INTRODUCTION

Dear Member:

Blue Cross and Blue Shield of South Carolina (BlueCross) is pleased to provide your Preferred Blue® Plan of Benefits. BlueCross provides you and your covered family members with cost-effective health care coverage both locally and on a nationwide basis.

Please refer to the benefits outlined in this Plan of Benefits for all your health care coverage.

The BlueCross networks offer the best geographic access to Providers and Hospitals of any Preferred Provider Organization (PPO) in the nation. This national coverage is available through the BlueCard® Program in which all BlueCross BlueShield Plans participate. For more Provider information visit our website at www.SouthCarolinaBlues.com.

We welcome you to our family of health care coverage through BlueCross and look forward to meeting your health care needs.

VISIT OUR WEBSITE AND MOBILE SITE

Through our Member website, www.SouthCarolinaBlues.com, you can access My Health Toolkit®, a source for instant, personalized Benefits and health information. As a Member, you can take full advantage of this interactive website to complete a variety of self-service transactions online from wherever you have Internet access. ***Need to order a replacement Member ID card? Need to check the status of a claim or download claim forms? Need to print an Explanation of Benefits (EOB)?***

You also can use such self-help tools as:

View **real-time status** of your eligibility, deductible, out-of-pocket and any health care account balances.

The **Doctor and Hospital Finder** is where you get the most recent information on our network of medical Providers and Hospitals. Search by name, address, gender, specialty and Hospital affiliation. You can also get information about medical schools attended, board certification status, languages spoken, handicap access, maps and driving directions.

Through our **Treatment Cost Estimator**, you can see your estimated out-of-pocket costs for over four hundred (400) treatment cost categories. Treatment cost categories include inpatient and outpatient procedures like Magnetic Resonance Imaging (MRIs) and Surgical Services. Costs are displayed by place of service and you can compare up to three (3) facilities on cost and quality. Your out-of-pocket costs displayed on the website are based on your Plan design and your real-time Benefit Year Deductible and Out-of-Pocket Maximum status. Your estimated costs will include any Copayment, Benefit Year Deductible and Coinsurance you would owe.

Our **Personal Health Record (PHR)** is more than a place to store your health information. Any time a medical or lab claim is processed, the information is fed to your PHR. You can print medication lists, add doctor's appointments and read up-to-date health and wellness articles.

On the go? The My Health Toolkit® mobile website offers Members features designed for smaller smartphone screens. Unlike some mobile tools, as a BlueCross Member, you do not need to download an app. When you want to access the mobile site, simply navigate to www.SouthCarolinaBlues.com on your smartphone.

IMPORTANT INFORMATION ABOUT YOUR HEALTH COVERAGE:

The Benefits you receive will depend on whether the Provider of medical services is a Participating or Non-Participating Provider. You will receive the maximum Benefits that can be paid if you use Participating Providers and you get Preauthorization, when required, before getting medical care. The amount you have to pay will increase when you do not use Participating Providers and if you do not get Preauthorization.

BlueCross makes every effort to contract with Providers that practice at participating Hospitals. Members of the Blue Cross and Blue Shield Association (BCBSA) also attempt to contract with Providers that practice at participating Hospitals. For various reasons, some Providers may elect not to contract as Participating Providers. If you use a Non-Participating Provider, you have no protection from balance billing from the Provider.

HOW TO GET HELP

How to get help with claims or benefit questions:

- From Columbia, South Carolina, dial 264-0015
- From anywhere else in or out of South Carolina, dial 1-800-760-9290

How to get help on Preauthorization:

For radiation oncology Services, Magnetic Resonance Imaging (MRIs), Magnetic Resonance Angiography (MRAs), Computerized Axial Tomography (CAT) scans or Positron Emission Tomography (PET) scans and musculoskeletal care in an Outpatient Facility:

- 1-866-500-7664

For all other medical care:

- 736-5990 from the Columbia, South Carolina area
- 1-800-327-3238 from all other South Carolina locations
- 1-800-334-7287 from outside South Carolina

Please do not call these numbers for claims inquiries.

Please note that Preauthorization is required for the procedures on the Schedule of Benefits that have a "Preauthorization" note.

Preauthorization for Mental Health Services and Substance Use Disorder Services:

- 699-7308 from the Columbia, South Carolina area
- 1-800-868-1032 from all other areas

How to get information on Drug coverage:

Drug Coverage is handled by Caremark. Caremark is an independent company that provides pharmacy Benefits on behalf of BlueCross.

For inquiries regarding the Prescription Drug Benefit, please call:

- 1-888-963-7290

For prior authorization on Prescription Drugs, please call:

- 1-800-294-5979

For inquiries regarding Specialty Drugs, please call:

- 1-800-237-2767

For inquiries regarding the status of prior authorization on Specialty Drugs, please call:

- 1-800-237-2767

You can also access Caremark from My Health Toolkit.

For information regarding Quantity versus Time Limits or Step Therapy Programs, contact your Customer Service Representative.

BlueCard outside the United States:

You may also call 1-800-810-BLUE (2583) when traveling outside the United States for assistance with locating an international Provider, in translating foreign languages and submitting claims.

Essential Advocate Questions:
The Corporation provides you and your Dependents with access to ***Essential Advocate***, a program that includes immediate care with the 24-hour Nurse Advisor plus the unique service of our health advocacy program tailored to bridge the gap between care and Benefits, Provider and patient, and Hospital and home. Members will experience personal support and receive individualized assistance provided by experienced health care and Benefit experts. The health advocates assist Members:

- Locating Providers through the BlueCross Doctor & Hospital Finder.
- Using online tools for treatment options and cost estimates.
- Educating Members on health plan Benefits and how they work.
- Researching current treatments.
- Resolution of health care claims.
- Preparing Members and family members for medical appointments.
- Understanding eldercare issues.
- Arranging transportation relating to medical needs.
- Navigating the BlueCross website, including cost estimator and quality tools.
- And much more.

Call 1-888-521-2583 to speak with a registered nurse or health advocate.

Health Coaching – Chronic Condition Questions:
The Corporation provides you with access to ***Health Coaching – Chronic Condition***, a program designed to help Members with the following conditions live healthier lives:

- Anxiety
- Attention deficit hyperactivity disorder
- Asthma (pediatric and adult)
- Bipolar disorder
- Coronary artery disease
- Chronic heart failure
- Chronic obstructive pulmonary disease
- Depression
- Diabetes (pediatric and adult)
- Hypertension (high blood pressure)
- Hyperlipidemia (high cholesterol)
- Metabolic health
- Migraine
- Recovery support

As a participant in ***Health Coaching – Chronic Condition***, you will receive personalized information and tools to help you learn more about your condition and ways to improve your health. You will also have access to a personal health coach – a health care professional who can help you reach your health goals.

If you are identified as someone with one of the conditions listed above who could benefit from the program, you will be automatically enrolled. If you do not wish to participate, you can disenroll by calling 1-855-838-5897.

Complex Care Management Questions:
The Corporation provides you with access to ***Complex Care Management***, a unique patient support and education program which provides you with a registered nurse case manager to assist you in making informed decisions about your health care when you're seriously ill or injured. Participation in the program is voluntary and at no cost to Members. For more information, call: 1-800-868-2500, extension 42648.

Rally Questions:
The Corporation provides you with access to ***Rally***, a program that can help guide you toward positive lifestyle choices. Once you have completed the confidential ***Rally*** Health Survey, you will receive your ***Rally*** age which may be higher or lower than your physical age based on risk factors and healthy behaviors. This program provides missions and challenges that improve overall health and wellbeing. Along the way, you will earn chances to enter prize sweepstakes. Rally is a product of Rally Health Inc. Rally Health Inc. is an independent company that provides the Rally program on behalf of BlueCross. To access the ***Rally*** Health Survey, login to My Health Toolkit.

Proactive Member Messaging Questions:
The Corporation provides you with access to ***Proactive Member Messaging***, a program that offers wellness reminders and program specific promotions. Proactive Member Messaging is offered through Relay®, a text marketing communications channel. Relay Network, LLC is an independent company that provides the ***Proactive Member Messaging*** program on behalf of BlueCross. To participate, call 1-844-206-0623.

