Health Choice

BlueChoice®
Healthcare Plan

SUMMARY PLAN DESCRIPTION

January 1, 2004

SRS
savannah river site

Administered By

BlueCross
BlueShield
of Georgia

F-1681.782 07/03

NOTICE

This document, which is called the **Summary Plan Description (SPD) Booklet,** describes the health benefits (herein called the Plan) as established by Westinghouse Savannah River Company, LLC, and Bechtel Savannah River, Incorporated (WSRC/BSRI) (herein called the Employer or Plan Sponsor). Persons eligible to participate in the Plan include those described herein who are connected by employment with the WSRC Team. "The WSRC Team" pertains to Westinghouse Savannah River Company, LLC (WSRC), Bechtel Savannah River, Incorporated (BSRI) and BWXT Savannah River, Inc., BNFL Savannah River, Inc. and CH2 Savannah River Company.

This SPD Booklet is a part of the Employer's Health Plan Document which Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. (BCBSHP) (herein called the Claims Administrator), An Independent Licensee of the Blue Cross and Blue Shield Association, administers under the Employer's Self funded Plan.

Every effort has been made to accurately describe the Plan in this SPD Booklet. However, if there should be a discrepancy between this SPD Booklet and the Health Plan Document, or if the Plan is required to operate in a different manner to comply with federal laws and regulations, the Health Plan Document or the appropriate federal laws and regulations will govern.

Important: This is not an insured benefit plan. The benefits described in this SPD Booklet or any rider or amendment attached hereto are self-insured by the Employer which is responsible for their payment. Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. provides claim administration services to the Plan, but Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. does not insure the benefits described.

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Summary of Benefits

All care must be received from or coordinated through the Primary Care Physician. A Participant has Direct Access to some specified In-Network providers without a Primary Care Physician Referral. Such providers include a gynecologist for obstetrical or gynecological-related conditions, a dermatologist; and an optometrist or ophthalmologist for medical conditions only.

All In-Network primary care must be received from the Primary Care Physician.

Lifetime Maximum Benefits ..... Unlimited

Percentage Payable (Unless Otherwise Specified) 100%
All payments are based on Eligible Charges and negotiated arrangements.

Hospital Inpatient Services
Room and Board (Semi-Private or ICU/CCU) 100%
Hospital Services and Supplies (x-ray, lab, anesthesia, etc.) 100%
Physician Services (surgeon, anesthesiologist, radiologist, pathologist, etc.) 100%

Outpatient Hospital Services
Outpatient Surgery Facility 100%
Outpatient Lab, X-ray and Anesthesia Services 100%
Outpatient Physician Services (surgeon, anesthesiologist, radiologist, pathologist, etc.) 100%

Emergency Room Copayment
Life-threatening medical conditions or serious Accidental Injuries $50

The emergency room Copayment is waived if admitted to the Hospital through the emergency room. Coverage is provided on a 24-hour basis for these services. Follow-up care must be coordinated through the Primary Care Physician.

Primary Care Physician notification, if not completed prior to emergency room visit, must occur within 48 hours of seeking emergency room care.

Non-emergency use of the emergency room is **NOT** covered.

Note: This Plan does not provide benefits for Mental Health care and Substance Abuse treatment. Westinghouse Savannah River Company provides these benefits through ValueOption. See below.

Expenses	Value Options Provider (With ongoing ValueOptions Management)	Non Network Provider
Inpatient mental health	**100% after $250 annual deductible per person* No limit on days After discharge, outpatient visit copays apply**	**Not covered**
Outpatient mental health	**$20 copay/visit No limit on visits**	**50% up to a maximum benefit of $25/visit Maximum 20 visits/person/year**
Chemical Dependency; Inpatient or outpatient	**100% after $250 annual deductible per person* No limit on days**	**Not covered**

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Summary of Benefits

Physician Office Services Copayment

Primary Care Physician, per office visit $10
Outpatient Surgery in Physician's office
Immunizations
Periodic Health Assessment

Specialist Physician (needs Primary Care Physician referral) $10
Outpatient Surgery in Physician's office
Maternity Care Visits (first visit only) (no referral needed)
Allergy office visits, shots, serum, tests
Physical/Occupational Therapy: 40 visits per calendar year
Speech Therapy: 30 visits per calendar year

Chiropractor (per office visit) $10
(Maximum of 15 visits per calendar year, Primary Care Physician referral is not required)

Prescription Drugs

Prescription Drug Copayment (Generic in Formulary), per prescription $10
30 day supply from participating pharmacies
Prescription Drug Copayment (Brand Name in Formulary), per prescription $20
30 day supply from participating pharmacies
Prescription Drug Copayment (Mail Order), per prescription $40
90 day supply via mail order

A limited number of Prescription Drugs require pre-authorization for Medical Necessity. If pre-authorization is not approved, then the designated drug will not be eligible for coverage. To determine if a drug requires pre-authorization, please call Customer Service.

Note: In-Network benefits are not paid for Prescription written by an Out-of-Network Provider.

Special Features:

- **Home Health Care Services:** 120 visits per calendar year 100%
- **Hospice Care Services:** 100%
- **Respiratory Therapy:** 40 visits per calendar year 100%
- **Skilled Nursing Facility:** 30 days per calendar year 100%

Types of Coverage

The type of coverage is determined by the Employee's selection at the time of enrollment through the Group.

Note: These benefits are valid for the Employer's current benefit period. The Employee will receive a revised Summary of Benefits if there is a change in the Plan's benefits.

BlueChoice Healthcare Plan (HMO)

Summary Notice

A thorough understanding of your coverage will enable you to use your benefits wisely. Please read this SPD Booklet carefully. If you have any questions about your benefits as presented in this SPD Booklet, please contact the Claims Administrator's Customer Service Department.

This SPD Booklet makes up the Covered Services provisions of the Health Plan Document. Its purpose is to help you understand your coverage and to provide an easy reference to explain the benefits. Further terms and conditions of the health care coverage and other benefits are contained in the Benefits Overview and General Information booklet. A copy of the Benefits Overview and General Information booklet is available on ShRINE or by contacting the WSRC People Support Service Center at 1-800-368-7333.

All care must be received from or coordinated through your Primary Care Physician. A Participant has Direct Access to some specified In-Network providers without a Primary Care Physician Referral. Such providers include a gynecologist for obstetrical or gynecological-related conditions; a dermatologist; and an optometrist or ophthalmologist for medical conditions only.

All In-Network primary care must be received from your Primary Care Physician.

A woman may refer herself directly to a BlueChoice Healthcare Plan gynecologist for obstetrical or gynecological-related conditions; a Primary Care Physician Referral is not required.

A Participant may go directly to a BlueChoice Healthcare Plan dermatologist; a Primary Care Physician Referral is not required.

A Participant may go directly to a BlueChoice Healthcare Plan Chiropractor (maximum of 15 visits per calendar year); a Primary Care Physician Referral is not required.

A Participant who seeks eye care may obtain such service directly from a BlueChoice Healthcare Plan ophthalmologist or optometrist who is licensed to provide eye care. This self-referral is for medical conditions only, not routine vision care.

When You're Away From Home

If you're away from the Service Area on business or pleasure, you still have coverage for Medical Emergencies. If you have a Medical Emergency, go to the nearest Hospital emergency room for treatment. If you're outside of the Service Area, you'll have to pay for any treatment you receive. The Claims Administrator will reimburse you except for any required Copayment or Out-of-Pocket amount. You will need a copy of any bills. Call Customer Service as soon as it's convenient and one of the representatives will tell you what you should do.

Should your treatment require you to be hospitalized, call the Customer Service Department or have someone call for you within 48 hours.

Important Phone Numbers

Pre-Admission Certification (PAC)

You should call your Primary Care Physician.

Your Primary Care Physician or the Hospital should call the following number for Pre-Admission Certification:

- Atlanta Calling Area (404) 237-2429
- All Other Areas 1-800-662-9023 or 1-800-722-6614

Customer Service

If you have a customer-service question, please call one of these numbers:

- Call 1-800-354-6928

Mental Health Care or Substance Abuse Treatment

This Plan does not provide benefits for Mental Healthcare and Substance Abuse treatment. Westinghouse Savannah River Company provides these benefits through ValueOptions. See details on pages 14 and 15.

- Call ValueOptions at 1-800-333-6557 for assistance.

Health and Wellness Line

For preventive health and wellness information for you and your family, call the BlueChoice Health and Wellness line 24 hours a day at

- 1-800-722-7427.

Please have your ID number available when you call. Requested information will be sent free of charge.

BlueChoice On-Call

A 7-day-a-week, 24 hour a day service available for all covered family members. When you or a covered family member is experiencing health symptoms, you may call BlueChoice On-Call to speak to a registered nurse. The nurse will provide information to help you decide on the most appropriate treatment or care. You may also listen to a variety of medical audio tapes or request written information on a variety of conditions.

- 1-888-724-BLUE (2583)

Special Phone Numbers

Please check your ID card for telephone numbers unique to your Group.

BlueChoice Healthcare Plan (HMO)

Eligibility

Coverage for the Employee

This SPD Booklet describes the benefits you may receive under this health care Plan. You are also called the Employee or Participant.

If an Employee is a Full Service Employee of the WSRC Team, the Employee is eligible for Covered Services under this Plan. There is no "waiting period" for coverage to commence once the Employee had properly enrolled for coverage. Full service employees of the WSRC Team who are also Dependents of retirees of DuPont Savannah River Plant (retirements prior to April 1, 1989) have DuPont medical coverage and therefore are not eligible to participate in this Plan. BSRI employees participating in union benefits, retirees, survivors and Total and Permanently Disabled Employees are also ineligible for this Plan. Your participation in this Plan must stay in effect for full calendar year.

Coverage for the Employee's Dependents

If the Employee is covered by this Plan, the Employee may enroll his or her eligible Dependents. The Employee and eligible Dependents are also referred to as Participants.

If the wrong birthdate of a child is entered on an application, the child has no coverage for the period for which he or she is not eligible under the rules of the Plan. Any overpayments made for coverage for any child under these conditions will be refunded to the Plan.

Eligible Dependents Include:

- Your lawful spouse in accordance with state law in your state of residence;
- Your "children", including your own children, legally adopted children, or stepchildren who primarily reside with you, and children supported solely by you for whom you have been appointed legal guardian. Your adopted children are covered from the time they are legally placed with you. You will be required to provide proof of legal guardianship or adoption. Also included are the Employee's children (or children of the Employee's Spouse) for whom the Employee has legal responsibility resulting from a valid court decree. In order to be eligible for coverage, your children must meet all of the following requirements: be unmarried, be under age 20; primarily reside with you in a regular parent/child relationship (or living at school while a full-time student); and the Employee must be able to claim them as dependents on their current federal income tax return. Medical coverage may be extended up to age 25 for full-time students at accredited institutions. Student eligibility will be reviewed every year beginning at age 20. This determination will be administered by the Claims Administrator;
- Unmarried children who are mentally or physically disabled and totally dependent on the Employee for support. To be eligible for coverage as an disabled/incapacitated Dependent, the Dependent must have been covered under this Plan or prior Creditable Coverage prior to reaching age 20. A certification form is available from the Employer or from the Claims Administrator and may be required to be updated periodically.

Benefits Administration reserves the right to request, at any time, documentation as proof of any Dependent's eligibility, as well as the right to remove any ineligible dependent retroactively from coverage, including the right to seek reimbursement for claims paid on any ineligible dependent.

Special Rules for "Dual Couples"

"Dual Couples" are WSRC Team Employees (or retirees) who have a spouse who also works for (or is retired from) the WSRC Team. Dual couples cannot be covered both as a Dependent and as an Employee under this Plan. In addition, no dependent child may be covered by more than one WSRC Team "parent" Employee.

For example, an Employee may elect to cover a Spouse and dependent children, while the Employee's Spouse elects to "waive" coverage and is the Employee's Dependent. Alternatively, the Employee may elect coverage for himself or herself and the Employee's child, while the Spouse elects Employee only coverage. (When an Employee makes this latter choice in this example, the Employee and the Employee's Spouse may elect to be covered by different medical options sponsored by the Employer.) But, an Employee and an Employee's Spouse may not cover each other or both cover the same child.

Initial Enrollees

Initial Enrollees and eligible Dependents, who were previously enrolled under group coverage which this Plan replaces, are eligible for coverage on the Effective Date of this coverage.

New Hires

If an Employee is a new hire, the Employee will have two weeks from the hire date to enroll for coverage by completing and returning the enrollment form to the People Support Service Center. If the Employee or the Employee's Dependents do not enroll when first eligible, the Employee and the Employee's Dependents will be

treated as Late Enrollees. Please refer to the **" Late Enrollees** " provision listed below.

Late Enrollees

If the Employee or the Employee's Dependents do not enroll when first eligible, it will be necessary to wait for the next open enrollment period. However, the Employee or the Employee's Dependents may be eligible for special enrollment as set out below.

Special Enrollment Periods

There are special enrollment periods for Employees or Dependents who:

1. Originally declined coverage because of other coverage, and
2. Exhausted COBRA benefits, lost eligibility for prior coverage, or Employer contributions toward coverage were terminated.
3. An individual who declined coverage must have certified in writing that they were covered by another health plan when they initially declined coverage under this Plan in order to later qualify under this special enrollment. Persons declining coverage will be given notice of the consequences when he or she originally decline coverage.

In addition, there are also special enrollment periods for new Dependents resulting from marriages, births or adoptions. An unenrolled Participant may enroll within 60 days of such a special qualifying event.

Important Notes:

1. Individuals enrolled during special enrollment periods are **not** Late Enrollees.
2. Individuals or Dependents must request coverage within 60 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).
3. Evidence of prior Creditable Coverage may be required and must be furnished by the Employee or the Employee's prior carrier.

When Coverage Begins

Employees are eligible for medical care coverage under this Plan on their first day of employment or at the beginning of a new Plan Year.

Changing Coverage

There may be an annual re-enrollment period during which time Participants may elect to change their options.

Types of Coverage

The types of coverage available to the Employee is indicated at the time of enrollment through the Employer.

Changing Coverage (Adding a Dependent)

As the Employee's family increases, the Employee may add new Dependents by contacting the WSRC Service Center within 60 days of the family status change. The WSRC Plan Administrator must notify the Claims Administrator. The WSRC Plan Administrator is the person named by the Employer to manage the Plan and answer questions about Plan details.

