SCANA Corporation Health and Welfare Plan

Retired Employee Healthcare Summary Plan Description

Amended and Restated
Effective
January 1, 2015

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INTRODUCTION

SCANA Corporation provides retiree health and welfare benefits through the SCANA Corporation Retiree Welfare Benefits Plan. This summary plan description (SPD) describes the medical, pharmacy, dental and vision benefits offered through the SCANA Corporation Retiree Welfare Benefits Plan to retired SCANA Employees and their eligible dependents, as well as coverage available through COBRA continuation. The benefits described herein are referred to collectively in this summary plan description as the "Plan" or "benefits".

Throughout this document, please note that "You" refers to you, a retired person, and/or, where applicable, your eligible dependent(s) – any covered person for whom a claim might be filed. SCANA refers to SCANA Corporation and its participating affiliates.

Certain benefits described in this SPD are provided under insurance contracts entered into between SCANA Corporation and insurers, while others are self-insured by SCANA Corporation and paid from the assets of the SCANA Corporation Retiree Welfare Benefits Trust. Nothing in this SPD creates or is intended to create a contract between you or your eligible dependents and SCANA or the Plan Administrator.

The operation of this summary plan description is governed by the Official Plan document for the SCANA Corporation Retiree Welfare Benefits Plan. If there is any inconsistency between the Official Plan document and any oral representation or any other written communication (such as this SPD), the Official Plan document will always govern. However, to the extent a benefit described in this SPD is provided under an insurance contract, the terms of the insurance contract will govern in the event there is an inconsistency between the Official Plan document or this SPD and the insurance contract unless the term or provision of the insurance contract violates applicable law.

Reservation of Rights

Although SCANA currently intends to continue the Plan indefinitely, SCANA reserves the right to modify, amend, or terminate any and all provisions of the Plan, including the medical benefits portion of the Plan, at any time. No employee has any vested right to any benefit or coverage under the Plan.

RETIRED EMPLOYEE ELIGIBILITY

Retired Employee Eligibility

If you satisfy one of the following criteria, you are eligible to participate in SCANA's retiree medical, pharmacy, vision and dental benefits as explained below. If you were hired on or after January 1, 2011 and later become eligible for benefits under this Plan, you will be responsible for the full cost of coverage elected under this Plan.

A. Retired Employees

At the time of your separation from employment with SCANA, if you are at least age fifty-five (55) and have at least twenty (20) years of full-time service with SCANA, you will be eligible to elect retiree medical, pharmacy and vision coverage under the plan.

Years of service with SCANA are tracked based on the number of full months and years from your date of hire until your date of separation from employment during which you are scheduled to work 32 or more hours per week.

Any non-continuous years of service will be treated as follows: (1) if you terminate employment before having at least five years of service and incur at least a five-year break from service, you will not be credited with any pre-break years of service; (2) if you terminate employment before having at least five years of service and incur less than a five-year break in service, you will be credited with pre-break years of service; and (3) if you terminate employment after having five or more years of service, you will be credited with any pre- break years of service regardless of the length of the interruption of service. If your separation from SCANA involves gross misconduct, SCANA reserves the right to determine that you are ineligible for retiree medical, pharmacy, and vision benefits.

You are eligible to elect retiree dental coverage if you are over age 65 and retired from SCANA before January 1, 1994.

- An employee who retires from SCANA can DEFER enrollment in SCANA's Retired Employee Health benefits one time and remain in deferred status as long as they choose.
- Once enrolled in one of SCANA's Retired Employee Health Benefits, if the retiree chooses to WAIVE coverage, eligibility for future benefits ends.
- Failure to pay applicable premiums constitutes WAIVING coverage and eligibility for future benefits ends.

B. Grandfathered Participants

Any participants covered under the Plan as of December 31, 2006 will remain eligible for coverage under the Plan.

C. Excluded Individuals

Eligible Retiree does not include any individual who does not satisfy the criteria as a retired employee or grandfathered participant described above.

Effective January 1, 2016, an Eligible Retiree also does not include:

1. Any individual who is a current full-time employee of SCANA; and

2. Any individual who is a participant in SCANA's medical benefit plan for active employees (including, but not limited to, an individual participating in SCANA's active employee medical benefit plan pursuant to COBRA).

DEPENDENT ELIGIBILITY

A. Eligible Dependents

Generally, if you are covered by the Plan, your eligible dependents can also be covered. If both you and your spouse are eligible for retiree benefits, either of you, but not both, may cover your children who are eligible dependents. No one may be considered a Dependent of more than one Participant. You are required to provide evidence of your Dependent's eligibility for coverage.

Your eligible dependent is any individual who, at the time of your retirement, is:

1. Your lawful spouse as determined under the laws of the state in which you were married.

2. Your son or daughter under the age of 26 (or age 23 for dental coverage.)

3. An individual who is 26 years of age or older, is primarily supported by you, and is incapable of self-sustaining employment because of a mental or physical disability. You should provide proof of the child's condition and dependence to the Plan within 31 days after the 26th birthday. The Plan may periodically ask for proof of continuation of the condition and dependence.

4. The biological or legally adopted child of your spouse at the time of your retirement, if your spouse has physical and legal custody of the child by a decreed court order and your spouse is also a Dependent covered under the same benefit coverage requested for the child.

5. A child for whom you have legal guardianship or is part of a Qualified Medical Child Support Order.

B. Eligibility for Coverage of Adopted Children

You must be legally obligated to support any adopted child, prior to your retirement, for the adopted child to be eligible for coverage under a retiree plan.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

C. Dependents of a Deceased Retiree

If you die while covered by SCANA retiree medical benefits, only your Eligible Dependents covered at the time of your death may continue these benefits as long as they remain eligible and pay the appropriate premiums. However, if you retired before January 1, 1994, your surviving spouse will not be eligible for retiree dental coverage.

D. Dependents of Active, Full-Time Employee

If you die as an active, full-time employee, your Dependents who, at that time, are participants in the active employee medical benefits sponsored by SCANA may become eligible for retiree medical, pharmacy and vision benefits if you were eligible for retiree health and welfare benefits under this Plan at the time of your death.

The SCANA Benefits team will provide information to your eligible Dependents of any coverage options under this Plan, if applicable.

E. Excluded Dependents

Eligible Dependents DO NOT include:

1. A dependent who is on active duty with the armed forces of any country;

2. A dependent who is eligible to be covered as an employee under another employer's group medical insurance plan and elects not to be covered under such plan; and

3. A dependent who is a participant in SCANA's active employee medical benefits plan (including, but not limited to, an individual participating in SCANA's active employee medical benefit plan pursuant to the COBRA).

F. Eligibility for Coverage under a Qualified Medical Child Support Order:

If a qualified medical child support order is issued for your child and you are an eligible employee, that child will be eligible for coverage as required by the order. You must notify SCANA and elect coverage for that child and yourself, if you are not already enrolled, within 31 days of a valid order being issued.

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement), or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan and satisfies all of the following:
(A copy of the Qualified Medical Child Support Order procedures may be obtained by contacting the Benefits Care Line at 803-217-4444.)

- The order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
- The order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
- The order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- The order states the period to which it applies; and
- If the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.
- The qualified medical child support order may not require the health insurance Plan to provide coverage for any type or form of benefit or option not otherwise provided under the Plan.

A copy of the Plan's Qualified Medical Child Support Order procedures may be obtained by contacting the Benefits Care Line at 803-217-4444

ENROLLING FOR COVERAGE

When Coverage Begins

When you are offered benefits for the first time under this Plan, you can choose not to enroll; thereby **deferring** enrollment. You can remain in a deferred status indefinitely. Every year during open enrollment, you will receive enrollment information, at which time you can enroll in the plan or continue to DEFER enrollment.

Once you enroll in the plan, you can re-enroll every year. If, however, you choose to WAIVE coverage, you and your dependents will permanently lose eligibility for Retiree Healthcare benefits. If you waive coverage you will no longer be sent enrollment information. If you are rehired by SCANA after you retire from the company and work more than 130 hours per month, you will lose eligibility under this Plan and be eligible for Active Healthcare benefits during your time of re-employment. However, your loss of retiree coverage will not be considered a waiver of coverage.

If you have NOT waived coverage, your coverage under the Plan will begin as follows:

- On the first day of the month after you enroll in a retiree healthcare option, otherwise on the date you first become eligible for coverage, provided you enroll in the Plan within 31 days of first becoming eligible and you pay the required cost of coverage; or
- If you do not enroll within 31 days of first becoming eligible, you will be automatically placed in a "deferred status". You will not be able to change your coverage until the next annual open enrollment unless you have a family status change or special enrollment event after 31 days of first becoming eligible. Your coverage will become effective on the date you first became eligible for coverage, or if during open enrollment, your coverage will become effective January 1; or
- On the date of your family status change or special enrollment event, provided you notify the SCANA Benefits team and enroll in the Plan within 31 days (60 days in the event of a Medicaid or Children's Health Insurance Program (CHIP) special enrollment) of the family status change or special enrollment event and pay the required cost of coverage; or
- If you currently participate in the Plan and do not enroll during the annual open enrollment period, you will be automatically enrolled in your previous year's coverage, provided it is still available. If your previous year's coverage option is not available, the Plan Administrator will determine the option you will be automatically enrolled in and provide notice to you. You will not be able to change your coverage until the next open enrollment unless you have a family status change or special enrollment.

Coverage for dependents under the Plan will begin as follows:

- On the date your coverage with the Plan begins if you enroll the dependent at that time and provide proof of dependent status; or

If you do not enroll your dependent and provide proof of dependent status within 31 days of when you first become eligible, you cannot enroll your

dependent until the next annual open enrollment unless you have a family status change or special enrollment event after 31 days of you first becoming eligible. The dependent coverage will become effective January 1 following his or her enrollment during the annual open enrollment period; or

- On the date you experience a family status change or special enrollment event that is consistent with your request to add your dependent, provided you notify the SCANA Benefits team, provide proof of dependent status and enroll your dependent in the Plan within 31 days (60 days in the event of a Medicaid or CHIP special enrollment) of the family status change or special enrollment event and pay the required cost of coverage; or

- On the later of the date specified in a qualified medical child support order (QMCSO), or the date the Plan administrator determines that the order is a QMCSO.

Changing Coverage

You may enroll yourself and your eligible dependents only when you first become eligible to participate in the Plan or during the annual open enrollment period and you cannot make changes during the Plan year. However, you can enroll in the Plan or make changes to your election if you have not previously waived coverage and experience certain qualifying change in status events, including a family status change or special enrollment event. If you are enrolled in the Plan, you will only be able to make changes to lower the tier of coverage (ex: move from family to retiree only coverage) which corresponds to your qualifying change in status event. You will not be allowed to increase your coverage level (ex: move from retiree only to family coverage) unless the increase in coverage level is being made by you in order to cover your dependent who has lost other employer-sponsored health coverage, and such individual was your dependent at the time of your retirement from SCANA. You also will not be allowed to change benefit Plan options unless your qualifying change in status event results in the loss of primary coverage for you. The permitted events upon which a change may be made are described below:

Family Status Changes. A change in coverage is allowed due to the following family status changes: a) change in your legal marital status due to death of a spouse, divorce, annulment or legal separation; b) death of a dependent; c) changes in employment status of you or your dependent at the time of your retirement resulting in eligibility or ineligibility for coverage; d) change in residence for you or your dependents where such change affects eligibility for coverage under the Plan; e) changes which cause a dependent to become eligible or ineligible for coverage; and f) termination of adoption proceedings.

Changes in coverage must pertain directly to the change in status and you must notify your SCANA Benefits team of your election to change coverage or enroll, and provide proof of the change in status event within 31 days of your change in status. Following timely notification and timely submission of election, your election would be effective as of the date of the change in status.

Special Enrollment Rights. If you and/or your dependents are entitled to special enrollment rights under the Plan, you may change your election to correspond with the special enrollment right. If you are eligible but deferred enrollment for coverage under the Plan, you or your dependent may enroll for coverage under the terms of the Plan if either of the following conditions are met: (a) you or your dependent is covered under a Medicaid plan or a state child health plan under the Children's Health Insurance Program ("CHIP") and coverage under the Medicaid or CHIP plan is terminated as a result of a loss of eligibility for such coverage, and you request coverage under this Plan no later than 60 days after termination of the Medicaid or CHIP coverage, or (b) you or your dependent become eligible for a premium assistance program (that could be used toward the Plan costs) under a Medicaid or state child health plan under CHIP and you request coverage under this Plan no later than 60 days after the date you or your dependent is determined to be eligible for the premium assistance.

Certain Judgments and Orders. If a judgment, decree, or order from a divorce, separation, annulment, or custody change requires you to cover your child under this Plan, you may change your election to provide coverage for the child. If the order requires that your former spouse cover the child under his or her plan, you may change your election to revoke coverage for the child. However, coverage for your spouse under this Plan is not allowed based on a judgment, decree, or order from a divorce, separation or annulment. Notwithstanding any judgment, decree, or order described above, changes to your election to cover an individual who was not your dependent at the time of your retirement from SCANA, or provide coverage after coverage has been waived are not allowed.

Entitlement to Medicare or Medicaid. If you or your dependent becomes entitled to Medicare or Medicaid, you may cancel that person's health coverage. Such a cancellation of coverage will be treated as a waiver of coverage under the Plan.

Significant Changes in Cost or Coverage. If there are significant increases in premiums or significant reductions of coverage, you may revoke your prior elections under this Plan and elect coverage under another Plan option with similar coverage, provided that you notify the SCANA Benefits team within 31 days of receiving written notice of the change.

Changes in Coverage Attributable to Spouse's Employment. If there is a significant change in your or your spouse's health coverage which is attributable to your spouse's employment, you may change your election under the Plan, provided that the change is on account of and consistent with the change in coverage, as determined by the Plan Administrator (in its sole discretion).

Minor Mid-Year Premium Increase. The amount of your premium payments under the Plan will be automatically increased to reflect any minor mid-year premium increases.

Prevention of Discrimination. To prevent the Plan from becoming discriminatory under the Internal Revenue Code, the Plan Administrator may modify your election(s) downward during the Plan year if you are a highly compensated individual.

OVERVIEW OF YOUR HEALTH CARE OPTIONS

This Plan includes health care options designed to help protect you and your family from financial loss due to health care problems. Your benefits also encourage cost-conscious health care choices and emphasize preventive care and healthy lifestyles. Below is an overview of each benefit and the options available:

If you are under age 65

- **Retiree Share plan**: After you meet your annual deductible, you will pay 20% of the allowable cost of medical services from in-network providers, until you reach your annual out-of-pocket maximum. Prescription drug benefit and vision benefit coinsurance or maximums do not count toward the Share Plan deductible, coinsurance or maximums. This is a self-insured plan option, administered by BlueCross BlueShield of South Carolina. See pages 10-39.

- **Health Reimbursement Account (HRA)**: An annual allowance that can be used to pay your premiums for non-SCANA third-party retiree medical plans, co-pays, deductibles, coinsurance and other eligible expenses. You will not be able to enroll in the Share plan option. See pages 40-43.

If you are age 65 or older

- **NEBCO Enhanced**: Medical and prescription drug coverage that coordinates with Medicare and helps pay some of the health care costs not covered by Medicare. You must be enrolled in Medicare Parts A and B. This is an insured benefit with coverage provided by Transamerica (medical coverage) and Sterling Life Insurance Company (prescription drug coverage). See pages 44-48.

- **Health Reimbursement Account (HRA)**: An annual allowance that can be used to pay your premiums for non-SCANA third-party medical plans, co-pays, deductibles, coinsurance and other eligible expenses. OneExchange administers the HRA. See pages 40-43.

Prescription Drug Benefits

Prescription drug benefits are automatic when you enroll in the Retiree Share plan or the NEBCO Enhanced plan. Retiree Share plan participants can use prescription benefits at the SCANA Pharmacy, retail pharmacies, Caremark Mail Order Pharmacy and Accredo Specialty Pharmacy. NEBCO participants can use any network pharmacy or Walgreens Mail Order pharmacy.

Vision Benefits

Vision benefits are also automatic when you enroll in the Retiree Share Plan. The vision benefit is administered by EyeMed Vision Care, which provides a nationwide network of providers. The vision benefit provides a free annual comprehensive eye exam and an allowance amount for most other services, lenses, contacts and frames through an in-network provider. Services through an out-of-network provider are generally reimbursed up to a fixed amount.

Dental Benefits

Dental Benefits are only available for retirees age 65 or older who retired from SCANA prior to January 1, 1994. These expenses do not integrate with or apply to medical benefits. The plan is fully insured and administered by Companion Life.

Tiers of Coverage

You may elect the appropriate coverage for your family needs:

- Retiree Only
- Retiree & Spouse
- Retiree & Children
- Family

Premiums

You and SCANA will share the cost of your coverage. You will be notified of the cost of your coverage at least annually. SCANA reserves the right to change the amount you pay for coverage each year. SCANA also reserves the right to charge appropriate surcharges and fees, in addition to your premium, for administering the plan.

If you do not provide your premium when it is due, you will receive an arrears notice after 30 days. After 60 days you will receive another arrears notice and your coverage will be suspended. After 90 days, your coverage will be terminated retroactively to the date your premium payment was first due. Failure to pay applicable premiums that results in a cancellation of coverage constitutes waiving of coverage and eligibility for future benefits ends.

Split Options (Only for retirees who retired after December 31, 1993)
If you elect NEBCO Enhanced, you and your eligible dependents may be able to split benefit options. Your eligible dependents under age 65 may be enrolled in the Retiree Share Plan option based on your dependent's age. Your spouse and dependent children must elect the same benefit option. No other split options are available. The cost of coverage for your eligible dependents will be at the retiree only (if only your spouse is covered) or retiree plus children rate.

Spousal Surcharge
If your spouse has active or retiree medical coverage available to him/her through his/her place of employment, a Spousal Surcharge will be required in addition to your normal premium if you elect to cover your spouse through SCANA's plan but your spouse declines coverage from his or her place of employment. Please contact the SCANA Benefits Team for more information if this may apply to you. **Providing false or misleading information related to this provision may result in loss of coverage under this Plan for you and your dependents retroactive to the date you provided the false or misleading information. You may also be required to repay any amounts paid by the Plan for you and your dependent(s) since you provided the false or misleading information, or if greater, the company and retiree share of the premium**.