Health Coaching – Lifestyle Questions:
The Corporation provides you with access to the ***Health Coaching – Lifestyle*** bundle, a collection of programs designed to help you improve your health and wellness lifestyle such as kicking a habit, exercising more or switching up your diet. You may also receive guidance as you adjust to a major change in your life, such as pregnancy. A health coach will provide support and help you create an action plan to meet your personal goals. The bundle includes the following programs:

- Back care
- Maternity (preconception, maternity and postpartum care)
- Stress management
- Tobacco-free living
- Weight management (adults and Children)

To participate, call 1-855-838-5897.

Telehealth Questions:
The Corporation provides you with access to ***Blue CareOnDemand***, a telehealth service. Blue CareOnDemand is offered through American Well. American Well is an independent company that provides telehealth hosting and software services on behalf of BlueCross. Blue CareOnDemand doctors can treat many of the most common health issues. The service offers treatment for cold and flu symptoms, allergies, skin irritations, pinkeye, ear infections, bronchitis, sinus infections and other specialties. Telehealth is not a replacement for primary care doctors. Members should maintain relationships with their primary care doctors and continue scheduling office visits for preventive care. We encourage Members to use the convenience of Blue CareOnDemand for treating unexpected, non-emergency health issues. Members can use Blue CareOnDemand to seek treatment from U.S. licensed health care professionals twenty-four (24) hours per day, seven (7) days per week and three hundred sixty-five (365) days per year through the convenience of video consultation.

There are two (2) ways for Members to register and create their patient profiles:

1. Download the “Blue CareOnDemand” mobile app from iTunes or Google Play.

2. Visit www.BlueCareOnDemandSC.com.

Once registered, Members can log in to the mobile app or website as needed and consult with doctors through video visits.

HOW TO FILE CLAIMS

Participating Providers have agreed to file claims for health care services they rendered to you. However, in the event a Provider does not file a claim for such services, it is your responsibility to file the claim. If you choose to use a Non-Participating Provider, you are responsible for filing your claim.

Once the claim has been processed, you will have quick access to an EOB through our website or by contacting customer service. An EOB will also be mailed to you. The EOB explains who provided the care, the kind of service or supply received, the amount billed, the Allowable Charge, the Coinsurance rate and the amount paid. It also shows Benefit Year Deductible information and the reasons for denying or reducing a claim. Please see this Plan of Benefits for more information.

The only time you must pay a Participating Provider is when you have a Benefit Year Deductible, Coinsurance, Copayment or when you have services or supplies that are not Covered Expenses under your Plan of Benefits.

If you need a claim form, you may obtain one from us at the address below or print a copy from the website. Or, call us at the telephone numbers listed on the previous page and we will send you a form. After filling out the claim form, send it to the address below:

Blue Cross and Blue Shield of South Carolina
Claims Service Center
Post Office Box 100300
Columbia, South Carolina 29202

Please refer to Article XI of this Plan of Benefits for more information on filing a claim.

SCHEDULE OF BENEFITS

Employer: South Carolina Trucking Association, Inc.
Plan 4
Plan of Benefits Effective Date: February 1, 2017

This Schedule of Benefits and the Benefits described herein are subject to all terms and conditions of this Plan of Benefits. In the event of a conflict between this Plan of Benefits and this Schedule of Benefits, this Schedule of Benefits shall control. Capitalized terms used in this Schedule of Benefits have the meaning given to such terms in this Plan of Benefits.

To maximize your Benefits, seek medical services from a Participating Provider. Please call 1-800-810-BLUE (2583) or access our website at www.SouthCarolinaBlues.com to find out if your Provider is a Participating Provider.

GENERAL PROVISIONS **When a Benefit is listed below and has a dollar or percentage amount associated with it, the Benefit will be provided to Members subject to the terms of this Plan of Benefits. When a Benefit has a "Covered" notation associated with it, the Benefit will pay based on the location of the service (e.g., inpatient, outpatient, office). When a Benefit has a "Non-Covered" notation associated with it, the Benefit is not available to the Member. All Benefits are subject to the dollar or percentage amount limitation associated with each Benefit in this Schedule of Benefits.**	
Probationary Period:	Coverage for new Employees hired following the Effective Date of the Plan of Benefits will commence at the discretion of the Employer.
In addition to meeting the requirements contained in this Plan of Benefits; the maximum age limitation to qualify as a Dependent Child is:	A Child under the age of twenty-six (26).
Actively at Work: **Minimum hours per week:** **Minimum weeks per year:**	 At least 30 hours per week. At least 48 weeks per year.

Benefit Year Deductible:	$4,000 per family with no one Member meeting more than $2,000 for Participating Providers. $8,000 per family with no one Member meeting more than $4,000 for Non-Participating Providers. Covered Expenses for services rendered by Participating or Non-Participating Providers will be applied only to the Participating Provider Benefit Year Deductible or the Non-Participating Provider Benefit Year Deductible, respectively.
Out-of-Pocket Maximums for Participating Providers:	**Standard Out-of-Pocket Maximums:** $9,000 per family with no one Member meeting more than $4,500. Benefit Year Deductibles and Coinsurance contribute to the Standard Out-of-Pocket Maximum. Allowable Charges for Coinsurance are paid at 100% after the Standard Out-of-Pocket Maximum is met, except as specified above. The Member will still be responsible for any applicable Copayments until the Out-of-Pocket Maximum is met. **Out-of-Pocket Maximums:** $14,300 per family with no one Member meeting more than $7,150. All Benefit Year Deductibles, Coinsurance and Copayments incurred, with the exception of chiropractic services, will contribute to the Out-of-Pocket Maximum. All Allowable Charges are paid at 100% after the Out-of-Pocket Maximum is met. If Coinsurance does not contribute to the Out-of-Pocket Maximum, the percentage of reimbursement does not change from the amount indicated on the Schedule of Benefits. Coinsurance, Benefit Year Deductibles and Copayments for services rendered at a Participating Provider will apply to the Standard Out-of-Pocket Maximum or Out-of-Pocket Maximum as listed above and will not be applied to the Non-Participating Provider Out-of-Pocket Maximum.

Out-of-Pocket Maximums for Non-Participating Providers:	$18,000 per family with no one Member meeting more than $9,000. Coinsurance for chiropractic services and Copayments do not contribute to the Out-of-Pocket Maximum determination. Allowable Charges are paid at 100% after the Out-of-Pocket Maximum is met. If Coinsurance does not contribute to the Out-of-Pocket Maximum, the percentage of reimbursement does not change from the amount indicated on the Schedule of Benefits. Coinsurance and Benefit Year Deductibles for services rendered at a Non-Participating Provider will apply to the Non-Participating Provider Out-of-Pocket Maximum only and will not be applied to either the Standard Out-of-Pocket Maximum or Out-of-Pocket Maximum for Participating Providers.

Benefit Year Deductibles and any Copayments must be met before any Covered Expenses can be paid.

This Schedule of Benefits applies during the 01/01 through 12/31 Benefit Year. The Anniversary Date is 12/01.

All Admissions require Preauthorization. If Preauthorization is not obtained, room and board charges will be denied. Other services may also require Preauthorization. Please see the Schedule of Benefits and Plan of Benefits for more information.

Preauthorization is required for the following outpatient Benefits:
Radiation treatment plans related to oncology
MRI
MRA
CAT scans
PET scans
Musculoskeletal care
Septoplasty
Any surgical procedure that may be potentially cosmetic: i.e., blepharoplasty, reduction mammoplasty
Hysterectomy
Investigational procedures
Applied Behavioral Analysis (ABA) related to Autism Spectrum Disorder
Radiation therapy
Cancer chemotherapy

Benefits for ABA related to Autism Spectrum Disorder, radiation treatment plans related to oncology, MRIs, MRAs, CAT scans and PET scans performed in an outpatient facility will be denied when Preauthorization is not obtained or approved by the Corporation. Benefits for any other outpatient services that require Preauthorization will be reduced by 50% of the Allowable Charge when Preauthorization is not obtained or approved by the Corporation. Please see the Mental Health Services and Substance Use Disorder Services section of the Schedule of Benefits for specific Preauthorization penalties related to those services.

All charges will be denied for human organ and tissue transplant services not performed at a Blue Distinction Center of Excellence or a transplant center approved by the Corporation in writing.

There are no annual or lifetime dollar limitations on essential health Benefits as defined by the Patient Protection and Affordable Care Act (PPACA).