Marriage and Stepchildren

An Employee may add a Spouse and eligible stepchildren within 60 days of the date of marriage by submitting an enrollment change form. The Effective Date will be the date of marriage. Remember, there may be an additional cost of coverage.

If an Employee does not apply for coverage to add a Spouse and stepchildren within 60 days of the date of marriage, the Spouse and stepchildren are considered Late Enrollees. Please refer to the **"Late Enrollees"** provision in this section.

Newborn and Adopted Children

A newborn or an adopted child is not covered automatically. Therefore, you should add any new baby or adopted child to your coverage as soon as possible, but it must be done within 60 days. To add a new dependent you should complete a Health Care Enrollment Change form and submit it to the WSRC Service Center no later than 60 days from the date of birth or the placement for adoption. If you attempt to add a dependent after the 60 days from the event date, the dependent would be considered a Late Enrollee. Please refer to the **"Late Enrollees"** provision in this section.

OBRA 1993 and Qualified Medical Child Support Orders

The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) provides specific rules for the coverage of adopted children and children subject to a Qualified Medical Child Support Order (QMCSO).

A QMCSO is an order or judgment from a court or administrative body, which directs the Plan to cover a child of an Employee enrolled under the health Plan. A National Medical Support Notice is deemed to be a QMCSO as is an order issued through a process established under state law and has the force and effect of law under the applicable state law.

The QMCSO must clearly identify all of the following:

- the name and last-known mailing address of the Participant;

- the name and last known mailing address of each child of the Participant who is recognized in the order as having a right to enrollment under a group health plan with respect to the participant;
- a reasonable description of the type of coverage to be provided to the child or the manner in which such type of coverage is to be determined;
- the period to which the order applies.

Upon receipt of an MCSO, the Employer or Plan Administrator will inform the Employee and each affected child of its receipt of the order and will explain the procedures for determining if the order is a QMCSO. The Employer will subsequently notify the Employee and the child(ren) of the determination.

A QMCSO cannot require the Employer to provide any type or form of benefit that it is not already offering.

Family and Medical Leave

If a covered Employee ceases active employment due to an Employer-approved medical leave of absence, in accordance with the Family and Medical Leave Act of 1993 (FMLA), coverage will be continued for up to 12 weeks under the same terms and conditions which would have applied had the Employee continued in active employment. The Employee must pay his or her contribution share toward the cost of coverage, if any contribution is required.

Changing Coverage or Removing a Dependent

When any of the following events occur, notify the Employer and ask for appropriate forms to complete:

- Divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Dependent child reaches age 20 and is not a full-time student or marries (see "When Coverage Terminates");
- Enrolled Dependent child becomes totally or permanently disabled;
- Stepchild no longer resides in your home.

Employee Not Actively at Work

New Hires

Generally, if an Employee is not actively at work on the date his or her coverage is to be effective, the Effective Date will be postponed until the date the Employee returns to active status. If an Employee is not actively at work due to health status, this provision will not apply. An Employee is also a person still employed by the Employer but not currently active due to health status.

Portability Provision

Any newly eligible Employee, Participant, Enrollee or Dependent is eligible for coverage immediately. A newly eligible person is an individual who was not previously eligible for coverage under this Plan.

How Benefits Work

Note: Capitalized terms such as Covered Services, Medical Necessity, Network Hospitals and Out-of-Pocket Limit are defined in the "Definitions" section.

Introduction

The Plan is a comprehensive plan that provides Primary and Referral health care services. All In-Network Care must be received from or coordinated through your Primary Care Physician. Direct Access In-Network is available for a gynecologist for obstetrical or gynecological-related conditions; a dermatologist; and an optometrist or ophthalmologist for medical conditions only. All Covered Services must be Medically Necessary, and coverage or certification of services that are not Medically Necessary may be denied.

Physicians and Hospitals participating in the Claims Administrator's networks are compensated using a variety of payment arrangements, including capitation, fee for service, per diem, discounted fees, and global reimbursement.

Eligible Charges

For In-Network services, Eligible Charges are determined by: (a) the Claims Administrator's negotiated arrangements; (b) pre-determined fee schedules; and (c) the applicable Reimbursement Rate. For Out-of-Network services, Eligible Charges are determined by: (a) the Usual, Customary and Reasonable (UCR) Fees; (b) a Provider's contracted fee schedule; (c) the applicable Reimbursement Rate; or (d) negotiated fees. Reimbursement for Out-of-Network, Participating and Non-Participating Providers is based on Eligible Charges for the type of service a Participant receives, for example, Hospital or Physician services.

Copayment

An Employee will be charged a Copayment amount for certain services. The Copayment amount may be a flat-dollar amount or a percentage of the total charge. Copayment amounts are shown in the **Summary of Benefits**. The emergency room Copayment is waived if an Employee is admitted to the Hospital through the emergency room.

Pre-Admission Certification (PAC)

Hospital Pre-certification

The Pre-Admission Certification Process

- Length-of-Stay Assignment indicates the number of Inpatient days usually Medically Necessary to treat a condition;
- Continued Stay Review/Concurrent Review determines whether a continued Inpatient stay is Medically Necessary;
  If your stay exceeds the number of days assigned under this Plan, the Hospital's charge for additional days beyond the assigned length of stay will not be paid. If all Primary Care Physician or Referral Specialist guidelines are followed, you will not be responsible for any eligible Hospital charge in excess of any applicable Copayment amount;
- Admission Review determines whether an unscheduled Inpatient admission or an admission not subject to pre-certification was Medically Necessary;
- Discharge Planning assesses the Participant's need for additional treatment after Hospital discharge.

In-Network Care

- If you are hospitalized other than for a Medical Emergency or maternity delivery admission and pre-admission certification was not obtained, all charges will be denied. You will be held harmless if all Network guidelines are followed. This means you will not be responsible for any bill in excess of any Copayments that apply.
- Ineligible Charges and Non-Covered Services are always the Participant's responsibility.
- PAC is the responsibility of the admitting Physician.

Pre-Admission Certification is not a guarantee of payment
Admissions are approved only when the appropriateness of the Inpatient setting can be substantiated. Actual payment is based upon eligibility for coverage and the Effective Date for any Participant and also will be dependent on, but not limited to, specific Plan coverage and the status of the coverage on the date services are rendered. The Plan will not cover services related to specific exclusions, including but not limited to, Custodial Care, Experimental and Investigational procedures and services determined not Medically Necessary.

Benefits

All Covered Services must be Medically Necessary As Defined in this Plan

Primary Care Physician (PCP)

All In-Network Care must be received from or coordinated through your Primary Care Physician (PCP). A Participant has Direct Access to some specified In-Network Providers without a Primary Care Physician Referral. Such Providers include a gynecologist for obstetrical or gynecological-related conditions, a dermatologist; and an optometrist or ophthalmologist for medical conditions only.

PCPs are required to provide or arrange for on-call coverage 24 hours a day, 7 days a week. If a Participant becomes sick or is injured after the PCP's regular office hours, the Participant should:

- call the PCP's office; and
- identify himself or herself as a Participant; and
- follow the PCP's or covering Physician's instructions.

If the Participant's Injury or illness is a Medical Emergency, the Participant should follow the procedures outlined under the Medical Emergency Care section.
Payment terms apply to all Covered Services. The following services are covered, if Medically Necessary. Please refer to the **Summary of Benefits** for payment explanations.

Specialist Physician

Your Primary Care Physician will refer you to a Specialist for appropriate care when necessary.

The specialist Physician will need to coordinate continuing care with your Primary Care Physician if either of the following two recommendations is made after your visit to the specialist:

- Additional care by the Specialist Physician is required;
- A Referral for another type of care is indicated.

Physician Services

Covered Services include the following:

In-Network visits to a Physician's office are subject to the per-visit Copayment indicated in the **Summary of Benefits**.

In-Network Preventive Care

The following services are Covered Services only if performed In-Network by your Primary Care Physician or by an obstetrician or gynecologist who is a Network Physician:

- Visits to a Physician's office are subject to the per visit Copayment indicated in the **Summary of Benefits**. Covered Services in the Physician's office include, but are not limited to:
  - Treatment or preventive services including periodic health examinations for adults and well-child care services for eligible Dependent children.
  - Family planning services and services for infertility subject to listed exclusions.
  - Immunizations in accordance with established age appropriate preventive health guidelines, exclusive of immunizations suggested for travel or required for employment.
  - Prenatal care visits. Only one (1) Copayment for all visits combined will be charged.
  - Benefits will be provided for one mammogram and one pap smear tissue examination per year, or more often when ordered by a Physician.
  - Benefits will be provided for annual prostate specific antigen tests for covered males who are 45 years of age of older; or covered males who are 40 years of age or older if ordered by a Physician.
  - Benefits will be provided for one annual Chlamydia screening test for covered females who are not more than 29 years old.

Urgent Care Services

Services rendered at contracted Urgent Care Centers are covered if the Participant is referred by the Participant's Primary Care Physician.

Network Hospital Services

For In-Network care, your Physician must arrange your admission. Your Plan provides Covered Services when the following services are Medically Necessary.

The following Hospital services are covered.

In-Patient Hospital Services

- Inpatient room charges. Covered Services include Semiprivate Room and board, general nursing care and intensive or cardiac care. If you stay in a private room, Eligible Charges are based on the Hospital's prevalent semiprivate rate. If you are admitted to a Hospital that has only private rooms, Eligible Charges are based on the Hospital's prevalent room rate.

Service and Supplies

- Your benefits cover services and supplies provided and billed by the Hospital while you're an Inpatient, including the use of operating, recovery and delivery rooms. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroencephalograms, x-ray examinations, and radiation therapy, speech therapy and occupational therapy are also covered.
- Convenience items (such as radios, TV's, record, tape or CD players, telephones, visitors' meals, etc.) will not be covered.

Length of Stay

- Determined by Medical Necessity.

Outpatient Hospital Services

Outpatient Services

Your Plan provides Covered Services when the following outpatient services are Medically Necessary: Pre-admission tests, surgery, diagnostic x-rays and laboratory services. Certain procedures require pre-certification by your Network Physician.

Medical Emergency Care

- Life-threatening emergency care or treatment for a Medical Emergency is covered on a 24-hour basis at any Hospital emergency room. Go to the nearest Hospital emergency room if you experience a life - threatening Medical Emergency. See "Definitions".
- The emergency room Copayment is required for initial services for Medical Emergencies rendered in the emergency room of a Hospital. Primary Care Physician notification, if not completed prior to emergency room visit, should occur within 48 hours of seeking emergency room care.
- Use of the emergency room for conditions that are not Medical Emergencies is **not** covered.
- A Participant is responsible for the required Copayment which is waived if a Participant is admitted to the Hospital through the emergency room.
- Follow-up care must be coordinated by your Primary Care Physician.

Other Covered Services

The Plan provides Covered Services when the following services are Medically Necessary.

Medical and Surgical Care
General care and treatment of illness or Injury, and surgical diagnostic procedures including the usual pre- and post-operative care.

Assistant Surgery
If Medically Necessary, services rendered by an assistant surgeon are covered in conjunction with a surgery which has been coordinated by the Participant's surgeon.

Registered Nurse First Assistant
Covered Services are provided for eligible registered nurse first assistants. Benefits are payable directly to a registered nurse first assistant if such services are payable to a surgical first assistant and such services are performed at the request of a Physician and within the scope of a registered nurse first assistant's professional license. No benefits are payable to a registered nurse first assistant who is employed by a Physician or Hospital.

Reconstructive Surgery
Pre-certification is required. Reconstructive Surgery does not include any service otherwise excluded in this SPD Booklet. (See Exclusions.)
Reconstructive Surgery is covered only to the extent Medically Necessary:

- To restore a function of any body area which has been altered by disease, trauma, congenital/developmental anomalies or previous therapeutic processes;
- To correct congenital defects of a dependent child that lead to functional impairment; and
- To correct medical complications or post-surgical deformity, unless the previous surgery was not a Covered Service.

Breast Cancer Patient Care
Covered Services are provided for Inpatient care following a mastectomy or lymph node dissection until the completion of an appropriate period of stay as determined by the attending Physician in consultation with the Participant. Follow-up visits are also included and may be conducted at home or at the Physician's office as determined by the attending Physician in consultation with the Participant.

Breast Reconstructive Surgery
Covered Services are provided following a mastectomy for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications, including lymphedemas.

Ovarian Cancer Surveillance Tests
1. Covered Services are provided for risk women 35 years of age and older. At risk women are defined as: (a) having a family history (i) with one or more first or second-degree relatives with ovarian cancer, (ii) of clusters of women relatives with breast cancer, (iii) of nonpolysis colorectal cancer; or (b) testing positive for BRCA1 or BRCA2 mutations.

2. Surveillance tests means annual screening using: (a) CA-125 serum tumor marker testing, (b) transvaginal ultrasound, and (c) pelvic examinations.

Obesity
Covered Services for obesity include up to two nutritional counseling visits when referred by your Primary Care Physician. Prescription Drugs and any other services or supplies for the treatment of obesity are not covered. Surgical treatment of obesity is only covered for patients meeting Medical Necessity criteria, as defined by the Claims Administrator. Pre-certification is required, and coverage is only provided for cost effective procedures with documented outcomes and safety.

Second Medical Opinion
Covered Services include a second medical opinion by a Network Physician with respect to any proposed surgical intervention or, when pre-certified by the Claims Administrator, for any medical care that is a Covered Service.

Oral Surgery
Pre-certification is required and must be obtained by the Participant from a Network Physician.

Covered Services include only the following:

- Fracture of facial bones;
- Lesions of the mouth, lip, or tongue which require a pathological exam;
- Incision of accessory sinuses, mouth salivary glands or ducts;
- Dislocations of the jaw;
- Removal of impacted teeth;
- Treatment of Temporomandibular Joint Syndrome (TMJ) or myofacial pain including only removable appliances for TMJ repositioning and related surgery

and diagnostic services. Covered Services do **not** include fixed or removable appliances which involve movement or repositioning of the teeth, or operative restoration of teeth (fillings), or prosthetics (crowns, bridges, dentures);
- Plastic repair of the mouth or lip necessary to correct traumatic injuries or congenital defects that will lead to functional impairments; and
- Initial services, supplies or appliances for dental care or treatment required as a result of, and directly related to, accidental bodily Injury to sound natural teeth or structure occurring while a Participant is covered by this Plan and performed within 180 days after the accident.