RETIREE SHARE PLAN

BENEFIT RESOURCES

Online Resources
The BlueCross website at www.SouthCarolinaBlues.com provides:

- A **Provider Directory** updated nightly;
- A list of **Network Pharmacies** through Caremark;
- **My Health Toolkit**® where you can view the status of claims, how much has been applied toward your deductible and out-of-pocket expenses, authorization statuses, eligibility requirements, and order ID cards;
- You can use the **Ask Customer Service** feature to get a response from a BlueCross representative.

Telephone Resources

BlueCross BlueShield of SC Customer Service	877-705-5428
PPO Network Providers	800-810-2583
Precertification – Inpatient, Outpatient, Durable Medical Equipment	800-334-7287
Precertification – Outpatient MRIs, MRAs, CAT or PET Scans	866-500-7664
Mental Health, Substance Abuse, and EAP	800-790-5770
Health Management Programs	855-838-5897
EyeMed	866-723-0513
Caremark Mail Order Pharmacy	888-963-7290
Accredo Specialty Pharmacy	877-512-5981
SCANA Pharmacy	803-217-9173
SCANA Benefits Department and BlueCross Onsite Representatives	803-217-4444

Provider Access
You have access to in-network or out-of-network providers.

When using the "in-network" benefits:

- Your care is coordinated by your in-network physician or specialist (You do not need a referral to see a specialist. You may select a participating network specialist and receive in-network benefits);
- The Plan pays a more substantial portion of the cost for routine office visits, inpatient or outpatient surgery, and hospital expenses after the annual deductible has been met.
- There are no claim forms to file;
- If you need to be hospitalized, your in-network physician will handle the authorization request for your hospital stay;
- Preventive care is covered at 100% as defined by the United States Preventive Services Task Force (USPSTF), such as physical exams, routine mammograms, well-baby checkups, and immunizations.

If you or your dependents need medical care while away from home, you also have access to a national network of in-network providers through the BlueCross BlueShield BlueCard program.There are two easy ways to identify in-network providers. The directory of providers is located on the internet at www.SouthCarolinaBlues.com. You can also call the number on the back of your member ID card: 1-800-810-2583.

Unable to Locate an In-Network Provider
If there are no in-network providers within a 50-mile radius of your home, you can call the number on the back of your ID card to obtain authorization to use a particular out-of-network provider at the in-network level of benefits. The plan will pay 80% and you will pay 20% of billed charges, after you meet the in-network benefit year deductible. Billed charges will likely exceed the negotiated allowable charges from in-network providers.

The service(s) received may also require prior authorization. The out-of-network provider has no obligation to pre-authorize services you may receive. It is your responsibility to obtain authorization from BlueCross BlueShield for any services that require prior authorization.

MANAGING YOUR CARE

Prior Authorization. The term prior authorization means the approval that an in-network provider must receive from a review organization with which BlueCross has contracted prior to services being rendered, in order for certain services and benefits to be covered under this Plan. Services that require prior authorization include, but are not limited to:

- Inpatient hospital services
- Inpatient services at any other participating health care facility
- Outpatient facility services
- Advanced radiological imaging
- Transplant services
- Hospice service
- Durable medical equipment for purchases over $1,000
- Inpatient rehabilitation and habilitation services
- Inpatient and outpatient mental health services and substance abuse services (MHSA).

Inpatient Certification Requirements for Hospital Confinement. The certification process is designed to help ensure that recommended services are medically necessary before they are given. BlueCross has contracted with a review organization, staffed by registered nurses, licensed mental health and substance abuse professionals, and other trained staff members. The review organization performs the certification process in conjunction with consultant physicians.

The certification process occurs at two different points to support your care:

- Preadmission certification (PAC)
- Continued stay review (CSR)

These two reviews refer to the processes used to certify the medical necessity and length of a hospital stay when you require treatment in a hospital:

- As a registered bed patient;
- For a partial hospitalization for the treatment of mental health or substance abuse;
- For the treatment of substance abuse in a substance abuse intensive outpatient therapy program; and
- For mental health or substance abuse residential treatment services.

Inpatient Certification
Your physician (in-network only) is responsible for obtaining prior certification before any non-emergency admission to a hospital. Failure to do so will result in denial of room and board. If you need to stay in the hospital longer than originally certified, your physician should request a continued stay review.

If you use an out-of-network provider, you are responsible for making sure the prior certification is done. If you fail to obtain prior certification, you will incur a penalty of $500 that does not contribute to your deductible or out-of-pocket maximum.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this Plan, except for the "Coordination of Benefits" section.

Emergency Admissions. In the case of an emergency admission, contact the review organization within 24 hours after the admission.

Outpatient Certification Requirements. Outpatient certification refers to the process used to certify the medical necessity of outpatient diagnostic testing and some outpatient procedures, including, but not limited to, advanced radiological imaging (CAT scans, MRI, MRA or PET scans) sclerotherapy, septoplasty, any potentially cosmetic procedure, and hysterectomies performed in an outpatient, free-standing surgical facility, other health care facility or a physician's office. Outpatient certification is performed through a utilization review program by a review organization with which BlueCross has contracted. Outpatient certification should only be requested for non-emergency procedures or services, and should be requested by your physician (in-network provider only) prior to having the procedure performed or the service rendered.

Your physician should call the toll-free number on the back of your ID card to determine if outpatient certification is required prior to any outpatient diagnostic testing or procedures.

If you use an out-of-network provider, you are responsible for making sure you have the appropriate certifications. If you fail to obtain certification for outpatient treatment, no benefits are paid, unless it's medically necessary. You will incur a penalty of $500 that does not contribute to your deductible or out-of-pocket maximum.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this Plan, except for the "Coordination of Benefits" section.

Case Management. Case management is a service provided through the review organization, which assists you when treatment becomes extraordinarily complex, costly or difficult to manage. This is most often beyond short-term hospital care. The goal of case management is to ensure that you receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a hospital or specialized facility.

If you need case management, a professional will work closely with you and your physician to determine appropriate treatment options which will best meet your needs and help to keep costs manageable. The case manager will help coordinate the treatment program and arrange for necessary resources. Case managers are also available to answer questions and provide ongoing support for your family in times of medical crisis.

You, your dependent or an attending physician can request case management services by calling the toll-free care line number shown on the back of your ID card during normal business hours, Monday through Friday.

Coverage for Maternity Hospital Stay. Group health plans and health insurance issuers generally may not, under a federal law known as the "Newborns' and Mothers' Health Protection Act," restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of the above periods.The law generally does not stop an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable. Please review the rest of this SPD for further details on the specific coverage available to you.

Women's Health and Cancer Rights Act (WHCRA). The Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Call member services at the toll-free number listed on your ID card for more information.

MEDICAL HEALTH CARE OPTIONS – SCHEDULE OF BENEFITS

The benefits schedules that follow are brief outlines describing the benefits which may be payable under the Retiree Share Plan option offered under the Plan. For further detail on covered expenses, limitations and exclusions, refer to the appropriate sections of this summary plan description or contact BlueCross at 1-877-705-5428.

The medical benefit options provide coverage for care in-network and out-of-network. To receive medical benefits, you and your dependents may be required to pay a portion of the covered expenses for services and supplies. That portion is the deductible or coinsurance.

Deductibles
The amount you pay toward medical expenses each year before the plan starts paying benefits. Once the deductible maximum in the Schedule of Benefits has been reached, you and your family need not satisfy any further medical deductible for the rest of that year.

Coinsurance
The term coinsurance means the percentage of charges for covered expenses that you or your dependent is required to pay under the Plan, after you meet the deductible.

Out-of-Pocket Expenses
Out-of-pocket expenses are covered expenses incurred for in-network and out-of-network charges that are not paid by the benefit Plan because of any deductible and coinsurance.

When the out-of-pocket maximum shown in the Schedule of Benefits is reached, benefits are payable at 100% except for non-compliance penalties and provider charges in excess of the allowable charge.

Accumulation of Plan Deductibles and Out-of-Pocket Maximums
Expenses incurred for either in-network provider or out-of-network provider charges will be used to satisfy both the in-network provider deductibles and out-of-pocket maximums and the out-of-network provider deductibles and out-of-pocket maximums simultaneously, until the in-network provider deductibles and out-of-pocket maximums have been satisfied. However, only expenses incurred for out-of-network provider charges will be used to satisfy the remainder of the out-of-network provider deductibles and out-of-pocket maximums. All other plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between in- and out-of-network, unless otherwise noted.

Calendar Year
Your benefit maximums and limits accumulate on a calendar year basis.

RETIREE SHARE
SCHEDULE OF BENEFITS

Benefit Provision	In-Network	Out-of-Network
Deductible Individual/Family	$1,500 $3,000	$3,000 $6,000
Office Visits – *all types* Outpatient Care Inpatient Care	20% ***After deductible***	40% ***After deductible***
Emergency/ Urgent care/ Ambulance	20% ***After deductible***	
Annual Out-of-Pocket Maximum ***deductible & coinsurance***	$3,000 Single $6,000 Family	$6,000 Single $12,000 Family

- Allowable charges are paid at 100% after the out-of-pocket maximum is met.
- Covered expenses that are applied to the out-of-pocket maximum shall contribute to both the in-network and out-of-network provider out-of-pocket maximums.
- If the claim pays secondary, coinsurance and benefit year deductible amounts will accumulate toward the out-of-pocket maximum.

For all services listed below, received from **in-network providers**, SCANA pays 80% of the allowable charge after the benefit year deductible. **You pay the remaining 20%** of the allowable charge after meeting your benefit year deductible. For all services listed below, received from **out-of-network providers**, SCANA **pays 60%** of the allowable charge after the benefit year deductible. You pay the remaining 40% of the allowable charge after meeting your benefit year deductible. You must pay the balance of the provider's charges.

SCHEDULE OF BENEFITS (continued)

Hospital charges for room and board related to admissions	Preauthorization is required for hospital admission
All other benefits in a hospital during an admission (including for example, facility charges related to the administration of anesthesia, obstetrical services1 including labor and delivery rooms, drugs, medicine, lab and X-ray services)	
Inpatient physical rehabilitation services	Preauthorization is required
Skilled nursing, rehabilitation and sub-acute facility admissions	Preauthorization is required, limited to combined 120 days per participant per benefits year; No prior hospitalization required
Hospital and ambulatory surgical center charges for benefits provided on an outpatient basis, including: lab, X-ray and other diagnostic services	Preauthorization is required for outpatient surgery
Surgical services, when rendered in a physician's office	
Physician services in a hospital	
Physician services for treatment in a hospital outpatient department or ambulatory surgical center	
Services in the physician's office including contraceptives, contraceptive devices and family planning	Physician services in the participant's home
Second surgical opinion	
All other physician services	
Durable medical equipment, prosthetics and orthopedic devices	Preauthorization is required if purchase or rental of durable medical equipment is $1,000 or more
Medical supplies	
Maternity Care	Employee or spouse only; no dependents[1]
Advanced radiological imaging (*at all places of service*) MRI, MRA, CAT scans, PET scans,	Preauthorization is required
Radiation therapy, cancer chemotherapy, respiratory therapy	Preauthorization is required
Urgent care when not filed as emergency care	
Emergency room and urgent care filed as an emergency treated as in-network regardless of the provider status	
Hospice care, limited to 6 months per episode, including bereavement counseling	Preauthorization is required
Short term habilitation or rehabilitative therapy including cardiac rehabilitation, physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation and cognitive therapy	Limited to 60 visits combined per participant per benefit year; see "outpatient rehabilitation" in the covered expenses section
Home health care	Preauthorization is required; unlimited visits, 16 hours per day maximum
Allergy injections	
Chiropractic devices, including modalities and office visits	Limited to 12 visits per participant per benefit year
Oral Surgery including removal of impacted teeth	Preauthorization required only if performed in an outpatient surgery center, not physician's office. In and out-of-network benefits apply
Temporomandibular Joint Disorder (TMJ) including treatment, excluding appliances and orthodontic treatment	Preauthorization is required for surgical and non- surgical and subject to medical necessity
Orthognathic surgery	Preauthorization is required
Treatment of morbid obesity including surgical procedures and bariatric surgery office visits[2]	See "Bariatric Exclusions" in the exclusions section of the Plan, page 26
Routine foot care/podiatry[3]	
Inpatient hospital charges for mental health services and substance abuse services	Preauthorization is required

Outpatient hospital or clinic charges for mental health services and substance abuse services	Preauthorization is required
Inpatient physician charges for mental health services and substance abuse services	Preauthorization is required
Outpatient physician charges for mental health services and substance abuse services	Preauthorization is required
Residential treatment center and services	Preauthorization is required
Office physician charges for mental health services and substance abuse services	Preauthorization is required

[1] No maternity or obstetrical services or supplies are covered for a participant who is a dependent child, except for life-threatening pregnancy complications to either the mother or fetus. BlueCross provides medical review to determine what constitutes a "life threatening" complication. An elective abortion is not considered to be a complication of pregnancy.

[2] Treatment of clinically severe obesity as defined by body mass index (BMI) is covered only at approved Blue Distinction Centers through the precertification process.

[3] Only covered in the case of diabetes or peripheral vascular disease, when medically necessary.

Important notes about preauthorization:

- In-network providers are required to precertify all hospital admissions, outpatient surgical procedures, some radiological imaging, and durable medical equipment (DME) that exceeds $1,000. In-network providers incur a penalty for non-emergency services that are not precertified.
- If you use an out-of-network provider, precertification is your responsibility, and you are responsible for paying the penalty if you fail to precertify.

For more information about precertification /preauthorization, see pages 8-9.

HUMAN ORGAN AND TISSUE TRANSPLANT SERVICES (EXCLUDING DRUGS)

Blue Distinction Center of Excellence	Transplants performed by a Blue Distinction Center of Excellence are covered at 100% after the benefit year deductible is met.	
In-Network Provider	SCANA pays 80% of the allowable charge after the benefit year deductible You pay the remaining 20% of the allowable charge after meeting the benefit year deductible	
Out-of-Network Provider	SCANA pays 60% of the allowable charge after the benefit year deductible, up to the per transplant lifetime maximum below:	
	Bone Marrow	$130,000
	Heart	$150,000
	Heart/Lung	$185,000
	Lung	$185,000
	Liver	$230,000
	Pancreas	$ 50,000
	Pancreas/Kidney	$ 80,000
	Kidney	$ 80,000

PREVENTIVE BENEFITS

The services below are covered at 100% when received from an in-network provider.

The benefit year deductible and applicable coinsurance does apply when services are received from out-of-network providers.

Preventive Benefits:

- Routine annual benefits rely on the United States Preventive Services Task Force guidelines for age limits. They include: immunizations, routine screening mammogram, PSA, Pap smear, colonoscopies and associated wellness exam.

- Specific laboratory tests and X-rays are covered at 100% if billed by physician's office or by any separate provider or facility in conjunction with a wellness exam.

- A diagnosis indicating family history will allow preventive screenings to be paid at 100%, regardless of age.

Contraceptives and Contraceptive Devices:

- Contraceptives: generic oral contraceptives, generic injections, Mirena IUD, Nexplanon implant, Ortho Evra Patch, Nuvaring, Ortho Flex, Ortho Coil, Ortho Flat, Wide-seal, Omniflex, Prentif and Femcap-vaginal - covered under the medical or pharmacy benefits at no cost to the member.

- All non-generic contraceptives are paid at the preferred brand and non-preferred brand drug payment levels, unless a generic contraceptive is unavailable.

Preventive Generic Medication – SCANA Pharmacy Only

- A defined list of generic medications are available at no cost to the employee through the SCANA Pharmacy. The list includes medications for the treatment of high blood pressure, high cholesterol, heart disease, diabetes, asthma, COPD, osteoporosis and prenatal vitamins. A complete list can be obtained by calling the SCANA Pharmacy at 803-217-9173

COVERED EXPENSES

Expenses incurred for services listed below are considered covered expenses if the services or supplies provided are recommended by a physician and are medically necessary for the care and treatment of an injury or a sickness, as determined by BlueCross. Any applicable deductibles or limits are shown in the Schedule of Benefits.

ALLERGY INJECTIONS

The Plan will pay covered expenses for allergy injections as set forth below:

1. For patients with demonstrated hypersensitivity that cannot be managed by medications or avoidance; and,

2. To ensure the potency and efficacy of the antigens, the provision of multiple dose vials is restricted to sufficient antigen for the lesser of a twelve (12) week or twenty-four (24) week dose; and,

3. When any of the following conditions are met:
    a. The patient has symptoms of allergic rhinitis and/or asthma after natural exposure to the allergen; or,

    b. The patient has a life-threatening allergy to insect stings or food; or,

    c. The patient has a skin test and/or serologic evidence of a potent extract of the antigen; or,

    d. Avoidance or pharmacological (drug) therapy cannot control allergic symptoms.

AMBULANCE

The Plan will pay covered expenses for ambulance transportation (including air ambulance when necessary) when used:

1. Locally to or from a hospital providing medically necessary services in connection with an accidental injury or as the result of an emergency medical condition; and,

2. To or from a hospital in connection with an admission.

BARIATRIC SURGERY OFFICE VISIT

The Plan will pay covered expenses for bariatric surgery office visit as set forth on the Schedule of Benefits.

CHIROPRACTIC SERVICES
The Plan will pay covered expenses for services and medical supplies required in connection with the detection and correction, by manual or mechanical means, of structural imbalance, distortion, or subluxation in the human body, for purposes of removing nerve interference and the effects of such nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

CLEFT LIP OR PALATE
The Plan will pay covered expenses for the care and treatment of a congenital cleft lip or palate, or both, and any physical condition or illness that is related to or developed as a result of a cleft lip or palate.

Benefits shall include, but not be limited to:

1. Oral and facial surgical services, surgical management and follow-up care; and

2. Prosthetic device treatment such as obturators, speech appliances and feeding appliances; and

3. Orthodontic treatment and management; and

4. Prosthodontia treatment and management; and

5. Otolaryngology treatment and management; and

6. Audiological assessment, treatment, and management, including surgically implanted amplification devices; and

7. Physical therapy assessment and treatment.

Benefits for a cleft lip or palate must be preauthorized. If a participant with a cleft lip or palate is covered by a dental policy, then teeth capping, prosthodontics, and orthodontics shall be covered by the dental policy to the limit of coverage provided under such dental policy prior to coverage under this Plan. Covered expenses for any excess medical expenses after coverage under any dental policy is exhausted shall be provided as for any other condition or illness under the terms and conditions of this Plan.