ADMISSIONS/INPATIENT BENEFITS OTHER THAN MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES		
	Participating Provider	**Non-Participating Provider**
Hospital charges for room and board related to Admissions	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
All other Benefits in a Hospital during an Admission (including for example, facility charges related to the administration of anesthesia, obstetrical services, including labor and delivery rooms, drugs, medicine, lab and X-ray services)	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Inpatient physical rehabilitation services when Preauthorized by the Corporation and performed by a Provider designated by the Corporation	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Skilled Nursing Facility Admissions, limited to sixty (60) days per Benefit Year (Preauthorization is required)	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

OUTPATIENT BENEFITS OTHER THAN MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES		
	Participating Provider	**Non-Participating Provider**
Hospital and Ambulatory Surgical Center charges for Benefits provided on an outpatient basis, including: lab, X-ray and other diagnostic services	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
True emergency room visits (Copayment waived if admitted)	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $300 Copayment The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible and Copayment	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $300 Copayment The Member must pay the balance of the Provider's charge
Non-true emergency room visits (Copayment waived if admitted)	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $300 Copayment The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible and Copayment	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
All other covered outpatient Benefits	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

PROVIDER SERVICES OTHER THAN MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES		
	Participating Provider	**Non-Participating Provider**
Provider Services in a Hospital	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Surgical Services, when rendered in a Hospital or Ambulatory Surgical Center	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Urgent Care	The Corporation pays 100% of the Allowable Charge after the Member pays a $50 Copayment	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider Services for treatment in a Hospital outpatient department or Ambulatory Surgical Center	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Services in the Provider's office, including contraceptives and birth control devices (other than maternity care, physical therapy, dialysis treatment and Second Surgical Opinion) This Benefit does not include preventive Benefits offered under the PPACA. See the preventive Benefits section in this Schedule of Benefits for payment of preventive Benefits under the PPACA.	The Corporation pays 100% of the Allowable Charge after the Member pays a $25 Copayment Office services by a Specialist will be paid at 100% of the Allowable Charge after a $40 Copayment	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	**Non-Participating Provider**
Provider Services in the Member's home	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Second Surgical Opinion	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
All other Provider Services	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES

Preauthorization is required for Mental Health Services and Substance Use Disorder Services. If Preauthorization is not obtained or approved by the Corporation, the following penalties will apply.

Inpatient: Denial of room and board
Outpatient partial hospitalization, repetitive transcranial magnetic stimulation (rTMS), electroconvulsive therapy (ECT), psychological testing and intensive outpatient programs: 50% of the Allowable Charge

	Participating Provider	**Non-Participating Provider**
Inpatient Hospital charges for Mental Health Services and Substance Use Disorder Services	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Residential Treatment Center Admissions for Mental Health Services and Substance Use Disorder Services	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Outpatient Hospital or clinic charges for Mental Health Services and Substance Use Disorder Services	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Inpatient Provider charges for Mental Health Services and Substance Use Disorder Services	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Outpatient Provider charges for Mental Health Services and Substance Use Disorder Services	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Office Provider charges for Mental Health Services and Substance Use Disorder Services	The Corporation pays 100% of the Allowable Charge after the Member pays a $25 Copayment	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Outpatient Hospital emergency room charges for Mental Health Services and Substance Use Disorder Services	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $300 Copayment The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible and Copayment	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $300 Copayment The Member must pay the balance of the Provider's charge

OTHER SERVICES		
	Participating Provider	**Non-Participating Provider**
Ambulance service (including air ambulance)	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 80% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member must pay the balance of the Provider's charge
Durable Medical Equipment, Prosthetics and Orthopedic Devices (if purchase or rental of Durable Medical Equipment is $500 or more, Preauthorization is required)	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	Non-Covered
Medical Supplies	Covered	Covered
Home Health Care, limited to sixty (60) visits per Benefit Year (Preauthorization is required)	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Hospice Care, limited to six (6) months per episode (Preauthorization is required)	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Colorectal cancer screenings limited to: • One (1) fecal occult blood testing of three (3) consecutive stool samples per Benefit Year • One (1) flexible sigmoidoscopy every five (5) years • One (1) double contrast barium enema every five (5) years • One (1) colonoscopy every ten (10) years	Covered	Covered
ABA related to Autism Spectrum Disorder limited to: • Members diagnosed at age eight (8) or younger • Members under the age of sixteen (16) (Preauthorization is required)	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	Non-Covered
Provider charges for rehabilitation related to physical therapy and occupational therapy (Limited to a combined thirty (30) visits per Member per Benefit Year. Please see the "Outpatient Rehabilitation" section in Article III of the Plan of Benefits for limitations)	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider charges for habilitation related to physical therapy and occupational therapy (Limited to a combined thirty (30) visits per Member per Benefit Year. Please see the "Outpatient Rehabilitation" section in Article III of the Plan of Benefits for limitations)	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Rehabilitation related to speech therapy (Limited to twenty (20) visits per Member per Benefit Year. Please see the “Outpatient Rehabilitation” section in Article III of the Plan of Benefits for limitations)	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Habilitation related to speech therapy (Limited to twenty (20) visits per Member per Benefit Year. Please see the “Outpatient Rehabilitation” section in Article III of the Plan of Benefits for limitations)	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Human organ and tissue transplant services Human organ and tissue transplant services are only covered if provided at a Blue Distinction® Center of Excellence or a transplant center approved by the Corporation in writing Provider charges are subject to the Benefit Year Deductible	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	Non-Covered
Allergy injections	The Corporation pays 100% of the Allowable Charge after the Member pays a $25 Copayment Office services by a Specialist will be paid at 100% of the Allowable Charge after a $40 Copayment	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Chiropractic services, including spinal manipulation/subluxation and modalities, limited to a $500 maximum payment per Member per Benefit Year	The Corporation pays 100% of the Allowable Charge after the Member pays a $40 Copayment	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Oxygen (Preauthorization is required)	Covered	Covered

	Participating Provider	Non-Participating Provider
Sustained Health services related to an annual physical exam (limited to $500 per Member per Benefit Year) This Benefit does not include preventive Benefits offered under the PPACA. Payment will be made for the PPACA preventive Benefits prior to Sustained Health services. See the preventive Benefits section in this Schedule of Benefits for payment of preventive Benefits under the PPACA.	The Corporation pays 100% of the Allowable Charge after the Member pays a $25 Copayment	Non-Covered

PREVENTIVE BENEFITS The Benefit Year Deductible does not apply to these Benefits		
	Participating Provider	**Non-Participating Provider**
Preventive Benefits under the PPACA (Refer to www.healthcare.gov for guidelines)	Covered	Non-Covered
Pap smear screenings (the report and interpretation only, limited to one (1) per Member per Benefit Year)	The Corporation pays 100% of the Allowable Charge	Non-Covered
Prostate screenings (limited to one (1) per Member per Benefit Year)	The Corporation pays 100% of the Allowable Charge	Non-Covered
Gynecological exam (limited to two (2) per Member per Benefit Year)	The Corporation pays 100% of the Allowable Charge	Non-Covered
In South Carolina:		
	SC Mammography Network	**All Other Providers**
Mammography screenings (limited to one (1) per Benefit Year for any female Member age forty (40) or older)	The Corporation pays 100% of the Allowable Charge	Non-Covered
Outside South Carolina:		
	Out-of-State Participating Providers	**All Other Providers**
Mammography screenings (limited to one (1) per Benefit Year for any female Member age forty (40) or older)	The Corporation pays 100% of the Allowable Charge	Non-Covered

PRESCRIPTION DRUG BENEFIT			
Prescription Drugs	**Mail Service Pharmacy**	**Participating Pharmacy**	**All Other Pharmacies**
Generic Drugs	The Member pays a $25 Prescription Drug Copayment for each prescription or refill, up to a 90 day supply	The Member pays a $15 Prescription Drug Copayment for each monthly prescription or refill, up to a 90 day supply	The Member will be responsible for 100% of the Allowable Charge at the pharmacy then will be reimbursed at 60% after a $15 Prescription Drug Copayment per Member for each monthly prescription or refill, up to a 90 day supply
Preferred Brand Drug	The Member pays a $90 Prescription Drug Copayment for each prescription or refill, up to a 90 day supply	The Member pays a $40 Prescription Drug Copayment for each prescription or refill, up to a 31 day supply	The Member will be responsible for 100% of the Allowable Charge at the pharmacy then will be reimbursed at 60% after a $40 Prescription Drug Copayment per Member for each prescription or refill, up to a 31 day supply
Non-Preferred Brand Drug	The Member pays a $175 Prescription Drug Copayment for each prescription or refill, up to a 90 day supply	The Member pays a $70 Prescription Drug Copayment for each prescription or refill, up to a 31 day supply	The Member will be responsible for 100% of the Allowable Charge at the pharmacy then will be reimbursed at 60% after a $70 Prescription Drug Copayment per Member for each prescription or refill, up to a 31 day supply

