize that those plans are not the subject of this action, and failed to mention that MUSC Options “option” was discontinued by the EIP in October 2008.

As contained in the Appellant’s Notice of Appeal to the EIP, the claim alleges that the Plaintiff is insured through the State Health Plan, which is a non-ERISA health benefit plan,² and that the State Health Plan is in violation of the diabetes mandate by its failure to provide coverage for diabetes education in accordance with the statutory mandate which has been in effect since 2000. (R. 333). The appeal alleged that over 15,000 State of South Carolina employees have some type of diabetes, and that the exact number of class members affected by the Respondent’s unlawful exclusion of coverage for diabetes education is known only to the Respondent and will need to be obtained from the Respondent. (R.34-41). The appeal to the EIP sought: (1) class action certification; (2) a declaration that the State of South Carolina benefit plan violates the diabetes mandate; (3) a declaration regarding the future rights of the members of the putative class; (4) reformation of the benefit plan to comply with the mandate; (4) disgorgement and return of all profits and/or monies which should have been paid to putative class, (5) an injunction to stop the Respondent from continuing their unlawful actions in the future, and (6) costs and attorneys fees. (R. 345).

² 29 U.S.C.A. § 1003(b)(1) expressly excludes government plans from the broad sweep of ERISA preemption of state laws. Silvera v. Mutual Life Ins. Co. of New York, 884 F.2d 423, 425 (9th Cir. 1989). ERISA expressly defines governmental plan as including a plan established by the government of a State or political subdivision 29 U.S.C.A. § 1002 (32).

During the above-referenced “administrative appeal” to the EIP, there was no hearing, no testimony, and no discovery. Unlike most cases that the ALC reviews in its appellate capacity, however, no evidentiary hearing takes place before the agency. The EIP Appeals Committee conducts a paper review of EIP’s initial coverage determination, which is also made without an evidentiary hearing.

ARGUMENT

A. THE STANDARD OF REVIEW

According to Respondent, the appeal of this matter from the EIP is subject to review pursuant to S.C. Code Ann. § 1-23-380 which provides for judicial review upon exhaustion of administrative remedies. Subsection (A) (5) states, in part, that

The court may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions are:

- (a) in violation of constitutional or statutory provisions;
- (b) in excess of the statutory authority of the agency;
- (c) made upon unlawful procedure;
- (d) affected by other error of law;
- (e) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or
- (f) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

Further, the reasoning behind the general rule that a review of the agency decision is not permitted to re-evaluate the credibility of witnesses does not apply here because the EIP does not conduct a contested case hearing with live witness testimony. The EIP makes its determination based solely on a paper review, and is thus not in a better position to evaluate credibility. See Grier v. South Carolina Budget & Control Board, Employee Insurance Program, 07-ALJ-30-0139-AP (2008), fn. 4, 7.

This matter is also governed by the Administrative Law Court Rules of Procedure, including but not limited to ALC Rule 68 which permits the Administrative Law Judge to apply the South Carolina Rules of Civil Procedure and Appellate Court Rules should the ALCRP not address the question, and Rule 69 which states that the ALC Rules shall govern all procedural aspects of the matter, notwithstanding other agency regulation or procedural rule, both of which were enacted effective April 30, 2009.

B. THE PLAIN AND UNAMBIGUOUS LANGUAGE OF THE DIABETES MANDATE, S.C. CODE ANN. § 38-71-46, APPLIES TO THE STATE HEALTH PLAN

The EIP erred by concluding that the State Health Plan was excluded from applicability of the diabetes mandate statute. Statutory interpretation is a question of law. City of Newberry v. Newberry Elec. Coop., Inc., 387 S.C. 254, 256, 692 S.E.2d 510, 512 (2010). "The cardinal rule of statutory construction is to ascertain and effectuate the intent of the legislature." Hardee v. McDowell, 381 S.C. 445, 453, 673 S.E.2d 813, 817 (2009) (internal quotation omitted). Under the plain meaning rule, the court is not permitted to change the meaning of a clear and unambiguous statute. Hodges v. Rainey, 341 S.C. 79, 85, 533 S.E.2d 578, 581 (2000). Where the statute's language is plain, unambiguous, and conveys a clear, definite meaning, the court may not impose a different meaning and need not employ rules of statutory interpretation. Gay v. Ariail, 381 S.C. 341, 345, 673 S.E.2d 418, 420 (2009).

The diabetes mandate statute states that it applies to "*every . . . group health insurance policy, or contract* issued or renewed in this State . . ." S.C. Code Ann. § 38-71-46 (a) (emphasis added). The seminal question in this appeal is whether this language applies to the Employee Insurance Program's State Health Plan, i.e. whether the State Health Plan is a "group health insurance policy, or contract issued or renewed in this State" under this statute. This is not the situation, as is often the case where the legislature omitted to define a term, thus creating the possibility of an ambiguity. Arguably recognizing the task of identifying which "insurance" products are subject to the diabetes mandate, the General Assembly defined the term "health insurance policy" for this particular statute to mean "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).” Id. 38-71-46(d).

The EIP concluded that this statute did not apply to the EIP. Appellant disagrees. Therefore, the question of law for this court is whether the EIP properly interpreted the language of S.C. Code Ann. §§ 38-71-46; 38-71-670(6); and 38-71-840(14). The entire text of section 38-71-46 is found infra. at pp.6-7.

S.C. Code Ann. § 38-71-670(6) defines “Health insurance coverage” as follows:

(6) "Health insurance coverage" means *benefits* consisting of medical care *provided* directly, *through insurance or reimbursement, or otherwise* and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer, except:

(a) coverage only for accident or disability income insurance or any combination of these;

(b) coverage issued as a supplement to liability insurance;

(c) liability insurance, including general liability insurance and automobile liability insurance;

(d) workers' compensation or similar insurance;

(e) automobile medical payment insurance;

(f) credit-only insurance;

(g) coverage for on-site medical clinics;

(h) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(i) if offered separately:

(i) limited scope dental or vision benefits;

- (ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these;
- (iii) other similar, limited benefits as are specified in regulations;
- (j) if offered as independent, noncoordinated benefits:
 - (i) coverage only for a specified disease or illness;
 - (ii) hospital indemnity or other fixed indemnity insurance;
- (k) if offered as a separate insurance policy:
 - (i) Medicare supplemental health insurance, as defined under Section 1882(g)(1) of the Social Security Act;
 - (ii) coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code; and
 - (iii) similar supplemental coverage under a group health plan.

S.C. Code Ann. § 38-71-670(6) (emphasis added). Similarly, S.C. Code Ann. § 38-71-840(14) is nearly identical and defines "Health insurance coverage" as follows:

(14) "Health insurance coverage" means *benefits* consisting of medical care *provided directly, through insurance or reimbursement, or otherwise* and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer, except:

- (a) coverage only for accident, or disability income insurance, or any combination of accident and disability income insurance;
- (b) coverage issued as a supplement to liability insurance;
- (c) liability insurance, including general liability insurance and automobile liability insurance;
- (d) workers' compensation or similar insurance;
- (e) automobile medical payment insurance;
- (f) credit-only insurance;
- (g) coverage for on-site medical clinics;

- (h) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;
 - (i) if offered separately:
 - (i) limited scope dental or vision benefits;
 - (ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these;
 - (iii) other similar, limited benefits as are specified in regulations;
- (j) if offered as independent, noncoordinated benefits:
 - (i) coverage only for a specified disease or illness;
 - (ii) hospital indemnity or other fixed indemnity insurance;
- (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.

S.C. Code Ann. § 38-71-840(14) (emphasis added).

The EIP's State Health Plan fits plainly within these broad statutory definitions of "health insurance policy" and "health insurance coverage" in that it provides *benefits, through insurance or reimbursement, or otherwise*, and the State Health Plan is *not* included within any of the 20+ enumerated exceptions. Therefore, this court should conclude that the State Health Plan is a "Health insurance policy" for purposes of the statutory mandate of S.C. Code Ann. § 38-71-46. "All rules of statutory construction are subservient to the one that the legislative intent must prevail if it can be reasonably discovered in the language used, and that language must be construed in the light of the intended purpose of the statute."

Broadhurst v. City of Myrtle Beach Election Comm'n, 342 S.C. 373; 380, 537 S.E.2d 543, 546 (2000). Title 38 entitled “The Insurance Law,” S.C. Code Ann. § 38-1-10, defines “accident and health insurance” as “insurance of human beings against death or personal injury . . . against sickness, ailment, and any type of physical disability resulting from accident or disease, and prepaid dental service, but not including coverages required by Workers’ Compensation Law of this State.” Id. § 38-1-20 (1).

As illustrated by the title of the statute: “**Diabetes Mellitus coverage in health insurance policies, diabetes education**,” the plain intent was to mandate insurance coverage for diabetes, and specifically require coverage for diabetes education. Further, the very first clause of section 38-71-46 states: “[o]n or after January 1, 2000, *every* . . . group health insurance policy or contract.” There is no more encompassing word than “every.” The legislature then referenced definitions for what it intended to be deemed an “insurance policy” under the diabetes mandate, and those definitions include the descriptor: “*benefits, through insurance or reimbursement, or otherwise.*” It would have been simple to exclude the State Health Plan from the plain language of the mandate, but the legislature did not. It would have been simple to enact another statute defining diabetes insurance coverage differently for the State Health Plan as the legislature did regarding mental health coverage, see for example S.C.Code Ann. § 38-71-290 (mandating standards for mental health coverage in “health insurance plans”) and S.C.Code Ann. § 1-11-780 (mandating different standards for mental health coverage for the EIP), both of which were enacted in 2005 with effective dates of June 30, 2006, years after the diabetes mandate at issue, but it did not. Further, there is nothing in section 38-71-46 which limits its applicability to licensed [by the

Department of Insurance] health insurance issuers as suggested by the EIP's explanation, infra at p. 9. Lastly, the court should take judicial notice of the fact that all members of the South Carolina General Assembly have the option of participating in the State Health Plan themselves, and therefore knowledge of its existence cannot be minimized.

C. IN THE ALTERNATIVE, IF THE COURT WERE TO FIND THAT SECTION 38-71-46 WERE AMBIGUOUS REGARDING ITS APPLICABILITY TO THE STATE HEALTH PLAN, THERE IS NO EVIDENCE OF ANY INTENT TO EXCLUDE APPLICATION TO THE STATE HEALTH PLAN

If the statute is ambiguous, courts must then construe the terms of the statute. Lester v. S.C. Workers' Comp. Comm'n, 334 S.C. 557, 561, 514 S.E.2d 751, 752 (1999). "A statute as a whole must receive practical, reasonable, and fair interpretation consonant with the purpose, design, and policy of lawmakers." Sloan v. S.C. Bd. of Physical Therapy Exam'rs, 370 S.C. 452, 468, 636 S.E.2d 598, 606 (2006). When faced with an undefined statutory term, the term must be interpreted in accordance with its usual and customary meaning. Branch v. City of Myrtle Beach, 340 S.C. 405, 409-10, 532 S.E.2d 289, 292 (2000). However, in this case, we do not have an undefined term. Instead we have definitions of "health insurance policy" with detailed exclusions.

Pertinent to the issue at bar, the canon of construction "*expressio unius est exclusio alterius*" or "*inclusio unius est exclusio alterius*" instructs that in order "to express or include one thing implies the exclusion of another, or of the alternative. The enumeration of exclusions from the operation of a statute indicates that the statute should apply to all cases not specifically excluded. Exceptions strengthen the force of the general law and enumeration weakens it as to things not expressed." See Riverwoods, LLC v. County of

Charleston, 349 S.C. 378, 384, 563 S.E.2d 651, 655 (2002) (quotations and citations omitted). See also W. Va. Pulp & Paper Co. v. Riddock, 225 S.C. 283, 288, 82 S.E.2d 189, 190 (1954) ("The inclusion in the statute of certain specified exclusions leaves the inference that the Legislature intended no other exclusions from the exemption.")

In both the definitional statutes expressly referenced in section 38-71-46, there are over twenty (20) exclusions, and the State Health Plan is not one of them.

D. THE SOUTH CAROLINA STATE BUDGET AND CONTROL BOARD
EMPLOYEE INSURANCE PROGRAM [STATE HEALTH PLAN] IS NOT
EXEMPT FROM THE SOUTH CAROLINA CODE OF INSURANCE

The EIP erred in its conclusion that it was not subject to the jurisdiction of the South Carolina Department of Insurance. It held that the benefits provided by the State Health Plan are not insurance, and therefore the State Health Plan is exempt from application of the entire Insurance Code, as found in Title 38, unless the subject insurance statute affirmatively states it applies to the State Health Plan. This conclusion (1) is not necessary to the issue at bar in this appeal - the meaning and applicability of S.C.Code Ann. § 38-71-46; (2) lacks a legal foundation; and (3) turns long-accepted principles of statutory interpretation on their head.

There is simply nothing to support the statement made by Respondent in all levels of the underlying appeal that S.C.Code Ann. § 38-71-46 does not apply to the State Health Plan. The Respondent *first* stated that conclusion on March 15, 2010, R. 277, and then made that statement to Appellant in a letter dated March 19, 2010, R. 243.

Respondent relied solely on S.C.Code Ann. § 1-11-780 as the legal basis for its contention that South Carolina General Assembly intended to exempt the State Health Plan from all Insurance regulation pursuant to Title 38. Section 1-11-780 provides in its entirety:

SECTION 1-11-780. **Mental health insurance.**

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.

(2005 Act No. 76, § 3, effective June 30, 2006). Also, the medical director of the EIP implicitly recognized the absence of legal support for the position that the EIP is not subject to Title 38 by stating that “the General Assembly *historically have[sic] acknowledged* the Department [of Insurance] has no jurisdiction over EIP,” (R. 111). There is simply no legal basis to conclude that section 1-11-780 - a narrowly tailored statute on mental health insurance coverage -- enacted years after the statute in question, was intended to apply to any other subject matter- much less to exempt the entire State Health Plan from application of the South Carolina Insurance Code. What the General Assembly has allegedly *historically acknowledged* plays no role in statutory interpretation, and other than the mental health insurance statute referenced above, the EIP fails to cite even to any other instance of this “historical acknowledgement.”

Respondent attempts to inject ERISA/insurance terminology into this question of statutory interpretation by emphasizing that the State Health Plan is a self-funded plan.³ This

³ Generally, there are several types of health benefit plans in the United States: (1) ERISA or private-sector, employer-sponsored group health plans, in which group are fully-insured and self-funded plans. Within the context of ERISA, whether a plan is fully-insured or self-funded is important because ERISA reflects different treatment for the self-funded plan, and also provides for pre-emption of state law for self-funded private ERISA benefit plans; (2) church plans are non-ERISA and expressly excluded from Title I of ERISA; (3) governmental plans are non-ERISA and expressly excluded from Title I of ERISA, and

distinction, while theoretically important if ERISA coverage were at issue, has no relevance to the matter at issue. This court is charged with interpretation of the language of the statutes at issue in this case, and the language in those statutes simply does not support the Respondent's position. It is undisputed that the State Health Plan is not subject to, or governed by ERISA because governmental plans are expressly excluded from ERISA.

The Respondent State Health Plan takes the position, in this case, however, that it is *also* not subject South Carolina Insurance law. As a result, in order for the Respondent to prevail, this court would ultimately have to conclude that that the South Carolina General Assembly intended for the State Health Plan to operate exempt from both federal and state insurance regulation. There is nothing in either Title 1 or Title 38 of the South Carolina Code of Laws which indicates such a relinquishment of lawmaking authority over an entity overseeing insurance benefits to over 400,000 (nearly 10% of the population) South Carolinians.

E. THIS COURT SHOULD REVERSE AND MODIFY THE EIP'S DECISION TO INCLUDE CLASS- BASED RELIEF, REFORMATION, DISGORGEMENT, AND INCLUDE AN AWARD OF ATTORNEYS FEES AND COSTS

The powers of the ALC allow for modification of the EIP's decision to include class-based relief. S.C.Code Ann. § 1-23-380(A)(5) provides that the ALC has the authority to modify a decision of the underlying agency if there has been a violation of state law. Further,

include the Federal Government Plan which is governed by, among other statutes, the Federal Employee Health Benefits Act and nonfederal government plans [i.e., the State Health Plan], 29 U.S.C.A. § 1003(b)(1); Silvera v. Mutual Life Ins. Co. of New York, 884 F.2d 423, 425 (9th Cir. 1989); 29 U.S.C.A. § 1002 (32); and (4) the direct purchase plan, a non-ERISA plan purchased by an individual directly from a health insurance company.

ALCR, Rule 68 provides that the court may apply the South Carolina Rules of Civil Procedure and Appellate Court Rules should the ALCRP not address the question. SCRCR, Rule 23 provides for Class Action treatment in a case if the court finds (1) numerosity, (2) commonality of questions of law or fact; (3) typicality of the representative's claim to the class, (4) adequacy of the representative and counsel, and (5) where primary relief is injunctive or declaratory, the amount in controversy exceed one hundred dollars for each member of the class.⁴

As referenced in the appeal papers submitted to the EIP on June 30, 2010, the Appellants made the issues of class certification and class-wide relief made part of the appeal. However, the EIP failed to address or consider the arguments and grounds submitted to it as the appeal. Instead, the EIP addressed Mr. Allen's singular claim and made the erroneous legal conclusion it was not subject to the diabetes mandate.

As attached to his Notice of Appeal to the EIP, the Appellant submitted all necessary elements of class treatment to the EIP. (R. 340-43). Paragraphs 7-16 of the Complaint alleged:

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

⁴ It is important to note that Appellant has attempted to have these claims decided in the Court of Common Pleas- a court of general jurisdiction. The Respondent took the position that the case as filed in Common Pleas (which included a class action complaint) had to be dismissed based on this pending administrative proceeding -- or for failure to fully exhaust administrative remedies. The Hon. Paul Burch granted summary judgment to the Respondent on the failure to exhaust administrative remedies, by final Order dated November 29, 2010. Appellant has filed a Notice of Appeal to the South Carolina Court of Appeals in that matter, and said appeal is currently pending.

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 dependent child with a value of approximately One Thousand & 00/100 US Dollars (\$1000.00) for diabetes outpatient self-management training and education which were denied by Defendant BCBSSC as administrator to the EIP, his claim, right and privileges are typical of the proposed class.

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.

Id. This court should modify the decision below to require the EIP to disclose all claims made by any insureds from the effective date of section 38-71-46 to the present, identify those insureds and the amount of their claim, and allow this case to proceed in the ALC as a class action.

Review of case law related to the availability of class-based claims and relief within the Administrative Law Court illustrates that the issue has arisen only within the context of the South Carolina Revenue Procedures Act, S.C.Code Ann §§ 12-60-10 et seq., a statutory scheme which contains an express prohibition against class actions in claims challenging the imposition of taxes. See, e.g. Drummond v. South Carolina Department of Revenue, 378 S.C. 362, 662 S.E.2d 587 (2008); Ward v. State, 343 S.C. 14, 538 S.E.2d 245 (2000); S.C.Code Ann. § 12-60-80(C) (Supp.2010). No other statute or South Carolina court opinion has addressed class-wide claims related to the Employee Insurance Programs or its claims process. However, unlike the Revenue Procedure Act, there is no prohibition against class-wide relief in either the EIP claims process set forth in its Plan or in the enabling statutes.