CLINICAL TRIALS
The Plan will pay for routine member costs for items and services related to approved clinical trials when:

1. The member has cancer or other life-threatening disease or condition as determined by BlueCross; and

2. The referring provider is a participating provider that has concluded that the member's participation in such trial would be appropriate, or the member provides medical and scientific information establishing that the member's participation in such trial would be appropriate; and

3. The services are furnished in connection with an approved clinical trial.

An approved clinical trial is one that is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition approved or funded through the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHRQ), the Centers for Medicare & Medicaid services (CMS), the Department of Defense (DOD), the Department of Veterans Affairs (VA), a qualified non- governmental research entity identified in the guidelines issued by the NIH or is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA).

Routine member costs for purposes of an approved clinical trial include items and services typically provided under the plan for a participant not enrolled in a clinical trial. However, such items and services do not include (a) the investigational item, device or service itself; (b) items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis; or (c) a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

DENTAL CARE FOR ACCIDENTAL INJURY
The Plan will pay covered expenses for dental services to natural teeth required because of accidental injury. For purposes of this section, an accidental injury is defined as an injury caused by a traumatic force, such as a car accident or a blow by a moving object. No covered expenses will be paid for injuries that occur while you are in the act of chewing or biting. Services for conditions that are not directly related to the accidental injury are not covered. The first visit to a dentist does not require preauthorization; however, the dentist must submit a plan for any future treatment to BlueCross for review and preauthorization before such treatment is rendered if covered expenses are to be paid. Benefits are limited to treatment for only one (1) year from the date of the accidental injury.

DIABETES EDUCATION
The Plan will pay covered expenses for outpatient self-management training and education for participants with diabetes mellitus provided that such training and educational benefits are rendered by a provider whose program is recognized by the American Diabetes Association.

DISEASE MANAGEMENT PROGRAM (HEALTH MANAGEMENT)
The Plan will offer participants who have an appropriate diagnosis the option to participate in the Plan Disease Management Program. A participant's participation in the Disease Management Program is voluntary.

DURABLE MEDICAL EQUIPMENT
The Plan will pay covered expenses for durable medical equipment. The Plan will decide (in its sole discretion) whether to buy or rent equipment and whether to repair or replace damaged or worn durable medical equipment. The Plan will not pay covered expenses for durable medical equipment that is solely used by a participant in a hospital or that the Plan determines (in its sole discretion) is included in any hospital room charge. Many items are rented for a few months and re-evaluated for effectiveness and medical necessity. The purchase price of the equipment typically equals ten months of rental.

EMERGENCY MEDICAL CARE
The Plan will pay covered expenses for care that is necessary as a result of an emergency medical condition.

HEALTH CARE HOTLINE
The Plan will provide participants with access to a health care hotline to answer your health-care-related questions.

HEMOPHILIA SERVICE
Must have care coordinated through a designated hemophilia treatment center at least once per benefit year or coverage of services for treatment of hemophilia will be reduced to 50%.

HOME HEALTH CARE
The Plan will pay covered expenses for preauthorized home health care when rendered to a homebound participant in the participant's current place of residence.

HOSPICE CARE
The Plan will pay covered expenses for preauthorized hospice care provided in an outpatient setting, including bereavement counseling.

HOSPITAL SERVICES
The Plan will pay covered expenses for admissions as follows:

1. Semi-private room, board, and general nursing care; and,

2. Private room, at semi-private rate as determined by the Plan; and,

3. Services performed in a special care unit when it is medically necessary that such services be performed in such unit rather than in another portion of the hospital; and,

4. Ancillary services and medical supplies, including services performed in operating, recovery and delivery rooms; and,

5. Diagnostic services, including interpretation of radiological and laboratory examinations, electrocardiograms, and electroencephalograms; and,

Benefits for admissions are subject to the requirements for preadmission review, emergency admission review, and continued stay review.

The day on which a participant leaves a hospital, with or without permission, is treated as a day of discharge and will not be counted as a day of admission, unless such participant returns to the hospital by midnight of the same day. The day a participant enters a hospital is treated as a day of admission. The days during which a participant is not physically present for inpatient care are not counted as admission days.

HUMAN ORGAN AND TISSUE TRANSPLANTS
1. The Plan will pay covered expenses for certain preauthorized human organ and tissue transplants. To be covered, such transplants must be provided from a human donor to a participant, and provided at a transplant center approved by SCANA's group health Plan. Covered expenses shall only be provided for the human organ and tissue transplants in the amounts set forth on the Schedule of Benefits.

2. The payment of covered expenses for living donor transplants will be subject to the following conditions:

   a. When both the transplant recipient and the donor are participants, covered expenses will be paid for both.

   b. When the transplant recipient is a participant and the donor is not, covered expenses will be paid for both the recipient and the donor to the extent that covered expenses to the donor are not provided by any other source.

   c. When the donor is a participant and the transplant recipient is not, no covered expenses will be paid to either the donor or the recipient.

3. Benefits for human organ and tissue transplants are subject to the benefit year deductible amount and will be provided according to the percentage and/or dollar maximum specified on the Schedule of Benefits.

4. Human organ and tissue transplant coverage includes expenses incurred for legal donor organ and tissue procurement and all inpatient and outpatient hospital and medical expenses for the transplant procedure and related preoperative and postoperative care, including immunosuppressive drug therapy and air ambulance expenses.

5. Transplants of tissue as set forth below (rather than whole major organs) are benefits under the Plan, subject to all of the provisions of the Plan as follows:

   a. Blood transfusions; and,

   b. Autologous parathyroid transplants; and,

   c. Corneal transplants; and,

   d. Bone and cartilage grafting; and,

   e. Skin grafting.

IMPACTED TOOTH REMOVAL
The Plan will pay covered expenses for services and medical supplies for the removal of impacted teeth.

IN-HOSPITAL MEDICAL SERVICE
The Plan will pay covered expenses for physician's visits to a participant during a medically necessary admission for treatment of a condition other than that for which surgical service or obstetrical service is required as follows:

1. In-hospital medical benefits primarily for mental health services and substance abuse services; and,

2. In-hospital medical benefits in a skilled nursing facility will be provided for visits of a physician, limited to one visit per day, not to exceed the number of visits set forth on the Schedule of Benefits.

3. Where two (2) or more physicians render in-hospital medical visits on the same day, payment for such services will be made only to one (1) physician.

4. Concurrent medical and surgical benefits for in-hospital medical services are only provided:

   a. When the condition for which in-hospital medical services requires medical care not related to surgical services or obstetrical service and does not constitute a part of the usual, necessary, and related preoperative or postoperative care, but requires supplemental skills not possessed by the attending surgeon or his/her assistant; and,

   b. When the surgical procedure performed is designated by the employer's group health plan as a warranted diagnostic procedure or as a minor surgical procedure.

5. When the same physician renders different levels of care on the same day, benefits will only be provided for the highest level of care.

INFERTILITY
Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed, and for initial testing performed specifically to determine the cause of infertility.

MAMMOGRAPHY TESTING
The Plan will pay 100% for one (1) screening mammography test per benefit year regardless of medical necessity for female participants who are within the appropriate age guidelines. The Plan will pay covered expenses for additional mammograms during a benefit year based on medical necessity.

MEDICAL SUPPLIES
The Plan will pay covered expenses for medical supplies, provided that the supplies are not covered by some other benefit.

MENTAL HEALTH SERVICES
The Plan will pay covered expenses for the inpatient and outpatient treatment for mental health services.

OBESITY RELATED PROCEDURES
The plan will pay covered expenses for the treatment of clinically severe obesity as defined by the body mass index (BMI). Covered only at approved Blue Distinction Centers through the precertification process.

OBSTETRICAL SERVICES
The Plan will pay covered expenses for preauthorized obstetrical services. Notwithstanding the preceding sentence, no maternity or obstetrical services or supplies are covered for a participant who is a dependent child, except for life-threatening pregnancy complications to either the mother or fetus. BlueCross provides medical review to determine what constitutes a "life-threatening" complication. An elective abortion is not considered to be a complication of pregnancy.

Midwives licensed and practicing in compliance with the Nurse Practices Act in a hospital will be covered under this benefit.

Under the terms of the Newborn and Mother's Health Act of 1996, the corporation generally may not restrict covered expenses for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery (not including the day of delivery), or less than ninety-six (96) hours following a cesarean section (not including the day of surgery). Nothing in this paragraph prohibits the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the specified time frames or from requesting additional time for hospitalization. In any case, the corporation may not require that a provider obtain authorization from the corporation for prescribing a length of stay not in excess of forty-eight (48) or ninety-six (96) hours as applicable. However, preauthorization is required to use certain providers or facilities, or to reduce out-of-pocket costs.

ORAL SURGERY
Charges for care of the mouth, teeth, gum and alveolar processes will be covered under your medical benefits only if that care is for the following procedures:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of mouth.
- Emergency repair due to injury to sound, natural teeth made within 12 months from the date of an accident.
- Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of mouth done within 12 months from the date of an accident.
- Excision of benign bony growths of the jaw and hard palate.
- External excision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands or ducts.
- Extraction of impacted wisdom teeth.
- Dental implants as a result of an accidental injury to sound, natural teeth as long as treatment for the injury began within 12 months of the accident.

ORTHOGNATHIC SURGERY
The Plan will pay covered expenses for any service related to the treatment of malpositions or deformities of the jaw bone(s), dysfunction of the muscles of mastication, or orthognathic deformities.

ORTHOPEDIC DEVICES
The Plan will pay covered expenses for preauthorized orthopedic devices.

ORTHOTIC DEVICES
The Plan will pay covered expenses for preauthorized orthotic devices that are not available on an over-the-counter basis.

OUTPATIENT HOSPITAL AND AMBULATORY SURGICAL CENTER SERVICES
The Plan will pay covered expenses for surgical services and diagnostic services, including radiological examinations, laboratory tests, and machine tests, performed in an outpatient hospital setting or an ambulatory surgical center. Preauthorization is required.

OUTPATIENT REHABILITATION SERVICES
The Plan will pay covered expenses, subject to the following paragraph, for physical therapy, occupational therapy, speech therapy and rehabilitation services as set forth on the Schedule of Benefits.

Covered expenses for outpatient rehabilitation services will be paid only following an acute incident involving disease, trauma or surgery that requires such care.

OXYGEN
The Plan will pay covered expenses for preauthorized oxygen. Durable medical equipment for oxygen use in a participant's home is covered under the durable medical equipment benefit.

PAP SMEAR
The Plan will pay covered expenses for a single pap smear as part of the annual gynecological examination benefit, regardless of medical necessity. The Plan will pay covered expenses for additional pap smears during a benefit year based on medical necessity.

PHYSICAL EXAMINATION
The Plan will pay covered expenses for a single annual physical examination each benefit year for participants who are within the appropriate age guidelines, regardless of medical necessity.

PHYSICIAN SERVICES
The Plan will pay covered expenses for physician services provided that when different levels of physician services are provided on the same day, covered expenses for such benefits will only be paid for the highest level of physician services.

PRESCRIPTION DRUGS

1. The Plan will pay covered expenses for prescription drugs (as specified on the Schedule of Benefits) that are used to treat a condition for which benefits are otherwise available. Any coinsurance percentage for prescription drugs is based on the allowable charge at the in-network pharmacy, and does not change due to receipt of any credits by the Plan. Copayments likewise do not change due to receipt of any credits by the health Plan.

2. Insulin shall be treated as a prescription drug whether injectable or otherwise.

3. The Plan may, in its sole discretion, place quantity limits on prescription drugs.

4. Over-the-counter medications used in compound drugs are covered, and the liquid version of Zantac, at the appropriate drug tier.

PREVENTIVE SERVICES
The Plan will pay for the following preventive health services:

1. Evidence-based services that have a rating of A or B in the current United States Preventive Services Task Force (USPSTF) recommendations;

2. Immunizations as recommended by the Centers for Disease Control and Prevention (CDC); and

3. Preventive care and screenings for children and women as recommended by the Health Resources and Services Administration (HRSA).

These benefits are provided without any cost-sharing by the participant when the services are provided by an in-network provider. Any other covered preventive screenings will be provided as specified in the Schedule of Benefits.

PROSTATE EXAMINATION
The Plan will pay covered expenses for one (1) prostate examination per benefit year, regardless of medical necessity, as set forth in the schedule of benefits for participants that are within the appropriate age guidelines. The Plan will pay covered expenses for additional prostate examinations during a benefit year based on medical necessity.

PROSTHETIC DEVICES
The Plan will only pay covered expenses for a prosthetic device, other than a dental or cranial prosthetic, which is a replacement for a body part and which meets minimum specifications for the body part it is replacing regardless of the functional activity level. Coverage is provided for the cost of the standard, non-luxury item only (as determined by the Plan). Components that are considered deluxe or upgraded over a standard model are not a covered service. Except as provided below, benefits are provided for only the initial temporary prosthesis and one (1) permanent prosthesis. No benefits are provided for repair, replacement or duplicates, nor are benefits provided for services related to the repair or replacement of such prosthetics except when necessary due to a change in the member's medical condition, and with prior authorization from the corporation.

Prosthetic devices do not include bioelectric, microprocessor or computer programmed prosthetic components.

RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES
In the case of a participant who is receiving covered expenses in connection with a mastectomy, the Plan will pay covered expenses for preauthorized services for each of the following (if requested by such participant):

1. Reconstruction of the breast on which the mastectomy has been performed; and

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prosthetic devices and physical complications at all stages of the mastectomy, including lymphedema.

REHABILITATION
The Plan will pay covered expenses for participation in a multidisciplinary team rehabilitation program only following severe neurologic or physical impairment as specified on the Schedule of Benefits if the following criteria are met:

1. All such treatment must be ordered by a medical doctor; and

2. All such treatment requires preauthorization and must be performed by a provider and at a location designated by the Plan; and

3. The documentation that accompanies a request for rehabilitation benefits must contain a detailed participant evaluation from a medical doctor that documents that to a degree of medical certainty the participant has rehabilitation potential such that there is an expectation that the participant will achieve an ability to provide self care and perform activities of daily living; and

4. All such rehabilitation benefits are subject to periodic review by the Plan.

After the initial rehabilitation period, continuation of rehabilitation benefits will require documentation that the participant is making substantial progress and that there continues to be significant potential for the achievement of the established rehabilitation goals.

RESIDENTIAL TREATMENT CENTER AND SERVICES
The Plan will pay covered expenses for residential treatment center and services as set forth on the Schedule of Benefits.

ROUTINE FOOT CARE/PODIATRY
The Plan will pay covered expenses for routine foot care/podiatry as set forth on the Schedule of Benefits.

SHORT TERM HABILITATION AND REHABILITATIVE THERAPY
The Plan will pay covered expenses for therapy as set forth on the Schedule of Benefits. Therapy days provided as part of home health care accumulate to the therapy maximum.

SKILLED NURSING FACILITY SERVICES
The Plan will pay covered expenses for admissions in a skilled nursing facility as follows:

1. Semi-private room, board, and general nursing care;

2. Private room, at semi-private rate as determined by the Plan;

3. Services performed in a special care unit when it is medically necessary that such services be performed in such unit;

4. Ancillary services and medical supplies including services performed in operating, recovery and delivery rooms;

5. Diagnostic services including interpretation of radiological and laboratory examinations, electrocardiograms, and electroencephalograms;

Benefits for admissions are subject to the requirements for preadmission review, emergency admission review, and continued stay review. The day on which a participant leaves a skilled nursing facility, with or without permission, is treated as a day of discharge and will not be counted as a day of admission, unless such participant returns to the skilled nursing facility by midnight of the same day. The day a participant enters a skilled nursing facility is treated as a day of admission. The days during which a participant is not physically present for inpatient care are not counted as admission days.

SPECIALTY DRUGS

The Plan will pay covered expenses for specialty drugs through Accredo Specialty Pharmacy. Covered expenses for specialty drugs dispensed to a participant shall not exceed the quantity and benefits maximum set by the Plan. Specialty drugs may be considered medical benefits. For any specialty drugs paid as medical benefits the benefits year deductible, out-of-pocket maximum and/or benefits maximum will apply. The participant may obtain a list of specialty drugs by contacting the Plan at the number listed on the ID card or at www.SouthCarolinaBlues.com.

Any coinsurance percentage for specialty drugs is based on the allowable charge at the in-network pharmacy and does not change due to receipt of any credits by the Plan. Copayments likewise do not change due to receipt of any credits by the Plan. Specialty drugs are not available at the SCANA Pharmacy.

SUBSTANCE ABUSE SERVICES

The Plan will pay covered expenses for substance abuse services as set forth on the Schedule of Benefits.

SURGICAL SERVICES

The Plan will pay covered expenses for surgical services performed by a medical doctor or oral surgeon for treatment and diagnosis of disease or injury or for obstetrical services, as follows:

1. Surgical services, subject to the following:

   a. If two (2) or more operations or procedures are performed at the same time, through the same surgical opening or by the same surgical approach, the total amount covered for such operations or procedures will be the allowable charge for the major procedure only.

   b. If two (2) or more operations or procedures are performed at the same time, through different surgical openings or by different surgical approaches, the total amount covered will be the allowable charge for the operation or procedure bearing the highest allowable charge, plus one-half of allowable charge for all other operations or procedures performed.

   c. If an operation consists of the excision of multiple skin lesions, the total amount covered will be the allowable charge for the procedure bearing the highest allowable charge, fifty (50%) percent for the procedure bearing the second and third highest allowable charges, twenty-five (25%) percent for the procedures bearing the fourth through the eighth highest allowable charges, and, ten (10%) percent for all other procedures. Provided, however, if the operation consists of the excision of multiple malignant lesions, the total amount covered will be the allowable charge for the procedure bearing the highest allowable charge, and fifty (50%) percent of the charge for each subsequent procedure.

   d. If an operation or procedure is performed in two (2) or more steps or stages, coverage for the entire operation or procedure will be limited to the allowable charge set forth for such operation or procedure.

   e. If two (2) or more medical doctors or oral surgeons perform operations or procedures in conjunction with one another, other than as an assistant surgeon or anesthesiologist, the allowable charge, subject to the above paragraphs, will be coverage for the services of only one (1) medical doctor or oral surgeon (as applicable) or will be prorated between them by the Plan when so requested by the medical doctor or oral surgeon in charge of the case.

   f. Certain surgical procedures are designated as separate procedures by the Plan, and the allowable charge is payable when such procedure is performed as a separate and single entity; however, when a separate procedure is performed as an integral part of another surgical procedure, the total amount covered will be the allowable charge for the major procedure only.