Private Duty Nursing Services

Pre-certification of Medical Necessity is required **from the Physician and must be confirmed by the Claims Administrator.**

Limitations for both Inpatient and Outpatient RN and LPN

- Eligible Charges for services of an RN or LPN, whether on an Inpatient or outpatient basis, limited to a $2,500 maximum per Participant per calendar year.
- Inpatient care is covered only when no intensive or cardiac care unit is available, and the care needed is beyond the capabilities of the Hospital's floor nurses.
- Eligible Charges do not include services when:
  - requested by, or for the convenience of, the patient or the patient's family;
  - services consist primarily of bathing, feeding, exercising, homemaking, moving the patient, giving oral medication, or acting as a companion or sitter;
  - the private duty nurse is a relative by blood or marriage or member of the household of the Participant;
  - Inpatient services could have been rendered by the Hospital's general nursing staff; or
  - outpatient services could be safely rendered by an individual other that an RN or LPN.

Hospital Visits

The Physician's visits to his or her patient in the Hospital are covered.

Consultation Services

Covered when the special skill and knowledge of a consulting Physician is required for the diagnosis or treatment of an illness or Injury.

General Anesthesia Services

Covered when ordered by the attending Physician and administered by another Physician who customarily bills for such services, in connection with a covered procedure.

Such anesthesia service includes the following procedures which are given to cause muscle relaxation, loss of feeling, or loss of consciousness:

- spinal or regional anesthesia;
- injection or inhalation of a drug or other agent (local infiltration is excluded).

Anesthesia services administered by a Certified Registered Nurse Anesthetist (CRNA) are only covered when billed by the supervising Physician.

Anesthesia Services for Certain Dental Patients

General anesthesia and associated Hospital or ambulatory surgical facility charges are covered in conjunction with dental care provided to the following:

1. Patients age 7 or younger or developmentally disabled.
2. An individual for whom a successful result cannot be expected by local anesthesia due to neurological disorder.
3. An individual who has sustained extensive facial or dental trauma, except for a Workers' Compensation claim.

Pre-certification is required.

Use of Operating and Treatment Rooms and Equipment

Diagnostic X-ray and Laboratory Procedures

Chemotherapy and Radioisotope, Radiation and Nuclear Medicine Therapy

Oxygen, Blood and Components, and Administration

Dressings, Splints, Casts when provided by a covered Physician

Colorectal Cancer Examinations and Laboratory Tests

Covered Services include colorectal cancer examinations and laboratory tests specified in current American Cancer Society guidelines for colorectal cancer screening. Benefits shall be provided for Members who are 50 years of age or older and less than 50 years of age and at high risk for colorectal cancer according to the current colorectal cancer screening guidelines of the American Cancer Society.

Diabetes

Equipment, supplies, pharmacological agents, and outpatient self-management training and education, including nutritional therapy for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes as prescribed by the Physician. Covered Services for outpatient self-management training and education must be provided by a certified, registered or licensed health care professional with expertise in diabetes.

Osteoporosis

Benefits will be provided for qualified individuals for reimbursement for scientifically proven bone mass measurement (bone density testing) for the prevention, diagnosis and treatment of osteoporosis for Participants meeting certain criteria.

Prescription Drugs

Covered Services are stated in the **Summary of Benefits**. All In-Network prescriptions must be written by either your Primary Care Physician, a Network Physician designated by your Primary Care Physician to provide services in his/her absence, an emergency room Physician (if your condition is a Medical Emergency), or a Specialist who is a Network Provider.

Your benefit design as shown in the **Summary of Benefits** will determine the Copayment of your Prescription Drug Plan for Formulary drugs and non-formulary drugs.

Covered Services may include:

Retail Prescription Drugs that have been prescribed by a Network Provider and obtained through a participating pharmacy. Retail Prescription Drugs shall, in all cases, be dispensed according to the Drug Formulary for prescriptions written and filled In-Network. The Drug Formulary may be amended from time to time by the Claims Administrator.

A Participant or prospective Participant shall be entitled upon request, to a copy of the Drug Formulary Guide, available through the member Guide or the Claims Administrator's Website. You may exercise your right to a non-formulary drug by filing a Formulary appeal.

You can obtain, without penalty and in a timely fashion, specific drugs and medications not included in the Formulary when:

- The Formulary's equivalent has been ineffective in the treatment of the patient's disease or condition; or
- The Formulary's drug causes or is reasonably expected to cause adverse or harmful reactions in the patient.

Maintenance drugs are available via mail order. To determine if a drug is considered a maintenance drug or requires pre-authorization, please call Customer Service. If a particular drug is not on the list of maintenance drugs, then it is not available through mail order.

A limited number of Prescription Drugs require pre-authorization for Medical Necessity. If pre-authorization is not approved, then the designated drug will not be eligible for coverage. To determine if a drug requires pre-authorization, please call Customer Service.

Insulin, which can be obtained over the counter, will only be covered under the Prescription Drug benefit when accompanied by a prescription.

The following are not Covered Services under this Plan:

1. Prescription Drug products for any amount dispensed which exceeds the FDA clinically recommended dosing schedule.
2. Prescription Drugs received through an Internet pharmacy provider or mail order provider except for the designated mail order provider.
3. Non-legend vitamins.
4. Smoking cessation products (including the use of Wellbutrin SR for this purpose).
5. Over-the-counter items.
6. Cosmetic drugs (e.g., Propecia).
7. Appetite suppressants (anorexiants).
8. Weight loss products.
9. Diet supplements.
10. Syringes (for use other than insulin).
11. Non-contraceptive injectables (except with pre-certification).
12. The administration or injection of any Prescription Drug or any drugs or medicines.
13. Prescription Drugs which are entirely consumed or administered at the time and place where the prescription order is issued.

14. Prescription refills in excess of the number specified by the Physician, or any refill dispensed after one year from the date of the prescription order.
15. Prescription Drugs for which there is no charge.
16. Charges for items such as therapeutic devices, artificial appliances, or similar devices, regardless of their intended use.
17. Prescription Drugs for use as an Inpatient or outpatient of a Hospital and Prescription Drugs provided for use in a convalescent care facility or nursing home which are ordinarily furnished by such facility for the care and treatment of Inpatients.
18. Charges for delivery of any Prescription Drugs.
19. Drugs and medicines which do not require a prescription order and which are not Prescription Drugs.
20. Prescription Drugs provided by a Physician whether or not a charge is made for such Prescription Drugs.
21. Prescription Drugs which are not Medically Necessary or which are determined not to be consistent with the diagnosis.
22. Prescription Drugs which we determine are not provided in accordance with accepted professional medical standards in the United States.
23. Any services or supplies, which are not specifically listed as covered under this Prescription Drug Plan.
24. Prescription Drugs which are Experimental or Investigational in nature as explained in the "Exclusions" section.

Nutritional Counseling

Nutritional counseling related to the medical management of certain disease states (subject to pre-certification).

Cardiac Rehabilitation

Programs require prior authorization and Individual Case Management.

Allergy conditions

Benefits are provided as stated in the **Summary of Benefits**.

Durable Medical Equipment

In addition to meeting criteria for Medical Necessity and applicable pre-certification requirements, the equipment must also be used to improve the functions of a malformed part of the body or to prevent or slow further decline of the Participant's medical condition. The equipment must be ordered and/or prescribed by a Physician and be appropriate for in-home use.

The equipment must meet the following criteria:

- It can stand repeated use;
- It is manufactured solely to serve a medical purpose;
- It is not merely for comfort or convenience;
- It is normally not useful to a person not ill or injured;
- It is ordered by a Physician;
- The Physician certifies in writing the Medical Necessity for the equipment. The Physician also states the length of time the equipment will be required. The Plan may require proof at any time of the continuing Medical Necessity of any item;
- It is related to the patient's physical disorder.

See the "Exclusions" section for services which are not covered.

Dialysis Treatment

Dialysis treatment is covered if care has been pre-certified by and coordinated through your Primary Care Physician.

Ambulance Service

Local service to a Hospital in connection with care for a Medical Emergency or if otherwise Medically Necessary whether you are in or out of the Claims Administrator's Service Area. Such service also covers your transfer from one Hospital to another if Medically Necessary. Air ambulance is covered subject to Medical Necessity.

Prosthetic Appliances

Prosthetic devices to improve or correct conditions resulting from an Accidental Injury or illness are covered if Medically Necessary and ordered by a Physician.

The following items related to prosthetic devices include artificial limbs and accessories, artificial eyes, lenses for eyes used after surgical removal of the lens(es) of the eye(s), arm braces, leg braces (and attached shoes), and external breast prostheses used after breast removal.

The following items are **excluded:** corrective shoes; dentures; replacing teeth or structures directly supporting teeth; except to correct traumatic injuries; electrical or magnetic continence aids (either anal or urethral); hearing aids or hearing devices; or implants for cosmetic purposes except for reconstruction following a mastectomy.

Physical Therapy/Occupational Therapy

Services by a Physician, a registered physical therapist (R.P.T.), a licensed occupational therapist (O.T.), limited to a combined total maximum visits per calendar year as outlined in the **Summary of Benefits**. All services rendered must be within the lawful scope of practice of, and rendered personally by, the individual provider. No coverage is available when such services are necessitated by Developmental Delay.

Chiropractic Care

Covered Services for In-Network spinal manipulation are available as shown in the **Summary of Benefits**. Covered Services are limited to exams, diagnostic x-rays and manipulations for musculoskeletal disorders.

Licensed Speech Therapist Services

The visits must be pre-certified by the Claims Administrator. Services must be ordered and supervised by a Physician as outlined in the **Summary of Benefits.** Services will be covered only to treat or promote recovery of the specific functional deficits identified. No coverage is available when such services are necessitated by Developmental Delay.

Maternity Care

Covered Services include Maternity Care on same basis for any other type of care, subject to your Plan's Copayment and/or percentage payable provisions.

Maternity benefits are provided for a female Employee and any eligible female Dependent.

Routine newborn nursery care is part of the mother's maternity benefits. The newborn pediatrician visit in the Hospital is covered In-Network.

Should the newborn require other than routine nursery care, the baby will be admitted to the Hospital in his or her own name (see "Changing Your Coverage" to add coverage for a newborn).

Under federal law, the Plan may not restrict the length of stay to less than the 48/96 hour periods or require prior certification for either length of stay. The length of hospitalization, which is Medically Necessary will be determined by the mother's attending Physician in consultation with the mother. Should the mother or infant be discharged before 48 hours following a normal delivery or 96 hours following a cesarean section delivery, the mother will have access to two post-discharge follow-up visits within the 48- or 96-hour period. These visits may be provided either in the Physician's office or in the mother's home by a Home Health Care Agency. The determination of the medically appropriate place of service and the type of provider rendering the service will be made by the mother's attending Physician.

Prenatal care visits. Only one (1) Copayment for all visits combined will be charged.

Skilled Nursing Facility Care

Benefits are provided as outlined in the **Summary of Benefits**. All Skilled Nursing Facility admissions must be pre-certified. Claims will be reviewed to verify that services consist of Skilled Convalescent Care that is medically consistent with the diagnosis.

Skilled Convalescent Care during a period of recovery is characterized by:

- A favorable prognosis;
- A reasonably predictable recovery time; and
- Services and/or facilities less intense than those of the acute general Hospital, but greater than those normally available at the patient's residence.

Covered Services include:

- Semiprivate or ward room charges including general nursing service, meals, and special diets. If a Participant stays in a private room, this Plan pays the amount of the Semiprivate Room rate toward the charge for the private room;
- Use of special care rooms;
- Pathology and Radiology;
- Physical or speech therapy;
- Oxygen and other gas therapy;
- Drugs and solutions used while a patient;
- Gauze, cotton, fabrics, solutions, plaster and other materials used in dressings, bandages, and casts.

This benefit is available only if the patient requires a Physician's continuous care and 24-hour-a-day nursing care.

Benefits will not be provided when:

- A Participant reaches the maximum level of recovery possible and no longer requires other than routine care;
- Care is primarily Custodial Care, not requiring definitive medical or 24-hour-a-day nursing service;
- Care is for mental illness including drug addiction, chronic brain syndromes and alcoholism, and no specific medical conditions exist that require care in a Skilled Nursing Facility;
- A Participant is undergoing senile deterioration, mental deficiency or retardation, and has no medical condition requiring care;
- The care rendered is for other than Skilled Convalescent Care.

Home Health Care Services

Home Health Care provides a program for the Participant's care and treatment in the home. Your coverage is outlined in the **Summary of Benefits**. A visit consists of up to 4 hours of care. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the Participant's attending Physician.

Covered Services Include:

1. Visits by an RN or LPN-Benefits cannot be provided for services if the nurse is related to the Participant.
2. Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy.
3. Visits to render services and/or supplies of a licensed Medical Social Services Worker when Medically Necessary to enable the Participant to understand the emotional, social, and environmental factors resulting from or affecting the Participant's illness.
4. Visits by a Home Health Nursing Aide when rendered under the direct supervision of an RN.
5. Administration of prescribed drugs.
6. Oxygen and its administration.
7. Nutritional guidance when Medically Necessary.

Covered Services for Home Health Care do not include:

1. Food, housing, homemaker services, sitters, home-delivered meals;
2. Home Health Care services which are not Medically Necessary or of a non-skilled level of care.
3. Services and/or supplies which are not included in the Home Health Care program as described.
4. Services of a person who ordinarily resides in the patient's home or is a member of the family of either the patient or patient's spouse.
5. Any services for any period during which the Participant is not under the continuing care of a Physician.
6. Convalescent or Custodial Care where the Participant has spent a period of time for recovery of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the patient.
7. Any services or supplies not specifically listed as Covered Services.
8. Routine care and/or examination of a newborn child.
9. Dietitian services.
10. Maintenance therapy.
11. Dialysis treatment.
12. Purchase or rental of dialysis equipment.
13. Private duty nursing care.

Hospice Care Services

Hospice benefits cover Inpatient and outpatient services for patients certified by a Physician as terminally ill with a life expectancy of six months or less.

The Plan provides Covered Services for Inpatient and outpatient Hospice care under certain conditions as stated in the **Summary of Benefits**. The Hospice treatment program must:

- Be recognized as an approved Hospice program by the Claims Administrator;
- Include support services to help covered family members deal with the patient's death; and
- Be directed by a Physician and coordinated by an RN with a treatment plan that:
  - provides an organized system of home care;
  - uses a Hospice team; and
  - has around-the-clock care available.