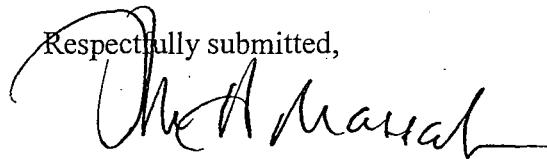
CONCLUSION

Accordingly, based upon the foregoing, the Respondent asks this Court to reverse the findings and conclusions of EIP, and find that the diabetes mandate was intended to apply to

the EIP, that the EIP has been in violation of said statute since its effective date of January 1, 2000. This court should modify the decision below to require the EIP to disclose all claims made by any insureds from the effective date of section 38-71-46 to the present, identify those insureds and the amount of their claim, and allow this case to proceed in the ALC as a class action for a determination of legal and equitable remedies as permitted, including the award of attorneys fees and costs to class counsel.

January 17, 2010

Respectfully submitted,

A handwritten signature in black ink, appearing to read "John A. Massalon", written over a horizontal line.

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STATE OF SOUTH CAROLINA
In the Administrative Law Court

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

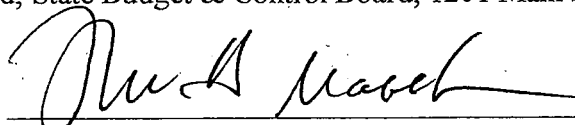
Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative
of other similarly situated State of South Carolina employees or retirees, ... Appellant,

v.

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

PROOF OF SERVICE

I certify that I have served the Brief of Appellant on Respondent of record by depositing
a copy of it in the United States Mail, postage prepaid, on January 18, 2011, addressed to their
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**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.

BRIEF OF RESPONDENT

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I. STATEMENT OF ISSUES ON APPEAL

WAS THE EMPLOYEE INSURANCE PROGRAM'S DECISION TO DENY A CLAIM FOR EVA ALLEN'S SEPARATELY-BILLED DIABETES EDUCATION CORRECT GIVEN THAT THE DECISION IS RATIONAL AND IS SUPPORTED BY THE SUBSTANTIAL EVIDENCE IN THE RECORD, APPLICABLE STATE LAW, AND THE TERMS OF THE STATE HEALTH PLAN?

II. STATEMENT OF THE CASE

This matter is before the Administrative Law Court pursuant to the appeal of Jeffrey Allen ("Appellant"). As an employee of Dorchester County School District Two, Appellant participated in the state insurance benefit program offered through the State of South Carolina Budget and Control Board Employee Insurance Program ("EIP"). Appellant specifically has covered his daughter, Eva Allen ("Dependent"), on his health insurance through the Group Health Benefits Plan of the Employees of the State of South Carolina, the Public School Districts, and Participating Entities ("State Health Plan").

On August 24, 2010, the EIP Appeals Committee issued a decision denying coverage for diabetes education on the basis it was not covered as a separately-billed claim under the State Health Plan. Pursuant to S.C. Code Ann. § 1-11-710(C) (2005), Appellant appealed the final determination of the EIP Appeals Committee to this Court.

III. STATEMENT OF FACTS

Under S.C. Code Ann. § 1-11-710(A)(1)(2005), the State Budget and Control Board ("the Board") is required to "make available to active and retired employees of this State . . . 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." In fulfillment of this mandate, the Board has established the Group Health Benefits Plan of the Employees of the State of South

Carolina, the Public School Districts, and Participating Entities ("State Health Plan" or "Plan"). The State Health Plan is a self-funded,¹ non-federal governmental health plan administered by EIP. (R.p. 326). BlueCross BlueShield of South Carolina ("BCBSSC"), a private contractor, is the third-party claims administrator for the State Health Plan. As such, BCBSSC processes and pays the claims for the Plan under the Plan's rules and with the Plan's money, and also provides the first level of review for coverage requests involving the State Health Plan. BCBSSC is not an insurer of the State Health Plan. (R.p. 326).

Appellant and Dependent have been covered by one of the health plan options offered through EIP since 2005.² Dependent was born July 20, 2005. (R.p. 291). Appellant was hired at Dorchester County effective August 2, 2005, with a benefits effective date of September 1, 2005. Appellant and Dependent were covered under MUSC Options from September 1, 2005, to December 31, 2006. Beginning January 1, 2007, Appellant and Dependent were covered by the Standard Plan.

Dependent was diagnosed with Type I diabetes in November 2007. On August 5,

¹ The term "self-funded" and its synonym "self-insured" are general terms used to describe, in the realm of health insurance as well as other types of insurance, "a plan under which a business maintains its own special fund to cover any loss. • Unlike other forms of insurance, there is no contract with an insurance company." Black's Law Dictionary 664 (8th ed. abr. 2005). In this context, it indicates a self-insurance arrangement in which an employer provides health or disability benefits to employees with its own funds. This term is used to differentiate from fully-insured plans, where the employer contracts an insurance company to cover its employees and their dependents. In self-funded health plans, the employer assumes the direct risk for payment of the claims for benefits, though it may employ an outside administrator to process the claims.

² 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.

2008, Appellant, Appellant'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. (R.pp. 283, 300). On August 27, 2008, BCBSSC sent Appellant an Explanation of Benefits ("EOB") showing the claim was denied. (R.pp. 284-285). The explanatory note read, "Your benefit plan does not cover education and/or training for this condition," in accordance with the terms of the Plan.

On February 25, 2009, Appellant's spouse wrote a letter of appeal to BCBSSC. (R.pp. 265-266). Appellant's spouse stated Appellant and Dependent were "insured under the South Carolina State Insurance Health Plan." Appellant'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. Appellant's spouse stated the Medical University of South Carolina ("MUSC") provides training for caregivers on how to properly operate the insulin pump. Appellant's spouse further indicated she, Appellant, their parents (Dependent's grandparents), and two nurses from Dependent's daycare attended the training on August 5, 2008. Appellant'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." 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?

(R.pp. 265-266).

On April 20, 2009, BCBSSC sent Appellant an adjusted EOB. (R.pp. 284-285). This EOB 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 that BCBSSC had requested additional medical information from the provider. The updated note explained if the information was received within 45 days, BCBSSC would review it and make a decision within 15 days of receipt. BCBSSC then stated if the information was not if the information was received after 45 days, the claim would be considered denied. BCBSSC further indicated that if the information was received after 45 days, but under 225, the appeal would move forward.

On September 30, 2009, Appellant's spouse wrote a letter to BCBSSC in follow-up. (R.pp. 272-273). She indicated her appeal had been pending since February 2009. Appellant'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. Appellant'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. Appellant's spouse then stated, "I am also enclosing a copy [of] the South Carolina statute which requires Diabetes Mellitus coverage in health insurance policies." Appellant's spouse included a photocopy of the text of S.C. Code Ann. § 38-71-46. (R.p. 303).

Subsequently, BCBSSC received Dependent's medical records from MUSC. Dependent's submitted records began with a letter dated July 9, 2008, with a pre-authorization request for Dependent's insulin pump from the manufacturer, Medtronic.

(R.p. 290). The items listed on Medtronic's request were an insulin pump with accompanying equipment, for a total of \$5,142.95.³

The records submitted with Appellant's diabetes education claim appeal 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. (R.pp. 291-302).

Dependent's earliest submitted visit note was from January 2, 2008. (R.pp. 298-299). The treating physician, Dr. Bowlby, indicated that Dependent had been diagnosed with Type I diabetes six weeks prior after being admitted to the emergency room with diabetic ketoacidosis.⁴ The record further indicated that Dependent was taking 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." In addition, it was noted that 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

³ This claim, 8E4953594000, was paid on the actual amount billed of \$4,988.40, with the total paid by the Plan at \$3,990.72, the normal rate of 80%.

⁴ 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. 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>. This emergency hospitalization claim was also paid by the Plan without issue.

months.

Dependent returned to Dr. Bowlby on April 9, 2008. (R.p. 296). Dr. Bowlby observed Dependent was doing better, with Appellant's spouse reporting Dependent's blood sugars had been more in target range since Dependent's previous visit. Appellant'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. Bowlby noted Dependent was doing better and recommended an insulin pump, scheduling follow-up with a nurse, Sharon Schwartz, R.N., C.D.E.,⁵ to discuss the option of an insulin pump.

A visit note from the August 5, 2008 educational session at issue in this appeal was also included in the records submitted to BCBSSC. (R.pp. 300-302). 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 also 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.

After receipt of the medical records, on March 15, 2010, Ashby Jordan, M.D., a

⁵ Certified Diabetes Educator.

board certified pediatrician and the Medical Director and Vice President of Medical Affairs for BCBSSC, reviewed Dependent's file in its entirety.⁶ (R.pp. 274-277). Dr. Jordan noted the services referenced were specifically excluded in the Standard Plan under Article 9, Paragraph O. Dr. Jordan 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 also noted the statute Appellant's spouse referenced in her appeal document did not apply to the State Health Plan.

On March 19, 2010, Brooks Goodman, Senior Director for State Operations at BCBSSC, sent Appellant a letter indicating the Medical Director had denied Appellant's appeal for the reasons stated above. (R.p. 320). Because the BCBSSC Medical Director did not approve the appeal, the appeal was sent for consideration by the BCBSSC appeals committee.

On April 2, 2010, BCBSSC sent Appellant a letter denying Appellant's appeal for additional benefits for the August 5, 2008 educational session. (R.pp. 321-323). The letter indicated it had reviewed Appellant's spouse's letters from February 25, 2009, and September 30, 2009; a web inquiry from Appellant's spouse 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 State Health 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, Paragraph O, and Article 7 excluded services not specifically covered. BCBSSC also noted § 38-71-46 did not apply to the self-funded State Health Plan.

⁶ The CV of Dr. Jordan is in the record at pages 324-325.

On June 30, 2010, Appellant's attorney appealed the denial to the EIP Appeals Committee. (R.pp. 333-334). Appellant's attorney noted, "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."⁷ Counsel for Appellant additionally 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; Appellant's motion for class certification; and Appellant's motion to compel and motion to stay decision on EIP's motion for summary judgment. (R.pp. 338-503).

On August 24, 2010, EIP wrote Appellant's counsel that the EIP Appeals Committee had denied the request for reimbursement for Dependent's diabetes education. (R.pp. 138-151). This denial letter concluded:

Determination of Appeals Committee

The Appeals Committee considered all of the evidence in Appellant'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

⁷ On November 25, 2009, while Appellant's administrative appeal was still pending, Appellant filed a putative class action suit against the South Carolina Budget and Control Board, EIP, and BCBSSC in the Court of Common Pleas for the Ninth Judicial Circuit in Charleston, alleging a violation of S.C. Code Ann. § 38-71-46. By order dated October 15, 2010, the Circuit Court granted EIP's and BCBSSC's motion for summary judgment dismissing Appellant's case with prejudice on the grounds that the administrative remedies under S.C. Code Ann. § 1-11-710(C) were Appellant's exclusive remedy, subject only to appeal to the South Carolina Administrative Law Court pursuant to S.C. Code Ann. § 1-23-600 (D). Appellant moved for reconsideration on November 11, 2010. By order dated November 29, 2010, the Circuit Court denied Appellant's motion for reconsideration. For the Court's convenience, a copy of the Circuit Court's order granting summary judgment is attached to Respondent's Brief as Exhibit A.

employees of the state, public school districts, and other participating entities listed in § 1-11-720. 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 Appellant, Appellant'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 Appellant'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 Appellant 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 Appellant 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, Appellant 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 Appellant'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 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.⁸ 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.

(R.pp. 149-151).

Appellant subsequently appealed this denial to the ALC on September 22, 2010.

(R.p. 95-97).

⁸ 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.

IV. ARGUMENT AND CITATION OF AUTHORITY

THE EMPLOYEE INSURANCE PROGRAM'S DECISION TO DENY A CLAIM FOR EVA ALLEN'S SEPARATELY-BILLED DIABETES EDUCATION WAS CORRECT GIVEN THAT THE DECISION IS RATIONAL AND IS SUPPORTED BY THE SUBSTANTIAL EVIDENCE IN THE RECORD, APPLICABLE STATE LAW, AND THE TERMS OF THE STATE HEALTH PLAN.

A. Standard of Review

In S.C. Code Ann. § 1-11-710(C), the General Assembly establishes the Board as the final agency arbiter of disputes under the Plan. Under that section:

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

Under the Board's procedures, which are set forth in Article 12 of the Plan, a claim is reviewed first by the third-party claims processor, in this case BCBSSC, with final agency appeal to the Plan Administrator, in this case EIP in the form of its Appeals Committee. As established in S.C. Code Ann. § 1-11-710(C), the appropriate standard of review is provided in § 1-23-380 of the Administrative Procedures Act ("APA") as follows:

The Court shall not substitute its judgment for that of the agency as to the weight of the evidence on questions of fact. The Court may affirm the decision of the agency or remand the case for further proceedings. The Court may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions or decisions are:

- a. in violation of constitutional or statutory provisions;
- b. in excess of the statutory authority of the agency;
- c. made upon unlawful procedures;
- d. affected by other error of law;
- e. clearly erroneous in view of the reliable, probative and substantial

- evidence on the whole record; or
- f. arbitrary or capricious as characterized by abuse of discretion or clearly unwarranted exercise of discretion.

S.C. Code Ann. § 1-23-380(5) (2008).⁹

The APA establishes the “substantial evidence” rule as the standard for judicial review of agency decisions. Roper Hosp. v. Bd. of S.C. Dept. of Health and Envtl. Ctrl., 306 S.C. 138, 410 S.E.2d 558 (1991); Lark v. Bi-Lo Inc., 276 S.C. 130, 276 S.E.2d 304 (1981). Under the substantial evidence standard of review, the Court may not substitute its judgment for that of the agency unless the agency’s findings are clearly erroneous in view of the reliable, probative, and substantial evidence in the whole record.). See Wilson v. State Budget & Ctrl. Bd. Employee Ins. Program, 374 S.C. 300, 648 S.E.2d 310 (Ct. App. 2007).

Substantial evidence is not a mere scintilla of evidence, but is evidence which, considering the record as a whole, would allow a reasonable mind to reach the conclusion the administrative agency reached to justify its action. Rogers v. Kunja Knitting Mills, Inc., 312 S.C. 377, 440 S.E.2d 401 (Ct.App. 1994). See also Ruocco v. S.C. State Bd. of Registration for Prof'l Eng'rs & Land Surveyors, 314 S.C. 111, 441 S.E.2d 829 (Ct. App. 1994) (when reviewing an agency’s decision under the APA to determine if substantial evidence exists, the record must be viewed as a whole to determine whether there is evidence allowing reasonable minds to reach the conclusion of the agency). An abuse of discretion occurs when a factual ruling is without evidentiary support. Fontaine v. Peitz,

⁹ The Plan itself provides at Paragraphs 6.2 and 12.6 that “any construction or interpretation of the Plan . . . or any other decision arising under the Plan, or exercise of judgment or discretion given to the Plan Administrator . . . shall be binding and conclusive so long as the decision of the Plan Administrator or its duly authorized agent is not arbitrary or capricious or in violation of the applicable statutory law.” (R. pp. 34, 80).

291 S.C. 536, 354 S.E.2d 565 (1987). The possibility of drawing two inconsistent conclusions from the evidence does not prevent an administrative agency's findings from being supported by substantial evidence. Sharp v. Case Produce, Inc., 336 S.C. 154, 519 S.E.2d 102 (1999).

B. Relevant Plan Provisions

The 2008 State Health Plan (Plan), established by the South Carolina Budget and Control Board, provides in pertinent part:

Article 6 Duties and Responsibilities

[see R.pp. 34-37]

Article 7 Schedule of Benefits

[see R.pp. 37-61]

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.¹ Benefits will not be provided for services or supplies not specifically listed in Article 7, Schedule of Benefits, inclusive;

(R.pp. 67-71).

Article 12 Claims Procedure

[see Record pp. 77-78]

The 2008 IBG provides:

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.

(R.pp. 446-447).

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.

(R.p. 470).

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.

(R.p. 483).

C. EIP's Denial of the Claim for Dependent's Separately-Billed Diabetes Education Was Rational and Supported by Substantial Evidence and Was, Therefore, Not Arbitrary or an Abuse of Discretion

1. Separately-Billed Diabetes Management Education Services Are Not Covered Under The State Health Plan

Under the established case law, "[a] decision is arbitrary or capricious if it is

without a rational basis, is based alone on one's will and not upon any course of reasoning and exercise of judgment, is made at pleasure, without adequate determining principles, or is governed by no fixed rules or standard." Deese v. S.C. State Bd. of Dentistry, 286 S.C. 182, 184-85, 332 S.E.2d 539, 541 (Ct. App. 1985).

EIP's claims determination was supported by substantial evidence and was not an abuse of discretion because individually-billed diabetes management education was not covered under the terms of the State Health Plan. A claim determination is supported by substantial evidence if there was evidence in the record upon which a reasonable mind could have relied to reach the same result. See Sierra Club v. Kiawah Resort Assocs., 318 S.C. 119, 456 S.E.2d 397 (1995). While the Plan undisputedly covered the insulin pump and accessories without issue, Dependent's separately-billed educational instruction was not included.

As evidenced by the records submitted during Appellant's claim, and by Appellant's own admissions, the services in question were educational services. The medical records and provider billing records specifically describe the charge in question as an educational service. (R.pp. 283, 300). In addition, Appellant's Brief at pages 7-8 states:

[t]he denial of benefits arose from an education session at MUSC on August 5, 2008. That day, Eva Allen's family and other caregivers...[attended] a training session set up by MUSC Pediatric Endocrinology to train those caregivers, and home and school how to operate an insulin pump...That training session lasted two hours and was taught by a MUSC diabetic educator.

(Appellant's Brief pp. 7-8) (Emphasis added).

Article 9, Paragraph O of the 2008 State Health Plan excludes educational services, outside of certain programmatically-offered situations. Diabetes education, as a

stand-alone claim, was not included under EIP's Hospice Program and/or Home Health Care Program and therefore was simply not covered. Additionally, Paragraph BB of the Plan states those services not enumerated in Article 7, Schedule of Benefits, are not covered; diabetes education was not listed in the Schedule of Benefits. Therefore, no benefits are payable for the educational services received by Appellant, Appellant's spouse, Dependent's grandparents, and two nurses on Dependent's behalf in relation to Dependent's insulin pump on August 5, 2008.

Contracts should be interpreted according the general rules of construction, and the language is to be understood in its plain, ordinary and popular sense. Universal Underwriters v. Metro. Prop. & Life Ins. Co., 298 S.C. 404, 380 S.E.2d 858 (Ct. App. 1989). It is not the function of the Court to rewrite or torture the meaning of the contract to extend coverage. Sphere Drake Ins. Co. v. Litchfield, 313 S.C. 471, 438 S.E.2d 275 (Ct. App. 1993). Based on the unambiguous language of the Plan applied to the medical evidence provided (and even Appellant's own brief), EIP's decision denying Appellant's request for additional benefits was not an abuse of discretion and was supported by substantial evidence: the services were separately-billed educational services, and such services are excluded under the Plan.

