

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM RICHLAND COUNTY
Court of Common Pleas

Roger L. Couch, Circuit Court Judge

Appellate Case No. 2020-001266

RECEIVED

Oct 02 2020

SC Court of Appeals

Lisa Beattie as Personal Representative for the Estate of Branch Beattie, Individually
and as the Representative of a Class of Similarly Situated Persons, Respondents,

v.

Blue Cross Blue Shield of South Carolina, and Companion Benefit Alternatives,
Inc., Appellants.

PETITION FOR REHEARING *EN BANC*

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STATEMENT OF ISSUES

1. DID THE COURT'S ORDER DISMISSING APPELLANTS' APPEAL OVERLOOK OR MISAPPREHEND THAT THE TRIAL COURT'S DENIAL OF APPELLANTS' MOTION TO DISMISS/STRIKE DEPRIVED THE DEFENDANTS OF A MODE OF TRIAL?
2. DOES APPELLANTS' PETITION FOR REHEARING PRESENT A QUESTION OF EXCEPTIONAL IMPORTANCE, AND/OR REQUIRE A DECISION BY THE FULL COURT TO SECURE OR MAINTAIN UNIFORMITY OF THE COURT'S DECISIONS SO AS TO REQUIRE A REHEARING *EN BANC*?

FACTS

Respondent's complaint alleged causes of action for bad faith failure to pay insurance benefits and for breach of contract against Appellants based on the denial of Respondent's request for Pre-Certification of certain levels of substance abuse treatment for her son, a covered dependent under The Medical University of South Carolina and The Medical University Hospital Authority ("MUSC Health Plan"). (Exhibit 1). Respondent further alleged that the MUSC Health Plan was a self-funded health plan administered by the South Carolina Public Employee Benefits Authority ("PEBA") and was part of the State of South Carolina Health Plan. Respondent further alleged that PEBA was the Plan Administrator of the MUSC Health Plan, Appellant Blue Cross Blue Shield of South Carolina ("BCBSSC") was the Third-Party Claims Processor for the MUSC Health Plan, and that Appellant Companion Benefit Alternatives ("CBA") was the Behavioral Health Manager and a Utilization Review Agency for the MUSC Health Plan.

Appellants moved to dismiss/strike Respondent's complaint arguing that because the MUSC Health Plan's Pre-Certification process determined whether a service provided or to be provided is eligible for reimbursement under the terms and conditions and limitations of the Plan, the denial or approval of Pre-Certification of services was a claim for benefits under the

MUSC Plan. Accordingly, Appellants argued in their Motion To Dismiss/Strike that Respondents were not entitled to a jury trial for breach of contract and bad faith failure to pay insurance benefits, because Respondent's causes of action were preempted by the exclusive statutory non-jury administrative remedies and procedures in S.C. Code Ann. § 1-11-710 (c) (Supp 2012), with any appeal going directly to the S.C. Administrative Law Court pursuant to S.C. Code Ann. § 1-23-600 (D) (Supp 2012). (Exhibit 2).

S.C. Code Ann. § 1-11-710 (c) states:

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

Id. Pursuant to and S.C. Code Ann. § 1-23-600 (D), any appeal of a decision on a claim for benefits under the MUSC Plan would go to the S.C. Administrative Law Court.

Therefore, Appellants' appeal presents a mode of trial issue of whether the parties are bound by the exclusive non-jury administrative remedies set for in S.C. Code Ann. § 1-11-710 (c)¹ with any appeal going to the S.C. Administrative Law Court pursuant to S.C. Code Ann. § 1-23-600 (D), or whether Respondent is entitled to a jury trial in circuit court for breach of contract and bad faith failure to pay insurance benefits.

ARGUMENT

1. THE COURT'S ORDER OVERLOOKED OR MISAPPREHENDED THAT THE TRIAL COURT'S DENIAL OF APPELLANTS' MOTION TO DISMISS/STRIKE DEPRIVED THE DEFENDANTS OF AN EXCLUSIVE STATUTORY MODE OF TRIAL.

¹ Cases under § 1-11-710 (c) and § 1-23-600 (D) are tried on an administrative record only without discovery.

Because the trial court's denial of Appellant's Motion to Dismiss/Strike presented a mode of trial issue, it was immediately appealable. Whether the parties are bound by the exclusive non-jury administrative remedies set for in S.C. Code Ann. § 1-11-710 (c) with any appeal going to the S.C. Administrative Law Court pursuant to S.C. Code Ann. § 1-23-600 (D), or whether Respondent is entitled to a jury trial in circuit court for breach of contract and bad faith failure to pay insurance benefits is a mode of trial issue.

While the Court of Appeal's September 23, 2020 order dismissing the appeal correctly noted that the general rule is that orders denying motions to dismiss and/or strike *usually* are not immediately appealable, the Court overlooked or misapprehended that the general rule does not apply when the denial involves a mode of trial issue. *See McFaddin v. Lohr*, 260 S.C. 242, 195 S.E.2d 385 (1973) (which was cited in the Court's order dismissing Appellant's appeal, recognizing that exceptions existed to the general rule that a denial of a motion to strike is not immediately appealable, where the S.C. Supreme Court found, "[w]hile we have recognized certain exceptions to the general rule, a careful examination of the counterclaim here interposed and the motion to strike fails to disclose any matter which would bring the instant appeal within any of the recognized exceptions."). Unlike the situation in *McFaddin*, the denial of Appellants' Motion to Dismiss/Strike falls within the mode of trial exception.

The S.C. Supreme Court has held on numerous occasions that pursuant to § 14-3-330(2), when a trial court's order deprives a party of a mode of trial to which it is entitled as a matter of right, such order is immediately appealable. *Lester v. Dawson*, 327 S.C. 263, 491 S.E.2d 240 (1997); *C&S Real Estate Services, Inc., v. Massengale*, 290 S.C. 299, 350 S.E.2d 191 (1986); *Creed v. Stokes*, 285 S.C. 542, 331 S.E.2d 351 (1985); *First Union National Bank of South*

Carolina v. Soden, 333 S.C. 554, 511 S.E.2d 372 (Ct. App. 1998); *Preferred Sav. Bank, Inc. v. Elkholy*, 303 S.C. 95, 399 S.E.2d 19 (Ct. App. 1990). These cases not only permitted, but indeed required, immediate appeal in the event of denial of a mode of trial to which a party was entitled as a matter of right. Failure to immediately appeal such an order forever bars appellate review. See, e.g., *Creed v. Stokes*, *supra*; *Flagstar Corp. v. Royal Surplus Lines*, 341 S.C. 68, 533 S.E.2d 331 (2000). Issues regarding mode of trial must be raised in the trial court at the first opportunity, and the order of the trial judge is immediately appealable. *Pelfrey v. Bank of Greer*, 270 S.C. 691, 244 S.E.2d 315 (1978). “The mode of trial, whether by the court, by a referee or master, or by a jury, is a matter material to obtaining a judgment, it follows that where a party is denied the mode of trial to which he is entitled by law, and required by an order to submit to some other mode of trial, such order is appealable.” *Ferguson v. Harrison*, 34 S.C. 169, 13 S.E. 332 (1891).

Appellant’s Motion to Dismiss/Strike was an attempt by Appellants to raise the mode of trial issue at the first opportunity as required by *Pelfrey*. By denying Appellant’s Motion to Dismiss/Strike, the trial court found that the parties were not bound by the exclusive non-jury administrative remedies set for in S.C. Code Ann. § 1-11-710 (c) and § 1-23-600 (D), and found that Respondent was entitled to a jury trial in circuit court, including full discovery, for breach of contract and bad faith failure to pay insurance benefits. To require the parties to fully litigate a lengthy and expensive jury trial, to include discovery, before making a final determination as to whether a jury trial was even available makes little sense. Because, Appellants’ appeal fully fell within the mode of trial exception under § 14-3-330(2), it should not have been dismissed.

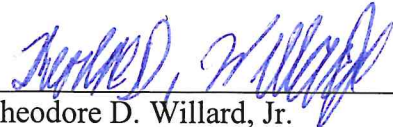
2. APPELLANTS’ PETITION FOR REHEARING PRESENTS A QUESTION OF EXCEPTIONAL IMPORTANCE, AND/OR REQUIRES A DECISION BY THE FULL

COURT TO SECURE OR MAINTAIN UNIFORMITY OF THE COURT'S
DECISIONS SO AS TO REQUIRE A REHEARING *EN BANC*.

The issue of whether or not a plan participant can circumvent the exclusive non-jury administrative remedies set for in S.C. Code Ann. § 1-11-710 (c) and § 1-23-600 (D), by requesting a jury trial in circuit court for breach of contract and bad faith failure to pay insurance benefits is a question of exceptional importance. Allowing every claimant to bring an expensive and prolonged jury trial in circuit court when the claimant disagrees with a claim determination, rather than follow the well-established, exclusive statutory remedies could adversely impact the plan, the plan's participants and the plan's administrators. This impact could include increases in the costs of coverage, increases in the costs of administrative services and possible limitations on what benefits and/or types coverages may be offer in the future. Additionally, the uptick in jury trials for claim determinations may cause a backlog in the Courts. Because this matter involves a question of exceptional importance, and/or requires a decision by the full Court to secure or maintain uniformity of the Court's decisions, Appellants respectfully request pursuant to SCAR 219 that Appellant's Petition for Rehearing be heard *en banc*.

CONCLUSION

For the forgoing reasons, Appellants' Petition For Rehearing should be granted and Appellants' appeal should be allowed.



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October 2, 2020

EXHIBIT 1

IN THE STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS
COUNTY OF RICHLAND) FOR THE 5TH JUDICIAL CIRCUIT
CASE NO: 2019-CP-40-_____

LISA BEATTIE AS PERSONAL
REPRESENTATIVE FOR THE ESTATE
OF BRANCH BEATTIE,
INDIVIDUALLY AND AS THE
REPRESENTATIVE OF A CLASS OF
SIMILARLY SITUATED PERSONS,
Plaintiff,

v.

BLUE CROSS BLUE SHIELD OF
SOUTH CAROLINA, and COMPANION
BENEFIT ALTERNATIVES, INC.
Defendants.

SUMMONS
(Jury Trial Demanded)

TO: DEFENDANTS ABOVE-NAMED

YOU ARE HEREBY SUMMONED and required to answer the Complaint in this action, a copy of which is herewith served upon you, and to serve a copy of your Answer to said Complaint upon the Plaintiff or his attorney, Roy T. Willey, Eric M. Poulin, Alexis W. McCumber, and Kenneth T. David at their office located at, 32 Ann St. Charleston, South Carolina, 29403, within thirty days after the service hereof, exclusive of the day of such service. If you fail to answer the Complaint within the time aforesaid, you may be found in default and Plaintiff will apply to the court for the relief demanded in the Complaint.

Dated at Charleston, South Carolina on January 16, 2019.

[signature block on following page]

ANASTOPOULO LAW FIRM, LLC

s/ Kenneth T. David

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Charleston, South Carolina
January 16, 2019.

IN THE STATE OF SOUTH CAROLINA)
COUNTY OF RICHLAND)

IN THE COURT OF COMMON PLEAS
FOR THE 5TH JUDICIAL CIRCUIT
CASE NO: 2019-CP-40-_____

LISA BEATTIE AS PERSONAL
REPRESENTATIVE FOR THE ESTATE
OF BRANCH BEATTIE,
INDIVIDUALLY AND AS THE
REPRESENTATIVE OF A CLASS OF
SIMILARLY SITUATED PERSONS,
Plaintiff,

**COMPLAINT
(Jury Trial Demanded)**

v.

BLUE CROSS BLUE SHIELD OF
SOUTH CAROLINA, and COMPANION
BENEFIT ALTERNATIVES, INC.
Defendants.

TO: DEFENDANTS ABOVE-NAMED

Plaintiff, Lisa Beattie, individually and as the representative of a class of similarly situated persons, files this Complaint against Defendants Blue Cross Blue Shield of South Carolina and Companion Benefit Alternatives and allege:

PARTIES

1. That Plaintiff, Lisa Beattie as Personal Representative of the Estate of Branch Beattie, (herein collectively referred to as "Plaintiff"), is a citizen and resident of Dorchester County, South Carolina.

2. The Estate of Branch Beattie is an estate lawfully probated in accordance with the laws of South Carolina in Dorchester County, South Carolina.

3. The Plaintiff is informed and believes that the Defendant, Blue Cross Blue Shield of South Carolina (BCBSSC), is a corporation organized and existing by virtue of the laws of South Carolina, operating and doing business as an insurance company, with its principal place of business in Richland County, South Carolina.

4. The Plaintiff is informed and believes that the Defendant, Companion Benefit Alternatives (CBA), is a corporation organized and existing by virtue of the laws of South Carolina, operating and doing business as a behavioral health insurance administrator and manager on behalf of BCBSSC, with its principal place of business in Richland County, South Carolina.

PROPOSED PLAINTIFF CLASS

5. That the proposed Plaintiff Class consists of the following: all persons who were covered under a policy of health insurance wherein they were entitled to mental health services, behavioral health services or substance abuse services, or similar health related services and were experiencing withdrawal symptoms and other related symptoms as a result of opioid and/or alcohol abuse and who suffered as a result of the acts and/or omissions similar to those herein below.

6. That the Plaintiff meets the prerequisites to bring this action on behalf of the Class because:

- a. Numerosity: That the proposed Plaintiff Class is believed to be in the hundreds, possibly thousands, and therefore is so numerous that joinder of all members is impracticable.
- b. Commonality: That there are questions of law and/or fact common to the named Plaintiff and to the proposed Plaintiff Class, including, but not limited to:
 - i. By engaging in a pattern and practice of wrongfully disputing and withholding benefits as “not medically necessary” in direct contravention to the meaning and intent of the Plan language defining the term;
 - ii. By engaging in a pattern and practice of persistently disputing level of care

- determinations made by qualified and experienced treating physicians and providers without regard to the meaning and intent of the health insurance plan language defining medical necessity;
- iii. By engaging in a pattern and practice of persistently disputing level of care determinations made by qualified and experienced treating physicians and providers at a patently excessive and unreasonable frequency so as to create an environment of uncertainty counterproductive to treatment and recovery;
 - iv. By engaging in a pattern and practice of persistently disputing level of care determinations made by qualified and experienced treating physicians and providers at a patently excessive and unreasonable frequency so as to disrupt provision of care, transition of care, and discharge planning;
 - v. By engaging in a pattern and practice of persistently overruling level of care determinations made by qualified and experienced treating physicians and providers – determinations with life or death consequences – without seeking or reviewing full clinical information;
 - vi. By engaging in a pattern and practice of persistently overruling level of care determinations made by qualified and experienced treating physicians and providers – determinations with life or death consequences – through case reviews by unqualified personnel, including social workers acting outside their scope of practice;
 - vii. By engaging in a pattern and practice of persistently overruling level of care determinations made by qualified and experienced treating physicians and providers – determinations with life or death consequences – through case

- reviews by medical doctors who did not fall within the definition of Physician, as that term is defined in health insurance plans, who lacked sufficient skill, training and experience in the specialized field of substance use disorders;
- viii. By engaging in a pattern and practice of persistently overruling level of care determinations made by qualified and experienced treating physicians and providers – determinations with life or death consequences – without seeking full independent medical examination;
 - ix. By engaging in a pattern and practice of denial of claims at virtually every level, requiring sequential appeals by policyholders and providers, through processes neither identified, described nor authorized by health insurance plans or like plans;
 - x. By engaging in a pattern and practice of denials based on purported lack of medical necessity that was pretextual;
 - xi. By engaging in a pattern and practice of interfering, impeding, manipulating, and micro-managing patient care, and particularly the care claimant's providers were attempting to provide in order to bring about recovery and to keep claimants safe;
 - xii. By failing to consider and, in fact, ignoring clinical information supporting claimant's claims for treatment as medically necessary;
 - xiii. By failing to conduct adequate investigations regarding clinical information supporting claimant's claims for treatment as medically necessary;
 - xiv. By failing to conduct adequate investigations regarding overwhelming credible scientific evidence supporting claimant's claims for treatment as

medically necessary;

- xv. By engaging in purported medical reviews of level of care and treatment decisions – determinations with life or death consequences – which were so markedly deficient in terms of time, substance, and detail as to patently violate reasonable standards of practice in the psychiatric community;
- xvi. By engaging in a pattern and practice of employing self-created, cookie-cutter criteria at odds with the language of health insurance and like plans at odds with generally accepted standards of medical practice based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, such as American Psychiatric Association Guidelines for Treatment of Patients with Substance Use Disorders, and the view of physicians practicing in this clinical area;
- xvii. By engaging in a pattern and practice of denying medically necessary treatment by employing self-created, cookie-cutter criteria, without consideration to the specific and unique factors with which claimants presented, including his history of long-term substance use, history of relapse, anxiety, post-traumatic stress disorder and major depressive disorder;
- xviii. In mandating step-down from a residential treatment environment directly to outpatient treatment in direct contravention of generally accepted standards of medical practice based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, such as American

Psychiatric Association Guidelines for Treatment of Patients with Substance Use Disorders, and the view of physicians practicing in this clinical area;

- xix. In wrongfully characterizing as non-acute and stable, claimants who were admittedly suffering from depressions, anxiety, and thoughts of hopelessness and worthlessness;
 - xx. In failing and refusing to consider the critical importance of family support and home environment and ultimately denying outpatient treatment in this patient whose family ties were strained;
 - xxi. In substituting their judgment for the clinical judgment of Physicians, as that term is defined in health insurance plans, and especially qualified and experienced treating physicians;
 - xxii. In engaging in a plan and practice of vetoing proper and legitimate treatment plans adamantly supported by qualified and experienced treating physicians most familiar with the complex clinical picture of claimants as necessary for their health, safety, and well-being;
 - xxiii. In failing to provide parity of treatment and claimant's severe substance use disorder;
 - xxiv. In exhibiting an utter indifference to the healthcare needs and safety of claimants;
- c. Typicality: That the claims of the named Plaintiff are typical of the claims of the proposed Class members, and defenses of named Defendants to Plaintiff's claims are typical of the defenses available to each member of the Class:
- i. Defendant's acts and/or omissions resulting in bad faith

- ii. Defendant's acts and /or omissions resulting in breach of contract
- iii. Defendant's acts and/or omissions resulting in wrongful death.

- d. Adequacy: That the representative named Plaintiff will fairly and adequately protect the interests of the proposed Plaintiff Class. Plaintiff has no interests that are antagonistic to or in conflict with the interest of the Class as a whole, and he has engaged competent counsel to ensure the protection of the interest of the Class as a whole.
- e. Amount in Controversy: That to the extent that the relief sought in this action is not injunctive or declaratory with respect to the Class as a whole, the amount in controversy exceeds one hundred dollars for each member of the Class.

7. That a Class is superior to all other available methods for the fair and efficient adjudication of the issues in dispute, since the interests of the members of the proposed Plaintiff Class in individually controlling the prosecution of the separate actions is low, and would create a risk of adjudications with respect to individual members of the Class, which would be dispositive of the interests of the other members not parties to the adjudications or substantially impair or impede their ability to protect their interests.

8. That a class is superior to all other available methods for the fair and efficient adjudication of these actions since prosecution of separate actions by individual members of the proposed Plaintiff Class could result in inconsistent rulings, requiring incompatible standards of conducts on the part of Defendants and substantially impairing the interests and prejudicing the proposed Plaintiff Class.

9. That a Class is superior because it ensures judicial efficiency, an efficient use of judicial resources, and lack of duplication.

10. That pursuant to South Carolina Rules of Civil Procedure, Rule 23(d)(1), Plaintiffs request this Court, as soon as practicable, issue an Order allowing this action to be maintained on behalf of all members of the proposed Plaintiff Class as described above.

11. That pursuant to South Carolina Rules of Civil Procedure, Rule 23(d)(2), Plaintiff requests this Court to direct that notice be given to the members of the proposed Class in the best manner practical under the circumstances, including to all members of the proposed Class who can be identified by any part through reasonable efforts:

- a. And that the Court will exclude the members from the Class is the member so requests by a specified date;
- b. And that the judgement, favorable or not, will bind and include all members of the Class who did not specifically request exclusion.

JURISDICTION AND VENUE

12. That this Court has jurisdiction over the parties and the subject matter of this action.

13. That venue is proper because the most substantial part of the alleged acts or omissions giving rise to this cause of action occurred in Richland County, South Carolina (where many case reviews and all claims denials originated).

FACTS

14. At all times, Plaintiff, Lisa Beattie, was an employee of the Medical University of South Carolina (MUSC).

15. As an employee of MUSC, Plaintiff was entitled to participate on behalf of herself, her spouse, and her dependent son, Branch Beattie (B.B.), in the MUSC Health Plan (MUSC Plan) administered and managed by Defendants BCBSSC and Companion Benefit

Alternatives, Inc.

16. At all relative times, Plaintiff participated on behalf of herself and her son, B.B., in the MUSC Plan offered through her continued employment at MUSC.

17. Plaintiff is informed and believes that at all times relevant, Plaintiff was a Covered Employee and her dependent son, B.B., was a Covered Dependent, constituting them as “Covered Persons” under the MUSC Plan (“the Plan”).

18. The MUSC Plan at issue was not and is not subject to the provisions of the Employee Retirement Income Security Act of 1971 (ERISA) and amendments thereunder.

19. At all times relevant, the Plan, is created by and arises out of the South Carolina State Agency, Public Employee Benefit Authority (PEBA)

20. At all times relevant, PEBA believes that the MUSC Plan is a “Grandfathered” health benefits plan and is therefore not required to meet the guidelines of the Affordable Care Act (ACA), other than certain consumer protections not relevant to the issue in question.

21. At all times relevant, the Plan is a South Carolina State health insurance plan sponsored by MUSC.

22. At all times relevant, the Plan provided that it would pay Covered Expenses “if [Covered Persons] need either inpatient and outpatient Mental Health Services, Behavioral Health Services or Substance Abuse Services”

23. At all times relevant, the Plan provided that it would pay Covered Expenses for Mental Health Services, Behavioral Health Services or Substance Abuse Services inside the “MUSC Health Plan Network”, “a Network Provider”, or also, and including, an “Out-of-network Provider.”

24. At all times relevant, Covered Expenses are described in the Plan as Covered

Medical Benefits.

25. At all times relevant, Covered Medical Benefits are described by the Plan as: “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.”

26. At all times relevant, the Plan defines Medical Necessity, Medically Necessary, or Necessary Service and Supply as:

- a. Is required to identify or treat an existing condition, illness, or injury; and
- b. Is prescribed or ordered by a Physician;
- c. Is consistent for treatment of the Covered Person’s illness, injury, or condition, and is rendered in accordance with recognized, appropriate medical and surgical practices prevailing in the medical specialty or field of medicine at the time rendered; and
- d. Is required for reasons other than the convenience of the patient.

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

27. At all times relevant, the Plan defines a Physician as: A licensed medical doctor, dentist, oral surgeon, podiatrist, osteopath, chiropractor, or psychiatrist acting within the scope of their license, excluding an intern, resident, or house physician.

28. At all times relevant, the Plan governing claims for benefits by B.B. did not, in any provision, reserve for the Employer, plan Sponsor, or Defendant CBA, any discretionary authority to make plan determinations of Medical Necessity, Medically Necessary, or Necessary Service or Supply to the Mental Health Services, Behavior Health Services or Substance Abuse Services ordered by B.B.'s treating Physicians and Providers for the treatment of B.B.'s health conditions.

29. At all relevant times, the plan describes the coverage for Behavioral Health disorders as:

Behavioral Health Disorders [from 7.8]: Subject to all the terms, conditions, limitations, and exclusions 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, Alcoholism, and Drug Abuse. All care must be in accordance with the utilization guidelines established by the Behavioral Health Manager for specified levels of care, and, where applicable, pre-certified by the Behavioral Health Manager. Notwithstanding anything in this Plan to the contrary, in accordance with the Mental Health Parity Act of 1996 (Act), as amended, and any regulations issued thereunder, the Plan will provide parity in the application of aggregate lifetime and annual dollar limits for mental health and substance use disorder benefits as compared with other dollar limits for medical benefits. The Plan will not place financial requirements or treatment limitations on mental health and substance use disorder benefits that are more restrictive than the most common financial requirements and treatment limitations placed on other medical benefits, as such requirements and limitations placed on other medical benefits are set forth in the Schedule of Benefits. To the extent the Plan provides out-of-network coverage for other medical benefits, it will also provide out-of-network coverage for mental health and substance use disorder benefits. This paragraph shall not apply to any Plan Year in which the Plan meets the cost exemption under Section 712(c)(2) of the Act and the Plan Administrator, in its sole discretion, chooses to apply such exemption. The criteria for a medical necessity determination made under this Plan with respect to mental health or substance use disorder benefits shall be made available by the Plan Administrator to any current or potential

Covered Person, beneficiary, or contracting Provider upon request.

30. At all times relevant, the Plan describes the conditions under which benefits at issue are determined to be covered as: “Treatment of Behavioral Health Disorders, Alcoholism, and Drug Abuse in the outpatient department of a Hospital or outside of a Hospital, limited to the benefits specified in paragraph 7.8, and, where applicable, subject to Pre-Certification by the Behavioral Health Manager; inpatient treatment in a Hospital of Behavioral Health Disorders, Alcoholism, and Drug Abuse, up to the benefits specified in paragraph 7.8 in a Hospital, and, where applicable, subject to Pre-Certification by the Behavioral Health Manager.”

31. At all times relevant, the Plan describes the Behavioral Health Manager as: “The entity retained by the Plan Administrator to manage Behavioral Health cases and process Behavioral Health claims under this Plan.”

32. At all times relevant, the Plan describes the application of benefits for treatment of Behavioral Health Disorders, Alcoholism, or Drug Abuse are 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.

33. At all times relevant, the Plan defined the review process for “certification” as: “The Behavioral Health Manager shall review and determine whether the services provided or to be provided to a Covered Person for a Behavioral Health Disorder, Alcoholism, or Drug Abuse are Medically Necessary, including but not limited to whether hospitalization, length-of-stay, or diagnostic ancillary services are necessary and appropriate for a Covered Person’s condition. The Behavioral Health manager also ensures that alternative methods of care are considered and it monitors all hospitalizations to identify the most appropriate and cost-effective setting for continued care.”

34. At all times relevant, the plan describes “certification” of the Behavioral Health Manager as:

- 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. The Certification is sent to the Third Party Administrator.
- 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.

35. At all times relevant, the Plan describes the “Behavioral Health Manager’s Recommendation and the Payment of Benefits” as:

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 is 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.

36. Pursuant to the definition in the Plan, at all times relevant, the primary definition of Medically Necessary or determination of Medical Necessity was to be made by a Physician, as defined in the MUSC Plan as required to identify or treat an existing condition, illness, or injury; and as prescribed or ordered by a Physician; and is consistent for treatment of the Covered Person's illness, injury, or condition, and is rendered in accordance with recognized, appropriate medical and surgical practices prevailing in the medical specialty or field of medicine at the time rendered; and is required for reasons other than the convenience of the patient

37. At all relevant times, the Defendants asserted and affirmed that they cannot and do not engage in the practice of medicine.

38. At all relevant times, the Defendants do not claim that the Behavioral Health Manager is a Physician as defined by the Plan.

39. At all relevant times, the Defendants do not claim that the Behavioral Health Manager engages in the practice of medicine.

40. At all relevant times, the Plan implicitly incorporated duties of good faith and fair dealing with respect to all terms and conditions of the Plan and with respect to all Covered Persons.

41. On May 18, 2017, B.B. was evaluated and admitted by Above It All Drug and Alcohol Treatment Center for Substance Abuse (Above It All) in Lake Arrowhead, California. At the time, B.B. was 23 years-old, 5'9" and weighed 118 pounds and was diagnosed by his treating physician with alcohol use disorder and sedative-hypnotic use disorder.

42. Substance abuse disorders are complex, multi-dimensional illnesses that are life-threatening.

43. B.B. explained his reason for admission to Above It All stating, "I'm seeking treatment to not die. If I keep using I'm pretty sure I'll die or be in jail. I'm tired of being a burden on my family and waking up hating myself."

44. Above It All concluded that B.B.'s substance abuse disorders required medication assisted detox known as subacute detoxification, along with medical and psychiatric evaluations as preparatory for transition into residential treatment.

45. Upon admission to Above It All, B.B.'s treating physician gathered information concerning B.B.'s substance abuse conditions, including but not limited to:

- a. B.B., since age 19, was drinking 8-20 beers or 1-2 bottles of wine per day;
- b. B.B. had not been sober for more than a week throughout his 4 years of substance

abuse;

- c. B.B. had been using Xanax daily for the 8 months prior to his admission at Above It All on May 18, 2017;
- d. B.B. had suffered a withdrawal seizure previously;
- e. B.B. had previously been part of two separate Intensive Outpatient Programs that were unsuccessful;
- f. B.B. was brought to Above It All by the Plaintiff after experiencing a blackout which required hospitalization.
- g. B.B.'s family history indicated a long line of addiction, his maternal aunt suffered from alcoholism, maternal grandfather suffered from alcoholism and opiate addiction, and his paternal grandfather suffered from alcoholism and committed suicide.

46. Plaintiff immediately began the process of securing benefits approval from Defendant's for B.B.'s medical treatment.

47. Defendant CBA on May 19, 2017 approved B.B. for treatment at Above It All for 5 days from May 18, 2017 through May 22, 2017. This approval acknowledged the services as medically necessary for benefit purposes.

48. Above It All provided the Request Form for residential treatment (RTC) benefits on May 23, 2017 at 12:08 pm, which form was filled out properly and in its entirety.

49. Defendant CBA questioned the medical necessity of the treatment and referred the benefit request to LaRon Phillips, MD. The referral was made at 4:23 pm on May 23, 2017.

50. The Plaintiff is informed and believes that the CBA referral to Dr. Phillips did not contain all pertinent information possessed by CBA regarding B.B.'s claim for residential, RTC

care or, in the alternative, Dr. Phillips chose not to review or consider all pertinent information.

51. At 5:08 pm, forty-four (44) minutes later, Dr. Phillips denied the claim based on “no history of withdrawal seizures or DT’s,” and “based on the clinical information provided, the member did not meet CBA Medical Necessity Criteria for admission to the Substance Use Disorder Residential Treatment – Rehabilitation level of care.”

52. The Plaintiff is informed and believes that the “criteria” referenced by Dr. Phillips are “utilization management criteria,” created by CBA for “management” of Substance Use Disorders at various levels of care. The Plaintiff is further informed and believes that Defendant CBA imposed such criteria without regard to the terms, conditions, and language of the MUSC health plan, South Carolina law, federal law, the age of patients, patients’ full co-morbidities in terms of other acute mental health diagnoses and issues, or requirement of parity.

53. An expedited appeal was submitted on May 25, 2017. In reviewing the appeal Defendant CBA acknowledged that B.B. was experiencing postacute withdrawal symptoms including diaphoresis, nausea, depressed mood, sleep disturbance, worthlessness, and hopelessness.

54. Defendant CBA also acknowledged B.B. had previous treatment that resulted in relapse.

55. Michael Cesta, MD, reviewed the appeal and concluded the appeal should be denied as failing to meet CBA’s medical necessity criterion for residential care treatment. Dr. Cesta determined that the medical necessity criteria was not met and that B.B., and individual with a history of unsuccessful rehabilitation and continued substance abuse, could live in a sober and sheltered environment, and therefore could have been treated in a less restrictive setting. Dr. Cesta states that criteria # 2, 4, and 5 were not met of the admission criteria because there were,

“no reports of failed attempts in partial and or intensive outpatient program in immediate preceding period.”

56. What neither Dr. Phillips nor Dr. Cesta were asked to determine and did not determine was whether a Physician, as defined in the Plan, exercising prudent clinical judgment, **would not** prescribe continued residential treatment (RTC) for B.B. to prevent, evaluate, diagnose or treat his illness, diseases and symptoms; or whether (2) continued residential treatment (RTC) **would be contrary** to generally accepted standards of medical practices; or whether (3) continued residential treatment (RTC) **would not be clinically appropriate** in terms of type, frequency, site and duration, and **would not be considered effective** for the treatment of B.B.’s illness and diseases; or whether (4) continued residential treatment (RTC) would be primarily for the convenience of B.B., his Physicians, or other health care Providers; or whether (5) a lower level of care at a less cost would be **at least as likely to produce equivalent therapeutic or diagnostic results** in treating B.B.’s illness and diseases.

57. There is no indication that Dr. Phillips or Dr. Cesta were asked to consider or did consider any credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, such as American Psychiatric Association Guidelines for Treatment of Patients with Substance Use Disorders, or the views of Physicians [as defined in the plan] practicing in relevant clinical areas as to accepted standards of medical practice in the treatment of young adults with alcohol dependence, opioid dependence, cocaine dependence, major depressive disorder, generalized anxiety disorder, and post-traumatic stress disorder who struggle with hopelessness, worthlessness, and substance abuse cravings and other symptoms.

58. B.B. exhibited these symptoms as of May 25, 2017.

59. Defendant CBA denied coverage on May 25, 2017 stating the expedited appeal request had been received and was denied due to the clinical information lacking to document acute behavioral health symptoms that required the requested level of care.

60. In making this determination and rendering the conclusion to deny care, there is no evidence that Dr. Cesta actually considered the Plan definition of Medically Necessary or considered any credible scientific evidenced published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, such as American Psychiatric Association Guidelines for Treatment of Patients with Substance Use Disorders, or the views of Physicians [as defined in the plan] practicing in relevant clinical areas.