Individual Case Management

The individual case management program is designed to ensure and provide payment of benefits to eligible Participants who, with their attending Physician, agree to treatment under an Alternative Benefit Plan intended to provide quality health care under lower cost alternatives. Such benefits will be determined on a case-by-case basis, and payment will be made only as agreed to under a written alternative benefit plan for each program participant.

The program includes:

- the identification of potential program participants through active casefinding and referral mechanisms;
- eligibility screening;
- preparation of alternative benefit plans;
- subsequent to the approval of the parties, transfer to alternative treatment settings in which quality care will be provided.

Eligibility

A Participant receiving benefits under an alternative benefit plan may, at any time, elect to discontinue the plan and revert to regular Plan benefits.

The Participant—or legal guardian or family member, if applicable—and the attending Physician must consent to explore with us the possibilities of transfer to an alternative treatment setting and, prior to implementation, agree to the alternative benefit plan.

Benefits for Individual Case Management

Benefits will be determined on a case-specific basis, depending on the plan of treatment, and may include Covered Services under the applicable Plan.

Services will be covered and payable as long as the treatment is required as outlined in the alternative benefit plan, and is less expensive than the original treatment plan which otherwise would have been followed. The Plan will determine the maximum approved payments allowable under this program.

Benefits under the Plan are furnished as an alternative to other Plan benefits and are limited to the following:

1. Services, equipment and supplies which are approved as Medically Necessary for the treatment and care of the Participant.
2. Non-structural modifications to the home which are required to meet minimum standards for safe operation of equipment.
3. When necessary for the long term care of the Participant in the home-setting, Respite Care to relieve family members or other persons caring for the Participant at home. (The Respite Care benefit can be credited at a rate of 24 hours for every month of care rendered in the home setting, and may be reimbursed for up to 6 consecutive days at a time. On an exception basis, up to 5 days per month of Respite Care may be approved when medical review of the case indicates that such action is appropriate. Payments for Respite Care will be deducted from the Participant's remaining available benefits under the Plan.)

The Participant must obtain pre-certification from the Claims Administrator regarding the treatment plan and proposed setting to be utilized during the Respite Care period.

Potential cases include but are not limited to:

- spinal cord Injury;
- severe head trauma/coma;
- respiratory dependence;
- degenerative muscular/neurological disorders;
- long term IV antibiotics;
- premature birth;
- burns;
- cardiovascular accident;
- cancer
- accidents
- terminal illnesses;
- other cases at the Plan's discretion.

Covered Services

- Services covered under individual case management will be determined on a case-by-case basis. Benefits may be provided for the rehabilitation of a Participant on an Inpatient, outpatient, or out-of-Hospital basis, as long as they are Medically Necessary, support the plan of treatment, and ensure quality of care.
- The Plan may provide or coordinate any of the types of Covered Services provided pursuant to this SPD Booklet.
- At its sole discretion, in the context of an individual case management program, the Plan may also provide or arrange for alternative services or extra-contractual benefits which are either (i) excluded in this SPD Booklet; (ii) neither excluded nor defined as Covered Services in this SPD Booklet, or (iii) exceeding the maximum for any Covered Service in this SPD Booklet.

Utilization

- Benefits will be provided only when and for as long as the Plan deems they are Medically Necessary. The approved alternative benefit plan of treatment will establish which benefits will be provided and for how long, and shall be subject to pre-certification and continuing review for Medical Necessity as set forth in such plan for treatment.
- The total benefits that may be paid will not exceed those which the Participant would have otherwise have received in the absence of individual case management benefits.

Exclusions

- Rehabilitation or Custodial Care for chronic (recurring) conditions that do not, in the Plan's sole discretion, significantly improve in an observable way within a reasonable period of time will not be a covered benefit under the individual case management program.

Individual Case Management Definitions

Case Manager

The person designated by the Claims Administrator to manage and coordinate the Participant's medical benefits under the individual case management program.

Provider

A Provider may be any facility or practitioner licensed or certified to give services or supplies consistent with the Plan of Treatment and approved.

Termination of Individual Case Management

Services in the alternative benefit plan approved by the Claims Administrator under individual case management will cease to be Covered Services under this Plan when:

1. Extra-contractual benefits or alternative services are no longer Medically Necessary due to a change in the patient's condition, or
2. The total amount of benefits paid for such services and for all other Covered Services equals the Lifetime Maximum Benefit.

Organ/Tissue/Bone Marrow Transplant

Covered Services include certain services and supplies not otherwise excluded in this SPD Booklet and rendered in association with a covered transplant, including pre-transplant procedures such as organ harvesting (Donor Costs), post-operative care (including antirejection drug treatment, if Prescription Drugs are covered under the Plan) and transplant related chemotherapy for cancer limited as follows.

A transplant means a procedure or series of procedures by which an organ or tissue is either:

- removed from the body of one person (called a donor) and implanted in the body of another person (called a recipient); or
- removed from and replaced in the same person's body (called a self-donor).

A covered transplant means a Medically Appropriate transplant is limited to one of the following organs or tissues.

- Human organ or tissue transplants for cornea, lung, heart or heart/lung, liver, kidney, pancreas or kidney and pancreas when transplanted together in the same operative session.
- Autologous (self-donor) bone marrow transplants with high-dose chemotherapy is considered eligible for coverage on a prior approval basis, but **only** if required in the treatment of :
  - Non-Hodgkin's lymphoma, intermediate or high grade Stage III or IVB;
  - Hodgkin's disease (lymphoma), Stages IIIA, IIIB, IVA, or IVB;
  - Neuroblastoma, Stage III or Stage IV;
  - Acute lymphocytic or nonlymphocytic leukemia patients in first or subsequent remission, who are at high risk for relapse and who do not have HLA-compatible donor available for allogenic bone marrow support;
  - Germ cell tumors (e.g., testicular, mediastinal, retroperitoneal, ovarian) that are refractory to standard dose chemotherapy, with FDA-approved platinum compounds;
  - Metastatic breast cancer that (a) has not been previously treated with systemic therapy, (b) is currently responsive to primary systemic therapy, or (c) has relapsed following response to first-line treatment;
  - Newly diagnosed or responsive multiple myeloma, previously untreated disease, those in a complete or partial remission, or those in a responsive relapse.
- Homogenic/allogenic (other donor) or syngeneic hematopoietic stem cells whether harvested from bone marrow peripheral blood or from any other source, but only if required in the treatment of:
  - aplastic anemia;
  - acute leukemia
  - severe combined immunodeficiency **exclusive** of acquired immune deficiency syndrome (AIDS);
  - infantile malignant osteoporosis;
  - chronic myelogenous leukemia;
  - lymphoma (Wiscott-Aldrich syndrome);
  - lysosomal storage disorder;
  - myelodysplastic syndrome.

"Donor Costs" means all costs, direct and indirect (including program administration costs), incurred in connection with:

- medical services required to remove the organ or tissue from either the donor's or the self-donor's body;
- preserving it; and
- transporting it to the site where the transplant is performed.

In treatment of cancer, the term "transplant" includes any chemotherapy and related courses of treatment which the transplant supports.

For purposes of this benefit, the term transplant does not include transplant of blood or blood derivatives (except hematopoietic stem cells) which will be considered as nontransplant related under the terms of the Plan.

"Facility Transplant" means all Medically Necessary services and supplies provided by a health care facility in connection with a covered transplant except donor costs and antirejection drugs.

"Medically Appropriate" means the recipient or self-donor meets the criteria for a transplant established by the Plan.

"Professional Provider Transplant Services" means All Medically Necessary services and supplies provided by a professional provider in connection with a covered transplant except Donor Costs and antirejection drugs.

Benefits for Antirejection Drugs

For antirejection drugs following the covered transplant, the Plan will pay according to the benefits for Prescription Drugs, if any, under the Plan.

Pre-certification Requirement
All transplant procedures must be pre-certified for type of transplant and be Medically Necessary and not Experimental or Investigational according to criteria established by the Claims Administrator. To pre-certify, call the BCBSHP office using the telephone number on your Identification Card.

The pre-certification requirements are a part of the benefit administration of the Plan and are not a treatment recommendation. The actual course of medical treatment the Participant chooses remains strictly a matter between the Participant and his or her Physician.

Your Physician must submit a complete medical history, including current diagnosis and name of the surgeon who will perform the transplant. The surgery must be performed at a recognized transplant center. The donor, donor recipient and the transplant surgery must meet required medical selection criteria as defined by the Claims Administrator.

If the transplant involves a living donor, benefits are as follows:

- If a Participant receives a transplant and the donor is also covered under this Plan, payment for the Participant and the donor will be made under each individual's coverage.
- If the donor is not covered under this Plan, payment for the Participant and the donor will be made under this Plan but will be limited by any payment which might be made under any other hospitalization coverage plan.
- If the Participant is the donor and the recipient is not covered under this Plan, payment for the Participant will be made under this Plan limited by any payment which might be made by the recipient's hospitalization coverage with another company. No payment will be made under this Plan for the recipient.

Please see the Exclusions section for Non-Covered Services.

ValueOptions--Mental Health Care and Substance Abuse Treatment

This Plan does not provide benefits for Mental Health and Substance Abuse treatment. Westinghouse Savannah River Company provides these benefits through ValueOptions. The benefits provided through ValueOptions are described below.

Regardless of whether you elect Prime Choice, Standard Choice, Basic Choice, or BlueChoice Healthcare Plan, your coverage for mental health and substance abuse services will be managed by ValueOptions. ValueOptions is the largest mental health plan administrator in the United States, with a Network of providers throughout the nation.

Often, when someone needs mental health, alcohol or drug treatment, it is difficult and confusing to find the right approach and level of care. ValueOptions will help you and your Dependents find and receive appropriate care. It complements the assistance available through the SRS Employee Assistance Program (EAP) and Site Medical Department. ValueOptions provides an independent, confidential assessment and referral service staffed and managed by trained clinicians for you and your Dependents. The Value Options Network is composed of licensed practitioners and facilities who meet strict credentialing requirements.

To contact ValueOptions, call their toll-free number, 1-800-333-6557, 24 hours a day, 7 days a week. A Clinical Care Manager will discuss your problem and assess your needs. Your Clinical Care Manager also will refer you to a qualified provider in your community.

The ValueOptions network of local providers includes Inpatient Hospitals, day treatment programs, specialty child and adolescent services, outpatient treatment programs, intensive outpatient alcohol and drug treatment programs, and professionals in private practice. ValueOptions reviews the treatment you receive from providers of these services in an effort to monitor the quality of care being provided by the Network and to determine the appropriateness and Medical Necessity for the continuation of your treatment.

You must call ValueOptions prior to seeking treatment. You also have the option to use the SRS EAP/Medical Department, which can assist you and put you in touch with ValueOptions, if necessary.

Going directly to a provider known to be in the Network is not sufficient to receive ValueOptions Network Benefits--you must be referred by ValueOptions.

It is important to remember that without pre-certification from ValueOptions (either directly or through the EAP/SRS Medical Department) your treatment will not be covered. (The only exception is coverage from non-network outpatient mental health treatment.) The EAP/SRS Medical Department is able to refer you to treatment programs; however, ValueOptions must be notified of the referral prior to beginning treatment. Ultimately, it is your responsibility to make sure that ValueOptions is pre-notified about any mental health or alcohol or drug treatment to receive Network benefits. Also, ValueOptions must approve extensions of treatment beyond the initial pre-certification.

For emergency services, ValueOptions clinicians are available 24 hours a day, 7 days a week. Employees must call ValueOptions at 1-800-333-6557 for a referral for Inpatient treatment. If there is a risk of your (or your Dependent) being a danger to yourself/himself/herself or to another person, ValueOptions will assist the caller in getting help. This may require ValueOptions to authorize admission to non-network facilities. After the patient is stabilized, continued coverage may be contingent on transferring the patient to a ValueOptions Network facility. Again, all mental health and alcohol and drug admissions and treatment programs must be pre-certified by ValueOptions.

*If a patient requires both Inpatient mental health services and Inpatient or outpatient chemical dependency treatment services in the same calendar year, only one $250 deductible will apply.

Note: This Plan does not provide benefits for Mental Health and Substance Abuse treatment. Westinghouse Savannah River Company provides these benefits through ValueOptions. The benefits provided through ValueOptions are described in the "Summary of Benefits".

Exclusions

What's Not Covered

The Plan does not provide benefits for:

1. Care, supplies, or equipment not Medically Necessary, as determined by the Plan, for the treatment of an Injury or illness.
2. Services that are not Covered Services under the Plan, even when a prior Referral has been issued by a Primary Care Physician.
3. In-Network non-emergency care, supplies, or equipment that are not authorized by your Primary Care Physician or by other certification procedures, except that Participants have the right to Direct Access to specified In-Network providers without a Primary Care Physician Referral. Such providers include a gynecologist for obstetrical or gynecological – related conditions, a dermatologist; and an optometrist/ophthalmologist for medical conditions only.
4. Services rendered or supplies provided before coverage begins, i.e., before a Participant's Effective Date, or after coverage ends. Such services and supplies shall include but not be limited to Inpatient Hospital admissions which begin before a Participant's Effective Date, continue after the Participant's Effective Date, and are covered by a prior carrier.
5. Any services rendered or supplies provided while you are confined in an Ineligible Hospital.
6. Any portion of a provider's fee or charge which is ordinarily due from a Participant but which has been waived. If a provider routinely waives (does not require the Participant to pay) an Out-of-Pocket amount, we will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived.
7. Care for any condition or Injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease or similar law.
8. Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service provided or available from the Veterans' Administration or military facilities as required by law.
9. Any item, service, supply or care not specifically listed as a Covered Service in this SPD Booklet.
10. Care given by a medical department or clinic run by your Employer.
11. Admission or continued Hospital or Skilled Nursing Facility stay for medical care or diagnostic studies not medically required on an Inpatient basis.