Prescription Drugs	Mail Service Pharmacy	Participating Pharmacy	All Other Pharmacies
*Contraceptives: oral contraceptives, cervical cap, diaphragms, emergency contraception, female condom, implantable rod, intrauterine device (IUD), patch, shot/injection, spermicide, sponge, vaginal contraceptive ring and approved sterilization procedures for women A complete list of specific Prescription Drugs or supplies covered at 100% is available at www.SouthCarolinaBlues.com	Prescription Drugs will be covered at 100%, up to a 90 day supply	Prescription Drugs will be covered at 100%, up to a 31 day supply	The Member will be responsible for 100% of the Allowable Charge at the pharmacy then will be reimbursed at 100%, up to a 31 day supply
**All other contraceptives (Prescription Drugs)	Covered	Covered	Covered
Sexual dysfunction Prescription Drugs	Non-Covered	Non-Covered	Non-Covered
Tobacco cessation Prescription Drugs	Covered	Covered	Covered
Obesity/weight control Prescription Drugs	Non-Covered	Non-Covered	Non-Covered
Infertility Prescription Drugs	Non-Covered	Non-Covered	Non-Covered
Cosmetic Prescription Drugs	Non-Covered	Non-Covered	Non-Covered
Prescription Drug deductible	$0 (No Prescription Drug deductible)	$0 (No Prescription Drug deductible)	$0 (No Prescription Drug deductible)
Prescription Drug out-of-pocket	$0 (No Prescription Drug out-of-pocket)	$0 (No Prescription Drug out-of-pocket)	$0 (No Prescription Drug out-of-pocket)
Maximum Prescription Drug Benefit	$0 (No maximum Prescription Drug Benefit)	$0 (No maximum Prescription Drug Benefit)	$0 (No maximum Prescription Drug Benefit)

Prescription Drugs	Mail Service Pharmacy	Participating Pharmacy	All Other Pharmacies
Diabetic syringes and supplies***	Covered	Covered	Covered
Syringes and related supplies for conditions, such as cancer or burns, test tape, surgical trays and renal dialysis supplies	Non-Covered	Non-Covered	Non-Covered
*Contraceptives listed above are covered under the participating medical Benefits at the same payment levels. Refill quantities for the contraceptives listed above may vary. **All other contraceptives are paid at the Generic, Preferred Brand and Non-Preferred Brand payment levels. ***A separate Prescription Drug Copayment applies for each supply purchase.			

SPECIALTY DRUG BENEFIT		
	Participating Pharmacy	**All Other Pharmacies**
Specialty Drugs	$125 Prescription Drug Copayment per Member for each prescription or refill, up to a 31 day supply	Non-Covered

AMENDMENT

Employer Name: South Carolina Trucking Association, Inc.
Employer Number: 26-87002-00 and appropriate subgroups
Effective Date: 02/01/17
Amendment Number: 1

The Plan of Benefits between the Employer and the Corporation is amended as follows:

The following definition in **ARTICLE I - DEFINITIONS** is deleted in its entirety and the following substituted therefore:

Prescription Drug: a drug or medicine that is:

1. Required to be labeled that it has been approved by the Food and Drug Administration; and,

2. Bears the legend "Caution: Federal Law prohibits dispensing without a prescription" prior to being dispensed or delivered, or labeled in a similar manner; or,

3. Insulin.

Additionally, to qualify as a Prescription Drug, the drug must:

1. Be prescribed by a licensed Provider acting within the scope of his or her license;

2. Not be entirely consumed at the time and place where the prescription is dispensed; and,

3. Be purchased for use outside a Hospital.

Certain Over-the-Counter Drugs may be designated as Prescription Drugs, at the discretion of the Corporation. Such designated Over-the-Counter Drugs will be listed on the PDL.

ARTICLE I - DEFINITIONS is amended by the addition of the following:

Prescription Drug List (PDL): a listing of drugs approved for a specified level of Benefits by the Corporation, under the Plan of Benefits. This list shall be developed and subject to periodic review and modification by the Corporation. The most up-to-date version of the PDL is available on the Corporation's website.

ARTICLE III – BENEFITS, SECTION E. BENEFITS is amended by the deletion and substitution of the following:

PRESCRIPTION DRUGS

1. Unless expressly excluded under Article IV, the Corporation will pay Covered Expenses for Prescription Drugs (as specified on the Schedule of Benefits) that are listed as covered on the PDL and are used to treat a condition for which Benefits are otherwise available. This may include certain Over-the-Counter Drugs designated by the Corporation as Prescription Drugs and listed as covered on the PDL. If so designated, these Over-the-Counter Drugs must be prescribed by a Provider. Any Coinsurance percentage for Prescription Drugs is based on the Allowable Charge and does not change due to receipt of any Credits by the Corporation. Copayments likewise do not change due to receipt of any Credits by the Corporation.

   For more information about Prescription Drugs, please refer to the PDL which can be found on the Corporation's website. A list of drugs that are not covered by the Corporation is also on the PDL.

   In certain instances, the Corporation provides for an exception process that allows a Member or his or her designee (or the prescribing Provider) to request and obtain access, on an expedited basis, to clinically appropriate drugs that otherwise are not covered on the PDL. For more information about this exception process, please contact the Corporation at the number provided on your Identification Card.

2. If a Provider prescribes a Brand Name Drug and an equivalent Generic Drug or Over-the-Counter Drug is available and listed as covered on the PDL (whether or not the Provider indicates in the prescription that the substitution of a Generic Drug or Over-the-Counter Drug is not allowed), and the Member still requests the Brand Name Drug, then any difference between the cost of the covered Generic Drug or Over-the-Counter Drug and the higher cost of the Brand Name Drug shall be the responsibility of the Member. This will be in addition to any Copayment or Coinsurance appropriate to the Brand Name Drug being purchased. In no instance will the Member be charged more than the actual retail price of the drug.

3. Insulin shall be treated as a Prescription Drug whether injectable or otherwise.

4. The Corporation may, in its discretion, place quantity limits on Prescription Drugs.

The following exclusions in **ARTICLE IV – EXCLUSIONS AND LIMITATIONS** are deleted in their entirety and the following substituted therefore:

OVER-THE-COUNTER DRUGS

Drugs that are available on an over-the-counter basis or are otherwise available without a prescription, except for Over-the-Counter Drugs that are designated as Prescription Drugs by the Corporation, listed as covered on the PDL accordingly and are prescribed by a Provider.

PRESCRIPTION DRUG EXCLUSIONS

- Prescription Drugs that are specifically listed on the PDL as excluded;
- Prescription Drugs that have not been prescribed by a Provider acting within the scope of his or her license;
- Drugs not approved by the FDA;
- Prescription Drugs for non-covered therapies, services, or conditions;
- Prescription Drug refills in excess of the number specified on the Provider's prescription order or Prescription Drug refills dispensed more than one (1) year after the original prescription date;
- More than a thirty-one (31) day supply for Prescription Drugs (ninety (90) day supply for Prescription Drugs obtained through a Mail Service Pharmacy), except as specified on the Schedule of Benefits;
- Any type of service or handling fee for Prescription Drugs, including fees for the administration or injection of a Prescription Drug;
- Dosages that exceed the recommended daily dosage of any Prescription Drug as determined by the Corporation based on the following guidelines as described in the current:

    1. United States Pharmacopeia (USP);
    2. Facts and Comparisons;
    3. Physicians' Desk Reference; and/or,
    4. National Formulary.