2. Surgical assistant services, that consist of the medically necessary service of one (1) medical doctor or oral surgeon who actively assists the operating surgeon when a covered surgical service is performed in a hospital, and when such surgical assistant service is not available by

an intern, resident, physician's assistant or in-house physician. The Plan will pay charges at the percentage of the allowable charge set forth on the Schedule of Benefits for the surgical service, not to exceed the medical doctor's or oral surgeon's (as applicable) actual charge.

3. Anesthesia services that consists of services rendered by a medical doctor, oral surgeon or a certified registered nurse anesthetist, other than the attending surgeon or his or her assistant, and includes the administration of spinal or rectal anesthesia, or a drug or other anesthetic agent by injection or inhalation, except by local infiltration, the purpose and effect of which administration is the obtaining of muscular relaxation, loss of sensation, or loss of consciousness. Additional benefits will not be provided for preoperative anesthesia consultation.

TELEMEDICINE
The plan will pay covered expenses for telemedicine consultation when the following exist. The use of medical information about a patient is exchanged from one eligible referring provider ("Referring Physician") site to another eligible consulting provider site ("Consulting Physician") via two-way, real-time, interactive, secured and HIPAA compliant, electronic audio and video telecommunications systems to provide medical care to a patient in circumstances in which in person, face-to-face contact with the consulting physician is not necessary. Telemedicine includes consultation, diagnostic, and treatment services. Telemedicine is not an expansion of covered services but an option for delivery of certain covered services. Such a service delivery option can, in some cases, provide increased access to specialists, better continuity of care, and elimination of the hardship of traveling extended distances. Quality of health care delivery must be maintained, regardless of the mode of delivery. A referring physician must have determined that medical care can be provided via electronic communication with no loss in the quality or efficacy of the care.

TEMPOROMANDIBULAR JOINT (TMJ) DISORDER
The Plan will pay covered expenses for any service for the treatment of dysfunctions or derangements of the temporomandibular joint, including orthognathic surgery for the treatment of dysfunctions or derangements of the temporomandibular joint.

TOBACCO CESSATION TREATMENT
The Plan will pay covered expenses for tobacco cessation treatment as described in the Wellness Programs section of the Plan.

URGENT CARE
The Plan will pay covered expenses for urgent care as set forth on the Schedule of Benefits.

EXCLUSIONS AND LIMITATIONS

REGARDLESS OF LANGUAGE CONTAINED ELSEWHERE IN THIS PLAN OF BENEFITS, THE FOLLOWING ARE NOT BENEFITS UNDER THIS PLAN OF BENEFITS. THE ONLY EXCEPTIONS TO THIS ARE AS FOLLOWS: (1) WHERE SUCH ITEMS ARE SPECIFICALLY INCLUDED (UP TO THE CORRESPONDING DOLLAR AMOUNT AND/OR COVERAGE PERCENTAGE) IN THE SCHEDULE OF BENEFITS OR IN ARTICLE III-BENEFITS, (2) SERVICES RENDERED BY A HEALTH CARE PROVIDER AS PART OF A PHYSICIAN INCENTIVE PROGRAM (E.G. PATIENT-CENTERED MEDICAL HOME PROGRAM), AN ACCOUNTABLE CARE ORGANIZATION OR EPISODE-BASED ARRANGEMENT OR (3) AS THE LAW REQUIRES (I.E. INTENTIONAL OR UNREASONABLE INJURIES OR ILLNESSES THAT RESULT FROM MEDICAL CONDITIONS OR DOMESTIC VIOLENCE). SUBJECT TO THE ABOVE-LISTED EXCEPTIONS, THE EMPLOYER'S GROUP HEALTH PLAN WILL NOT PAY ANY AMOUNT FOR THE FOLLOWING:

ACUPUNCTURE
Acupuncture treatment or services.

ACTS OF WAR
Illness contracted or injury sustained as a result of a participant's participation as a combatant in a declared or undeclared war, or any act of war, or while in military service.

ADMISSIONS THAT ARE NOT PREAUTHORIZED
If Preauthorization is not received for an otherwise covered expense related to an admission, penalties will be applied (up to and including denial of the covered expenses) as set forth on the Schedule of Benefits.

BARIATRIC EXCLUSIONS
Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity, unless medically necessary.

Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.

BEHAVIORAL, EDUCATIONAL OR ALTERNATE THERAPY PROGRAMS
Any behavioral, educational or alternative therapy techniques to target cognition, behavior, language and social skills modification, including:

1. Animal assisted therapy

2. Applied behavioral analysis therapy
3. Developmental Individual-Difference Relationship-based model (DIR)
4. Facilitated communication
5. Floor time
6. Higashi schools/daily life
7. Holding therapy
8. Movement therapies
9. Music therapy
10. Relationship Development Intervention (RDI)
11. Teaching, Expanding, Appreciating, Collaborating and Holistic (TEACCH) programs

BENEFITS PROVIDED BY STATE OR FEDERAL PROGRAMS
Any service or charge for a service to the extent that the participant is entitled to payment or benefits relating to such service under any state or federal program that provides health care benefits, including Medicare, but only to the extent that benefits are paid or are payable under such programs.

BENEFITS PROVIDED UNDER ANY LAW
Any service or charge for a service to the extent a participant is entitled to receive payment or benefits pursuant to any local, state or federal law. This exclusion applies whether or not the participant has applied for or received payment for the service. This exclusion includes, but is not limited to, benefits provided by the Veterans Administration for a service-related disability, or any state or federal hospital services for which the participant is not legally obligated to pay.

BIO-FEEDBACK SERVICES
Bio-feedback when related to psychological services.

COMPLICATIONS FROM FAILURE TO COMPLETE TREATMENT
Complications that occur because a participant did not follow the course of treatment prescribed by a provider, including complications that occur because a participant left a hospital against medical advice.

COMPLICATIONS FROM NON-COVERED SERVICES
Complications arising from a participant's receipt or use of either services or medical supplies or other treatment that are not benefits, including complications arising from a participant's use of discount services.

COPYING CHARGES
Fees for copying or production of medical records and/or claims filing.

COSMETIC SERVICES

1. This Plan of benefits excludes cosmetic or reconstructive procedures, and any related services or medical supplies, which alter appearance but do not restore or improve impaired physical function. Examples of services that are cosmetic and are not covered are:

    a. Rhinoplasty (nose);

    b. Mentoplasty (chin);

    c. Rhytidoplasty (face lift);

    d. Glabellar rhytidoplasty (forehead lift);

e. Surgical planing (dermabrasion);

f. Blepharoplasty (eyelid);

g. Mammoplasty (reduction, suspension or augmentation of the breast);

h. Superficial chemosurgery (chemical peel of the face); and,

i. Rhytidectomy (abdomen, legs, hips, buttocks, or elsewhere including lipectomy or adipectomy).

2. A cosmetic service may, under certain circumstances, be considered restorative in nature. In order for benefits to be available for such restorative surgery, the following requirements must be met:

   a. The service must be necessary to correct a loss of physical function or alleviate significant pain; or,

   b. The service must be necessary due to a malappearance or deformity that was caused by physical trauma, surgery or congenital anomaly; and,

   c. The proposed surgery or treatment must be preauthorized.

CUSTODIAL OR LONG-TERM CARE SERVICES
Admissions, or portions thereof, for custodial care or long-term care, including:

1. Rest care;

2. Long-term acute or chronic psychiatric care;

3. Care to assist a participant in the performance of activities of daily living (including, but not limited to: walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation, and taking medication);

4. Care in a sanitarium;

5. Custodial or long-term care; or,

6. Psychiatric or substance abuse residential treatment, including: residential treatment centers, therapeutic schools, wilderness/boot camps, therapeutic boarding homes, half-way houses, and therapeutic group homes.

DENTAL SERVICES
Any dental procedures involving tooth structures, excision or extraction of teeth, gingival tissue, alveolar process, dental X-rays, preparation of mouth for dentures, or other procedures of dental origin. However, that such procedures may be preauthorized if the need for dental services results from an accidental injury within one (1) year prior to the date of such services and the participant is not covered by other health or dental insurance.

DISCOUNT SERVICES
Any charges that result from the use of discount services, including charges related to any injury or illness that results from a participant's use of discount services. Discount services are not covered under the Plan of benefits, and participants must pay for discounted services.

EYEGLASSES
Eyeglasses or contact lenses of any type, even though dispensed by a prescription (except after cataract surgery).

FOOD SUPPLEMENTS
Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, orthomolecular therapy including infant formula, nutrients, vitamins and food supplements. Enteral feedings when not a sole source of nutrition.

GROWTH HORMONE THERAPY
Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, growth hormone therapy for patients over 18 years of age. Growth hormone therapy for patients 18 years of age or younger is excluded unless for documented growth hormone deficiency.

HEARING AIDS
Hearing aids or examinations for the prescription or fitting of hearing aids.

HUMAN ORGAN AND TISSUE TRANSPLANTS
Human organ and tissue transplants that are not:

1. Preauthorized; or,

2. Performed by a provider as designated by the corporation; or,

3. Listed as a covered transplant on the Schedule of Benefits.

IMPOTENCE
Services or supplies related to any treatment for impotence, unless deemed medically necessary through the precertification process.

INCAPACITATED DEPENDENTS
Any service, supply or charge for an incapacitated dependent that is not enrolled by the maximum dependent child age listed on the schedule of benefits.

INJURY OR ILLNESS RESULTING FROM CRIMINAL ACTIVITY
Illness contracted or injury sustained as a result of a riot or insurrection, or while engaged in the commission of a felony or an illegal occupation.

INPATIENT DIAGNOSTIC AND EVALUATIVE PROCEDURES
Inpatient care and related physician services rendered in conjunction with an admission, which is principally for diagnostic studies or evaluative procedures that could have been performed on an outpatient basis are not covered unless the participant's medical condition alone required admission.

INVESTIGATIONAL OR EXPERIMENTAL SERVICES
Services or supplies or drugs that are investigational or experimental.

LIFESTYLE IMPROVEMENT SERVICES
Services or supplies relating to lifestyle improvements including, but not limited to, nutrition counseling or physical fitness programs.

MEMBERSHIP DUES AND OTHER FEES
Amounts payable (whether in the form of initiation fees, annual dues or otherwise) for membership or use of any gym, workout center, fitness center, club, golf course, wellness center, health club, weight control organization or other similar entity or payable to a trainer of any type.

MISSED PROVIDER APPOINTMENTS
Charges for a participant's appointment with a provider that the participant did not attend.

NO LEGAL OBLIGATION TO PAY
Any service, supply or charge the participant is not legally obligated to pay.

NOT MEDICALLY NECESSARY SERVICES OR SUPPLIES
Any service or supply that is not medically necessary. However, if a service is determined to be not medically necessary because it was not rendered in the least costly setting, covered expenses will be paid in an amount equal to the amount payable had the service been rendered in the least costly setting.

PAIN MANAGEMENT PROGRAMS
Chronic pain management programs or multi-disciplinary pain management programs, unless medically necessary.

PHYSICAL THERAPY ADMISSIONS
All admissions solely for physical therapy, except as provided in the covered expenses section under rehabilitation benefits.

PHYSICIAN CHARGES
Charges by a physician for blood and blood derivatives and for charges for prescription drugs that are not consumed at the physician's office.

PRE-MARITAL AND PRE-EMPLOYMENT EXAMINATIONS
Charges for services, supplies or fees for premarital or pre-employment examinations.

PREGNANCY OF A DEPENDENT CHILD
A covered dependent child's pregnancy, including childbirth, except for life-threatening pregnancy complications to either the mother or fetus. BlueCross provides medical review to determine what constitutes a life-threatening complication.

PREOPERATIVE ANESTHESIA CONSULTATION
Charges for preoperative anesthesia consultation.

PROSTHETIC DEVICES
Prosthetic Devices do not include bioelectric, microprocessor or computer programmed prosthetic components.

PSYCHOLOGICAL AND EDUCATIONAL TESTING
Psychological or educational diagnostic testing to determine job or occupational placement, school placement or for other educational purposes, or to determine if a learning disability exists.

RADIOLOGY MANAGEMENT
All charges for MRIs, MRAs, CAT scans or PET scans in an office or outpatient facility when the required preauthorization is not obtained.

RELATIONSHIP COUNSELING
Relationship counseling, including marriage counseling, for the treatment of premarital, marital or relationship dysfunction.

SERVICES FOR CERTAIN DIAGNOSES OR DISORDERS
Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, medical supplies or services or charges for the diagnosis or treatment of learning disabilities, developmental speech delay, perceptual disorders, mental retardation, vocational rehabilitation, animal assisted therapy, repetitive transcranial magnetic stimulation (rTMS), eye movement desensitization and reprocessing (EMDR), behavioral therapy for solitary maladaptive habits, or rapid opiate detoxification.

SERVICES FOR COUNSELING OR PSYCHOTHERAPY
Counseling and psychotherapy services for the following conditions:

1. Feeding and eating disorders in early childhood and infancy;
2. Tic disorders except when related to Tourette's disorder;
3. Elimination disorders;
4. Mental disorders due to a general medical condition;
5. Sexual function disorders;
6. Sleep disorders;
7. Medication induced movement disorders; or
8. Nicotine dependence unless specifically listed as a benefits in this Plan or on the Schedule of Benefits.

SERVICES NOT LISTED AS COVERED BENEFITS
Medical supplies or services or other items not specifically listed as a covered expense in the covered expenses section of this Plan or on the schedule of benefits.

SERVICES PRIOR TO MEMBER EFFECTIVE DATE OR PLAN OF BENEFITS EFFECTIVE DATE
Any charges for medical supplies or services rendered to the participant prior to the participant's effective date, the employer's effective date, or after the participant's coverage terminates, except as provided in the COBRA and ERISA rights sections. (see pages 53 and 67)

SERVICES RENDERED BY FAMILY
Any medical supplies or services rendered by a participant to him or herself or rendered by a participant's immediate family (parent, child, spouse, brother, sister, grandparent or in-law).

SERVICES RESULTING FROM INTOXICATION OR DRUG USE
Any service (other than substance abuse services), medical supplies, charges or losses resulting from a participant being intoxicated or under the influence of any drug or other substance; abusing alcohol, drugs, or other substance; or, taking some action the purpose of which is to create a euphoric state or alter consciousness, unless taken on the advice of a physician.

SEX CHANGE
Any medical supplies or services or charges incurred for consultation, therapy, surgery or any procedures related to changing a participant's sex.

TRAVEL
Travel, whether or not recommended by a physician, unless directly related to human organ or tissue transplants when preauthorized.

VISION CARE SERVICES
Any medical supply or service rendered to a participant for vision care.

WHEELCHAIRS OR POWER OPERATED VEHICLES
Unless such item has a percentage or dollar amount associated with it on the Schedule of Benefits, manual or motorized wheelchairs or power-operated vehicles such as scooters for mobility outside of the home setting. Coverage for these devices to assist with mobility in the home setting is subject to the establishment of medical necessity by the corporation.

WORKERS' COMPENSATION
This policy does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained by a participant that arises out of, in connection with, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the participant. Benefits will not be provided under this Plan if coverage under the Workers' Compensation Act or similar law would have been available to the participant but the participant elects exemption from available workers' compensation coverage; waives entitlement to workers' compensation benefits for which he/she is eligible; failed to timely file a claim for workers' compensation benefits; or, the participant sought treatment for the injury or illness from a provider which is not authorized by the participant'

RETIREE SHARE PLAN PRESCRIPTION DRUG HEALTH CARE OPTIONS
SCHEDULE OF BENEFITS

<table>
<tr><th></th><th>SCANA
Pharmacy</th><th>In Network
Retail or Mail Order</th><th>Per Rx
Out-of-Pocket Maximum</th></tr>
<tr><td>Preventive Generic Medications[1]</td><td>Free</td><td>30%</td><td rowspan="2">$100/31-day
$250/90-day</td></tr>
<tr><td>Non-preventive Generic Medications
and Preferred Brand Medication</td><td>25%</td><td>30%</td></tr>
<tr><td>Non-Preferred Brand</td><td colspan="2">50%</td><td>None</td></tr>
<tr><td>Specialty Medications
31 day supply only</td><td colspan="2">Accredo Specialty Pharmacy ONLY
50%</td><td>$250/31-day</td></tr>
<tr><td colspan="4"><u>90-day Prescriptions:</u> Only available at the SCANA Pharmacy or Caremark Mail Order Pharmacy
<u>Over-the-Counter (OTC) Medications:</u> Not covered under the prescription benefit if available OTC (except Zantac liquid).
<u>Out-of-Network Benefits:</u> Only available with 50% coinsurance for generic and preferred brand only.</td></tr>
</table>

[1] Specific generic medications included can change without notice.

PRESCRIPTION DRUG BENEFITS
Most medicines are available in a generic form, which cost less than their brand name counterparts. By law, both brand name and generic medicines must meet the same standards for safety, purity, strength, and quality. You can determine if your prescription drug is generic, preferred brand or non-preferred by visiting SouthCarolinaBlues.com or calling the toll free number shown on the back of your ID card.

A generic medicine has the same indications, cautions and instructions as a brand name; however, generics cost less, because their manufacturers do not have to pay the initial startup costs for the medicine. This savings enables you to enjoy lower coinsurance for generic medicines.

Certain medications may require preauthorization. You may call the number on your ID card for additional information.

PRESCRIPTION DRUG COVERED EXPENSES
If you incur expenses for pharmacy charges for medically necessary prescription drugs ordered by a physician, SCANA will pay that portion of the expenses remaining after you meet the required deductible or have paid the required coinsurance as shown in the Schedule of Benefits. Coverage also includes prescription drugs dispensed by a pharmacy for a prescription issued to you by a licensed dentist for the prevention of infection or pain in conjunction with an invasive dental procedure.

When you are issued a prescription for a prescription drug as part of emergency services and that prescription cannot reasonably be filled by an in-network pharmacy, the prescription will be covered by the Plan, as if filled by an in-network pharmacy.

Benefits include coverage of insulin, insulin needles and syringes, insulin pens, glucose test strips and lancets. Coverage also includes injectable drugs or medicines.

You may experience a cost savings when you opt to use the SCANA Pharmacy. The SCANA Pharmacy is staffed with licensed pharmacists and located at the SCANA Corporate Headquarters. Employees and their dependents who elect SCANA medical coverage may use the pharmacy to have prescriptions filled.