61. Dr. Cesta either intentionally or with conscious disregard failed to apply even the inappropriate, medically and scientifically unsupportable CBA “criteria” to B.B.’s known symptoms, diagnoses, and risk factors.

62. Dr. Cesta’s decision entirely ignores that B.B. had previously underwent rehabilitation that resulted in relapse.

63. Credible scientific evidence, in fact, demonstrates that early discharge of substance use disorder patients from residential programs is associated with relapse and death, and that inadequate treatment virtually guarantees relapse and the need for additional treatment.

64. B.B. was admitted to Care Forward on May 31, 2017 as a transition from detox at Above It All.

65. Plaintiff once again, immediately began the process of securing benefits approval from Defendants for B.B.’s treatment at Care Forward.

66. Care Forward submitted the partial hospitalization request form to Defendant

CBA at 12:37 pm on June 1, 2017, which was filled out properly and in its entirety.

67. Defendant CBA approved B.B.'s stay with Care Forward for the following dates June 8, 2017, June 9, 2017, June 12, 2017 through June 19, 2017 and June 21, 2017. An update for continued stay was due on June 21, 2017.

68. Care Forward provided the requisite update through an intensive outpatient request on June 21, 2017 and the following dates of continued care were approved June 22, 2017 through June 27, 2017.

69. Care Forward submitted an intensive outpatient request for continued care on June 28, 2017, B.B.'s treating physician noted that B.B. was a high risk for relapse provided his long term drug use and previous failed rehabilitation.

70. Defendant CBA determined the June 28, 2017 intensive outpatient request needed to be reviewed by April Richardson, MD.

71. Dr. Richardson denied the continued care request form on June 28, 2017 stating criteria # 2, 4, and 5 were questionable and that B.B. was not at a high risk of relapse.

72. What Dr. Richardson was not asked to determine and did not determine was whether a Physician, as defined in the Plan, exercising prudent clinical judgment, **would not** prescribe continued residential treatment (RTC) for B.B. to prevent, evaluate, diagnose or treat his illness, diseases and symptoms; or whether (2) continued residential treatment (RTC) **would be contrary** to generally accepted standards of medical practices; or whether (3) continued residential treatment (RTC) **would not be clinically appropriate** in terms of type, frequency, site and duration, and **would not be considered effective** for the treatment of B.B.'s illness and diseases; or whether (4) continued residential treatment (RTC) would be primarily for the convenience of B.B., his Physicians, or other health care Providers; or whether (5) a lower level

or care at a less cost would be **at least as likely to produce equivalent therapeutic or diagnostic results** in treating B.B.'s illness and diseases.

73. There is no indication that Dr. Richardson was asked to consider or did consider any credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, such as American Psychiatric Association Guidelines for Treatment of Patients with Substance Use Disorders, or the views of Physicians [as defined in the plan] practicing in relevant clinical areas as to accepted standards of medical practice in the treatment of young adults with alcohol dependence, opioid dependence, cocaine dependence, major depressive disorder, generalized anxiety disorder, and post-traumatic stress disorder who struggle with hopelessness, worthlessness, and substance abuse cravings and other symptoms exhibited by B.B. as of June 28, 2017.

74. Dr. Richardson either intentionally or with conscious disregard failed to apply even the inappropriate, medically and scientifically unsupportable CBA "criteria" to B.B.'s known symptoms, diagnoses, and risk factors.

75. Dr. Richardson's decision entirely ignores that B.B. had previously underwent rehabilitation that resulted in relapse.

76. B.B. was sent home to Summerville, South Carolina on July 2, 2017 to transition care at the Medical University of South Carolina (MUSC) beginning on July 10, 2017. The intensive outpatient program was denied by Defendant CBA on July 6, 2017. The denial noted there were no acute issues requiring the intensive treatment at the time of the request and also that there did not appear to be any imminent risk for relapse or readmission to a higher level of care.

77. B.B. was unable to continue the treatment he needed and relapsed.

78. On August 17, 2017, B.B. died of a fentanyl and heroin overdose.

FOR A FIRST CAUSE OF ACTION
(Wrongful Death – Bad Faith)

79. Plaintiff realleges and reiterates all of the allegations set forth in Paragraphs 1 through 78 herein above as fully as if repeated herein verbatim.

80. Plaintiff is informed and believes that pursuant to the Plan, Defendants owed Member of the Plan, including Covered Dependents, and specifically B.B., a duty of good faith and fair dealing in implementing the policy provisions, administration of the Plan, and handling claims for benefits.

81. Plaintiff is informed and believes that Defendants breached their duties of good faith and fair dealing, and acted unreasonably and in bad faith and in reckless disregard of the rights, safety and well-being of B.B., in the following particulars:

- a. By engaging in a pattern and practice of wrongfully disputing and withholding benefits as “not medically necessary” in direct contravention to the meaning and intent of the Plan language defining the term;
- b. By engaging in a pattern and practice of persistently disputing level of care determinations made by qualified and experienced treating physicians and providers without regard to the meaning and intent of the Plan language defining medical necessity;
- c. By engaging in a pattern and practice of persistently disputing level of care determinations made by qualified and experienced treating physicians and providers at a patently excessive and unreasonable frequency so as to create an environment of uncertainty counterproductive to treatment and recovery;

- d. By engaging in a pattern and practice of persistently disputing level of care determinations made by qualified and experienced treating physicians and providers at a patently excessive and unreasonable frequency so as to disrupt provision of care, transition of care, and discharge planning;
- e. By engaging in a pattern and practice of persistently overruling level of care determinations made by qualified and experienced treating physicians and providers – determinations with life or death consequences – without seeking or reviewing full clinical information;
- f. By engaging in a pattern and practice of persistently overruling level of care determinations made by qualified and experienced treating physicians and providers – determinations with life or death consequences – through case reviews by unqualified personnel, including social workers acting outside their scope of practice;
- g. By engaging in a pattern and practice of persistently overruling level of care determinations made by qualified and experienced treating physicians and providers – determinations with life or death consequences – through case reviews by medical doctors who did not fall within the definition of Physician, as that term is defined in the Plan, and like plans, who lacked sufficient skill, training and experience in the specialized field of substance use disorders;
- h. By engaging in a pattern and practice of persistently overruling level of care determinations made by qualified and experienced treating physicians and providers – determinations with life or death consequences – without seeking full independent medical examination, including in B.B.’s case, despite B.B.’s

complex clinical presentation;

- i. By engaging in a pattern and practice of denial of claims at virtually every level, requiring sequential appeals by policyholders and providers, through processes neither identified, described nor authorized by the Plan or like plans;
- j. By engaging in a pattern and practice of denials based on purported lack of medical necessity that was pretextual;
- k. By engaging in a pattern and practice of interfering, impeding, manipulating, and micro-managing patient care, and particularly the care claimant's providers were attempting to provide in order to bring about recovery and to keep him safe;
- l. By failing to consider and, in fact, ignoring clinical information supporting claimant's claims for treatment as medically necessary;
- m. By failing to conduct adequate investigations regarding clinical information supporting claimant's claims for treatment as medically necessary;
- n. By failing to conduct adequate investigations regarding overwhelming credible scientific evidence supporting claimant's claims for treatment as medically necessary;
- o. By engaging in purported medical reviews of level of care and treatment decisions – determinations with life or death consequences – which were so markedly deficient in terms of time, substance, and detail as to patently violate reasonable standards of practice in the psychiatric community;
- p. By engaging in a pattern and practice of employing self-created, cookie-cutter criteria at odds with the language of the Plan and like plans at odds with generally accepted standards of medical practice based on credible scientific evidence

published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, such as American Psychiatric Association Guidelines for Treatment of Patients with Substance Use Disorders, and the view of physicians practicing in this clinical area;

- q. By engaging in a pattern and practice of denying medically necessary treatment by employing self-created, cookie-cutter criteria, without consideration to the specific and unique factors with which B.B., and similar claimants presented, including his history of long-term substance use, history of relapse, anxiety, post-traumatic stress disorder and major depressive disorder;
- r. In mandating step-down from a residential treatment environment directly to outpatient treatment in direct contravention of generally accepted standards of medical practice based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, such as American Psychiatric Association Guidelines for Treatment of Patients with Substance Use Disorders, and the view of physicians practicing in this clinical area;
- s. In wrongfully characterizing as non-acute and stable this young adult male who:
 - (1) was suffering major depression at a level of 8 on a 1-10 scale;
 - (2) continued to have substance cravings at a level of 8 on a 1-10 scale;
 - (3) expressed hopelessness and worthlessness;
 - (4) was suffering from generalized anxiety disorder;
- t. In failing and refusing to consider the critical importance of family support and

home environment and ultimately denying outpatient treatment in this patient whose family ties were strained;

- u. In substituting their judgment for the clinical judgment of Physicians, as that term is defined in the Plan, and especially qualified and experienced treating physicians;
- v. In engaging in a plan and practice of vetoing proper and legitimate treatment plans adamantly supported by qualified and experienced treating physicians most familiar with the complex clinical picture of B.B. and like individuals as necessary for their health, safety, and well-being;
- w. In failing to provide parity of treatment for B.B.'s and like claimant's severe substance use disorder;
- x. In exhibiting an utter indifference to the healthcare needs and safety of claimants;
- y. In such other respects and may be ascertained through discovery.

82. The Plaintiff is informed and believes that as a direct and proximate result of Defendants' bad faith and tortious conduct as aforesaid, B.B. and like claimants did not receive the care, mental health services and therapy he desperately needed, resulting in B.B.'s death on August 17, 2017, and other claimants ongoing struggles and/or deaths. The Plaintiff's decedent's statutory beneficiaries have, as a direct and proximate result of the bad faith and tortious conduct of Defendants, lost the aid, comfort, companionship and society of the decedent, and have suffered severe and extreme emotional distress, mental suffering, anxiety, grief and sorrow, for which the Plaintiff is entitled to recover on behalf of the statutory beneficiaries, pursuant to §15-51-10, *et seq.*, *S.C. Code Ann.*, actual and punitive damages, in an amount to be determined by the jury at the trial of this action.

FOR A SECOND CAUSE OF ACTION
(Survival Action – Bad Faith)

83. Plaintiff realleges and reiterates all of the allegations set forth in Paragraphs 1 through 82 herein above as fully as if repeated herein verbatim.

84. Plaintiff is informed and believes that, the days and hours before his death, B.B. suffered severe and extreme psychological, mental and emotional pain and suffering, and emotional distress, anxiety, and hopelessness that were a direct and proximate result of the bad faith and tortious conduct of Defendants, for which the Plaintiff's decedent's Estate is entitled pursuant to §15-5-90, *S.C. Code Ann.*, to actual and punitive damages, in an amount to be determined by the jury at the trial of this action.

FOR A THIRD CAUSE OF ACTION
(Breach of Contract)

85. Plaintiff realleges and reiterates all of the allegations set forth in Paragraphs 1 through 84 herein above as fully as if repeated herein verbatim.

86. That, at all times hereinafter mentioned, Defendants, through its agents, servants, and employees were transacting business in the State of South Carolina when it sold Plaintiff and Class insureds the policy.

87. That Plaintiff and the Class insureds have otherwise performed all conditions as required by the Policy.

88. That Defendants' conduct, as described above, was in violation of the respective policies of insurance between Defendants, Plaintiff, and the Class insureds, and constitutes a breach of contract.

89. That, as a direct and proximate result of Defendants' breach of contract, Plaintiff

and the Class insureds have sustained damages as set forth above.

90. That Plaintiff and the Class insureds are entitled to judgment against Defendants for the full amount of their actual damages and attorney's fees.

WHEREFORE, Plaintiff prays for judgment against Defendants in an amount to be ascertained by the jury at the trial of this action, for all damages, punitive and actual, for the cost and disbursements of this action, both pre-judgment and post-judgment interest, and for such other and further relief, in law or in equity, in favor of Plaintiff as this Court may deem just and proper.

Respectfully Submitted,

ANASTOPOULO LAW FIRM, LLC

s/ Kenneth T. David
Kenneth T. David, Esquire
S.C. Bar No.: 103434
Lane D. Jefferies, Esquire
S.C. Bar No.: 101764
Roy T. Willey, IV, Esquire
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32 Ann Street
Charleston, S.C. 29403
(843) 614-8888

Charleston, South Carolina
January 16, 2019.

EXHIBIT 2

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	FOR THE FIFTH JUDICIAL CIRCUIT
COUNTY OF RICHLAND	)	
		CIVIL ACTION No.: 2019-CP-40-0341
Lisa Beattie As The Personal	)	
Representative For The Estate of Branch	)	
Beattie, Individually and As The	)	
Representative of a Class of Similarly	)	
Situated Persons,	)	
	)	DEFENDANTS' MOTION TO DISMISS
	)	PURSUANT TO SCRPC 12(b)(1) AND
Plaintiff,	)	12(b)(6) AND TO STRIKE PURSUANT
	)	TO 12(f)
v.	)	
	)	
Blue Cross Blue Shield of South Carolina,	)	
And Companion Benefit Alternatives, Inc.,	)	
	)	
Defendants.	)	
	)	

TO: ROY T. WILLEY, IV, ERIC M. POULIN, ALEXIS W. MCCUMBER, AND
KENNETH T. DAVID, ATTORNEYS FOR PLAINTIFF:

Defendants Blue Cross Blue Shield of South Carolina ("BCBSSC") and Companion Benefits Alternatives, Inc. ("CBA"), by and through their undersigned counsel, move this Court to be heard on the tenth (10th) day after service hereof, or as soon thereafter as counsel may be heard, pursuant to South Carolina Rule of Civil Procedure 12(b)(1), 12(b)(6) and 12(f), for an order dismissing Plaintiff's Complaint and/or striking Plaintiff's class action allegations. The grounds for this motion are that:

1. Plaintiff's causes of action are preempted by the exclusive remedies set forth in S.C. Code Ann. § 1-11-710 (C) and the language of the MUSC Health Plan;
2. Plaintiff failed to exhaust her administrative remedies under the MUSC Health Plan in a timely manner pursuant to S.C. Code Ann. § 1-11-710(C), § 1-23-380 and the language of the MUSC Health Plan;

3. The Administrative Law Court has exclusive jurisdiction over appeals from decisions of the MUSC Health Plan pursuant to S.C. Code Ann. § 1-23-600 (D) and the language of the MUSC Health Plan;
4. Defendants cannot be liable for breach of contract because they are not parties to a contract with Plaintiff;
5. Defendants BCBSSC and CBA cannot be liable for bad faith failure to pay insurance benefits as a matter of law because they are not the insurer of the MUSC Health Plan; and
6. Plaintiff's class action allegations should be dismissed or stricken because they do not meet the requirements of SCRCP 23(a).

I. BACKGROUND

Plaintiff, Lisa Beattie as the Personal Representative for the Estate of Branch Beattie, individually, and as the representative of a class of similarly situated persons, brings this action to recover health insurance benefits under MUSC Group Health Plan For Employees of The Medical University of South Carolina and The Medical University Hospital Authority ("MUSC Health Plan") in which Decedent Branch Beattie was a covered dependent. (Complaint ¶¶ 14-17). Plaintiff alleges causes of action for bad faith failure to pay insurance benefits resulting in an alleged wrongful death and a survival action (Complaint ¶¶ 79-84) and for breach of contract (Complaint ¶¶ 85-90).

Plaintiff's Complaint alleges that the MUSC Health Plan was created by and arises out of the South Carolina Public Employee Benefits Authority ("PEBA") and that the MUSC Health Plan is part of the State of South Carolina Health Plan. (Complaint ¶¶ 19, 21). Pursuant to S.C. Code Ann. § 1-11-710(A)(1), the PEBA board was 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.” S.C. Code Ann. § 1-11-710(A)(1) (Supp. 2013).

Under the terms of the 2017 MUSC Health Plan which was referred to and quoted in Plaintiff’s Complaint, a true and correct copy of which is attached hereto as Exhibit A, the MUSC Health Plan established by PEBA was a self-funded plan with PEBA designated as the Plan Administrator. (Plan ¶¶ 1.1; 2.63). BCBSSC was the Third-Party Claims Processor for the MUSC Health Plan. (Complaint ¶ 15; Plan ¶ 2.90). CBA was the Behavioral Health Manager and a Utilization Review Agency for the MUSC health Plan. (Complaint ¶ 15; Plan ¶¶ 2.12, 2.92). Neither BCBSSC, nor CBA were insurers of the MUSC Health Plan.

The terms of the MUSC Health Plan set out the administrative process required to challenge a denial of benefits and clearly stated that these administrative procedures were a plan participant’s exclusive remedy. The Plan Stated in relevant part:

12.10 Appeal Procedure

A Covered Person has a right to appeal an adverse decision under these claims procedures. The exclusive remedy for the denial of benefits shall be as provided by statute and by the procedures of PEBA Insurance Benefits. (Emphasis added).

(Plan ¶ 2.10)

A. Request for Reconsideration

4. Request for Reconsideration Deadline. The Request for Reconsideration of an adverse benefit decision must be filed within 180 days following the Covered Person’s receipt of the notification of adverse benefit decision, except that the appeal of a decision by the Third Party Claims Processor or Utilization Review Agency to reduce or terminate an initially approved course of treatment (see the definition of Concurrent Care decision) must be filed within 30 days of the Covered Person’s receipt of the notification of the decision of the Third Party Claims Processor or Utilization Review Agency to reduce or terminate. Failure to comply with this deadline will cause the Covered Person to forfeit any right to

any further review of an adverse decision under these procedures or in a court of law. (Emphasis added).

(Plan ¶ 12.10 (A)(4)).

B. Request for External Review and Plan Administrator Review

1. Filing of Request for External Review and Plan Administrator Review. A Covered Person (or someone acting on the Covered Person's behalf) may request External Review and Plan Administrator Review of an adverse benefit decision by the Third Party Claims Processor or Utilization Review Agency of a Request for Reconsideration by filing a written Request for External Review and Plan Administrator Review with the Plan Administrator within four (4) months after the Covered Person's date of receipt of a notice of an adverse benefit determination.

(Plan ¶ 12.10 (B)(1)).

4. External Review by IRO.

. . .

To the extent the IRO's final External Review decision is adverse to the Covered Person and upholds the adverse benefit determination by the Third Party Claims Processor or Utilization Review Agency, the IRO's External Review decision may be appealed to the Administrative Law Court within 30 days of the Covered Person's receipt of the adverse decision in accordance with paragraph C below. Instead of appealing directly to the Administrative Law Court, the Covered Person may first seek a Voluntary Additional Appeal to the Plan Administrator in accordance with subparagraph (5) below. (Emphasis added).

(Plan ¶ 12.10 (B)(4)).

. . .

5. Voluntary Additional Appeal to Plan Administrator. After an adverse determination by the IRO pursuant to an External Review provided in paragraph 12.10(B)(4), after a Preliminary Determination that a claim is not eligible for External Review under paragraphs 12.10(B)(2) and 12.10(B)(3), or that benefits will not be paid, the Covered Person may request a review by the Plan Administrator or its designee who shall review the Covered Person's claim. This additional review is voluntary. The Covered Person must make the request for review within 90 days after notice of the denial of benefits. Appeals may be brought only by the Covered Person at issue, their Authorized Representative (who cannot be a Provider, a Provider's Representative, or Benefits

Administrator) or a licensed attorney admitted to practice in South Carolina. The filing of this appeal shall be deemed to be consent for the Plan Administrator or its designee to review all medical records necessary for a determination of the appeal. To hear the appeal, the Plan Administrator may appoint up to five representatives who are familiar with group health benefits and the MUSC Health Plan and who were not involved in the initial denial of benefits.

(Plan ¶ 12.10 (B)(5)).

C. Judicial Review. The exclusive remedy for the denial of benefits shall be as provided in paragraphs 12.10.A and 12.10.B and by judicial review of that decision under 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 paragraphs 12.10.A and 12.10.B, nor will such action be brought after the expiration of the applicable period for commencing such actions. Any construction or interpretation of the Plan; determination of eligibility; any decision arising under the Plan; or any 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, capricious, or in violation of applicable statutes. (Emphasis added).

(Plan ¶ 12.10 (C)).

Because Plaintiff's Complaint is an action seeking health insurance benefits under the MUSC Health Plan, Plaintiff is limited to the exclusive remedies set forth in S.C. Code Ann. § 1-11-710 (C) and the MUSC Health Plan. Pursuant to S.C. Code Ann. § 1-23-600 (D) and the terms of the MUSC Plan, appeals involving claims under the MUSC Plan are under the exclusive jurisdiction of the Administrative Law Court. Accordingly, this Court has no subject matter jurisdiction to Plaintiff's claims. Additionally, Plaintiff's Complaint fails to allege sufficient facts to state causes of action against BCBSSC and CBA because: (1) the Complaint is preempted by S.C. Code Ann. § 1-11-710(c) which is Plaintiff's exclusive remedy, (2) Plaintiff failed to exhaust her administrative remedies in a timely manner under the MUSC Health Plan, (3) Plaintiff cannot recover for breach of contract against Defendants because Plaintiff has no contract with Defendants, (4) BCBSSC and CBA are not the insurers of the MUSC Health Plan and therefore cannot be liable for bad faith as a matter of law, and (5) Plaintiff's class action

allegations fail as a matter of law because they do not meet the requirements of SCRCP 23 (a).

II. MOTION TO DISMISS STANDARD

A. SCRCP 12(b)(1)

The question of subject matter jurisdiction is a question of law for the court. *Capital City Ins. Co. v. BP Staff, Inc.*, 382 S.C. 92, 99, 674 S.E.2d 524, 528 (Ct. App. 2009). The court may consider affidavits on a question of law in a jurisdictional motion under SCRCP 12(b)(1) without converting the motion into one for summary judgment. *Baird v. Charleston County*, 333 S.C. 519, 511 S.E.2d 69 (1999). The proper procedure for raising lack of subject matter jurisdiction prior to trial is to file a motion to dismiss pursuant to Rule 12(b)(1), SCRCP, rather than a motion for summary judgment pursuant to Rule 56, SCRCP. *Woodard v. Westvaco Corp.*, 319 S.C. 240, 460 S.E.2d 392 (1995), *overruled on other grounds by Sabb v. South Carolina State Univ.*, 350 S.C. 416, 567 S.E.2d 231 (2002).

B. SCRCP 12(b)(6)

Under Rule SCRCP 12(b)(6), a defendant may make a motion to dismiss based on a failure to state facts sufficient to constitute a cause of action. Generally, in considering a 12(b)(6) motion, the trial court must base its ruling solely upon allegations set forth on the face of the complaint. *Stiles v. Onorato*, 318 S.C. 297, 457 S.E.2d 601 (1995). However, in ruling on a 12 (b)(6) motion, the Court may consider documents that are referred to in the complaint, but are not attached. *Brazell v. Windsor*, 384 S.C. 512, 682 S.E.2d 824 (2009) (“allowing a trial court to consider documents that are incorporated by reference in the complaint but not actually attached thereto prevents a plaintiff from benefiting from his own oversight or from surviving a motion to dismiss by intentionally omitting documents upon which their claims are based.”). If a conflict exists between the bare allegations of the complaint and any document attached to or referenced

in the complaint, the document prevails. *Goines v. Valley Cmty. Servs. Bd.*, 822 F.3d 159, 166 (4th Cir. 2016); *Fayetteville Inv'rs v. Commercial Builders, Inc.*, 936 F.2d 1462, 1465 (4th Cir. 1991). The 12(b)(6) motion may not be sustained if the facts alleged and inferences therefrom would entitle the plaintiff to any relief on any theory. *Id.* However, a mere conclusory allegation, unsupported by any particularized allegations of fact, is insufficient to defeat a motion to dismiss. *Jones v. Gilstrap*, 288 S.C. 525, 528, 343 S.E.2d 646, 648 (Ct. App. 1986).

C. SCRCP 12(f)

A motion to strike under Rule 12(f), SCRCP, which challenges a theory of recovery in the complaint, is in the nature of a motion to dismiss under Rule 12(b)(6), SCRCP. *McCormick v. England*, 328 S.C. 627, 632, 494 S.E.2d 431, 433 (Ct. App. 1997).

III. DISCUSSION

A. Plaintiff's Complaint Should be Dismissed Because Plaintiff Is Limited To The Exclusive Administrative Remedies Contained In S.C. Code Ann. § 1-11-710(C).

A participant and/or beneficiary challenging an award of benefits under MUSC Plan is limited to the remedies set forth in S.C. Code Ann. § 1-11-710. § 1-11-710(C) provides as follows:

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

Id.

Because Plaintiff is claiming health insurance benefits from the MUSC Health Plan which Plaintiff admits is a state health plan created by PEBA, Plaintiff is limited to the exclusive administrative remedies set forth § 1-11-710(C) and the terms of the MUSC Health Plan. The

MUSC Health Plan clearly states that Plaintiff's exclusive remedy is limited to following the administrative appeals process under the plan, with any subsequent appeal to be to the S.C. Administrative Law Court. The relief Plaintiff seeks in her Complaint is not the type of relief allowed under the § 1-11-710(C) and the terms of the MUSC Health Plan. Accordingly, Plaintiff's Complaint fails to state a cause of action and should be dismissed.

It is well settled a court ordinarily will refuse to intervene where a special statutory remedy has been provided. "Gratuitous interference" in the administrative process should be avoided. *Williams Furniture Corp. v. Southern Coatings & Chemical Co.*, 216 S.C. 1, 7-8, 56 S.E.2d 576, 579 (1949); *Smith v. The South Carolina Retirement System*, 336 S.C. 505, 520 S.E.2d 339 (Ct. App. 1999). The Court, therefore, should not serve as a substitute for "a tribunal of original jurisdiction in issues that are ripe for litigation by the usual processes." *Williams Furniture Corp.*, at 579; see also *Garris v. Governing Bd. of South Carolina Reinsurance Facility*, 319 S.C. 388, 390, 461 S.E.2d 819, 821 (1995) ("relief will ordinarily be refused where another remedy will be more effective or appropriate under the circumstances," as "relief is not generally available to one who has not exhausted administrative remedies."). In general, judicial review is appropriate only when appeal is from a final agency order. *Id.* at 821 (citing S.C. Code Ann. § 1-23-380 (A)). Accordingly, Plaintiff's Complaint should be dismissed for failure to state a claim.

B. **Plaintiff's Complaint Should Be Dismissed Because Plaintiff Failed to Exhaust Her Administrative Remedies In A Timely Manner Under S.C. Code Ann. § 1-11-710(C) and The Terms of The MUSC Health Plan.**

Plaintiff's Complaint fails because Plaintiff failed to exhaust her administrative remedies under the MUSC Health Plan in a timely manner. S.C. Code § 1-11-710(C) and Paragraph 12.10 (C) of the MUSC Health Plan clearly set out the requirement that a Plaintiff must exhaust her

administrative remedies in a timely manner prior to bringing an action. *See Holmes v. ResCare HomeCare*, 2016 U.S. Dist. LEXIS 27795 (D.S.C. 2016) (dismissing Title VII discrimination case for failure to allege exhaustion of administrative remedies because exhaustion of administrative remedies was a necessary element of the claim); *Dickson v. Microsoft Corp.*, 309 F.3d 193, 213 (4th Cir. 2002) (Plaintiff has burden of alleging facts sufficient to state all the elements of a claim).

Plaintiff's complaint alleges that Plaintiff's request for concurrent care services for residential treatment from a facility named Above It All in Lake Arrowhead, California was initially denied on May 23, 2017. (Complaint ¶¶ 47-51). Plaintiff subsequently filed an expedited appeal which was denied on May 25, 2017. (Complaint ¶¶ 53, 59). Pursuant to Paragraphs 12.10 (B)(4) and 12.10 (B)(5) of the MUSC Health Plan, Plaintiff had 30 days to appeal the May 25, 2017 expedited appeal denial either directly to the S.C. Administrative Law Court, or to PEBA. However, Plaintiff did neither and waited until January 16, 2019, over six months after the deadline, to file this action in Circuit Court in Richland County.

Plaintiff's Complaint also alleges that Plaintiff's request for concurrent care services for intensive outpatient treatment from a facility named Care Forward was denied on June 28, 2017. (Complaint ¶¶ 67-71). However, Plaintiff failed to allege that Plaintiff took any steps to challenge this denial, including making a request for reconsideration, which was a required condition precedent. Paragraph 12.10 (A)(4) of the MUSC Health Plan states that concurrent care appeals for reconsideration must be made within 30 days of notice of the denial. Paragraph 12.10 (A)(4) goes on to state that, "[f]ailure to comply with this deadline will cause the Covered Person to forfeit any right to any further review of an adverse decision under these procedures or in a court of law."

Finally, Plaintiff's Complaint alleges that Plaintiff's request for concurrent care services for intensive outpatient treatment from MUSC was denied on July 6, 2017. (Complaint ¶ 76). However, Plaintiff failed to allege that Plaintiff took any steps to challenge this denial, including making a request for reconsideration, which was a required condition precedent under Paragraph 12.10 (A)(4) of the MUSC Health Plan.

Because Plaintiff failed to exhaust her administrative remedies in a timely manner, Plaintiff's complaint fails as a matter of law. In *Unisys Corporation v. The South Carolina Budget and Control Board*, 346 S.C. 158, 551 S.E.2d 263 (2001), the Supreme Court interpreted a similar statutory provision requiring exhaustion of administrative remedies and providing exclusive jurisdiction for the administrative appeals process to the State Budget and Control Board. After reviewing the statute, the Court held that because the claimant "is required to exhaust administrative remedies as a matter of law, dismissal under Rule 12(b) (6) for failure to state a claim was proper." *Id.* at 176, 273 (emphasis added). *See also Evans v. State of South Carolina*, 344 S.C. 60, 543 S.E.2d 547 (2001) (holding that the circuit court erred by not requiring state retirement program claimants to exhaust administrative remedies before filing lawsuit); *Hyde v. South Carolina Department of Mental Health*, 314 S.C. 207, 442 S.E.2d 582 (1994) (holding that trial judge abused his discretion by holding that plaintiff did not have to exhaust administrative remedies); *Southern Railway Co. v. Order of Railway Conductors of America*, 210 S.C. 121, 41 S.E.2d 774 (1947) (holding that exhaustion of administrative remedies precludes court from hearing case when remedies have not been exhausted and statute providing for exhaustion, by its express terms, gives exclusive jurisdiction to administrative agency). Because the exhaustion of administrative remedies requirement is mandatory, it cannot be ignored. Accordingly, Plaintiff's Complaint should be dismissed for failure to exhaust

administrative remedies.

C. The Administrative Law Court Has Exclusive Jurisdiction Over Appeals Concerning Benefits Under The MUSC Health Plan.

Even assuming for the sake of argument that Decedent did exhaust her administrative remedies under the MUSC Health Plan, which she did not, appeals involving claims under the MUSC Health Plan are under the exclusive jurisdiction of the Administrative Law Court. Accordingly, this Court has no subject matter jurisdiction. Pursuant to S.C. Code Ann. § 1-11-710(C), the exclusive remedy available to Plaintiff is the administrative review process provided by the Plan, “subject only to appellate judicial review consistent with the standards provided in Section 1-23-380.” Pursuant to S.C. Code Ann. § 1-23-600 (D), “[a]n administrative law judge also shall preside over all appeals from final decisions of contested cases pursuant to the Administrative Procedures Act, Article I, Section 22, Constitution of the State of South Carolina, 1895, or another law...” Likewise, Paragraphs 12.10 (B)(4) and 12.10(C) of the MUSC Health Plan also state that appeals involving claims for benefits under the MUSC Health Plan are to go to the Administrative Law Court. Because the Administrative Law Court has exclusive jurisdiction over MUSC Health Plan appeals, this Court has no subject matter jurisdiction over the Plaintiff’s Complaint.

D. BCBSSC and CBA Cannot Be Liable For Breach of Contract As a Matter of Law Because They Have No Contract With Plaintiff.

The MUSC Health Plan established by PEBA was a self-funded plan with PEBA designated as the Plan Administrator. (Plan ¶¶ 1.1; 2.63). BCBSSC was the Third-Party Claims Processor for the MUSC Health Plan. (Complaint ¶ 15; Plan ¶ 2.90). CBA was the Behavioral Health Manager and a Utilization Review Agency for the MUSC health Plan. (Complaint ¶ 15; Plan ¶¶ 2.12, 2.92). Neither BCBSSC, nor CBA were insurers of the MUSC Health Plan and

neither Defendant had a contract with Plaintiff.

Plaintiff is not entitled to any relief against BCBSSC and CBA because Plaintiff's exclusive remedy to recover benefits under the MUSC Health Plan was to exhaust her administrative remedies under S.C. Code Ann. § 1-11-710 (C). Because Plaintiff's sole remedy is against the MUSC Health Plan for benefits, not against the Third-Party Claims Processor, the Behavioral Health Manager and/or a Utilization Review Agency, Plaintiff's Complaint fails as a matter of law. Defendants were not the insurer of the plan and had no contractual privity with Plaintiff. Therefore, there was no contractual duty owed by Defendants to Plaintiff. Generally, one not in privity of contract with another cannot maintain an action against him in breach of contract, and any damage resulting from the breach of contract between the defendant and a third party is not, as such, recoverable by the plaintiff. *Windsor Green Owners Assoc. v. Allied Signal*, 362 S.C. 12, 605 S.E.2d 750 (Ct. App. 2004). Accordingly, Plaintiff's breach of contract cause of action fails as a matter of law.

E. BCBSSC and CBA Cannot Be Liable For Bad Faith As a Matter of Law Because They Are Not The Insurer of The MUSC Health Plan.