- Prescription Drugs used for or related to cosmetic purposes, including hair growth, and skin wrinkles, except as specified on the Schedule of Benefits;
- Prescription Drugs related to any treatment for infertility or impotence (except when prescribed for benign prostatic hypertrophy), including but not limited to, fertility drugs, except as specified on the Schedule of Benefits;
- Prescription Drugs administered or dispensed in a Provider's office, Skilled Nursing Facility, Hospital or any other place that is not a pharmacy licensed to dispense Prescription Drugs in the state where it is operated;
- Over-the-Counter Drugs and over-the-counter supplies or supplements, except for Over-the-Counter Drugs that are designated by the Corporation as Prescription Drugs and are listed as covered on the PDL and are prescribed by a Provider;
- Prescription Drugs that are being prescribed for a specific medical condition that are not approved by the FDA for treatment of that condition (except for (i) Prescription Drugs for a specific medical condition that have at least two (2) formal clinical studies or (ii) Prescription Drugs for the treatment of a specific type of cancer, provided the drug is recognized for treatment of that specific cancer in at least one (1) standard, universally accepted reference compendia or is found to be safe and effective in formal clinical studies, the results of which have been published in peer reviewed professional medical journals);

- Prescription Drugs that are not consistent with the diagnosis and treatment of a Member's illness, injury or condition, or are excessive in terms of the scope, duration, dosage or intensity of drug therapy that is needed to provide safe, adequate and appropriate care;

- Prescription Drugs or services that require Preauthorization by the Corporation and Preauthorization is not obtained;

- Prescription Drugs for injury or disease that are paid by worker's compensation benefits (if a worker's compensation claim is settled, it will be considered paid by worker's compensation benefits);

- Prescription Drugs for obesity or weight control, contraceptives or tobacco cessation, except as specified on the Schedule of Benefits with respect to such Prescription Drugs;

- Prescription Drugs that are not authorized when part of a Step Therapy Program;

- Prescription Drugs which are new to the market and which are under clinical review by the Corporation shall be listed on the PDL as excluded until the clinical review has been completed and a final determination has been made as to whether the drug should be covered;

- Prescription Drugs, regardless of therapeutic class, that are determined to offer no clinical or cost effective advantage over other comparable Prescription Drugs already covered under the PDL; and,

- Vitamins, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind, except for prescription prenatal vitamins or prescription vitamin B-12 injections for anemias, neuropathies or dementias secondary to a vitamin B-12 deficiency.

THIS IS AN AMENDMENT TO YOUR PRESENT PLAN OF BENEFITS.

AMENDMENT

Employer Name: South Carolina Trucking Association, Inc.
Employer Number: 26-87002-00 and appropriate subgroups
Effective Date: 02/01/17
Amendment Number: 2

The Plan of Benefits between the Employer and the Corporation is amended as follows:

ARTICLE I – DEFINITIONS is amended by the addition of the following:

Accountable Care Organization (ACO): a group of healthcare Providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their Member populations.

Care Coordination: organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.

Care Coordinator: an individual within a Provider organization who facilitates Care Coordination for patients.

Care Coordinator Fee: a fixed amount paid by a Blue Cross and/or Blue Shield Licensee to Providers periodically for Care Coordination under a VBP.

Global Payment/Total Cost of Care: a payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient such as outpatient, physician, ancillary, hospital services and Prescription Drugs.

Negotiated Arrangement/Negotiated National Account Arrangement: an agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard Program.

Patient-Centered Medical Home (PCMH): a model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified physicians.

Provider Incentive: an additional amount of compensation paid to a healthcare Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.

Value-Based Shared Savings: a payment mechanism in which the Provider and payer share cost savings achieved against a target cost budget based upon agreed upon terms and may include downside risk.

Value-Based Program (VBP): a healthcare delivery model such as a patient-centered medical home ("PCMH"), accountable care organization ("ACO"), capitation arrangements or episode-based arrangements aimed at improving patient health quality and outcomes with respect to certain diseases and/or conditions. These services are facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment. The VBP is described further in this Contract and the Plan of Benefits.

ARTICLE IV – EXCLUSIONS AND LIMITATIONS is amended by the deletion first paragraph and following substituted therefore:

THE CORPORATION WILL NOT PAY ANY AMOUNT FOR THE SERVICES AND PRODUCTS LISTED IN THIS ARTICLE IV EXCEPT: (1) SERVICES ARE RENDERED BY A HEALTH CARE PROVIDER AS PART OF A VALUE-BASED PROGRAM OR (2) IF REQUIRED BY LAW.

ARTICLE XII – GENERAL PROVISIONS is amended by the deletion of the **BLUECARD PROGRAM** and the following substituted therefore:

I. Out-of-Area Services

Overview

The Corporation has a variety of relationships with other Blue Cross and/or Blue Shield Licensees, referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever Members access healthcare services outside the geographic area the Corporation serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the geographic area the Corporation serves, Members obtain care from healthcare Providers that have a contractual agreement ("Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from healthcare Providers in the Host Blue geographic area that do not have a contractual agreement ("Non-Participating Providers") with the Host Blue. The Corporation will remain responsible for fulfilling our contractual obligations to you. The Corporation's payment practices in both instances are described below.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits except when paid as medical claims/Benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party.

A. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Members access covered healthcare services within the geographic area served by a Host Blue, the Host Blue will be responsible for contracting and handling all interactions with its Participating Providers. The financial terms of the BlueCard Program are described generally below.

Liability Calculation Method Per Claim

Unless subject to a fixed dollar Copayment, the calculation of the Member liability on claims for covered healthcare services will be based on the lower of the Participating Provider's billed covered charges or the negotiated price made available to the Corporation by the Host Blue.

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's healthcare Provider contracts. The negotiated price made available to the Corporation by the Host Blue may be represented by one of the following:

(i) An actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases; or

(ii) An estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the Provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or

(iii) An average price. An average price is a percentage of billed covered charges in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare Providers or a similar classification of its Providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues determine whether or not they will use an actual, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over-or underestimation of past prices (i.e., prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid or anticipated to be paid to Providers or refunds received or anticipated to be received from Providers). However, the BlueCard Program requires that the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by the Corporation in determining your Premiums.

C. Special Cases: Value-Based Programs

BlueCard Program

The Corporation has included a factor for bulk distributions from Host Blues in the Employer's Premium for Value-Based Programs when applicable under this contract.

If the Member receives covered healthcare services under a Value-Based Program inside a Host Blue's service area, the Member will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to the Corporation through average pricing or fee schedule adjustments.

D. Return of Overpayments

Recoveries of overpayments/from a Host Blue or its Participating and Non-Participating Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits/healthcare Provider/hospital bill audits, credit balance audits, utilization review refunds and unsolicited refunds. Recoveries will be applied/ so that corrections will be made, in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to the Corporation, they will be credited to the Employer account. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be charged to the Employer as a percentage of the recovery.

E. Inter-Plan Programs: Taxes/Surcharges/Fees

In some instances laws or regulations may impose a surcharge, tax or other fee that applies to insured accounts. If applicable, the Corporation will include any such surcharge, tax or other fee in determining the Employer's Premium.

F. Non-Participating Providers Outside the Corporation's Service Area

1. Member Liability Calculation

When covered healthcare services are provided outside of the Corporation's service area by Non-Participating Providers, the amount(s) a Member pays for such services will generally be based on either the Host Blue's Non-Participating Provider local payment or the pricing arrangements required by applicable law. In these situations, the Member may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment the Corporation will make for the covered services as set forth in this paragraph. Payments for out-of-network emergency services are governed by applicable law.

2. Exceptions

In some exception cases, the Corporation may pay claims from Non-Participating Providers outside of the Corporation's service area based on the Provider's billed charge. This may occur in situations where a Member did not have reasonable access to a Participating Provider, as determined by the Corporation in the Corporation's sole and absolute discretion or by applicable law. In other exception cases, the Corporation may pay such claims based on the payment the Corporation would make if the Corporation were paying a Non-Participating Provider inside of the Corporation's service area. This may occur where the Host Blue's corresponding payment would be more than the Corporation's in-service area Non-Participating Provider payment. The Corporation may choose to negotiate a payment with such a Provider on an exception basis.

Unless otherwise stated, in any of these exception situations, the Member may be responsible for the difference between the amount that the Non-Participating Provider bills and payment the Corporation will make for the covered services as set forth in this paragraph.

G. BlueCard Worldwide® Program

- **General Information**

If Members are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard service area"), they may be able to take advantage of the BlueCard Worldwide Program when accessing covered healthcare services. The BlueCard Worldwide Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the BlueCard Worldwide Program assists Members with accessing a network of inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when Members receive care from Providers outside the BlueCard service area, the Members will typically have to pay the Providers and submit the claims themselves to obtain reimbursement for these services.