12. Shoe inserts, orthotics (except for care of the diabetic foot), and orthopedic shoe (except when orthopedic shoes is joined to a brace).
13. Routine care of corns, bunions (except capsular or related surgery), calluses, toe nails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenail), flat feet, fallen arches, weak feet, chronic foot strain, or a symptomatic complaints related to the feet.
14. Daily room charges while the Plan is paying for an Intensive care, cardiac care, or other special care unit.
15. Vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related or routine examinations and services. Eye refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service.
16. Hearing aids, hearing devices and related or routine examinations and services.
17. Routine physical examinations, screening procedures, and immunizations necessitated by employment, foreign travel or participation in school athletic programs, recreational camps or retreats, which are not called for by known symptoms, illness or Injury except those which may be specifically listed as covered in this SPD Booklet.
18. The following items related to Durable Medical Equipment are specifically **excluded**:
    - Air conditioners, humidifiers, dehumidifiers, or purifiers;
    - Arch supports, or orthopedic or corrective shoes;
    - Heating pads, hot water bottles, home enema equipment, or rubber gloves;
    - Sterile water;
    - Deluxe equipment, such as motor-driven chairs or beds, when standard equipment is adequate;
    - Rental or purchase of equipment if you are in a facility which provides such equipment;
    - Pools, spas, and whirlpools;
    - Electric stair chairs or elevator chairs;
    - Physical fitness, exercise, or ultraviolet/tanning equipment;
    - Residential structural modification to facilitate the use of equipment;
    - Other items of equipment that we determine do not meet the listed criteria.
19. Custodial Care, domiciliary care, rest cures, or travel expenses even if recommended for health reasons by a Physician. Inpatient room and board charges in connection with a Hospital or Skilled Nursing Facility stay primarily for environmental change, Physical Therapy or treatment of chronic pain, except as specifically stated as Covered Services. Transportation to another area for medical care is also excluded except when Medically Necessary for you to be moved by ambulance from one Hospital to another Hospital. Ambulance transportation from the Hospital to the home is not covered.
20. Services provided by a rest home, a home for the aged, a nursing home or any similar facility.
21. Services provided by a Skilled Nursing Facility, except as specifically stated as Covered Services.
22. Care, supplies, or equipment not Medically Necessary for the treatment of an Injury or illness. Non-covered supplies are inclusive of but not limited to band aids, tape, non-sterile gloves, thermometers, heating pads, hot water bottles, home enema equipment, sterile water and bed boards. Other non-covered items include household supplies, including but not limited to, deluxe equipment, such as motor-driven chairs or bed, electric stair chairs or elevator chairs, the purchase or rental of exercise cycles, physical fitness, ultraviolet/tanning equipment, water purifiers, hypo-allergenic pillows, mattresses, or waterbeds, whirlpool, spa or swimming pools, exercise and massage equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a Participant's house or place of business, and adjustments made to vehicles.
23. Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery, unless treatment relating to such consequences is Medically Necessary. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty and services for the correction of asymmetry is not covered, except when determined to be Medically Necessary.
    - This exclusion does not apply to surgery to restore function if any body area has been altered by disease, trauma, congenital/developmental anomalies, or previous therapeutic processes. This exclusion does not apply to surgery to correct the results of Injuries when performed within 2 years of the event causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.
    - This exclusion does not apply to Breast Reconstructive Surgery. Please see the "Benefits" section of this SPD Booklet.
24. Treatment resulting from complications of non-covered procedures is not covered.

25. Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions (except impacted teeth); endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery; vestibuloplasties; alveoplasties; dental procedures involving teeth and their bone or tissue supporting structures; frenulectomy; or other dental procedures except those specifically listed as covered in this SPD Booklet.
26. Except as outlined in the "Benefits" section, any services or supplies for the treatment of obesity, including but not limited to, weight reduction, medical care or Prescription drugs, or dietary control (except as related to covered nutritional counseling). Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding except when it's the sole means of nutrition. Food supplements. Services for Inpatient treatment of bulimia, anorexia or other eating disorders which consist primarily of behavior modification, diet and weight monitoring and education. Any services or supplies that involve weight reduction as the main method of treatment, including medical, psychiatric care or counseling. Weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature. Procedures including but not limited to liposuction, gastric balloons, and wiring of the jaw.
27. Surgical care or medical treatment or study related to the modification of sex (transsexualism) or medical or surgical services or supplies for treatment of sexual dysfunctions or inadequacies, including treatment for impotency (except male organic erectile dysfunction.)
28. Transportation provided by other than a state licensed professional ambulance service, and ambulance services other than in a Medical Emergency.
29. Hair transplants, hair pieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth.
30. Advice or consultation given by any form of telecommunication.
31. Treatments, procedures, equipment, drugs, devices, or supplies (hereafter called "services") which are, in the Claims Administrator's judgement, Experimental or Investigational for the diagnosis for which the Participant is being treated. An Experimental or Investigational service is not made eligible for coverage by the fact that other treatment is considered by a Participant's Physician to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.
32. Services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage.
33. Charges for failure to keep a scheduled visit or completion of claim forms; for Physician or Hospital's stand-by services; for holiday or overtime rates.
34. Services rendered by a provider who is a close relative or member of your household. Close relative means wife or husband, parent, child, brother or sister, by blood, marriage or adoption.
35. Services for outpatient therapy or rehabilitation other than those specifically listed in this SPD Booklet. Excluded forms of therapy include, but are not limited to, vestibular rehabilitation, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, cognitive therapy, electromagnetic therapy, vision perception training (orthoptics), salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne, services and supplies for smoking cessation programs and treatment of nicotine addiction, and carbon dioxide.
36. Radial keratotomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.
37. Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the Participant had applied for such benefits. Services that can be provided through a government program for which you as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.
38. Services paid under Medicare or which would have been paid if the Participant had applied for Medicare and claimed Medicare benefits. With respect to end-stage renal disease (ESRD), the Plan will pay your Hospital and medical bills for 30 months and Medicare shall be treated as the secondary payor whether or not the Participant has enrolled in Medicare Part B.
39. Expenses in excess of Usual, Customary and Reasonable Fees (UCR).
40. Services related to or performed in conjunction with artificial insemination, in-vitro fertilization, reverse sterilization or combination thereof.
41. Biofeedback, recreational, or educational or sleep therapy or other forms of self-care or self-help training and any related diagnostic testing.

42. Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.
43. Mental Health Care and Substance Abuse Treatment. (Benefits are administered by ValueOptions, not BlueChoice Healthcare Plan.)
44. Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, or Developmental Delay.
45. Inpatient rehabilitation in the Hospital or Hospital-based rehabilitation facility, when the Participant is medically stable and does not require skilled nursing care or the constant availability of a Physician or:
    - the treatment is for maintenance therapy; or
    - the Participant has no restorative potential; or
    - the treatment is for congenital learning or neurological disability/disorder; or
    - the treatment is for communication training, educational training or vocational training.
46. Injuries received while committing a crime.
47. Biomicroscopy, field charting or aniseikonic investigation.
48. Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) or visual training.
49. Methadone is excluded for coverage when used (1) for any maintenance program and/or for the treatment of drug addiction or dependency(unless the Plan has mental health outpatient benefits) and (2) for the management of chronic, non-malignant pain and/or any off-label usage which does not meet established off-label coverage guidelines. Such maintenance programs must meet Medical Necessity requirements.
50. Non-emergency treatment of chronic illnesses received outside the United States performed without pre-authorization.
51. Any drug or other item which does not require a prescription.
52. The following services and supplies rendered in connection with organ/tissue/bone marrow transplants:
    - Surgical or medical care related to animal organ transplants, animal tissue transplants, (except for porcine heart valves) artificial organ transplants or mechanical organ transplants;
    - Transportation, travel or lodging expenses for non-donor family members;
    - Donation related services or supplies, including search, associated with organ acquisition and procurement.
    - Chemotherapy with autologous, allogenic or syngenic hematopoietic stem cells transplant for treatment of any type of cancer not specifically named as covered;
    - Any transplant not specifically listed as covered.
53. Acupuncture and acupuncture therapy.
54. Private room, except as specified as Covered Services.
55. Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or Injury.
56. Court-ordered services, or those required by court order as a condition of parole or probation.
57. Hypnotherapy.
58. Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.
59. Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
60. Specific medical reports, including those not directly related to treatment of the Participant, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
61. Thermograms and thermography.

Coordination of Benefits (COB)

If you, your spouse, or your Dependents have duplicate coverage under another plan, any other group medical expense coverage, or any local, state or governmental plan (except school accident insurance coverage and Medicaid), then benefits payable under this Plan will be coordinated with the benefits payable under the other plan. The total benefits paid by both plans will not exceed 100% UCR, the per diem negotiated fee or the contracted amount.

Allowable Expense means any necessary, reasonable and customary expense at least a portion of which is covered under at least one of the plans covering the person for whom the claim is made. The claim determination period is the calendar year.

Order of Benefit Determination

When you have duplicate coverage, claims will be paid as follows:

- **Automobile Insurance**. Medical benefits available through automobile insurance coverage will be determined before that of any other plan.
- **Non-Dependent/Dependent**. The benefits of the plan which covers the person as an Employee (other than as a Dependent) are determined before those of the plan which covers the person as a Dependent.
- **Dependent Child/Parents Not Separated or Divorced.** Except as stated below, when this Plan and another plan cover the same child as a Dependent of different persons, called **"parents"**:
  - **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.**
  - If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

    However, if the other plan does not have the rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
- **Dependent Child/Parents Separated or Divorced.** If two or more plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - first, the plan of the parent with custody of the child;
  - then, the plan of the spouse of the parent with custody of the child; and
  - finally, the plan of the parent not having custody of the child.

    However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses, and the company 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. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the company has that actual knowledge.
- **Joint Custody.** If the specific terms of a court decree state that the parents shall have 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 outlined above for "Dependent Child/Parents not Separated or Divorced."
- **Active/Inactive Employee.** The benefits of a plan that covers a person as an Employee who is neither laid off nor retired (or as that Employee's Dependent) are determined before those of a plan that covers that person as a laid-off or retired Employee (or as that Employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- **Longer/Shorter Length of Coverage.** If none of the above rules determine the order of benefits, the benefits of the plan which covered an Employee or Participant longer are determined before those of the plan that covered that person for the shorter time.

Effect on the Benefits of this Plan

This section applies when, in accordance with the Order of Benefit Determination Rules, this Plan is a secondary Plan to one or more other plans. In that event the benefits of this Plan may be reduced under this section. Such other plan or plans are referred to as "the other plan" below.

Reduction in this Plan's benefits. The benefits of this Plan will be reduced when the sum of:

- the benefits that would be payable for the Allowable Expenses under this Plan in the absence of this provision; and
- the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this provision, whether or not claim is made, exceed those Allowable Expenses in a claim determination period. In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Miscellaneous Rights

- **Right to Receive and Release Necessary Information.** Certain facts are needed to apply these rules. The Claims Administrator has the right to decide which facts it needs. The Claims Administrator may get needed facts from or give them to any other organization or person as necessary to coordinate benefits. The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan

must give the Claims Administrator any facts needed to pay the claim.

- **Facility of Payment.** A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Plan will not have to pay that amount again.
- **Right of Reimbursement.** If the amount of the payment made by the Plan is more than it should have paid under this provision, it may recover the excess from one or more of:
  - the persons it has paid or for whom it has paid,
  - insurance companies, or
  - other organizations.

Subrogation

In the event benefits are provided to or on behalf of a Participant under the terms of this Plan, the Participant 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. The Plan shall be subrogated, at its expense, to the rights of recovery of such Participant against any such liable third party.

If, however, the Participant receives a settlement, judgment, or other payment relating to an injury or illness from another person, firm, corporation, organization or business entity for the injury or illness, the Participant agrees to reimburse the Plan in full, and in first priority, for benefits paid by the Plan relating to the injury or illness. The Plan's right of recovery applies regardless of whether the recovery, or a portion thereof, is specifically designated as payment for, but not limited to, medical benefits, pain and suffering, lost wages, other specified damages, or whether the Participant has been made whole or fully compensated for his/her injuries.

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, any medical payments (Med-Pay), no fault, personal injury protection (PIP), malpractice, or any other insurance coverages which are paid or payable.

The Plan will not pay attorney's fees, costs, or other expenses associated with a claim or lawsuit without the expressed written authorization of the Plan.

The Participant shall not do anything to hinder the Plan's right of subrogation and/or reimbursement. The Participant shall cooperate with the Plan, execute all documents, and do all things necessary to protect and secure the Plan's right of subrogation and/or reimbursement, including asset a claim or lawsuit against the third party or any insurance coverages to which the Participant may be entitled. Failure to cooperate with the Plan will entitle the Plan to withhold benefits due the Participant under the Plan Document. Failure to reimburse the Plan as required will entitle the Plan to deny future benefit payments for all Beneficiaries under this policy until the subrogation/reimbursement amount has been paid in full.

General Information

Balance Billing

Participating Physicians are prohibited from balance billing. A Participating Physician has signed an agreement with the Claims Administrator to accept the Claims Administrator's determination of the Usual, Customary and Reasonable Fee for Covered Services rendered to a Participant who is his or her patient. A Participant is not liable for any fee in excess of this determination or negotiated fee, except what is due under the Plan, e.g., Copayments.

Proof of Loss, Payment of Claims

If you incur out-of-area claims, please submit the bill to the Claim Administrator. Please include your ID number in order to verify that you are an active Participant.

Timeliness of Filing and Payment of Claims (Out-of-Area Only)

In the event you submit a claim, to receive benefits, a properly completed claim form with any necessary reports and records must be filed within 90 days of the date of service. Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In this case, the Claims Administrator will notify you within 15 working days of the reason for the delay and list all information needed to continue processing your claim. After this data is received, claims processing will be completed.

Network Providers

The Plan. provides or makes payment for Medically Necessary covered health care services received by the Participant. The health care services are subject to the

limitations, exclusions, and Copayments specified in the SPD Booklet. Unless otherwise specified, all services must be coordinated by the Primary Care Physician you have selected from the provider directory.

Unauthorized Use of Identification Card

If you permit your Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Questions About Coverage or Claims

If you have questions about your coverage, contact your Plan Administrator or the Claims Administrator's Customer Service Department. Be sure to always give your ID number. If you wish to get a full copy of the Utilization Review program procedures, contact the Customer Service Department.

Write

Customer Service Department
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.
P.O. Box 7368
Columbus, Georgia 31908

When asking about a claim, give the following information:

- ID number;
- Patient name and address;
- Date of service; type of service received; and
- Provider name and address (Hospital or doctor).

Complaints about Service

As a Participant, you have a right to express dissatisfaction and to expect unbiased resolution of issues. Please utilize the following procedures to tell the Claims Administrator when you are displeased with any aspect of services rendered.