Because Plaintiff did not have a policy of insurance with Defendants, Defendants cannot be liable for bad faith as a matter of law.¹ The "duty of good faith arising under the contract does not extend to a person who is not a party to the insurance contract." *Charleston Dry Cleaners & Laundry, Inc. v. Zurich American Insurance Co.*, 355 S.C. 614, 586 S.E.2d 586, 588 (2003) (finding that an independent insurance adjuster owes no duty of care to an insured). The South Carolina Supreme Court, in *Nichols v. State Farm Mut. Auto. Ins. Co.*, 279 S.C. 336, 306 S.E.2d 616 (1983), recognized the tort of bad faith refusal to pay benefits to named insureds and

¹ Likewise, a claim under the S.C. Wrongful Death Act lies in the decedent's estate only when the decedent possessed the right of recovery at his death. *Estate of Stokes v. Pee Dee Family*

allowed a first-party claim by the insured against an insurer for bad faith in processing claims for benefits due under a “mutually binding contract of insurance,” *Id.* The South Carolina Supreme Court expressly disallowed third-party bad faith claims. *See Kleckley v. Northwestern Nat. Cas. Co.*, 338 S.C. 131, 526 S.E.2d 218 (2000). Because the duty of good faith only is owed by the parties to the mutual insurance contract, only a party to that contract can be liable for bad faith. South Carolina does not recognize a cause of action for bad faith by the insured against an independent adjusting company, any such claim is imputed to the insurer. *Charleston Dry Cleaners*, at 588-89. Because the MUSC Health Plan was self-funded, and Defendants were merely the Third-Party Claims Processor, the Behavioral Health Manager and/or a Utilization Review Agency with limited authority to make utilization review recommendations, and had no contractual privity with Plaintiff by virtue of any insurance contract, no bad faith claim can be brought by Plaintiff against these Defendants as a matter of law.

Additionally, as independent third-party claim processors and utilization reviewers, Defendants owed no duty to Plaintiff. South Carolina follows the general rule that declines to recognize a general duty of due care from an independent insurance adjuster or insurance adjusting company to an insured. *Charleston Dry Cleaners & Laundry v. Zurich American Ins. Co.*, 355 S.C. 614, 586 S.E.2d 586 (2003). Defendants were outside companies hired by PEBA to provide administrative claim adjusting services. Therefore, under the reasoning of *Charleston Dry Cleaners*, these Defendants owed Plaintiff no duty and Plaintiff’s bad faith cause of action against these Defendants fails as a matter of law.

F. Plaintiff’s Class Action Allegations Should Be Dismissed and/or Stricken Because They Do Not Meet The Requirements of SCRCP 23(a).

1. The Standard For Class Certification.

Physicians, L.L.P., 389 S.C. 343, 699 S.E.2d 143 (2010).

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), SCRPC. 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), SCRPC. 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 Property Owners Ass'n*, *supra*. Failure to satisfy even one prerequisite is fatal to class certification. *Id.*

Class actions are exceptions and not the rule. *Ortiz v. Fibreboard Corp.*, 527 U.S. 815, 846 (1999); *see also Broussard v. Meineke Discount Muffler Shops, Inc.*, 155 F.3d 331, 345 (4th Cir. 1998) (“[A] class action is ‘an exception to the usual rule that litigation is conducted by and on behalf of the individual named parties only.’”); *Grazia v. S. C. State Plastering, LLC*, 390 S.C. 562, 575, 703 S.E.2d 197, 203-204 (2010) (recognizing that class-actions are exceptions to the general rule that litigation is conducted on behalf of individuals) (citing *Califano v. Yamasaki*, 442 U.S. 682, 700- 01 (1979)).

Rule 23, SCRPC, which governs class actions, cannot be used to enlarge the rights of plaintiffs because, like other rules of civil procedure, it affects only matters of practice and procedure. *Deposit Guar. Nat'l Bank v. Roper*, 445 U.S. 326, 332 (1980), *reh'g denied*, 446 U.S. 947 (1980) (“right of a litigant to employ Rule 23 is procedural right only, ancillary to the

litigation of substantive claims”). “Thus courts considering class certification must rigorously apply the requirements of Rule 23 to avoid the real risk, realized here, of a composite case being much stronger than any plaintiff’s individual action would be.” *Broussard*, 155 F.3d at 345. Finally, and in service of the first two principles, the Court must conduct a rigorous analysis to decide whether the prerequisites for class certification exist. The failure of the proponents to satisfy any one of the prerequisites is fatal to class certification.” *Waller v. Seabrook Island Prop. Owners Ass’n*, 300 S.C. 465, 467, 388 S.E.2d 799, 801 (1990) (citing *Gen. Tel. Co. of Southwest v. Falcon*, 457 U.S. 147(1982)).² A court examining the question of class certification must look at the legal elements of the underlying causes of action and defenses and determine whether the named plaintiff’s claims satisfy the requirements of Rule 23 within the framework of the substantive law applicable to those claims. *Gen. Tel. Co. of Southwest*, 457 U.S. at 160; *Gardner*, 353 S.C. at 21-23, 577 S.E.2d at 200-201.

Pursuant to Rule 23(d) SCRPC, the court may make appropriate orders “[a]s soon as practicable after the commencement of an action brought as a class action, the court shall determine by order whether it is to be so maintained.” “Although the question of whether a class action should be certified is typically raised by the plaintiff in a motion for class certification, either party may prompt the court to make this determination.” *Thornton vs. South Carolina Electric & Gas Corporation*, 391 S.C. 297, n. 8, 705 S.E.2d 475, n. 8 (Ct. App. 2011),

2. **Numerosity**

Plaintiff’s Complaint failed to properly plead the numerosity requirement because Plaintiff failed to allege any specific facts establishing numerosity. The Complaint alleges,

² “Since our Rules of Procedure are based on the Federal Rules, where there is no South Carolina law, we look to the construction placed on the Federal Rules of Civil Procedure.” *Gardner v. Newsome Chevrolet-Buick, Inc.*, 304 S.C. 328, 404 S.E.2d 200 (1991).

“[t]hat the proposed class is believed to be in the hundreds, probably thousands, and therefore is so numerous that joinder of all members is impracticable.” (Complaint ¶16.a). Merely making conclusory allegations speculating as to the class size are insufficient. As with all of the requirements of Rule 23, the burden of proving that the class is so numerous that joinder is impracticable lies with the party seeking class certification. To meet that burden, the class proponent generally must proffer evidence of the number of members in the purported class. “The party seeking certification may not rely on conclusory allegations that joinder would be impracticable, or on mere speculation regarding the size of the class.” 5-23 Moore’s Federal Practice-Civil §23.22[3]; *Fleming v. Travenol Labs., Inc.*, 707 F.2d 829, 833 (5th Cir. 1983) (numerosity requirement not met because plaintiff merely alleged that class was so numerous as to make joinder impracticable); *Stevens v. City of Baton Rouge*, 700 F. Supp. 869, 873 (M.D. La. 1988) , *aff’d*, 884 F.2d 576 (5th Cir. 1989) (no finding of numerosity because plaintiff failed to produce evidence of class size); *In re Cardinal Indus., Inc.*, 139 B.R. 703, 705-706 (S.D. Ohio 1991) (mere conjecture insufficient to establish numerosity); *Marcial v. Coronet Ins. Co.*, 880 F.2d 954, 957 (7th Cir. 1989) (numerosity not found because, although plaintiffs alleged that putative class contained 400-600 members, plaintiffs failed to establish that defendant took action in dispute with regard to any of these individuals); *Kohn v. Mucia*, 776 F. Supp. 348, 352 (N.D. Ill. 1991) (in action by car owners challenging state vehicle code, plaintiffs offered evidence that City of Chicago disposed of almost 160,000 vehicles in two years, but showing did not establish numerosity because plaintiffs failed to offer any evidence that cars were properly registered); *Belles v. Schweiker*, 720 F.2d 509, 515 (8th Cir. 1983) (because plaintiff could not identify any other person subjected to similar treatment, numerosity not satisfied); *Siles v. ILGWU Nat’l Ret. Fund*, 783 F.2d 923, 930 (9th Cir. 1986) (numerosity not met in case charging

that pension fund eligibility requirements violated ERISA because, although plaintiff presented evidence that 31,000 employees were covered by plan and lost their jobs, plaintiff failed to show how many employees were eligible for and failed to receive benefits). Because Plaintiff's numerosity allegation is merely conclusory and speculative, it fails to meet the numerosity requirements of Rule 23(a) as a matter of law.

3. Commonality

To establish commonality, a party must show that "there are questions of law or fact common to the class." Rule 23(a), SCRCRP. In practical terms this means the party must articulate the existence of "significant common, legal, or factual issues" which bind the proposed class together. *Gardner v. S.C. Dep't of Revenue*, 353 S.C. 1, 14, 577 S.E.2d 190, 197 (2003). Commonality is met only where the class shares a determinative issue. *Gardner*, citing *Stott v. Haworth*, 916 F.2d 134, 145 (4th Cir.1990) ("certification is proper only when a determinative critical issue overshadows all other issues; and "questions [that are] in no way dispositive and [which] simply propel the action into a posture where judicial scrutiny is necessary for just adjudication" are insufficient to establish commonality under Rule 23(a)(2), FRCP); *see also Peoples v. Wendover Funding Inc.*, 179 F.R.D. 492, 498 (D. Md.1998) ("a representative plaintiff cannot establish commonality . . . if the court must investigate each plaintiff's individual claim."). Requiring individualized examination negates the benefits of a class action suit. *See O'Quinn v. Beach Associates*, 272 S.C. 95, 104, 249 S.E.2d 734, 738 (1978) ("[t]he very purpose of a class action is to avoid the necessity of requiring each member of the class to prove the elements of the cause of action."); *Sprague v. General Motors Corp.*, 133 F.3d 388, 397 (6th Cir. 1998) (need for individualized liability determinations precluded class treatment).

a. Bad Faith Failure To Pay Insurance Benefits

Plaintiff's primary cause of action, bad faith failure to pay insurance benefits, fails to meet the commonality requirement of Rule 23(a) as a matter of law. As the South Carolina Supreme Court has stated on many occasions, bad faith refusal to pay first party benefits under a contract of insurance includes: (1) the existence of a mutually binding contract of insurance between Plaintiff and Defendant; (2) refusal by the insurer to pay benefits due under the contract; (3) resulting from the insurer's bad faith or unreasonable action in breach of the implied covenant of good faith and fair dealing arising in the contract; and (4) causing damage to the insured. *Howard v. State Farm Automobile Insurance Co.*, 316 S.C. 445, 450 S.E.2d 582 (1994). The key consideration in a bad faith claim is whether the insurance company acted in bad faith or unreasonably. It follows that "[i]f there is a reasonable ground for contesting a claim, there is no bad faith." *Crossley v. State Farm Mutual Insurance Co.*, 307 S.C. 354, 415 S.E.2d 393 (1992). "Whether an insurance company is liable for bad faith must be judged by the evidence before it at the time it denied the claim or if the insurance company did not specifically deny the claim by the evidence it had before it at the time the suit was filed." *Howard*, 316 S.C. at 450, S.E.2d at 584 (1994). Because a bad faith case requires an individual inquiry as to the facts before the insurance company at the time the claim was denied, thereby necessitating mini-trials on liability, bad faith cases are ill-suited to class-wide resolution. As the S.C. District Court held in *Comer v. Life Ins. Co.*, 2010 U.S. Dist. LEXIS 2959 (D.S.C. 2010), *vacated on other grounds by*, 2011 U.S. Dist. LEXIS 36042 (D.S.C., Mar. 31, 2011),

Determining whether the facts support the denial of benefits, or whether there was any reasonable basis for failing to pay benefits, requires an individual assessment of the facts of each claim. Unlike determining liability based on a uniform course of contract interpretation, the bad faith claim compels the court to consider any reason for not paying the alleged benefits owed under the contract. All manner and variety of defenses have been forecast by Alabama Life. Accordingly, the court finds the bad faith claims atypical of one another, necessitating mini-trials on liability, and ill-suited to class-wide resolution.

Id.; see also, *In re Katrina Canal Breaches Litig. v. State Farm Fire & Cas. Co.*, 401 Fed. Appx. 88, 2010 U.S. App. LEXIS 23399 (5th Cir. 2010) (upholding the denial of class certification in an insurance bad faith case because the Court must necessarily inquire into reasonableness of the insurer's decision based "on the facts known to the insurer at the time of its action" and that this inquiry will necessarily involve detailed and individualized considerations of each class members' claim); *Newell v. State Farm General Ins. Co.*, 118 Cal.App.4th 1094, 13 Cal. Rptr. 3d 343 (2004) (dismissing class action allegations in a bad faith case because recovery would involve an individual assessment of each insured's claim). Because South Carolina law would require the Court to review the facts before the insurance company at the time any coverage decision were made to determine if the decision was reasonable, the Court would have to conduct a mini-trial for each class member's claim. Therefore, Plaintiff's bad faith allegations do not meet Rule 23(a)'s commonality requirement and Plaintiff's class action allegations should be dismissed and/or stricken.

b. Statute of Limitations

Plaintiff's Complaint also fails to meet Rule 23(a)'s commonality requirement because Defendants' anticipated statute of limitation defense requires an individualized determination as to when each purported class member's cause of action accrued. Plaintiff's Complaint makes no attempt to limit the proposed class with any date restriction. Therefore the statute of limitations defense is a key issue that would have to be addressed by the Court. Under South Carolina law, the "Discovery Rule" applies to determine when a cause of action for breach of contract or bad faith accrues. *Rumpf v. Mass. Mutual Life Ins. Co.*, 357 S.C. 386, 395-96, 593 S.E.2d 183, 187-88 (Ct. App. 2004). The South Carolina Supreme Court has repeatedly held that a statute of

limitations begins to run when the party either knew or should have known that some legal right had been invaded. *See Epstein v. Brown*, 363 S.C. 372, 376, 610 S.E.2d 816, 818 (2005) (stating a statute of limitations begins to run when a party through the exercise of reasonable diligence would be put on notice that a legal right had been invaded); *Dean v. Ruscon Corp.*, 321 S.C. 360, 363, 468 S.E. 2d 645, 647 (1996) (“The statute runs from the date the injured party either knows or should have known by the exercise of reasonable diligence that a cause of action arises from the wrongful conduct.”); *Johnston v. Bowen*, 313 S.C. 61, 64, 437 S.E.2d 45, 47 (1993) (“[T]he injured party must act with some promptness where facts and circumstances of the injury would put a person of common knowledge and experience on notice that some right of his had been invaded or that some claim against another party might exist.”).

Because the Court must conduct an individualized inquiry as to when each member of the class knew or should have known his cause of action arose, the commonality requirement of Rule 23 (a) is not met and Plaintiff’s class action allegations should be dismissed and/or stricken. *See Thorn v. Jefferson-Pilot Life Ins. Co.*, 2004 U.S. Dist. Lexis 31124 (D.S.C. 2004), *affirmed*, 445 F.3d 311 (4th Cir. 2006) (holding that class certification was not proper under Rule 23 (a) in that the “Federal Discovery Rule” necessarily required an individualized determination as to when each class member’s claim “accrued.” *Broussard v. Meineke Discount Muffler Shops, Inc.*, 155 F.3d 331 (4th Cir. 1998), held that “when the defendant’s affirmative defenses (such as the statute of limitations) may depend on facts peculiar to each plaintiff’s case, class certification is erroneous [under Rule 23(a)].” *Id.* at 342. Similarly, in *Gunnells v. Healthplan Servs., Inc.*, 348 F.3d 417 (4th Cir. 2003) the Fourth Circuit held that when an affirmative defense “would require individualized inquiry in at least some cases . . . ‘class certification is erroneous.’” *Id.* at 438; *Lucken v. Bryce’s Mountain Resort, Inc.*, 538 F.2d 597 (4th Cir. 1976) (relying, in

affirming denial of class certification, on the individual nature of the necessary proof as to the issue of tolling of the statute of limitations).

c. ERISA Preemption

Plaintiff's Complaint also fails to meet Rule 23(a)'s commonality requirement because Paragraph 5 of Plaintiff's Complaint defines the class so broadly that it would cover individuals whose health plans were governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §1001 *et seq.*, which preempts state law. ERISA contains a specific preemption clause which states: "[e]xcept as provided in subsection (b) of this section, the provisions of [ERISA] shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan..." 29 U.S.C. § 1144(a); *See Metropolitan Life Insurance Company v. Taylor*, 481 U.S. 58, 107 S.Ct. 1542, 95 L.Ed.2d 55 (1987). The U.S. Supreme Court has recognized that the force of ERISA's preemption is strong and its scope wide. *See E.G. FMC Corporation v. Holiday*, 498 U.S. 52, 58, 111 S.Ct. 403, 407-08, 112 L.Ed.2d 356 (1990). "The phrase 'relates to' is given a broad common sense meaning '[a] law relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 96-97, 103 S.Ct. 2890, 2899-900, 77 L.Ed.2d 490 (1983). ERISA is the "exclusive vehicle for actions by ERISA plan participants and beneficiaries, asserting improper processing of a claim for benefits ..." *Pilot Life v. Dedeaux*, 489 U.S. 41, 107 S.Ct. 1549, 95 L.Ed. 39 (1987), "[A]fter *Pilot Life*, any contention that the state law claims here are not preempted by ERISA would be frivolous ..." *Maker v. Health Care Corp. of Mid Atlantic*, 872 F.2d 80, 82 (4th Cir. 1989). ERISA preempts state law causes of action for breach of contract and bad faith. *See Pilot Life Insurance Company v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987) (holding ERISA preempted claims

under Mississippi's common law, tort and contract allegations alleging bad faith); *Custer v. Pan American Life Insurance Company*, 12 F.3d 410 (4th Cir. 1993) (holding ERISA preempted a cause of action under West Virginia's unfair trade practices statutes); and *Duncan v. Provident Mutual Life Insurance Company*, 310 S.C. 465, 427 S.E.2d 657 (1993) (holding ERISA preempted a claim under South Carolina's common law of bad faith).

“[W]hen a complaint contains state law claims that fit within the scope of ERISA's § 502 civil enforcement provision, those claims are converted into federal claims.” *Darcangelo v. Verizon Communications, Inc.*, 292 F.3d 181, 187 (4th Cir. 2002). A plaintiff is not entitled to compensatory or punitive damages on a claim brought pursuant to ERISA. *Id.*; *Eweka v. Hartford Life and Acc. Ins. Co.*, 955 F. Supp. 2d 556, 568 (E.D.Va. 2013); *Gauldin v. Honda Power Equip. Mfg., Inc.*, 351 F. Supp. 2d 455, 458 (M.D.N.C. 2005). Additionally, a plaintiff is not entitled to a jury trial under ERISA. *Phelps v. C.T. Enters.*, 394 F.3d 213, 222 (4th Cir. 2005) (“[P]roceedings to determine rights under employee benefit plans are equitable in character and thus a matter for a judge, not a jury”); *Berry v. Ciba-Geigy Corp.*, 761 F.2d 1003, 1006-07 (4th Cir.1985) (finding that plaintiffs in ERISA actions are not entitled to a jury trial).

Because Plaintiff's Complaint also involves federal law under ERISA, which differs significantly from S.C. state law as far as substance, mode of trial and available damages, Plaintiff's Complaint fails to meet Rule 23(a)'s commonality requirement and should be dismissed and/or stricken.

d. Individualized Review of Each Class Member's Medical Condition

Additionally, Plaintiff's Complaint fails to meet Rule 23(a)'s commonality requirement because the Court would have to conduct an individualized review of each class member's medical condition to ascertain if the member's condition met the definition of medical necessity

under each member's plan or policy. Such an analysis would entail conducting multiple mini-trials on each member's health status including a review of voluminous medical records and the testimony of multiple medical experts to see if the requirements for medical necessity were met for each member. Having to conduct multiple mini-trials to prove that each member's claim met the requirements of the plan or policy defeats the purpose of a class action. *O'Quinn*, 272 S.C. 95, 104, 249 S.E.2d 734, 738 (1978) (“[t]he very purpose of a class action is to avoid the necessity of requiring each member of the class to prove the elements of the cause of action.”)

4. Typicality

As was stated in 5-23 *Moore's Federal Practice-Civil* §23.24[1]:

One or more members of a class may sue or be sued as representative parties on behalf of all only if the representative parties' claims or defenses are typical of the claims or defenses of the class. This “typicality” requirement attempts to ensure that the representative parties' (named plaintiffs') interests are substantially aligned with those of absent class members. Thus, any potential conflict or antagonism between the class representatives and the interests of the absent class members will preclude certification of the class. By ensuring that the class representative's claims are similar to and aligned with those of the class, the typicality requirement also promotes efficient case management and fair representation.

Id.

“The premise of the typicality requirement is simply stated: as goes the claim of the named plaintiff, so go the claims of the class.” *Broussard*, 155 F.3d at 340 (citing *Sprague*, 133 F.3d 388, *cert. denied*, 524 U.S. 923 (1998)). The “[t]ypicality requirement . . . limit[s] the class claims to those fairly encompassed by the named plaintiffs' claims.” *Gen. Tel. Co. v. EEOC*, 446 U.S. 318, 330 (1980). Typicality “ensures that no claim of a class member, or significant aspects of such a claim, will go unrepresented by representative plaintiff.” *McElhaney v. Eli & Lilly Co.*, 93 F.R.D. 875, 878 (D.S.D. 1982). “[I]n the course of proving her own claim, plaintiff must also prove the claims of the other members of the class. The claims and defenses of the class

representative would not be typical if [they] would require substantially more or less proof than required for the other members of the class. *Id.*, 93 F.R.D. at 878. Moreover, it is well established that the presence of even an arguable defense peculiar to the named plaintiff or a small subset of the plaintiff class may destroy the required typicality of the class, . . .” *J. H. Cohn & Co. v. Am. Appraisal Assoc., Inc.*, 628 F.2d 994, 999 (7th Cir. 1980) (citing *Koos v. First Nat’l Bank of Peoria*, 496 F.2d 1162, 1164–65 (7th Cir. 1974)). Accordingly, the Plaintiff and putative class member’s claims are not typical if their legal or factual positions are different from that of the purported class members. *See* 7A Charles A. Wright, *et al.*, *Federal Practice and Procedure* § 1764 (2d ed. 1986).

a. Exhaustion of Administrative Remedies

Because the named Plaintiff failed to exhaust her administrative remedies under S.C. Code Ann. § 1-11-710 (c) and the terms of the MUSC Health Plan, Plaintiff’s Complaint fails to meet Rule 23(a)’s typicality requirement. As was previously discussed, 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). However, Plaintiff failed to exhaust her administrative remedies under the MUSC Health Plan, which is a complete bar to recovery.

Courts have denied class certification where the named plaintiffs were subject to exhaustion defenses. *See, e.g., Scott v. New York City Dist. Council of Carpenters Pension Plan*, 224 F.R.D. 353, 355 (S.D.N.Y. 2004) (“Determining whether Scott has exhausted his administrative remedies would require an individualized assessment of the facts and circumstances surrounding his claim for benefits. Such an assessment constitutes a defense unique to Scott that threatens to become the focus of the litigation.”); *Carlstrom v. Decisionone*

Corp., 217 F.R.D. 514, 516 (D. Mont. 2003) (“Failure to exhaust raises a defense unique to [plaintiff], which also defeats the typicality requirement.”); *Clancy v. Employers Health Ins. Co.*, 82 F. Supp. 2d 589, 601 (E.D. La. 1999) (denying class certification because the proposed class representative failed to exhaust her administrative remedies creating a unique defense to her claim); *Gary Plastic Packaging v. Merrill Lynch*, 903 F.2d 176, 180 (2nd Cir. 1990)(concluding that class certification should be denied as to claims for which the proposed class representatives are subject to unique defenses that predictably will become a major focus of litigation). Because Plaintiff is subject to the failure to exhaust defense, she does not meet the typicality requirement under Rule 23 (a).

b. Plaintiff Not Injured By All Defendants

Plaintiff additionally does not meet the typicality requirement in that Plaintiff has not been injured by the Defendants. By statute, Plaintiff’s sole remedy is against the MUSC Health Plan for benefits, not against the Defendants who were acting as the Third-Party Claims Processor, the Behavioral Health Manager and/or a Utilization Review Agency. Defendants were not the insurer of the Plan and had no contractual privity with Plaintiff. Therefore, there was no contractual duty owed by Defendants to Plaintiff. Because any liability under the MUSC Health Plan flows only from the MUSC Health Plan, Defendants had no liability to Plaintiff as a matter of law. *See Green v. Industrial Life and health Insurance*, 199 S.C. 262, 185 S.E.2d 873 (1942) (an agent is not liable for a contract of a known principal); *Charleston Dry Cleaners v. Zurich American Insurance Company*, 355 S.C. 614, 586 S.E.2d 586 (2003) (South Carolina does not recognize a general duty of care from an independent insurance adjuster to an insurer.).

Courts have denied class certification for lack of typicality where the plaintiff was not injured by all of the defendants. “To meet the typicality requirement, there must be at least one

class representative who has been injured by and has a claim against each and every defendant.” 5-23 *Moore’s Federal Practice-Civil* §23.24[6] [a]; *Thompson v. Board of Educ. of Romeo Cmty. Schs.*, 709 F.2d 1200, 1204-1205 (6th Cir. 1983) (class not certified in sex discrimination suit because plaintiff was not injured by each of eight different defendants); *Thillens, Inc. v. Community Currency Exch. Ass’n. of Ill., Inc.*, 97 F.R.D. 668, 675 (N.D. Ill. 1983) ; *Easter v. American West Fin.*, 381 F.3d 948, 962 (9th Cir. 2004) (borrowers who sued financial institutions on usury and consumer protection theories did not have standing to sue defendants who never held any loans of named plaintiffs). Because Plaintiff was not injured by Defendants, Plaintiff’s Complaint fails to meet Rule 23(a)’s typicality requirement.

5. **Adequacy of Representation**

In determining whether a particular named plaintiff will adequately represent a proposed class pursuant to Rule 23(a)(4) one factor the Court must consider is whether the named plaintiff has interests that are antagonistic or adverse to those of the rest of the class. *Waller v. Seabrook Island Property Owners Ass’n*, 300 S.C. 465, 388 S.E.2d 799 (1990), *citing Runion v. U.S. Shelter*, 98 F.R.D. 313 (D.S.C. 1983) (case sets forth all criteria to be considered in determining whether a particular named plaintiff will adequately represent a proposed class). If so, that plaintiff will not be considered an adequate representative of the class. The kind of antagonism that will defeat the maintenance of a class action is the kind which relates to the subject matter in controversy, as when the named representative has a claim which conflicts with the economic interests of the class. *Waller*. The issue of whether a named plaintiff will adequately protect the interests of the class members is a question of fact which depends upon the circumstances of each case. *Id.* A Plaintiff must demonstrate he has no interest antagonistic to or in conflict with the interests of the unnamed members of the class such that they are fairly and adequately able to

protect the interests of the purported class. *Id.*; *Sullivan v. Winn-Dixie Greenville, Inc.*, 62 F.R.D. 370 (D.S.C. 1974).

Courts have held that a class representative is an inadequate class representative when he is subject to a unique defense that could become the focus of the litigation.

If a proposed class representative is subject to a defense that is unique to the representative and that could become a focus of the litigation, the class representative will not satisfy the adequacy-of-representation requirement. This rule mirrors a similar limitation for the typicality requirement. The justification for the rule is that the class representative may become distracted by the presence of a unique defense, causing plaintiff's representation of the class as a whole to suffer.

To preclude class certification, the defendant need not establish that the class representative's claim ultimately would be defeated by the unique defense. Rather, class treatment generally will be denied if a unique defense is even arguably present. If it is obvious to the court that the defense has absolutely no merit, however, the defense will not preclude class certification. On the other hand, to defeat class certification on the grounds that the representation is inadequate, the defense unique to the class representative must be so central to the litigation that it has real potential to divert the class representative's attention, to the detriment of other class members.

5-23 *Moore's Federal Practice-Civil* §23.25[2] [b] [iv].

a. A Conflict of Interest Exists Because Plaintiff Is Subject To The Unique Defense of Failure To exhaust Administrative Remedies.

Courts have held that a class representative that is subject to a unique defense of failure to exhaust administrative remedies is not an appropriate class representative because the unique defense creates a conflict of interest. *Miller v. Board of education of the Albuquerque Public Schools*, 455 F.Supp.2d 1286 (D.N.M. 2006) ("Such a conflict is likely to be present if the members of the proposed class are subject to the defense of failure to exhaust administrative remedies, while the class representatives are not."); *Gary Plastic Packaging v. Merrill Lynch*, 903 F.2d 176, 180 (2nd Cir. 1990)(concluding that class certification should be denied as to

claims for which the proposed class representatives are subject to unique defenses that predictably will become a major focus of litigation). As was previously discussed, because Plaintiff is subject to a unique defense of failure to exhaust administrative remedies under § 11-710 (c) and the terms of the MUSC Health Plan, Plaintiff is not an adequate class representative under Rule 23(a).

b. The Fact That Plaintiff's Complaint Seeks To Recover For Wrongful Death and Survival Damages As A Personal Representative of The Estate Branch Beattie Creates A Conflict of Interest That Prevents Plaintiff From Adequately Representing A Class.

As a proposed class representative, Plaintiff has a potentially conflicting duty to represent all class members equally, and even to “spend estate assets to pay the costs of the representation.” See *First Interstate Bank of Nev. v. Chapman & Cutler*, 837 F.2d 775, 781 (7th Cir. 1988) (noting that these fiduciary duties may collide); *In re FleetBoston Fin. Corp. Sec. Litig.*, 253 F.R.D. 315, 324 (D.N.J. 2008) (observing fiduciary duties as executor could conflict with fiduciary obligations as class representative). Plaintiff has not alleged that she sought permission from the beneficiaries of the estate and/or the probate court before filing this lawsuit. Bound by potentially conflicting duties to the estate and its beneficiaries and to putative class members, Plaintiff is an unsuitable representative under Rule 23(a). See *First Interstate Bank*, 837 F.2d at 781 (finding that given the potential conflict of interest, the Estate would need to provide, at minimum, record evidence that all the beneficiaries consented to the class representation); see also *In re FleetBoston*, 253 F.R.D. at 323-326 (relying on *First Interstate* and refusing to appoint executor as class representative where record contained no evidence of consent by estate beneficiaries or probate order approving executor's pursuit of class action). Because Plaintiff's role as both a personal representative of an estate and a class representative

creates a conflict of interest, Plaintiff cannot be an adequate representative of the class as a matter of law.

IV. CONCLUSION

For the foregoing reasons, Defendants' motion to dismiss pursuant to SCRCP 12(b)(1) and 12(b)(6), and motion to strike pursuant to 12(f) should be granted.

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February 19, 2019
Columbia, South Carolina

EXHIBIT A

MUSC GROUP HEALTH BENEFITS PLAN FOR
EMPLOYEES OF THE MEDICAL UNIVERSITY OF
SOUTH CAROLINA AND THE MEDICAL
UNIVERSITY HOSPITAL AUTHORITY

ADOPTED BY
THE STATE PUBLIC EMPLOYEE BENEFIT AUTHORITY
Effective January 1, 2017

S.C. Public Employee Benefit Authority
202 Arbor Lake Drive
Columbia, South Carolina 29223
803-737-6800

ARTICLE 1.

ESTABLISHMENT AND PURPOSE OF PLAN

1.1 Name and Purpose

The name of this Plan is the MUSC Group Health Benefits Plan for Employees of Medical University of South Carolina and Medical University Hospital Authority (hereinafter "MUSC Health Plan" or "Plan"). The State of South Carolina ("the State"), through the Public Employee Benefit Authority ("PEBA") Insurance Benefits has established a self-funded employee welfare benefit plan for the exclusive benefit of the participants and has adopted this Plan. The purpose of this Plan is to provide for the payment of illness, accident, or other benefits to the participants of this Plan and their eligible dependents.

1.2 Establishment and Effective Date

The MUSC Health Plan was established on January 1, 2014. This Plan, as amended, became effective January 1, 2017.

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 that conflicts with the law of any governmental body or agency having 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 Summary Plan Guide

The Plan Administrator shall provide to eligible Subscribers a summary plan guide containing a summary of the benefits of this Plan and the rights and obligations of Covered Persons under this Plan. The Guide may provide more detail than this Plan document, but in the event of a conflict between the Guide and the Plan, the Plan is controlling.

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 Subscribers 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 no increase or reduction in benefits shall be effective with respect to expenses Incurred prior to the date a material change was adopted by the Planholder, regardless of the effective date of the change.

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 Subscribers. 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 Subscriber if sent by regular mail, postage prepaid, to the last address of such Subscriber, on the records of the Plan Administrator. Subscribers shall be solely responsible for providing the Plan Administrator with a current address and notifying the Plan Administrator in writing of any change in the Subscriber's address.

1.10 Waiver

The failure of the Plan Administrator to enforce strictly any provision of this Plan shall not be construed as a waiver of the provision. Rather, the Plan Administrator reserves the right to enforce strictly 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 PEBA Insurance Benefits, 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, nor shall any such Clerical Errors cause to be in force or to continue in force coverage that 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 Subscriber.