Limitations
Each prescription order or refill shall be limited as follows:

- Up to a consecutive thirty-one (31) day supply at a retail pharmacy, unless limited by the drug manufacturer's packaging; or
- Up to a consecutive ninety (90)-day supply at a mail order in-network pharmacy or the SCANA Pharmacy, unless limited by the drug manufacturer's packaging or by law; or
- Up to a dosage limit as determined by the BlueCross provider organization's Pharmacy and Therapeutics Committee (P&T Committee).
- A 31-day supply only for specialty prescriptions.

Prior Authorization Required for Certain Drugs
The Plan may require special prior authorization to fill certain types of drugs. If your pharmacist tells you that a prescription medicine prescribed by your doctor requires prior authorization, ask your pharmacist or doctor to call BlueCross. You can inquire if your prescription drug is part of this group of medications by calling the toll-free number shown on the back of your ID card or by visiting www.SouthCarolinaBlues.com.

Quantity Management
The quantity management program promotes the safe use of medications and limits the amount of some medications your benefit plan covers. The limits are based on U.S. Food and Drug Administration and manufacturer dosing guidelines, medical literature, safety, accepted medical practice, appropriate use and benefit plans. The limits only affect the amount of medication your benefit plan covers. You and your doctor make the final decision about the amount of medication that is right for you.

PRESCRIPTION DRUG EXCLUSIONS
No payment will be made for the following expenses:

1. Prescription drugs that have not been prescribed by a physician;
2. Prescription drugs not approved by the Food and Drug Administration;
3. Prescription drugs for non-covered therapies, services, or conditions;
4. Prescription drug refills in excess of the number specified on the physician's prescription order or prescription drug refills dispensed more than one (1) year after the original prescription date;
5. Any type of service or handling fee (with the exception of the dispensing fee charged by the pharmacist for filling a prescription) for prescription drugs, including fees for the administration or injection of a prescription drug;
6. Dosages that exceed the recommended daily dosage of any prescription drug as described in the current physician's desk reference or as recommended under the guidelines of the pharmacy benefits manager, whichever is lower;
7. Prescription drugs used for or related to cosmetic purposes, including hair growth, unless otherwise specified on the Schedule of Benefits;

8. Prescription drugs related to any treatment for infertility, including but not limited to, fertility drugs;

9. Prescription drugs administered or dispensed in a physician'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;

10. With the exception of compound drugs and Zantac Liquid, any medication available over the counter is not covered under the prescription benefit, regardless of dose or formulation. This includes, but is not limited to, the list below:

    a. Omeprazole (Prilosec)

    b. Omeprazole/Sodium Bicarbonate (Zegerid);

    c. Lansoprazole (Prevacid)

    d. Esomeprazole (Nexium)

    e. Ranitidine (Zantac)

    f. Famotidine (Pepsid)

    g. Loratadine (Claritin)

    h. Cetirizine (Zyrtec)

    i. Fexofenadine (Allegra)

    j. Ibuprophen (Motrin)

    k. Naproxen (Naprosyn, Aleve, Anaprox)

    l. Vitamins (except prenatal and Vitamin D 50,000 i.u.);

11. Prescription drugs that are being prescribed for a specific medical condition that are not approved by the Food and Drug Administration for treatment of that condition (except for prescription drugs for a specific medical condition that has at least two (2) formal clinical studies for the condition for which the participant intends to use it; or 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 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);

12. Prescription drugs that are not consistent with the diagnosis and treatment of a participant'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;

13. Prescription drugs or services that require preauthorization by the corporation and preauthorization is not obtained;

14. Prescription drugs for injury or disease that are paid by workers' compensation benefits (if a workers' compensation claim is settled, it will be considered paid by workers' compensation benefits);

15. Prescription drugs that are not medically necessary;

16. Prescription drugs that are not authorized when part of a Step Therapy Program, excluding PPI and NSA classes of drugs.

17. Food and Drug Administration (FDA)-approved drugs used for purposes other than those approved by the FDA, unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or The American Hospital Formulary service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer reviewed national professional medical journal;

18. Any prescription and non-prescription supplies (such as ostomy supplies), devices, and appliances;

19. Implantable contraceptive products (these devices may be available through the Family Planning benefit under the medical plan);

20. Any prescription vitamins (other than pre-natal vitamins and Vitamin D 50,000 i.u), dietary supplements and fluoride products;

21. Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;

22. Replacement of prescription drugs and related supplies due to loss or theft;

23. Drugs used to enhance athletic performance;

24. Drugs which are to be taken by or administered to a member while the member is a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;

Other limitations are shown in the "General Limitations" section.

Reimbursement/Filing a Claim: Prescription Drugs
When you purchase your prescription drugs through an in-network pharmacy, you pay only the pharmacy coinsurance amount, after applicable deductible, as shown in the benefits schedule at the time of purchase. You do not need to file a claim form.

For participants in all Plans, if you purchase your prescription drugs through an out-of-network pharmacy in conjunction with emergency services, you pay the full cost at the time of purchase. You must submit a claim form to be reimbursed at the in-network pharmacy level of benefits. For non-emergency prescriptions, if you purchase your prescription drugs through any out-of-network pharmacy, you pay the full cost at the time of purchase and then you must submit a claim form to be reimbursed at the out-of-network pharmacy level of benefits.

Contact BlueCross at 877-705-5428 or www.SouthCarolinaBlues.com to obtain the appropriate claim form.To purchase prescription drugs from the Caremark Mail-Order Pharmacy, refer to the customer service phone number on your ID card.

VISION BENEFITS (FOR RETIREE SHARE PARTICIPANTS)

SCANA Corporation has arranged access to quality vision care and prescription eyewear through a network of in-network providers. If you choose to visit an out-of-network provider, you will receive the out-of-network benefit reimbursements, provided you pay the provider in full at the time of service and then submit a completed out-of-network claim form and copy of your receipt to EYEMED Vision Care, SCANA's vision care administrator, at:

EyeMed Vision Care
Attn: OON Claims
P.O. Box 8504
Mason, Ohio 45040
888-362-7463

Vision Benefit Frequency

Exam: Once every 12 months
Frames: Once every 24 months
Lenses or Contact Lenses: Once every 12 months

Vision Care Services	In-Network	Out-of-Network
Exam with Dilation as Necessary	$0 Copayment	Up to $60
Contact Lens Fit and Follow-Up:		
Standard Contact Lens Fit and Follow-up Visits*	$55 Copayment	Non-Covered
Premium Contact Lens Fit and Follow-up Visits**	10% off retail price	Non-Covered
Frames (Any available frame at provider location)	$135 allowance, 20% off balance over $135	Up to $82
Standard Plastic Lenses:		
Single Vision	$0 Copayment	Up to $78
Bifocal	$0 Copayment	Up to $97
Trifocal	$0 Copayment	Up to $107
Lenticular	$0 Copayment	Up to $150
Standard Progressive Lens	$0 Copayment	Up to $149
Premium Progressive lens	$120 allowance, 80% off balance over $120	Up to $149
Progressive Vision Allowance	$0 Copayment	Up to $149
Lens Options:		
Tint (Solid and Gradient)	$15	Non-Covered
Standard Plastic Scratch-Resistance	$15	Non-Covered
Standard Polycarbonate – Adults	$40	Non-Covered
Standard Polycarbonate – Children under 19	$0	Non-Covered
Standard Anti-Reflective Coating	$45	Non-Covered
Polarized	20% off retail price	
Other Add-Ons and Services	20% off retail price	Non-Covered
Additional Pairs Benefit		
Completed Pair of eyeglasses	40% off retail price	Non-Covered
Conventional Contact Lenses once the funded benefit is used	15% off retail price	Non-Covered
Contact Lenses:		
Conventional	$0 Copayment, $135 allowance, 15% off balance over $135	Up to $125
Disposable	$0 Copayment, $135 allowance, plus balance over $135	Up to $125
Medically Necessary	$0 Copayment, Paid-in-Full	Up to $210

* Standard Contact Lens Fitting - spherical clear contact lenses in conventional wear and planned replacement (Examples include but not limited to disposable, frequent replacement, etc.)

** Premium Contact Lens Fitting - all lens designs, materials and specialty fittings other than Standard Contact Lenses (Examples include toric, multifocal, etc.)

Additional discounts:

- Participants will receive a 20% discount on items not covered by the plan at in-network providers, which may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed provider's professional services, or contact lenses. Retail prices may vary by location.

- Discounts do not apply for benefits provided by other group benefit plans. Allowances are one-time use benefits; no remaining balance.
- Lost or broken materials are not covered.
- Participants also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.
- Participants also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA vision. Since Lasik or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization please call 1-877-5LASER6.
- After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.EyeMedVisionCare.com. The contact lens benefit allowance is not applicable to this service.

Plan Limitations/Exclusions:

- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
- Medical and/or surgical treatment of the eye, eyes or supporting structures;
- Any eye or vision examination, or any corrective eyewear required by a policyholder as a condition of employment; safety eyewear
- Services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
- Plano (non-prescription) lenses and/or contact lenses;
- Non-prescription sunglasses;
- Two pair of glasses in lieu of bifocals;
- Services or materials provided by any other group benefit plan providing vision care;
- Services rendered after the date an insured person ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured person are within 31 days from the date of such order.
- Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefits frequency when vision materials would next become available.

COORDINATING WITH OTHER PLANS

If you are covered under more than one plan, this section provides an overview of how benefits payable from all such plans will be coordinated. You should file all claims with each plan. Coverage coordinated between this Plan and another plan or plans may not guarantee 100% total reimbursement.

When this Plan is a primary plan, its benefits are determined before those of the other plan without considering the other plan's benefits. When this Plan is a secondary plan, its benefits are determined after those of the other plan. You may either receive reduced benefits or no benefit because of the other plan's benefits.

When processing a claim under this Plan as secondary, BlueCross will determine the amount this Plan would have paid for an allowable expense if it were primary. If this amount is greater than the benefit that the actual primary plan did pay, it would be reduced by the amount paid by the actual primary plan and this plan, as secondary, would pay you the difference. If the benefit paid by the primary plan is the same or more for an allowable expense than this Plan would have paid as primary, no further benefit will be paid under this Plan.

	Primary Plan	Secondary	Plan Result
Example 1	Primary plan covers a service at **80%** of the allowable	Covers a service at **80%** of the allowable	Secondary plan pays nothing; member pays **20%**
Example 2	Primary plan covers a service at **60%** of the allowable	Covers a service at **80%** of the allowable	Secondary plan pays **20%** of the allowable; member pays **20%**
Example 3	Primary plan doesn't cover the service	Covers the service at **80%** of the allowable	Secondary plan pays **80%**; member pays **20%**
Example 4	Primary plan covers the service at **80%** of the allowable	Secondary plan doesn't cover the service	Secondary Plan pays nothing; member pays **20%**

Determining Primary/Secondary Coverage
The following guidelines will help you to determine which plans provide primary coverage and which plans provide secondary coverage for you and your family:

- If you and your dependents are enrolled in the SCANA Plan, and you are not covered under any other insurance plan, then the SCANA Plan is your primary plan;
- If you are enrolled in the SCANA Plan and you have coverage under a plan other than SCANA's Plan, the SCANA Plan is primary unless the other plan is provided by your current employer, in which case, the SCANA Plan will be secondary and the other plan will be primary;
- If your spouse has coverage through a plan other than SCANA's, that coverage is primary for your spouse and the SCANA Plan is secondary for your spouse, if you are carrying SCANA coverage on you and your spouse. Plus, if your spouse covers you through his/her primary plan, your spouse's plan is secondary for you;
- Primary coverage for dependent children is determined by the "birthday rule" when both parents cover the child under separate coverage. The plan of the parent whose birthday comes first in the calendar year, regardless of the year of birth, is primary for dependent children. In the event that both parents have the same birth date, the plan of the parent who has been employed the longest will be primary for the dependent children. A plan that does not use maintenance/coordination of benefits is automatically primary for your dependent children;
- Special rules may apply in cases of multiple coverage not addressed by these rules, such as divorced parents, or conflicting coordination of benefits provisions.

SCANA Corporation or BlueCross will annually request "other insurance" information from you regarding other group health insurance coverage you may carry for yourself and/or any of your eligible dependents. This request may occur in connection with a submitted claim; if so, you will be advised that the other insurance information (including an Explanation of Benefits from the other insurance carrier) is required before the submitted claim will be processed for payment. If no response is received within 90 days, the claim will be denied. If the requested information is subsequently received by our claim administrator, the claim will be processed.

Recovery of Excess Benefits
If this Plan pays charges for services and supplies that should have been paid by the actual primary plan, BlueCross will have the right to recover such payments.

BlueCross will have sole discretion to seek such recovery from any person to, or for whom, or, respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If requested, you may be required to deliver to BlueCross such instruments and documents necessary to secure the right of recovery.

Right to Receive and Release Information
BlueCross, without consent or notice to you, may obtain information from and release information to any other plan in order to coordinate your benefits. If requested, you must provide BlueCross with claim related information determined necessary to coordinate your benefits.

WELLNESS PROGRAMS (FOR RETIREE SHARE PLAN PARTICIPANTS)

Health Management:
You have access to ***Health Management***, a disease management program for participants with any of the following diseases:

- Asthma
- COPD (Chronic Obstructive Pulmonary Disease or chronic lung problems)
- Diabetes
- Heart failure
- Coronary artery disease (Heart Disease)
- Hypertension (High Blood Pressure)
- Hyperlipidemia (High Cholesterol)
- Migraine

The purpose of this program is to help you understand your risk factors and treatment options, explore healthy lifestyle choices, set and reach realistic health goals and learn to successfully self-manage your condition. You may receive educational resources periodically, and you can call health coaches for additional support and information at 1-855-838-5897.

CLAIMS PROCEDURES

ELIGIBILITY CLAIMS PROCEDURES (For All Participants)

1. Decisions on eligibility to participate in the Plan are reviewed by the SCANA Benefits team and decided in a uniform and non-discriminatory manner. If you or your dependent were denied enrollment in the Plan and believe that you or your dependent are entitled to participate, you may file a claim in writing with the benefits manager at SCANA Corporation, Mail Code C131, 220 Operation Way, Cayce, SC 29033. The benefits manager will make a determination and notify you of that determination within 90 days after receipt of your claim. If special circumstances require up to another 90 days to process the claim, the benefits manager will notify you that an extension is needed within the initial 90 days. This notice of extension will describe the special circumstances requiring an extension and the date the benefits manager expects to issue a determination.

2. If you disagree with the decision of the benefits manager, you can appeal in writing to the Plan Administrator within 60 days of the claim denial. The plan administrator will notify you of the decision on appeal within sixty (60) days after receipt of your appeal, unless special circumstances require an extension of time of up to sixty (60) days for processing the appeal. If an extension is required, the plan administrator will notify you before the expiration of the initial 60-day period that explains the special circumstances that require an extension of time and includes the date by which the Plan Administrator expects to issue a determination on the appeal.

CLAIMS FILING PROCEDURES (Retiree Share Participants Only. Claims procedures for other benefit options are contained in the applicable benefit booklets for such benefit options.)

1. Where a network provider renders services, generally the network provider will file the claim on a Participant's behalf. However, the Participant is responsible for ensuring that the claim is filed.

2. Written notice of receipt of services on which a claim is based must be furnished to the BlueCross, at its address listed in the benefit booklet, within twenty (20) days of the beginning of services, or as soon thereafter as is reasonably possible. Failure to give notice within the time does not invalidate nor reduce any claim if the Participant can show that it was not reasonably possible to give the notice within the required time frame and if notice was given as soon as reasonably possible. Upon receipt of the notice, the BlueCross BlueShield furnish or cause a claim form to be furnished to the Participant. If the claim form is not furnished within fifteen (15) days after BlueCross receives the notice, the Participant will be deemed to have complied with the requirements of this Plan as to proof of loss. The Participant must submit written proof covering the character and extent of the services within the time fixed for filing proof of loss.

3. For benefits not provided by a network provider, the Participant is responsible for filing claims with BlueCross BlueShield. When filing the claims, the Participant will need the following:

a. A claim form for each Participant. Participants can get claim forms from a Participant services representative at the telephone number indicated on the Identification Card or via BlueCross BlueShield's website, www.SouthCarolinaBlues.com.

b. Itemized bills from the network provider (s). These bills should contain all the following:

   i. Provider's name and address;

   ii. Participant's name and date of birth;

   iii. Participant's Identification Card number;

   iv. Description and cost of each service;

   v. Date that each service took place; and,

   vi. Description of the illness or injury and diagnosis.

c. Participants must complete each claim form and attach the itemized bill(s) to it. If a Participant has other insurance that already paid on the claim(s), the Participant should also attach a copy of the other Plan's EOB notice.

   i. Participants should make copies of all claim forms and itemized bills for the Participant's records since they will not be returned. Claims should be mailed to BlueCross BlueShield's address listed on the claim form.

4. BlueCross BlueShield must receive the claim within ninety (90) days after the beginning of services. Failure to file the claim within the ninety (90) day period, however, will not prevent payment of Covered Expenses if the Participant shows that it was not reasonably possible to file the claim timely, provided the claim is filed as soon as is reasonably possible. Except in the absence of legal capacity, claims must be filed no later than twelve (12) months following the date services were received.

5. Receipt of a claim by BlueCross will be deemed written proof of loss and will serve as written authorization from the Participant to BlueCross BlueShield to obtain any medical or financial records and documents useful to BlueCross BlueShield. BlueCross BlueShield, however, is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at the time the claim was processed. Any party who submits medical or financial reports and documents to the BlueCross BlueShield in support of a Participant's claim will be deemed to be acting as the agent of the Participant. If the Participant desires to appoint an Authorized Representative in connection with such Participant's claims, the Participant should contact the BlueCross BlueShield for an Authorized Representative form.

6. There are four (4) types of claims: Pre-Service Claims, Urgent Care Claims, Post-Service Claims, and Concurrent Care claims. BlueCross and BlueShield will make a determination for each type of claim within the following time periods:

   i. Pre-Service Claim

      (1) A determination will be provided in writing or in electronic form within a reasonable period of time, appropriate to the medical circumstances, but no later than fifteen (15) days from receipt of the claim.

      (2) If a Pre-service Claim is improperly filed, or otherwise does not follow applicable procedures, the Participant will be sent notification within five (5) days of receipt of the claim.