- **Inpatient Services**

In most cases, if Members contact the BlueCard Worldwide Service Center for assistance, hospitals will not require Members to pay for covered inpatient services, except for their cost-share amounts/Benefit Year Deductibles, Coinsurance, etc. In such cases, the hospital will submit Member claims to the BlueCard Worldwide Service Center to initiate claims processing. However, if the Member paid in full at the time of service, the Member must submit a claim to obtain reimbursement for covered healthcare services.

- **Outpatient Services**

Physicians, urgent care centers and other outpatient Providers located outside the BlueCard service area will typically require Members to pay in full at the time of service. Members must submit a claim to obtain reimbursement for covered healthcare services.

- **Submitting a BlueCard Worldwide Claim**

When Members pay for covered healthcare services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Members should complete a BlueCard Worldwide International claim form and send the claim form with the Provider's itemized bill(s) to the BlueCard Worldwide Service Center address on the form to initiate claims processing. The claim form is available from the Corporation, the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com. If Members need assistance with their claim submissions, they should call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

AMENDMENT

Employer Name: South Carolina Trucking Association, Inc.
Employer Number: 26-87002-00 and appropriate subgroups
Effective Date: 02/01/17
Amendment Number: 3

The Plan of Benefits between the Employer and the Corporation is amended as follows:

The following benefit in **ARTICLE III - BENEFITS** is deleted in its entirety and the following substituted therefore:

EMERGENCY MEDICAL CARE

The Corporation will pay Covered Expenses for care that is necessary as a result of an Emergency Medical Condition. The Maximum Payment for Emergency Medical Conditions at a Non-Participating Provider will be the greatest of the following:

1. The amount negotiated with Participating Providers for the particular emergency services (reduced by any in-network Copayment or Coinsurance);

2. The amount for emergency services calculated using same method the Corporation uses for out-of-network services, but substituting the relevant in-network Copayment or Coinsurance for the out-of-network Copayment or Coinsurance requirements; or

3. The amount for the emergency services that would be paid under Medicare, reduced by any in-network Copayment or Coinsurance for the services.

THIS IS AN AMENDMENT TO YOUR PRESENT PLAN OF BENEFITS.

AMENDMENT

Employer Name: South Carolina Trucking Association, Inc.
Employer Number: 26-87002-00 and appropriate subgroups
Effective Date: 02/01/17
Amendment Number: 4

The Plan of Benefits between the Employer and the Corporation is amended as follows:

The following definition is added to **ARTICLE I – DEFINITIONS**:

Telehealth: the exchange of Member information during which Members can have a telephone or video consultation with a licensed health care professional. Telehealth does not require two-way audio or video consultations between a referring Provider and/or specialist.

The following definition in **ARTICLE I – DEFINITIONS** is deleted in its entirety and the following substituted therefore:

Telemedicine: the exchange of Member information from one eligible referring licensed Provider (for purposes of Telemedicine outlined herein, the "Referring Provider") site to another eligible consulting licensed Provider (for purposes of Telemedicine outlined herein, the "Consulting Provider") site for the purpose of providing medical care to a Member in circumstances in which in person, face-to-face contact with the Consulting Provider is not necessary. The exchange must occur via two-way, real-time, interactive, HIPAA-compliant, electronic audio and video telecommunications systems.

The following benefit is added to **ARTICLE III - BENEFITS**:

TELEHEALTH

The Corporation will pay Covered Expenses for Telehealth services which are initiated by either a Member or Provider and are provided by licensed health care professionals who have been credentialed as eligible Telehealth Providers.

The following benefit in **ARTICLE III - BENEFITS** is deleted in its entirety and the following substituted therefore:

TELEMEDICINE

The Corporation will pay Covered Expenses for Telemedicine services as follows:

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

Consulting and referring Providers must be Participating Providers who have been credentialed as eligible Telemedicine Providers.

Telemedicine services will be covered by the Corporation under the following circumstances:

1. The medical care is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and not in excess of the Member's need; and,

2. The medical care can be safely furnished, and there is no equally effective, more conservative and less costly treatment available.

Examples of interactions that are not reimbursable Telemedicine services and will not be reimbursed are:

1. Telephone conversations;

2. E-mail messages;

3. Facsimile transmissions; or,

4. Internet-based audio-video communication that is not secure and HIPAA-compliant (e.g., Skype).

The **TELEHEALTH** exclusion in **Article IV – EXCLUSIONS AND LIMITATIONS** is deleted in its entirety.

AMENDMENT

Employer Name: South Carolina Trucking Association, Inc.
Employer Number: 26-87002-00 and appropriate subgroups
Effective Date: 02/01/17
Amendment Number: 5

The Plan of Benefits between the Employer and the Corporation is amended as follows:

The following definition in **ARTICLE I – DEFINITIONS** is deleted in its entirety and the following substituted therefore:

COBRA Administrator: the Corporation or its designated subcontractor (who the Corporation has contracted with to provide administrative Services related to COBRA). For purposes of this Contract, the COBRA Administrator may also provide Direct Billing Services as outlined in the Contract and Plan of Benefits if applicable.

THIS IS AN AMENDMENT TO YOUR PRESENT PLAN OF BENEFITS.

AMENDMENT

Employer Name: South Carolina Trucking Association, Inc.
Employer Number: 26-87002-00 and appropriate subgroups
Effective Date: 02/01/17
Amendment Number: 6

The Plan of Benefits between the Employer and the Corporation is amended as follows:

ARTICLE III – BENEFITS, SECTION E. BENEFITS is amended by the deletion and substitution of the following:

SPECIALTY DRUGS

The Corporation will pay Covered Expenses for Specialty Drugs as set forth on the Schedule of Benefits. Covered Expenses for Specialty Drugs dispensed to a Member shall not exceed the quantity and Benefit maximum set by the Corporation. Certain Specialty Drugs may only be covered under the pharmacy Benefit. Certain Specialty Drugs may require Preauthorization. For any Specialty Drug, the Benefit Year Deductible, Out-of-Pocket Maximum and/or Benefit maximum will apply as set forth on the Schedule of Benefits. A list of Specialty Drugs, as well as information about any related requirements and/or restrictions, may be obtained by contacting the Corporation at the number listed on the Identification Card or at www.SouthCarolinaBlues.com.

Any Coinsurance percentage for Specialty Drugs is based on the Allowable Charge at the Participating Provider, and does not change due to receipt of any Credits by the Corporation. Copayments likewise do not change due to receipt of any Credits by the Corporation.

In certain instances, the Corporation provides for an exception process that allows a Member or his or her designee (or the prescribing Provider) to request and obtain access to clinically appropriate drugs that otherwise are not covered on the PDL. For more information about this exception process, please contact the Corporation at the number provided on your Identification Card.

The following bulleted exclusions in **ARTICLE IV – EXCLUSIONS AND LIMITATIONS** are deleted in their entirety and the following substituted therefore:

PRESCRIPTION DRUG EXCLUSIONS

- Prescription Drugs or services administered or dispensed when the required Preauthorization is not obtained.

- Prescription Drugs that are not consistent with the diagnosis and treatment of a Member's illness, injury or condition, are excessive in terms of the scope, duration, dosage or intensity of drug therapy that is needed to provide safe, adequate and appropriate care or are not provided in compliance with any applicable place of service requirements;

- Prescription Drugs that are specifically listed on the website as excluded;

THIS IS AN AMENDMENT TO YOUR PRESENT PLAN OF BENEFITS.

AMENDMENT

Employer Name: South Carolina Trucking Association, Inc.
Employer Number: 26-87002-00 and appropriate subgroups
Effective Date: 02/01/17
Amendment Number: 7

The Plan of Benefits between the Employer and the Corporation is amended as follows:

ARTICLE I - DEFINITIONS is amended by the addition of the following:

Emergency: an unexpected and usually dangerous situation that calls for immediate action.

Emergency Services: services, supplies and treatment for stabilization, evaluation and/or initial treatment of an Emergency Medical Condition when provided on an outpatient basis at a Hospital Emergency room or department.

The term **Emergency Medical Care** in **ARTICLE I - DEFINITIONS** is deleted in its entirety and any reference to the term throughout the Plan of Benefits. The term **Emergency Services** is substituted therefore.