1.12 Workers' Compensation

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

1.13 Headings

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

1.14 Misstatements and Omissions

If any relevant fact has been misstated or omitted, in whole or in part, whether intentional or not, by, or on behalf of, any person on an application, the Notice of Election Form, or other document, or information submitted or required to be submitted to the Plan Administrator, Third Party Claims Processor, or Utilization Review Agency to obtain or retain coverage under this Plan, the true facts shall be used to determine whether coverage is in force and the extent, if any, of such coverage. Upon the discovery of any such misstatement or omission, coverage may be terminated prospectively. If the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact, coverage may be terminated retroactively to the date of the act, practice, or omission, and an equitable adjustment of any contributions may be made and the

Plan Administrator may recover the amount of any claims paid in error due to the act, practice, or omission.

1.15 Use of Social Security Numbers on Application

The Plan is required by federal law to obtain the Social Security Number of each Covered Person. The Subscriber's Social Security 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 Subscriber.

ARTICLE 2.

DEFINITIONS

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

2.1 Active Employee

An Employee who is engaged in Active Employment.

2.2 Active Employment

The Employee is actively at work on a Full-Time basis, performing all the regular duties of their occupation at an established business location of the Employer or another location to which they may be required to travel to perform the duties of their employment. An Employee shall be deemed to be engaged in Active Employment while on jury duty or on any regular nonworking day including holidays or vacation days established and published by the Employer if the Employee was engaged in Active Employment on the last preceding regular working day. Provided the Employee's participation in the Plan will not be prevented or delayed if (i) the Employee's absence from work is due to any health-related reason, including a medical condition, Hospital confinement, or a disability; or (ii) the Employee is on leave under the Family and Medical Leave Act on the Effective Date of this Plan. In no event, however, will an Employee be considered to be in Active Employment if they have not reported for work or if they or their Employer has effectively terminated their employment.

2.3 Advanced Practice Registered Nurse

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

2.4 Agent for Service of Process

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

2.5 Alcoholism

A morbid state caused by excessive and compulsive consumption of alcohol that interferes with

the patient's health and social or economic functioning.

2.6 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.

2.7 Allowed Amount

The amount established by the Plan Administrator in the Schedule of Reimbursement Rates for the applicable Provider Network. For charges not included in the Schedule of Reimbursement Rates, the Allowed Amount 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, unless the charge is specifically excluded by this Plan or by other terms and conditions of coverage. In the absence of data referred to above, the Third Party Claims Processor, through its medical staff or medical consultants, will determine the Allowed Amount based upon comparable or similar services or procedures.

2.8 Alternative Treatment Plan

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

2.9 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.) devoted full-time to such supervision and who permits a surgical procedure to be performed only by a duly-qualified Physician privileged to perform such procedure in at least one area Hospital, as defined in this Plan, at the time the procedure is performed;
- 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 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, laboratory tests, and x-rays; an operative report; and a discharge summary.

2.10 Ambulatory Surgical Center Network

A group of Ambulatory Surgical Centers, which have contracted with the Plan Administrator or Third Party Claims Processor to accept from the State a payment methodology for medical services rendered by the Ambulatory Surgical Center to Covered Persons utilizing the Tier B State Health Plan component of the Plan.

2.11 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.

2.12 Behavioral Health Manager

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

2.13 Behavioral Health Provider

A psychiatrist, psychologist, psychological/neuropsychological tester, Master's Level Therapist, Registered Nurse (including Advanced Practice Registered Nurse), full Board Certified Behavior Analyst (for Applied Behavioral Analysis only), or any other entity or individual or institutional health care provider eligible to participate in the Behavioral Health Provider Network and acting within the scope of their or its own current, active license.

2.14 Child

Shall mean and include a Subscriber's:

- A. natural child;
- B. stepchild;
- C. adopted child;

- D. child placed for adoption, which means the Subscriber has assumed and retains a legal obligation for total or partial support of the child in anticipation of adopting the child;
- E. foster child, placed by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;
- F. child for whom Subscriber has legal custody, which means Subscriber has guardianship responsibility as well as financial responsibility; and
- G. child for whom Subscriber is required to provide health insurance due to a court order.

2.15 Chiropractic Services

Any service payable by the Plan and provided by a licensed chiropractor.

2.16 Clerical Error

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

2.17 Coinsurance

That percentage of the Allowed Amount for Covered Medical Benefits, in excess of the individual or Family Deductible, that is payable by the Covered Person under the tier of the Plan utilized.

2.18 Congenital

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

2.19 Co-payment

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

2.20 Cost Sharing

Amounts paid by a Covered Person for Medical Care or Prescription Drug Expenses, including Deductibles, Coinsurance and Co-payments. The term does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

2.21 Covered Dependent

A Subscriber's Dependent, who has met the eligibility requirements and is enrolled under the Plan.

2.22 Covered Employee

An Employee who has met the eligibility requirements and is enrolled under this Plan.

2.23 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.

2.24 Covered Medical Benefit

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.

2.25 Covered Medical Benefits Coinsurance Maximum

Means the total of the eligible Medical Benefits Coinsurance payable by the Covered Employee in one Plan Year for individual or family Covered Medical Benefits before the Plan provides coverage for 100 percent of the Allowed Amount for Covered Medical Benefits, not including applicable Co-payments, as set out in paragraphs 7.1.A.4, 7.1.B.4 and 7.1.C.4.

2.26 Covered Person

A Subscriber, or a Dependent thereof, who has met the eligibility requirements, is enrolled in this Plan, and to whom benefits are payable under this Plan.

2.27 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 that usually can be self-administered and that does not entail or require the continuous attention of trained medical personnel, and that does not require the skills of qualified technical or professional caregiver.

2.28 Deductible

The annual aggregated Allowed Amount of charges for which the Covered Person is financially responsible before the Plan has financial responsibility, as indicated in paragraphs 7.1.A.1, 7.1.B.1, and 7.1.C.1. Co-payments do not apply toward satisfaction of the Deductible, and Co-payments continue to apply after the Deductible has been met. There is an individual Deductible and a family Deductible. Under paragraph 7.1.A.1, there is a Deductible of \$385 for an individual and \$770 for family with respect to services under Tier A, the PCMH component of the Plan. Under paragraph 7.1.B.1, there is a Deductible of \$445 for an individual and \$890 for family with respect to services under Tier B (in-network State Health Plan Networks) of the Plan. Under paragraph 7.1.C.1 there is a Deductible of \$445 for an individual and \$890 for family with respect to services under Tier C (Out of Network) of the Plan. Amounts paid by a Covered Person for allowed charges under any tier of the Plan, other than Co-payments, are counted toward the Tier A Deductible or the Tier B/Tier C Deductible without distinction. Thus, amounts required to be paid by the Covered Person because an applicable Deductible has not been met in any tier count toward the satisfaction of the Tier A Deductible and the Tier B/Tier C Deductible.

2.29 Dependent

Shall mean and include a Subscriber's:

- A. **Dependent Spouse.** Legally recognized spouse under South Carolina law, or former spouse who is required to be covered by either a divorce decree or court order, but not both the spouse and former spouse. Provided, however, that if a spouse is also eligible for coverage or benefits as an Employee of the State, public 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. Dependent Child.** Child younger than 26 years of age. The Plan Administrator may require the Subscriber to submit due proof of the Child's relationship with the Subscriber within 31 days of enrollment, and at such other reasonable times;
- C. Incapacitated Dependent Child.** Unmarried Child, 26 years of age or older, who is incapable of self-sustaining employment because of mental illness, retardation, or physical handicap and is principally dependent (more than 50 percent) on the Subscriber 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 Subscriber to submit due proof of such incapacity and dependency satisfactory to the Plan Administrator within 31 days of initial enrollment, upon attaining age 26, and at such other reasonable times, but not more frequently than annually. It shall be the Subscriber's responsibility to notify the Plan Administrator when the Child is no longer incapacitated.

2.30 Diagnosis Related Groups ("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 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.

2.31 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 that is medically prescribed or administered.

2.32 Durable Medical Equipment

Any equipment that:

- 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.

2.33 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 but no earlier than January 1, 2017.

2.34 Employee

A person employed by the Medical University of South Carolina or the Medical University Hospital Authority on a Full-Time basis, and who receives compensation from the Employer. If an Employer elects to obtain other health insurance coverage for its persons employed on a nonpermanent, Full-Time basis, such persons do not constitute Employees under this paragraph.

2.35 Employer

The Medical University of South Carolina and Medical University Hospital Authority.

2.36 Enrollment Date

The Enrollment Date is (i) for Employees, the hire date; (ii) for persons who enroll under the special eligibility situations of paragraph 3.7, the effective date of coverage.

2.37 Family

A Subscriber and their Covered Dependents.

2.38 Full-Time

Shall mean an Employee who is credited with an average of at least 30 hours of service per week. Provided, however, an Employer may exercise a one-time, irrevocable option to elect the definition of Full-Time to mean an Employee who is credited with an average of at least 20 hours of service per week, and to apply this definition, upon notification to, and acceptance by, PEBA Insurance Benefits. Full-Time status for purposes of eligibility to participate in the Plan is determined in accordance with the process set out in paragraphs 3.15, 3.16, and 3.17 of the Plan.

2.39 Full-Time Permanent

Shall mean a permanent Employee who works at least 30 hours per week. Provided, however, an Employer may exercise a one-time, irrevocable option to elect the definition of Full-Time to mean a permanent Employee who works at least 20 hours per week, and to apply this definition, upon notification to, and acceptance by, PEBA Insurance Benefits.

2.40 Health Care Professional

A Physician or other licensed health care provider acting within the scope of their or its current, active license.

2.41 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.

2.42 Hospice Agency

A private or public agency or organization that administers and provides care for terminally ill patients (i) pursuant to a written treatment plan approved by a Physician and reviewed at least once a month by the Physician, and (ii) that is licensed or certified as a Hospice or Hospice care

agency by the appropriate state regulatory agency, if licensing is required.

2.43 Hospital

- A. For other than a psychiatric facility, a short-term acute care (i) general Hospital, (ii) children's Hospital, (iii) eye, ear, nose, and throat Hospital, (iv) maternity Hospital, or (v) long-term acute care 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 nurses physically present and on duty. Such institutions or facilities, 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 Healthcare Organizations or a similarly nationally recognized accrediting organization.
- B. A psychiatric facility for the treatment of Behavioral Health Disorders, Drug Abuse, or Alcoholism, that, for compensation from their patients and on an inpatient basis, 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 nurses physically present and on duty. Such institutions or facilities for Behavioral Health Disorders, or Drug Abuse, 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 Healthcare Organizations or a similarly nationally recognized accrediting organization.
- 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 (i) rest, (ii) the aged, (iii) rehabilitative care, whether or not such institution or facility is affiliated with or part of a Hospital, except as provided in paragraph 7.16 Rehabilitation Care, (iv) cognitive/behavioral rehabilitative care, and (v) community re-entry programs.

Determination of whether an institution or facility is for long-term chronic care, the treatment of Behavioral Health Disorders, or 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's or facility's applicable license to provide specific services.

2.44 Hospital or Ambulatory Surgical Center Charges

The Allowed Amount for Medically 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.

2.45 Hospital Network

The MUSC Health Plan Hospital Network and the State Health Plan Hospital Network.

2.46 Incurred

An expense, charge, penalty, or benefit is Incurred for purposes of this Plan on the date the service or supply charged was rendered or received.

2.47 Intensive Care Unit

A separate, clearly designated service area maintained within a Hospital that 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.

2.48 Intermittent

Shall mean part-time Skilled Nursing or Home Health care provided on a less than daily basis for up to four hours per day, or Skilled Nursing or Home Health care provided on a daily basis not to exceed eight hours per day, for fixed and definite 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 for exceptional circumstances. The period of such extension must be predictable and fixed. Intermittent care is subject to the requirements of pre-approval by the Utilization Review Agency, and all limitations and exclusions on such benefits in paragraphs 7.11 Hospice Care and 7.13 Home Health Care Services.

2.49 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.

2.50 Medical Necessity, Medically Necessary, or Necessary Service and Supply

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

- A. Is required to identify or treat an existing condition, illness, or injury; and
- B. Is prescribed or ordered by a Physician; and

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

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

2.51 MUSC Health Plan Hospital Network

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

2.52 MUSC Health Plan Physician Network

Those Health Care Providers who have contracted with the Plan Administrator or a Third Party Claims Processor to accept from the State a standard payment methodology for their services rendered to Covered Persons utilizing the Tier A component of the Plan.

2.53 Obstetrical Care

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

2.54 Open Enrollment Period

The period held in October of every year, more fully described in paragraph 3.16, when any eligible Subscriber may enroll or disenroll themselves or eligible Dependents in the Medical Benefits Program without regard to any special eligibility situations. Changes made during the Open Enrollment Period will become effective the following January 1.

2.55 Orthopedic Appliance

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

2.56 Outpatient

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

2.57 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.

2.58 Patient-Centered Medical Home

A health care setting that facilitates partnerships between individual patients, their personal

physicians and, when appropriate, the patient's family. Care is facilitated by patient registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it, and in a culturally and linguistically appropriate manner.

2.59 Pharmacy Benefits Manager

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

2.60 Physician

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

2.61 Plan

This MUSC Health Plan.

2.62 Planholder

The State of South Carolina, which provides the health plan for Employees of the Medical University of South Carolina and the Medical University Hospital Authority by law through PEBA.

2.63 Plan Administrator

The South Carolina Public Employee Benefit Authority.

2.64 Plan Year

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

2.65 Predecessor Plan

Shall mean: (1) the State Health Plan established January 1, 1990, as amended, 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.

2.66 Pre-Certification or Certification

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

2.67 Prescription Drug Program

The Prescription Drug Program is administered by the Pharmacy Benefits Manager which coordinates activities relating to prescription drug claims under the Plan. This includes, but is not limited to, processing of drug claims, managing the network of pharmacies that have agreed to accept a contracted payment methodology for prescription drugs, providing drug utilization review to determine appropriateness of the medication and its use, providing a drug formulary consisting of drugs with differing patient payment tiers, which may include non-coverage of certain brand products, providing specialty pharmacy programs to promote the cost effective use of specialty medication, and other activities designed to promote cost effectiveness.

2.68 Preventive Care

Means the following: a) evidence-based items or services with an A or B rating in the current recommendation of the United States Preventive Services Task Force (USPSTF) with respect to the Covered Person involved; b) immunizations for routine use in children, adolescents, or adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person Involved; c) evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and d) other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women. The above Preventive Care services are required to be provided to participants with no Cost Sharing and are rendered solely for the purpose of health maintenance and not for the treatment of an illness. Recommendations and guidelines will be covered by this Plan on the first Plan Year that begins on or after the date that is one year after the date the recommendation or guideline is issued. A complete list of all required recommendations and guidelines is available at <https://www.healthcare.gov/coverage/preventive-care-benefits/>. The Plan will use reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service to the extent not specified in the recommendation or guideline.

2.69 Primary Care Physician

The personal Physician a Covered Person selects from the MUSC Health Plan Physician Network to coordinate all aspects of care when the Covered Person is utilizing the Tier A MUSC Health Plan component of the Plan.

2.70 Professional Ambulance

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

2.71 Prosthetic Appliance

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

2.72 Provider

A Physician, Advanced Practice Registered Nurse, Behavioral Health Provider, Ambulatory Surgical Center, Free Standing Emergency Care Center, or Hospital, as those terms are defined in this Plan.

2.73 Provider's Billed Charges

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

2.74 Room and Board

Room, board, general duty nursing, and any other services, supplies, or items regularly furnished by the Hospital and included in the total charge as a condition of occupancy of the class of

accommodations occupied, including blood. Room and board does not include professional services of Physicians or intensive nursing care by whatever name called.

2.75 Schedule of Reimbursement Rates

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

2.76 Second Opinion

A Second Opinion shall mean and consist of the Covered Person obtaining an examination or evaluation from a second qualified Physician to either confirm or challenge the Medical Necessity of a recommended, elective, non-emergency surgical procedure, medical procedure, treatment, or hospitalization for treatment of mental illness or chemical dependency prior to undergoing or continuing the treatment, hospitalization, or procedure.

2.77 Semi-Private Room

A Hospital room containing two or more patient beds.

2.78 Skilled Nursing Care

The skilled nursing and skilled rehabilitation services furnished according to Physician's orders that require: (a) the skills of a qualified technical or licensed professional health care provider 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.

2.79 Skilled Nursing Facility

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

- A.** Maintains permanent and full-time facilities for bed care of resident patients; and
- B.** Has available at all times the services of a Physician; and
- C.** Has a registered nurse (R.N.) or Physician on full-time duty in charge of patient care, and one or more registered nurses (R.N.) or licensed practical nurses (L.P.N.) on duty at all times; and
- D.** Maintains a daily medical record for each patient; and
- E.** Is primarily engaged in providing continuous Skilled Nursing Care for sick or injured persons during the convalescent stage of their illness or injuries and is not, other than incidentally, a rest home or a home for Custodial Care or for the aged; and
- F.** Is operating lawfully as a nursing home in the jurisdiction where it is located.

In no event, however, shall such term include an institution or facility primarily engaged in the care

or treatment of Drug Abuse or Alcoholism.

2.80 Specialty Physician

A Physician who provides specialty care to a Covered Person who is utilizing the Tier A MUSC Health Plan component of the Plan upon referral from a Primary Care Physician.

2.81 State

The State of South Carolina.

2.82 State Health Plan Hospital Network

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

2.83 State Health Plan Physician Network

Those health care providers who have contracted with the Plan Administrator or a Third Party Claims Processor to accept from the State a standard payment methodology for their services rendered to Covered Persons under the Tier B State Health Plan component of the Plan.

2.84 Subscriber

An Active Employee, Surviving Child/Surviving Spouse, or COBRA enrollee of the Employer.

2.85 Surgery

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

2.86 Surviving Child

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

2.87 Surviving Spouse

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

2.88 Telehealth

The exchange of a Covered Person's information during which the Covered Person can have a telephone or video consultation with a licensed health care professional. Telehealth does not require two-way audio or video consultations between a Referring Provider and Consulting Provider, as these terms are defined in Section 2.86.

2.89 Telemedicine

The exchange of a Covered Person's information from one eligible referring licensed provider (for purposes of Telemedicine outlined herein, the "Referring Provider") site to another eligible consulting licensed Provider (for purposes of Telemedicine outlined herein, the "Consulting

Provider") site for the purpose of providing medical care to a Covered Person in circumstances in which in-person, face-to-face contact with the Consulting Provider is not necessary. The exchange must occur via two-way, real-time, interactive, HIPAA-compliant, electronic audio and video telecommunications systems.

2.90 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 prescription drug claims, and the Behavioral Health Manager, which processes Behavioral Health claims.

2.91 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 Benefits under the Plan to Covered Persons.

2.92 Utilization Review Agency

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

ARTICLE 3.

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

3.1 Eligibility

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

- A.** All Employees and their Dependents, provided however, that a spouse of a Covered Employee who is also an Employee may be covered only as an Employee and not as a Dependent;
- B.** The Surviving Spouse and Surviving Child of a deceased Covered Employee;
- D.** All Employees and Dependents eligible for coverage as the result of COBRA under Article 11.

3.2 Employee Enrollment

To enroll under this Plan, each eligible Employee must complete within 31 days of their eligibility for coverage: (i) a Notice of Election, and (ii) 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 paragraph 3.7, Special Eligibility Situations, such Employee may be enrolled for coverage only during such Open Enrollment Periods or Special Eligibility Situations 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 elects coverage under this Plan 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.
- 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 (i) on the first day of the month that the Employee commences Active Employment, provided that the Employee commences Active Employment on the first calendar day of that month; or (ii) on the first day of the following month provided that the Employee commences Active Employment on any day other than the first calendar day and the first working day of the month. Otherwise, if the Employee commences Active Employment on the first working day of the month, other than the first calendar day of the month, the Employee may choose to commence coverage under this Plan on either the first day of that month or the first day of the following month. For purposes of this paragraph, the first working day of the month is the first day that is not a Saturday, Sunday, or holiday. The first working day of the month is not an Employer-specific first working day.

3.4 Eligibility for Dependent Coverage

Each Employee, who has one or more Dependents on the date the Employee becomes eligible for coverage, shall be eligible to enroll each Dependent for coverage on such date. Each Employee without a Dependent on the date the Employee becomes eligible for coverage shall be eligible to enroll each Dependent for coverage on the date the Employee acquires a Dependent. In both cases, the Employee must meet the requirements of paragraph 3.5 below.

3.5 Dependent Enrollment

To obtain Dependent coverage under this Plan, each eligible Employee must be covered under this Plan and file a timely Notice of Election form selecting Dependent coverage for eligible Dependents. If the Employee acquires a Dependent as defined herein after the Effective Date of the Employee's coverage, the Employee has 31 days from the date the Dependent was acquired to enroll the Dependent 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 or Special Eligibility Situations as may be established by the Plan Administrator.

3.6 Commencement of Dependent Coverage

Each eligible Employee, who has satisfied the requirements of paragraph 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 they were acquired.

3.7 Special Eligibility Situations

A. Adding Coverage. If an Employee has not enrolled themselves or eligible Dependents for coverage within 31 days of first becoming eligible or during a prior Open Enrollment Period and subsequently wishes to elect such coverage, the Employee may do so under the following Special Eligibility Situations. If the Employee does not do so within the time frame specified for a Special Eligibility Situation, they must wait for the next Open Enrollment Period.

1. An Employee's Child may be added within 31 days of:
 - a. the Child's birth;
 - b. adoption of the Child;
 - c. the Child's placement for adoption;
 - d. the Child's placement for foster care;
 - e. the Child becoming a stepchild;
 - f. the Employee gaining legal custody of the Child; or
 - g. the date of other court order mandating coverage of the Child by the Employee.

Coverage under this paragraph shall commence on the day of the event described in this subparagraph. The Employee must submit a Notice of Election within 31 days of the date of the event. Satisfactory documentation of the circumstances surrounding the event must accompany the Notice of Election. The Employee and all eligible Dependents may be enrolled in coverage at this time.

2. An Employee's spouse may be added within 31 days of marriage. Coverage under this paragraph shall commence on the date of the marriage. The Employee must submit a Notice of Election within 31 days of the date of the marriage. Satisfactory documentation of the circumstances surrounding the marriage must accompany the Notice of Election. The Employee and all eligible Dependents may be enrolled in coverage at this time.
3. An Employee, Employee's spouse, or Employee's Child covered under the employer health plan of the Employee's spouse and who subsequently loses coverage because
 - a. the spouse's employer canceled its present group insurance,
 - b. the spouse's employer canceled its contribution to its group insurance,
 - c. death of a the Employee's spouse; or
 - d. the Employee's spouse left such employment or experienced a reduction in hours

is eligible for coverage under this Plan commencing on the date of loss of coverage. The Employee must submit a Notice of Election within 31 days of the date of loss of coverage. A satisfactory statement of the circumstances surrounding the loss of coverage must accompany the revised Notice of Election.

4. An Employee, Employee's spouse, or Employee's Child who loses coverage under another employer's health plan because of
 - a. legal separation,
 - b. divorce,
 - c. cessation of dependent status; or
 - d. other similar loss of coverage

is eligible for coverage under this Plan commencing on the date of loss of coverage. The Employee must submit a Notice of Election within 31 days of the date of loss of coverage. A satisfactory statement of the circumstances surrounding the loss of coverage must accompany the revised Notice of Election.

5. An Employee, Employee's spouse, or Employee's Child who
 - a. loses coverage under Medicaid or CHIP because of loss of eligibility may enroll for coverage within 60 days of the loss of coverage; or
 - b. becomes eligible for a premium assistance subsidy under Medicaid or CHIP may enroll within 60 days of when eligibility for premium assistance subsidy is determined.

Coverage for the Employee, the Employee's spouse, or the Employee's Child enrolled under this paragraph shall commence on the date of loss of Medicaid or CHIP coverage, or the date eligibility for premium assistance is determined. The Employee must submit a Notice of Election within 60 days of the date of loss of coverage or date eligibility for premium assistance is determined. A satisfactory statement of the circumstances surrounding the loss of coverage or determination of eligibility for premium assistance must accompany the Notice of Election.

6. Upon the addition of an Employee's spouse or Employee's Child to the Employee's coverage under 3.7.A.1–5, the Employee may change the selected coverage under the Plan.
7. An Employee, Employee's spouse, or Employee's Child who was mobilized or called to active duty with the National Guard or a Reserve unit and who dropped coverage under this Plan may re-enroll in the Plan upon discharge or release from active duty and resumption of employment with an eligible Employer. The Employee must submit a Notice of Election within 31 days of discharge, release from active duty, or resumption of employment, whichever is latest.

B. Dropping Coverage. An Employee or Covered Dependents who otherwise continue to meet eligibility requirements under the Plan may drop coverage in the following Special Eligibility Situations. If the Employee does not do so within the time frame specified for a Special Eligibility Situation, the Employee and Covered Dependents either must wait (1) for the next Open Enrollment Period or (2) for the Employee Covered Dependents to cease meeting eligibility requirements under the terms of the Plan for coverage to be dropped.

1. An Employee or Covered Dependent who acquires other employer group coverage may drop coverage within 31 days. Coverage under this paragraph shall end on the first of the month after the gain of other coverage or on the first of the month if coverage is gained on the first of the month. The Employee must submit a Notice of Election within 31 days of the gain of other employer group coverage. Satisfactory documentation of the circumstances surrounding the event must accompany the Notice of Election.
2. An Employee's spouse may be dropped within 31 days of divorce or legal separation. Coverage under this paragraph shall end on the first of the month after the Notice of Election is submitted. The Employee must submit a Notice of Election within 31 days of the date of the event. Satisfactory documentation of the circumstances surrounding the event must accompany the Notice of Election.
3. An Employee or Covered Dependent who
 - a. gains coverage under Medicaid or CHIP may drop coverage within 60 days of the gain of coverage; or
 - b. loses eligibility for a premium assistance subsidy under Medicaid or CHIP may drop coverage within 60 days from the date of notification of loss of eligibility.

Coverage for the Employee or Covered Dependent dropped under this paragraph shall end on the date of gain of Medicaid or CHIP coverage, or the date of the notification regarding loss of eligibility for premium assistance. Otherwise, coverage shall end the first of the month following the submission of a Notice of Election, if provided in accordance with the time limits in this paragraph. The Employee must submit a Notice of Election within 60 days of the notification of gain of coverage or within 60 days of notification of loss of eligibility for premium assistance. A satisfactory statement of the circumstances surrounding the loss of coverage or determination of eligibility for premium assistance must accompany the revised Notice of Election.

C. Other Changes in Status or Applicable Events. An Employee may change and make a new election or revoke an election to participate in the Plan during the Plan Year if the Employee is otherwise allowed to make an election change under the Flexible Benefits Plan for Employees of the State of South Carolina and Local Subdivisions.

E. Notification Obligations. Each Employee must notify the Plan Administrator as soon as possible of: (i) a change in address; (ii) entrance into the military; (iii) eligibility or entitlement for Medicare; (iv) an individual ceasing to be a Dependent under the terms of the Plan; or (v) any other change in status or other applicable event that might affect the Employee's or the Employee's Dependents' coverage under Plan. If an Employee does not provide such notice, the Employee may be liable for the costs, fees, and expenses incurred by the Plan,

the Plan Sponsor, the Plan Administrator, or the Employer for failure to notify. The Plan Administrator may request whatever documentation it deems necessary to substantiate a claimed change in status or other applicable event. The failure to notify the Plan Administrator of any event listed above or other events affecting eligibility under the Plan may be deemed by the Plan Administrator to be an act that constitutes fraud and an intentional misrepresentation of material fact prohibited by the Plan, which may result in a retroactive termination of coverage. Coverage under the Plan will not continue beyond the last date of eligibility even if an Employee has failed to provide notice as required by this paragraph.

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 during which:

- A. The Employee's employment terminates;
- B. The Employee ceases to qualify as an Employee;
- C. The Employee ceases to be in a class of Employees eligible for coverage;
- D. Coverage is discontinued with respect to the class of Employees to which such Employee belongs; or
- E. This Plan is terminated with respect to all Employees.

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. When the Employee's contribution becomes 60 days past due, coverage will terminate retroactively to the last day of the month for which the Employee paid the full premium. When an Employee dies, coverage terminates 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 during which:

- A. The Employee ceases to be in a class of Employees eligible for Dependent coverage under this Plan;
- B. All Dependent coverage under this Plan terminates;
- C. Any particular Dependent ceases to be a Dependent of the Employee under paragraph 2.29. The existing coverage of any Surviving Child will not be affected by the remarriage of the Surviving Spouse;
- D. 31 days have lapsed since the date of birth of a newborn, unless the Employee has enrolled the newborn as required by paragraph 3.5; or
- E. Under such other conditions as established by the Planholder.

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. When the Employee's contribution becomes 60 days past due, coverage will terminate retroactively to the last day of the month for which the Employee paid the full premium. When an Employee or a Covered Dependent dies, coverage terminates on the day following the date of death of the Employee or the Covered Dependent. However, after death of the Employee, coverage of the Covered Dependent may continue under Article 10, Continuation of Coverage, or Article 11, COBRA. The existing coverage of any Surviving Child will not be affected by the remarriage of the Surviving Spouse.

3.10 Effect of Divorce or Annulment on Dependent Eligibility

A Child of an Employee who was covered under Section 2.26.C and 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 2.29.C are met.

3.11 Open Enrollment

An Open Enrollment Period will be held during the month of October every year for an effective date of coverage on the following January 1. 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.

3.12 Termination of Retiree's Coverage

An Employee who retires shall terminate participation in this Plan as of midnight on the last day of the month during which he retired.

3.13 Termination of Coverage of Survivors; Continuation of Coverage

The coverage of a Surviving Spouse and Surviving Children of a deceased Employee shall terminate as provided in paragraphs 3.9 unless extended under the Continuation of Coverage provisions in Article 10.

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

All rights to receive benefits provided under this Plan for services Incurred by 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.

3.15 Ongoing Employees

- A.** An Ongoing Employee is an Employee who has been employed by an Employer for an entire Standard Measurement Period, as that term is defined in paragraph 3.15.B.

- B. A Standard Measurement Period for Ongoing Employees begins on October 4th of each calendar year and ends on October 3rd of the next calendar year. For Plan Year 2017, the Standard Measurement Period runs from October 4, 2015, and ends on October 3, 2016.
- C. An Ongoing Employee meeting the requirements of paragraph 3.22.E may enroll annually during an Open Enrollment Period with coverage effective for a Standard Stability Period beginning the following January 1st. For Plan Year 2017, the Administrative Period begins October 4, 2016, and ends on December 31, 2016. Notwithstanding the length of the Administrative Period, all enrollment documents must be filed with PEBA during the Open Enrollment Period.
- D. A Standard Stability Period for Ongoing Employees begins January 1 of each year and ends on the following December 31, and is synonymous with the Plan Year as defined in paragraph 2.64.
- E. An Ongoing Employee who is credited by their Employer with an average of at least 30 hours of service per week after completing a Standard Measurement Period is eligible to enroll under this Plan during the Open Enrollment Period held during the Administrative Period for coverage that will be effective for the entire duration of the following Standard Stability Period, provided the Ongoing Employee does not otherwise experience a termination event under the Plan. An Ongoing Employee who remains employed during a Standard Stability Period is eligible throughout that Standard Stability Period, regardless of the number of hours worked during that Standard Stability Period. An Ongoing Employee who ceases work and is not credited with an hour of service for less than 13 weeks (26 weeks for educational institutions) and who then resumes work with the same Employer during the same Standard Stability Period will be eligible to resume participation in the Plan as of the first day of the calendar month following resumption of work, even if the Ongoing Employee resumes employment in a position that is not reasonably expected to be a Full-Time position.
- F. An Ongoing Employee who has been found not to meet the 30-hour-per-week average during a Standard Measurement Period is not eligible for the Plan as an Ongoing Employee through the entirety of the following Standard Stability Period. However, such an Employee may be eligible for some or all of such Standard Stability Period under another provision of this Plan, such as reclassification of employment.
- G. In the case of a conflict between another provision of this Plan and this paragraph, this paragraph will govern an Ongoing Employee's eligibility and coverage. The Ongoing Employee's coverage is otherwise governed by the entirety of this Plan.

3.16 New Variable Hour, New Part-Time, and New Seasonal Employees

A. Definitions

- 1. A New Part-Time Employee is a new Employee who has not completed a Standard Measurement Period and who, upon hire, is reasonably expected to be employed on average fewer than 30 hours of service per week during an Initial Measurement Period, as defined in paragraph 3.16.B.