      (3) An extension of fifteen (15) days is permitted if BlueCross BlueShield (on behalf of the Plan) determines that, for reasons beyond the control of BlueCross BlueShield, an extension is necessary. If an extension is necessary the BlueCross BlueShield will notify the Participant within the initial fifteen (15) day time period that an extension is necessary, the circumstances requiring the extension, and the date BlueCross BlueShield expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Participant will have at least forty-five (45) days to provide the required information. If BlueCross BlueShield does not receive the required information within the forty-five (45) day time period, the claim will be denied. BlueCross BlueShield will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If the BlueCross BlueShield receives the requested information after the forty-five (45) days, but within two hundred twenty-five (225) days, the claim will be reviewed as a first level appeal.

ii. Urgent Care Claim

(1) A determination will be sent to the Participant in writing or in electronic form as soon as possible taking into account the medical exigencies, but no later than seventy-two (72) hours from receipt of the claim.

(2) If the Participant's Urgent Care Claim is determined to be incomplete, the Participant will be sent a notice to this effect within twenty-four (24) hours of receipt of the claim. The Participant will then have forty-eight (48) hours to provide the additional information. Failure to provide the additional information within forty-eight (48) hours may result in the denial of the claim.

(3) If the Participant requests an extension of urgent care benefits beyond an initially determined period and makes the request at least twenty-four (24) hours prior to the expiration of the original determination period, the Participant will be notified within twenty-four (24) hours of receipt of the request for an extension.

iii. Post-Service Claim

(1) A determination will be sent within a reasonable time period, but no later than thirty (30) days from receipt of the claim.

(2) An extension of fifteen (15) days may be necessary if BlueCross BlueShield (on behalf of the Plan) determines that, for reasons beyond the control of BlueCross BlueShield, an extension is necessary. If an extension is necessary, the BlueCross BlueShield will notify the Participant within the initial thirty (30) day time period that an extension is necessary, the circumstances requiring the extension, and the date the BlueCross BlueShield expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Participant will have at least forty-five (45) days to provide the required information. If BlueCross BlueShield does not receive the required information within the forty-five (45) day time period, the claim will be denied. BlueCross BlueShield will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If the BlueCross BlueShield receives the requested information after the forty-five (45) days, but within two hundred twenty-five (225) days, the claim will be reviewed as a first level appeal.

iv. Concurrent Care Claim

(1) The Participant will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction or termination to allow the Participant time to appeal the decision before the benefits are reduced or terminated.

g. Notice of Determination

7. If the Participant's claim is filed properly, and the claim is in part or wholly denied, the Participant will receive notice of an Adverse Benefit Determination in a culturally and linguistically appropriate manner, that will:

a. Include information sufficient to identify the claim involved (including date of service, health care Provider, claim amount (if applicable) and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings;

b. State the specific reason(s) for the Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the standard (if any) that was used in denying the claim;

c. State that the Participant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Participant's claim;

d. Reference the specific Plan of Benefits provisions on which the determination is based;

e. Describe additional material or information, if any, needed to complete the claim and the reasons such material or information is necessary;

f. Describe the claims review procedures and the Plan and the time limits applicable to such procedures, including a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review;

g. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request);

h. If the reason for denial is based on a lack of Medical Necessity or Investigational or Experimental Services exclusion or similar limitation, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);

i. Provide a description of available internal appeals and external review processes, including information regarding how to initiate such appeals;

j. Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and external review processes ERISA.

k. Participant will be provided, as soon as practicable upon request, the diagnosis and treatment codes and their corresponding meanings, associated with the Adverse Benefit Determination.

l. No decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual will be made based upon the likelihood that the individual will support the denial of Benefits.

m. The Participant will also receive a notice if the claim is approved.

APPEAL PROCEDURES FOR AN ADVERSE BENEFIT DETERMINATION (Retiree Share Participants Only)

1. Participant has one hundred eighty (180) days from receipt of an Adverse Benefit Determination to file an appeal. An appeal must meet the following requirements:

   a. An appeal must be in writing;

   b. An appeal must be sent (via U.S. mail) at the address below:

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

   c. The appeal request must state that a formal appeal is being requested and include all pertinent information regarding the claim in question; and,

   d. An appeal must include the Participant's name, address, identification number and any other information, documentation or materials that support the Participant's appeal.

2. The Participant may submit written comments, documents, or other information in support of the appeal, and will (upon request) have access to all documents relevant to the claim. A person other than the person who made the initial decision will conduct the appeal. No deference will be afforded to the initial determination.

3. The Participant must raise all issues and grounds for appealing an Adverse Benefit Determination at every stage of the appeals process, or such issues and grounds will be deemed permanently waived.

4. If the appealed claim involves an exercise of medical judgment, BlueCross BlueShield will consult with an appropriately qualified health care practitioner with training and experience in the relevant field of medicine. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on the appeal.

5. The final decision on the appeal will be made within the time periods specified below:

   a. Pre-Service Claim

      BlueCross BlueShield (on behalf of the Plan) will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than thirty (30) days after receipt of the appeal. If the participant disagrees with BlueCross decision, the participant can submit a second appeal within ninety (90) days after receipt of the final decision of the first appeal. BlueCross (on behalf of the Plan) will decide the second appeal within a reasonable period of time, taking into account the medical circumstances, but no later than fifteen (15) days after receipt of the second appeal.

   b. Urgent Care Claim

      The Participant may request an expedited appeal of an Urgent Care Claim. This expedited appeal request may be made orally, and BlueCross BlueShield (on behalf of the Plan) will communicate with the Participant by telephone or facsimile. BlueCross BlueShield (on behalf of the Plan)

will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than seventy-two (72) hours after receipt of the request for an expedited appeal.

c. Post-Service Claim

BlueCross BlueShield (on behalf of the Plan) will decide the appeal within a reasonable period of time, but no later than sixty (60) days after receipt of the appeal. If the participant disagrees with BlueCross' decision, the participant can submit a second appeal within ninety (90) days after receipt of the final decision of the first appeal. BlueCross (on behalf of the Plan) will decide the second appeal within a reasonable period of time, but no later than thirty (30) days after receipt of the second appeal.

d. Concurrent Care Claim

BlueCross BlueShield (on behalf of the Plan) will decide the appeal of Concurrent Care claims within the time frames set forth in Section 4(a-c) depending on whether such claim is also a Pre-Service Claim, an Urgent Care Claim or a Post-Service Claim.

6. Notice of Final Internal Appeals Determination

a. If a Participant's appeal is denied in whole or in part, the Participant will receive notice of an Adverse Benefit Determination, in a culturally and linguistically appropriate manner, that will:

i. Include information sufficient to identify the claim involved (including date of service, health care Provider, claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings;

ii. State specific reason(s) for the Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the standard (if any) that was used in denying the claim and a discussion of the decision;

iii. Reference specific provision(s) of the Plan of Benefits on which the Benefit determination is based;

iv. State that the Participant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for Benefits;

v. Describe any mandatory or voluntary appeal procedures offered by BlueCross BlueShield (on behalf of the Plan) and the Participant's right to obtain such information;

vi. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request);

vii. If the reason for an Adverse Benefit Determination on appeal is based on a lack of Medical Necessity, Investigational or Experimental services or other limitation or exclusion, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);

viii. Include a statement regarding the Participant's right to bring an action under section 502(a) of ERISA.

7. The Participant will also receive, free of charge, any new or additional evidence considered, relied upon, or generated in connection with the claim. This evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Benefit Determination is received, to give the Participant a reasonable opportunity to respond prior to that date.

8. If the Adverse Benefit Determination is based on a new or additional rationale, then the Participant will be provided with the rationale, free of charge. The rationale will be provided as soon as possible and sufficiently in advance of the date of the Adverse Benefit Determination to give the Participant a reasonable opportunity to respond prior to that date.

9. The Participant will be provided, as soon as practicable upon request, the diagnosis and treatment codes and their corresponding meanings, associated with the Adverse Benefit Determination.

10. No decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual will be made based upon the likelihood that the individual will support the denial of Benefits.

11. A Participant's claim and appeals will be decided pursuant to a good faith interpretation of the Plan, in the best interest of the Participant, without

taking into account either the amount of the Benefits that will be paid to the Participant or the financial impact on the Plan.

a. The Participant will also receive a notice if the claim on appeal is approved.

12. SCANA has retained BlueCross BlueShield to make the initial claims determination as well as determinations on appeal as the claims fiduciary. Accordingly, the Plan Administrator has delegated to BlueCross BlueShield discretionary authority to construe and interpret questions of related to claims for benefits under the terms of the Plan. The Plan Administrator delegates to BlueCross BlueShield the discretionary authority to make utilization review and precertification determinations for the purpose of making claim decisions under the Plan and to interpret and construe the Plan as necessary to make such determinations. It is understood and agreed that the BlueCross BlueShield is a fiduciary with respect to its exercise of such discretionary authority. In making its decision, BlueCross BlueShield will rely on the Plan, its internal procedures and will rely on eligibility data provided by the Company. BlueCross BlueShield will undertake the responsibility for providing the initial and appellate reviews and final determination of claims that have been denied in whole or in part in accordance with the rules set forth in ERISA Section 503 and the regulations there under.

VOLUNTARY LEVEL APPEAL PROCEDURES (Retiree Share Participants Only)

1. The Participant shall have sixty (60) calendar days from receipt of a second level appeal adverse benefits determination to file an appeal to the Plan Administrator. This appeal is completely voluntary but must be filed and completed prior to any external review process is initiated. An appeal must meet the following requirements:

   a. An appeal must be in writing;

   b. The appeal must be sent to the Plan Administrator at the address in the Plan Information section of this document;

   c. The appeal must include the name, address of the participant, and all relevant information in support of the appeal.

2. The Plan Administrator will review the appeal and make a determination within a reasonable period of time, but no later than 90 days after receipt of the voluntary appeal. If additional information is needed, as determined by the Plan Administrator, the time to decide the appeal will be suspended until such information is reviewed.

EXTERNAL REVIEW PROCEDURES (Retiree Share Participants Only)

1. After a Participant has completed the appeal process, a Participant may be entitled to an additional, external review of the Participant's claim at no cost to the Participant. An external review may be used to reconsider the Participant's claim if BlueCross BlueShield has denied, either in whole or in part, the Participant's claim. In order to qualify for external review, the claim must have been denied, reduced, or terminated because:

   a. It does not meet the requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness; or,

   b. It is an Investigational or Experimental Service and it involves a life-threatening or seriously disabling condition.

2. After a Participant has completed the appeal process, (and an Adverse Benefit Determination has been made) such Participant will be notified in writing of such Participant's right to request an external review. The Participant should file a request for external review within four (4) months of receiving the notice of BlueCross BlueShield's decision on the Participant's appeal. In order to receive an external review, the Participant will be required to authorize the release of such Participant's medical records (if needed in the review for the purpose of reaching a decision on Participant's claim).

3. Within five (5) business days of the date of receipt of a Participant's request for an external review, BlueCross BlueShield will respond by either:

   a. Assigning the Participant's request for an external review to an independent review organization and forwarding the Participants records to such organization; or,

   b. Notifying the Participant in writing that the Participant's request does not meet the requirements for an external review and the reasons for the Corporation's decision.

4. The external review organization will take action on the Participant's request for an external review within forty-five (45) days after it receives the request for external review from the Corporation.

5. Expedited external reviews are available if the Participant's Provider certifies that the Participant has a Serious Medical Condition. A Serious

Medical Condition, as used in this paragraph, means one that requires immediate medical attention to avoid serious impairment to body functions, serious harm to an organ or body part, or that would place the Participant's health in serious jeopardy. If the Participant may be held financially responsible for the treatment, a Participant may request an expedited review of BlueCross BlueShield's decision if BlueCross BlueShield's denial of Benefits involves Emergency Medical Care and the Participant has not been discharged from the treating Hospital. The independent review organization must make its decision within seventy-two (72) hours after it receives the request for expedited review.

SUBROGATION – INSURER'S RIGHT OF REIMBURSEMENT

As a condition to receiving benefits under this Plan, you must:

- Reimburse the Plan for any such benefits paid or payable to you, or on your behalf, when said benefits are recovered, in any form, regardless of how classified or characterized including but not limited to amounts allocated to attorney's fees, from any person, corporation, entity, no-fault carrier, uninsured motorist carrier, underinsured motorist carrier, other insurance policies or funds; and

- Refrain from releasing any party, person, corporation, entity, insurance company, insurance policies or funds that may be liable for or obligated to you for the injury or condition without obtaining the Plan's written approval; and

- Without limiting the preceding, subrogate the Plan to any and all claims, causes of action or rights that they have or that may arise against any person, corporation and/or other entity and to any coverage, no-fault coverage, uninsured motorist coverage, underinsured motorist coverage, other insurance policies or funds ("Coverage") for which you claim an entitlement to benefits under this Plan, regardless of how classified or characterized.

- Rights of the plan under this section are not conditional on the entry of a judgment or finding of fault by any party, including but not limited to a court, agency, or any third party.

In the event you settle, recover or are reimbursed by any third party or coverage, you must hold any such funds received in trust for the benefit of the Plan, and to reimburse the Plan for all benefits paid or that will be paid as a result of the injury or condition. The Plan's subrogation rights shall be considered a first priority claim and shall be paid in full before any other claims for you as the result of the illness or injury, regardless of whether you are made whole. If you fail to reimburse the Plan for all benefits paid or to be paid, as a result of the injury or condition, out of any recovery or reimbursement received, you will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from you. If you fail to reimburse the Plan for all benefits paid or to be paid, as a result of the injury or condition, the Plan may withhold payment of future benefits until such amounts are repaid in full.

You are required to execute and return all required documents to the Plan Administrator and shall supply other reasonable information and assistance as requested by the Plan Administrator regarding the claim or potential claim. If the required documentation is not executed and returned or if information and assistance is not provided to the Plan Administrator upon request, no benefits will be payable under the Plan with respect to costs incurred in connection with such illness or injury. Failure to obtain the requested information, however, will not preclude the Plan Administrator from pursuing the Plan's subrogation and reimbursement rights.

If you (or your guardian or estate) decide to pursue a third party or any coverage available to them as a result of an injury or condition, you must include the Plan's subrogation claim in that action and if there is failure to do so, the Plan will be legally presumed to be included in such action or recovery. In the event you decide not to pursue any and all third parties or coverage, you authorize the Plan to pursue, sue, compromise or settle any such claims in their name, to execute any and all documents necessary to pursue said claims in their name, and agrees to fully cooperate with the Plan in the prosecution of any such claims. You (or your guardian or estate) agree to take no prejudicial actions against the subrogation rights of the Plan or to in any way impede the action taken by the Plan to recover its subrogation claim. Such cooperation shall include a duty to provide information, execute and deliver any acknowledgment and other legal instruments documenting the Plan's subrogation rights and take such action as requested by the Plan to secure the subrogation claim. Such cooperation shall include a duty to provide information, execute and deliver any acknowledgment and other legal instruments documenting the Plan's subrogation rights and take such action as requested by the Plan to secure the subrogation rights of the Plan.

The Plan will not pay or be responsible, without its written consent, for any fees or costs, including but not limited to attorney's fees, associated with your pursuing a claim against any coverage or third party. The plan administrator retains sole and final discretion for interpreting the terms and conditions of this Plan document. The Plan Administrator may amend the Plan in its sole discretion at anytime without notice. This right of subrogation and reimbursement applies to you, your guardian(s), estate, executor, personal representative, and heir(s). In the event of any overpayment of benefits by this Plan, the Plan will have the right to recover the overpayment. If you are paid a benefit greater than allowed in accordance with the provisions of the Plan, you will be requested to refund the overpayment. If payment is made on your behalf to a hospital, physician or other provider of health care, and that payment is found to be an overpayment, the Plan will request a refund, the Plan will then request the overpayment from you. If the refund is not received from the provider or you, the amount of the overpayment will be deducted from future benefits for you.

For the purposes of implementing the terms of this Plan, the Plan Administrator retains the right to request any medical information from any insurance company or provider of service it deems necessary to properly process a claim. Any person claiming benefits under this Plan shall furnish to the plan administrator such information as may be necessary to implement this provision.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

The HRA is a bookkeeping account credited with the amounts as listed below and is reduced from time to time by the amount of eligible expenses for which you are reimbursed under the Plan. The account is not funded and does not accrue interest. All reimbursements are paid out of SCANA general assets. OneExchange has been delegated as the Claims Administrator and will administer the HRA.

OneExchange can also support you in evaluating and choosing a Medicare supplemental health care plan and prescription drug coverage that fit your individual health care needs and budget. OneExchange will work with you at no cost to obtain quotes for you on a broad range of Medicare plans and provide you personal assistance in helping you choose the one that works best for you.

Should you have any questions regarding your HRA account or need assistance in choosing an individual health and/or drug plan, OneExchange customer service representatives are available Monday through Friday, from 9 a.m. to 9 p.m. Eastern Time. Their toll-free number is 866-715-4673.

If you have any questions after reviewing the information provided you may call OneExchange toll-free at **866-715-4673** or go to their website at **medicare.oneexchange.com/scanacorporation**

A. HRA amount and availability

SCANA will contribute a fixed amount annually to your HRA account administered by OneExchange.

Pre-65 Retirees

	Retiree	Retiree plus spouse	Retiree and child*	Family*
Annual Allowance	$6,604	$13,208	$13,208	$19,812

*Annual maximum, regardless of the number of dependents.

65 and Older Retirees

	Retiree	Retiree plus spouse	Retiree and child*	Family*
Annual Allowance	$2,131	$4,262 (over 65 spouse)	$4,262 (over 65 dependent)	$10,866 (over 65 spouse/ under 65 dependent)
		$8,735 (under 65 spouse)	$8,735 (under 65 dependent)	$15,339 (under 65 spouse/ dependent)

* Annual maximum, regardless of the number of dependents.

NOTE: Retirees or their dependents entering the plan mid-year will receive a prorated amount for that year, based on the month of enrollment.

The HRA funds may be used to:

- pay for premiums for third-party retiree medical plans offered outside of SCANA's Plan
- pay co-pays, deductibles and coinsurance
- purchase Medicare Part D coverage
- pay for Medicare Part B premiums

You are reimbursed on the costs up to the maximum allowed. If you select this option, you will not be able to enroll in other SCANA plans. Any amounts in the account at the end of the plan year will not rollover to the next plan year.