The following definitions in **ARTICLE I - DEFINITIONS** are deleted in their entirety and the following substituted therefore:

Investigational or Experimental Services: surgical or medical procedures, supplies, devices or drugs which, at the time provided, or sought to be provided, are in the judgment of the Corporation, not recognized as conforming to generally accepted medical or behavioral health practice in the United States, or the procedure, drug or device:

1. Has not received required final approval in the United States to market from appropriate government bodies;

2. Is one about which the peer-reviewed medical literature in the United States does not permit conclusions concerning its effect on health outcomes;

3. Is not demonstrated in the United States to be superior to established alternatives;

4. Has not been demonstrated in the United States to improve net health outcomes; or,

5. Is one in which the improvement claimed is not demonstrated in the United States to be obtainable outside the Investigational or Experimental setting.

Medically Necessary/Medical Necessity: health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical or behavioral health practice;

2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;

3. Not primarily for the convenience of the patient, patient's caregiver(s) or Provider; and,

4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

All requirements of the above-referenced definition must be met in order for a health care service to be deemed Medically Necessary. The failure of a health care service to meet any one of the above referenced requirements means, in the discretion of the Corporation or CBA, the health care service does not meet the definition of Medically Necessary/Medical Necessity.

For the purposes of determining Medically Necessary/Medical Necessity:

1. The Corporation and CBA have the discretion to utilize and rely upon any medical and behavioral health (which includes substance use and mental health) standards, policies, guidelines, criteria, protocols, manuals, publications, studies or literature (herein collectively referred to as "criteria"), whether developed by them or others, which in their discretion are determined to be generally accepted by the medical and/or behavioral health community;

2. "Generally accepted standards of medical or behavioral health practice" means United States standards that are based on credible scientific evidence published in peer-reviewed medical and/or behavioral health literature generally recognized by the relevant United States medical or behavioral health community, physician or behavioral health specialty society recommendations, and/or any other factors deemed relevant in the discretion of the Corporation or CBA; and,

3. The Corporation and CBA may use, including but not limited to, Corporate Administrative Medical ("CAM") Policies, Technology Evaluation Center ("TEC") Assessments, Behavioral Health Care Utilization Management Criteria and/or any Care Guidelines or criteria by MCG Health, LLC or affiliated companies which reflect and are clinically appropriate health care services and generally accepted standards of medical and behavioral health practice. MCG Health, LLC and/or its affiliated companies are independent companies that develop evidence based guidelines and criteria for medical, behavioral health and insurance industries to interpret clinical determinations and determine the medical necessity and appropriateness of requested services, procedures, devices and supplies.

Participating Provider: a Provider who has a current, valid Provider Agreement related to this Plan of Benefits.

ARTICLE III – BENEFITS is amended by the deletion of **AMBULANCE** and the following substituted therefore:

AMBULANCE SERVICES

The Corporation will pay Covered Expenses for professional ground and air ambulance services to the nearest network Hospital in case of an accident or Emergency Medical Condition. The following requirements apply to all ground and air ambulance services and transports:

1. The transport is Preauthorized as Medically Necessary and reasonable under the circumstances;

2. A Member is transported;

3. The destination is local within the United States; and,

4. The facility is medically appropriate to treat the Member's condition.

The Corporation will pay Covered Expenses for ground ambulance transport between two Hospitals only when such ground ambulance transport has been Preauthorized and the Corporation confirms that the receiving Hospital is the closest facility that can provide medically appropriate care to treat the Member's condition. However, no Benefits are available for ground or air ambulance services or transport if a Member is transferred from one facility to a new facility for the purpose of the Member obtaining a lower level of care at the new receiving facility. A Non-Participating Provider may balance bill the Member for charges not paid by the Corporation. Repatriation is excluded and is not a Benefit for which Covered Expenses are payable.

If a Member seeks Preauthorization to be transported as an inpatient from one Hospital to a second Hospital using an air ambulance, the following requirements must be met:

1. The first Hospital does not have the needed Hospital or skilled nursing care to treat the Member's illness or injury (such as burn care, cardiac care, trauma care, and critical care);

2. The second Hospital is the nearest medically appropriate facility to treat the Member's illness or injury;

3. A ground ambulance transport would endanger the Member's medical condition; and,

4. The transport is not related to a hospitalization outside the United States.

ARTICLE III – BENEFITS is amended by the deletion of **EMERGENCY MEDICAL CARE** and the following substituted therefore:

EMERGENCY SERVICES

The Corporation will pay Covered Expenses for care that is necessary as a result of an Emergency Medical Condition. Benefits are only available to treat an Emergency Medical Condition provided on an outpatient basis at a Hospital Emergency room or department, and only for as long as the condition continues to be considered an Emergency.

The Maximum Payment for Emergency Medical Conditions at a Non-Participating Provider will be the greatest of the following:

1. The amount negotiated with Participating Providers for the particular Emergency Services (reduced by any in-network Copayment or Coinsurance);

2. The amount for Emergency Services calculated using same method the Corporation uses for out-of-network services, but substituting the relevant in-network Copayment or Coinsurance for the out-of-network Copayment or Coinsurance requirements; or,

3. The amount for Emergency Services that would be paid under Medicare, reduced by any in-network Copayment or Coinsurance for the services.

ARTICLE IV – EXCLUSIONS AND LIMITATIONS is amended by the addition of the following:

REPATRIATION

Services and supplies received as the result of transporting a Member, regardless of cause, from a foreign country to the Member's residence in the United States.

The following exclusions in **ARTICLE IV – EXCLUSIONS AND LIMITATIONS** are deleted in their entirety and the following substituted therefore:

ORTHOGNATHIC SURGERY

Any service related to the treatment of malpositions or deformities of the jaw bone(s), dysfunction of the muscles of mastication, or orthognathic deformities, regardless of cause, except as specified on the Schedule of Benefits.

TEMPOROMANDIBULAR JOINT (TMJ) DISORDER

Any service for the treatment of dysfunctions or derangements of the temporomandibular joint, regardless of cause. This exclusion also applies to orthognathic surgery for the treatment of dysfunctions or derangements of the temporomandibular joint, regardless of cause, except as specified on the Schedule of Benefits.

THIS IS AN AMENDMENT TO YOUR PRESENT PLAN OF BENEFITS.

AMENDMENT

Employer Name: South Carolina Trucking Association, Inc.
Employer Number: 26-87002-00 and appropriate subgroups
Effective Date: 02/01/17
Amendment Number: 8

The Plan of Benefits between the Employer and the Corporation is amended as follows:

The following benefit is added to **ARTICLE III - BENEFITS**

Gender Dysphoria

The Corporation will pay Covered Expenses for Medical Supplies, services or charges related to the diagnosis or treatment of gender dysphoria as outlined in the Corporation's medical policy.

The following exclusion in **ARTICLE IV – EXCLUSIONS AND LIMITATIONS** is deleted in its entirety and the following substituted therefore:

SEX CHANGE

Any Medical Supplies, services or charges incurred for surgery or any procedures related to changing a Member's sex.

THIS IS AN AMENDMENT TO YOUR PRESENT PLAN OF BENEFITS.

AMENDMENT

Employer Name: South Carolina Trucking Association, Inc.
Employer Number: 26-87002-00 and appropriate subgroups
Effective Date: 02/01/17
Amendment Number: 9

The Plan of Benefits between the Employer and the Corporation is amended as follows:

All references to "Employer's Group Health Plan" throughout the Plan of Benefits are replaced with the term "Group Health Plan".

All references to the term "Employer" are replaced with "Association" in the definitions entitled Benefits Checklist, Contract, Grace Period, Membership Application, Plan Administrator, Plan of Benefits and Premium.

ARTICLE I - DEFINITIONS is amended by the addition of the following term:

Association: the professional association in which the Employer participates and which has established and sponsors the Group Health Plan.

The definition entitled **COBRA Administrator** in **Article I – DEFINITIONS** is deleted in its entirety.

The following definitions in **Article I – DEFINITIONS** are deleted in their entirety and the following substituted therefore:

Credit(s): financial Credits (including rebates and/or other amounts) may be received by the Corporation directly from drug manufacturers or other Providers through a Pharmacy Benefit Manager. Credits are used to help stabilize overall rates and to offset expenses and may not be payable to the Association, Employer or Members.