1. Call the Customer Service Department. The phone number is on your ID Card. Tell the representative your problem and he or she will work to resolve it for you as quickly as possible.
2. If you are not satisfied with the answer, you may file a formal complaint, preferably, but not necessarily, in writing. This request for a further review of your concerns should be addressed to the location provided by the Customer Service Representative at the number on your ID Card.
3. If, depending on the nature of your complaint, you remain dissatisfied after receiving the response, you will be offered the right to appeal the decision. At the conclusion of this formalized re-review of your specific concerns, a final written response will be generated to you, which will, hopefully bring the matter to a satisfactory conclusion for you.

Complaints about Provider Service

If your complaint involves care received from a provider, please call the Customer Service number. Your complaint will be resolved in a timely manner.

Terms of Your Coverage

The Plan provides benefits described in this SPD Booklet only for eligible Participants. The health care services are subject to the limitations, exclusions, Copayments, and percentage payable requirements specified in this SPD Booklet. Any group plan or certificate which you received previously will be replaced by this Plan.

Benefit payment for Covered Services or supplies will be made either directly to the Network Hospital (or Network Facility), the Network Physician or to you depending upon whether services were rendered by a Network or Non-Network Provider.

Neither the Plan nor the Claims Administrator is responsible for any Injuries or damages you may suffer due to actions of any Hospital, Physician or other person.

In order to process your claims, the Claims Administrator or the Plan Administrator may request additional information about the medical treatment you received and/or other group health insurance you may have. This information will be treated confidentially.

An oral explanation of your benefits by an Employee of the Claims Administrator, Plan Administrator, Plan Sponsor or Employer is not legally binding. Any correspondence mailed to you will be sent to your most current address. You are responsible for notifying the Plan Administrator and the Claims Administrator of a new address.

General Information

Fraudulent statements on application forms and on electronic submissions will invalidate any payment or claims for services and be grounds for voiding the Participant's coverage.

The Plan Administrator and the Claims Administrator are relieved of their responsibilities without breach, if their duties become impossible to perform by acts of God, war, terrorism, fire etc.

The Claims Administrator will adhere to the Plan Sponsor's instructions and allow the Plan Sponsor to meet all of the Plan Sponsor's responsibilities under applicable

state and federal law. It is the Plan Sponsor's responsibility to adhere to all applicable state and federal laws and the Claims Administrator does not assume any responsibility for compliance.

Changes in Coverage

The Plan Sponsor may change the benefits described in this SPD Booklet. The Participant will be informed of such a change as required by law

Acts Beyond Reasonable Control (Force Majeure)

Should the performance of any act required by this coverage be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive government laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations.

Care Received Outside the United States

You will receive Plan benefits for care and treatment received outside the United States. Plan provisions will apply. Any care received must be a Covered Service. Please pay the provider of service at the time you receive treatment and obtain appropriate documentation of services received including bills, receipts, letters and medical narrative. This information should be submitted with your claim. All services will be subject to appropriateness of care. The Plan Administrator will reimburse you directly. Payment will be based on Eligible Charges and based on the UCR of the Participant's legal residence (i. e., local UCR). Assignments of benefits to foreign providers or facilities cannot be honored.

Licensed Controlled Affiliate

The Participant hereby expressly acknowledges his/her understanding that this policy constitutes a contract solely between the Employer Group and BCBSHP, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting BCBSHP to use the Blue Cross and Blue Shield Service Marks in the state of Georgia, and that we are not contracting as the agent of the Association. The Employer Group further acknowledges and agrees that it has not entered into this policy based upon representations by any person other than BCBSHP and that no person, entity, or organization other than BCBSHP shall be held accountable or liable to the Participant for any of BCBSHP's obligation to the Participant created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of BCBSHP other than those obligations created under other provisions of this agreement.

Calculation of Coinsurance and Other Participant Liability

When you obtain health care services outside the Service Area, the amount you pay for Covered Services is usually calculated on the **lower** of:

- The actual billed charges for your Covered Services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan passes on to the Claims Administrator.

Often this "negotiated price" will consist of a simple discount. But sometimes it is an estimated final price that factors in expected settlements or other non-claims transactions with your health care provider or with a specific group of providers. The negotiated price may also be a discount from billed charges that reflects **average** expected savings. The estimated or average price may be adjusted in the future to correct for over-or underestimation of past prices.

In addition, laws in a small number of states require Blue Cross and/or Blue Shield Plans to use a basis for calculating your payment for Covered Services that does not reflect the entire savings realized on a particular claim. When you receive covered health care services in those states, your required payment for these services will be calculated using their statutory methods.

When Coverage Terminates

Termination of Coverage

Membership for you and your enrolled family members may be continued as long as you are employed by the Employer and meet eligibility requirements. It ceases if your employment ends, if you no longer meet eligibility requirements, if the Plan ceases, or if you fail to make any required contribution toward the cost of your coverage. In any case, your coverage would end at the expiration of the period covered by your last contribution.

Coverage of an enrolled child ceases automatically when the child marries or attains age 20 (except full-time students at accredited institutions covered up to age 25), whichever occurs first. Coverage of an unmarried handicapped child over age 20 ceases if the child is found to be no longer totally or permanently disabled. Coverage of the Spouse of an Employee terminates automatically as of the date of divorce or death.

Should you or any family members be receiving covered care in the Hospital at the time your membership terminates for reasons other than your Employer's cancellation of this Plan, or failure to pay the required Premiums, benefits for Hospital Inpatient care will be provided only to the extent available for that Hospital stay.

HIPAA

The various WSRC/BSRI Health Choice medical options of which the Plan is simply a part, do not deny coverage to Employees or Dependents because of pre-existing medical conditions. However, should you leave the WSRC Team and go work for another company, your medical coverage may be affected by your new company's restrictions relative to pre-existing conditions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which medical insurance coverage may be excluded for medical conditions that were present before you enrolled in your new company's medical benefits plan.

Under HIPAA, a pre-existing condition exclusion in another company's plan generally may not be imposed for more than 12 months (18 months for a Late Enrollee). The exclusion period is reduced by the amount of your prior health coverage under the WSRC/BSRI Health Choice medical plan. When you leave employment with the WSRC Team, you are entitled to a "Certificate of Group Health Plan Coverage" which will be automatically provided to you by Benefits Administration. This Certificate will show evidence of your prior medical coverage under the WSRC/BSRI Health Choice options, including the beginning and ending dates of your medical, dental and vision care coverages. You should provide this Certificate to your new employer. If you buy health insurance other than through an employer group health plan, the Certificate showing prior coverage may help you obtain coverage without a pre-existing condition clause.

For information on Privacy of Protected Health Information see the Overview Booklet in the WSRC/BSRI Benefits Handbook.

Continuation Coverage (COBRA)

What is continuation coverage?

Federal Law requires that most group health plans (including this Plan) give Employees and their families the opportunity to continue health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee covered under the group health plan, a covered employee's spouse and dependent children of the covered employee.

COBRA continuation coverage is available in the event you and/or your Dependent's coverage terminates due to certain qualifying events described below. The Company will automatically provide you with COBRA information for these two qualifying events:

- Termination of your employment for any reason, including retirement, voluntary termination, etc., other than for gross misconduct;
- A reduction in your work hours of work causing ineligibility for coverage.

It is your or your Dependent's responsibility to notify Benefits Administration within 60 days of the following qualifying events:

- Your dependent child no longer meets the eligibility requirements for coverage;
- Your divorce or legal separation;
- You become entitled to Medicare benefits;
- Your death.

If you desire to exercise your right to continuation of coverage under COBRA, you must do so within 60 days following the date of the event that terminated your coverage. To remove a dependent from your coverage you should complete an OSR 5-200 Health Care Enrollment Change form and submit it to the WSRC People Support Service Center no later than 60 days from the date of the qualifying event. You may be required to provide official documentation supporting your request such as a copy of your divorce decree.

The following is the address and phone number for the submission of requests for COBRA continuation coverage:
WSRC People Support Service Center
Bldg. 703-47A
Aiken, SC 29808
Phone 800-368-7333

Continuation coverage is the same coverage that the Plan gives to other Participants under the Plan who are not receiving continuation coverage. Each qualified Participant who elects continuation coverage will have the same rights under the Plan as other Participants covered under the Plan, including open enrollment and special enrollment rights.

How long will continuation coverage last?

In most cases of a loss of coverage due to end of employment or reduction in hours of employment coverage may be continued up to 18 months. In the case

of losses of coverage due to an Employee's death, divorce or legal separation, the Employee's enrollment in Medicare, or a dependent child ceasing to be a dependent under the terms of the Plan, coverage may be continued up to 36 months.

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified Participant becomes covered under another group health plan that does not impose any pre-existing condition of the qualified Participant, if a covered Employee enrolls in Medicare, or if the Employer ceases to provide any group health plan for its Employees. Continuation may also be terminated for any reason the Plan would terminate coverage of a Participant not receiving continuation coverage (such as fraud).

If you elect continuation coverage, an extension of the maximum period of 18 months of coverage is available if a qualified Participant is disabled or a second qualifying event occurs. You must notify Blue Cross Blue Shield of SC COBRA Administration Unit, P.O. Box 100136, Columbia, SC 29202-3136, phone (800) 325-6596 Option 5, of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

An 11-month extension of coverage may be available if any of the qualified Participants are disabled. The Social Security Administration (SSA) must determine that the qualified Participant was disabled at some time during the first 60 days of continuation coverage, and you must notify Blue Cross Blue Shield of SC COBRA Administration Unit. WSRC Benefits Administration, Bldg. 703-47A, Aiken, SC 29808, phone 800-368-7333 must always be notified of SSA Disability award or denial if the disabled individual is receiving benefits under the WSRC/BSRI Total and Permanent Disability Plan. You must make the notifications within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage to qualify for the extension. All of the qualified Participants who have elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified Participant is determined by SSA to no longer be disabled, you must notify Blue Cross Blue Shield of SC COBRA Administration Unit and WSRC Benefits Administration of the fact within 30 days of SSA's determination.

An 18-month extension of coverage will be available to Spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include the death of a covered Employee, divorce or separation from the covered Employee, the covered Employee's enrolling in Medicare, or a dependent child ceasing to be eligible for coverage as a dependent under the Plan. You must notify Blue Cross Blue Shield of SC COBRA Administration Unit within 60 days after a second qualifying event occurs.

Each qualified Participant covered at the time the coverage was lost has an independent right to elect continuation coverage. For example, both the Employee and the Employee's Spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. A qualified Participant must elect coverage by the date specified on the election form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified Participant may change a prior rejection of continuation coverage any time until that date.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and the election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after your group health coverage ends because of the qualifying event. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Each qualified Participant may be required to pay the entire cost of continuation coverage. The amount a qualified Participant may be required to pay may not exceed 102 percent of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated Plan Participant who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent). The required payment for continuation coverage can be found on Benefits Home Page on

ShRINE or by contacting the WSRC Service Center at 800-368-7333 or locally at 803-725-7772.
If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact Blue Cross Blue Shield of SC COBRA Administration Unit at (800) 325-6596 Option 5 to confirm the correct amount of your first payment.

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the 1st of the month. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The COBRA Administration will send periodic notices of payment due for these coverage periods.

Periodic payments for continuation coverage should be sent to:

COBRA Administration Unit
P.O. Box 100136
Columbia, SC 29202-3136

Although periodic payments are due by the 1st of the month, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan and your coverage will be suspended retroactively back to the due date. You will be responsible for any claims filed and/or paid by the Plan after your coverage ended.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability ACT (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

In order to protect your family's rights, it is your responsibility to keep the COBRA Administration Unit and WSRC informed of any changes in addresses of family members.

Continuation of Coverage (Federal Law – USERRA)

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Employee may have a right to continuation of benefits subject to the conditions described below.

Under USERRA, if the Employee (or his or her Dependents) is covered under the Plan, and if the Employee becomes absent from employment by reason of military leave, the Employee (or his or her Dependents) may have the right to elect to continue health coverage under the Plan. In order to be eligible for coverage during the period that the Employee is gone on military leave, the Employee must give reasonable notice to the Employer of his or her military leave and the Employee will be entitled to COBRA-like rights with respect to his or her medical benefits in that the Employee and his or her dependents can elect to continue coverage under the Plan for a period of 18 months from the date the military leave commences or, if sooner, the period ending on the day after the deadline for the Employee to apply for or return to work with the Employer. During military leave, the Employee is required to pay the Employer for the entire cost of such coverage, including any elected dependents' coverage. However, if the Employee's absence is less than 31 days, the Employer must continue to pay its portion of the Premiums and the Employee is only required to pay his or her share of the Premiums without the COBRA-type 2% administrative surcharge.

Also, when the Employee returns to work, if the Employee meets the requirements specified below, USERRA states that the Employer must waive any exclusions and waiting periods, even if the Employee did not elect COBRA continuation. These requirements are (i) the Employee gave reasonable notice to his or her Employer of military leave, (ii) the military leave cannot exceed a prescribed period (which is generally five (5) years, except in unusual or extraordinary circumstances) and the Employee must have received no less than an honorable discharge (or, in the case of an officer, not been sentenced to a correctional institution), and (iii) the Employee must apply for reemployment or return to work in a timely manner upon expiration of the military leave (ranging from a single day up to 90 days, depending upon

the period that he or she was gone). The Employee may also have to provide documentation to the Employer upon reemployment that would confirm eligibility. This protection applies to the Employee upon reemployment, as well as to any Dependent who has become covered under the Plan by reason of the Employee's reinstatement of coverage.

Governmental Health Care Programs

Under federal law, for groups with 20 or more employees, all active employees (regardless of age) can remain on the group health plan and receive group benefits as primary coverage. Also, spouses (regardless of age) of active employees can remain on the group health plan and receive group benefits as primary coverage.

Direct questions about Medicare eligibility and enrollment to your local Social Security Administration office.

Definitions

Accidental Injury

Bodily Injury sustained by a Participant as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity or any other cause) for care which the Participant receives. Such care must occur while this Plan is in force. It does not include injuries for which benefits are provided under any Workers' Compensation, Employer's liability or similar law.

After-Hours Office Visit

Care rendered as a result of a condition that has an onset after the Primary Care Physician's business hours.

Applicant

The corporation, partnership, sole proprietorship, other organization or group which applied for this Plan.