2. A New Seasonal Employee is a new Employee who has not completed a Standard Measurement Period and who is hired into a position for which the customary annual employment is six months or fewer. The reference to customary means that by the nature of the position, an Employee in this position typically works for a period of six months or fewer, and that period begins each calendar year in approximately the same part of the year, such as summer or winter.
 3. A New Variable Hour Employee is a new Employee who has not completed a Standard Measurement Period and who, upon hire, the Employer cannot determine whether the Employee is reasonably expected to be employed on average at least 30 hours of service per week during an Initial Measurement Period because the Employee's hours are variable or otherwise uncertain.
- B. An Initial Measurement Period for New Variable Hour, Part-Time, and Seasonal Employees begins on the first day of the month following a New Variable Hour, Part-Time, or Seasonal Employee's date of hire and ends twelve months later. A Standard Measurement Period may begin during, and run concurrently with, portions of an Initial Measurement Period.
 - C. A New Variable Hour, Part-Time, or Seasonal Employee meeting the requirements of paragraph 3.16.E may enroll during an Initial Administrative Period beginning the day following the end of their Initial Measurement Period and ending the last day of the same calendar month.
 - D. An Initial Stability Period for New Variable Hour, Part-Time, and Seasonal Employees begins the first of the calendar month after the end of the Initial Administrative Period and ends the day before in the following calendar year.
 - E. A New Variable Hour, Part-Time, or Seasonal Employee who is credited by their Employer with an average of at least 30 hours of service per week after completing an Initial Measurement Period is eligible to enroll in coverage under this Plan during the Administrative Period and for the entire duration of the following Initial Stability Period. A New Variable Hour, Part-Time, or Seasonal Employee who remains employed during an Initial Stability Period is eligible throughout that Initial Stability Period, regardless of the number of hours worked during that Initial Stability Period. A New Variable Hour, Part-Time, or Seasonal Employee who ceases work and is not credited with an hour of service for less than 13 weeks (26 weeks for educational institutions) and who then resumes work with the same Employer during the same Initial Stability Period will be eligible to resume participation in the Plan as of the first day of the calendar month following resumption of work, even if the New Variable Hour, Part-Time, or Seasonal Employee resumes employment in a position that is not reasonably expected to be a Full-Time position.
 - F. A New Variable Hour, Part-Time, or Seasonal Employee who has been found not to work an average of at least 30 hours per week during an Initial Measurement Period is not eligible for benefits as a Variable Hour, Part-Time, or Seasonal Employee through the entirety of the following Initial Stability Period. However, such an Employee may be eligible for some or all of such Standard Stability Period under another provision of this Plan (e.g., after becoming an Ongoing Employee and gaining coverage through the provisions of paragraph 3.15). However, if a new Variable Hour, Part-Time, or Seasonal Employee materially changes employment status before the end of the Initial Measurement Period in such a way that, if the Employee had begun employment in the new position, the Employee would have reasonably been expected to be a Full-Time Employee, the Employee will be treated as a

Full-Time Employee and will be eligible for coverage under the Plan no later than the first day of the month following the change in employment status or, if earlier, as of the first day of the first month following the end of the Initial Measurement Period if the Employee averages more than 30 Hours of Service per week during the Initial Measurement Period and related Administrative Period.

- G. Once a New Variable Hour, Part-Time, or Seasonal Employee meets the definition of an Ongoing Employee in paragraph 3.15.A, the Employee's eligibility to participate in the Plan is determined in accordance with the process set out in paragraph 3.15.
- H. In the case of a conflict between another provision of this Plan and this paragraph, this paragraph will govern the New Variable Hour, Part-Time, or Seasonal Employee's eligibility and coverage. The New Variable Hour, Part-Time, or Seasonal Employee's coverage is otherwise governed by the entirety of this Plan.

3.17 New Full-Time Employee

- A. If an Employer reasonably determines, based on the facts and circumstances at the date of hire, that a newly hired Employee will be a Full-Time Employee, the new Employee is eligible to participate in the Plan in accordance with paragraphs 3.2 and 3.3. If the Employee's hours are reduced below the threshold for Full-Time employment before the Employee has completed a full Standard Measurement Period, then the Employee's eligibility will be determined on a month-to-month basis until completion of a Standard Measurement Period.
- B. Once a New Full-Time Employee meets the definition of an Ongoing Employee, the Employee's eligibility to participate in the Plan is determined in accordance with the process set out in paragraph 3.15.

ARTICLE 4.

PAYMENT OR REIMBURSEMENT OF MEDICAL EXPENSES

4.1 Payment for Medical Care

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

ARTICLE 5.

CONTRIBUTIONS

5.1 Employee Contribution

To be covered under this Plan, each eligible Employee 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 who elects to have their 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. A Surviving Spouse or Surviving Child of a deceased Employee who elect coverage under Article 10, Continuation of Coverage; provided, however:
 - 1. For the Surviving Spouse or Surviving Child of an Employee who was killed in the line of duty after December 31, 2001, while working for a State agency or public school district, the full premium for coverage of the Surviving Spouse or Surviving Child is waived for a period of twelve months after the Employee's death. Following the twelve-month waiver, the premium for coverage of the Surviving Spouse or Surviving Child is determined according to paragraph 5.1 as long as eligible.
 - 2. For the Surviving Spouse or Surviving Child of a deceased Employee who was not killed in the line of duty, the full premium for coverage is waived for a period of twelve months after the Employee's death if there was a State contribution to the premium and as long as the Surviving Spouse or Surviving Child is not an Employee and remains eligible for coverage. Following the twelve-month waiver, the Surviving Spouse or Surviving Child may continue coverage as long as eligible by paying the full premium.
- B. Those electing to extend coverage as provided in Article 11 under COBRA (an additional administrative fee may also apply).

5.3 Tobacco-User Surcharge

A tobacco-user surcharge is added to each Subscriber's health coverage contribution who does not certify with PEBA Insurance Benefits as a non-tobacco-user. A tobacco user is a person who uses any tobacco products including but not limited to cigarettes, cigars, pipes, and oral tobacco products. The surcharge is \$40 per Subscriber per month for Subscriber Only coverage or \$60 per Subscriber per month for a Subscriber who covers any Dependents, regardless of the number

of tobacco users covered on the Subscriber's health coverage.

- A. To avoid the tobacco-user surcharge, the Subscriber must certify on a form prescribed by PEBA Insurance Benefits that no one on the Subscriber's health coverage uses or has used tobacco products during the previous six months, or the Subscriber must complete a tobacco cessation program approved by the Plan Administrator within a time period established by the Plan Administrator.
- B. To remove a tobacco-user surcharge, the Subscriber must certify on the form described in subparagraph A. above that no one on the Subscriber's health coverage uses or has used tobacco products during the previous six months, or the Subscriber must provide written proof that the tobacco user(s) has completed a tobacco cessation program approved by the Plan Administrator within a time period established by the Plan Administrator. The tobacco-user surcharge will be removed prospectively for the month following the processing of the certification or receipt of written proof.
- C. If anyone covered on a non-tobacco-user Subscriber's health coverage begins using tobacco, the Subscriber must notify PEBA Insurance Benefits within 30 days of the change. The tobacco-user surcharge will be applied in the following month.
- D. If it is determined that a Subscriber submitted a false certification in order to avoid or remove the tobacco-user surcharge, the Subscriber will be subject to payment of the tobacco-user and non-tobacco user premium difference since last certification.

ARTICLE 6.

DUTIES AND RESPONSIBILITIES

6.1 Planholder Duties

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

- A. The appointment or removal of the Plan Administrator, Third Party Claims Processor, Utilization Review Agency, and other entities or their delegates that implement the Plan;
- B. The design of this Plan, including the right to amend this Plan and any other document relating to this Plan;
- C. The qualification of this Plan under the applicable law;
- D. The formation and maintenance of the funding policy of this Plan;
- E. The amendment and termination of this Plan;
- F. The determination of the amount of participant contributions under this Plan; and
- 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. The Plan Administrator's or its duly authorized agent's decision regarding any construction or interpretation of the Plan; determination of eligibility; 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 is not arbitrary, capricious, or in violation of applicable statutory law. 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 the Plan 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 covered under this Plan;
- D. To be responsible for the reporting and disclosure requirements imposed upon plan administrators under applicable law;
- E. To receive from the State, Subscribers, 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 Plan's financial condition, receipts, and disbursements;
- G. To maintain all records of this Plan;
- H. To review all claims for benefits under this Plan, as necessary;
- 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 Subscribers 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; and
- M. To do all other acts 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, including but not limited to the following:

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

6.4 Duties and Powers of Utilization Review Agency

The 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, verify, 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; to conduct, monitor, and undertake a concurrent review of hospitalizations; and to 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, Subscribers, 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 policies as related to the Plan's Hospital Network; and
- H. To do such other acts as may be necessary, 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 Benefit Design

The Plan's benefit structure is divided into three tiers:

- Tier A benefits apply to care delivered to a Covered Person within the MUSC Health Plan Hospital Network or MUSC Health Plan Physician Network.
- Tier B benefits apply to care delivered to a Covered Person by a provider participating in the State Health Plan Ambulatory Surgical Center Network, State Health Plan Hospital Network, or State Health Plan Physician Network.
- Tier C benefits apply to out-of-network care delivered to a Covered Person by a provider not participating in the State Health Plan Ambulatory Surgical Center Network, State Health Plan Hospital Network, State Health Plan Physician Network, MUSC Health Plan Hospital Network, or MUSC Health Plan Physician Network.

Payment for Covered Medical Benefits 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. Tier A: MUSC Health Plan Benefit

1. **Deductible.** The annual Individual Deductible for care delivered within the Tier A MUSC Health Plan Hospital Network or MUSC Health Plan Physician Network shall be \$385, and a Covered Person shall pay annually the first \$385 of Allowed Amounts Incurred in one Plan Year for Covered Medical Benefits before becoming eligible for Plan benefits under Tier A. Co-payments do not apply toward

satisfaction of the Deductible, and Co-payments continue to apply after the Deductible has been met. The annual Family Deductible shall be \$770. The annual Family Deductible is not considered satisfied for any Covered Person until the Family's total Covered Medical Benefits exceed \$770. Payment of Deductible amounts, by any two or more Family members, totaling \$770 of Covered Medical Benefits for that Plan Year shall satisfy the Deductible for all Covered Persons in that Family. If an Employee's spouse is covered by the State Health Plan Standard Plan, the Employee and Spouse shall share the Tier A MUSC Health Plan Deductible. Amounts paid by a Covered Person for allowed charges under any tier of the Plan, other than Co-payments, are counted toward the Tier A Deductible or the Tier B/Tier C Deductible without distinction. Thus, amounts required to be paid by the Covered Person because an applicable Deductible has not been met in any tier count toward the satisfaction of the Tier A Deductible and the Tier B/Tier C Deductible.

2. **Medical Benefit Coinsurance.** After the Individual or Family Deductible has been met during the Plan Year, the Plan will pay 80 percent of the Allowed Amount for the Covered Person's Covered Medical Benefits for care rendered under the Tier A MUSC Health Plan Hospital Network and MUSC Health Plan Physician Network. Co-payments continue to apply after the Deductible has been met.
3. **Penalty.** A patient, who is a Covered Person, who does not obtain Pre-Certification from the Utilization Review Agency as required by Article 15 for care delivered within the Tier A MUSC Health Plan Hospital Network or MUSC Health Plan Physician Network shall be responsible for all the costs Incurred for these professional services.
4. **Medical Benefit Coinsurance Maximum.** For care delivered within the Tier A MUSC Health Plan Hospital Network or MUSC Health Plan Physician Network, after the annual Deductible has been met and a Covered Person has Incurred in the Plan Year Coinsurance of \$2,200 for Covered Medical Benefits, or Coinsurance of \$4,400 for Covered Medical Benefits Incurred in the Plan Year by any combination of Family members, the Plan will pay 100 percent of the Allowed Amount of the Covered Person's Covered Medical Benefits, except that Co-payments continue to apply after the Medical Benefit Coinsurance Maximum has been reached. Coinsurance amounts paid by a Covered Person in either Tier A or Tier B will count toward both for the Tier A and Tier B Coinsurance Maximum; however amounts Incurred under Tier C do not count toward the Coinsurance Maximum related to care delivered under Tier A or Tier B, and amounts Incurred under Tier A or Tier B do not count toward the Coinsurance Maximum related to care delivered under Tier C. Provided that the penalty in paragraph 3 above is not included in those expenses used to satisfy the Coinsurance Maximum, and provided further, that the Covered Medical Benefits Incurred for such treatment or during such admission are always subject to Coinsurance.
5. **Shared Medical Benefit Co-insurance Maximum.** The payments for Covered Medical Benefits that may satisfy the Deductible and Coinsurance Maximum provisions of paragraphs 7.1.A.1 and 7.1.A.4 are those Incurred by one or more Covered Family members enrolled in the Plan or the State Health Plan.
6. **Cost Sharing.** The cost-sharing set out below is applicable to care delivered to a

Covered Person within the Tier A MUSC Health Plan Hospital Network or MUSC Health Plan Physician Network:

- a. Inpatient-Facility: \$0 copay and no coinsurance or deductible.
- b. Inpatient-Professional: Anesthesia and Other \$0 copay; coinsurance and deductible apply.
- c. Outpatient-Facility-Surgical: \$265 copay; no coinsurance or deductible applies.
- d. Outpatient-Minor Surgery: \$75 copay; no coinsurance or deductible applies.
- e. Outpatient-Facility-Radiological Advanced: \$75 copay; no coinsurance or deductible applies.
- f. Outpatient-Facility-Radiological Regular: \$75 copay; no coinsurance or deductible applies.
- g. Outpatient-Facility-Pathology/LAB: \$20 copay; no coinsurance or deductible applies.
- h. Outpatient-Facility-Preventive ACA: \$0 copay; no coinsurance or deductible applies.
- i. Outpatient-Facility-Clinic Visit: \$0 copay; no coinsurance or deductible applies.
- j. Outpatient-Facility-ER: An Emergency Room visit is subject to a \$159 Co-Payment per Emergency Room visit. Co-payment is waived if the patient is admitted to the Hospital
- k. Outpatient-Facility-Cancer Diagnosis 1: \$0 copay; no coinsurance or deductible applies.
- l. Outpatient-Facility-Physical Therapy/Occupational Therapy/Speech Therapy-Referred: \$0 copay; coinsurance and deductible apply.
- m. Outpatient-Facility-Venipuncture: \$0 copay; no coinsurance or deductible applies.
- n. Outpatient-Facility-Behavioral Health 3: \$25 copay; no coinsurance or deductible applies.
- o. Outpatient-Facility-Infertility 4: \$0 copay; deductible and 30% coinsurance apply.
- p. Outpatient-Facility-ESRD Diagnosis 5: \$0 copay; no coinsurance or deductible applies.
- q. Outpatient-Facility-Other: \$75 copay; no coinsurance or deductible applies.
- r. Outpatient-Professional-True Primary Care Physician (processed as a PCP): \$25 copay; no coinsurance or deductible applies.
- s. Outpatient-Professional-Specialist Referred: \$45 copay; no coinsurance or deductible applies.
- t. Outpatient-Professional-Preventive ACA: \$0 copay; no coinsurance or deductible applies.
- u. Outpatient-Professional-Behavioral Health: \$25 copay; no coinsurance or deductible applies.
- v. Outpatient-Professional-Infertility 4: \$0 copay; deductible and 30% coinsurance apply.
- w. Outpatient-Professional-Anesthesia: \$0 copay; no coinsurance or deductible applies.
- x. Outpatient-Professional-Venipuncture: \$0 copay; no coinsurance or deductible applies.
- y. Office-True Primary Care Physician (processed as a PCP): \$25 copay; no coinsurance or deductible applies.
- z. Office- Specialist Referred: \$45 copay; no coinsurance or deductible applies.

- aa.** Office-Preventive ACA: \$0 copay; no coinsurance or deductible applies.
- bb.** Office-Radiological Advanced: \$75 copay; no coinsurance or deductible applies.
- cc.** Office-PT/OT/ST-Referred: \$ 0 copay: coinsurance and deductible apply.
- dd.** Office-Anesthesia: \$0 copay; no coinsurance or deductible applies.
- ee.** Office-Behavioral Health: \$25 copay; no coinsurance or deductible applies.
- ff.** Office-Infertility 4: \$0 copay; deductible and 30% coinsurance apply.
- gg.** Office-Venipuncture: \$0 copay; no coinsurance or deductible applies.
- hh.** Home Health-All: \$0 copay; coinsurance and deductible apply.
- ii.** Other Non-ACA Preventive Care: To the extent not otherwise covered under ACA Preventive care, the following other preventive measures provided under Article 7 will have cost shares provided in those paragraphs: Mammography (7.14), Pap Test (7.16), Well Care (7.19), Preventive Screenings for Employees (7.20), and Colonoscopy (7.23).

B. Tier B: State Health Plan Networks

- 1. Deductible.** The annual Individual Deductible for care delivered by a provider participating in the State Health Plan Ambulatory Surgical Center Network, State Health Plan Hospital Network, or State Health Plan Physician Network shall be \$445, and a Covered Person shall pay annually the first \$445 of the Allowed Amount for Covered Medical Benefits Incurred in the Plan Year before becoming eligible for Plan benefits under Tier B. Co-payments do not apply toward satisfaction of the Deductible, and Co-payments continue to apply after the Deductible has been met. The annual Family Deductible shall be \$890. Payment of Deductible amounts by any two or more Family members totaling \$890 of Covered Medical Benefits for that Plan Year shall satisfy the Deductible for all Covered Persons in that Family. If an Employee's spouse is covered by the Standard State Health Plan Family, the Employee and Spouse shall share the Tier B State Health Plan Networks Deductible. Amounts paid by a Covered Person for allowed charges under any tier of the Plan, other than Co-payments, are counted toward the Tier A Deductible or the Tier B/Tier C Deductible without distinction. Thus, amounts required to be paid by the Covered Person because an applicable Deductible has not been met in any tier count toward the satisfaction of the Tier A Deductible and the Tier B/Tier C Deductible.
- 2. Medical Benefit Coinsurance.** After the Individual or Family Deductible has been met for the Plan Year, the Plan will pay 80 percent of the Allowed Amount for the Covered Person's Covered Medical Benefits, for care delivered by a provider participating in the State Health Plan Ambulatory Surgical Center Network, State Health Plan Hospital Network, or State Health Plan Physician Network. Co-payments continue to apply after the Deductible has been met.
- 3. Penalty.** A patient, who is a Covered Person who does not obtain Pre-Certification from the Utilization Review Agency as required by Article 15 for care delivered by a provider participating in the State Health Plan Ambulatory Surgical Center Network, State Health Plan Hospital Network, or State Health Plan Physician Network, shall, in addition to the normal Tier B Deductible, and all other terms and conditions of the Plan, shall be responsible for all the costs Incurred for these professional services.

4. **Medical Benefit Coinsurance Maximum.** For care delivered within the State Health Plan Ambulatory Surgical Center Network, State Health Plan Hospital Network or State Health Plan Physician Network, after the annual Deductible has been met and a Covered Person has Incurred Coinsurance of \$2,540 for Covered Medical Benefits in the Plan Year, or Coinsurance of \$5,080 for Covered Medical Benefits have been Incurred in the Plan Year by any combination of Family members, the Plan will pay 100 percent of the Allowed Amount of the Covered Person's Covered Medical Benefits, except that Co-payments continue up to apply after the Medical Benefit Coinsurance Maximum has been reached. Coinsurance amounts paid by a Covered Person in either Tier A or Tier B will count toward both the Tier A and Tier B Coinsurance Maximum; however amounts Incurred under Tier C do not count toward the Coinsurance Maximum related to care delivered under Tier A or Tier B, and amounts Incurred under Tier A or Tier B do not count toward the Coinsurance Maximum related to care delivered under Tier C. Provided that: (1) the penalty in paragraph 3 above, and (2) Covered Medical Benefits 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 Coinsurance Maximum, and provided further, that the Covered Medical Benefits Incurred for such treatment or during such admission are always subject to Coinsurance.
5. **Shared Medical Benefit Coinsurance Maximum.** The payments for Covered Medical Benefits that may satisfy the Deductible and Coinsurance Maximum provisions of paragraphs 7.1.B.1 and 7.1.B.4 are those Incurred by one or more Covered Family members enrolled in the Plan or the State Health Plan.
6. **Cost Sharing.** The cost-sharing set out below is applicable to care delivered by a provider participating in the State Health Plan Ambulatory Surgical Center Network, State Health Plan Hospital Network or State Health Plan Physician Network to a Covered Person under Tier B of the Plan:
 - a. Professional Care: Office visit with Primary Care Physician for Preventive Care: Not covered under Tier B: other preventive measures provided under Article 7 will have cost shares provided in those paragraphs: Mammography (7.14), Pap Test (7.16), Well Care (7.19), Preventive Screenings for Employees (7.20), and Colonoscopy (7.23);
 - b. Professional Care: Office Visit with Primary Care Physician other than Preventive Care: \$12 Co-payment, plus Coinsurance and Deductible;
 - c. Professional Care: Specialist Visit to Specialty Physician: \$12 Co-payment, plus Coinsurance and Deductible;
 - d. Professional Care: Office Visit with physician practicing within a Patient-Centered Medical Home other than Preventative Care participating in the Third Party Claims Processor's Patient Centered Medical Home program: Co-payment is waived, and after the individual or Family Deductible has been paid during the Plan Year, the Plan will pay 90 percent of the Allowed Amount for the Covered Person's Covered Medical Benefits in excess of the Deductible.

- e. Emergency Room Visit: An Emergency Room visit is subject to a \$159 Co-Payment per Emergency Room visit, to be waived if the patient is admitted to the hospital.
- f. Outpatient Hospital Care: Preventive Care: Not covered under Tier B: other preventive measures provided under Article 7 will have cost shares provided in those Paragraphs: Mammography (7.14), Pap Test (7.16), Well Care (7.19), Preventive Screenings for Employees (7.20), and Colonoscopy (7.23);
- g. Outpatient Hospital Care: Coordinated by the Primary Care Physician: \$95 Co-payment, plus Coinsurance and Deductible;
- h. Outpatient Hospital Care: Coordinated by a Specialty Physician: \$95 Co-payment, plus Coinsurance and Deductible;
- i. Outpatient Hospital Care: Specialty Non-coordinated: \$95 Co-payment, plus Coinsurance and Deductible;
- j. Outpatient Hospital Care Surgical: \$95 Co-payment, plus Coinsurance and Deductible;
- k. Outpatient Hospital Care Radiology: \$95 Co-payment, plus Coinsurance and Deductible;
- l. Outpatient Hospital Care Pathology: \$95 Co-payment, plus Coinsurance and Deductible;
- m. Inpatient Hospital: Facility: Subject to Deductible and Coinsurance;
- n. Inpatient Hospital: Professional: Subject to Deductible and Coinsurance;
- o. High-end Radiology (MRI, CT, CAT, PET): \$95 Co-payment, plus Deductible and Coinsurance.

C. Tier C, Out-of-Network

1. **Deductible.** The annual individual Deductible for care delivered by a provider not participating in the MUSC Hospital Network, MUSC Physician Network, State Health Plan Ambulatory Surgical Center Network, State Health Plan Hospital Network, or State Health Plan Physician Network shall be \$445, and a Covered Person shall pay annually the first \$445 of the Allowed Amount for Covered Medical Benefits Incurred in the Plan Year before becoming eligible for Plan benefits under Tier C. Co-payments do not apply toward satisfaction of the Deductible, and Co-payments continue to apply after the Deductible has been met. The annual Family Deductible shall be \$890. Payment of Deductible amounts by any two or more Family members totaling \$890 of Covered Medical Benefits for that Plan Year shall satisfy the Deductible for all Covered Persons in that Family. If an Employee's spouse is covered by the Standard State Health Plan, the Employee and Spouse shall share the Tier C Out-of-Network Deductible. Amounts paid by a Covered Person for allowed charges under any tier of the Plan, other than Co-payments, are counted toward the Tier A Deductible or the Tier B/Tier C Deductible without distinction. Thus, amounts required to be paid by the Covered Person because an applicable Deductible has not been met in any tier count toward the satisfaction of the Tier A Deductible and the Tier B/Tier C Deductible.
2. **Medical Benefit Coinsurance.** After the individual or Family Deductible has been met for the Plan Year, the Plan will pay 60 percent of the Allowed Amount for the Covered Person's Covered Medical Benefits for care delivered by a provider not participating in the MUSC Health Plan Hospital Network, MUSC Health Plan Physician Network, State Health Plan Ambulatory Surgical Center Network, State

Health Plan Hospital Network, or State Health Plan Physician Network. Co-payments continue to apply after the Deductible has been met.

3. **Penalty.** A patient, who is a Covered Person, who does not obtain Pre-certification from the Utilization Review Agency as required by Article 15 for care delivered by a provider not participating in the MUSC Health Plan Hospital Network, MUSC Health Plan Physician Network, State Health Plan Ambulatory Surgical Center Network, State Health Plan Hospital Network, or State Health Plan Physician Network, shall, in addition to the normal Tier C Deductible, and all other terms and conditions of the Plan, shall be responsible for all the costs Incurred for these professional services.
4. **Coinsurance Maximum.** For care delivered by a provider not participating in the MUSC Health Plan Hospital Network, MUSC Health Plan Physician Network, State Health Plan Ambulatory Surgical Center Network, State Health Plan Hospital Network or State Health Plan Physician Network, after the annual Deductible has been met and a Covered Person has Incurred Coinsurance of \$5,080 for Covered Medical Benefits in the Plan Year, or Coinsurance of \$10,160 for Covered Medical Benefits have been Incurred in the Plan Year by any combination of Family members, the Plan will pay 100 percent of Allowed Amount of the Covered Person's Covered Medical Benefits, except that Co-payments continue to apply after the Medical Benefit Coinsurance Maximum has been reached. Amounts Incurred under Tier C do not count toward the Coinsurance Maximum related to care delivered under Tier A or Tier B, and amounts Incurred under Tier A or Tier B do not count toward the Coinsurance Maximum related to care delivered under Tier C. Provided that: (1) the penalty in paragraph 3 above; and (2) Covered Medical Benefits 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 Coinsurance Maximum, and provided further, that the Covered Medical Benefits Incurred for such treatment or during such admission are always subject to Coinsurance.
5. **Shared Out-of-Pocket Maximum.** The payments for Covered Medical Benefits that may satisfy the Deductible and Coinsurance Maximum provisions of paragraphs 7.1.C.1 and 7.1.C.4 are those Incurred by one or more Covered Family members enrolled in the Plan or the State Health Plan.
6. **Cost Sharing.** The cost-sharing set out below is applicable to care delivered to a Covered Person receiving care from a provider not participating in the MUSC Health Plan Hospital Network, MUSC Health Plan Physician Network, State Health Plan Ambulatory Surgical Center Network, State Health Plan Hospital Network, or State Health Plan Physician Network under Tier C of the Plan:
 - a. Professional Care: Office visit with Primary Care Physician for Preventive Care: Not covered under Tier C: other preventive measures provided under Article 7 will have cost shares provided in those Paragraphs: Mammography (7.14), Pap Test (7.16), Well Care (7.19), Preventive Screenings for Employees (7.20), and Colonoscopy (7.23);
 - b. Professional Care: Office Visit with Primary Care Physician other than Preventive Care: \$12 Co-payment, plus Coinsurance and Deductible;

- c. Professional Care: Specialist Visit to Specialty Physician referred by Primary Care Physician: \$12 Co-payment, plus Coinsurance and Deductible;
- d. Professional Care: Specialist Visit to Specialty Physician without required referral from Primary Care Physician: \$12 Co-payment, plus Coinsurance and Deductible;
- e. Emergency Room Visit: An Emergency Room visit is subject to a \$159 Co-Payment per Emergency Room visit. Co-payment is waived if the patient is admitted to the Hospital;
- f. Outpatient Hospital Care: Preventive Care: Not covered under Tier C: other preventive measures provided under Article 7 will have cost shares provided in those paragraphs: Mammography (7.14), Pap Test (7.16), Well Care (7.19), Preventive Screenings for Employees (7.20), and Colonoscopy (7.23);
- g. Outpatient Hospital Care: Coordinated by the Primary Care Physician: \$95 Co-payment, plus Coinsurance and Deductible;
- h. Outpatient Hospital Care: Coordinated by a Specialty Physician: \$95 Co-payment, plus Coinsurance and Deductible;
- i. Outpatient Hospital Care: Specialty Non-coordinated: \$95 Co-payment, plus Coinsurance and Deductible;
- j. Outpatient Hospital Care Surgical: \$95 Co-payment, plus Coinsurance and Deductible;
- k. Outpatient Hospital Care Radiology: \$95 Co-payment, plus Coinsurance and Deductible;
- l. Outpatient Hospital Care Pathology: \$95 Co-payment, plus Coinsurance and Deductible;
- m. Inpatient Hospital: Facility: Subject to Deductible and Coinsurance;
- n. Inpatient Hospital: Professional: Subject to Deductible and Coinsurance;
- o. High-end Radiology (MRI, CT, CAT, PET): \$95 Co-payment, plus Deductible and Coinsurance.

7.2 Maximum Out of Pocket Limits

The Maximum Out-of-Pocket Limit during a Plan Year is Cost Sharing of \$6,850 for an individual and Cost Sharing of \$13,700 for any combination of covered Family members. The Plan will pay 100% of the Allowed Amount with respect to Covered Medical Benefits and there is no Co-payment with respect to the Prescription Drug Program after the Maximum Out-of-Pocket Limit has been reached during a Plan Year. The Maximum Out-of-Pocket Limit applies regardless of whether the Covered Person has met the Medical Benefits Coinsurance Maximum during the Plan Year in any tier. Cost sharing amounts Incurred under Tier C, penalties imposed under the Plan (e.g., for failing to follow Pre-certification requirements), premiums, and balance-billed charges to not count toward the Maximum Out-of-Pocket Limit.

7.3 Covered Medical Benefits

Covered Medical Benefits include 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 the Allowed Amount or the Provider's Billed Charge, whichever is less.

The benefits for Chiropractic Services 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. 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. The maximum amount payable for Chiropractic Services for the Plan Year is \$2,000.

- B.** The benefits for services of a podiatrist, acting within the scope of their 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;
- C.** Blood transfusions, including the cost of blood and blood plasma, either inpatient or outpatient, but excluding blood and blood products replaced by donors and related storage fees.
- D.** Licensed registered nurse (R.N.) charges for nursing care in a Hospital where no special care units are provided.
- E.** 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.
- F.** 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 Pre-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 Covered Person 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; shoe supports; knee braces; and bandages, gauze, and similar equipment are not Covered Medical Benefits.
- G.** 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.

Supplies and equipment that have solely non-therapeutic uses are not Covered Medical Benefits.

- H. Professional ambulance services 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.
- I. 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. Charges for Prosthetic Appliances that have solely non-therapeutic uses, including a wig or hairpiece, are not Covered Medical Benefits. The Plan will provide benefits that are consistent with the Women's Health and Cancer Rights Act, which requires coverage for prostheses and physical complications at all states of a mastectomy. Accordingly, the Plan will cover the initial breast prosthesis and subsequent replacements thereof for Covered Persons undergoing a Medically Necessary mastectomy.
- J. Oxygen and rental of equipment for its administration outside of a Hospital, with rental payments not to exceed the equipment's purchase price.
- K. Orthopedic braces, crutches, lifts attached to braces, and orthopedic shoes that are Medically Necessary and required by a specific diagnosis. Orthopedic shoes are limited to one pair per six-month interval. Supplies or shoes that have solely non-therapeutic uses are not a Covered Medical Benefit.
- L. Occupational and physical therapy services, when provided by a licensed Occupational Therapist or Physical Therapist.
- M. Treatment of Behavioral Health Disorders, Alcoholism, and Drug Abuse in the outpatient department of a Hospital or outside of a Hospital, limited to the benefits specified in paragraph 7.8, and, where applicable, subject to Pre-Certification by the Behavioral Health Manager.
- N. Inpatient treatment in a Hospital of Behavioral Health Disorders, Alcoholism, and Drug

Abuse, up to the benefits specified in paragraph 7.8 in a Hospital, and, where applicable, subject to Pre-Certification by the Behavioral Health Manager.

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

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

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

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

- 1.** 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.).
- 2.** Speech therapy for dysfunctions that are self-correcting, such as natural dysfluency or developmental articulation errors in young children.
- 3.** Speech therapy for verbal apraxia or stuttering/stammering unless due to a specific disease or brain injury.
- 4.** Speech therapy associated with any of the following conditions:
 - a.** Behavioral disorders;
 - b.** Attention disorders;
 - c.** Conceptual handicap; and
 - d.** Mental retardation.

- P. Dental care and treatments, dental surgery, or dental applications, limited to:**

- 1.** Allowed Amount 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. Allowed Amount for natural and artificial teeth, dentures, bridges, etc., made necessary by accidental bodily injury occurring while a Covered Person is continuously covered, limited to care begun within 365 days of such accident, and while the Covered Person remains continuously covered under this Plan.
 4. Allowed Amount for natural and artificial teeth, dentures, bridges, etc., made necessary by loss of teeth due to cancer treatment or as a result of a congenital birth defect.
- Q.** 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 major human organ transplant procedures are Covered Medical Benefits 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 Benefits 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;
 - 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 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;
 - b. Bone marrow transplantation is the Covered Person's only reasonable opportunity to survive;
 - 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;
 - 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;
 - 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. The Plan will pay benefits for a major human organ transplant listed in paragraphs 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 Utilization Review Agency 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.
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: (i) there are no other recognized treatments that provide the Covered Person with a better prognosis for the illness or injury; (ii) 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 (iii) the Utilization Review Agency, 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 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, lung, 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 meal 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 subparagraph shall not exceed \$10,000 for expenses Incurred within five days immediately prior to and 365 days immediately following a covered organ transplant procedure. These transportation expenses are specifically for transportation of the Covered Person and an accompanying individual 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.
- R. Telehealth:** The Plan will pay Covered Expenses for Telehealth services which are initiated by either a Member or Provider and are provided by licensed health care professionals who have been credentialed as eligible Telehealth Providers.
- S. Telemedicine:** The Plan will pay Covered Expenses for Telemedicine services under the following circumstances:
1. The medical care is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and not in excess of the Covered Person's need;
 2. The medical care can be safely furnished, and there is no equally effective, more conservative, and less costly treatment available; and
 3. Consulting and referring Providers must be Participating Contracting Providers who have been credentialed as eligible Telemedicine Providers by the Third Party Claims Administrator.

Office and outpatient visits that are conducted via Telemedicine are counted towards any applicable Benefit limits for these services.