A. Eligible Expenses
Your HRA is a convenient way to be reimbursed for your health care premiums, deductibles, co-pays, coinsurance, etc. Only eligible expenses incurred within the plan year (January 1 - December 31) and submitted within 90-days after the end of the plan year will be eligible for reimbursement. To view an online list of eligible expenses, access the OneExchange website. To obtain a list of eligible expenses over the phone, contact OneExchange directly. A OneExchange representative will be happy to help you.

The following expenses may not be reimbursed form your HRA:

- expenses incurred prior to the date you became a participant in the HRA;
- expenses incurred after the date you cease to be a participant in the HRA;
- expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan.

To view a complete list of all other expenses that are not eligible for reimbursement go to the OneExchange website or contact a OneExchange representative.

B. Accessing your HRA
You may access your HRA account information online through the OneExchange website, or by calling their toll-free number. To access your account online or to contact by phone, use the website address and phone number listed above.

C. Web site information
The OneExchange website has all of your current account information, including your account balance and claim status. Using the Web site, you may also file a claim for reimbursement or enroll in direct deposit.

The website also has helpful information about obtaining individual health, dental and vision insurance outside of the SCANA plan options available. OneExchange representatives are also available to assist you identifying other individual and/or Medicare coverage options available to you.

CLAIMS PROCEDURES – SUBMITTING CLAIMS

For your convenience, you may submit claims online or by using a paper claim form. Whichever option you choose, you will need to provide documentation of your expenses.

To file a claim online, you will need to log into your HRA account at medicare.oneexchange.com/scanacorporation.

- Once you are in your HRA Account online, click File a Claim under Quick Links.
- Select Pay Me.
- Enter the following claim information: type of expense, date of expense and amount of expense. To add additional claims, select Add Another Claim.
- After entering in all your claims, click Next.
- Confirm all expense details, then click Next. To make changes, click Previous.
- Select Fax or Upload (Upload requires claims to be provided in PDF format).
- To Fax, click on Create Coversheet, then print, sign and fax the form (and itemized receipts) to 1-866-932-2567.
- To upload, use the Browse button to select your receipts in PDF format from your computer.
- To add additional documents, click on Add Additional Document.
- Check the Signature Box at the bottom of the page to sign your claim.
- Click Submit.

If you have signed up for eNotify, PayFlex on behalf of OneExchange will send a confirmation email once your claim has been processed.

To file a paper claim via mail or fax, you will need to:

1. Complete, sign and date the claim form (which can be printed from the OneExchange website at medicare.oneexchange. com/scanacorporation or by contacting OneExchange at 866-715-4673). Attach a copy of your expense receipt(s) or documentation of the expense.

Note: To submit a claim for monthly premiums, attach a copy of the premium invoice from your plan, a copy of your bank statement OR a copy of your cashed check as documentation of your payment. Otherwise, your receipt or documentation must include:

- Name of health care provider or merchant
- Name of patient
- Identification of product or description of service
- Date of service or purchase
- Amount paid or owed

2. Mail or fax claim form and documentation to: Mail: PayFlex Systems USA, Inc.
   OneExchange HRA
   P.O. Box 3039
   Omaha, NE 68103-3039
   Fax: (402) 231-4310

When faxing, your claim form should be the first page, followed by receipts or supporting documentation. You do not need to provide a separate cover sheet.

Claims and Reimbursement

1. Reimbursement process
   Once your claim and receipts have been received and approved, you will receive payment within 14 days. If you have elected direct deposit, payment will be issued within three days of the claim approval.

   For quicker access to your reimbursement, sign up for direct deposit online or request the direct deposit election form from an OneExchange representative.

2. Claim forms and automatic reimbursement
   If you have elected to receive automatic reimbursement from your HRA for premium payments, you do not have to submit claims for these expenses in order to be reimbursed. To verify whether or not you chose automatic reimbursement, please refer to your confirmation letter from OneExchange.

Claim Denials and Appeals
If a claim for benefits is denied in part or in whole, you have the right to file a formal appeal as described below.

1. How to Appeal a Denied Claim

   If you wish to appeal a denied claim, you must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

   - the patient's name and ID number as shown on the ID card;
   - the provider's or insurer's name;
   - the date of medical service or period of coverage;
   - the reason you think your claim should be paid; and
   - any documentation or other written information to support your request.

If you wish to request a formal appeal of a denied claim for reimbursement, the appeals should be submitted to:

PayFlex Systems USA, Inc.
OneExchange HRA
P.O. Box 3039
Omaha, NE 68103-3039
Fax: (402) 231-4310

2. Review of an Appeal

   OneExchange will conduct a full and fair review of your appeal. The appeal may be reviewed by:

   - an appropriate individual(s) who did not make the initial benefit determination; and
   - a health care professional who was not consulted during the initial benefit determination process.

     Once the review is complete, if OneExchange upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

3. Timing

   - If your claim is incomplete,
     - OneExchange must notify you within 30 days
     - You must then provide completed claim information to OneExchange within 45 days after receiving an extension notice
   - If OneExchange denies your initial claim, they must notify you of the denial:
     - If the initial claim is complete, within 30 days
     - After receiving the completed claim (if the initial claim is incomplete), within 30 days
     - You must appeal the claim denial no later than 180 days after receiving the denial
   - If OneExchange denies your appeal, they must notify you of the denial 30 days after receiving the first level appeal
   - OneExchange may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control

4. Limitation of Action

   You cannot bring any legal action against the Plan, SCANA, or the OneExchange to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against the Plan, SCANA, or the Claims Administrator, you must do so within one (1) year from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against the Plan or the Claims Administrator.

NEBCO ENHANCED

Medicare Supplement for Retirees Age 65 and Over

NEBCO Enhanced coverage, underwritten by Transamerica Life Insurance Company (medical) and Sterling Life Insurance Company (prescription drug), is an insured benefit. The controlling policies and certificates of coverage are incorporated by reference and include the applicable claims procedures. To the extent this document or the policy or certificate of coverage conflict, the policy and/or certificate of coverage control.

Retiree Medical Insurance Enhanced Plan

Medicare (Part A) - Hospital services - Per Benefit Period*

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days All but	**$1,260** (Part A deductible)	**$1,260** (Part A deductible)	**$0**
61st through 90th day	All but $315 per day	$315 per day	**$0**
91st day and after:			
While using 60 lifetime reserve days	All but $630 per day	$630 per day	**$0**
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	**$0**
Beyond the Additional 365 days	$0	$0	**All costs**
Skilled Nursing Facility Care*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	**$0**
21st through 100th day	All but $157.50 per day	$157.50 per day	**$0**
101st day and after	$0	$0	**All costs**
Blood			
First 3 pints	$0	100%	**$0**
Additional amounts	100%	$0	
Hospice Care			
Available as long as your doctor certifies that you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and limited inpatient respite care	$0	**Balance**

Administered by AmWINS, formerly
National Employee Benefit Companies, Inc. (NEBCO)

AmWINS Group Benefits

Retiree Medical Insurance Enhanced Plan (continued)

Medicare (Part B) Medical Services – Per Calendar Year

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses - In or Out of the Hospital and Out-patient Hospital Treatment, such as Physician's services, in-patient and out-patient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
Medicare Part B Deductible	$0	$0	**$147 (Part B Deductible)**
Medicare-approved amounts	Generally 80%	$0	**20% up to $500 including the Medicare Part B Deductible**
After payment of the standard Part B Deductible and an annual Policy deductible totaling $500, the plan pays 20% of Medicare-eligible Part B expenses.	Generally 80%	20%	**$0**
Part B Excess Charges (Above Medicare-approved amounts)	$0	100%	**$0**
Blood			
First 3 pints	$0	All costs	**$0**
Medicare Part B Deductible	$0	$0	**$147 (Part B Deductible)**
Medicare-approved amounts	Generally 80%	$0	**20% up to $500 including the Medicare Part B Deductible**
After payment of the standard Part B Deductible and an annual Policy deductible totaling $500, the plan pays 20% of Medicare-eligible Part B expenses.	Generally 80%	20%	**$0**
Clinical Laboratory Services			
Blood tests for Diagnostic Services	100%	$0	**$0**

Administered by AmWINS, formerly
National Employee Benefit Companies, Inc. (NEBCO)

AmWINS Group Benefits

Retiree Medical Insurance Enhanced Plan (continued)

Medicare Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care			
Medicare-approved services:			
Medically necessary skilled care services and medical supplies			
Durable medical equipment:	100%	$0	$0
Medicare Part B Deductible	$0	$0	$147 (Part B Deductible)
Medicare-approved amounts	Generally 80%	$0	20% up to $500 including the Medicare Part B Deductible
After payment of the standard Part B Deductible and an annual Policy deductible totaling $500, the plan pays 20% of Medicare-eligible Part B expenses.	Generally 80%	20% Services	$0 Medicare Pays

Other Benefits Not Covered Medicare

Services	Medicare Pays	Plan Pays	You Pay
Foreign Travel			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:			
First $250 each calendar year	$0	$0	**$250**
Remainder of charges	$0	80% to a lifetime maximum of $50,000	**20% and amounts over the $50,000 lifetime maximum**

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**Once you have been billed $147 of Medicare-Approved amounts for covered services, your Medicare Part B Deductible will have been met for the calendar year.

The summary of program benefits described herein is for illustrative purposes only. In case of differences or errors, the Group Policy governs.

Benefits will not be paid for any expenses which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified. For complete details please see the Master Policy. This policy is renewable at the option of the insurer.

Administered by AmWINS, formerly
National Employee Benefit Companies, Inc. (NEBCO)

AmWINS Group Benefits

The prescription drug plan included in the NEBCO option is **Rx Plan 1**. Retirees can buy up to **Rx Plan 2** for an additional monthly fee.

Rx Plan 1
Prescription Drug Plan - Summary of Benefits
2015 Enhanced Medicare Part D Four-Tier Plan

Enhanced Medicare Part D plan with no annual deductible and no gap in coverage		
Deductible: $0		
Tier	**30-Day Retail Pharmacy† Coinsurance**	**90 Day Retail Pharmacy or Mail Order† Coinsurance**
Tier 1: Generic	30% (maximum out of pocket of $100 per prescription)	30% (maximum out of pocket of $250 per prescription)
Tier 2: Preferred Brand	30% (maximum out of pocket of $100 per prescription)	30% (maximum out of pocket of $250 per prescription)
Tier 3: Non-Preferred Brand & High Cost Generics	50% (maximum out of pocket of $100 per prescription on High Cost Generics Only)	50% (maximum out of pocket of $250 per prescription on High Cost Generics Only)
Tier 4: Specialty and High Priced Brand Drugs	50% (maximum out of pocket of $250 per prescription)	Not Available
Catastrophic Coverage: Total out-of-pocket expenses of $4,700.00+	**Greater of 5% or $2.65 co-payment for generic drugs Greater of 5% or $6.60 for all covered drugs**	

Formulary (drug list): Includes nearly all generic drugs covered by Medicare Part D and most commonly used brand name drugs.

Non-Preferred Brand Drugs are those medications that are higher cost brands and are less cost-effective than preferred brand drugs.

High Priced Brand Drugs those medications that cost more than $600.00 for a 30 day supply.

Plan Service Area: All 50 states of the United States along with most U.S. Territories.

Network Pharmacies: There are more than 63,000 network pharmacies nationwide, including Walgreens, CVS, Rite-Aid, Wal-Mart, and Target.

†Up to a 34 day supply on prescriptions is available through participating retail pharmacy locations. Up to a 93 day supply on prescriptions is available through mail order and may be available through participating retail pharmacy locations.

Rx Plan 2- Buy-Up Option
Prescription Drug Plan - Summary of Benefits
2015 Enhanced Medicare Part D Four-Tier Plan

Four-Tier Plan **Enhanced Medicare Part D plan with no annual deductible and no gap in coverage**		
Deductible: $0		
Copay Tier	30-Day Retail Pharmacy† Copay	90 Day Retail Pharmacy or Mail Order† Copay
Tier 1: Generic	$8	$20
Tier 2: Preferred Brand	$45	$90
Tier 3: Non-Preferred Generic & Non-Preferred Brand	$95	$285
Tier 4: Some Generic & Brand and Specialty	33%	33%
Coverage in Gap*	**Same copay schedule as above.**	
Catastrophic Coverage: Total out-of-pocket expenses of $4,700.00+	**Greater of 5% or $2.65 co-payment for generic and multi-source drugs. Greater of 5% or $6.60 for all other covered drugs.**	

Formulary (drug list): Includes nearly all generic drugs covered by Medicare Part D and most commonly used brand name drugs.

Plan Service Area: All 50 states of the United States along with most U.S. Territories.

Network Pharmacies: More than 60,000 network pharmacies nationwide, including Walgreens, CVS, Rite-Aid, Wal-Mart, and Target.

*Your Coverage Gap copay already includes the 50% manufacturer's discount on covered brand name drugs to Part D enrollees not already receiving extra help.

†Up to a 34 day supply on prescriptions is available through participating retail pharmacy locations. Up to a 93 day supply on prescriptions is available through mail order and may be available through participating retail pharmacy locations.

Note: In the event the Employer Group terminates coverage before the end of the coverage year, 90 day prescriptions will be reduced to a 30 day prescription.

The benefit information provided is a brief summary, not a complete description of benefits. For more information contact the plan. Benefits, formulary, pharmacy network, provider network, premium and/or co-payments/co-insurance may change on January 1 of each year. Limitations, copayments and restrictions may apply.

Retiree Only	**Retiree & Spouse**	**Spouse/Surviving Spouse Only**
❑ Enhanced Rx Plan 2 **$55.00** additional per month	❑ Enhanced Rx Plan 2 **$110.00** additional per month	❑ Enhanced Rx Plan 2 **$55.00** additional per month

COMPANION LIFE DENTAL (For those retired prior to 1994)

Companion Life Dental coverage is an insured benefit. The controlling policy and certificate of coverage provided to you is incorporated by reference, and to the extent this document or the policy or certificate of coverage conflict, the policy and/or certificate of coverage control. Payment is based upon allowable charges in the area in which service is rendered. Any dentist charge above the allowable charge is not a covered expense.

Schedule of Benefits

Program Deductible	
Per Individual Family Unit Waived for Type I Services	$50 Contract Year 3 Yes
Type I Preventive Services	
Oral exams, cleanings (two per 12 months), bitewing X rays (one per 12 months), space maintainers, pain treatment, sealants, full-mouth X-rays	100%
Type II Basic Services	
Fillings, anesthesia, endodontics, simple and surgical extractions, oral surgery, perodontics Benefit waiting period	80% None
Type III Major Services	
Crowns, inlays, onlays, dentures, bridges, implants Benefit waiting period	50% None
Contract Year Maximum	$1,500
Type IV Orthodontia (child(ren) only)	Not Selected

WHEN COVERAGE ENDS

Termination Coverage – Your Coverage
Your coverage will cease on the earliest date below:

- The end of the month following the date you cease to be an Eligible Retired Employee or cease to qualify for the coverage;
- The 91st day after you fail to make required premium payments;
- The date the Plan is terminated.
- The date you submit a false claim or are involved in any other form of fraudulent act related to the Plan.

Termination of Coverage – Dependent Coverage
Your coverage for all of your Dependents will cease on the earliest date below:

- The date your coverage ceases;
- The end of the month following the last day you cease to be eligible for Dependent coverage;
- The 91st day after you fail to make required premium payments;
- The end of the month following the last day the date Dependent coverage is canceled;
- The end of the month following the last day the date you pre-decease your spouse, provided you meet certain active criteria.

The coverage for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent. In the case of a dependent Child, coverage will terminate at the end of the month following the date that child reaches the limiting age.

CONTINUATION OF GROUP HEALTH COVERAGE RIGHTS (COBRA)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires employers providing group health plan coverage to offer covered participants the opportunity to temporarily extend their coverage at group rates in certain instances when coverage under the Plan would otherwise end.

General

At the time you retire, you will be given the choice of electing COBRA continuation coverage under the Active Employee Healthcare SPD of the SCANA Corporation Health and Welfare Plan ("active Plan") or enrolling in the healthcare benefits under this SCANA Corporation Retiree Welfare Benefits Plan (for purposes of this COBRA section referred to as the "retiree Plan"). If you elect to enroll in the retiree Plan, you will forfeit your right to continuation coverage.

Dental benefits is covered by the retiree Plan only for individuals who retired from SCANA at age 65 or older who retired from SCANA prior to January 1, 1994. If you have dental coverage under the active Plan at the time you retire, you may be able to elect COBRA continuation coverage for those benefits.

Your covered eligible dependents may still have COBRA continuation rights under the retiree Plan if:

- you or your spouse dies;
- you are divorced or legally separated;
- your dependents cease to be eligible dependents;
- you are entitled to Medicare benefits; or
- the company files for bankruptcy.

These events are referred to as "qualifying events." Through COBRA, your eligible dependents may continue the same healthcare coverage they had before the event that qualified them for COBRA. If coverage for non-COBRA beneficiaries is modified, coverage made available to your eligible dependent through COBRA will be similarly modified.

COBRA coverage is provided subject to your eligibility for coverage as described below. The COBRA Administrator reserves the right to terminate your and your dependents' coverage retroactively if it's determined that you and/or your dependents are ineligible for COBRA coverage under the terms of the retiree Plan.

Individuals who elect continued coverage under COBRA generally have to pay the entire cost of that coverage plus a 2% administrative fee.

For more information, contact your COBRA administrator in writing at:

Vice President of Human Resources
SCANA Corporation
Mail Code C121
220 Operation Way
Cayce, SC 29033
803-217-4444

You also can contact the COBRA administrator by calling 803-217-4444.

COBRA-at-a-Glance

The following table provides an overview of available COBRA coverage for most types of healthcare coverage that can be continued under COBRA if your eligible dependent loses coverage under a plan based on a qualifying event. See the following sections of this summary for more details.

Who Is Affected	Qualifying Event	Who Is Eligible for COBRA Coverage	Duration of COBRA Coverage*
Your Spouse or Dependent Child	You die	Your covered dependents	Up to 36 months
	You and your enrolled spouse become divorced or legally separated	Your covered dependents, including your former spouse	Up to 36 months
	You become entitled to Medicare (Part A, Part B, or both)	Your covered dependents	Up to 36 months
	The Company files for bankruptcy under Title 11, United States Code (This is a qualifying event for any eligible dependents if there is a substantial elimination of coverage within one year before or after the date bankruptcy was filed.)	Your covered dependents	Up to 36 months
Your Dependent Child	Your dependent child is no longer an eligible dependent (for example, due to reaching a plan's age limit, or marriage).	Your covered dependent child	Up to 36 months

*Duration of COBRA coverage is measured from the last day of the month in which the qualifying event occurs and is not available for more than a total of 36 months.