2. S.C. Code Ann. § 38-71-46 Has No Application To The State Health Plan

Apparently recognizing that the terms of the State Health Plan specifically exclude standalone educational services like the session at issue, Appellant argues the State Health Plan should be reformed pursuant to S.C. Code Ann. § 38-71-46 to cover diabetes education. However, Appellant's argument fails in that the EIP Appeals Committee correctly found S.C. Code Ann. § 38-71-46 had no application to the State

Health Plan because the State Health Plan is a self-funded, non-federal governmental plan and is not subject to regulation by the South Carolina Department of Insurance ("SCDOI").

The primary rule of statutory interpretation is to ascertain and effectuate the intent of the Legislature. See Auto Owners Ins. Co. v. Rollison, 378 S.C. 600, 609, 663 S.E.2d 484, 488 (2008). Where the statute's language is plain, unambiguous, and conveys a clear, definite meaning, the rules of statutory interpretation are not needed and the court has no right to impose another meaning. Gay v. Ariail, 381 S.C. 341, 345, 673 S.E.2d 418, 420 (2009). "The primary rule of statutory construction requires that legislative intent prevail if it can reasonably be discovered in the language used construed in light of the intended purpose. Sections which are part of the same general statutory law of the state should be construed together and each given effect if it can be done by any reasonable construction." Glover v. Suitt Const. Co., 318 S.C. 465, 469, 458 S.E.2d 535, 537 (1995). "It is proper to consider the title or caption of an act in aid of construction to show the intent of the legislature." Lindsay v. Southern Farm Bureau Cas. Ins. Co., 258 S.C. 272, 277, 188 S.E.2d 374, 376 (1972). But, "they may not be construed to limit the plain meaning of the text." Gamer v. Houck, 312 S.C. 481, 486, 435 S.E.2d 847, 849 (1993).

A plain reading of S.C. Code Ann. § 38-71-46 and the statutes incorporated therein indicates it has no application to the State Health Plan. S.C. Code Ann. § 38-71-46 makes no mention that it applies to the State Health Plan, EIP, the South Carolina Budget and Control Board, or any combination thereof. S.C. Code Ann. § 38-71-46 states:

(A) On or after January 1, 2000, every health maintenance organization, individual and group health insurance policy, or contract issued or renewed in this State must provide coverage for equipment, supplies, Food and Drug Administration-approved medication indicated for the treatment of diabetes, and outpatient self-management training and education for treatment of people with diabetes mellitus, if medically necessary, and prescribed by a health care professional who is legally authorized to prescribe such items and who demonstrates adherence to minimum standards of care for diabetes mellitus as adopted and published by the Diabetes Initiative of South Carolina.

(D) For purposes of this section: "Health insurance policy" means a health benefit plan, contract, or evidence of coverage providing health insurance coverage as defined in Section 38-71-670 (6)^[10] and Section 38-71-840 (14).

Id. (Emphasis added).

S.C. Code Ann. §38-71-840 (14), which involves group health insurance, defines health insurance coverage as:

(14) "Health insurance coverage" means benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer, except:

- (a) coverage only for accident, or disability income insurance, or any combination of accident and disability income insurance;
- (b) coverage issued as a supplement to liability insurance;
- (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;

¹⁰ S.C. Code Ann. § 38-71-670(6) contains identical language to S.C. Code Ann. § 38-71-840(14) and applies to individual policies. Because the coverage at issue is group coverage, S.C. Code Ann. § 38-71-670(6) is not relevant to the analysis.

- (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.

Id. (Emphasis added).

S.C. Code Ann. §38-71-840 (16) defines a “health insurance issuer” as:

(16) “Health insurance issuer” or “issuer” means any entity that provides health insurance coverage in this State. For purposes of this section, “issuer” includes an insurance company, a health maintenance organization, and any other entity providing health insurance coverage which is licensed to engage in the business of insurance in this State and which is subject to state insurance regulation.

Id. (Emphasis added).

Because the State Health Plan is a self-funded plan and not “health insurance coverage” pursuant to S.C. Code Ann. § 38-71-840 (14), and because EIP is not licensed to engage in the business of insurance in this State and not a “health insurance issuer” subject to insurance regulation pursuant to S.C. Code Ann. § 38-71-840(16), S.C. Code Ann. § 38-71-46 has no application to the State Health Plan and EIP. Contrary to Appellant’s assertion, the important distinction between a self-funded health plan and a fully-insured health plan is not limited to cases governed by the well-known Employee Retirement Income Security Act (ERISA). As noted above, the dictionary definition of “self-insured” means the employer has assumed the risk obligation, and “there is no

contract with an insurance company.” Black’s Law Dictionary 664 (8th ed. abr. 2005).

As the United States Supreme Court has recognized, self-funded plans generally are not subject to state insurance regulation. See FMC Corporation v. Holliday, 498 U.S. 52 (1990) (self-funded plans usually are not subject to state insurance regulation). The State Health Plan is a self-funded, non-federal, governmental health plan for employees of state agencies, public school districts, and other public entities, administered by EIP, and is not a fully-insured plan. (R.p. 326). EIP is not licensed to engage in the business of insurance in this State and is not subject to insurance regulation by the SCDOI. See S.C. Code Ann. § 1-11-780 (Supp. 2009) (“The State Employee Insurance Program...is not under the jurisdiction of the Department of Insurance”). The SCDOI itself explains the differing regulatory obligations based on the type of health insurance an employer offers, and directs self-insured plan consumers to the pertinent authority for issues or complaints:

What if You Aren’t Protected by Your State?

If the health plan is self-funded and offered by a private sector employer. . . take unresolved complaints to the U.S. Department of Labor (DOL). . . .

What If You Are a South Carolina State Employee?

The South Carolina State Employee's Health Plan (medical, dental and disability coverage) comes under the jurisdiction of the South Carolina State Employee Insurance Program.

See S.C. Dep’t of Ins., Consumer Information: Health Insurance Information for South Carolina Consumers, <https://online.doi.sc.gov/Eng/Public/Consumer/healthinfoSCconsumer.aspx> (last visited Feb. 10, 2011). Because S.C. Code Ann. § 38-71-46 is a state insurance statute, it has no application to a self-funded health plan.

Appellant’s attempt to rely on the doctrine of “the enumeration of exclusions from the operation of a statute indicates that the statute should apply to all cases not

specifically excluded” has no application because S.C. Code Ann. § 38-71-46 and the statutes incorporated therein are not ambiguous. “If a statute’s language is plain, unambiguous, and conveys a clear meaning, ‘the rules of statutory interpretation are not needed and the court has no right to impose another meaning.’” Hodges v. Rainey, 341 S.C. 79, 85, 533 S.E.2d 578, 582 (2000). Simply put, S.C. Code Ann. § 38-71-46 only applies to “health insurance coverage” issued by an “insurance issuer” licensed and regulated by the SCDOI. The State Health Plan is not “health insurance coverage,” nor is EIP an “insurance issuer.” Accordingly, the State Health Plan does not meet even the preliminary requirements under S.C. Code Ann. § 38-71-840(16). Therefore, any analysis of the exclusions under S.C. Code Ann. § 38-71-840(16) is irrelevant.

Even assuming for the sake of argument that S.C. Code Ann. § 38-71-46 is ambiguous and resorting to the rules of statutory construction is needed, S.C. Code Ann. § 38-71-46 still does not apply to the State Health Plan. The Legislature recently and explicitly recognized the lack of jurisdiction of the SCDOI over EIP as recently as 2005:

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,^[11] 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.

2005 Act No. 76, § 3, codified as S.C. Code Ann. § 1-11-780 (Supp. 2010). (Emphasis added). The remainder of Act 76 created § 38-71-290 separately and distinctly from the

¹¹ The prior coverage beginning in 2002 that is referenced in this statute is from repealed § 1-11-760 (repealed 2005), which also pertained to mental health coverage mandates for EIP. See S.C. Code Ann. § 1-11-760 (repealed 2005). The former statute took effect in 2002 with a built-in repeal date effective in 2005. See 2000 S.C. Act No. 341, § 4, codified at S.C. Code Ann. § 1-11-760 (repealed 2005). The former law also specifically defined what entity it applied to: “State Health Insurance Plan means health insurance plans offered or administered by the State Budget and Control Board.” S.C. Code Ann. § 1-11-760 (repealed 2005). This section explicitly set out requirements for mental health coverage by EIP, and by EIP only, and former § 1-11-760 clearly was located in Title 1, Chapter 11, Article 5.

portion of the legislation addressing EIP. See 2005 Act. No. 76, § 1, codified as S.C. Code Ann. § 38-71-290 (Supp. 2010). The Legislature was aware it needed to name EIP separately and purposefully outside of a general insurance statute in Title 38, Chapter 71, if it wanted EIP to comply with the contents of that statute. Additionally, the General Assembly plainly ratified its long-term understanding that EIP “is not under the jurisdiction of the Department of Insurance.”

In fact, in the 1990s and into the 2000s, the Legislature passed a series of health insurance coverage mandates in Title 38, Chapter 71, Article 1.¹² With the exception of § 38-71-280, regarding autism spectrum disorder, none of these laws or their preceding bills mentioned EIP, the State Health Plan, or the Budget and Control Board. Then in 2007, the Legislature passed § 38-71-280, mandating coverage for autism spectrum disorder care.¹³ In § 38-71-280, the Legislature specifically stated it desired the statute apply to EIP: “It includes the State Health Plan. . . . ‘State Health Plan’ means the employee and retiree insurance program provided for in Article 5, Chapter 11, Title 1.” S.C. Code Ann. § 38-71-280(A)(4)-(5). The statute made specific reference to EIP’s governing Code sections, again underscoring the General Assembly’s knowledge that EIP is governed differently. Accordingly, the Legislature deliberately referenced the State Health Plan and EIP’s enabling statutes to make the Legislature’s intent clear that

¹² Chronologically, these statutes requiring coverage were: § 38-71-240, for cleft lip and palate care (1993 S.C. Act No. 129, § 1); § 38-71-143, for children placed for adoption (1994 S.C. Act No. 481, § 2); § 38-71-135, for postpartum care for mothers and newborns (1996 S.C. Act No. 335, § 1, amended by 1997 S.C. Act No. 5, § 4); § 38-71-125, for mastectomies and related treatment (1998 S.C. Act No. 329, § 3); § 38-71-130, for breast reconstruction following mastectomy (1998 S.C. Act No. 329, § 4); § 38-71-145, for mammograms, pap smears, and prostate cancer examinations (1998 S.C. Act No. 329, § 5); § 38-71-215, for dermatology referrals (1998 S.C. Act No. 353, § 1); § 38-71-46, for diabetes mellitus care, with attendant education and equipment (1999 S.C. Act No. 98, § 5, amended by 2000 Act No. 348, § 1); and § 38-71-280, autism spectrum disorder care (2007 S.C. Act No. 65, § 1).

¹³ Notably, § 38-71-280 mandating State Health Plan autism coverage followed § 1-11-780’s acknowledgment of no SCDOI jurisdiction over EIP.

§ 38-71-280 applied to EIP because simply passing a statute in Title 38, Chapter 71, without a special reference or cross-reference would not do so.

Amidst this series of legislation, the bill that would become § 38-71-46 and mandate the provision of diabetes mellitus coverage by health insurers was introduced and passed in 1999, one session and one year before § 1-11-760 (repealed 2005) would explicitly require EIP to provide mental health coverage. The original diabetes health insurance coverage legislation had no references to EIP in its text. See 1999 S.C. Act No. 98 (codified at S.C. Code Ann. § 38-71-46). Perhaps more importantly, § 38-71-46 was later amended in the same session in which § 1-11-760 (repealed 2005) became law. See 2000 S.C. Act No. 348 (amending coverage mandates for diabetes mellitus); 2000 S.C. Act No. 341 (mandating EIP provide mental health coverage). The Legislature was clearly aware at the time § 38-71-46 was amended in 2000 that for the statute to apply to EIP, EIP needed to be identified in the statute. However, the Legislature chose not to do so, and § 38-71-46 makes no mention of its application to the State Health Plan, unlike the contemporaneously and subsequently passed legislation. By Appellant's own admission, "the court should take judicial notice that the members of the South Carolina General Assembly have the option of participating in the State Health Plan themselves, and therefore knowledge of its existence cannot be minimized." (Appellant's Brief p. 19).

The Legislature made it very clear when mandates otherwise restricted to health insurers were to apply to the State Health Plan. When EIP was to be included, the Legislature either: (1) amended EIP's governing statutes in Title 1, Chapter 11, Article 5; (2) made a direct reference to those statutes in its legislation; or (3) at a minimum, identified EIP by name in its legislation. The Legislature was aware EIP was not

governed by the SCDOI and specifically stated this fact in 2005 legislation. The Legislature also acknowledged that EIP was not governed by the mandates in Title 38, Chapter 71, Article 1, unless a specific intent to do so was stated in the statute. Finally, § 38-71-46 itself was passed contemporaneously with other legislation specifically indicating application to EIP; yet § 38-71-46 remained silent regarding EIP and the State Health Plan. If the Legislature had intended § 38-71-46 to apply to EIP, it would have indicated that in the statute itself or associated legislation.

Appellant argues finding § 38-71-46 does not apply to the State Health Plan means the State Health Plan is devoid of regulation. However, Appellant's argument is without merit. First, the State Health Plan was created by the Legislature, and the Legislature acknowledges the existence of the State Health Plan on a regular basis. One example of this ongoing recognition is the inclusion of the State Health Plan annually in state budget provisos, which would not take place with a regular insurance plan. Second, the State Health Plan is specifically regulated by S.C. Code Title 1, Chapter 11, Article 5, and those parts of Title 38, Chapter 71 that specifically refer to the State Health Plan, as is the basis for the preceding analysis: the Legislature has the power to control the State Health Plan when it decides to pass legislation accordingly. Third, in addition to state regulation, federal laws and regulations, although not ERISA, also govern the State Health Plan through the U.S. Department of Health and Human Services.¹⁴ Accordingly, Plaintiff's argument that the State Health Plan is without regulation is incorrect.

3. *Appellant is Not Entitled to Assert Class Action Relief Pursuant to the Statutorily*

¹⁴ As a self-funded, nonfederal governmental plan, the State Health Plan is subject to the Public Health Service Act, 42 U.S.C. § 201 et seq., which includes such well-known federal laws as HIPAA and COBRA, and was amended significantly by the recent health care reform act. See, e.g., Centers for Medicare & Medicaid Servs., Regulations & Guidance, Self-fundedNonfederalGovernmentalPlans, <https://www.cms.gov/SelfFundedNonFedGovPlan/> (last visited Feb. 10, 2011).

Provided Procedure and Remedies

The administrative remedies under S.C. Code Ann. § 1-11-710(C) are Appellant's exclusive remedy. A participant and/or beneficiary challenging an award of benefits under the State Health Plan is limited to the remedies set forth in S.C. Code Ann. § 1-11-710(C), which provides as follows:

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

Id. (Emphasis added). Appellant's appeal to the ALC dated September 22, 2010, stated the relief he was seeking in the following manner: "[t]he agency has denied claimant's claim for diabetes education/outpatient self-management training, after the claim was denied by Blue Cross-Blue Shield of South Carolina. This denial is in violation of S.C. Code § 38-71-46(A). The relief sought is payment of claimant's claim." (Emphasis added) (R.p. 96). Appellant is also requesting the Court interpret the terms of the State Health Plan to include the coverage set out in S.C. Code Ann. § 38-71-46. Appellant further alleges he is entitled to disgorged benefits from the plan for unlawful denials of coverage and for injunctive relief enjoining further denial of claims for diabetes outpatient self-management training and education. (R.p. 250). The interpretation of the State Health Plan and the resolution of claims for benefits under the Plan are exactly the types of remedies contemplated by § 1-11-710(C).¹⁵

¹⁵ Paragraph 1.3 of the State Health Plan states:

1.3 Applicable Law

This Plan is established and will be maintained with the intention of meeting the

specifically allowed by § 1-11-710(C) and the claims procedure set forth in the State Health Plan. To allow the remedy would be a waiver of the State's sovereign immunity. Allowing class action relief with the award requested would exceed the State's liability beyond the terms and conditions prescribed by the statute.

Appellant correctly observes the issue of class-based claims in the ALC has been within the context of the Revenue Procedures Act, which does in fact contain a prohibition against class actions. However, in addition to the prohibition on class action relief, those statutes also state "(A) Except as provided in subsection (B), there is no remedy other than those provided in this chapter in any case involving the illegal or wrongful collection of taxes, or attempt to collect taxes." S.C. Code Ann. § 12-60-80(A). Subsection (B), allowing challenges to the constitutionality of tax laws to be filed in circuit court, and subsection (C), disallowing the class actions, were passed in 2003, amidst the cases Appellant cites. See 2003 Act No. 69, § 3.CC (codified at S.C. Code Ann. § 12-60-80(B)-(C)); Drummond v. S.C. Dep't of Rev., 378 S.C. 362, 662 S.E.2d 587 (2008); Ward v. State, 343 S.C. 14, 583 S.E. 2d (2000). Three years before subsection (C) was passed, Ward actually addressed whether administrative remedies had to be exhausted when challenging the constitutionality of a statute. 343 S.C. at 18, 538 S.E.2d at 247. In Drummond, the court found the individual relief regarding disgorgement of tax monies to individuals was properly sent to the Administrative Law Court, 378 S.C. at 369, 662 S.E.2d at 590, but a constitutional issue properly went to the circuit court under subsection (B) of the statute. Id. Both cases support the limitation of individual administrative remedies to the statutes at issue, not a broadening of statutory relief to include class actions as a remedy.

Even assuming for the sake of argument that Appellant could request class action relief under S.C. Code Ann. § 1-11-710(C), Appellant is not entitled to class action relief in the present case in that he failed to request it during the course of his administrative claim with BCBSSC and EIP. While it is undisputed that Appellant brought a purported class action in circuit court that was dismissed by summary judgment, Appellant never requested class action relief as part of his administrative claim. Appellant's administrative appeal letters dated February 25, 2009, and September 30, 2009 make no mention of a class action. (R.pp. 265-266, 272-273).

Appellant's appeal letter dated June 30, 2010 stated, "[a]s you already know the Plaintiffs have brought a putative class action lawsuit against 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 (sic) set forth in detail in the attached pleadings in the civil action in Charleston County Court of Common Pleas, and are incorporated into this appeal letter." (R.p. 333). While this letter and the pleadings submitted with it were submitted for informational purposes that Appellant was seeking a class action in circuit court, Appellant at no time asserted he was entitled to class action relief as part of his administrative claim.

The conclusion is further supported by Appellant's appeal to the ALC dated September 22, 2010, wherein Appellant stated the relief he was seeking as: "[t]he agency has denied claimant's claim for diabetes education/outpatient self-management training, after the claim was denied by Blue Cross-Blue Shield of South Carolina. This denial is in violation of S.C. Code § 38-71-46(A). The relief sought is payment of claimant's claim." (Emphasis added) (R.p. 96). By failing to request class action relief during Appellant's

administrative appeal, Appellant waived any right to assert class action relief before the ALC.