Examples of interactions that are not reimbursable Telemedicine services and will not be reimbursed include, but are not limited to, (i) telephone conversations, (ii) e-mail messages, (iii) facsimile transmissions, or (iv) internet-based audio-video communication that is not secure and HIPAA-compliant (e.g., Skype).

7.4 Hospital or Ambulatory Surgical Center 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 that 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. Inpatient Hospitals in Networks — Fixed Rate DRG or Per Diem.** The Plan will pay to a Hospital in the Hospital Network compensation calculated from the applicable fixed rate DRG or per diem rate provided in the agreement between the Planholder and the In-Network Hospital as full payment for the Plan's share of the inpatient, Medically Necessary, Covered Medical Benefits rendered to a Covered Person by the Hospital. The Subscriber payment to the Hospital shall be limited to the appropriate Deductible or Coinsurance calculated from the lesser of (i) the fixed rate DRG or per diem rate established in the Agreement or (ii) the Provider's Billed Charge. 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. Out-of-Network Inpatient Hospital — Fixed Rate DRG or Per Diem.** The Plan will pay to a Hospital compensation calculated from the lesser of (i) the applicable fixed rate DRG or per diem rate established for In-Network Hospitals or (ii) the Provider's Billed Charge as full payment of the Plan's share of Medically Necessary, Covered Medical Benefits rendered to a Covered Person by the Hospital.
- C. Outpatient Hospitals in Networks — APC Priced.** The Plan will pay to a Hospital in the Hospital Network compensation calculated from the applicable Ambulatory Patient Classifications (APC) rate provided in the agreement between the Planholder and the In-Network Hospital as full payment for the Plan's share of the outpatient, Medically Necessary, Covered Medical Benefits rendered to a Covered Person by the Hospital. The Subscriber payment to the Hospital shall be limited to appropriate Deductible or Coinsurance calculated from the lesser of (i) the APC rate established in the Agreement or (ii) the Provider's Billed Charge. 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.
- D. Out-of-Network Outpatient Hospital — APC Priced.** The Plan will pay to a Hospital compensation calculated from the lesser of (i) the applicable APC rate established for In-Network Hospitals or (ii) the Provider's Billed Charge as full payment of the Plan's share of outpatient, Medically Necessary, Covered Medical Benefits rendered to a Covered Person by the Hospital.
- E. Ambulatory Surgical Centers in Networks — Payment Group Priced.** The Plan will pay

to an Ambulatory Surgical Center in the Ambulatory Surgical Center Network compensation calculated from the applicable Payment Group rate provided in the agreement between the Planholder and the In-Network Ambulatory Surgical Center as full payment for the Plan's share of the Medically Necessary, Covered Medical Benefits rendered to a Covered Person by the Ambulatory Surgical Center. The Subscriber payment to the Ambulatory Surgical Center shall be limited to appropriate Deductible or Coinsurance calculated from the lesser of (i) the Payment Group rate established in the Agreement or (ii) the Provider's Billed Charge. 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.

- F. Out-of-Network Ambulatory Surgical Centers — Payment Group Priced.** The Plan will pay to an Ambulatory Surgical Center compensation calculated from the lesser of (i) the applicable Payment Group rate established for Ambulatory Surgical Centers or (ii) the Provider's Billed Charge as full payment of the Plan's share of Medically Necessary, Covered Medical Benefits rendered to a Covered Person by the Ambulatory Surgical Center.

G. Charges by DRG, Per Diem, APC, or Payment Group

- 1. Hospital Room and Board.** In all cases not payable as provided in paragraphs A through F above, the Plan will pay the lesser of the Provider's Billed Charge or the Allowed Amount for the semi-private room, board, and general nursing care for the Covered Person, and the lesser of the Provider's Billed Charge or the Allowed Amount for a newborn Child delivered from the Covered Person. When Medically Necessary, the Plan will pay the lesser of the Provider's Billed Charge or the Allowed Amount 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 Provider's Billed Charge or the Allowed Amount for Medically Necessary services, medicines, blood, 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 Medically Necessary emergency treatment as a result of an accident or acute emergency illness, or the Covered Person 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 their assistant, or any charges made for infiltration anesthesia.

3. Other Ambulatory Surgical Center charges for Covered Services. The Plan will pay the lesser of the Provider's Billed Charge or the Allowed Amount for Medically Necessary services, medicines, blood, blood plasma not replaced, and supplies for diagnoses or treatment of the illness or injury 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, their assistant, or any charges made for infiltration anesthesia.

H. Limitation. No benefit shall be payable under 7.4, Hospital or Ambulatory Surgical Center Benefits, with respect to charges for care of the sick or injured made by any institution or facility that does not qualify as a Hospital or Ambulatory Surgical Center as defined in 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 Allowed Amount 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 Allowed Amount for the operation or procedure bearing the highest allowance plus 50 percent of the Allowed Amount 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 Allowed Amount for the procedure bearing the highest allowance, 50 percent for the procedures bearing the second and third highest Allowed Amount, 25 percent for the procedures bearing the fourth through the eighth highest Allowed Amount, and 10 percent for all other procedures. If the operation consists of the excision of multiple malignant lesions, the total amount covered will be the Allowed Amount for the procedure bearing the highest allowance and 50 percent of the Allowed Amount 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 Allowed Amount 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 Allowed Amount, subject to the above paragraphs, will be covered 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 that normally are exploratory in nature are designated as "Independent Procedures" by the Plan, and the Allowed Amount 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 Allowed Amount for the major procedure only;
 7. Medically Necessary surgical correction of disorders of the temporomandibular 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 by the Utilization Review Agency for these procedures is required and the total amount covered will be the Allowed Amount for the procedure performed. Except as provided in this subparagraph, however, services or supplies for temporomandibular joint conditions are not covered under the Plan. See paragraph 9.KK.
 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. See paragraph 9.LL.
- B. Surgical Assistant Service**, which consists of the Medically Necessary service of one Physician or Physician Assistant 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 Allowed Amount for the Surgical Service, not to exceed the Provider's Billed Charge.

- C. Anesthesia Service**, which consists of services rendered by a Physician or a certified registered nurse anesthetist, other than the attending surgeon or their 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 Provider's Billed Charge but not to exceed the Allowed Amount;
 2. In-Hospital medical benefits primarily for treatment of mental or nervous conditions, Alcoholism, or Drug Abuse will be provided for each Covered Person subject to limitations of paragraph 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: (i) 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 their assistant, (ii) 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 (iii) 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 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 a non-excluded abortion, as well as in-Hospital medical service for conditions related directly to pregnancy, limited to the Allowed Amount 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, laboratory, and pathological services ordered by the attending Physician for a Covered Person who is a registered bed patient in a Hospital, Skilled Nursing Facility, or admitted at an Ambulatory Surgical Center;
 - 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; and
- B.** Clinical laboratory and tissue diagnostic examinations and medical diagnostic procedures for the diagnosis of an illness or injury. The Physician charges for any machine-generated tests are not a Covered Medical Benefit 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 that 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 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 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, conditions, limitations, and exclusions 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, Alcoholism, and Drug Abuse. All care must be in accordance with the utilization guidelines established by the Behavioral Health Manager for specified levels of care, and, where applicable, pre-certified by the Behavioral Health Manager. Notwithstanding anything in this Plan to the contrary, in accordance with the Mental Health Parity Act of 1996 (Act), as amended, and any regulations issued thereunder, the Plan will provide parity in the application of aggregate lifetime and annual dollar limits for mental health and substance use disorder benefits as compared with other dollar limits for medical benefits. The Plan will not place financial requirements or treatment limitations on mental health and substance use disorder benefits that are more restrictive than the most common financial requirements and treatment limitations placed on other medical benefits, as such requirements and limitations placed on other medical benefits are set forth in the Schedule of Benefits. To the extent the Plan provides out-of-network coverage for other medical benefits, it will also provide out-of-network coverage for mental health and substance use disorder benefits. This paragraph shall not apply to any Plan Year in which the Plan meets the cost exemption under Section 712(c)(2) of the Act and the Plan Administrator, in its sole discretion, chooses to apply such exemption. The criteria for a medical necessity determination made under this Plan with respect to mental health or substance use disorder benefits shall be made available by the Plan Administrator to any current or potential Covered Person, beneficiary, or contracting Provider upon request.

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

Facility, Hospice Care, Alternative Treatment Plan, and Home Health Care services as provided in paragraphs 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 paragraph 7.5.D.3 and the requirement that all admissions and readmissions to a Skilled Nursing Facility be Pre-Certified by the Utilization Review Agency, the Plan will provide benefits for the Allowed Amount for room, board, and a skilled nursing level of treatment in such facility for up to 60 days in any Plan Year.

7.11 Hospice Care

Subject to all the terms, conditions, limitations, and exclusions 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 that 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, and 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 nursing care provided by a registered nurse or licensed practical nurse;
 - b. Part-time or Intermittent home health aide 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 80 visits per person including bereavement counseling.
- 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 that are not solely related to the care of the Covered Person; 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 their family;
 - f. Respite care that 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. **Allowed Amount.** For purposes of this paragraph only an Allowed Amount includes: (i) all costs otherwise allowed under this Plan; and (ii) 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, and 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; and
 - 2. The Allowed Amount for the Alternative Treatment Plan, as defined in this

paragraph, 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 requirement, the 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 Allowed Amount for the following Medically Necessary services and supplies provided a Covered Person in the home:

- A.** Covered Medical Benefits for purposes of this paragraph shall be limited to:
 - 1.** Part-time or Intermittent nursing care by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), where appropriate;
 - 2.** Part-time or Intermittent home health aide services that consist primarily of caring for the individual;
 - 3.** Physical, occupational, or speech therapy provided by the Home Health Care agency; and
 - 4.** Medical drugs, supplies, Durable Medical Equipment, 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 100 visits. A visit shall consist of up to four hours, whether consecutive or non-consecutive, within any 24-hour period, and 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;
 - 3.** Covered Medical Benefits under this paragraph shall not include:
 - a.** Any service or supply rendered by a person who ordinarily resides in the home of the Covered Person, is a member of the Covered Person's family, or is a member 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 paragraph 15.1.8.E at 100 percent of the Allowed Amount or the Provider's Billed Charge, whichever is less.

7.14 Mammography Testing

The Plan will provide benefits for routine mammography testing for female Covered Persons over the age of 35 enrolled in the Plan and without regard to the Plan Deductible, Coinsurance or Co-payment, subject to the following terms and conditions:

- A. Benefits under this paragraph are limited to one mammogram for a female Covered Person between the ages of 35 through 39; one mammogram, each Plan Year, for a female Covered Person, between over the age of 40;
- B. Benefits under this paragraph are payable only for routine four-view mammograms that are defined as elective procedures undertaken without the presence of symptoms, and are performed only at facilities in Tier A or B;
- C. Benefits under this paragraph 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 or for 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 Allowed Amount or the Provider's Billed Charge, whichever is less.

7.16 Pap Test

The Plan will pay a benefit for one Pap Test each Plan Year for a female Covered Person between the ages of 18 through 65, including an appropriate-level office visit associated with the Pap Test, without any requirement for a Deductible, Co-payment, or Coinsurance. This paragraph applies to all tiers of the Plan, provided that the member is responsible for any balance bill that may be charged by a provider in Tier C.

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 shall refer to therapy beginning soon after the onset of illness or

injury. In many cases, acute 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 a 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 Healthcare Organizations (JCAHO), 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; pulmonary rehabilitation, except in conjunction with a covered and approved lung transplant or as a perioperative conditioning component for lung volume reduction surgery; or long term rehabilitation after the acute rehabilitation 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 paragraph 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

Benefits 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 6 cycles of Intrauterine Insemination (IUI) and a maximum total of three completed cycles of zygote or gamete intrafallopian transfer (ZIFT or GIFT) or In Vitro Fertilization (IVF). 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 under this Plan, the State Health Plan Standard Plan, the State Health Plan Savings Plan, or the Medicare Supplemental Plan for infertility treatments since January 1, 1990, are used in computing the lifetime maximum benefit;

- B.** The benefits for infertility treatment are always subject to Coinsurance at a rate of 30 percent of the Allowed Amount for Covered Medical Benefits or Covered Prescription Drug Expenses;
- C.** Coinsurance paid by the Covered Person for the infertility services cannot be used to satisfy the Medical Benefits Coinsurance Maximum in 7.1.A.4, 7.1.B.4, 7.1.C.4;
- 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 or vasectomy, whether or not surgically reversed.

7.19 Well Care

- A.** The Plan will provide benefits for routine Well Child Care visits for a covered Child through age 18 and immunizations for Covered Persons enrolled in the Plan and without regard to the Plan Deductible, Co-payments, or Coinsurance, subject to the following terms and conditions:
 - 1.** Well Child Care visits will be paid at 100 percent of the allowed amount for approved routine exams, Centers for Disease Control-recommended immunizations, American Academy of Pediatrics-recommended services specific to certain ages, and lab tests when an in-network doctor provides these checkups. Well Child Care visits benefits for will be allowed as follows:
 - a.** Younger than 1 year old (up to six visits);
 - b.** 1 year old (up to three visits);
 - c.** 2 years old (up to two visits); and
 - d.** 3 years old until they turn 19 years old (one visit a year).
 - 2.** Benefits are provided for all immunizations at the appropriate ages recommended by the American Academy of Pediatrics for children through age 18, and for adults within the Centers for Disease Control and Prevention recommended intervals.

Benefits under this subparagraph are payable only for services rendered by the participating providers in Tier A and B Networks in accordance with guidelines established by the Plan Administrator.

- B.** The Plan will provide benefits for one routine annual physical for Covered Persons age 19 and older enrolled in the Savings Plan.
- C.** Benefits under this paragraph are payable without regard to the Plan Deductible or Coinsurance.

7.20 Preventive Screenings for Employees

The Plan will provide benefits for a routine 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 Plan will pay benefits only for one screening per Covered Person per Plan Year at providers designated by the Plan Administrator, and subject to the ability of the Plan Administrator and the Provider to schedule a screening session at the workplace. The screening is provided without regard to the Plan Deductible and Coinsurance. Workplace screening benefits are payable only for (i) Covered Employees who are actively at work and their Covered Spouses.

7.21 Covered Prescription Drug Expenses

Drugs and medicines that are required to bear the legend "Caution: Federal law prohibits dispensing without prescription," insulin and related supplies, 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.

There is no coverage for: (1) except as provided in paragraph 7.26, any medicines or drugs that are in the Food and Drug Administration (FDA) phases I, II, or III testing, whether or not prescribed by a Physician; (2) 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; or (3) prescription drugs or medicines purchased at pharmacies not participating in the State Pharmacy Network. 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.

- A.** For Covered Persons enrolled in the Plan, the expenses described in this paragraph are not Covered Medical Benefits for purposes of paragraph 7.1. of the Plan of Benefits.
- B. Prescription Drugs Obtained at MUSC Health Network (Tier A):**
 - 1. The Covered Person shall pay for up to a 31-day supply of a drug: (a) the lesser of the allowance established for a Tier 2 brand name drug or a \$30 Co-payment; (b) the lesser of the allowance established for a Tier 3 brand name drug or a \$50 Co-payment; or (c) the lesser of the allowance established for a generic drug or a

\$6 Co-payment. If an FDA-approved generic equivalent is available, payment for a brand name drug is limited to what is payable for the FDA-approved generic equivalent. Covered Persons may obtain up to a maximum of a 90-day supply of medication; however, a separate Co-payment is required for each additional 31-day supply of medication received at retail.

2. A voluntary mail service prescription drug benefit is available at a pharmacy established by the Pharmacy Benefits Manager for home delivery of 90-day supplies of covered prescription medications. A retail maintenance network of certain participating pharmacies operating in the State may also be utilized to obtain 90-day supplies of covered prescription medications at the same price as mail order. Patient co-payments at the mail service pharmacy, or at a pharmacy participating in the Retail Maintenance Network, for a 90-day supply of covered medication shall be: (a) the lesser of the allowance established for a Tier 2 brand name drug or an \$80 Co-payment; (b) the lesser of the allowance established for a Tier 3 brand name drug or a \$140 Co-payment; or (c) the lesser of the allowance established for a generic drug or an \$18 Co-payment.

C. Prescription Drugs Obtained at a State Health Plan In-network Provider (Tier B):

1. The Covered Person shall pay for up to a 31-day supply of a drug: (a) the lesser of the allowance established for a Tier 2 brand name drug or a \$38 Co-payment; (b) the lesser of the allowance established for a Tier 3 brand name drug or a \$63 Co-payment; or (c) the lesser of the allowance established for a generic drug or a \$9 Co-payment. Provided, however, that if an FDA-approved generic equivalent is available, payment for a brand name drug is limited to what is payable for the FDA-approved 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.
2. A voluntary mail service prescription drug benefit is available at a pharmacy established by the Pharmacy Benefits Manager for home delivery of 90-day supplies of covered prescription medications. A retail maintenance network of certain participating pharmacies operating in the State may also be utilized to obtain 90-day supplies of covered prescription medications at the same price as mail order. Patient co-payments at the mail service pharmacy, or at a pharmacy participating in the Retail Maintenance Network, for a 90-day supply of covered medication shall be: (a) the lesser of the allowance established for a Tier 2 brand name drug or a \$95 co-payment; (b) the lesser of the allowance established for a Tier 3 brand name drug or a \$158 co-payment; or (c) the lesser of the allowance established for a generic drug or a \$22 co-payment.

- D. There is an annual prescription drug Co-payment maximum of \$2,640 per Covered Person. The difference between the cost of a brand name drug and the cost of a generic drug is not counted towards the annual Co-payment maximum.
- E. The State of South Carolina Group Health Benefits Plan has adopted an Employee Group Waiver Plan (EGWP) Prescription Drug Plan for the benefit of Covered Persons enrolled in the Medicare Supplemental Plan and for those enrolled in the State Health Plan Standard

Plan who are eligible for Medicare Part D. The EGWP Prescription Drug Plan provides at least the same prescription benefit the Covered Person receives as an enrollee in the Standard Plan in terms of Co-payment and out-of-pocket maximum, but may provide more. A Covered Person eligible for the EGWP Prescription Drug Plan may elect out of the EGWP program and return to the Standard Plan drug benefit.

- F. FDA-approved tobacco cessation pharmaceuticals will be provided at no costs to the Covered Person through pharmacies participating in the State Pharmacy Network.

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 colonoscopies, including the consultation and associated anesthesia during the procedure, at the cost to the Covered Person at in-network providers for both diagnostic services and routine services within the age ranges specified by the American Cancer Society recommendations. Benefits under this paragraph are not subject to the Plan Deductible and Coinsurance. This paragraph applies to all tiers of the Plan, provided that the member is responsible for any balance bill that may be charged by a provider in Tier C.

7.24 Autism Spectrum Disorders

The Plan will provide benefits for Applied Behavioral Analysis for a Covered Person who is diagnosed with Autism Spectrum Disorder. Notwithstanding paragraph 7.3.O, benefits are provided for speech therapy for treatment of Autism Spectrum Disorders. All services are subject to the guidelines formulated by the Behavioral Health Manager, are limited to the benefits specified in paragraph 7.8, and must be Pre-Certified by the Behavioral Health Manager.

7.25 Preventive Care

All Preventive Care shall be provided to a Covered Person without a Co-Payment, Deductible or Coinsurance under Tier A of the Plan. Preventive Care is not covered under Tier B or Tier C of the Plan. To the extent not otherwise covered under Preventive Care, other preventive measures set out in Article 7 of the Plan are covered in accordance with those Paragraphs: Mammography (7.14), Pap Test (7.16), Well Care (7.19), Preventive Screenings for Employees (7.20) and Colonoscopy (7.23).

7.26 Coverage of Clinical Trials

- A. The Plan will not deny a Covered Person who is a "Qualified Individual" participation "Approved Clinical Trial" with respect to treatment of a "Life Threatening Condition" where the Utilization Review Agency has determined the Covered Person is eligible to participate in the Approved Clinical Trial. Furthermore, the Plan will not deny (or limit or impose additional conditions on) the coverage of "Routine Patient Costs" for items and services furnished in connection with participation in the Approval Clinical Trial. Finally, the Plan will not discriminate against a Qualified Individual on the basis of the individual's participation in an Approved Clinical Trial. To be eligible to participate in the Approved Clinical Trial, the

Utilization Review Agency must determine that the Covered Person's participation in the Approved Clinical Trial is appropriate to treat the Covered Person's Life Threatening Condition. The Utilization Review Agency's determination may be based on the referring Physician's conclusions or medical or scientific information provided by the Covered Person.

- B.** If one or more MUSC Health Plan Physician Network Providers is participating in an Approved Clinical Trial, the Plan may require that a Qualified Individual participate in the Approved Clinical Trial through such a MUSC Health Plan Physician Network Provider if the Network Provider will accept the Qualified Individual as a participant in the Approved Clinical Trial.
- C.** Notwithstanding paragraph (B) above, paragraph (A) above shall apply to a Qualified Individual participating in an Approved Clinical Trial that is conducted outside the State in which the Qualified Individual resides.
- D.** For purposes of paragraph 7.26.A of the Plan, the following terms are defined as follows:
 - 1.** "Approved Clinical Trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following subsections:
 - a.** The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following: (a) the National Institutes of Health; (b) the Centers for Disease Control and Prevention; (c) the Agency for Health Care Research and Quality; (d) The Centers for Medicare & Medicaid Services; (e) cooperative group or center of any of the entities described in subsections (a) through (d) above or the Department of Defense or the Department of Veteran Affairs; (f) a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or (g) the Department of Veteran Affairs, the Department of Defense, or the Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines: (i) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and (ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - b.** The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
 - c.** The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
 - 2.** "Life-Threatening Condition" is a disease or condition likely to result in death unless the course of the disease or condition is interrupted.
 - 3.** "Qualified Individual" is means a Covered Person who meets the following conditions: (a) the Covered Person is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and (b) either:

- a. the referring Health Care Professional is a participating health care provider and has concluded that the Covered Person's participation in such Approved Clinical Trial would be appropriate based upon the Covered Person meeting the conditions of the trial protocol; or
- b. the Covered Person provides medical and scientific information establishing that the Covered Person's participation in the Approved Clinical Trial would be appropriate based upon the Covered Person meeting the conditions of the trial protocol.

"Routine Patient Costs" include items and services typically provided under the Plan for a Covered Person not enrolled in an Approved Clinical Trial. However, such items and services do not include (a) the investigational item, device, or service itself; (b) items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis; or (c) a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

7.24 Diabetes Education

Outpatient and office based self-management training and education for the treatment of Covered Persons 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, shall be provided at no cost to the Covered Person, provided that the self-management training and education conforms 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 and is provided by an in-network provider.

7.26 Contraceptives

No cost sharing shall be applied to otherwise covered contraceptives for Subscribers and Spouses.

ARTICLE 8.

COORDINATION OF BENEFITS

8.1 Definitions for this Article

- A. **Plan.** For purposes of this Article, "Plan" means any program that 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, subscriber contracts, or coverage through HMOs 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 coordination of benefits (COB), and if a program or other arrangement for coverage has more than one part and the COB provisions apply to one part, then each part of the program or arrangement is considered a separate Plan.

- B. Dependent.** With respect to this Article, any person included in the definition of Dependent in paragraph 2.29 herein and, with respect to any other Plan, any person who qualifies as a dependent under such Plan.
- C. Primary Plan.** A Plan under which benefits must be determined without taking the existence of another Plan into consideration. There may be more than one Primary Plan. The provisions of paragraph 8.2 determine whether a Plan is Primary or Secondary.
- D. Secondary Plan.** A Plan that is not a Primary Plan. When this Plan is a Secondary Plan its benefits are determined after those of the other Plan 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 that 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 that applies:

- A. Coverage as a Non-Dependent or Dependent.** The benefits of a Plan that 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 (the birthday rule); 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. If the other Plan does not have the birthday 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. 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. 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 that 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 that covers that person as a laid off or retired employee, or as a dependent of a laid off or retired employee. 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 of coverage.

- F. Longer - Shorter Length of Coverage.** If none of the above paragraphs A–E determine the order of benefits, the benefits of the Plan that covered an employee, member, or subscriber for a longer term 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 above rule will be used to determine which one of them assumes the primary position.

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 rules of this Plan establish that this Plan is the Secondary Plan, this Plan will pay the lesser of:
1. The benefits that would be payable for the Covered Medical Benefit(s) under this Plan if it were the Primary Plan, without regard to this COB provision; or
 2.
 - a. If the Provider is a Participating Provider in the Primary Plan, the difference between the other Plan's allowed amount(s) for the Covered Medical Benefit(s) and the benefits the other Plan would pay as Primary, without regard to any COB or similarly intended provision in that Plan and whether or not the claim was filed; or
 - b. If the Provider is a Non-Participating Provider for the Primary Plan, the difference between the Provider's Billed Charge and the benefits the other Plan would pay as Primary, without regard to any COB or similarly intended provision in that Plan and whether or not the claim was filed.

Payment for each Covered Medical Benefit will be determined in the manner above when this Plan is Secondary. When this Plan is Secondary, it will not pay any benefits for expenses this Plan would not cover as Primary. The benefits this Plan pays as Secondary will not exceed the total benefits this Plan would pay as Primary, nor will the payments from this Plan exceed the other Plan's patient liability amount(s). Any benefits paid under this provision are charged against any applicable benefit limit of this Plan.

- C. Subscriber's Responsibility.** The Subscriber is responsible for filing or processing claims through another health insurance 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, other organization, or person any information that 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 that 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. Amounts so paid will be deemed to be benefits paid under this Plan. 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 Covered Medical Benefits in a total amount in excess of the amount necessary to satisfy the purposes of this Article (regardless of whether such overpayments were made as a result of an error by the Third Party Claims Processor, the Plan Administrator, or any other person or entity related to the Plan), the Third Party Claims Processor will be entitled to recover on behalf of the Plan such excess amounts from a Covered Person or any group insurer, Plan, or other person or organization contractually obligated to such Covered Person with respect to such Covered Medical Benefits. The Subscriber, for themselves or on behalf of their 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, except as provided in subsection C below, Coordination of Benefits for End Stage Renal Disease (ESRD). 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, except as provided in subsection C below, Coordination of Benefits for ESRD.
- C. **Coordination of Benefits for End Stage Renal Disease (ESRD).** Subscribers diagnosed with ESRD must apply for Medicare coverage when enrolled in this Plan. This Plan requires Covered Persons diagnosed with ESRD to apply for Medicare coverage (parts A and B) under the ESRD entitlement reason during the first 33 months of treatment. After the Covered Person's first dialysis treatment, a 3 month waiting period will begin before Medicare coverage is available. A 30 month coordination period exists in which this Plan is primary and Medicare is secondary.

The coordination period is 30 months long and starts on the date the Subscriber is eligible to receive Medicare benefits. On the 31st month, Medicare becomes the primary payer and this Plan becomes secondary. If the Subscriber applies for Medicare and does not qualify, this Plan will continue as primary payer.

If the Subscriber chooses not to enroll in Medicare Parts A and B, but is eligible to participate in the Medicare program, this Plan will limit coverage to coordinate benefits with what would have been paid by Parts A and B of Medicare if the subscriber was enrolled after the 33rd month from the first date of dialysis.

Notes:

- 1.** The Medicare three month waiting period may be shortened or eliminated if the Covered Person:
 - a.** takes part in a home dialysis program;
 - b.** is admitted to a Medicare–approved hospital for services related to kidney transplant; or
 - c.** is scheduled for a kidney transplant prior to the end of the coordination period.
- 2.** Medicare coverage due to ESRD ends 12 months after dialysis treatments end. However, termination of dialysis is unlikely unless the person receives a kidney transplant. For Covered Persons who undergo a kidney transplant, Medicare coverage would end 36 months after a successful transplant. An unsuccessful transplant usually requires a resumption of dialysis treatment.

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:

- A.** Any service or charge for service that is not Medically Necessary; any service or charge for service that 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 enacted or 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, “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, any act of war, or while in the military service.
- E. Any charges for services commencing prior to the Covered Person’s coverage under this Plan or rendered after the termination of coverage under this Plan, except as provided in Article 10, Continuation of Coverage, or Article 11, COBRA, of this Plan.
- F. Services or charges Incurred for acupuncture or biofeedback.
- G. Except for Clinical Trials covered pursuant to paragraph 7.26 of the Plan, any surgical or medical procedures determined by the medical staff of the Third Party Claims Processor, with appropriate consultation, to be experimental, investigational, or not accepted medical practice. Experimental or investigational procedures are those medical or surgical procedures, supplies, devices, or drugs that, 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. 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 paragraphs 7.19 Well Care and 7.25 Preventive Care.
- I. Admissions or portions thereof for: (i) sanitarium care or rest cures, (ii) physical or occupational therapy, or (iii) 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 therefrom. 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); 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. Notwithstanding the foregoing, if a Covered Person is receiving benefits under the Plan in connection with a mastectomy and if the Covered Person elects breast reconstruction in connection with such mastectomy, the Plan shall cover:

1. reconstruction of the breast on which the mastectomy has been or will be performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. prostheses and physical complications at all stages of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the Covered Person.

The Plan shall not: (i) deny any Covered Person eligibility or continued eligibility to enroll or to renew coverage under the terms of the Plan solely for the purpose of avoiding the coverage provided under this subparagraph; or (ii) penalize or otherwise reduce or limit the reimbursement of an attending Provider, or provide incentives (monetary or otherwise) to an attending Provider to induce the Provider to provide care to a Covered Person in a manner inconsistent with the coverage provided in this paragraph.

- 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 that are principally for the preserving of teeth or the preparation of the mouth for dentures, except as specified under paragraph 7.3.P.
- L.** Physician’s charges for medicine, drugs, appliances, supplies, blood, and blood derivatives, unless these items are Covered Medical Benefits under the Plan, and then only to the extent 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; 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 paragraph 7.3.Q.7.
- 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 (except for Diabetes Education under paragraph 7.27), or milieu therapy.
- P. Weight loss treatments and 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, sibling, or grandparent, whether biological, adopted, 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 paragraphs 7.1.A, B, and C and paragraphs 15.1.8 and 15.2.8.
- S. Charges for chronic pain management programs or any program developed by centers with multidisciplinary staffs intended to provide the interventions necessary to allow the patient to develop pain coping skills and freedom from dependence on analgesic medications.
- T. With respect to a Dependent Child, charges that are the result of the Dependent Child's infertility treatment, pregnancy, or complications from the Dependent Child's pregnancy or childbirth.
- U. Any services, supplies, or charges for, or in connection with, any procedure or surgery designed to reverse a prior vasectomy or tubal ligation, provided that the procedure is elective and not Medically Necessary to treat a pre-existing condition.
- V. Assisted reproductive technologies, except as provided in paragraph 7.18.
- 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 for other educational purposes; milieu therapy; or to determine learning disability.
- Y. Transcutaneous electrical nerve stimulation when the primary purpose is the treatment of pain. This exclusion does not include muscle stimulation units when they are used to strengthen specific muscles in situations where 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.** 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. Benefits for related Physician services are limited to one visit per week for up to the maximum benefits provided in paragraph 7.9.
- AA.** Benefits will not be provided for services or supplies not specifically listed in Article 7, Schedule of Benefits, inclusive.
- BB.** 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.
- CC.** Equipment purchased or requested by the Covered Person with or without a prescription, including Durable Medical Equipment, that has a solely non-therapeutic use, 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, ankle, or knee braces whose primary or sole purpose is to allow participation in athletics but are not documented to be Medically Necessary; and bandages, gauze; and similar equipment. Breast pumps are not covered except for those specific models available at no cost to Covered Persons through the Third Party Claims Processor.
- DD.** Items, including but not limited to medications, purchased over-the-counter.
- EE.** Fees for medical records or claims filing.
- FF.** Any service, supply, or charge for which the Employee or Dependent is not legally obligated to pay, as well as any deductible, coinsurance, or charges, or parts thereof, that a Hospital or health care Provider waives on an other than isolated case-by-case basis.
- GG.** Additional benefits will not be provided for preoperative anesthesia consultation.
- HH.** When the same Physician renders different levels of care on the same day, benefits will only be provided for the highest level of care.
- II.** Any medical service, supply, or charge that is prescribed or ordered by a Physician because an anatomical variation causes psychological problems.
- JJ.** Any service or supply related to dysfunctional conditions of the muscles of mastication, or derangement of the temporomandibular joint (TMJ), including office visits, splints, braces, guards, etc. This exclusion shall not apply to the Medically Necessary surgical correction of disorders of the temporomandibular joint that meet the conditions of paragraph 7.5.A.7.

- KK.** 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 paragraph 7.5.A.8.
- LL.** Sclerotherapy, 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.
- MM.** 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 is not a Covered Medical Benefit.
- NN.** Food supplements, even if ordered or prescribed by a Physician.
- OO.** Services and supplies rendered after death including but not limited to transportation and autopsies.
- PP.** Smoking cessation or deterrence products or services, 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, or as covered under paragraph 7.25, Preventive Care.
- QQ.** Services performed by service or therapy animals or their handlers.
- RR.** An otherwise legal abortion, except in cases of rape, incest, or where the mother's medical condition is one which, on the basis of the physician's good faith judgment, so complicates the pregnancy as to necessitate an immediate abortion to avert the risk of her death or for which a delay will create serious risk of substantial and irreversible impairment of major bodily function.
- SS.** Any services or charges related to Employee Assistance Programs.
- TT.** Complications arising from Covered Person's receipt of either Hospital services, medical services, medical supplies or other treatments that are not considered Covered Medical Benefits, including complications arising from a Covered Person's use of discount services.
- UU.** In the Savings Plan, non-sedating antihistamine medications or prescription drugs to treat erectile dysfunction are not a Covered Medical Benefit.
- VV.** Unless otherwise provided by law, contraceptives prescribed for a solely contraceptive use are not a Covered Medical Benefit for a Dependent Child. Coverage of contraceptives (oral, patches, injectables, transdermal, intravaginal, etc.) for a Dependent Child require a prior authorization and approval for a non-contraceptive medical use.