Application for Enrollment

The original and any subsequent forms completed and signed by the Employee seeking coverage. Such Application may take the form of an electronic submission.

Benefit Period

One year, January 1 – December 31 (also called year or calendar year). It does not begin before a Participant's Effective Date. It does not continue after a Participant's coverage ends.

Brand Name Drugs

A drug item which is under patent by its original innovator or marketer. The patent protects the drug from competition from other drug companies. There are two types of Brand Name Drugs:

- Single Source Brand: those drugs that are produced by only one manufacturer and do not have a generic equivalent available.
- Multi-Source Brand: those drugs that are produced by multiple pharmaceutical manufacturers and do have a generic equivalent available on the market.

Chiropractor

A practitioner in restoring normal functions of the nerve system by manipulation and treatment of the structures of the human body, especially those of the spinal column.

Claims Administrator

The company the Plan Sponsor chose to administer their health benefits. Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. was chosen to administer this Plan.

Complications of Pregnancy

Complications of Pregnancy result from conditions requiring Hospital confinement when the pregnancy is not terminated. The diagnoses of the complications are distinct from pregnancy but adversely affected or caused by pregnancy.

Such conditions include acute nephritis, nephrosis, cardiac decompensation, missed or threatened abortion, preeclampsia, intrauterine fetal growth retardation and similar medical and surgical conditions of comparable severity. An ectopic pregnancy which is terminated is also considered a Complication of Pregnancy.

Complications of Pregnancy shall not include false labor, caesarean section, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy which are not diagnosed distinctly as Complications of Pregnancy.

Congenital Anomaly

A condition or conditions that are present at birth regardless of causation. Such conditions may be hereditary or due to some influence during gestation.

Coordination of Benefits

A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claim payment delays by establishing an order in

which plans pay their claims and providing an authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

Copayment

A cost-sharing arrangement in which a Participant pays a specified charge for a Covered Service, such as the Copayment indicated in the **Summary of Benefits** for an office visit. The Participant is usually responsible for payment of the Copayment at the time the health care is rendered. Typical Copayments are fixed or variable flat amounts for Physician office visits, Prescription Drugs or Hospital services. Copayments are distinguished from Coinsurance as flat dollar amounts rather than percentages of the charges for services rendered. Copayments may be collected by the provider of service or the Claims Administrator.

Cosmetic Surgery

Any non-medically necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, physical appearance or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. Cosmetic surgery includes but is not limited to rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of Cosmetic Surgery.

Covered Dependent

Any Dependent in an Employee's family who meets all the requirements of the Eligibility section of this SPD Booklet, has enrolled in the Plan, and is subject to Premium requirements set forth in this Plan.

Covered Services

Medically Necessary health care services and supplies that are (a) defined as Covered Services in the Participant's Plan, (b) not excluded under such Plan, (c) not Experimental or Investigational and (d) provided in accordance with such Plan.

Creditable Coverage

Coverage under another health benefit plan is medical expense coverage with no greater than a 63 day gap in coverage under any of the following: (a) Medicare or Medicaid; (b) an Employer-based accident and sickness insurance or health benefit arrangement; (c) an individual accident and sickness insurance policy; (d) a spouse's benefits or coverage under Medicare or Medicaid or an Employer-based health insurance benefit arrangement; (e) a conversion policy; or (f) similar coverage as defined in OCGA 33-30-15.

Custodial Care

Any type or care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-hospital Skilled Nursing Facility care; (c) is a level such that the Participant has reached the maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Participant's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the Participant, general maintenance care of colostomy or ileostomy, routine services to maintain other service which can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

Dependent

Dependents are defined on page 1 of this SPD Booklet under the subtitle, "Eligible Dependents".

Direct Access

A Participant has the right to receive services from specified providers without a Primary Care Physician Referral. This is called Direct Access. Such providers include a gynecologist for obstetrical or gynecological-related conditions, a dermatologist, an optometrist/ophthalmologist for medical conditions only.

Durable Medical Equipment

Equipment which is (a) made to withstand prolonged use; (b) made for and mainly used in the treatment of a disease or Injury; (c) suited for use while not confined as an Inpatient at a Hospital; (d) not normally of use to persons who do not have a disease or Injury; (e) not for exercise or training.

Effective Date
The date for which the Plan approves an individual application for coverage. For individuals who join this Group after the first enrollment period, the Effective Date is the date the Plan approves each future Participant according to its normal procedures.

Elective Surgical Procedure
A surgical procedure that is not considered to be an emergency, and may be delayed by the Participant to a later point in time.

Eligible Charges
Those charges for services and supplies (a) defined as Covered Services and not excluded under the Participant's Plan; (b) that are Medically Necessary; and (c) that are provided in accordance with the Participant's Plan. For In-Network services, Eligible Charges are determined by: (a) Claims Administrator's negotiated arrangements; (b) pre-determined fee schedules; and (c) the applicable Reimbursement Rate. For Out-of-Network services, Eligible Charges are determined by: (a) the Usual, Customary and Reasonable (UCR) Fees; (b) a provider's contracted fee schedule; (c) the applicable Reimbursement Rate; and or (d) negotiated fees. All payment determinations for Hospital Services are based on the applicable Reimbursement Rate. Reimbursement for Out-of-Network, Participating and Non-Participating Providers is based on Eligible Charges for the type of service a Participant receives, for example, Hospital or Physician services.

Employee
A person who is engaged in active employment with the Employer and is eligible for coverage under the employment regulations of the Employer.

Employer
An Employer who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer by executing a formal document that so provides Employees may be listed under the heading "Important Information and statement of ERISA Rights".

Experimental or Investigational
Services which are considered Experimental or Investigational include services which (1) have not been approved by the Federal Food and Drug Administration or (2) for which medical and scientific evidence does not demonstrate that the expected benefits of the proposed treatment would be greater than the benefits of any available standard treatment and that adverse risks of the proposed treatment will not be substantially increased over those standard treatments. Such determination must result from prudent professional practices and be supported by at least two documents of medical and scientific evidence. Medical and scientific evidence means:

1. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
2. Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medikus (EMBASE), Medline, and MEDLARS data base or Health Services Technology Assessment Research (HSTAR);
3. Medical journals recognized by the United States Secretary of Health and Human Services, under Section 18961(t)(2) of the Social Security Act;
4. The following standard reference compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;
5. Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the Federal Agency for Health Care Policy and Research, National Institute of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, and any National board recognized by the National Institutes of Health for the purpose of evaluating the medical value of heath services; or
6. It meets the Technology Assessment Criteria as outlined in the "Definitions" Section of this SPD Booklet.

Formulary, BCBSHP Formulary, Preferred Drug Formulary or Drug Formulary
A document setting forth certain rules relating to the coverage of pharmaceuticals that may include but not be limited to (1) a listing of preferred prescription medications that are covered and/or prioritized in order of preference by the Claims Administrator, and are dispensed to Participants through pharmacies that are Network Providers, and (2) pre-certification rules. This list is subject to periodic review. Charges for medications may be Ineligible Charges, in whole or in part, if a Participant selects a medication not included in the Formulary.

Freestanding Ambulatory Facility (Surgi-Center)

A facility, with a staff of Physicians, at which surgical procedures are performed on an outpatient basis--no patients stay overnight. The facility offers continuous service by both Physicians and Registered Nurses (R.N.s). It must be licensed by the appropriate state agency. A Physician's office does not qualify as a Freestanding Ambulatory Facility.

Generic Drugs

Prescription Drugs that are not Brand Name Drugs but which are made up of equivalent ingredients.

Health Plan Document

This SPD Booklet in conjunction with the Health Plan Document, the Group Master Application, if any, the Formulary, any amendments or riders and your Identification Card constitutes the entire Plan. If there is any conflict between either this SPD Booklet or the Health Plan Document and any amendment or rider, the amendment or rider shall control. If there is any conflict between this SPD Booklet and the Health Plan Document, the Health Plan Document shall control.

Home Health Care

Care, by a state-licensed program or provider, for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician.

Home Health Care Agency

A provider which renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician. It must be licensed by the appropriate state agency.

Hospice

A provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's Physician. It must be licensed by the appropriate state agency.

Hospice Care Program

A coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill Participant and his or her covered family members, by providing palliative and supportive medical, nursing and other services through at-home or Inpatient care. The Hospice must be licensed by the appropriate state agency and must be funded as a Hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illnesses.

Hospital

An institution licensed by the appropriate state agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. "Hospital" does not mean other than incidentally:

- An extended care facility; nursing home; place for rest; facility for care of the aged;
- A custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- An institution for exceptional or handicapped children.

Identification Card

The latest card given to you showing your ID number and Group number, the type of coverage you have and the date the coverage became effective.

Ineligible Charges

Charges for health care services that are not Eligible Charges because the services are not Medically Necessary or pre-admission certification was not obtained. Such charges are not eligible for payment.

Ineligible Hospital

A facility which does not meet the minimum requirements to become a Participating Hospital. Services rendered to a Participant by such a Hospital are not eligible for payment.

Ineligible Provider

A provider which does not meet the minimum requirements to become a Participating Provider or with whom the Claims Administrator does not directly contract. Services rendered to a Participant by such a provider are not eligible for payment.

Infertile or Infertility

The condition of a presumably healthy Participant who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual vaginal intercourse. This does not include conditions for men

when the cause is a vasectomy or orchiectomy or for women when the cause is tubal ligation or hysterectomy.

Initial Enrollee
A person actively employed by the Employer (or one of that person's eligible Dependents) on the original Effective Date of the Health Plan Document.

Injury
Bodily harm from a non-occupational accident.

In-Network Care
Covered Services provided to Participants and appropriately coordinated by the Primary Care Physician through Network Hospital and Network Providers or selected by the Participant from Network Providers for which a Primary Care Physician referral is not required. Such providers include a gynecologist for obstetrical or gynecological – related conditions, a dermatologist, an optometrist/ophthalmologist for medical conditions only.

Inpatient
A Participant who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Intensive Care Unit
A special unit of a Hospital that: 1. treats patients with serious illnesses or Injuries; 2. can provide special life-saving methods and equipment; 3. admits patients without regard to prognosis; and 4. provides constant observation of patients by a specially trained nursing staff.

Late Enrollees
Late Enrollees mean Employees or Dependents who request enrollment in a health benefit plan after the initial open enrollment period. An individual will not be considered a Late Enrollee if: (a) the person enrolls during his/her initial enrollment period under the Plan: (b) the person enrolls during a special enrollment period; or (c) a court orders that coverage be provided for a minor covered Dependent under an Employee's Plan, but only as long as the Employee requests enrollment for such Dependent within thirty-one (31) days after the court order is so issued. Late Enrollees are those who declined coverage during the initial open enrollment period and did not submit a certification to the Plan Administrator that coverage was declined because other coverage existed.

Maternity Care
Obstetrical care received both before and after the delivery of a child or children. It also includes care for miscarriage or abortion. It includes regular nursery care for a newborn infant as long as the mother's Hospital stay is a covered benefit and the newborn infant is an eligible Participant under the Plan.

MCSO-Medical Child Support Order
An MCSO is any court judgment, decree or order (including a court's approval of a domestic relations settlement agreement) or a National Medical Support Notice that:

- provides for child support payment related to health benefits with respect to the child of a group health plan participant or requires health benefit coverage of such child in such plan, and is ordered under state domestic relations law; or
- enforces a state law relating to medical child support payment with respect to a group health plan.

Medical Emergency
"Emergency services," "emergency care," or "Medical Emergency" means those health care services that are provided for a condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead to prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is of such a nature that failure to obtain immediate medical care could result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunctions of any bodily organ or part. Such conditions include but are NOT limited to, chest pain, stroke, poisoning, serious breathing difficulty, unconsciousness, severe burns or cuts, uncontrolled bleeding, or convulsions and such other acute conditions as may be determined to be Medical Emergencies by the Plan.

Medical Facility
Any Hospital, ambulatory care facility, chemical dependency facility, skilled nursing care facility, home health agency or mental health facility, as defined in this SPD Booklet. The facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific requirements established by the Claims Administrator.

Medical Necessity or Medically Necessary
The Plan reserves the right to determine whether a service or supply is Medically Necessary. The fact that a Physician has prescribed, ordered, recommended or approved a service or supply does not, in itself, make it Medically Necessary.

The Plan considers a service Medically Necessary if it is:

- appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the patient's condition;

- compatible with the standards of acceptable medical practice in the United States;
- not provided solely for your convenience or the convenience of the Physician, health care provider or Hospital;
- not primarily Custodial Care; and
- provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms.

For example, a Hospital stay is necessary when treatment cannot be safely provided on an outpatient basis.

Mental Health Disorders

Includes (whether organic or non-organic, whether of biological, non-biological, genetic, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions, psychiatric conditions and drug, alcohol or chemical dependency. This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, chemical dependency disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. This is intended to include disorders, conditions, and illnesses listed in the Diagnostic and Statistical Manual of Mental Disorders.

Network Hospital

A Hospital located in Georgia which is a party to a written agreement with, and in a form approved by, the Claims Administrator to provide services to Participants; or a Hospital outside of Georgia which is a party to an agreement with another Blue Cross and Blue Shield HMO BLUE USA Plan.

Network Provider

A Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services and supplies in the Service Area that has a Network Provider contract with the Claims Administrator to provide Covered Services to Participants. Also referred to as In-Network Provider.

New Hire

A person who is not employed by the Employer prior to January 1 of the current Plan year.

Non-Covered Services

Services that are not benefits specifically provided under the Plan, are excluded by the Plan, are provided by an Ineligible Provider, or are otherwise not eligible to be Covered Services, whether or not they are Medically Necessary.

Non-Participating Provider

A Hospital, Physician, Freestanding Ambulatory Facility (Surgi-Center), Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services or supplies, that does not have a Participating Agreement with the Claims Administrator to provide services to Participants at the time services are rendered.

Out-of-Area Urgent Care

Covered Services required in order to prevent serious deterioration of a Participant's health that results from an unforeseen illness or Injury if the Participant is temporarily absent from the Claims Administrator's Service Area and receipt of the health care service cannot be delayed until the Participant's return to the Service Area.

Out-of-Network Provider

A Hospital, Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services and supplies, that does not have a Network Provider contract with the Claims Administrator. This provider may also be referred to as a Non-Network Provider.