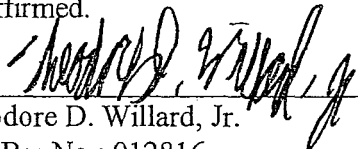
Further assuming for the sake of argument that Appellant was entitled to request class action relief under S.C. Code Ann. § 1-11-710(C), Appellant failed to produce any evidence during the claim that class action treatment was appropriate. Proponents of class certification bear the burden of proving five prerequisites under South Carolina law. Waller v. Seabrook Island Property Owners Ass'n, 300 S.C. 465, 388 S.E.2d 799 (1990); Rule 23(a), SCRCF. The prerequisites are: (1) the class must be "so numerous that joinder of all members is impracticable;" (2) there must be "questions of law or fact common to the class;" (3) the "claims or defenses of the representative parties [must be] typical of the claims or defenses of the class;" (4) "the representative parties [must] fairly and adequately protect the interests of the class;" and (5) "the amount in controversy [must] exceed one hundred dollars for each member of the class." Rule 23(a), SCRCF. The first four criteria are often referred to as the requirements for numerosity, commonality, typicality, and adequacy of representation. In deciding whether class certification is proper, the court must apply a rigorous analysis to determine each prerequisite is satisfied. Waller v. Seabrook Island Prop. Owners Ass'n, 300 S.C. at 467, 388 S.E.2d at 801. Failure to satisfy even one prerequisite is fatal to class certification. Id.

While Appellant did submit his state court pleadings as part of his State Health Plan claim, Appellant submitted no evidence to support these class action allegations. When determining whether the requirements of Rule 23 have been met, a court must not merely rely on the allegations found in the Plaintiff's complaint. City of Ann Arbor v. Sonoco Products Co., 279 F.R.D. 247 (D.S.C. 2010). Here, Appellant failed to submit

any evidence during his claim supporting the five Rule 23 requirements for class action treatment.^{17, 18} Accordingly, class action treatment, even if it were available, would not be appropriate.

IV. CONCLUSION

For the foregoing reasons, the decision of the Appeals Committee of the Employee Insurance Program should be affirmed.


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ATTORNEYS FOR RESPONDENTS

February 17, 2011
Columbia, South Carolina

¹⁷ For example, Appellant's claim fails on the third element because he did not submit evidence or argument that his claim is typical of the claims of the class. Not only did he fail to submit evidence of typicality, the information provided to the EIP Appeals Committee did not contain any indication of how Appellant's claim would be typical of a particular class. It was unclear whether Appellant was seeking to represent a class of State Health Plan participants that were denied coverage for the type of education Dependent received, all diabetes education, or all types of education.

¹⁸ Moreover, Appellant's claim also fails on the fifth element, the \$100 threshold. While Appellant noted and the record supports the cost MUSC billed was \$560.00 for the group session, there is no evidence that this is the standard rate billed for such services. According to the American Association of Diabetes Educators, the national average for such services by Medicare is \$23.08 for G0108, the code for individual education, and \$12.99 for G0109, the code for group educational services. Most programs set their fees as a percentage of Medicare, around 150%. See Am. Ass'n of Diabetes Eds., Ask the Reimbursement ExpertQ&A, http://www.diabeteseducator.org/Members/Reimbursement_QxA.html (last visited February 10, 2011). In fact, Medicaid's allowable charges for such services in South Carolina in 2008 were \$24.47 for an individual diabetes education session and \$13.85 for group education, respectively. In 2011, they are \$52.75 and \$18.04, respectively. See Centers for Medicare & Medicaid Servs., Physician Fee Schedule Search, <http://www.cms.gov/apps/physician-fee-schedule> (last visited February 10, 2011). Accordingly, the amount in controversy for class actions is not met.

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

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

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

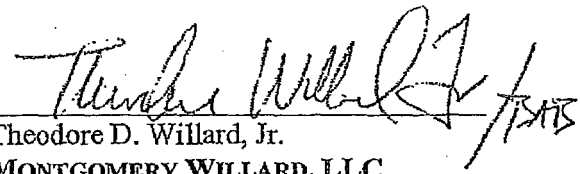
vs.

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

CERTIFICATE OF SERVICE

I certify that I have served a copy of the Brief of Respondent on Jeffrey D. Allen by depositing one copy of it in the United States Mail, postage prepaid on February 17, 2011, addressed to his attorneys of record, John A. Massalon, 134 Meeting Street, Suite 100, Charleston, South Carolina 29401 and Matthew D. Hamrick, 1017 Chuck Dawley Blvd., Mt. Pleasant, South Carolina 29464.

February 17, 2011


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ATTORNEYS FOR THE RESPONDENT

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,)

ORDER

v.)

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

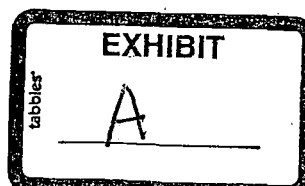
Defendants.)

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

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

I. BACKGROUND

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



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

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

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

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

19. Plaintiff seeks, individually and as legal guardian for Jane Doe, and on behalf of all class members, a declaration of the rights of the parties hereto: that Defendants are required to issue and administer all health benefit plans offered

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

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

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

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

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

II. STANDARD FOR SUMMARY JUDGMENT

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

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

III. DISCUSSION

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

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

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

Id. (Emphasis added).

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

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

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

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

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

¹ Paragraph 1.3 of the State Health Plan states:

1.3 Applicable Law

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

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

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

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

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

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

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

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

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

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

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

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

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

prejudice as a matter of law.³

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

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

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

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

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

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

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

IV. CONCLUSION

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

IT IS SO ORDERED.


PAUL M. BURCH
PRESIDING JUDGE

September 10/12th 2010
Charleston, South Carolina

STATE OF SOUTH CAROLINA
In the Administrative Law Court

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

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

v.

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

REPLY BRIEF OF APPELLANT

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ARGUMENT

A. RESPONDENT'S INTERPRETATION OF S.C. CODE ANN. § 38-71-840 (14) IS NOT SUPPORTED BY THE PLAIN MEANING RULE AND IS UNREASONABLE

"The primary purpose in construing a statute is to ascertain legislative intent."

Gordon v. Phillips Utils., Inc., 362 S.C. 403, 406, 608 S.E.2d 425, 427 (2005). "The legislature's intent should be ascertained primarily from the plain language of the statute." State v. Landis, 362 S.C. 97, 102, 606 S.E.2d 503, 505 (Ct. App. 2004); State v. Morgan, 352 S.C. 359, 366, 574 S.E.2d 203, 206 (Ct. App. 2002); Stephen v. Avins Constr. Co., 324 S.C. 334, 338, 478 S.E.2d 74, 76 (Ct. App. 1996).

In its Brief, Respondent relies mostly on the inclusion of the words "offered by a health insurance issuer" in section 38-71-840 (14) to support its position that the State Health Plan is not insurance, but a "self-funded" benefit plan exempt from state regulation. However, the plain language of the section 38-71-46 [the diabetes mandate] at issue simply does not support that argument. "What a legislature says in the text of a statute is considered the best evidence of the legislative intent or will." Knotts v. S.C. Dept of Natural Resources, 348 S.C. 1, 10, 558 S.E.2d 511, 516 (2002) (quoting Norman J. Singer, *Sutherland Statutory Construction*, §46.03 at 94 (5th Ed. 1992)). Respondent can cite to no other reasoning for its proposed interpretation. Instead, the diabetes coverage mandate at issue states plainly that it applies to "every health maintenance organization, individual and group health insurance policy, or contract issued or renewed in this State," and then within its own terms, states that for the purposes of this statute, "Health insurance policy" means a health benefit plan,

contract, or evidence of coverage providing health insurance coverage as defined in . . .
Section 38-71-840(14).”

The General Assembly did not expressly reference or incorporate the definition of “health insurance issuer,” found at section 38-71-840(16) and relied upon by Respondent, into the diabetes mandate. Further, the plain language of section 38-71-840(14), which does include the term “health insurance issuer” does not support the Respondent’s conclusion that the presence of the term “health insurance issuer” removes the State Health Plan from application of the diabetes mandate statute. (Respondent’s Brief. at 19).

S.C. Code Ann. § 38-71-670(14) provides:

(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 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.

Id. (emphasis added). Broken down into its elements, the first paragraph of section 38-71-840(14) defines health insurance coverage [and therefore determines whether the diabetes mandate applies to the Respondent State Health Plan] to include ‘benefits consisting of medical care’

- (1) provided directly through insurance,
- (2) provided directly through reimbursement, or
- (3) provided otherwise.

Then, the statute expands, by use of the words “and including”, that definition by adding the following specific kinds of “items and services paid for as medical care”:

- (a) under any hospital service policy, certificate, or plan contract
- (b) under any medical service policy, certificate, or plan contract, or
- (c) under any health maintenance organization contract offered by a health insurance issuer.

Then, the statute specifically excludes, by use of the word “except,” twelve (12) kinds of insurance, which exclusions do not include the State Health Plan in any way. Reading section 38-71-840(14) this way makes sense and, at the same time, illustrates the torturous nature of the Respondent’s proposed interpretation.

“A statute as a whole must receive a practical, reasonable, and fair interpretation consonant with the purpose, design, and policy of the lawmakers.” Browning v. Hartvigsen, 307 S.C. 122, 125, 414 S.E.2d 115, 117 (1992). “The real purpose and intent of the lawmakers will prevail over the literal import of the words.” Id. “Courts will reject a

statutory interpretation which would lead to a result so plainly absurd that it could not have been intended by the legislature or would defeat the plain legislative intention.” *Id.* (citing Unisun Ins. Co. v. Schmidt, 339 S.C. 362, 368, 529 S.E.2d 280, 283 (2000); Kiriakides v. United Artists Communications, Inc., 312 S.C. 271, 275, 440 S.E.2d 364, 366 (1994)).

Respondent argues that only a “health insurance issuer,” as that term is defined in section 37-71-840(16) can provide “health insurance coverage.” However, in order for that argument to work within the context of the section 38-71-840(14), the clause “offered by a health insurance issuer” would need to modify each subject in the sentence. So, for example, Respondent’s interpretation would result in the following reading: Health Insurance Coverage means “benefits consisting of medical care”

- (1) provided directly through insurance offered by a health insurance issuer,
- (2) provided directly through reimbursement offered by a health insurance issuer, or
- (3) provided otherwise offered by a health insurance issuer

“and including items and services paid for as medical care”:

- (a) under any hospital service policy, certificate, or plan contract offered by a health insurance issuer
- (b) under any medical service policy, certificate, or plan contract offered by a health insurance issuer, or
- (c) under any health maintenance organization contract offered by a health insurance issuer

This interpretation results in an illogical interpretation, and renders most of the language in the definition completely meaningless and unnecessary. If the Respondent’s interpretation were correct, then the General Assembly could have simply defined health insurance coverage to mean any benefits consisting of medical care offered by a health insurance issuer. It did not. Whereas, an interpretation where the phrase “offered by a health

insurance issuer” only modifies “health maintenance organization contract” has a natural reading, complies with general rules of punctuation, and appears to comport with the purpose of the statute – to broadly define “health insurance coverage.” “A court should not consider a particular clause in a statute as being construed in isolation, but should read it in conjunction with the purpose of the whole statute and the policy of the law.” Browning, 307 S.C. at 125, 414 S.E.2d at 117. Further, use of this definition to define the scope of the diabetes mandate also comports with the stated intent to apply the diabetes mandate to “every policy or contract issued in the State.”

The EIPS’s State Health Plan fits plainly within all three general categories of section 38-71-843(14) in that it provides “benefits consisting of medical care” (1) provided directly through insurance, (2) provided directly through reimbursement, or (3) provided otherwise. The State Health Plan provides benefits directly through insurance because that is what it calls itself. (Supp. R. 419-86 – South Carolina Employee Insurance Program’s Employee Insurance Guide). If what is provided is not “directly through insurance” because the State Health Plan is self-funded, then the benefits it provides are provided “directly through reimbursement.” Lastly, if what the State Health Plan provides is not directly through insurance nor directly through reimbursement, the provisions of its benefits certainly fall into the otherwise provided catch-all.

This statutory interpretation issue is not a complicated one. The diabetes mandate is clear that the legislative intent was that it apply to all providers of medical care benefits, and the State Health Plan fits plainly within those definitions.

B. THE "SELF-FUNDED" LABEL IS NOT RELEVANT

Respondent states that the distinction between a self-funded plan and a fully-insured plan is not limited to the ERISA context. However, the only case it cites in support of that proposition, FMC Corporation v. Holliday, 498 U.S. 52 (1990), is in fact an ERISA case. The terms self-funded or self-insured are not found in the diabetes mandate, nor in the definitions recited therein, and are not relevant to the issue at bar.

C. JURISDICTION OVER THE STATE HEALTH PLAN BY THE BUDGET AND CONTROL BOARD'S EMPLOYEE INSURANCE PLAN DOES NOT RENDER THE DIABETES MANDATE INAPPLICABLE

Respondent argues that passing statements about the jurisdiction over the State Health Plan – for example, as part of a sentence in the mental health insurance mandate, and as part of a Dept. of Ins. Consumer Information internet site – renders the State Health Plan exempt from the language of the diabetes mandate at issue in this case. However, there is nothing in those statements that alters the requirement of the court to discern the intent of the legislature from the plain language of the statute. This court should reject the Respondent's reliance on the 2005 mental health parity statute, S.C.Code Ann. §38-71-46, as cited on page 21 of the Respondent's Brief. That statute was passed into law five years after the diabetes mandate, and there is nothing in the language of the mental health parity statute which expands it to any other subject matter.

D. APPELLANT REQUESTED CLASS RELIEF BELOW

Respondent argues that Appellant failed to raise the class action claim below and has therefore waived that claim. While Respondent's citation to the actual Notice of Appeal to the ALJ is correct, SCALC Rule 33(B) provides that the notice of appeal from the final

decision of the agency shall include:

a general statement of the grounds for appeal and as provided in S.C. Code Ann. §1-23-380 (A)(6). The grounds for appeal may be amended, supplemented or modified in the statement of issues in the brief required by Rule 37(B)(1);

All of the grounds for this appeal were set out in detail in the Appellant's Statement of Issues, including the class action claim.

Further, as referenced in the appeal submitted to the EIP on June 30, 2010, the Appellant made the issues of class certification and class-wide relief part of the appeal. (Supp. R. 333). Appellant expressly stated that the claims and grounds for relief, which included class relief, were being incorporated into the appeal. *Id.* There is no plainer way to include those claims. The EIP failed to address or consider the arguments and grounds submitted to it as the appeal, and instead addressed only the singular benefit claim making the erroneous legal conclusion it was not subject to the diabetes mandate. The EIP's ignoring the class claim cannot be the basis for waiver by the Appellant.

Lastly, the Respondent argues that Appellant failed to produce evidence during the claim that class action treatment was appropriate. The agency, in this case the EIP, provided no hearing, no method for the Appellant to discover evidence, most of which would only be available to the Respondent, that class action treatment was appropriate. Instead, Appellant filed for relief, including class relief in circuit court and sought discovery from the Respondent and Defendant Blue Cross and Blue Shield of South Carolina, which was refused by said Defendants in circuit court. (Supp. R. 501-502). Respondent should not be permitted to complain about the lack of evidence when it refused to conduct discovery.

CONCLUSION

Accordingly, based upon the foregoing and the Appellants Initial Brief, the Respondent asks this Court to reverse the findings and conclusions of EIP, and find that the diabetes mandate was intended to apply to the EIP, that the EIP has been in violation of said statute since its effective date of January 1, 2000. This court should modify the decision below to require the EIP to disclose all claims made by any insureds from the effective date of section 38-71-46 to the present, identify those insureds and the amount of their claim, and allow this case to proceed in the ALC as a class action for a determination of legal and equitable remedies as permitted, including the award of attorneys fees and costs to class counsel.

March 4, 2011

Respectfully submitted,



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STATE OF SOUTH CAROLINA
In the Administrative Law Court

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

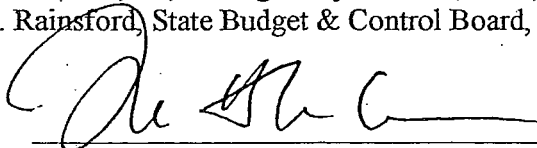
Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees or retirees, ... Appellant,

v.

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

PROOF OF SERVICE

I certify that I have served the Reply Brief of Appellant on Respondent of record by depositing a copy of it in the United States Mail, postage prepaid, on March 4, 2011, addressed to their attorneys of record, Theodore D. Willard, Jr., Montgomery Willard, LLC, P.O. Box 11886, Columbia, SC, 29211 and Kelly H. Rainsford, State Budget & Control Board, 1201 Main Street, Suite 300, Columbia, SC 29201.



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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.

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Wills & Massalon

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STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Jeffrey D. Allen,

Petitioner,

v.

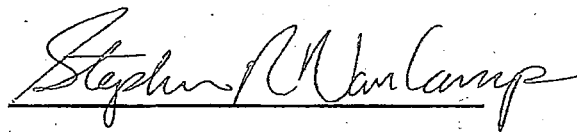
South Carolina Budget and Control
Board, Employee Insurance Program,

Respondent.

Docket No. 10-ALJ-300710 -AP

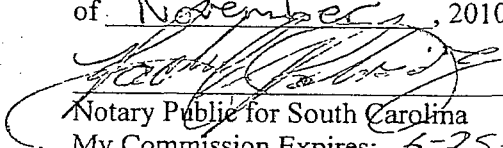
**CERTIFICATION OF THE
ADMINISTRATIVE RECORD**

I, Stephen R. Van Camp, of the Employee Insurance Program of the South Carolina State Budget and Control Board, do hereby certify that the attached documents represent a complete copy of the administrative record reviewed in the matter of Jeffrey D. Allen's claim for benefits under the State of South Carolina Group Health Benefits Plan.



Stephen R. Van Camp

Sworn to before me this 5th day
of November, 2010.



Notary Public for South Carolina

My Commission Expires: 6-25-2014

Exhibit A

ARTICLE 1.

ESTABLISHMENT AND PURPOSE OF PLAN

1.1 Name and Purpose

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

1.2 Establishment and Effective Date

This Plan is a continuation of and replaces the Health Benefits Plan initially established on July 1, 1972, and this Plan becomes effective January 1, 2008.

1.3 Applicable Law

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

1.4 Entire Plan

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

1.5 Plan Description

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

1.6 Changes to Plan

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

1.7 Effect of Changes

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

- A. No increase or reduction in benefits shall be effective with respect to Covered Expenses incurred prior to the date a material change was adopted by the Planholder, regardless of the effective date of the change; and,
- B. No change shall become effective with respect to any Covered Person who was hospitalized on the effective date of such change until the date such person ceases to be hospitalized.

1.8 Termination of Plan

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

1.9 Written Notice

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

1.10 Waiver

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

1.11 Clerical Error or Delay

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

1.12 Workers' Compensation

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

1.13 Gender

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

1.14 Headings

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

1.15 Misstatements on Application

If any relevant fact has been misstated or omitted by, or on behalf of, any person on the Notice of Election Form, or other document, or information submitted or required to be submitted to the Plan Administrator, Third Party Claims Processor or Utilization Review Agency to obtain or retain coverage under this Plan, the true facts shall be used to determine whether coverage is in force and the extent, if any, of such coverage. Upon the discovery of any such misstatement coverage may be terminated retroactively to the date of the act or omission, or misstatement, and an equitable adjustment of any contributions will be made if this is in order and the Plan Administrator may recover the amount of claims paid.