ARTICLE 10.

CONTINUATION OF COVERAGE

10.1 Incapacitated Dependent Child

The coverage of an unmarried Incapacitated Dependent Child under this Plan may be continued after the Child reaches age 26. To continue coverage for an Incapacitated Dependent Child, the Employee's coverage must remain in force, and the Employee must provide proof of the Dependent Child's incapacity and dependency to the Plan Administrator within 31 days of the Dependent Child reaching the age of 26 and at such other reasonable times, but not more than annually.

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. 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 Surviving Children

The Covered Surviving Spouse and Covered Surviving Children of a deceased Active 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 premium as set forth in paragraph 5.2, subject to the following limitations:

- A. Such Surviving Spouse or Surviving Children must be covered under the Plan at the time of the Employee's death (other than any Child born after the death of the Employee but before the remarriage of the Surviving Spouse);
- B. The coverage of a Surviving Spouse provided under this paragraph shall terminate upon remarriage;
- C. The existing coverage of any Surviving Children will not be affected 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 the Surviving Child no longer meets the definition of a Dependent Child.
- D. In no event shall any Surviving Spouse or Surviving Child who feloniously and intentionally kills the Active Employee be entitled to coverage;
- E. Upon the termination of this continuation coverage for a Surviving Spouse or a Surviving Child, such Surviving Spouse or Surviving Child may not reenroll in the Plan thereafter unless:
 - 1. The Surviving Spouse or Surviving Child remains enrolled in the State Dental or State Vision Plan. If enrolled in State Dental or State Vision, an otherwise eligible Surviving Spouse or Surviving Child may reenroll in the Plan within 31 days of a special eligibility situation or during open enrollment; or

2. The Surviving Spouse or Surviving Child gains eligibility as an Active Employee and continues coverage in the Plan as an Active Employee. An otherwise eligible Surviving Spouse or Surviving Child may only reenroll in the Plan within 31 days of losing eligibility as an Active Employee.
- F. Except as provided in this paragraph and paragraph 10.4, the coverage of a Surviving Spouse and Surviving Children of a deceased Employee shall terminate as provided in paragraph 3.9.

10.4 Surviving Spouse and Surviving Child Continuation Coverage and COBRA

Upon the death of the Employee that would entitle a Surviving Spouse or Surviving Child to continuation coverage pursuant to paragraph 10.3, such Surviving Spouse or Surviving Child shall, in accordance with applicable law, be provided with an opportunity to elect COBRA continuation coverage as described in Article 11. Such Surviving Spouse or Surviving Child may elect COBRA continuation coverage or the continuation coverage in paragraph 10.3. A Surviving Spouse or Surviving Child shall not be eligible for the continuation coverage provided under paragraph 10.3 unless the Surviving Spouse or Surviving Child declines to elect continuation coverage under COBRA as set forth in Article 11.

ARTICLE 11.

COBRA

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

COBRA requires that a Qualified Beneficiary 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 Qualified Beneficiary before the Qualifying Event and identical to the coverage provided to similarly situated Employees to whom a Qualifying Event has not occurred. Continuation Coverage may not be conditioned upon evidence of good health. If the Plan provides an Open Enrollment Period during which similarly situated Active Employees may choose to be covered under another group health plan, or to add or eliminate coverage of family members, the Plan shall provide the same opportunity to Qualified Beneficiaries who have elected continuation coverage. If continuation coverage under the Plan is elected by a Qualified Beneficiary, expenses already credited to the Plan's applicable Cost Sharing features for the year will be carried forward into the continuation coverage elected for that year.

Notwithstanding any other provision of this Article, a Qualified Beneficiary may elect to continue coverage under the Savings Plan regardless of what coverage they had when they became a Qualified Beneficiary.

Qualified Beneficiaries may be eligible for more affordable coverage options through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as through special enrollment in a Spouse's plan if elected within 30 days after the loss of

coverage under this Plan). Some of these options may cost less than COBRA continuation coverage. Qualified Beneficiaries should compare other coverage options with COBRA continuation coverage. Once the choice is made, it is difficult or impossible to modify the decision.

The Health Insurance Marketplace offers “one-stop shopping” to find and compare private health insurance options. Qualified Beneficiaries might be eligible for a tax credit that lowers monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and co-payments) for policies purchased on the Marketplace. The Marketplace may be accessed at www.HealthCare.gov. Qualified Beneficiaries have a 60-day special enrollment period from the time that coverage is lost under the Plan to enroll in the Marketplace. If enrollment does not occur in the 60-day special enrollment period, enrollment in the Marketplace may occur during the Marketplace's annual open enrollment period.

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 a spouse;
- D. The Employee becoming entitled to Medicare coverage; and
- E. A Dependent Child ceasing to qualify as an eligible Dependent under the Plan.

11.3 Qualified Beneficiary

A Qualified Beneficiary is any individual who, on the day before the Qualifying Event, is a beneficiary under the Plan and is any of the following:

- A. The Employee whose employment was terminated (other than for gross misconduct) or work hours were reduced so as to render the Employee ineligible for coverage;
- B. The Spouse of the Employee; or
- C. The Dependent Child of the Employee, including a Child who is born to or placed for adoption with the Employee during the period of continuation coverage.

11.4 Notice by Employee, Spouse, or Child

In cases of divorce or legal separation of the Employee from a Spouse, or when a Child ceases 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 (i) the date of the Qualifying Event, or (ii) 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 occurrence of either event, the

Dependent will not be given the opportunity to continue coverage.

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 continued coverage under COBRA, 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. The notice must be provided within 60 days after the latest of: (i) the date of the determination of disability under the Social Security Act; (ii) the date the Qualifying Event occurs; (iii) the date the Qualified Beneficiary loses or would lose coverage; or (iv) the date the Qualified Beneficiary is notified of their notice obligation. In addition, the Qualified Beneficiary must also notify the Plan Administrator within 30 days of any determination that the Employee or Dependent is no longer disabled.

11.5 Notice By Plan Administrator

The Plan Administrator shall provide, at the time of commencement of coverage under the Plan, written notice to each Covered Employee and to the Spouse of the Covered Employee (if any) of their rights to continuation coverage. The Plan may satisfy this obligation by furnishing a single notice addressed to both a Covered Employee and the Covered Employee's Spouse if they both reside at the Covered Employee's address, and the Spouse's coverage commences on or after the date on which the Covered Employee's coverage commences, but not later than the date by which this general notice must be provided. No separate notice is required to be sent to Dependent Children who share a residence with a Covered Employee or a Covered Employee's Spouse. This general notice shall be provided not later than the earlier of: (i) 90 days after such individual's coverage commencement date under the Plan; or (ii) the date on which the Plan Administrator is required to furnish a COBRA election notice as described in this paragraph.

The Employer shall notify the Plan Administrator or its designee in the event of a Covered Employee's death, termination of employment (other than gross misconduct), reduction in hours, or entitlement to Medicare benefits within 30 days after the later of: (i) the date of the Qualifying Event; or (ii) the date that the Qualified Beneficiary would lose coverage due to the Qualifying Event.

The Covered Employee and the Covered Employee's Dependent(s) shall be notified by the Plan Administrator or its designee of their right to elect continuation coverage: (i) in the event of the Covered Employee's death, termination, reduction in hours or entitlement to Medicare benefits; and (ii) if the Covered Employee is notified by the Plan Administrator or its designee initially, in the event of divorce or legal separation of the Covered Employee from the Covered Employee's Spouse, disability, or in the event of a Child ceasing to be a Dependent Child under the Plan, within 14 days of the date on which the Plan Administrator or its designee was notified of these Qualifying Events. Election form shall be sent by U.S. Mail, postage pre-paid, to the last known address of the Qualified Beneficiaries unless the Plan Administrator has been notified in writing to the contrary. The last known address shall be deemed to be the most recent address in the records of the Plan Administrator. In the event the Covered Employee/former Covered Employee changes address, it is their responsibility to notify the Plan Administrator of any change in address. The Plan Administrator shall not be responsible for notices sent to the wrong address if the more recent address was not provided in the above manner. Notification to a Covered Employee/former Covered Employee who elected spousal coverage shall be sent with an envelope addressed to the Covered Employee and Spouse. Election forms sent to an Covered Employee/former Covered Employee that has one or more Children/Dependents covered shall be addressed to the

Covered Employee (if the Spouse was not covered) or to the Covered Employee and Spouse (if spousal coverage was elected), and each shall be deemed to include notification to any Dependent Children, unless the Plan Administrator has actual knowledge of a different address for a Dependent Child before the date the election form is mailed and any such notification to the Plan Administrator was in writing sent via either U.S. Mail or facsimile.

In addition, if a Covered Employee or Dependent is not entitled to receive Continuation Coverage, they will be so notified and will be provided with an explanation as to why they are not entitled to this Continuation Coverage. This notice shall be provided within 14 days of the date that the Plan Administrator was provided with the notice of the purported qualifying event.

11.6 Election of Coverage

Continued coverage is not automatic. Coverage must be elected within 60 days of the later of the following: (i) the date coverage ceases because of the Qualifying Event; or (ii) the date the Qualified Beneficiary is sent notice of the right to elect continuation coverage.

11.7 Premium Required

The Plan will determine the amount of premium to be charged for continued coverage for any period, which will be a reasonable estimate of the cost of providing coverage for such period for similarly situated individuals, determined on an actuarial basis and considering such factors as may be provided by law.

- A.** The Plan may require a Qualified Beneficiary to pay a contribution for coverage that does not exceed 102% of the applicable premium for that period.
- B.** For Qualified Beneficiaries whose coverage is continued as a result of disability, the Plan may require the Qualified Beneficiary to pay a contribution for coverage that does not exceed 150% of the applicable premium for continued coverage months 19–29.
- C.** Contributions for coverage shall be paid in monthly installments.
- D.** If continued coverage is elected, the monthly contribution for coverage for those months up to and including the month in which the election is made must be made within 45 days of the date of election. Failure to pay this premium on the date due shall result in cancellation of continued coverage back to the initial date coverage would have terminated as a result of the Qualifying Event.
- E.** Without further notice from the Plan, the Qualified Beneficiary must pay each following monthly contribution for coverage by the first day of the month for which coverage is to be effective. If payment is not received by the Plan within 30 days of the payment's due date, continued coverage will terminate. This 30 day grace period does not apply to the first contribution required under paragraph D.
- F.** No claim will be payable under this paragraph for any period for which the contribution for coverage is not received from or on behalf of the Qualified Beneficiary.
- G.** It is Qualified Beneficiary's responsibility to pay the premium on time. If the Plan Administrator provides a Qualified Beneficiary with payment reminders or payment coupons,

but later ceases to do so, it still remains the Qualified Beneficiary's responsibility to make the premium payments on time even if the Qualified Beneficiary no longer receives the payment reminders or coupons, and even if the Qualified Beneficiary is not notified of the cessation of the payment reminders or coupons.

11.8 Maximum Length of Coverage

Continuation Coverage is a temporary continuation of coverage. In general, the following rules will determine the length of the coverage. However, there are two situations that can extend the coverage: disability and second qualifying events.

- A. A Qualified Beneficiary who loses coverage due to the reduction in hours or termination of employment (other than for gross misconduct) of a Covered Employee may continue coverage under the Plan for up to 18 months from the date of the Qualifying Event.
- B. A Qualified Beneficiary who loses coverage due to the Covered Employee's death, divorce, legal separation, or entitlement to Medicare, and Dependent Children who have become ineligible for coverage, may continue coverage under the Plan for up to 36 months from the date of the Qualifying Event. In the event of the Covered Employee's death, the Spouse and Child are entitled to continuation coverage as described in Article 10 above in lieu of COBRA continuation coverage (see paragraph 10.4).
- C. If a Covered Employee became entitled to Medicare benefits less than 18 months before the Participant's employment ended or their hours were reduced, the Spouse and Children of the Covered Employee may continue coverage under the Plan for up to thirty-six 36 months from the date of the Medicare entitlement

In the event of a disability determination, this Qualified Beneficiary is entitled to 29 months of continuation coverage if the Qualified Beneficiary provides notice of the determination of disability before the end of 18 months of coverage and within 60 days of the later of these dates: (i) the date of the SSA Disability determination notification; (ii) the date of the qualifying event; (iii) the date of the initial COBRA notice; or (iv) the date the subscriber lost coverage because of the qualifying event.

If a Qualified Beneficiary is continuing coverage due to a Qualifying Event for which the maximum continuation coverage is 18 or 29 months, and a second Qualifying Event occurs during the 18 or 29 month period, all individuals who were Qualified Beneficiaries in connection with the initial Qualifying Event and who are still Qualified Beneficiaries at the time of the second Qualifying Event may elect to continue coverage under the Plan for up to 36 months from the date of the first Qualifying Event.

For example, this extension may be available to the Spouse and any Dependent Children who are already receiving continuation coverage if the Covered Employee or former Covered Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

11.9 Early Termination of Continuation Coverage

Coverage under paragraph 11.8 may end before the end of the maximum coverage period and will occur on the date of the earliest of any of the following:

- A. The date the State or the Employer associated with the Qualified Beneficiary ceases to provide any group health plan to any Employee;
- B. The date, including any grace period provided herein, the Qualified Beneficiary fails to make any required payment;
- C. The first date after the date of election in which the Qualified Beneficiary is covered under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary. An Employee who, on the date of the Qualifying Event, is covered by a plan (including Medicare) other than this Plan, remains eligible for continuation coverage under COBRA under this Plan;
- D. The date the Employee or eligible Dependent already enrolled for continuation coverage under COBRA becomes entitled to Medicare; and
- E. For disabled Qualified Beneficiaries continuing coverage for up to 29 months, the last day of the month coincident with or following 30 days from the date of a final determination by the Social Security Administration that such Qualified Beneficiary is no longer disabled.

Notwithstanding the foregoing, the Plan may also terminate the continuation coverage of a Qualified Beneficiary for cause on the same basis that the Plan could terminate the coverage of a similarly situated non-COBRA beneficiary for cause (e.g., in the case of submitting fraudulent claims to the Plan).

In the event a Qualified Beneficiary's continuation coverage terminates before the duration of continuation coverage (either 18, 29, or 36 months after the Qualifying Event), the Plan Administrator shall notify the Qualified Beneficiary of the early termination date and the reason for early termination of continuation coverage. Such notice will be provided as soon as practicable following the Plan Administrator's determination that continuation coverage should terminate.

11.10 Persons on Military Leave

Any Covered Employee who is covered under this Plan immediately prior to the Covered Employee's covered absence for Service in the Uniformed Service shall be entitled to elect to continue coverage under this Plan for the Covered Employee and the Covered Employee's Dependent(s) during the Covered Employee's leave for Service in the Uniformed Service pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Such coverage is available if the Covered Employee is absent from employment because of voluntary or involuntary performance of duty in the Army; Navy; Marine Corps; Air Force; Coast Guard; the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty; the commissioned corps of the Public Health Service; the reserve components of each of these services; and any other category of persons designated by the President of the United States in time of war or national emergency. Uniformed services also include certain types of service by members in the National Disaster Medical System and certain types of service by certain members of the Reserve Officers' Training Corps.

The Covered Employee may elect to continue coverage described in this Article by reason

of Service in the Uniformed Services for themselves and their covered Dependents. Dependents do not have an independent right to elect USERRA continuation coverage. The election period for continued coverage shall begin on the date the Covered Employee gives the Employer advance notice that they are required to report for Uniformed Service (whether such service is voluntary or involuntary) and shall end 60 days after the date the Covered Employee would lose coverage under the Plan.

If the Covered Employee is unable to give advance notice of Uniformed Service, the Covered Employee may still be able to elect USERRA continuation coverage if the failure to give advance notice was because giving such notice was impossible, unreasonable, or precluded by military necessity. In such case, the election period shall begin on the date the Covered Employee leaves for Uniformed Service and shall end on the earlier of: (i) the 36-month period beginning on the date on which the Covered Employee's absence for the Uniformed Service begins; or (ii) the date on which the Covered Employee fails to return from Uniformed Service or apply for a position of employment as provided under 20 CFR. §§ 1002.115-123. For these purposes, "military necessity" occurs only when deemed to be so by a designated military authority as described in 20 CFR § 1002.86 and may include situations where a mission, operation, exercise, or requirement is classified or could be compromised or otherwise adversely affected by public knowledge. It may be impossible or unreasonable to give advance notice under certain circumstances such as when the Employer is unavailable or the Covered Employee is required to report for Uniformed Service in an extremely short period of time.

The election of USERRA continuation coverage must be made on a form provided by the Plan Administrator and made within the 60-day period described herein. An election is considered to be made on the date it is sent to the Plan Administrator. If timely elected pursuant to this paragraph, coverage shall be reinstated as of the date the Covered Employee lost coverage due to absence for Service in the Uniformed Service and shall last for the period set forth below, provided the Covered Employee pays all unpaid costs for the coverage as described in this paragraph.

Any Covered Employee or Dependent who elects to continue coverage under this provision shall be required to pay 102% of the applicable premium as discussed in paragraph 11.7 above. Any Covered Employee (and the Dependents of such Covered Employee) who is on military leave for less than 31 days shall not be required to pay more than the cost of coverage typically charged to similarly situated Covered Employees (and their Dependents).

A Covered Employee who is absent from work by reason of Service in the Uniformed Services may be eligible for COBRA continuation coverage. The USERRA continuation coverage provided in this paragraph shall not limit or otherwise interfere with those COBRA continuation coverage rights detailed above. Any USERRA continuation coverage provided under this paragraph shall run concurrently with any COBRA Continuation Coverage available under this Plan.

The Employer shall promptly reinstate Plan coverage when a Covered Employee is reemployed after Service in the Uniformed Service. A request to reinstate Plan coverage must be made by the Covered Employee within 30 days of reemployment (presuming the Covered Employee has sought reemployment with the Plan in compliance with 20 CFR Part 1002, Subpart C). If no request is made within this time period, no coverage shall be reinstated under the Plan. When a Covered Employee's coverage under the Plan is reinstated, they will not be subject to any exclusion or waiting periods. However, this rule does not apply

to any conditions that were Incurred or that were aggravated during the Covered Employee's service in uniformed services.

The USERRA continuation coverage provided to a Covered Employee serving in the Uniformed Services shall be identical to the coverage provided under the Plan to similarly situated persons covered by the Plan who are active. If coverage is modified under the Plan for any group of similarly situated beneficiaries, such coverage shall also be modified in the same manner for all individuals who are covered under USERRA continuation coverage. Continuation coverage may not be conditioned on evidence of good health. If the Plan provides an Open Enrollment Period during which similarly situated active Employees may choose to be covered under another group health plan or under another benefit package within the Plan, or to add or eliminate coverage of family members, the Plan shall provide the same opportunity to individuals who have elected USERRA continuation coverage.

ARTICLE 12.

CLAIMS PROCEDURE

12.1 Categories of Claims

As described below, there are four categories of claims that can be made under the Plan, each with somewhat different claim and appeal rules. The primary difference is the timeframe within which claims and appeals must be determined.

- A. Pre-Service Claim.** A claim is a pre-service claim if the Plan specifically conditions receipt of the benefit, in whole or in part, on receiving approval in advance of obtaining the medical care, unless the claim involves urgent care, as defined below. Benefits under the Plan that require approval in advance are specifically noted in the Plan as being subject to Pre-Certification.
- B. Urgent Care Claim.** An urgent care claim is a special type of pre-service claim. A claim involving urgent care is any pre-service claim for medical care or treatment with respect to which the application of the time periods that otherwise apply to pre-service claims could seriously jeopardize the Covered Person's life or health or ability to regain maximum function or would, in the opinion of a physician with knowledge of the Covered Person's medical condition, subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

On receipt of a pre-service claim, the Plan will make a determination of whether it involves urgent care, provided that, if a physician with knowledge of the Covered Person's medical condition determines that a claim involves urgent care, the claim shall be treated as an urgent care claim.

- C. Post-Service Claim.** A post-service claim is any claim for a benefit under the Plan that is not a pre-service claim, an urgent care claim, or a concurrent care claim.
- D. Concurrent Care Claim.** A concurrent care decision occurs where the Plan approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims: (a) where reconsideration of the approval results in a reduction or termination of the initially approved period of time or

number of treatments; and (b) where an extension is requested beyond the initially approved period of time or number of treatments.

- E. **Change in Claim Type.** The claim type is determined initially when the claim is filed. However, if the nature of the claim changes as it proceeds through these claims procedures, the claim may be re-characterized. For example, a claim may initially be an urgent care claim. If the urgency subsides, it may be re-characterized as a pre-service claim.

12.2 Making a Claim for Benefits

- A. A Covered Person will present an identification card when applying for services covered under this Plan;
- B. Except for Urgent Care Claims, discussed below in paragraph 12.3, 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, provided the Covered Person submits written proof covering the character and extent of the loss as described in paragraphs C–E below;
- C. A Covered Person must complete or cause to be completed and file or cause to be filed a claim on forms prescribed by the Plan Administrator or Third Party Claims Processor, along with all documentation, including medical records, required by the Plan Administrator or Third Party Claims Processor. 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 records, financial records, and other 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;
- 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 file the claim timely, provided the claim is filed as soon as is reasonably possible but in no event, except in the absence of legal capacity, later than 12 months following the end of the Plan Year in which the goods or services were provided;
- E. 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.

12.3 Urgent Care Claims

In light of the expedited timeframes for decision of Urgent Care Claims, an Urgent Care Claim for benefits may be submitted to the Third Party Claims Processors by telephone, by fax, or by e-mail. The claim should include at least the following information:

- A. the identity of the Covered Person;
- B. a specific medical condition or symptom; and
- C. a specific treatment, service, or product for which approval or payment is requested.

12.4 Incorrectly Filed Claims

These claims procedures do not apply to any request for benefits that is not made in accordance with these claims procedures, except that: (a) in the case of an incorrectly filed Pre-service Claim, the Covered Person shall be notified as soon as possible but no later than five days following receipt by the Plan of the incorrectly filed claim; and (b) in the case of an incorrectly filed Urgent Care Claim, the Covered Person shall be notified as soon as possible but no later than 24 hours following receipt by the Plan of the incorrectly filed claim. The notice shall explain that the request is not a claim and describe the proper procedures for filing a claim. The notice may be oral unless written notice is specifically requested by the Covered Person. This special timing rule applies only to urgent care claims and pre-service claims that: (a) are received by the person or unit customarily responsible for handling benefit matters; and (b) specify a claimant, a medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

12.5 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 Plan's Provider Networks ("Participating Providers") and to any other Providers with whom the Plan Administrator has agreed to make direct payments ("Contracting Providers"). These payments will be made 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 that is: (i) signed by a Covered Person, and (ii) 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: (i) a non-participating provider who was offered and declined membership in the networks; (ii) a non-participating Provider who did not meet the standards and qualifications for membership in the networks; or (iii) a supplier of medical goods, supplies, or drugs, unless specifically authorized by the Plan Administrator. The Covered Person may assign benefits to non-participating Providers rendering Medical Care under the Plan who are not within the scope of the networks, 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 paragraph shall not be construed as a waiver of its rights to enforce this paragraph in the event of subsequent assignments.

If a Provider who may accept assignment of benefits files a health insurance claim form with the Third Party Claims Processor that is: (i) signed by a Covered Person, and (ii) 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.

12.6 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 illness is the basis of a claim when and as often as it may reasonably be required during the pendency of a claim or action hereunder.

12.7 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.

12.8 Timeframe for Third Party Claims Processor or Utilization Review Agency to Make Initial Determination Regarding Benefit Claims

- A. Pre-Service Claims:** The Third Party Claims Processor or Utilization Review Agency shall decide an initial Pre-Service Claim within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim.
- B. Urgent Care Claims:** The Third Party Claims Processor or , Utilization Review Agency shall decide an initial Urgent Care Claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim.
- C. Concurrent Care Extension Request:** If a claim is a request to extend a concurrent care decision (defined above) involving Urgent Care and if the claim is made at least 24 hours prior to the end of the initially approved period of time or number of treatments, the Third Party Claims Processor or Utilization Review Agency shall decide the claim within no more than 24 hours after receipt of the claim. Any other request to extend a concurrent care decision shall be decided by the Third Party Claims Processor or Utilization Review Agency in the otherwise applicable timeframes for Pre-Service, Urgent Care, or Post-Service Claims.
- D. Concurrent Care Early Termination:** A decision by the Third Party Claims Processor or Utilization Review Agency to reduce or terminate an initially approved course of treatment is an adverse benefit decision that may be appealed by the Covered Person under these claims procedures, as explained below. Notification to the Covered Person of a decision by the Third Party Claims Processor or Utilization Review Agency to reduce or terminate an initially approved course of treatment shall be provided sufficiently in advance of the reduction or termination to allow the Covered Person to appeal the adverse decision and receive a decision on review under these procedures prior to the reduction or termination.
- E. Post-Service Claim:** The Third Party Claims Processor or Utilization Review Agency shall decide an initial Post-Service Claim within a reasonable time but no later than 30 days after receipt of the claim.
- F. When Extensions of Time Are Permitted:** Despite the specified timeframes, nothing prevents the Covered Person from voluntarily agreeing to extend the above timeframes. In

addition, if the Third Party Claims Processor or Utilization Review Agency is not able to decide a Pre-Service or Post-Service Claim within the above timeframes due to matters beyond its control, one 15-day extension of the applicable timeframe is permitted, provided that the Covered Person is notified in writing prior to the expiration of the initial timeframe applicable to the claim. The extension notice shall include a description of the matters beyond the Third Party Claims Processor's or Utilization Review Agency's control that justify the extension and the date by which a decision is expected. No extension is permitted for Urgent Care Claims.

- G. Incomplete Claims:** If any information needed to process a claim is missing, the claim shall be treated as an incomplete claim.
- H. How Incomplete Urgent Care Claims Are Treated:** If an Urgent Care Claim is incomplete, the Third Party Claims Processor or Utilization Review Agency shall notify the Covered Person as soon as possible, but no later than 24 hours following receipt of the incomplete claim. The notification may be made orally to the Covered Person, unless the Covered Person requests written notice and the notification shall describe the information necessary to complete the claim and shall specify a reasonable time, no less than 48 hours, within which the claim must be completed. The Third Party Claims Processor or Utilization Review Agency shall decide the claim as soon as possible but not later than 48 hours after the earlier of: (a) receipt of the specified information; or (b) the end of the period of time provided to submit the specified information.
- I. How Other Incomplete Claims Are Treated:** If a Pre-Service or Post-Service Claim is incomplete, the Third Party Claims Processor or Utilization Review Agency may deny the claim or may take an extension of time, as described above. If the Third Party Claims Processor or Utilization Review Agency takes an extension of time, the extension notice shall include a description of the missing information and shall specify a timeframe, no less than 45 days, in which the necessary information must be provided. The timeframe for deciding the claim shall be suspended from the date the extension notice is received by the Covered Person until the date the missing necessary information is provided to the Third Party Claims Processor or Utilization Review Agency. If the requested information is provided, the Third Party Claims Processor or Utilization Review Agency shall decide the claim within the extended period specified in the extension notice. If the requested information is not provided within the time specified, the claim may be decided without that information.

12.9 Notification of Initial Benefit Decision by Third Party Claims Processor or Utilization Review Agency

- A. Pre-Service and Urgent Care:** Written notification of the Third Party Claim Processor's or Utilization Review Agency's decision on a Pre-Service or Urgent Care Claim shall be provided to the Covered Person whether or not the decision is adverse.
- B. Definition of Adverse:** A decision on a claim is "adverse" if it is: (a) a denial, reduction, or termination of; or (b) a failure to provide or make payment (in whole or in part) for a Plan benefit, including determinations based on eligibility and utilization review, or a failure to cover a benefit because it is determined to be experimental or investigational or not Medically Necessary. It also means a Rescission of coverage whether or not, in connection with the Rescission, there is an adverse effect on any particular benefit at that time.

C. Notification of Adverse Benefit Decision: Written notification shall be provided to the Covered Person of the Third Party Claims Processor's or Utilization Review Agency's adverse decision on a claim and shall include the following, in a manner calculated to be understood by the Covered Person:

1. a statement of the specific reason(s) for the decision;
2. reference(s) to the specific Plan provision(s) on which the decision is based;
3. a description of any additional material or information necessary to perfect the claim and why such information is necessary;
4. a description of the Plan procedures and time limits for appeal of the decision and the right to obtain information about those procedures, information on the External Review process under paragraph 12.10.B, and the right to appeal to a court of law;
5. a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
6. if the decision involves scientific or clinical judgment, either: (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to the Covered Person's medical circumstances; or (b) a statement that such explanation will be provided at no charge upon request;
7. information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
8. the denial code and its corresponding meaning, as well as a description of the Benefit Administrator's standard, if any, that was used in the denial of the claim;
9. the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Services Act to assist individuals with the internal claims and appeals and External Review processes; and
10. in the case of an Urgent Care Claim, an explanation of the expedited review methods available for such claims.

Notification of the Third Party Claims Processor's or Utilization Review Agency's adverse decision on an Urgent Care Claim may be provided orally, but written notification shall be furnished not later than three days after the oral notice.

12.10 Appeal Procedure

A Covered Person has a right to appeal an adverse decision under these claims procedures. . The exclusive remedy for the denial of benefits shall be as provided by statute and by the procedures of PEBA Insurance Benefits.

A. Request for Reconsideration

1. **Non-Urgent Care Claim Appeal.** Except for Urgent Care Claims, discussed below, an appeal of an adverse benefit decision is filed when a Covered Person (or authorized representative) submits a written Request for Reconsideration to the Third Party Claims Processor or Utilization Review Agency. Appeals regarding eligibility decisions will be referred by the Third Party Claims Processor or the Utilization Review Agency to the Plan Administrator for determination. A written Request for Reconsideration will be treated as received by the Third Party Claims Processor or Utilization Review Agency: (a) on the date it is hand-delivered to the Third Party Claims Processor or Utilization Review Agency; or (b) on the date that it is deposited in the U.S. Mail for first-class delivery in a properly stamped envelope containing the address of the Third Party Claims Processor or Utilization Review Agency. The postmark on any such envelope will be proof of the date of mailing.
2. **Urgent Care Appeals.** In light of the expedited timeframes for decision of Urgent Care Claims, an Urgent Care Request for Reconsideration may be submitted to the Third Party Claims Processor or Utilization Review Agency by telephone, by fax, or by e-mail. The Urgent Care Request for Reconsideration should include at least the following information:
 - a. the identity of the Covered Person;
 - b. a specific medical condition or symptom;
 - c. a specific treatment, service, or product for which approval or payment is requested; and
 - d. any reasons why the appeal should be processed on a more expedited basis.
3. **Submission of Comments.** A Covered Person has the right to submit documents, written comments, or other information in support of a Request for Reconsideration, without regard to whether such information was submitted or considered in the initial benefit determination.
4. **Request for Reconsideration Deadline.** The Request for Reconsideration of an adverse benefit decision must be filed within 180 days following the Covered Person's receipt of the notification of adverse benefit decision, except that the appeal of a decision by the Third Party Claims Processor or Utilization Review Agency to reduce or terminate an initially approved course of treatment (see the definition of Concurrent Care decision) must be filed within 30 days of the Covered Person's receipt of the notification of the decision of the Third Party Claims Processor or Utilization Review Agency to reduce or terminate. Failure to comply with this deadline will cause the Covered Person to forfeit any right to any further review of an adverse decision under these procedures or in a court of law.
5. **How the Request of Reconsideration Will Be Decided.** The Reconsideration of an adverse benefit decision will be reviewed and decided by the Plan Administrator (with regard to appeals of eligibility decisions), Third Party Claims Processor, or the Utilization Review Agency. The person who reviews and decides

the Reconsideration request will be a different individual than the person who made the Initial Benefit decision and will not be a subordinate of the person who made the Initial Benefit decision. Before issuing a final decision on Reconsideration that is based on a rationale that was not included in the Initial Benefit determination, the Plan Administrator, Third Party Claims Processor, or the Utilization Review Agency will provide the Covered Person, free of charge, with the rationale as soon as possible and sufficiently in advance of the final Reconsideration decision to give the Covered Person a reasonable opportunity to respond. The Plan Administrator, Third Party Claims Processor, or the Utilization Review Agency will follow these procedures when deciding any Request for Reconsideration:

- a. **Consideration of Comments.** The Plan Administrator, Third Party Claims Processor, or the Utilization Review Agency will take into account all information submitted by the Covered Person, whether or not presented or available at the Initial Benefit decision. The Plan Administrator, Third Party Claims Processor, or the Utilization Review Agency will give no deference to the Initial Benefit decision.
- b. **Consultation with Expert.** In the case of a claim denied on the grounds of a medical judgment, the Third Party Claims Processor or the Utilization Review Agency will consult with a health professional with appropriate training and experience. The Health Care Professional who is consulted upon Reconsideration will not be the same individual who was consulted, if any, regarding the Initial Benefit decision or a subordinate of that individual.
- c. **Access to Relevant Information.** A Covered Person shall, on request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Person's claim for benefits. If the advice of a medical or vocational expert was obtained in connection with the Initial Benefit decision, the names of each such expert shall be provided on request by the Covered Person, regardless of whether the advice was relied on by the Plan Administrator, Third Party Claims Processor, or the Utilization Review Agency.
- d. **Expedited Methods for Urgent Care.** All necessary information in connection with an Urgent Care Request for Reconsideration shall be transmitted between the Plan Administrator, Third Party Claims Processor, or the Utilization Review Agency and the Covered Person by telephone, fax, or e-mail.