Participant

The Employee and each Dependent, as defined in this SPD Booklet, while such person is covered by this Plan.

Participating Hospital

A Hospital located in Georgia which is a party to a written agreement with, and in a form approved by, Blue Cross Blue Shield of Georgia, Inc.; or a Hospital outside of Georgia which is a party to an agreement with another Blue Cross and Blue Shield Plan; or a Hospital outside Georgia located in an area not served by any Blue Cross and Blue Shield Plan.

Participating Provider

A Hospital, Physician, Freestanding Ambulatory Facility (Surgical Center), Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services or supplies that has signed a Participating Agreement with BCBSGA to accept its determination of Usual, Customary and Reasonable Fees (UCR) or other payment provisions for Covered Services rendered to a Participant who is his or her patient.

Periodic Health Assessment

A medical examination that provides for age-specific preventive services that improve the health and well-being of a patient being examined. This examination is provided through the network by Primary Care

Physicians. The frequency and content of the health assessment are determined by established guidelines and the Participant's personal history.

Physical Therapy
The care of disease or Injury by such methods as massage, hydrotherapy, heat, or similar care. This service could be provided or prescribed, overseen and billed for by the Physician, or given by a physiotherapist on an Inpatient basis on the orders of a licensed Physician and billed by the Hospital.

Physician
Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O) approved by the Composite State Board of Medical Examiners, any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery; Optometrists and Clinical Psychologists (Ph.D) are also providers when acting within the scope of their licenses, and when rendering services covered under this Plan.

Plan
The arrangement chosen by the Plan Sponsor to fund and provide for delivery of the Plan Sponsor's health benefits.

Plan Administrator
The person or entity named by the Plan Sponsor to manage the Plan and answer questions about Plan details.

Plan Sponsor
The legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination.

Plan Year
A period of one year commencing on January 1 and ending at 12:00 midnight on the last day of the one year period.

Premium
The amount that the Employee or Participant is required to pay to continue coverage.

Prescription Drug
A drug which cannot be purchased except with a prescription from a Physician and which must be dispensed by a pharmacist.

Primary Care Physician (PCP)
A licensed Physician who is a Participating Provider trained in general family practice, pediatrics or internal medicine, and has entered into an agreement to coordinate the care of Participants. Your Primary Care Physician provides initial care and basic medical services, assists you in obtaining pre-certification of Medically Necessary Referrals for Specialist and Hospital care, and provides you with continuity of care.

Professional Ambulance Service
A state-licensed emergency vehicle which carries via the public streets or in the air injured or sick persons to a Hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.

QMCSO – Qualified Medical Child Support Order
A QMCSO creates or recognizes a right of a child who is recognized under the order as having the right to be enrolled under the health benefit plan to receive benefits for which the Employee is entitled under the plan; and includes the name and last known address of the Employee and each such child, a reasonable description of the type of coverage to be provided by the plan, the period for which coverage must be provided and each plan to which the order applies.

Referral
Specific instructions from a Participant's Primary Care Physician, in conformance with policies and procedures, that direct a Participant to a In-Network Provider for Medically Necessary care.

Reimbursement Rate
The percentage of Eligible Charges calculated each year by the Claims Administrator and BCBSGA for any In-Network or Participating Hospital. The payment rate will be applied to all Hospital Inpatient and outpatient claims during the payment period, including Out-of-Network and Non-Participating Hospitals.

Respite Care
Care furnished during a period of time when the Participant's family or usual caretaker cannot, or will not, attend to the Participant's needs.

Semiprivate Room
A Hospital room which contains two or more beds.

Service Area
Includes counties listed in the appropriate Service Area Map. (Please refer to your Provider Directory.)

Skilled Convalescent Care
Care required, while recovering from an illness or Injury, which is received in a Skilled Nursing Facility. This care requires a level or care or services less than that in a Hospital, but more than could be given at the patient's home or in a nursing home not certified as a Skilled Nursing Facility.

Skilled Nursing Facility
An institution operated alone or with a Hospital which gives care after a Participant leaves the Hospital for a condition requiring more care than can be rendered at home. It must be licensed by the appropriate state agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise determined to meet the reasonable standards applied by any of the aforesaid authorities.

Spinal Manipulation
Correction of subluxations in the body to remove nerve interference or its effects. Interference must be the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

Spouse
For the purpose of this Plan, your Spouse is defined as the lawful Spouse in accordance with the state law in your state of residence.

Substance Abuse
Any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.

Technology Assessment Criteria
Five criteria all procedures must meet in order to be Covered Services under this Plan.

1. The technology must have final approval from the appropriate government regulatory bodies.
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
3. The technology must improve the net health outcome.
4. The technology must be as beneficial as any established alternative.
5. The technology must be beneficial in practice.

Urgent Care Center
A facility, appropriately licensed and meeting BCBSHP standards for an Urgent Care Center, with a staff of Physicians, at which urgently-needed medical procedures are performed on an outpatient basis--no patients stay overnight. The facility offers continuous service by both Physicians and registered nurses (R.N.s). A Physician's office does not qualify as an Urgent Care Center.

Usual-Customary-Reasonable (UCR) Fees (as determined by the Claims Administrator and approved by the Plan):

Usual Fee: The fee a Physician most frequently receives as reimbursement for the procedure performed.

Customary Fee: Based on a competitive profile of the usual fees received as reimbursement by similar Physicians in a given geographic area for the procedure performed, according to the Claims Administratior's records.

Reasonable Fee: The fee different from usual or customary fees because of unusual circumstances involving complications requiring additional time, skill and experience.

If it does not pay at contracted rates, the Plan may pay up to the usual fee not to exceed the customary fee, unless special circumstances or complications occur, in which case the Plan may consider the reasonable fee.

All payments are based on the UCR applicable to the Participant's actual residence (i.e., local UCR).

Utilization Review
A function performed by the Plan Administrator or by an organization or entity selected by the Plan Administrator to review and approve whether the services provided are Medically Necessary, including but not limited to, whether acute hospitalization, length of stay, outpatient care or diagnostic services are appropriate.

You and your
Refer to the Employee, Participant and each Covered Dependent.

Important Information and Statement of ERISA Rights

1. Plan Name.
Health Choice Medical Plan. This is a self-insured Welfare Plan.

2. Plan Sponsor.
The name and address of the entity which established and maintains the Plan is:
Westinghouse Savannah River Company, L.L.C. and Bechtel, Savannah River, Inc.

3. Employer I.D. Numbers:
Westinghouse Savannah River Company, L.L.C.--
82-0510443
Bechtel Savannah River, Inc.--
94-3077224
BNFL, Savannah River Inc. Corporation--
54-1813446
BWXT Savannah River, Inc.—
54-1804131
CH2SRC, LLC - 02-0693747

4. Plan Number:
501

5. Plan Year Ends:
December 31

6. Plan Administrator and Named Fiduciary:
Benefits Administration
Westinghouse Savannah River Company, L.L.C.
Attn: Plan Administrator Health Choice Medical Plan
Building 703-47A
Aiken, SC 29808

7. Agent for Legal Process:
Corporation Service Company
1301 Gervais Street
Columbia, SC 29201
Phone 800-927-9800

8. Type of Plan:
The Plan provides Health benefits.

9. Description of Benefits.
The Plan Description sets forth the benefits provided under this Plan. A brief explanation of these benefits may be found in the section entitled "Summary of Benefits". A more detailed description of the benefits appears in the sections entitled "Benefits".

10. Eligibility for Participation.
The eligibility requirements for participation under this Plan are set forth in this SPD Booklet in the section entitled "Eligibility".

General Information About ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) entitles you, as a Participant of the Plan, to:

1. Examine, without charge, at the Plan Administrator's office all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by this plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies; and
3. Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary financial report.

In addition to creating rights for you and other Employees, ERISA imposes duties on the people responsible for the operation of your Employee benefit Plan. The people who operate your Plan are called plan fiduciaries. They must handle your Plan prudently and in the best interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your right under ERISA. If your claim for welfare benefits is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claims reviewed and reconsidered within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request Plan Documents from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide you the materials and pay you up to $110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal Court. If plan fiduciaries misuse the Plan's

money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order you to pay these expenses, for example, if it finds your claim is frivolous. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Claims Disclosure Notice
This SPD Booklet contains information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Claims Administrator. In addition to this information, if this *Plan* is subject to ERISA, ERISA applies some additional claim procedure rules. The additional rules required by ERISA are set forth below. To the extent that the ERISA claim procedure rules are more beneficial to you, they will apply in place of any similar claim procedure rules included in this SPD Booklet.

Urgent Care. The Plan must notify you, within 72-hours after receiving your request for benefits, that the request has been received and what your benefits are determined to be. If your request for benefits does not contain all the necessary information, the Plan must notify you within 24-hours after receiving it and tell you what information is missing. Any notice to you by the Plan will be orally by telephone or in writing by facsimile or other fast means. You have at least 48-hours to give the Plan the additional information needed to process your request for benefits. You may give the Plan the additional information needed orally by telephone or in writing by facsimile or other fast means.

If your request for benefits is denied in whole or in part, you will receive a notice of the denial within 72-hours after the Plan's receipt of the request for benefits or 48 hours after receipt of all the information needed to process your request for benefits, if the information is received in a timely manner as stated above. The notice will explain the reason for the denial and the Plan provision upon which the decision is based. You have 180-days to appeal the decision. You may appeal the decision orally by telephone or in writing by facsimile or other fast means. Within 72-hours after the Plan receives your appeal, if your claim is still considered urgent under the circumstances at the time of the appeal, the Plan must notify you of the decision. The Plan will notify you orally by telephone or in writing by facsimile or other fast means. If your claim is no longer considered urgent, it will be handled in the same manner as a Non-Urgent Care Pre-Service or Post-Service appeal, depending upon the circumstances.

Non-Urgent Care Pre-Service (when care has not yet been received). The Plan must notify you, within 15-days after receiving your request for benefits, that the request has been received and what your benefits are determined to be. If the Plan needs more than 15-days to determine your benefits, due to reasons beyond its control, the Plan must notify you within that 15-days period that more time is needed to determine your benefits. But, in any case, even with an extension, the Plan cannot take more than 30-days to determine your benefits. If you do not properly submit all the necessary information for your claim, the Plan must notify you, within 5-days after receiving it and tell you what information is missing. You have 45-days to provide the Plan with the information needed to process your request for benefits. The time period during which the Plan is waiting for receipt of the necessary information is not counted toward the time frame in which the Plan must make the benefit determination.

If your claim is denied in whole or in part, you will receive a written notice of the denial within the time frame noted above after the Plan has all the information needed to process your request for benefits, if the information is received in a timely manner as stated above. The written notice will explain the reason for the denial and the Plan provisions upon which the decision was made. You have 180-days to appeal an adverse benefit determination. Your appeal must be in writing. Within 30-days after a pre-service appeal is received, the Plan must notify you of the decision. The notice of the decision will be in writing.

Concurrent Care Decisions. If, after approving a request for benefits in connection with your illness or Injury, the Plan decides to reduce or end the benefits that had been approved for you, in whole or in part:

- The Plan must notify you sufficiently in advance of the reduction in benefits, or the end of benefits, to allow you the opportunity to appeal the decision before the reduction in benefits or end of benefits occurs. In the notice to you, the Plan must explain the reason for reducing or ending your benefits and the plan provisions upon which the decision was made.
- To keep the benefits you already have approved, you must successfully appeal the decision to reduce or end those benefits. You must make your appeal to the Plan at least 24-hours prior to the occurrence of

the reduction or ending of benefits. If you appeal the decision to reduce or end your benefits when there is less than 24-hours to the occurrence of the reduction or ending of benefits, your appeal will be treated as if you were appealing a non-urgent care denial of benefits (see "Urgent Care" above).

- If your appeal for benefits is received at least 24-hours prior to the occurrence of the reduction or ending of benefits, the Plan must notify you of the decision regarding your appeal within 72-hours of the receipt of your appeal. If your appeal of the decision to reduce or end your benefits is denied, in whole or in part, the Plan must explain the reason for the denial of benefits and the Plan provisions upon which the decision was made. You may further appeal the denial of benefits according to the rules for appeal of an urgent care denial of benefits (see "Urgent Care" above).

Non - Urgent Care Post-Service (reimbursement for cost of medical care). The Plan must notify you, within 30-days after receiving your request for benefits, that the request has been received and what your benefits are determined to be. If more than 30-days are needed to determine your benefits, due to reasons beyond the Plan's control, the Plan must notify you within that 30-day period that more time is needed to determine your benefits. But, in any case, even with an extension, the Plan cannot take more than 45-days to determine your benefits. If you do not submit all the necessary information for your claim, the Plan must notify you, within 30-days after receiving it and tell you what information is missing. You have 45-days to provide the information needed to process your claim. The time period during which the Plan is waiting for receipt of the necessary information is not counted toward the time frame in which the Plan must make the benefit determination.

If your claim is denied in whole or in part, you will receive a written notice of the adverse benefit determination within the time frame stated above after the Plan has all the information needed to process your request for benefits, if the information is received within the time frame noted above. The written notice will explain the reason for the adverse benefit determination and the Plan provisions upon which the decision was made. You have 180-days to appeal the adverse benefit determination. Your appeal must be in writing. Within 60-days after receiving your appeal, the Plan must notify you of the decision. The notice to you of the decision will be in writing.

Note: You, your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits with the Plan and request a review of the adverse benefit determination. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed free of charge; and issues outlining the basis of the appeal may be submitted. You may have representation throughout the appeal and review procedure.

Medical information the Plan or the Claims Administrator has regarding your case will be released to you or an attorney only by written authorization from your provider and/or the Hospital.

Please Note: Appeals will be administered by the Claims Administrator. Any appeals should be sent to Blue Cross and Blue Shield of Georgia, Inc.

Eligibility for benefits should not be viewed as a guarantee of employment. Also, while WSRC/BSRI intends to continue providing a comprehensive benefits program, WSRC/BSRI reserves the right to modify or terminate any of the benefit plans at any time. For more information on the procedures to modify or terminate benefit plans, refer to the Benefits Overview and General Information book (part of the WSRC & BSRI Benefits Handbook.).

BlueChoice®
Healthcare Plan

Administered by Blue Cross Blue Shield
Healthcare Plan of Georgia, an Independent Licensee
of the Blue Cross and Blue Shield Association

GID: July, 2003
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