1.16 Use of Social Security Numbers on Application

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

ARTICLE 2.

DEFINITIONS

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

2.1 Active Employee

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

2.2 Active Employment

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

day. In no event will an Employee be considered to be in Active Employment if he has not reported for work or if he has effectively terminated employment.

2.3 Actual or Normal Charges

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

2.4 Acute Medical Illness

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

2.5 Agent for Service of Process

The Plan Administrator.

2.6 Alcoholism

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

2.7 Alcoholism Treatment Center

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

2.8 Allowable Charge

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

2.9 Alternative Treatment Plan

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

2.10 Ambulatory Surgical Center

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

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

2.11 Ambulatory Surgical Center Network

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

2.12 Behavioral Health Disorders

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

otherwise excluded by the terms and conditions of this Plan.

2.13 Behavioral Health Manager

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

2.14 Behavioral Health Provider

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

2.15 Benefit Year

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

2.16 Bodily Injury and Sickness

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

2.17 Child

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

2.18 Clerical Error

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

2.19 Coinsurance

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

2.20 Congenital

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

2.21 Co-payment

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

2.22 Covered Dependent

A Dependent of a Covered Employee, who has met the eligibility requirements and is enrolled under the Plan and to whom benefits are payable under this Plan.

2.23 Covered Employee

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

2.24 Covered Hospital Services

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

2.25 Covered Medical Expense

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

2.26 Covered Person

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

2.27 Creditable Coverage

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

2.28 Custodial Care

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

2.29 Customary Charge or Reasonable and Customary Charge

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

and/or medical consultants, determine the Reasonable and Customary Charge based upon comparable or similar services or procedures.

2.30 Deductible

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

2.31 Dependent

Shall mean and include a Covered Employee's:

- A. Lawful spouse, or former spouse who is required to be covered by either a divorce decree or court order, but not both. Provided, however, that if a spouse is also eligible for coverage or benefits as an Employee of the State, school district or a participating entity, the spouse is eligible for coverage only as an Employee and not as a Dependent. However, a Part-Time Teacher who is the Spouse of a Covered Employee may be covered as either an Employee or as a Dependent, but not as both;
- B. Unmarried Child under 19 years of age, who is principally dependent (more than fifty percent) upon the Covered Employee for maintenance and support. The Plan Administrator may require the Covered Employee to submit due proof of the Dependent Child relationship with the Covered Employee within 31 days of enrollment, and at such other reasonable times;
- C. Unmarried Child, over 19 years of age, who is incapable of self-sustaining employment because of mental illness, retardation or physical handicap and is principally dependent (more than fifty percent) on the Covered Employee for maintenance and support, provided that the Child was covered continuously under the Plan or a Predecessor Plan, prior to the date of incapacitation. The Plan Administrator may require the Covered Employee to submit due proof of such incapacity and dependency satisfactory to the Plan Administrator within 31 days of initial enrollment, upon attaining age 19 and at such other reasonable times, but not more frequently than annually. It shall be the Employee's responsibility to notify the Plan Administrator when the Child is no longer incapacitated;
- D. Unmarried Child, over 19 years of age, but under 25 years of age, who is a Full-Time Student as defined in 2.45, and is principally dependent (more than fifty percent) upon the Covered Employee for maintenance and support. The Plan Administrator may require the Covered Employee to submit due proof of such Full-Time Student status and dependency satisfactory to the Plan Administrator within 31 days of enrollment, upon attaining age 19 and at such other reasonable times, but not more frequently than annually. It shall be the Employee's responsibility to notify the Plan Administrator when the Child is no longer a Full-Time Student.

2.32 Diagnosis Related Groups (hereinafter "DRG")

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

2.33 Drug Abuse

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

2.34 Durable Medical Equipment

Any equipment which:

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

2.35 Effective Date

Shall mean:

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

2.36 Eligible Expense

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

2.37 Employee

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

2.38 Employer

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

2.39 Enrollment Date

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

2.40 Expense Incurred

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

2.41 Extended Role Nurse

An individual who has satisfied the State Board of Nursing's requirements as a nurse practitioner, certified nurse midwife, certified registered nurse anesthetist or clinical nurse specialist contained in State Board of Nursing Regulation 91-2, who is functioning in the extended role as that term is defined in the regulation, and who is in independent practice. The Plan only recognizes a certified nurse midwife licensed by the State Board of Nursing as a Provider for purposes of midwife coverage. A lay midwife, or a midwife whose only licensure is through the Department of Health and Environmental Control (DHEC), is not recognized, or reimbursed, as a Provider, by the Plan.

2.42 Family

A Covered Employee and his Covered Dependents, if any.

2.43 Free Standing Emergency Care Center

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

2.44 Full-Time

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

2.45 Full-Time Student

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

- A. High school. Correspondence course participation does not constitute attendance

as a Full-Time Student under this section; or

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

Except as provided above, a Child shall cease to be a Dependent eligible for coverage as a Full-Time Student at 12 midnight on the last day of the month after: (1) attaining the age of 25; or (2) notice that the Child ceased being a Full-Time Student by not attending school for any reason other than injury or sickness which prevents the student from attending, provided such Child would otherwise be a Full-Time Student but for such injury or sickness; or (3) failure to provide evidence of Full-Time Student status as required by 2.30.D.

2.46 Health Care Professional

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

2.47 Home Health Care

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

2.48 Hospice

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

2.49 Hospital

- A. For other than a psychiatric facility, a short-term acute care (1) general Hospital, (2) children's Hospital, (3) eye, ear, nose and throat Hospital, or (4) maternity Hospital, licensed by the state in which it operates that, for compensation from its

patients and on an inpatient basis, is primarily engaged in providing diagnostic and therapeutic facilities for the medical or surgical diagnosis and treatment of injured or sick persons, by or under the supervision of a staff of Physicians duly licensed to practice medicine, and that provides continuous 24 hours-a-day services by licensed, registered, graduate nurses physically present and on duty.

- B. A psychiatric facility for the treatment of behavioral health disorders, drug addiction or alcoholism for compensation from their patients and on an inpatient basis, and which is engaged in providing diagnostic and therapeutic care by or under the supervision of a staff of Physicians duly licensed to practice medicine to persons suffering from mental or nervous conditions or drug or alcohol dependency, and which provides continuous 24 hours-a-day services by licensed, registered, graduate nurses physically present and on duty. Such institutions or facilities for behavioral health disorders, or drug addiction or alcoholism, if located in South Carolina must be licensed by the State of South Carolina and if located outside of South Carolina must be approved by the Joint Commission on Accreditation of Hospitals;
- C. Provided, however, the term "Hospital" does not include any long-term chronic care institutions or institutions that are, other than incidentally, a nursing home or place for (a) rest, (b) the aged, (c) rehabilitative care whether or not such institution or facility is affiliated with or part of a Hospital, except as provided in 7.17 Rehabilitation Care, (d) cognitive/behavioral rehabilitative care and (e) community re-entry programs.

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

2.50 Hospital or Ambulatory Surgical Center Miscellaneous Charges

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

2.51 Hospital Network

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

2.52 Intensive Care Unit

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

- A. It is solely for the treatment of patients who require special medical attention because of their medical condition;
- B. It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital;
- C. It provides a concentration of special life-saving equipment immediately available at all times for the treatment of patients confined within such area;
- D. It contains at least two beds for the accommodation of critically ill patients; and
- E. It provides at least one professional registered nurse who continuously and constantly attends the patient confined in such area on a 24 hours-a-day basis.

2.53 Intermittent

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

2.54 Late Entrant

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

2.55 Market

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

2.56 Market Charge

The amount determined by the Plan Administrator to be the prevailing charge for a

specific DRG category within a specified market.

2.57 Medical Care

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

2.58 Medical Necessity; Medically Necessary or Necessary Service and Supply

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

- A. Is required to identify or treat an existing illness or injury; and
- B. Is prescribed or ordered by a Physician; and
- C. Is consistent with the Covered Person's illness, injury, or condition, and in accordance with proper medical and surgical practices prevailing in the medical specialty or field of medicine at the time rendered; and
- D. Is required for reasons other than the convenience of the patient.

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

2.59 Obstetrical Care

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

2.60 Open Enrollment Period

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

2.61 Orthopedic Appliance

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

2.62 Outpatient

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

2.63 Out-of-Pocket Limitation

For Covered Medical and Behavioral Health Expenses, the total of the eligible coinsurance payable by the Covered Employee in one Plan Year for individual or family

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

2.64 Partial Hospitalization Programs

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

2.65 Part-Time Teacher

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

2.66 Pharmacy Benefits Manager

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

2.67 Physician

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

2.68 Physician Network

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

2.69 Plan

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

2.70 Planholder

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

2.71 Plan Administrator

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

2.72 Plan Year

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

2.73 Predecessor Plan

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

2.74 Pre-Certification or Certification

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

2.75 Pre-existing Condition

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

2.76 Prescription Drug Program

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

2.77 Professional Ambulance

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

2.78 Program

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

2.79 Prosthetic Appliance

Any device that replaces all or part of a missing body organ or body member. Provided,

however, a wig, hairpiece or any other artificial substitute for scalp hair is not a Covered Medical Expense under the Plan.

2.80 Provider

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

2.81 Reasonable and Customary Charge

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

2.82 Retiree

An Employee who is retired under the terms and conditions of the State Retirement Systems and meets one or more of the following eligibility requirements in order to participate in the State's Plan of Benefits. An eligible retiree shall be defined as:

- A. A person covered by the Plan who terminates employment with at least 20 years of earned service credit with a State-Covered Entity before eligibility for retirement under a State retirement system is eligible for the Plan effective with the date of retirement under a State retirement system, if the last five years are consecutive and in a Full-Time, permanent position with a State-Covered Entity. Provided, however, that a person covered by the Plan who terminated employment with at least 18 years earned service credit with a State-Covered Entity before eligibility for retirement under a state retirement system prior to 1990 is eligible for the Plan effective on the date of retirement, if this person returns to a State-Covered Entity and is covered by the Plan and completes at least two consecutive years in a full-time permanent position prior to the date of retirement.
- B. A member of the General Assembly, who leaves office or retires with at least eight years of credited service in the General Assembly Retirement System, is eligible to participate in the Plan by paying the full premium costs as determined by the State Budget and Control Board.
- C. Former municipal and county council members, who have served on council for at least 12 years and have been covered under the State's plans at the time of termination from council, are eligible to continue the state insurance benefits by paying full premium costs, provided the county or municipal council elects to allow this coverage for former members.
- D. An Active Employee covered by the Plan and retiring with 10 or more years of State-Covered Entity service credited under a State retirement system is eligible

for state-paid premiums, if the last five years of service are consecutive and in a Full-Time permanent position with a State-Covered Entity. Special conditions apply to the following:

1. A person covered by the Plan, who has attained the age of 55, has at least 25 years of credited service under a State-Covered Entity and elects early retirement must pay the full premium costs as determined by the State Budget and Control Board until the earlier of attaining age 60 or the date the person would have 30 (28 for persons retiring on or after January 1, 2001) years' creditable service if early retirement had not occurred.
 2. A person covered by the Plan, who has at least 25 years credited service under a State-Covered Entity, and who purchases up to three years of additional service credit under the "Special Monthly Contributor Provision" and retires, shall pay the full premium costs as determined by the State Budget and Control Board for the service credit purchased.
- E. A person covered by the Plan who retires with at least five years of service with a State-Covered Entity credited under a State retirement system is eligible to participate in the Plan by paying the full premium costs as determined by the State Budget and Control Board, provided the last five years are consecutive and in a Full-Time permanent position with a State-Covered Entity.
- F. All Employees of State-Covered Entities whose most recent hire date was before July 1, 1984, who were or would have been eligible for the Plan upon completion of five years of service are exempt from the provisions of this section and are eligible for the Plan, effective on the date of their retirement, provided the last five years are consecutive and in a Full-Time permanent position with a State-Covered Entity.
- G. Those Retirees, who by the terms of their retirement, are covered by the Plan but are not receiving any State contribution to their premium for health insurance.

2.83 Room and Board

Room, board, general duty nursing, and any other services regularly furnished by the Hospital as a condition of occupancy of the class of accommodations occupied, including blood, but not including professional services of Physicians nor intensive nursing care by whatever name called.

2.84 Schedule of Reimbursement Rates

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

2.85 Second Opinion

Shall mean and consist of the Covered Person obtaining a second opinion from a qualified Physician regarding the Medical Necessity of a recommended, elective, non-emergency surgical procedure, medical procedure or treatment or hospitalization for

treatment of mental illness or chemical dependency prior to undergoing or continuing the treatment, hospitalization or procedure.

2.86 Semi-Private Room

A Hospital room containing two or more patient beds.

2.87 Significant Break in Coverage

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

2.88 Skilled Nursing Care

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

2.89 Skilled Nursing Facility

An institution other than a Hospital, which meets all of the following requirements:

- A. Maintains permanent and full-time facilities for bed care of resident patients; and
- B. Has available at all times the services of a Physician; and
- C. Has a registered nurse (R.N.) or Physician on full-time duty in charge of patient care, and one or more registered nurses (R.N.) or licensed practical nurses (L.P.N.) on duty at all times; and
- D. Maintains a daily medical record for each patient; and
- E. Is primarily engaged in providing continuous skilled nursing care for sick or injured persons during the convalescent stage of their illness or injuries and is not, other than incidentally, a rest home or a home for custodial care or for the aged; and
- F. Is operating lawfully as a nursing home in the jurisdiction where it is located; in no event, however, shall such term include an institution primarily engaged in the care and treatment of drug addicts or alcoholism.

2.90 State-Covered Entity

Any State agency, public school district, or any other entity granted by statute the right to participate in the Plan and participating in the Plan.

2.91 Subscriber

An Active or Retired Employee, Surviving Dependent Child/Surviving Spouse or COBRA continuee of a state agency, public school district, participating county or other eligible entity.

2.92 Surgery

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

2.93 Surviving Dependent Child

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

2.94 Surviving Spouse

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

2.95 Third Party Claims Processor

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

2.96 Transplant Network

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

2.97 Utilization Review Agency

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

ARTICLE 3.

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

3.1 Eligibility

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

- A. All Full-Time Employees, as defined in 2.37 and 2.44, and their Dependents, as defined in 2.31, provided however, that a spouse or a child of a Covered Employee who is also a State Employee may be covered only as an Employee and not as a Dependent.
- B. All Full-Time Employees who are on leave without pay status or disabled but not retired status, and their Dependents, as defined in 2.31, for up to one year. The Employer may apply to the Plan Administrator to extend leave without pay status for an Employee beyond one year with demonstration of extraordinary circumstances. The Plan Administrator shall have the sole discretion to determine if leave without pay status may be extended beyond one year;
- C. All Retirees, as defined in 2.82, and their Dependents, as defined in 2.31;
- D. The Surviving Spouse, as defined in 2.94, and Covered Dependent Child, as defined in 2.31, of a deceased active or retired Employee, as defined in 2.22 and 2.93;
- E. All Employees and Dependents eligible for coverage as the result of COBRA in Article 11;
- F. All Part-Time Teachers, as defined in 2.65, and their Dependents, as defined in 2.31, provided however, that a Part-Time Teacher who is the Spouse of a Covered Employee who is a State Employee may be covered as either an Employee or as a Dependent, but not as both.

3.2 Employee Enrollment

To enroll under this Plan, each eligible Employee must complete within 31 days of his eligibility for coverage: (1) a Notice of Election, and (2) any other forms required by the Plan Administrator. If the Employee fails to complete such timely Notice of Election, payroll deduction authorization form, and other required forms within 31 days following

the Employee's eligibility date, and such Employee is not eligible for coverage under 3.7, Special Eligibility Situations, such Employee may be enrolled for coverage only during such Open Enrollment Periods as may be established by the Plan Administrator.

3.3 Commencement of Employee Coverage

Employee coverage under this Plan shall commence as follows:

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

3.4 Eligibility for Dependent Coverage

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

3.5 Dependent Enrollment

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

3.6 Commencement for Dependent Coverage

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

3.7 Special Eligibility Situations

- A. The spouse of an Employee, who was covered as an Employee under another employer's health plan, and any Dependent covered under the spouse's plan including the Employee, who subsequently loses coverage because that employer canceled its present group insurance, the employer canceled its contribution to its group insurance, or the spouse of the employee left such employment, is eligible for coverage under this Plan commencing on the date of loss of coverage, provided that a satisfactory statement of the circumstances surrounding the loss of coverage accompanies the revised Notice of Election.
- B. An Employee, and any Dependent of an Employee, who loses coverage as a Dependent under another employer's health plan as the result of separation or divorce or other similar involuntary loss of coverage, is eligible for coverage under this Plan commencing on the date of loss of coverage provided that a satisfactory statement of the circumstances surrounding the loss of coverage accompanies the Notice of Election.
- C. Coverage under the special eligibility situations in Paragraph A and B above commences upon the date of loss of the earlier coverage, and those eligible under Paragraph A and B are not considered Late Entrants, provided that such persons comply with the requirements of sections 3.2 and 3.5 within 31 days of the loss of coverage.
- D. An Employee, and any Dependent of an Employee, who was called to active duty with the National Guard or a Reserve unit, or who was mobilized and who dropped coverage under this Plan or under an HMO offered by the State as an alternative to this Plan, upon discharge or release from active duty and resumption of employment with an eligible Employer, may re-enroll in this Plan. The time period for exclusions based upon pre-existing condition commences upon the original date of employment, and not the date of re-employment.
- E. Notwithstanding any other provisions, an Employee may enroll for coverage for the Employee and all eligible Dependents provided that (1) the Employee is eligible for coverage under the Plan but is not currently enrolled; (2) the Employee declined coverage under the Plan when it was offered previously; (3) another individual (a spouse or child) has become a Dependent of the Employee through marriage, birth, adoption or placement for adoption; and (4) the request for enrollment is made within 31 days of the events described in (3) above. Coverage for the Employee and any Dependent enrolled under this paragraph shall commence on the day of the qualifying event.

3.8 Termination of Employee's Coverage

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

- A. Termination of the Employee's employment;

- B. The date the Employee ceases to qualify as an Employee;
- C. The date the Employee ceases to be in a class of Employees eligible for coverage;
- D. Sixty days from the date that the Employee's contribution for coverage is due;
- E. The date coverage is discontinued with respect to the class of Employees to which such Employee belongs;
- F. The date this Plan is terminated with respect to all Employees;
- G. Provided, however, that when an Employee requests the termination of coverage during the Open Enrollment period, coverage will terminate at midnight the following December 31st;
- H. Provided, however, that coverage of an Employee ceases on the day following the date of death of the Employee.

3.9 Termination of Dependent's Coverage

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

- A. The date the Employee ceases to be in a class of Employees eligible for Dependent coverage under this Plan;
- B. The date all Dependent coverage under this Plan terminates;
- C. Sixty days from the date that the Employee's contribution for coverage is due;
- D. The date that any particular Dependent ceases to be a Dependent of the Employee as defined in 2.31. The existing coverage of any Surviving Dependent Child will not be affected by the remarriage of the Surviving Spouse;
- E. The 31st day after the date of birth of a newborn, unless the Employee has enrolled the newborn as required by paragraph 3.5, or under such conditions as established by the Planholder;
- F. Provided, however, that when an Employee requests the termination of dependent coverage during the Open Enrollment period, coverage will terminate at midnight the following December 31st;
- G. Provided, however, that coverage of a Dependent ceases on the day following the date of death of the Dependent or the Employee, however after death of the Employee, coverage of the Dependent may continue under Article 10, Continuation of Coverage, or Article 11 COBRA.