6. Timeframes for Deciding Request for Reconsideration

- a. **Pre-Service Claims.** The Plan Administrator, Third Party Claims Processor, or the Utilization Review Agency shall decide the Reconsideration of a Pre-Service Claim within a reasonable time appropriate to the medical circumstances but no later than thirty (30) days after receipt by the Plan Administrator, Third Party Claims Processor, or the Utilization Review Agency of the Request for Reconsideration.

- b. **Urgent Care Claims.** The Plan Administrator, Third Party Claims Processor, or the Utilization Review Agency shall decide the Reconsideration of an Urgent Care Claim as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours after receipt by the Plan Administrator, Third Party Claims Processor, or the Utilization Review Agency of the Request for Reconsideration.
 - c. **Post-Service Claims.** The Plan Administrator, Third Party Claims Processor, or the Utilization Review Agency shall decide the reconsideration of a Post-Service Claim within a reasonable period but no later than sixty (60) days after receipt by the Plan Administrator, Third Party Claims Processor, or the Utilization Review Agency Plan of the Request for Reconsideration. Provided that if medical records have been requested, 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.
 - d. **Concurrent Care Claims.** The Third Party Claims Processor or the Utilization Review Agency shall decide the Reconsideration of a decision by the Third Party Claims Processor or the Utilization Review Agency to reduce or terminate an initially approved course of treatment (see the definition of Concurrent Care Decision) before the proposed reduction or termination takes place. The Third Party Claims Processor or the Utilization Review Agency shall decide the Reconsideration of a denied request to extend any Concurrent Care decision in the Reconsideration timeframe for Pre-Service, Urgent Care, or Post-Service Claims described above, as appropriate to the request.
- 7. **Notification of Decision on Reconsideration.** The Plan Administrator, Third Party Claims Processor, or the Utilization Review Agency shall provide written notification of the Reconsideration decision to the Covered Person whether or not the decision is adverse.
 - a. **Definition of Adverse:** A decision on a Request for Reconsideration is "adverse" if it is: (a) a denial, reduction, or termination of; or (b) a failure to provide or make payment (in whole or in part) for a Plan benefit, including determinations based on eligibility and utilization review, or a failure to cover a benefit because it is determined to be experimental or investigational or not Medically Necessary. It also means a Rescission of coverage whether or not, in connection with the Rescission, there is an adverse effect on any particular benefit at that time.
 - b. **Notification of Adverse Request for Reconsideration Decision:** Written notification shall be provided to the Covered Person of an adverse decision on Reconsideration and shall include the following, written in a manner calculated to be understood by the Covered Person:
 - i. a statement of the specific reason(s) for the decision;
 - ii. reference(s) to the specific Plan provision(s) on which the decision is based;

- iii. a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
- iv. if the decision involves scientific or clinical judgment, either: (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to the Covered Person's medical circumstances; or (b) a statement that such explanation will be provided at no charge upon request;
- v. information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- vi. the denial code and its corresponding meaning, as well as a description of the Plan Administrator's, Third Party Claims Processor's, or Utilization Review Agency's standard, if any, that was used in the denial of the claim;
- vii. the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Services Act to assist individuals with the internal claims and appeals and External Review processes;
- viii. a description of the review procedures and time limits, including information regarding how to initiate an appeal information on the External Review process, and a statement of the claimant's right to appeal to a court of law;
- ix. if the denial is a Final Denial, a discussion of the decision; and
- x. a statement indicating entitlement to receive on request, and without charge, reasonable access to or copies of all documents, records, or other information relevant to the determination.

Notification of an adverse decision on Reconsideration of an Urgent Care Claim may be provided orally, but written notification shall be furnished not later than three days after the oral notice.

B. Request for External Review and Plan Administrator Review

- 1. Filing of Request for External Review and Plan Administrator Review.** A Covered Person (or someone acting on the Covered Person's behalf) may request External Review and Plan Administrator Review of an adverse benefit decision by the Third Party Claims Processor or Utilization Review Agency of a Request for Reconsideration by filing a written Request for External Review and Plan Administrator Review with the Plan Administrator within four (4) months after the Covered Person's date of receipt of a notice of an adverse benefit determination.
- 2. Preliminary Review of Standard External Review by Plan Administrator.** Within five (5) business days following the date of receipt of the Request for a standard External Review and Plan Administrator Review, the Plan Administrator shall conduct a Preliminary Review of the Request to determine whether:

- a. the Covered Person is (or was) covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, the Covered Person was covered under the Plan at the time the health care item or service was provided;
- b. the adverse benefit determination is not based on the fact that the Covered Person was not eligible for coverage under the Plan;
- c. the adverse benefit determination involved medical judgment (including, but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational) or a Rescission of coverage (whether or not the Rescission has any effect on any particular benefit at that time);
- d. the Covered Person has exhausted the Plan's internal appeal process (unless exhaustion is not otherwise required); and
- e. the Covered Person has provided all the information and forms required to process an External Review.

The Covered Person will be notified of the results of the Preliminary Review within one business day after completion of the Preliminary Review. If the Request is incomplete, the notice must describe the information needed to complete the Request, and set forth the time limit for the Covered Person to provide the additional information needed (the longer of the initial four month period within which to request an External Review or, if later, forty-eight (48) hours (or such longer period specifically identified in the notice) after the receipt of the notice).

If the claim is eligible for External Review, the Plan Administrator will randomly assign one of three accredited Independent Review Organizations (IRO) to conduct the External Review.

If the claim is not eligible for External Review, the Plan Administrator shall notify the Covered Person and the notification shall include the reasons for its ineligibility. Such a claim may be appealed to the Administrative Law Court within 30 days of the Covered Person's receipt of the adverse decision in accordance with paragraph C below. Instead of appealing directly to the Administrative Law Court, the Covered Person may first seek a Voluntary Additional Appeal to the Plan Administrator in accordance with subparagraph (5) below.

3. **Expedited External Review of Urgent Care Claims.** Expedited External Review may be requested by the Covered Person when the Third Party Claims Processor or Utilization Review Agency issues an adverse benefit determination of a Request for Reconsideration involving an Urgent Care Claim. The request for an Expedited External Review must be made in writing to the Plan Administrator. Immediately upon receipt of the request for an Expedited External Review, the Plan Administrator will determine whether the request meets the eligibility requirements described above in subparagraph (2) for a standard External Review. If the request meets the requirements for standard External Review, the Covered Person

will be notified of the determination, and an IRO will be assigned as described above for a standard External Review.

If the claim is not eligible for External Review, the Plan Administrator shall notify the Covered Person and the notification shall include the reasons for its ineligibility. At the Covered Person's request, such a claim may be appealed to the Administrative Law Court within 30 days of the Covered Person's receipt of the adverse decision in accordance with Paragraph C below. Instead of appealing directly to the Administrative Law Court, the Covered Person may first seek a Voluntary Additional Appeal to the Plan Administrator in accordance with subparagraph (5) below.

4. **External Review by IRO.** The IRO shall forward any information submitted by the Covered Person to the Third Party Claims Processor or Utilization Review Agency within one business day of receipt. Upon receipt of any such information, the Third Party Claims Processor or Utilization Review Agency may reconsider its adverse benefit determination that is the subject of the External Review Reconsideration, but the reconsideration by the Plan Administrator must not delay the External Review. The External Review may be terminated as a result of reconsideration only if the Third Party Claims Processor or Utilization Review Agency decides to reverse its adverse benefit determination and provide coverage or payment. In such case, the Third Party Claims Processor or Utilization Review Agency must provide written notice of its decision to the claimant and the IRS within one business day and the IRO shall then terminate the External Review.

The Third Party Claims Processor or Utilization Review Agency will provide the IRO with the documents and information considered in making the adverse benefit determination within five (5) business days after the date of assignment of the IRO. Failure by the Third Party Claims Processor or Utilization Review Agency to timely provide the documents and information shall not delay the conduct of the External Review. If the Third Party Claims Processor or Utilization Review Agency fails to timely provide the documents and information, the assigned IRO may terminate the External Review and make a decision to reverse the adverse benefit determination. In such case, the IRO shall notify the claimant and the Third Party Claims Processor or Utilization Review Agency of its decision within one business day.

The Covered Person shall be notified that the Covered Person may submit additional information in writing to the IRO within 10 business days of the IRO's notification that it has been assigned the Request for External Review. The IRO will review all of the information and documents timely received. In making its decision, the IRO is not bound by the Third Party Claim Processor's or Utilization Review Agency's prior determination. To the extent additional information or documents are available and the IRO considers them appropriate, the IRO may also consider the following in reaching a decision:

- a. the Covered Person's medical records;
- b. the attending Health Care Professional's recommendation;

- c. reports from appropriate Health Care Professionals and other documents submitted by the Plan, the Third Party Claims Processor, the Utilization Review Agency, the Covered Person, or the Covered Person's treating health care provider;
- d. the terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- e. appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- f. any applicable clinical review criteria developed and used by the Plan; and
- g. the opinion of the IRO's clinical reviewer or reviewers after considering information noted above, as appropriate.

The IRO will provide written notice of the final External Review decision to the Covered Person and the Plan Administrator within 45 days after the IRO receives the request for External Review. The notice will contain the following:

- a. a general description of the reason for the request for External Review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial;
- b. the date the IRO received the assignment to conduct External Review and the date of the adverse benefit determination;
- c. references to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching the decision;
- d. a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied upon in making its decision;
- e. a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or the claimant;
- f. a statement that judicial review may be available to the claimant; and
- g. current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

To the extent the final External Review decision reverses the Third Party Claims Processor's or Utilization Review Agency's decision (as was reflected in the notice

of adverse benefit determination), the Plan shall follow the final External Review decision of the IRO.

In the case of an Expedited External Review, the IRO will provide the notice of the final External Review decision as expeditiously as the Covered Person's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the Request for an Expedited External Review. To the extent the final External Review decision reverses the Third Party Claims Processor's or Utilization Review Agency's decision (as was reflected in the notice of adverse benefit determination), the Plan shall follow the final External Review decision of the IRO. If the IRO's notice of decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours.

To the extent the IRO's final External Review decision is adverse to the Covered Person and upholds the adverse benefit determination by the Third Party Claims Processor or Utilization Review Agency, the IRO's External Review decision may be appealed to the Administrative Law Court within 30 days of the Covered Person's receipt of the adverse decision in accordance with paragraph C below. Instead of appealing directly to the Administrative Law Court, the Covered Person may first seek a Voluntary Additional Appeal to the Plan Administrator in accordance with subparagraph (5) below.

5. **Voluntary Additional Appeal to Plan Administrator.** After an adverse determination by the IRO pursuant to an External Review provided in paragraph 12.10(B)(4), after a Preliminary Determination that a claim is not eligible for External Review under paragraphs 12.10(B)(2) and 12.10(B)(3), or that benefits will not be paid, the Covered Person may request a review by the Plan Administrator or its designee who shall review the Covered Person's claim. This additional review is voluntary. The Covered Person must make the request for review within 90 days after notice of the denial of benefits. Appeals may be brought only by the Covered Person at issue, their Authorized Representative (who cannot be a Provider, a Provider's Representative, or Benefits Administrator) or a licensed attorney admitted to practice in South Carolina. The filing of this appeal shall be deemed to be consent for the Plan Administrator or its designee to review all medical records necessary for a determination of the appeal. To hear the appeal, the Plan Administrator may appoint up to five representatives who are familiar with group health benefits and the MUSC Health Plan and who were not involved in the initial denial of benefits.

The Covered Person may submit additional information for review within 30 days of filing their appeal. The Plan Administrator or its designee may request from the Third Party Claims Processor, the Utilization Review Agency, and the External IRO information they reviewed by it, including the pertinent medical records, and may request any additional information from the Third Party Claims Processor, the Utilization Review Agency, the External IRO, the Covered Person, independent medical personnel, or other sources as in its judgment may be required to make a determination. The Plan Administrator or its designee shall consider all information submitted by the Covered Person and received in response to requests for additional information, along with the terms and conditions of the Plan. The Plan

Administrator or its designee shall issue a written decision within 180 days after the receipt of all material provided by the Covered Person and requested by the Plan Administrator or its designee. In the event the Covered Person does not respond to a request for information within 60 days, the appeal will be deemed to be waived and will be dismissed.

The Plan Administrator or its designee shall provide specific reasons for the decision, including citation to the pertinent Plan provisions, and may, if the Plan Administrator or the Plan Administrator's designee agrees with the External IRO, Third Party Claims Processor, or Utilization Review Agency, deny the claim of the Covered Person. If the Plan Administrator or its designee agrees with the Covered Person, they may approve the claim or such portion as is appropriate. The Plan Administrator or the Plan Administrator's designee must state in writing the provisions of the Plan justifying the result. The decision of the Plan Administrator or its designee on these matters is binding and conclusive, subject to review pursuant to paragraph 12.5.C.

The discretionary authority provided to the Plan Administrator or its designee 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.

- C. Judicial Review.** The exclusive remedy for the denial of benefits shall be as provided in paragraphs 12.10.A and 12.10.B and by judicial review of that decision under 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 paragraphs 12.10.A and 12.10.B, nor will such action be brought after the expiration of the applicable period for commencing such actions. Any construction or interpretation of the Plan; determination of eligibility; any decision arising under the Plan; or any 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, capricious, or in violation of applicable statutes.

12.11 EFFECT OF FEDERAL GUIDANCE ON CLAIMS PROCEDURES

Any information, processes, standards of review, or other elements that are required to be provided under this Article shall be provided or applied only if the Plan is required to do so under applicable legal requirements and the U.S. Departments of Labor, Treasury, and Health and Human Services are currently enforcing such requirements. For these purposes, the Plan may rely fully on the U.S. Department of Labor Technical Release 2011-01, the U.S. Department of Labor Technical Release 2011-02, the June 24, 2011 amendment to the interim final regulations published July 23, 2010, and any subsequent guidance.

12.12 FORM AND MANNER OF NOTICES

Notices provided pursuant to this Article with respect to internal claims and appeals and External Reviews shall be provided in a culturally and linguistically appropriate manner pursuant to Department of Labor regulations. Accordingly, with respect to an address in any United States county to which a notice is sent, if ten percent (10%) or more of the population residing in the county is literate only in the same non-English language (the "applicable non-English language"), the Third Party Claims Processor or Utilization Review Agency, as applicable shall: (i) provide

oral language services (such as a telephone customer assistance hotline) that include answering questions in the applicable non-English language; (ii) provide notices sent under this Article in the applicable non-English language upon request; and (iii) include a statement in the English versions of all notices sent under this Article, prominently displayed in the applicable non-English language, clearly indicating how to access the language services provided by the Plan. Any information, processes, standards of review, or other elements that are required to be provided under this

12.13 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.

12.14 Privacy of Protected Health Information

- A.** The Plan shall use Protected Health Information to the extent of and in accordance with the uses and disclosures permitted by Health Insurance Portability and Accountability Act of 1996, as amended, (HIPAA) and its implementing regulations (45 CFR Parts 160-64). Specifically, the Plan shall use and disclose Protected Health Information for purposes related to health care treatment, Payment for health care, and Health Care Operations. For purposes of this paragraph, Plan Sponsor shall mean, for the sole purpose of compliance with the mandates of the HIPAA, the Public Employee Benefit Authority, 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. For purposes of this paragraph, the terms "Payment" and "Health Care Operations" (as well as any other capitalized term not otherwise defined in this Plan) shall have the meanings provided under 45 CFR Parts 160-64.
- B.** The Plan may:
- 1.** Disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of: (i) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (ii) modifying, amending, or terminating the Plan.
 - 2.** Disclose to the Plan Sponsor information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer offered by the Plan.
 - 3.** Disclose Protected Health Information to the Plan Sponsor to carry out Plan administration functions that the Plan Sponsor performs.
 - 4.** With an authorization from the Covered Person, disclose Protected Health Information to the Plan Sponsor for purposes related to the administration of other employee benefit plans and fringe benefits sponsored by the Plan Sponsor.
 - 5.** Not permit a health insurance issuer with respect to the Plan to disclose Protected Health Information to the Plan Sponsor except as permitted by this paragraph.

6. Not disclose (and may not permit a health insurance issuer to disclose) Protected Health Information to the Plan Sponsor as otherwise permitted by this paragraph unless a statement is included in the Plan's notice of privacy practices that the Plan (or a health insurance issuer with respect to the Plan) may disclose Protected Health Information to the Plan Sponsor.
 7. Not disclose Protected Health Information to the Plan Sponsor for the purpose of employment related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
- C. Prior to disclosing any Protected Health Information to the Plan Sponsor, the Plan Sponsor must certify (and the Plan is hereby amended to state) that the Plan Sponsor agrees to the following (and the Plan will require that the Plan Sponsor):
1. Not use or further disclose Protected Health Information other than as permitted or required by the Plan document or as required by law;
 2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information;
 3. Not use or disclose Protected Health Information for employment-related actions and decisions unless authorized by an individual;
 4. Not use or disclose Protected Health Information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
 5. Report to the Plan any Protected Health Information use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
 6. Make Protected Health Information available to an individual in accordance with HIPAA's access requirements pursuant to 45 CFR § 164.524;
 7. Make Protected Health Information available for amendment and incorporate any amendments to Protected Health Information in accordance with 45 CFR § 164.526;
 8. Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;
 9. Make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of the Department of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA; and
 10. If feasible, return or destroy all Protected Health Information received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such

Protected Health Information when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

- D.** With respect to PHI, the Plan Administrator agrees to reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the Plan Administrator on behalf of the Plan. Specifically, such safeguarding entails an obligation to:
- 1.** Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that the Plan Administrator creates, receives, maintains, or transmits on behalf of the Plan;
 - 2.** Ensure that the adequate separation as required by 45 CFR 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
 - 3.** Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
 - 4.** Report to the Plan any security incident of which it becomes aware.
- E.** 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, as amended, (HIPAA) and its implementing regulations (45 CFR Parts 160-64). Plan Sponsor shall mean, for the sole purpose of compliance with the mandates of the HIPAA, the Public Employee Benefit Authority, 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.

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.

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.

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 HIPAA, 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.

ARTICLE 12A

REVIEW OF ADMINISTRATIVE CLAIMS BY PEBA

12A.1 Review of Administrative Claims under Article 12A

An “administrative claim” is an administrative decision by PEBA that does not involve the filing of a claim for Covered Medical Benefits under Article 12 of the Plan, including, but not limited to, decisions concerning: an individual’s eligibility to participate in the Plan; a subscriber’s COBRA eligibility; enrollment matters; tobacco surcharge; and dependent documentation. An individual may request review of PEBA’s determination concerning administrative claims in accordance with the procedures set forth in this Article.

12A.2 Claims for Covered Medical Benefits Reviewed under Article 12

A claim for Covered Medical Benefits is a request for a plan benefit or benefits made by a claimant in accordance with the Plan’s procedure for filing benefit claims set out in Article 12 of the Plan. If a participant files a claim for Covered Medical Benefits under Article 12, appeals regarding the denial of the claim for Covered Medical Benefits must be reviewed under the procedures set forth in Article 12 even if the basis for the denial of the claim is ineligibility to participate in the Plan or some other non-medical administrative reason.

12A.3 Informal Denial

If an individual or their employer’s benefits administrator makes an informal oral or written request regarding an administrative claim that is denied by PEBA, the subscriber or their employer’s benefits administrator may seek review of this informal denial by filing a written request for Departmental Review in accordance with paragraph 12A.4.

12A.4 Departmental Review

- A.** An individual or their employer’s benefits administrator may submit a written request to PEBA for Departmental Review of an administrative claim. The individual or their employer’s benefits administrator may submit the written request for Departmental Review: (i) of a previous informal denial of the administrative claim under paragraph 12A.3; or (ii) as an initial request to PEBA regarding an administrative claim.
- B.** The relevant department of PEBA shall review the written request and shall make a written determination regarding the administrative claim. If the written request concerning an administrative claim is denied, the written determination shall contain an appeals notice informing the subscriber that the Departmental Review denial may be appealed to the PEBA Administrative Appeals Committee within 90 days of the date of the Departmental Review denial.

12A.5 Administrative Appeals to PEBA

- A.** An individual whose administrative claim was denied in whole or in part pursuant to Departmental Review under paragraph 12A.4 may appeal the denial to the PEBA within 90 days of the date of the Departmental Review denial. The individual may submit additional information for review within 30 days of filing their appeal.

- B. The Plan Administrator or its designee shall appoint up to five representatives who are familiar with group health benefits, the State Health Plan, and the MUSC Health Plan and who have not been involved in any previous denial determination in the matter under consideration.
- C. The Plan Administrator or its designee shall consider all written information submitted, the terms and conditions of the MUSC Health Plan, all information received in response to requests for information, and other sources as in its judgment may be required to make a determination. The Plan Administrator or its designee shall issue a written decision within 180 days after the receipt of all material provided by the Covered Person and requested by the Plan Administrator or its designee. In the event the Covered Person does not respond to a request for information within 60 days, the appeal will be deemed to be waived and will be dismissed.

The Plan Administrator or its designee shall provide specific reasons for the decision, including citation to the pertinent Plan provisions, and may deny the claim of the individual. If the Plan Administrator or its designee agrees with the individual, they may approve the claim or such portion as is appropriate. The Plan Administrator or the Plan Administrator's designee must state in writing the provisions of the Plan justifying the result. The decision of the Plan Administrator or its designee on these matters is binding and conclusive, subject to review pursuant to paragraph 12A.6.

The discretionary authority provided to the Plan Administrator or its designee 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.

12A.6 Judicial Review

The exclusive remedy for the denial of an administrative claim shall be as provided in paragraphs 12A.3, 12A.4, and 12A.5, and by judicial review of that decision under S.C. Code Ann. Section 1-23-380, as amended, as provided by statute. No appeal may be brought until an individual exhausts the review procedure set forth in paragraphs 12A.4 and 12A.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, capricious, or in violation of applicable statutes.

ARTICLE 13.

NOTICE

Except as otherwise provided in this Plan, any notice that may be required hereunder shall be effective: to the Plan Administrator, when sent to its office; to a Third Party Claims Processor, when sent to its office; to a Utilization Review Agency, when sent to its office; and to a Covered Person, when addressed to the Covered Person at the address as it appears in 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 and the Plan's right of full recovery shall not be limited by any characterization of the nature or purpose of the amounts recovered or by the identity of the party from which recovery is obtained. If a payment is made under this Plan, and the person to or for whom it is made recovers monies from a third party described above as a result of settlement, judgment, or otherwise, that person shall hold in trust for the Plan the proceeds of such recovery and reimburse the Plan to the extent of such payments 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, or no fault or malpractice insurance coverages that are paid or payable. The Plan shall have a first priority lien against the proceeds of any recovery by the Covered Person and against future benefits due under the Plan in the amount of any claims paid. The Plan shall have the right to impose a constructive trust over such proceeds, and shall be reimbursed from them. If the Covered Person fails to repay the Plan from the proceeds of any recovery, the Plan Administrator or its designee may satisfy the lien by deducting the amount from future claims otherwise payable under the Plan.

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. Any attorney's fees or other expenses owed by the Covered Person shall not reduce the amount of reimbursement due to the Plan. To the full extent allowed by law, the Plan hereby disclaims any "make whole" or "common fund" doctrine that might otherwise be applicable to its recovery hereunder. 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, including the giving of testimony in any action filed by the Plan. The Covered Person may not release any responsible party from its obligation, or otherwise take any other action that could prejudice recovery by the Plan, without the written consent of the Planholder. If a Covered Person fails or refuses to cooperate in connection with the assertion of claims against a responsible third party, the Plan Administrator or its designee may deny payment of claims (regardless of whether such claims are related to the acts or omissions of the third party or other persons against whom the Covered Person may have a right of recovery) and treat prior claims paid as overpayments recoverable by offset against future Plan benefits or by other action of the Plan Administrator or its designee. Further, if a Covered Person fails or refuses to comply with these provisions by reimbursing the Plan as required herein, the Plan has the right to impose a constructive trust over such any and all funds received by the Covered Person, or as to which the Covered Person has

the right to receive. The Plan, through the Plan Administrator, has the authority to pursue any and all legal and equitable relief available to enforce the rights contained in this paragraph, against any and all appropriate parties who may be in possession of the funds described herein.

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. The Plan, through the Plan Administrator shall have full discretionary authority to interpret the provisions of this paragraph, and to administer and pursue the Plan's subrogation and reimbursement rights under this paragraph.

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 braces;
- 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.
- L. Advanced diagnostic imaging procedures, including but not limited to: Magnetic Resonance Imaging (MRI); Magnetic Resonance Angiogram (MRA); Computed Axial Tomography (CT scan); and Positron Emission Tomography (PET scan).

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, that 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. All extended care benefits in paragraphs 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 that results in an admission to a Hospital, whether the procedure is performed in a Hospital, Ambulatory Surgical Center, or Physician's office.

15.1.5 Concurrent Review of Hospitalization and Individual Case Management

The Utilization Review Agency shall review and determine whether the services provided or to be provided to a Covered Person for a Hospital stay are Medically Necessary, including but not limited to whether hospitalization, length-of-stay, or diagnostic ancillary services are necessary and appropriate for a Covered Person's condition. The Utilization Review Agency also ensures that alternative methods of care are considered and it 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, 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 Alternative Treatment Plan. Subject to limitations, exclusions, and eligibility requirements, Physician benefits will be paid in accordance with the schedule of benefits. The medical costs paid by the Covered Person shall be counted towards satisfaction of the Coinsurance Maximum under paragraphs 7.1.A.4, 7.1.B.4, and 7.1.C.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 Benefits.

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, the Physician or Hospital, and Third Party Claims Processor of that decision. The selection of the course of treatment remains with the 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 Coinsurance Maximum of paragraphs 7.1.A.4, 7.1.B.4, and 7.1.C.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's condition provided by the Physician, and communicated to the Covered Person, family member, Physician, and Hospital. Confinements beyond the length of stay designated by the Utilization Review Agency may be determined to be without Medical Necessity, and reimbursement denied for Room and Board. Other Medically Necessary charges may be covered.
- C. Second Opinions** may be required by the Utilization Review Agency as a condition to Pre-Certification, ongoing certification, 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 paragraph 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. If they are Medically Necessary:

1. The costs of a second opinion shall not be included in those costs that satisfy the Coinsurance Maximum of paragraphs 7.1.A.4, 7.1.B.4, and 7.1.C.4; and
2. The cost of a second opinion shall always be subject to the Coinsurance requirement of the selected Plan.

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

1. The costs Incurred shall not be included in those that satisfy the Coinsurance Maximum of paragraphs 7.1.A.4, 7.1.B.4 and 7.1.C.4; and
2. The costs Incurred shall always be subject to the Coinsurance requirement of the selected plan.

E. Medical Social Worker Services. 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 Allowed Amount, or the Provider's Billed 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.

F. Failure to Obtain Pre-certification of Advanced Diagnostic Imaging Procedures. If an in-network South Carolina Provider does not receive Pre-Certification for advanced diagnostic imaging services including but not limited to: Magnetic Resonance Imaging (MRI); Magnetic Resonance Angiogram (MRA); Computed Axial Tomography (CT scan); and Positron Emission Tomography (PET scan), the Provider will not be paid for the service, and no liability shall accrue to the Subscriber or Covered Person for the cost of the service. If a Covered Person, without Pre-Certification, receives advanced diagnostic imaging services from an out-of-network or out-of-state Provider, the Provider will not be paid for the service, and the Subscriber or Covered Person shall be responsible for the entire cost of the service.

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 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, 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, Physician, Hospital, and the Third Party Claims Processor. A determination by the Utilization Review Agency that the proposed treatment is within generally recognized medical standards and procedures does not guarantee payment because other conditions, including eligibility requirements, other limitations or exclusions, satisfaction of deductibles, and other provisions of the Plan must be satisfied before payment is made by the Third Party Claims Processor.

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

15.1.10 Comprehensive Maternity Management

A Covered Person, upon becoming aware of pregnancy, shall notify the Utilization Review Agency. A maternity coordinator providing education and counseling for the mother shall monitor each case. The Covered Person must also separately notify the Utilization Review Agency of the hospital admission as described in paragraphs 15.1.2 and 15.1.4, and is subject to all requirements for hospital admission in that section. Notwithstanding anything in this Plan to the contrary, in accordance with the Newborns' and Mothers' Health Protection Act, the Plan shall not restrict any Inpatient Hospital confinement in connection with childbirth for the mother or Newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a caesarean section or require that a provider obtain authorization from the Plan for prescribing a confinement not in excess of the above time periods. However, the mother's or Newborn's attending provider, after consulting with the mother, may discharge the mother or the Newborn earlier than 48 hours (or 96 hours as applicable). The provisions of this paragraph shall apply to that portion of a confinement that exceeds the above time periods.

SECTION 2

15.2.1 Application

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

For treatment of a Behavioral Health Disorder, Alcoholism, or Drug Abuse in the United States or Canada, the Covered Person, an authorized family member, or the Behavioral Health Provider treating the Covered Person shall contact the Behavioral Health Manager for Pre-Certification of Medical Necessity at least 24 hours before the Covered Person's receipt of facility Inpatient, Partial Hospitalization, Intensive Outpatient Program, Electroconvulsive Therapy services, professional psychological/ neuropsychological testing, Applied Behavior Analysis Therapy

services, and Repetitive Transcranial Magnetic Therapy.

15.2.3 Limited Exception to Pre-Certification

Pre-certification is not required:

- A.** For any Hospital admission outside the United States or Canada that 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 48 hours or the next working day, whichever is longer, of any emergency admission. 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 to a Covered Person for a Behavioral Health Disorder, Alcoholism, or Drug Abuse are Medically Necessary, including but not limited to whether hospitalization, length-of-stay, or diagnostic ancillary services are necessary and appropriate for a Covered Person's condition. The Behavioral Health manager also ensures that alternative methods of care are considered and it 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, 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, 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 Behavioral Health Provider, the Plan Administrator, and the Covered Person.

The Behavioral Health Manager, after consulting with the treating Behavioral Health Provider and others as appropriate, may recommend an Alternative Treatment Plan in a less intensive care setting. If accepted by the treating Behavioral Health Provider, Covered Person, and Plan Administrator, the Behavioral Health Manager will assist, as necessary, in implementing the Alternative Treatment Plan. Subject to limitations, exclusions, and eligibility requirements, Behavioral Health Provider benefits will be paid in accordance with the schedule of benefits. The medical costs paid by the Covered Person shall be counted towards satisfaction of the Coinsurance Maximum under paragraphs 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 that would otherwise not be covered under the Plan will be considered as Covered Medical Benefits.

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. The Certification is sent to the Third Party Administrator.
- 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 Article shall be subject to the following:
1. A \$200 penalty for each admission to a Hospital, when none of the days of admission are pre-authorized (waived for Partial Hospitalizations and Intensive Outpatient Program services);
 2. The costs Incurred during the hospitalization, treatment, or extended benefit program shall not be included in those that satisfy the Coinsurance Maximum of paragraphs 7.1.A.4, 7.1.B.4, and 7.1.C.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.
 4. A Covered Person who does not obtain Pre-certification as required by this Article for specified professional services in paragraph 15.2.2 shall be responsible for all the costs Incurred for these professional services.

If the Covered Person 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, reimbursement will be denied and payments by the Covered Person will be subject to paragraph 2 above.

- 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 will be denied. Other Medically Necessary charges may be covered.
- 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 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 Behavioral Health Manager as provided in 7.15, subject to all other terms and conditions of the Plan. Second opinions obtained without Pre-Certification by the Behavioral Health Manager shall be subject to all other terms and conditions of the Plan, including the requirement that they be Medically Necessary. If they are Medically Necessary:
 - 1. The costs of a second opinion shall not be included in those costs that satisfy the Coinsurance Maximum of paragraphs 7.1.A.4, 7.1.B.4, and 7.1.C.4; and
 - 2. The cost of a second opinion shall always be subject to the Coinsurance requirement of the selected 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 is 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.

End of Plan

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October 2, 2020

The Honorable Jenny Abbott Kitchings
Clerk of Court, South Carolina Court of Appeals
1220 Senate Street
Columbia, South Carolina 29201

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SC Court of Appeals

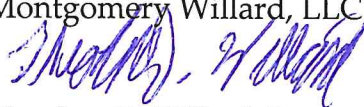
**Re: Lisa Beattie as Personal Representative for the Estate of Branch Beattie,
Individually and as the Representative of a Class Similarly Situated Persons vs.
Blue Cross Blue Shield of South Carolina and Companion Benefit Alternatives,
Inc.,
Appellate Case No.: 2020-001266
Our File No: 2196314**

Dear Ms. Kitchings:

Enclosed please find the original Appellant's Petition For Rehearing *En Banc* and Proof of Service in the above-referenced matter. Please file the originals and return file stamped copies of each to this office. The filing fee check in the amount of \$50.00 will be sent under separate cover.

If you have any questions, please do not hesitate to contact me.

Very truly yours,

Montgomery Willard, LLC

Theodore D. Willard, Jr.

Enclosures

cc: Alexis W. McCumber, Esquire
Roy T. Willey, IV, Esquire
Eric M. Poulin, Esquire
Matt Foss, Esquire