Reimbursements to a Participating Pharmacy, or discounted prices charged at pharmacies, are not affected by these Credits. Any Coinsurance that a Member must pay for Prescription Drugs or Specialty Drugs is based upon the Allowable Charge at the pharmacy, and does not change due to receipt of any Credit by the Corporation. Copayments are not affected by any Credit.

Employee: any Employee of the Employer who is eligible for coverage, as provided in Article II of this Plan of Benefits, and who is so designated to the Corporation by the Association, even if such classification is determined to be erroneous or is retroactively revised.

Employer: the entity which has elected coverage through a written agreement with the Association.

Group Health Plan: an Employee welfare Benefit Plan established and sponsored by the Association to the extent that such Plan provides health Benefits to Employees or their Dependents, as defined under the terms of such Group Health Plan, directly or through insurance, reimbursement, or otherwise. This Plan of Benefits is a Group Health Plan.

Probationary Period: the period of continuous employment (if included on the Schedule of Benefits) with the Employer that an Employee must complete before becoming eligible to enroll in this Plan of Benefits. The Association may require an additional orientation period.

All references to the term “Employer” are replaced with “Association” in the following sections of the Plan of Benefits: Article II(C)(5), Article V(F), Article VI(D), Article VI(F), Article VI(I), the AMENDMENT section of Article XII, the DISCLOSURE TO ASSOCIATION section of Article XII with the exception of Section A(3) and the NOTICES section of Article XII.

Section C(1) in **Article II – ELIGIBILITY FOR COVERAGE** is deleted in its entirety and the following substituted therefore:

1. Employees and Dependents Eligible on the Employer’s Effective Date.

   For Employees (and such Employee’s Dependents for whom such Employee has elected coverage) who are Actively at Work prior to and on the Employer’s Effective Date, coverage will generally commence on this Plan of Benefits Effective Date.

   If the Corporation receives an Employee’s Membership Application dated after the Employer’s Effective Date, coverage will commence on the date chosen by the Association.

Section C(6)(c)(iii) in **Article II – ELIGIBILITY FOR COVERAGE** is deleted in its entirety and the following substituted therefore:

iii. Was one of multiple Plans offered by the Association and the Employee elected a different plan during an open enrollment period or when the Association terminates all similarly situated individuals;

The last paragraph in Section C(6) in **Article II – ELIGIBILITY FOR COVERAGE** is deleted in its entirety and the following substituted therefore:

The above list is not an all-inclusive list of situations when an Employee or Dependent loses eligibility. For situations other than those listed above see the Association.

Section E in **Article II – ELIGIBILITY FOR COVERAGE** is deleted in its entirety and the following substituted therefore:

E. MEMBERSHIP APPLICATION

The Corporation will only accept a Membership Application submitted by the Association on behalf of each Employee. The Corporation will not accept a Membership Application directly from an Employer, Employee or Dependent.

The first paragraph in section A of **Article VI – TERMINATION OF THIS PLAN OF BENEFITS** is deleted in its entirety and the following substituted therefore:

TERMINATION OF EMPLOYEE’S COVERAGE AND ALL OF SUCH EMPLOYEE’S DEPENDENTS’ COVERAGE WILL OCCUR ON THE EARLIEST OF THE FOLLOWING CONDITIONS:

Sections B(1) and B(2) in **Article VI – TERMINATION OF THIS PLAN OF BENEFITS** are deleted in their entirety and the following substituted therefore:

1. If the Premium remains unpaid after the Grace Period, this Plan of Benefits shall automatically terminate, without prior notice to the Association, Employer, or to any Member, immediately after the last day of the Grace Period.

2. If an Employer fails to pay its Premium after the Grace Period, this Plan of Benefits for that Employer shall terminate at the discretion of the Association for nonpayment of Premium, without any prior notice to the Employer or Members, immediately after the last day of the Grace Period. Additionally, the Corporation retains the right to terminate this Plan of Benefits for the Association, Employer and Members in the event the Association fails to pay any or all the Premium and such amount remains unpaid after the Grace Period.

Section E(1) in **Article VI – TERMINATION OF THIS PLAN OF BENEFITS** is deleted in its entirety and the following substituted therefore:

1. The Corporation may terminate coverage under this Plan of Benefits if:

    a. The Corporation ceases to offer coverage of the type of group health insurance coverage provided by this Plan of Benefits and provides notice to the Association and Members at least ninety (90) days prior to the date of the discontinuation of such coverage;

    b. The Corporation offers to the Association the option to purchase any other group health insurance currently being offered by the Corporation to a Group Health Plan in such market; and,

    c. The Corporation acts uniformly without regard to the claims experience of the Association or any Health Status-Related Factor relating to any Members or Employees or Dependents who may become eligible for such coverage.

Section E(2)(b) in **Article VI – TERMINATION OF THIS PLAN OF BENEFITS** is deleted in its entirety and the following substituted therefore:

    b. If the Corporation provides notice to the DOI and to the Association and Members of such discontinuation at least one hundred eighty (180) days prior to the date of the discontinuation of such coverage;

Section B(2) in **Article VII – CONVERSION AND CONTINUATION OF COVERAGE** is deleted in its entirety.

Section C(1)(a) and (b) in **Article VII – CONVERSION AND CONTINUATION OF COVERAGE** are deleted in their entirety and the following substituted therefore:

    a. Timely Notifications and Determinations.

        In the case of any Medical Child Support Order received by the Corporation:

i. The Employer shall promptly notify the Employee and each Alternate Recipient of the receipt of the Medical Child Support Order and the Corporation's procedures for determining whether Medical Child Support Orders are Qualified Medical Child Support Orders; and,

ii. Within a reasonable period after receipt of such Qualified Medical Child Support Order, the Employer shall determine whether such order is a Qualified Medical Child Support Order and notify the Employee and each Alternate Recipient of such determination.

b. Establishment of Procedures for Determining Qualified Status of Orders.

The Employer shall establish reasonable procedures to determine whether Medical Child Support Orders are Qualified Medical Child Support Orders and to administer the provision of Covered Expenses under of such qualified orders. The Employer's procedures:

i. Shall be in writing;

ii. Shall provide for the notification of each person specified in a Medical Child Support Order as eligible to receive Benefits under this Plan of Benefits (at the address included in the Medical Child Support Order) of the Employer's procedures promptly upon receipt by the Employer of the Medical Child Support Order; and,

iii. Shall permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

Section B in **Article X – ERISA RIGHTS** is deleted in its entirety and the following substituted therefore:

B. CONTINUATION COVERAGE

Members are entitled to continue health care coverage for themselves and their Dependents if there is a loss of coverage under this Plan of Benefits as a result of a Qualifying Event. The Member or Dependents may have to pay for such continuation coverage. Employee Members should review any documents provided by the Employer or Association outlining COBRA continuation coverage rights.

Section C in **Article X – ERISA RIGHTS** is deleted in its entirety and the following substituted therefore:

C. PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Members, ERISA imposes duties upon the people who are responsible for the operation of an employee welfare benefit plan. The people who administer an employee welfare benefit plan are called "fiduciaries," and have a duty to do so prudently and in the interest of the Members. The Association is a fiduciary of this Plan of Benefits. No one, including the Association and Employer, may fire or otherwise discriminate against a Member in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA.

Section D(3) in **Article X – ERISA RIGHTS** is deleted in its entirety and the following substituted therefore:

3. No one, including the Association, Employer, the Members' union, or any other person, may fire an Employee or otherwise discriminate against an Employee in any way to prevent an Employee from obtaining a Benefit or exercising the Employee's rights under ERISA.

The section entitled **MEMBERSHIP APPLICATION** in **Article XII – GENERAL PROVISIONS** is deleted in its entirety and the following substituted therefore:

MEMBERSHIP APPLICATION

The Corporation will only accept a Membership Application submitted by the Association. The Corporation will not accept Membership Applications directly from an Employer, Employee or Dependent.

The section entitled **REPLACEMENT COVERAGE** in **Article XII – GENERAL PROVISIONS** is deleted in its entirety and the following substituted therefore:

REPLACEMENT COVERAGE

If this Plan of Benefits replaced the prior Plan, all eligible persons who were validly covered under that Plan on its termination date will be covered on the Plan of Benefits Effective Date of this Plan of Benefits, provided such persons are enrolled for coverage as stated in Article II.

THIS IS AN AMENDMENT TO YOUR PRESENT PLAN OF BENEFITS.