3.10 Effect of Divorce or Annulment on Dependent Eligibility

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

3.11 Retiree Enrollment

- A. An Employee, who is covered under this Plan or an HMO approved by the State as an alternative to this Plan, at the time he elects retirement, may elect coverage under this Plan as a Retiree by completing within 31 days of eligibility for coverage: (1) Notice of Election, and (2) any other forms required by the Plan Administrator. If the Employee fails to complete such Notice of Election, retirement check authorization form, and other required forms within 31 days following the Employee's eligibility date, such Employee may be enrolled for coverage only during such Open Enrollment periods as may be established by the Plan Administrator.
- B. An Employee, who is not covered by this Plan or an HMO approved by the State as an alternative to this Plan, at the time he elects retirement, may enroll as a Retiree by completing within 31 days of eligibility for coverage as a Retiree: (1) Notice of Election, and (2) any other forms required by the Plan Administrator. If the Employee fails to complete such Notice of Election, retirement check deduction authorization form, and other required forms within 31 days following the Employee's eligibility date, such Employee may be enrolled for coverage only during such Open Enrollment periods as may be established by the Plan Administrator.
- C. Medicare Supplemental Plan Open Enrollment was held in October 2007 for an effective date of coverage on January 1, 2008. An Open Enrollment period will be held every two years thereafter. During the enrollment period, the eligible Retiree may change from or to the Medicare Supplemental coverage. Coverage changes will become effective the following January 1.

3.12 Enrollment of Dependents of the Retiree

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

- B. A Dependent of an Employee, who is not covered by this Plan or an HMO approved by the State as an alternative to this Plan, at the time the Employee elects retirement, may be enrolled as the Dependent of a Retiree by completing within 31 days of the Employee's eligibility for coverage as a Retiree: (1) Notice of Election, and (2) any other forms required by the Plan Administrator. If the Employee fails to complete such Notice of Election, retirement check deduction authorization form, and other required forms within 31 days following the Employee's eligibility date, the Dependent may be enrolled for coverage only during such Open Enrollment periods as may be established by the Plan Administrator.
- C. A Medicare Supplemental Plan Open Enrollment was held in October 2007 for an effective date of coverage on January 1, 2008. An Open Enrollment period will be held every two years thereafter. During the enrollment period, the eligible Retiree may change from or to the Medicare Supplemental coverage. Coverage changes will become effective the following January 1.

3.13 Open Enrollment

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

1. Dependent Children:

- A. May be added within 31 days of birth, adoption or legal custody;
- B. May be added within 31 days of when they are no longer covered under other group insurance because the employer discontinued such insurance, the employer canceled its contribution to its group insurance, or the parent lost coverage due to employment termination, and provided that proof of loss of coverage is supplied;
- C. May be added within 31 days of when they are acquired by marriage, so long as they are living in a parent-child relationship with the Employee or Retiree;
- D. Must be dropped when dependency ends at age 19, unless approved as an incapacitated dependent, or unless proof of Full-Time Student status is provided for dependents age 19 through 24;
- E. Must be dropped at age 25 and older (regardless of whether a Full-Time Student) unless approved as an incapacitated dependent;
- F. Must be dropped upon marriage of the Dependent, upon full-time employment of the Dependent, or when the Dependent is no longer

principally dependent (more than fifty percent); upon the Employee or Retiree.

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

2. Dependent Spouse:

- A. May be added within 31 days of marriage; or
- B. May be added within 31 days of loss of coverage because such group insurance was discontinued by the employer, the employer canceled its contribution to its group insurance, or employment was terminated, and provided that proof of loss of coverage is supplied;
- C. Must be dropped from Dependent status when they are eligible to enroll as a State Employee or Retiree;
- D. May be dropped within 31 days of when they are divorced or legally separated; or
- E. May be dropped within 31 days of acquisition of other group coverage, provided proof of such coverage is established.

- 3. An Eligible Employee or Retiree may select coverage under the Plan or a Participating HMO within the Program annually.

3.14 Commencement of Coverage for Retiree and Dependents

Retirees and Dependents, who are Covered Persons under this Plan or an HMO approved by the State as an alternative to this Plan, at the time of the retirement of the Employee, and who are re-enrolled as Covered Persons at the time of retirement, remain covered under this Plan. Retirees and Dependents, who are not Covered Persons under this Plan or an HMO approved by the State as an alternative to this Plan, at the time of the retirement of the Employee, and who are enrolled in this Plan at the time of retirement, shall be covered on the first day of the month following the approval of the application for enrollment as a Retiree or Dependent under this Plan. A Dependent who is acquired after retirement, and enrolled within 31 days of the date the Dependent is acquired, shall be covered from the date the Dependent was acquired. A Retiree, not otherwise eligible for coverage as a Retiree, who is approved for disability benefits through the South Carolina Retirement Systems (SCRS), shall have the coverage under the Plan commence no earlier than the first day of the month following SCRS' approval of the disability.

3.15 Termination of Retiree's Coverage

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

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

- B. The date the Retiree ceases to be in a class eligible for coverage;
- C. Sixty days from the date the Retiree fails to make the required contribution for coverage;
- D. The date coverage is discontinued with respect to the class of Retiree to which such Retiree belongs;
- E. The date this Plan is terminated with respect to all Retirees;
- F. Provided, however, that when a retiree requests the termination of coverage during the Open Enrollment period, coverage will terminate at midnight the following December 31st.
- G. Provided, however, that coverage of a Retiree ceases on the day following the date of death of the Retiree.

3.16 Termination of Coverage of Dependent of Retiree

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

- A. The date the Retiree ceases to be in a class of Employees eligible for Dependent coverage under this Plan;
- B. The date all Dependent coverage under this Plan terminates;
- C. Sixty days from the date that the Retiree's contribution for coverage is due;
- D. The date that any particular Dependent ceases to be a Dependent of the Employee as defined in 2.31. The existing coverage of any Surviving Dependent Child will not be affected by the remarriage of the Surviving Spouse;
- E. Provided, however, that when an Retiree requests the termination of dependent coverage during the Open Enrollment period, coverage will terminate at midnight the following December 31st;
- F. Provided, however, that coverage of a Dependent ceases on the day following the date of death of the Dependent or the Retiree. However, after death of the Retiree, coverage of the Dependent may continue under Article 10, Continuation of Coverage, or Article 11, COBRA.

3.17 Effect of Termination of Coverage;

Hospitalization at Time of Termination

All rights to receive benefits provided under this Plan for services rendered to a Covered Person after the termination of coverage will automatically cease, provided, however, that a Covered Person confined to a Hospital or Skilled Nursing Facility on the date of termination of coverage shall be entitled to receive the benefits specified in the Plan for

each day of that admission, subject to all the other terms, conditions, limitations and exclusions of this Plan.

ARTICLE 4.

PAYMENT OR REIMBURSEMENT OF MEDICAL EXPENSES

4.1 Payment for Medical Care

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

4.2 Changes to Plan

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

ARTICLE 5.

CONTRIBUTIONS

5.1 Employee Contribution

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

5.2 Contribution of Entire Premium

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

- A. Full-Time Employees who elect leave-without-pay status;
- B. A Surviving Spouse (excluding a Spouse who is a State Employee) and eligible Dependents of a deceased Active or Retired Employee who elect coverage under Article 10, Continuation of Coverage, provided, however:
 - 1. The full premium for coverage for the Surviving Spouse (who is not a State Employee) and/or Dependent of a deceased Active or Retired Employee, who elected coverage under the Savings Plan, the Standard Plan or the Medicare Supplemental Plan and for which there was a State contribution to the premium is waived for one year after the Active or Retired Employee's death; and
 - 2. Provided, however, that following the one-year waiver, the premium for coverage for the Surviving Spouse and/or Dependent of a deceased Active or Retired Employee who was killed in the line of duty after December 31, 2001, and while working for a State Covered Entity; for whom there was a state contribution to the premium, may contribute the amount determined under 5.1 as long as eligible.
- C. Those electing to extend coverage as provided in Article 11 under COBRA;

- D. Those hired on or after July 1, 1984, and who retired with five years, but less than 10 years, active service;
- E. Those Retirees who, by the terms of their retirement, are covered by the Plan but are not receiving any State contribution to their premium for health insurance.

ARTICLE 6.

DUTIES AND RESPONSIBILITIES

6.1 Planholder Duties

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

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

6.2 Plan Administrator Duties

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

- A. To administer this Plan according to its terms and to be accountable to the State with regard to the administration of this Plan;
- B. To construe and interpret this Plan in a nondiscriminatory manner; to decide all questions of eligibility; and to determine all questions arising in the administration and application of this Plan;
- C. To determine the types of benefits allowable under this Plan;
- D. To be responsible for the reporting and disclosure requirements imposed upon administrators under applicable law;
- E. To receive from the State and from Employee participants and Dependents such information as shall be necessary for the proper administration of this Plan, and to furnish the State, upon request, such reports with respect to the administration of this Plan as are reasonable and appropriate;
- F. To receive, review and keep on file (as it deems convenient or proper) reports of the financial condition, and of the receipts and disbursements;
- G. To maintain all records of this Plan;
- H. To review as necessary, all claims for benefits under this Plan;
- I. To determine the manner and time of payment of benefits under this Plan;
- J. To apprise the State as to the amounts and timing of disbursements for payment of benefits and expenses under this Plan;
- K. To prescribe procedures to be followed by participants and dependents in filing claims for benefits under this Plan;
- L. To furnish the State such reports with respect to the processing and payment of claims under this Plan as are reasonable and appropriate;
- M. To do all other acts or things as may be necessary for the proper administration of this Plan.

6.3 Duties and Powers of Third Party Claims Processor

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

- A. To act under the direction and control of the Plan Administrator;
- B. To receive, review and verify and investigate as necessary, all claims for benefits under this Plan;

- C. To determine the amounts, manner and item of payment of benefits under this Plan;
- D. To apprise the Plan Administrator as to the amounts and dates of disbursements for payment of benefits and expenses under this Plan;
- E. To receive from the State, the Plan Administrator, the Utilization Review Agency and participants and Dependents such information as shall be necessary for the proper processing and payment of claims under this Plan;
- F. To furnish the Plan Administrator, upon request, such reports with respect to the processing and payment of claims under this Plan as are reasonable and appropriate;
- G. To maintain records relating to claims for benefits, processing of claims, and payment or denial of claims for benefits;
- H. To administer contracts between the Plan Administrator and providers as a part of a provider network;
- I. Any other related duties.

6.4 Duties and Powers of Utilization Review Agency

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

- A. To act under the direction and control of the Plan Administrator;
- B. To receive, review and verify and investigate and monitor as necessary, all requests for pre-certification required under the Plan including, but not limited to, non-emergency Hospital admissions, surgical procedures, length of stay limitations, and extended care benefits provided under this Plan; and to conduct and monitor and undertake a concurrent review of hospitalizations and conduct individual case management as necessary and all other utilization review activity required by this Plan;
- C. To apprise the Plan Administrator and Third Party Claims Processor, if applicable, as to the Utilization Review Agency's determination as to Pre-certification, extended care benefits, concurrent review of hospitalization, case management, maternity management, behavioral health case management and other utilization review activities as may affect the amounts and timing of the payment of benefits under this Plan;
- D. To receive from the State, the Plan Administrator, the Third Party Claims Processor and participants and dependents such information as shall be necessary for the proper processing and administration of the utilization review activities under the Plan;

- E. To furnish the State and the Plan Administrator upon request, and Third Party Claims Processor, if applicable, such reports with respect to the utilization review activities under this Plan as are reasonable and appropriate;
- F. To maintain records relating to pre-certification, extended care benefits, concurrent review of hospitalization, case management and other utilization review and case management activities required by the Plan;
- G. To perform DRG validation audits and administer out-of-state policy as related to the Plan's Hospital Network;
- H. To do such other acts as may be necessary, or as requested by the Plan Administrator, or required by the contract between the Plan Administrator and the Utilization Review Agency to properly handle the administration of the utilization review activities under this Plan.

ARTICLE 7.

SCHEDULE OF BENEFITS

7.1 Covered Medical Expenses

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

A. Savings Plan

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

2. **Coinsurance.** After the individual or Family Deductible has been paid 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 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.

ARTICLE 8.

COORDINATION OF BENEFITS

8.1 Definitions for this Article

- A. **Plan.** For purposes of this Article means any program which provides benefits or services for or by reason of medical care or treatment including:
1. Any group insurance and group subscriber contracts;
 2. Any uninsured arrangements of group coverage;
 3. Any group coverage through health maintenance organizations (HMOs) and other prepayment, group practice and individual practice plans;
 4. Any group hospital indemnity plans to the extent that the benefits exceed \$100 per day;
 5. Any medical benefits coverage in group and individual automobile "no fault" and traditional automobile "fault" type contracts;
 6. Any coverage under a governmental plan, or coverage required to be provided by law, but does not include a State Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the Social Security Act, as amended);
 7. But does not include insurance contracts or subscriber contracts, or coverage through HMO or other prepayment, group practice or individual practice plans, to the extent that they provide individual or family coverage; and does not include blanket insurance contracts, franchise insurance contracts or a State Plan under Medicaid, and shall not include a law or plan, when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

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

- B. **Allowable Expense.** As used in this Article only, any Necessary, Reasonable and/or Customary expense for the service of a Physician which is normally billed to private patients and any Necessary, Reasonable and/or Customary expense for items of Hospital Benefits which would normally appear on the Hospital's or Skilled Nursing Facility's regular statement of charges, provided that such item is covered at least in part by one or more Plans covering the person for whom the claim is

made. An allowable expense does not include the difference between the cost of a private room and a semiprivate room unless the patient's stay in a private hospital room is medically necessary in generally accepted medical practice, nor does it include any reduction of benefits under a Primary Plan because the covered person did not comply with the plan provisions such as Pre-certification of services or admission, or provisions for or second surgical opinions or similar plan provisions. Payment under this Plan of Benefits cannot exceed the amount which would ordinarily be payable in the absence of this Article.

- C. **Dependent.** With respect to this Article, any person included in the definition of Dependent in 2.30 herein and, with respect to any other Plan, any person who qualifies as a dependent under such Plan.
- D. **Primary Plan.** A Plan whose benefits must be determined without taking the existence of another Plan into consideration. There may be more than one Primary Plan. The provisions of paragraph 8.2 determine whether a Plan is Primary or Secondary.
- E. **Secondary Plan.** A Plan that is not a Primary Plan. When this Plan is a Secondary Plan its benefits are determined after those of the other Plan's and may be reduced because of the other Plan's benefits. The provisions of paragraph 8.2 determine whether a Plan is Primary or Secondary.

8.2 Order of Determination of Benefits

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

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

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

covered the other parent for a shorter period of time;

3. Provided, however, that if the other Plan does not have the rule described in B(1) above (the birthday rule) but has the gender rule so that the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

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

1. First, the Plan of the parent with custody of the child;
2. Second, the Plan of the spouse of the parent with custody of the child;
3. Third, the Plan of the parent who does not have custody of the child;
4. Provided, however, that if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan;
5. Provided further, that if the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules in paragraph B above.

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

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

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

F. Longer - Shorter Length of Coverage. If none of the above rules A-E above determine the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan

that covered that person for the shorter term.

Note: The Consolidated Omnibus Budget Reconciliation Act of 1987 (COBRA) originally provided that coverage under a new group health plan caused the COBRA coverage to end. An amendment passed as part of H.R. 3299 (1989) allows the COBRA coverage to continue if the other group plan contains any pre-existing condition limitation. In this instance, two policies will cover an individual, and the COBRA coverage will be the secondary payor.

8.3 Effect of Order of Determination of Benefits on this Plan

A. This Plan is Primary. When the order of determination rules of this Plan establish that this Plan is the Primary Plan, the benefits provided by this Plan shall be determined without consideration of the benefits of any other Plan.

B. This Plan is Secondary. When the order of determination of benefits rules of this Plan determines that this Plan is the Secondary Plan, the benefits of this Plan will be reduced when the sum of: (1) the benefits that would be payable for the Allowable Expense under this Plan in the absence of this COB provision; and (2) the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provision with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses. In that case, the benefits of this Plan will be reduced so that they, and the benefits payable under the other Plans, do not total more than those Allowable Expenses. When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

8.4 Right to Receive and Release Information

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

8.5 Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this Article have been made under any other Plan, the Third Party Claims Processor will have the right to pay over to any organization making such other payments any amounts it determines to be warranted in order to satisfy the intent of this Article, and amounts so paid will be deemed to be benefits paid under this Plan, and to the extent of such payments for Covered Medical Benefits, the Plan will be fully discharged from liability. The term "payments" includes providing benefits in the form of services, in which case the term "payment made" means the reasonable cash value of the benefits provided in the form of services.

8.6 Right of Recovery

Whenever payments have been made under this Plan by the Third Party Claims Processor with respect to Allowable Expenses in a total amount in excess of the amount necessary to satisfy the purposes of this Article, the Third Party Claims Processor will be entitled to recover on behalf of the Plan such excess amounts from a Covered Person or any group insurer, Plan, or other person or organization contractually obligated to such Covered Person with respect to such Allowable Expenses. The Employee, for himself, or on behalf of, his Dependents will, upon request, execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to this Plan or any other Plan.

8.7 Medicare

A. This Plan will provide primary coverage for Active Employees, age 65 and over, and their Dependents who have elected to enroll in Medicare and who are also enrolled in this Plan. Medicare is secondary for a Covered Person during the first 30 months in which the Covered Person is eligible for Medicare solely because of permanent kidney failure, and thereafter, Medicare is primary and the Plan is secondary. Federal law prohibits active Employees, who elect Medicare as their primary coverage, from enrolling in the Plan as a supplement.

B. This Plan is primary and Medicare is secondary for an Active Employee or Dependent of an Active Employee under age 65 and eligible for Medicare by reason of disability, other than end stage renal disease.

C. For Retired Employees and their Dependents eligible for Medicare, the benefits paid under this Plan will be determined in the following manner:

1. Benefits available under this Plan less benefits paid or payable under Parts A and B of Medicare.
2. When Medicare is primary and this Plan is secondary, benefits will be coordinated with both Parts A and B of Medicare, whether or not the Covered Person is actually receiving both Parts A and B of Medicare.
3. Retirees who return to Active Employment, again, are eligible for the Plan. Federal law prohibits active Employees who elect Medicare as their primary coverage from enrolling in the Plan as a supplement.

ARTICLE 9

EXCLUSIONS AND LIMITATIONS

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

- A. Any service or charge for service which is not Medically Necessary as defined in paragraph 2.58; any service or charge for service which is performed in a more costly setting than that required by a Covered Person's condition, in which case benefits will be limited to the benefits due had the services been performed in the least costly setting required by the Covered Person's condition;
- B. Any service or charge for service to the extent a Covered Person is entitled to payment or benefits (whether or not any such payment or benefits have been applied for or paid) pursuant to any law (now existing or as may be amended) of the United States, (except Medicaid) or any state or political subdivision thereof. Without limiting the generality of the foregoing, this exclusion applies to benefits provided by, or payable under, Workers' Compensation Laws, the Veterans Administration, or any state or federal hospital for which hospital services the Covered Person is not legally obligated to pay. This exclusion applies if the Covered Person receives any benefits or payments in whole or in part, and it applies to any settlement or other agreement, including any settlement of "doubtful and disputed" claims, or "clincher" agreements, or any other agreement regardless of how characterized, and even if the document or release specifically excludes payment for medical expenses;
- C. Any service or charge for service to the extent a Covered Person is entitled to payment or benefits under state or federal programs of health care, excluding Medicare and amendments thereto, but only to the extent that benefits are provided or reimbursement is paid or payable hereunder;
- D. Illness contracted or injury sustained as a result of declared or undeclared war or any act of war, or while in the military service;
- E. Any charges for services commencing prior to the Covered Person's coverage hereunder or rendered after the termination of coverage, except as provided in Article 10, Continuation of Coverage, or Article 11, COBRA, of this Plan. This exclusion also applies to all hospital charges incurred during a continuous hospital stay when the admission occurred before, and the discharge occurred after, the effective date of coverage, and there is pre-existing coverage for that admission. Physician charges are payable from the date of commencement of coverage;

- F. Services or charges incurred for acupuncture;
- G. Any surgical or medical procedures determined by the medical staff of the Third Party Claims Processor with appropriate consultation, to be experimental or investigational or not accepted medical practice. Experimental or investigational procedures are those medical or surgical procedures, supplies, devices, or drugs, which at the time provided, or sought to be provided:
 - 1. Are not recognized as conforming to accepted medical practice in the relevant medical specialty or field of medicine; or
 - 2. The procedures, drugs or devices have not received final approval to Market from appropriate government bodies; or
 - 3. Are those about which the peer-reviewed medical literature does not permit conclusions concerning their effect on health outcomes; or
 - 4. Are not demonstrated to be as beneficial as established alternatives; or
 - 5. Have not been demonstrated, to a statistically significant level, to improve the net health outcomes; or
 - 6. Are those in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting;
- H. Services, supplies or charges for premarital, pre-employment, or routine physical examinations, when no injury or illness is present, and except as provided in 7.19, well care and immunizations;
- I. Admissions or portions thereof for: (1) sanitarium care or rest cures, (2) physical or occupational therapy, or (3) Custodial Care;
- J. Hospital and Physicians services and prescription drugs related to procedures or goods that have primarily cosmetic effects including but not limited to cosmetic surgery, or the complications resulting there from. Cosmetic goods, procedures or surgery shall mean all goods, procedures, and surgical procedures performed to improve appearance or to correct a deformity without restoring a bodily function. In the instances of the following and other procedures which might be considered "cosmetic"— e.g., rhinoplasty (nose), mentoplasty (chin), rhytidoplasty (face lift), glabellar rhytidoplasty, surgical planing (dermabrasion), blepharoplasty (eyelid), mammoplasty (suspension or augmentation), superficial chemosurgery (acid peel of the face) and rhytidectomy (abdomen, legs, hips, or buttocks including lipectomy or adipectomy)—benefits may only be provided when the malappearance or deformity was caused by physical trauma, surgery, or congenital anomaly (as opposed to familial characteristics or aging phenomenon) occurring after the Covered Person's Effective Date of coverage under this Plan; provided, however, that surgery to correct a cleft 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.

ARTICLE 10.

CONTINUATION OF COVERAGE

10.1 Incapacitated Dependent Child

The coverage of a Dependent Child under this Plan will not be terminated upon the attainment of the limiting age specified in the Plan while the Child is, and continues to be both (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap, and (b) principally dependent (more than 50%) upon the Subscriber for support and maintenance, so long as continued proof of such incapacity and dependency is furnished to the Plan Administrator by the Employee within 31 days of such Child's attainment of the limiting age of 19, and at such other reasonable times, but not more than annually, and provided further, that coverage remains in force for the Employee.

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

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

10.3 Surviving Spouse and/or Dependent Children

The Covered Surviving Spouse and/or Covered Dependent Children of a deceased Active or Retired Employee, including any Child born after the death of the Employee but before the remarriage of the Surviving Spouse, shall be eligible to continue the coverage; provided they pay the entire premium without any contribution by the Employer or State, provided however:

- A. The premium due from a Covered Surviving Spouse (who is not a State Employee) and/or Covered Dependent Children of a deceased Active or Retired Employee (whose surviving parent is not an Active or Retired Employee) and for which there was a State contribution to the Employee/Retiree premium shall be waived for one year from the date of the Employee's or Retiree's death.

After one year, the Surviving Spouse and Dependent Children shall be eligible to continue the coverage, provided that they pay the entire premium for such coverage without any contribution by the Employer or State; provided, however the Surviving Spouse and/or Dependent may pay the premium at the employer-funded

rate as long as eligible if the deceased Active or Retired Employee was killed in the line of duty after December 31, 2001, and while working for State Covered Entity;

- B. The coverage of a Surviving Spouse provided under this section shall terminate upon remarriage but, in no event shall any Surviving Spouse or Dependent who feloniously and intentionally kills the Active or Retired Employee be entitled to any premium waiver;
- C. The existing coverage of any Dependent Children will not be effected by the remarriage of the Surviving Spouse, but such coverage is subject to all the terms, conditions, limitations and exclusions of the Plan, including the requirement that coverage ceases on the date that a Covered Dependent no longer meets the definition of a Dependent.

ARTICLE 11.

COBRA

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

COBRA requires that a Covered Person who would otherwise lose coverage as a result of a "qualifying event" as defined in that act, is entitled to elect to temporarily extend health coverage under this Plan. The coverage will be identical to the coverage provided to the Covered Employee before the qualifying event and identical to the coverage provided similarly situated Employees to whom a qualifying event has not occurred.

11.2 Qualifying Event

A qualifying event is any one of the following:

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

eligible Dependent Child.

11.3 Notice by Employee, Spouse or Dependent

In cases of divorce or legal separation of the Employee from his spouse or a Dependent ceasing to qualify as an eligible Dependent under the Plan, the Employee or eligible Dependent is responsible for notifying the benefits office of the Employer or the Plan Administrator within 60 days after the later of (a) the date of the qualifying event, or (b) the date the Dependent would lose coverage on account of the qualifying event. If the Plan Administrator is not notified within 60 days of the happening of either event, the Dependent will not be given the opportunity to continue coverage. Provided further, that an Employee or Dependent who is determined to be disabled under Title II or XVI of the Social Security Act, either before the qualifying event or during the first 60 days of COBRA coverage, must provide notice of the determination of disability before the end of the first 18 months of coverage to be eligible for up to 29 months of continuation coverage, and must also notify the Plan Administrator within 30 days of any determination that the Employee or Dependent is no longer disabled.

11.4 Notice By Plan Administrator

The Plan Administrator or employing entity shall, as required by statute, notify the Covered Employee when commencing coverage of the right to continue health and dental coverage, and within 14 days of the termination or reduction of hours or other qualifying event for which the Plan Administrator must notify the Employee. Notice to the Spouse is deemed notice to any Covered Dependent of the Employee.

11.5 Election of Coverage

Continued coverage is not automatic. Coverage must be elected within 60 days of the later of the following:

1. The date coverage ceases because of the "qualifying event,"
2. The date the Employee or eligible Dependent is sent notice of the right to elect continuation coverage.

11.6 Premium Required

Except as provided below, the Employee or eligible Dependent will be required to pay a premium calculated as provided by law for the continued coverage and have the option to make these payments in monthly installments. The eligible Employee or Dependent will have 45 days from the date of election to pay the first premium, which shall include the period when coverage commenced, regardless of the date that the first premium is due. Subsequent premiums are subject to a grace period of 30 days.

11.7 Length of Coverage

The maximum period for continued coverage for a "qualified event" involving termination of employment or a reduction in hours is 18 months. Provided, however, that an Employee or Covered Dependent, who is determined to be disabled under Title II or XVI of the Social Security Act, either before the qualifying event or during the first 60 days of COBRA coverage, is entitled to 29 months of continuation coverage, but only if the

Employee or Covered Dependent has provided notice of the determination of disability before the end of 18 months of coverage. If a second qualifying event occurs within this 18- (or 29-) month period, the coverage for any affected Dependent who was a Covered Person under the Plan at the time of the first qualifying event, and, at the time of the second qualifying event, may be extended up to 36 months from the first qualifying event. For all other qualifying events, the maximum period of coverage is 36 months.

Coverage under this section may end sooner than the periods listed in the preceding paragraph, and will occur on the date of the earliest of any of the following:

- A. The date the State ceases to provide any group health plan to any Employee;
- B. The date, including any grace period provided herein, the Employee or eligible Dependent fails to make any required payment;
- C. The first date after the date of election in which the Employee or eligible Dependent is covered under any other group health plan which does not contain any exclusion or limitation with respect to any preexisting condition of the Employee or eligible Dependent. Provided, however, that an Employee who, on the date of the qualifying event, is covered by a plan (including Medicare), other than this Plan, remains eligible for COBRA coverage under this Plan;
- D. the date the Employee or eligible Dependent already enrolled for COBRA coverage becomes entitled to Medicare.

11.8 Order of Determination of Benefits

If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of determination:

- 1. First, the benefits of a plan covering the person as an employee, member or subscriber (or as the person's Dependent); and
- 2. Second, the benefits under the continuation coverage.

ARTICLE 12.

CLAIMS PROCEDURE

12.1 Claim for Payment of Benefits.

- A. A Covered Person will present an identification card when applying for services covered under this Plan;
- B. Written notice of care on which a claim is based must be furnished to the Third Party Claims Processor within 90 days of the beginning of care, or as soon thereafter as is reasonably possible. Upon receipt of the notice, the Third Party Claims Processor will furnish or cause to be furnished to the Covered Person a claim form. If the claim form is not furnished within 15 days after the receipt of the notice by the Third Party Claims Processor the Covered Person will be deemed to have complied with the requirements of this Plan as to proof of loss, if he submits written proof covering the character and extent of the loss within the Plan time fixed for filing proof of loss;
- C. A Covered Person must complete or cause to be completed a claim, on forms prescribed by the Plan Administrator or Third Party Claims Processor, and will file it or cause it to be filed, along with all documentation, including medical records, required by the Plan Administrator or Third Party Claims Processor;
- D. The claim must be received by the Third Party Claims Processor within 90 days after the beginning of care; however, failure to file the claim within the 90-day period will not prevent payment of benefits if the Covered Person shows that it was not reasonably possible to timely file the claim, provided the claim is filed as soon as is reasonably possible, in no event, except in the absence of legal capacity, later than 12 months following the end of the Benefit Year in which the goods or services were provided;
- E. The claim will be deemed written proof of loss and written authorization from the Covered Person to the Third Party Claims Processor to obtain any medical or financial records and documents useful to the Third Party Claims Processor, however, the Third Party Claims Processor is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied to it at the time the claim was processed. Any party who submits medical or financial reports and documents to the Third Party Claims Processor in support of a Covered Person's claim will be deemed to be acting as the agent of the Covered Person.

12.2 Payment of Claims

The Third Party Claims Processor will pay benefits as described in Article 7, Schedule of Benefits, of this Plan directly to Providers who are members in the Provider, Ambulatory Surgical Center or Hospital networks (hereinafter referred to as "participating providers") and any other Providers with whom the Plan Administrator has agreed to make direct payments, automatically, and without any assignment of benefits by the subscriber, when the participating or contracting provider files a health insurance claim form with the Third Party Claims Processor signed by a Covered Person, completed in full, using procedure codes designated by the Third Party Claims Processor for all services rendered.

The right to assign any benefits due and payable hereunder is expressly prohibited except as provided herein. In particular, and without limiting the generality of the foregoing, the Covered Person may not assign any benefits, and the Plan Administrator shall not recognize any assignment of benefits, to: (1) a non-participating provider who was offered and declined membership in the networks; or, (2) a non-participating Provider who did not meet the standards and qualifications for membership in the networks, or (3) a supplier of medical goods, supplies or drugs, unless specifically authorized by the Plan Administrator. Provided, however, the Covered Person may assign benefits to non-participating Providers rendering covered medical services under the Plan who are not within the scope of the networks, or who were not offered and did not decline membership in the networks or as specifically authorized by the Plan Administrator. Failure by the Plan Administrator or the Third Party Claims Processor to reject an assignment of benefits prohibited by this section shall not be construed as a waiver of its rights to enforce this section in the event of subsequent assignments.

A Provider who may accept assignment of benefits shall file a health insurance claim form with the Third Party Claims Processor signed by a Covered Person, completed in full, using procedure codes designated by the Third Party Claims Processor for all services rendered, the Third Party Claims Processor will pay the benefits to the provider. Except as provided above, the Third Party Claims Processor on behalf of the Plan will pay all benefits directly to the Covered Person upon receipt of due proof of loss.

12.3 Allocation and Apportionment of Benefits

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

12.4 Information and Records

As permitted under the Health Insurance Portability and Accountability Act of 1996, the Third Party Claims Processor, as agent of the Plan Administrator, is entitled to obtain such authorization for medical and hospital records as it may reasonably require from any provider of services incident to the administration of the benefits hereunder and the attending Physician's certification as to the Medical Necessity for care or treatment.

12.5 Review of Claims Denied in Whole or Part

If the Third Party Claims Processor, or the Utilization Review Agency or their designee determines that any person who has submitted a claim for the payment or pre-certification of benefits under the Plan is not entitled to receive all or part of the benefits sought, the Third Party Claims Processor, Utilization Review Agency or their designee, shall inform the claimant of such determination and the reasons therefore, with specific reference to pertinent provisions of the Plan. The exclusive remedy for the denial of benefits shall be as provided by statute and by the procedures of the Budget and Control Board.

- A. Reconsideration by Third Party Claims Processor or Utilization Review Agency.** A Covered Person, after receipt of notification of the Third Party Claims Processor's or the Utilization Review Agency's action on his claim, must request a review of any benefits denied in whole or in part within six months of notice of the denial of benefits by the Third Party Claims Processor or the Utilization Review Agency. To request a review of that agency's decision, the Covered Person must write the appropriate agency giving reasons why the claim should be approved. The claimant may also request an expedited reconsideration of the decision denying benefits.

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

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

The director, or his designees, may request from the Third Party Claims Processor information reviewed by it, including the pertinent medical records, and may request any additional information from the Third Party Claims Processor, the Utilization Review Agency or the claimant, or from independent medical personnel or other source as in their judgment may be required to make a determination. The

director or his designees shall consider all information submitted, the terms and conditions of the Plan and shall render a decision within 30 days of the receipt of any requested material, providing reasons for the decision and citation of any applicable Plan provisions.

The director, or his designee, shall provide specific reasons for the decision and citation of the pertinent Plan provisions, and may, if the director or his designee agrees with the Third Party Claims Processor or Utilization Review Agency, deny the claim of the Covered Person, and if he agrees with the Covered Person, approve the claim or such portion as is appropriate, provided, however, the director, or his designee, must state in writing the provisions of the Plan justifying the result. The decision of the director, or his designee, on these matters is binding and conclusive, subject to review pursuant to 12.6.

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

12.6 Legal Actions

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

12.7 Identification Cards and Booklets

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

12.8 Right to Examine Covered Person

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

12.9 Access to Information

The Plan Administrator will be provided access to all claims data and supporting documents of any person covered under the Plan for purpose of auditing the claims

adjudication procedures. According to the guidelines set forth under the Health Insurance Portability and Accountability Act of 1996, the Plan Administrator agrees to restrict access to all such data and documents to those of the Plan Administrator's employees directly responsible for conduct of the audit, and to assure that the data and documents are handled on a strictly confidential basis.

12.10 Privacy of Protected Health Information

(a) The Plan Administrator and any business associate servicing the Plan will disclose Plan participants' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions for the Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-64). Plan Sponsor shall mean, for the sole purpose of compliance with the mandates of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the South Carolina Budget and Control Board, which established, and maintains, the Group Health Benefits Plan for the Employees of the State of South Carolina, the Public School Districts and Participating Entities.

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

ARTICLE 13.

NOTICE

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

ARTICLE 14.

SUBROGATION RIGHTS

In the event benefits are provided to, or on behalf of, a Covered Person under the terms

of this Plan, the Covered Person agrees as a condition of receiving benefits under the Plan to transfer to the Plan all rights to recover damages in full for such benefits when the injury or illness occurs through the act or omission of another person, firm, corporation, or organization. If, however, a Covered Person receives payment for such medical expenses from another person, firm, corporation, organization or business entity paid by, or on behalf, of the person or entity who allegedly caused the injury or illness, the Covered Person agrees to reimburse the Plan in full for any medical expenses paid by the Plan. The Plan's right of full recovery may be from the third party, any liability or other insurance covering the third party, the insured's own uninsured motorist insurance, underinsured motorist insurance, any medical payments, no fault or malpractice insurance coverages which are paid or payable. The Plan may enforce its reimbursement rights by requiring the Covered Person to cooperate and to assert a claim to any of the foregoing coverages to which the Covered Person may be entitled. The Plan will not pay fees or costs associated with a claim or lawsuit without its express written authorization. The Covered Person shall cooperate with the Planholder and Third Party Claims Processor, if appropriate, on behalf of the Planholder and execute all instruments and do all things necessary to protect and secure the Planholder's right of subrogation. In the event benefits are provided to, or on behalf of, a Covered Person under the terms of this Plan, the Planholder shall be subrogated, at its expense and unless specifically prohibited by law, to the rights of recovery of such Covered Person against any person, firm, corporation, or organization, including such Covered Person's right to uninsured motorists benefits as defined by the South Carolina Motor Vehicle Financial Responsibility Act, as amended, provided, however, that the Planholder shall not be subrogated to such Covered Person's rights to Personal Injury Protection (PIP) benefits as defined by the South Carolina Automobile Reparation Reform Act of 1974, as amended. The Covered Person shall cooperate with the Planholder and Third Party Claims Processor if appropriate, on behalf of the Planholder and execute all instruments and do all things necessary to protect and secure the Planholder's right of subrogation.

ARTICLE 15.

UTILIZATION REVIEW AND MANDATORY CASE MANAGEMENT

SECTION 1

15.1.1 Application

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

benefits for behavioral disorders under the Plan is subject to, and contingent upon, the Covered Person's compliance with the provisions of Section 2 of this Article and the utilization guidelines established by the Behavioral Health Manager.

15.1.2 Pre-Certification of Medical Care

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

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

- J. Any purchase or rental of Durable Medical Equipment;
- K. High-cost outpatient non-surgical procedures, to be determined at the discretion of the Utilization Review Agency.

15.1.3 Limited Exception to Pre-Certification

Pre-admission certification is not required:

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

15.1.4 Notification of Emergency Admission or Surgical Procedure

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

15.1.5 Concurrent Review of Hospitalization and Individual Case Management

The Hospital stay of any Covered Person shall be monitored by the Utilization Review Agency, which reviews the services and evaluates whether they are appropriate for the diagnosis, and insures that alternative methods of care are considered. Also, the Utilization Review Agency monitors all hospitalizations to identify the most appropriate and cost-effective setting for continued medical care.

15.1.6 Alternative Treatment Plan

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

The Utilization Review Agency after consulting with the treating Physician, and others as appropriate, may recommend an Alternative Treatment Plan in a less intensive care setting. If accepted by the treating Physician, Covered Person and Plan Administrator,

the Utilization Review Agency will assist, as necessary, in implementing the Alternate Treatment Plan. Subject to limitations and exclusions and eligibility requirements, Physician benefits will be paid in accordance with the schedule of benefits, and the medical costs paid by the Covered Person shall be counted towards satisfaction of the out-of-pocket totals under 7.1.A.4 and 7.1.B.4. In addition, services and supplies that are Medically Necessary because of the Alternative Treatment Plan and which would otherwise not be covered under the Plan will be considered as Covered Medical Expenses.

15.1.7 Certification by Utilization Review Agency

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

15.1.8 Failure to Comply with Utilization Review Requirements

- A. **Failure to Obtain Pre-Admission Review.** A patient or Covered Person who does not obtain preadmission review and Pre-certification as required by this Article, in addition to the normal deductible and all other terms and conditions of the selected Plan, shall be subject to the following:
1. A \$200 penalty for each admission to a Hospital or Skilled Nursing Facility;
 2. The costs incurred during the hospitalization, treatment or extended benefit program shall not be included in those that satisfy the Out-of-

Pocket Limitations of 7.1.A.4 and 7.1.B.4;

3. The costs incurred during the hospitalization, treatment, or extended benefit program shall always be subject to the Coinsurance requirement of the selected plan.

B. Stays in Excess of Length of Stay Limitation. The length of stay limitation is established by the Utilization Review Agency after consultation with the treating Physician, and in light of the information on the Covered Person or patient's condition provided by the Physician, and communicated to the Covered Person, patient, family member, Physician and Hospital. Confinements beyond of the length of stay designated by the Utilization Review Agency may be determined to be without Medical Necessity, and reimbursement denied for Room and Board. Other Medically Necessary charges may be covered.

C. Second Opinions may be required by the Utilization Review Agency as a condition to Pre-certification, ongoing certification, or in conjunction with case management or when providing an alternative treatment option. If the opinions are divided, a third opinion may be required, which shall be controlling. The plan will pay the benefits for the second opinions required by the Utilization Review Agency as provided in 7.15. Second opinions obtained without Certification by the Utilization Review Agency shall be subject to all other terms and conditions of the Plan, including the requirement that they be Medically Necessary, and in addition, if they are Medically Necessary:

1. The costs of a second opinion shall not be included in those costs that satisfy the Out-of-Pocket Limitations of 7.1.4.A and 7.1.4.B; and
2. The cost of a second opinion shall always be subject to the Coinsurance requirement of the selected Plan.

D. Other Services or Supplies Obtained without Certification from the Utilization Review Agency required by this Plan shall be subject to all the terms, conditions, limitations and exclusions of the Plan, as well as the following:

1. The costs incurred shall not be included in those that satisfy the out-of-pocket limitations of 7.1.A.4 and 7.1.B.4; and
2. The costs incurred shall always be subject to the coinsurance requirement of the selected plan.

E. The Utilization Review Agency may require medical social worker services as a condition of pre-certification of Covered Services. The Plan will pay for the services of a medical social worker as provided in paragraph 7.13.B, at 100 percent of the Reasonable and Customary or Allowable Charge, or the Actual Charge, whichever is less for the purpose of evaluating the patient's needs and identifying other resources, both family and community for which the patient is eligible but are not covered by insurance.

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

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

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

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

15.1.10 Comprehensive Maternity Management

A Covered Person, upon becoming aware of pregnancy, shall notify the Utilization Review Agency. A maternity coordinator providing education and counseling for the mother shall monitor each case. The Covered Person shall be subject to the penalties described in 15.18.A for failure to notify the Utilization Review Agency during the first trimester of the pregnancy or refusal to participate in the comprehensive maternity management program. This penalty shall be in addition to that in force for failure to notify the Utilization Review Agency of the hospital admission as described in 15.1.2 and 15.1.4.

SECTION 2

15.2.1 Application

The payment of benefits under the Plan for treatment of Behavioral Health Disorders or

Alcoholism or Drug Abuse is subject to, and contingent upon, the Covered Person's compliance with the following procedures and in accordance with the utilization review procedures established by the Behavioral Health Manager.

15.2.2 Pre-Certification for Covered Behavioral Health Services

The Covered Person, an authorized family member, or Behavioral Health Provider treating the Covered Person shall contact the Behavioral Health Manager at least 24 hours before the Covered Person's receipt of professional, outpatient, or inpatient services for treatment of a Behavioral Health Disorder or Alcoholism or Drug Abuse in the United States or Canada.

15.2.3 Limited Exception to Pre-Certification

Pre-certification is not required:

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

15.2.4 Notification of Psychiatric Emergency

The Behavioral Health Provider, Covered Person, or family member shall notify the Behavioral Health Manager within 24 hours of any emergency admission or any emergency treatment of a Covered Person for a Behavioral Health Disorder or Alcoholism or Drug Abuse. The determination of whether a particular set of facts constitutes an emergency shall be made by the Behavioral Health Manager in conformity with applicable criteria.

15.2.5 Review of Hospitalization and Individual Case Management

The Behavioral Health Manager shall review and determine whether the services provided or to be provided a Covered Person for a Behavioral Health Disorder or Alcoholism or Drug Abuse are Medically Necessary, including but not limited to whether outpatient care, hospitalization, length-of-stay, or diagnostic ancillary services are necessary and appropriate for a Covered Person's condition. Also, the Behavioral Health Manager monitors all hospitalizations to identify the most appropriate and cost-effective setting for continued care.

15.2.6 Alternative Treatment Plan

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

than the one in which the Covered Person is presently receiving medical care. An Alternative Treatment Plan requires the approval of the treating Physician or Behavioral Health Provider, the Plan Administrator and the Covered Person.

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

15.2.7 Certification by Behavioral Health Manager

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

15.2.8 Failure to Comply with Utilization Review Requirements

- A. Failure to Obtain Pre-Certification.** A Covered Person who does not obtain Pre-certification as required by this Section, or a Covered Person who requests

services after being informed by the Behavioral Health Provider prior to the rendition of such services that the Behavioral Health Manager has denied Pre-certification of such services, shall be responsible for all the costs incurred during the hospitalization or treatment.

- B. Stays in Excess of Length of Stay Limitation.** The length of stay limitation is established by the Behavioral Health Manager after consultation with the treating Behavioral Health Provider, and in light of the information on the Covered Person or patient's condition provided by the Behavioral Health Provider, and communicated to the Covered Person and Behavioral Health Provider. Confinements beyond of the length of stay designated by the Behavioral Health Manager may be determined to be without Medical Necessity, and reimbursement for charges incurred denied.
- C. Second Opinions.** Second Opinions may be required by the Behavioral Health Manager as a condition of Pre-certification, ongoing certification, or in conjunction with case management. If the opinions are divided, a third opinion may be required, which shall be controlling. The plan will pay the benefits for the second opinions required by the Behavioral Health Manager as provided in 7.15, subject to all other terms and conditions of the Plan, provided however, that second opinions obtained without Pre-certification by the Behavioral Health Manager are not a Covered Benefit under the Plan.

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

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

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

The Behavioral Health Manager, after consulting with the treating Behavioral Health Provider and reviewing the matter under its internal procedures, may disagree with some medical services recommended or provided by the treating Behavioral Health Provider.

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

ARTICLE 16.

MEDICARE SUPPLEMENTAL PLAN

16.1 Medicare Supplemental Plan

Medicare is the primary coverage for Retirees eligible for Medicare. To supplement Medicare, the State Health Plan of Benefits also offers a Medicare Supplemental Plan.

A. Enrollment.

Retirees eligible for Medicare, who are enrolled, or eligible to enroll, in the Plan as a Retiree, may enroll in the Medicare Supplemental Plan. The terms, conditions and procedures applicable to enrollment in the Plan as a Retiree under 3.11, are applicable to Retiree enrollment in the Medicare Supplemental Plan. Provided, however, a Retiree enrolled in the Medicare Supplemental Plan may not subsequently enroll in the Standard Plan as secondary coverage to Medicare.

B. Benefits.

1. **Hospital Admissions.** The Medicare Supplemental Plan will pay the following benefits for covered services received in the United States after Medicare Part A benefits have been paid:
 - a) The Medicare Part A hospital Deductible;
 - b) The Coinsurance (after Medicare payment) for the 61st through 150th day of hospitalization, up to the Medicare-approved charge;
 - c) 100 percent of Medicare-approved charges and reimbursed at the rate approved and paid by Medicare after the 150th day, if medically necessary; and,
 - d) The Coinsurance for Durable Medical Equipment up to the Medicare-approved charge.
2. **Skilled Nursing Facility.** The Medicare Supplemental Plan will pay the following benefits after Medicare has paid benefits:

- a) The Coinsurance (after Medicare payment) for the 21st through the 100th day of confinement in a Skilled Nursing Facility, up to the Medicare approved charge; and,
 - b) 100 percent of the Medicare-approved charges and reimbursed at the rate approved and paid by Medicare for confinement after the 100th day in a Skilled Nursing Facility, if medically necessary, and if approved by the Utilization Review Agency. The maximum annual benefit per covered person is \$6,000.
- 3. **Physician Charges.** The Medicare Supplemental Plan will pay the following benefits:
 - a) The Medicare Part B deductible;
 - b) The Medicare Coinsurance (currently 20 percent or 50 percent for behavioral health disorders) of the Medicare-approved charge for physician's services for surgery, necessary home and office visits, in- hospital visits, and other physician's services not otherwise excluded by Medicare or this Plan;
 - c) 20 percent of Medicare approved charges for physician's services rendered in the outpatient department of a hospital for treatment of accidental injury, medical emergencies, minor surgery and diagnostic services.
- 4. **Home Health Care.** The Medicare Supplemental Plan will pay the following benefits for medically necessary Home Health Care services:
 - a) The Medicare Part B Deductible;
 - b) The Coinsurance for any services or costs Medicare does not cover;
 - c) 20 percent of Medicare approved charges for Durable Medical Equipment;
 - d) Provided, however, the maximum benefit per Covered Person per Benefit Year is 100 visits or \$5,000, whichever occurs first; and further provided that the Medicare Supplemental Plan does not include benefits for services rendered by a person who ordinarily resides in the home, is a member of the family or a member of the family of the spouse of the Covered Person, and further provided that Home Health Care benefits do not include private duty nursing services except as provided in 16.1.B.5, Private Duty Nursing Services, and subject to all the terms and conditions of that section.
- 5. **Private Duty Nursing Services.** These services are the private services of a registered nurse (RN) or a licensed practical nurse (L.P.N.), which have been certified in writing by a physician as medically necessary. The Medicare Supplemental Plan will pay, subject to an annual \$200 Deductible, as follows:

- a) 80 percent of Allowable Charges for private duty nursing in a Hospital where no special units are provided; and
 - b) 80 percent of Allowable Charges for private duty nursing in the Retiree's home;
 - c) Provided, however, that coverage is limited to no more than three nurses per day, and the maximum annual benefit per Covered Person per Benefit Year is \$5,000, up to a maximum lifetime benefit of \$25,000;
6. **Prescription Drugs.** Prescription drugs are payable under the terms of Paragraph 7.21 of the Plan.

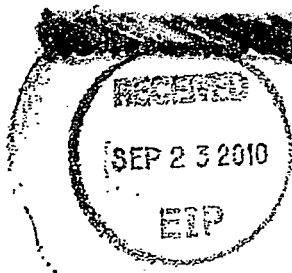
End of Plan

Exhibit B



RICHARDSON, PATRICK,
WESTBROOK & BRICKMAN, LLC

September 22, 2010



James C. Bradley
Michael J. Brickman
Elizabeth Middleton Burke
J. David Butler
Aaron R. Dias
Jerry Hudson Evans
Nina H. Fields
Thomas P. Grassette, Jr.
H. Blair Hahn
Lapriel S. Hallwanger
Shaw D. Hamrick
David Hendricks
Gregory A. Lofstead
Christiaan A. Marcum
Katie McElveen
Christopher J. Moore
Daniel O. Myers
Karl E. Novak
Kimberly Keesers Palmer
Charles W. Patrick, Jr.
Terry E. Richardson, Jr.
Thomas D. Rogers
A. Hoyt Rowell, III
Brady R. Thomas
T. Christopher Tuck
James L. Ward, Jr.
Edward J. Westbrook
Kenneth J. Wilson
Robert S. Wood

Of Counsel:
Gordon C. Rhea (CA, DC & USA only)
James H. Rion, Jr.
Howard Siegel (DC & MD only)
David L. Suggs (MN & NY only)
Robert M. Turkewitz

South Carolina Administrative Law Court
Edgar A. Brown Building
1205 Pendleton Street, Suite 224
Columbia, SC 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 vs. South Carolina Budget and Control Board Employee
Insurance Program and Blue Cross and Blue Shield of South Carolina.
Civil Action No.: 09-CP-10-7404*

Dear Sir/Madam:

Enclosed for filing with the court, please find SOUTH CAROLINA ADMINISTRATIVE
LAW COURT (SC ALC) REQUEST FOR CONTESTED CASE HEARING FORM.

Thank you for your time.

Sincerely,

Julie Murray
Paralegal to Matthew D. Hamrick, Esq.

Enclosure

cc: Stephen R. Van Camp
Theodore D. Willard, Jr., Esq.
Kelly H. Rainsford, Esq.
John A. Massalon, Esq.
Christy F. Allen, Esq.

**South Carolina Administrative Law Court (SC ALC)
Request for Contested Case Hearing FORM**

Last Name: <u>ALLEN</u>		First: <u>JEFFREY</u>	Middle: <u>D.</u>	☒ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Docket No. (To Be Completed by ALC)
Mailing Address: <u>[REDACTED]</u>			City: <u>CHARLESTON</u>		State and Zip: <u>SC 29414</u>	
Home Number: <u>(843) 709-0369</u>		Work Number:		Cell Number:		*E-Mail Address:
*By providing your e-mail address, you consent to receive court orders and notices via electronic transmission						
REPRESENTATION						
Are you representing yourself? ☐ Yes ☒ No			If No, please complete the following:			
Are you represented by an Attorney? ☒ Yes ☐ No			Are you represented by a CPA? ☐ Yes ☒ No			
Name of Attorney: <u>JOHN MASSALONE & MATTHEW HAMRICK</u>			Name of CPA:			
Mailing Address: <u>P.O. BOX 859</u>			Mailing Address:			
City, State and Zip: <u>CHARLESTON, SC 29402</u>			City, State and Zip:			
Work Number, Cell Number and E-mail Address: <u>(843) 727-1144</u>			Work Number, Cell Number and E-mail Address: <u>(843) 727-6568</u>			
<u>JMASSALONE@WALAWFIRM.COM</u>			<u>MHAMRICK@RMB.COM</u>			
CASE INFORMATION						
Name of the Agency that issued the decision: (Example - Dept. of Revenue, Dept. of Insurance, DHEC) <u>SC BUDGET AND CONTROL BOARD EMPLOYEE INSURANCE PROGRA</u>						
In order to have your case processed, you must attach the agency decision. Is it attached?: ☒ Yes ☐ No			If no, please explain:			
Date the decision was issued: <u>AUG. 24, 2010</u>			Date the decision was received: <u>AUG. 24, 2010</u>			
Please provide a brief statement regarding why the hearing is being requested and the relief sought: <u>THE AGENCY HAS DENIED CLAIMANT'S CLAIM FOR DIABETES EDUCATION/OUTPATIENT SELF-MANAGEMENT TRAINING AFTER THE CLAIM WAS DENIED BY BLUE-CROSS BLUESHIELD OF SC. THIS DENIAL OF THE CLAIM IS IN VIOLATION OF SC CODE § 38-71-46(A). THE RELIEF SOUGHT IS PAYMENT OF CLAIMANT'S CLAIM.</u>						
Payment via ☒ Check ☐ Money Order ☐ Cash for \$ 100 (applicable filing fee pursuant to ALC Rule 71) is being submitted today to the Administrative Law Court via ☒ U.S. Postal Service ☐ Hand-delivery						
<u>MATTHEW HAMRICK, ATTORNEY FOR CLAIMANT</u>			<u>9/22/10</u>			
☒ Your Signature or Signature of Attorney/CPA			Date			

CERTIFICATE OF SERVICE (MUST BE COMPLETED)			
Your Name: <u>MATTHEW D. HAMRICK</u>		Date: <u>9/22/10</u>	City: <u>CHARLESTON</u> State: <u>SC</u>
I hereby certify that on the date and place listed above, I served a copy of the foregoing Request for Contested Case Hearing on all other parties to this matter by depositing the same in the United States Mail, postage paid, and addressed as follows (use the reverse side for any additional names):			
<u>STEPHEN R. VANCAMP</u>		<u>SC BUDGET AND CONTROL BOARD</u>	
<u>EMPLOYEE INSURANCE PROGRAM</u>		<u>1201 MAIN ST., SUITE 300</u>	
Name and/or Agency		City, State and Zip	
<u>THEODORE WILLARD, ESQ. 1102 CALHOUN ST.</u>		<u>COLUMBIA, SC 29211</u>	
Name and/or Agency		City, State and Zip	
<u>*SEE REVERSE SIDE FOR ADDITIONAL NAMES</u>			
<u>MATTHEW HAMRICK, ATTORNEY FOR CLAIMANT</u>		<u>9/22/10</u>	
☒ Your Signature or Signature of Attorney/CPA		Date	

*ALSO SERVED UPON:

KELLY RAINSFORD, ESQ.

EMPLOYEE INSURANCE PROGRAM
1201 MAIN ST., SUITE 300
COLUMBIA, SC 29201-3230

MARK SANFORD, CHAIRMAN
GOVERNOR

CONVERSE A. CHELLIS, III, CPA
STATE TREASURER

RICHARD ECKSTROM, CPA
COMPTROLLER GENERAL



SC BUDGET AND CONTROL BOARD

EMPLOYEE INSURANCE PROGRAM

(803) 734-0678
FAX: (803) 737-0557

HUGH K. LEATHERMAN, SR.
CHAIRMAN, SENATE FINANCE
COMMITTEE

DANIEL T. COOPER
CHAIRMAN, HOUSE WAYS AND MEANS
COMMITTEE

FRANK W. FUSCO
EXECUTIVE DIRECTOR

August 24, 2010

John A. Massalon, Esquire
Wills Massalon & Allen, LLC
PO Box 859
Charleston, South Carolina 29402

RE: State of South Carolina Group Health Benefits Plan
Subscriber: Jeffrey D. Allen
Patient: [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

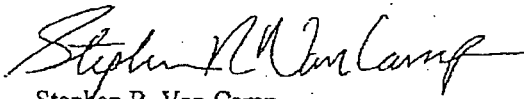
An appeal is commenced by filing a notice of appeal with the ALC within 30 days of receipt of this letter. If you need any further information regarding your client's appeal, please contact the ALC at (803)734-0550.

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 HIPA [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 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.

Exhibit C

MARK SANFORD, CHAIRMAN
GOVERNOR
CONVERSE A. CHELLIS, III, CPA
STATE TREASURER
RICHARD ECKSTROM, CPA
COMPTROLLER GENERAL



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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