If you are a qualified beneficiary and you lose coverage under the Plan due to the death of the retiree, a divorce or legal separation, or due to a child's loss of dependency status, you must notify the Plan administrator of the event within 60 days after the qualifying event occurs or you will lose your right to elect COBRA continuation coverage.

Electing COBRA Coverage. If you are a qualified beneficiary and you experience a qualifying event, you will receive a qualifying event notice from the COBRA administrator describing your rights to elect COBRA continuation coverage, as well as an election form you can use to apply for that coverage. Remember, if the qualifying event is a divorce, legal separation, or a child's loss of dependency status, you must first notify the COBRA administrator of the event before this notice will be sent to you. If you do not receive a qualifying event notice and election form within 30 days of your qualifying event (or within 14 days of the date you notified the Plan administrator of a qualifying event, if applicable), you should contact the COBRA administrator.

Although each qualified beneficiary has an independent right to elect COBRA coverage, the qualifying event notice and election form will usually only be sent to your spouse, at the address shown in the records of the Plan. However, if the records of the Plan show that your spouse lives at different locations, or that a dependent child lives at a different location, separate notices will be sent. For this reason, it is very important that you keep the Plan administrator informed of your current address and the addresses of your spouse and covered dependents. Again, each qualified beneficiary has an independent right to elect COBRA continuation coverage. Parents may elect COBRA continuation coverage on behalf of their minor children.

COBRA coverage will be provided only if it is elected by a qualified beneficiary during the COBRA election period. The COBRA election period begins on the date of the qualifying event and ends 60 days after the date a qualifying event notice is sent to the qualified beneficiary or, if later, the date the qualified beneficiary would otherwise lose coverage as a result of the qualifying event. For elections sent by mail, the postmark date is used to determine whether an election was made prior to the end of the COBRA election period.

If elected, COBRA coverage begins on the date coverage would otherwise have been lost. The Plan does not permit you to waive COBRA coverage during the election period and then revoke the waiver before the end of the election period in order to elect coverage as of a date other than the date coverage was initially lost.

Prior to the time a qualified beneficiary elects COBRA coverage, his or her coverage under the Plan will be terminated. However, the coverage will be retroactively reinstated to the date coverage was lost following a timely election of COBRA coverage and the timely payment by the qualified beneficiary of the first premium payment. This means that, until you elect COBRA coverage, any provider who asks will be told that your coverage has been terminated, but may be retroactively reinstated if you timely elect and pay for COBRA coverage.

Paying for COBRA Coverage. Qualified beneficiaries must pay for each one-month period of COBRA coverage on a monthly basis. A period of COBRA coverage runs from the first day of the month through the end of that month, except that the initial period of coverage runs from the date coverage was lost due to the qualifying event, through the end of the month in which the qualifying event occurred.

The cost for each one-month period of COBRA coverage depends on the type of coverage that is being continued. The cost will be communicated to you in the qualifying event notice sent to you by the Plan administrator. The cost may change at the beginning of each Plan year. Any changes will be communicated to you.

The first payment for COBRA coverage must be postmarked or received by the Plan no later than 45 days after the date you elect COBRA coverage. The first payment must include payment for all one-month periods of coverage that have begun between the date coverage was lost and the date the first premium payment is received. If the payment is not postmarked or received within 45 days of the date you elected COBRA coverage, you will lose your right to COBRA coverage.

Payments for subsequent one-month periods are due on the first day of those periods and should be sent to the Plan administrator. You will have a 30-day grace period to send in these payments, but they must be postmarked or received no later than 30 days after the first day of the coverage period or your COBRA coverage will be terminated retroactively to the first day of that period and cannot be reinstated. Any

payment that is less than the full premium payment due will not be accepted unless the balance is paid prior to the end of the normal grace period. In some cases, however, if your payment is not significantly less than the applicable premium, you will have 30 days following the date you are notified of the shortfall to make up the balance.

If payment for a period of COBRA coverage is made after the first day of that period, your coverage will be continued but will be subject to retroactive termination if payment for that period is not received during the grace period. However, any claims incurred prior to payment will not be processed until payment is made. This means that, until you pay for COBRA coverage, any health care provider who asks will be told that your coverage is in force, but may be retroactively terminated if you do not timely pay for COBRA coverage. In addition, you will be required to reimburse the Plan for any claims that are paid if you do not subsequently send in timely payment.

Application of Deductibles and Other Plan Limits. If COBRA coverage begins during the middle of a Plan year, the qualified beneficiary's deductibles for the remainder of the Plan year will be administered as follows:

Each qualified beneficiary who elects COBRA coverage will receive credit for any expenses previously applied during the Plan year to his or her individual deductible.

If the qualified beneficiary was previously part of a family unit, only those expenses incurred by family members electing COBRA coverage will be credited. If the qualifying event results in more than one family unit (for example, due to a divorce), the expenses incurred by the members assigned to a given family unit following the COBRA election shall be credited as of the date coverage begins.

Other plan limits will be applied consistent with the rules applicable for deductibles.

How to Notify the Plan Administrator. You must send written notice of a qualifying event that is a divorce, a legal separation, or a child's loss of dependent status, to the COBRA Administrator within 60 days of the event. Notice must be sent by first-class mail or other nationally-recognized courier service; by fax; e-mail; or by hand delivery. Oral notice will not be accepted. Contact information for the COBRA Administrator is located above and in the Plan Information section of this document. Your notice must include your name and the names of other affected family members, the type of qualifying event and written documentation of the event that identifies the date on which the event occurred. You should keep a copy, for your records, of any notices you send to the COBRA Administrator.

Any notices required to be provided to the COBRA Administrator may be provided by you, a qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of either of them, and will be sufficient for all beneficiaries affected by the same qualifying event.

If You Have Questions. Questions concerning the Plan or your COBRA continuation coverage rights should be addressed to the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act ("HIPAA"), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's employee benefits Security Administration ("EBSA") in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

DEFINITIONS

You will find terms throughout this SPD.To help you understand your benefits, most of these terms are defined in the following definitions section.

Charges
The term charges means the actual billed charges submitted by a provider. The allowed charges are what the provider has contracted directly or indirectly with BlueCross to receive.

Claimant
A covered participant or covered dependent or provider, to whom payment for services may be assigned, who is making claims for services under this Plan.

Coinsurance
The term coinsurance means the percentage of charges for covered expenses that a covered person is required to pay under the Plan.

Cross Accumulation
The dollars you spend toward meeting your plan deductible and maximum out-of-pocket costs for in-network services apply toward meeting your deductible and maximum out-of-pocket costs for out-of-network services.

Likewise, the dollars you spend toward meeting your plan deductible and maximum out-of-pocket costs for out-of-network services apply toward meeting your deductible and maximum out-of-pocket costs for in-network services. However, only expenses incurred for out-of- network provider charges will be used to satisfy the remainder of the out-of-network provider deductibles and out-of-pocket maximums.

Custodial Services
The term custodial services means any services which are not intended primarily to treat a specific injury or sickness (including mental illness, alcohol or drug abuse). Custodial services include, but shall not be limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as: (a) walking; (b) grooming; (c) bathing; (d) dressing; (e) getting in or out of bed; (f) toileting; (g) eating; (h) preparing foods; or (i) taking medications that can usually be self-administered; and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

Deductible
The amount you pay toward medical expenses each year before the Plan starts paying benefits.

Dentist
The term dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the dental services described in this booklet.

Durable Medical Equipment:
Medical equipment that:

1. Can withstand repeated use; and,
2. Is medically necessary; and,
3. Is customarily used for the treatment of a member's illness, injury, disease or disorder; and,
4. Is appropriate for use in the home; and,
5. Is not useful to a member in the absence of illness or injury; and,
6. Does not include appliances that are provided solely for the member's comfort or convenience; and,
7. Is a standard, non-luxury item (as determined by the employer's group health Plan); and,
8. Is ordered by a medical doctor, oral surgeon, podiatrist, or osteopath.

Prosthetic devices, orthopedic devices and orthotic devices are considered durable medical equipment when the required preauthorization is obtained.

Emergency Services
Emergency services are medical, psychiatric, surgical, hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily injury or serious sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention.
Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the hospital on the UB92 claim form, or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.

"Emergency Medical Condition" means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part.

"Emergency services" means, with respect to an emergency medical condition: (a) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and (b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

Employer
The term employer means the applicable subsidiary of SCANA Corporation, the Plan sponsor self-insuring the Retiree Share Plan benefits described in this Plan, on whose behalf BlueCross is providing claim administration services.

Expense Incurred
An expense is incurred when the service or the supply for which it is incurred is provided.

Free-Standing Surgical Facility
The term free-standing surgical facility means an institution that meets all of the following requirements:

- It has a medical staff of physicians, nurses and licensed anesthesiologists;
- It maintains at least two operating rooms and one recovery room;
- It maintains diagnostic laboratory and X-ray facilities;
- It has equipment for emergency care;
- It has a blood supply;
- It maintains medical records;
- It has agreements with hospitals for immediate acceptance of patients who need hospital confinement on an inpatient basis; and
- It is licensed in accordance with the laws of the appropriate legally authorized agency.

Home Health Aide
The term home health aide means a person who: (a) provides care of a medical or therapeutic nature; and (b) reports to and is under the direct supervision of a home health care agency.

Home Health Care Agency
The term home health care agency means a hospital or a non-profit or public home health care agency which:

- Primarily provides skilled nursing services and other therapeutic services under the supervision of a physician or a registered graduate nurse;
- Is run according to rules established by a group of professional persons;
- Maintains clinical records on all patients;

- Does not primarily provide custodial care or care and treatment of the mentally ill;

- But only if, in those jurisdictions where licensure by statute exists, that home health care agency is licensed and run according to the laws that pertain to agencies which provide home health care.

Home Health Care Plan
The term home health care plan means a plan for care and treatment of a person in his home. To qualify, the plan must be established and approved in writing by a physician who certifies that the person would require confinement in a hospital or skilled nursing facility if he did not have the care and treatment stated in the plan.

Hospice Care Program
The term hospice care program means:

- A coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;

- A program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness.

Hospice Care Services
The term hospice care services means any services provided by: (a) a hospital, (b) a skilled nursing facility or a similar institution, (c) a home health care agency, (d) a hospice facility, or (e) any other licensed facility or agency under a hospice care program.

Hospice Facility
The term hospice facility means an institution or part of it which:

- Primarily provides care for terminally ill patients;

- Is accredited by the National Hospice Organization;

- Meets standards established by BlueCross for the Retiree Share Plan; and

- Fulfills any licensing requirements of the state or locality in which it operates.

- A program for persons who have a terminal illness and for the families of those persons.

Hospital
The term hospital means:

- An institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of physicians; and (c) provides 24-hour service by registered graduate nurses;

- An institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of hospitals; or

- An institution which: (a) specializes in treatment of mental illness, alcohol or drug abuse or other related illness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate legally authorized agency.

The term hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

Hospital Inpatient or Confined in a Hospital
A person will be considered confined in a hospital if he is:

- A registered bed patient in a hospital upon the recommendation of a physician; or

- Receiving treatment for mental health and substance abuse services in a partial hospitalization program;

- Receiving treatment for substance abuse in a substance abuse intensive therapy program;

- Receiving treatment in a mental health residential treatment center.

Injury
The term injury means an accidental bodily injury.

Maximum Payment
The maximum amount the Plan will pay for a particular benefit.

Medicaid
The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965, as amended.

Medically Necessary
The term medically necessary means a service or supply which is determined to be required for the treatment or evaluation of a medical condition which is consistent with the diagnosis, and which would not have been omitted under generally accepted medical standards, or provided in a less intensive setting.

Medical Necessity
Health care services and supplies which are determined to be: (a) no more than required to meet the basic health needs of the covered participant; (b) consistent with the diagnosis of the condition for which they are required; (c) consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by medical research; (d) required for purposes other than the comfort and convenience of the patient or their physician; (e) rendered in the least intensive setting that is appropriate for the delivery of health care; and (f) of demonstrated medical value.

Medicare
The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Necessary Services and Supplies
The term necessary services and supplies includes:

- Any charges, except charges for room and board, made by a hospital on its own behalf for medical services and supplies actually used during hospital confinement;
- Any charges, by whomever made, for licensed ambulance service to or from the nearest hospital where the needed medical care and treatment can be provided; and
- Any charges, by whomever made, for the administration of anesthetics during hospital confinement.

The term necessary services and supplies will not include any charges for special nursing fees, dental fees or medical fees.

Nurse
The term nurse means a registered graduate nurse, a licensed practical nurse or a licensed vocational nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

Ophthalmologist
A physician operating within the scope of his license when he performs any of the vision care services described in this booklet.

Optometrist
A physician operating within the scope of his license when he performs any of the vision care services described in this booklet.

Out-of-Pocket Expenses
Out-of-pocket maximums limit the amount of money you pay in one calendar year for services and protect you against the financial burden of a serious illness or injury. Once you reach the out-of-pocket maximum, the Plan may pay 100% of covered expenses for the remainder of the year. Out-of-pocket expenses apply to charges from both in-network and out-of-network providers.

Participant
A participant is a SCANA retiree or his/her dependent(s) who has satisfied the eligibility and enrollment requirements under the plan.

Participating In-Network Pharmacy
In-network pharmacy means the SCANA in-house pharmacy, a retail pharmacy or mail-order pharmacy which has contracted with BlueCross either directly or indirectly to provide prescription services to its covered participants.

Participating In-Network Provider
The term in-network provider means:

- An institution, facility or agency which has entered into a contract with a Preferred Provider Organization (referred to as the PPO) to provide medical services at a predetermined cost .

- A health care professional who has entered into a contract with a PPO to provide medical services at predetermined fees.

Pharmacy
The term pharmacy means your SCANA in-house pharmacy, a retail pharmacy, or a mail-order pharmacy.

Pharmacy & Therapeutics (P&T) Committee
A committee of provider organization participants comprised of medical providers, pharmacists, medical directors and pharmacy directors, which reviews medications for safety and efficacy. The P&T Committee evaluates medications for potential addition to or deletion from the formulary and may also set dosage and dispensing limits on medications.

Physician
The term physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where coverage is provided if he is:

- Operating within the scope of his license; and

- Performing a service for which benefits are provided under this Plan when performed by a physician.

Prescription Drug
Prescription drug means; (a) a drug which has been approved by the Food and Drug Administration for safety and efficacy; or (b) certain drugs approved under the Drug Efficacy Study Implementation review; or (c) drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a prescription order; or (d) injectable insulin.

Prescription Drug List
Prescription drug list means a listing of approved prescription drugs and related supplies. The prescription drugs and related supplies included in the prescription drug list have been approved in accordance with parameters established by the P&T Committee. The prescription drug list is regularly reviewed and updated.

Prescription Order
Prescription order means the lawful authorization for a prescription drug or related supply by a physician who is duly licensed to make such authorization within the course of such physician's professional practice or each authorized refill thereof.

Primary Care Physician
The term primary care physician means a physician: (a) who qualifies as a in-network provider in general practice, internal medicine, family practice or pediatrics; and (b) who has been selected by you, as authorized by the provider organization, to provide or arrange for medical care for you or any of your insured dependents.

Preventive Services
Preventive services means preventive care services provided on an outpatient basis at a physician's office or a hospital that have been recommended to be effective in either the early detection of disease or in the prevention of disease. The Plan covers items and services in the following preventive care categories in accordance with federal law:

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive services Task Force;

- immunizations as recommended from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

- with respect to infants, children and adolescents, preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and services Administration.

For a detailed list of the covered services, see the government website http://www.healthcare.gov/law/about/provisions/services/lists.html.

Proper Verification
Proper verification refers to the documentation necessary to substantiate a qualifying change in status. Examples of proper verification include but are not limited to marriage license, affidavit of common law marriage, birth certificate, divorce decree, and verification of other coverage.

Provider Organization
The term provider organization refers to a network of in-network providers.

Psychologist
The term psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include: (1) any other licensed counseling practitioner whose services are required to be covered by law in the locality where coverage is provided if he is: (a) operating within the scope of his license; and (b) performing a service for which benefits are provided under this Plan when performed by a psychologist; and (2) any psychotherapist while he is providing care authorized by the provider organization if he is: (a)
state licensed or nationally certified by his professional discipline; and (b) performing a service for which benefits are provided under this Plan when performed by a psychologist.

Related Supplies
Related supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

Review Organization
The review organization is an organization with a staff of clinicians which may include physicians, registered nurses, licensed mental health and substance abuse professionals, and other trained staff participants who perform utilization
review services.

Room and Board
The term room and board includes all charges made by a hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

Sickness - For Medical Insurance
The term sickness means a physical or mental illness. It also includes pregnancy for employees and spouses. Expenses incurred for routine hospital and pediatric care of a newborn child prior to discharge from the hospital nursery will be considered to be incurred as a result
of sickness.

Skilled Nursing Facility
The term skilled nursing facility means a licensed institution (other than a hospital, as defined) which specializes in:

- Physical rehabilitation on an inpatient basis; or
- Skilled nursing and medical care on an inpatient basis;
- but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of physicians; and (c) provides nurses' services.

Special Injectables
Injectable drugs are medications that may be physician-administered or self-administered via an injection. These drugs require prior authorization. These drugs do not include immunizations, insulin or any medications administered intravenously on a continuous basis for a period of time.

Specialist
The term specialist means a physician who provides specialized services, and is not engaged in general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics.

Surviving Spouse
A person you have been legally married to as of your date of death.

Terminal Illness
A terminal illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a physician.

Urgent Care
Urgent care is medical, surgical, hospital or related health care services and testing which are not emergency services, but which are, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a physician's recommendation that the covered participant should not travel due to any medical condition.

Urgent Care Center
The term urgent care center means a medical facility where ambulatory patients can be treated for urgent care conditions.

You (or your)
A person in the eligible group, including the employee and any dependents.

ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U. S. Department of Labor and available at the Public Disclosure Room of the employee benefits Security Administration;

- Obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated SPDs. The Plan Administrator may make a reasonable charge for the copies; and

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for your spouse and/or dependents if there is a loss of coverage under the Plan as a result of a family status change. You may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your federal continuation coverage rights;

Prudent Actions by Plan Fiduciaries
In addition to creating rights for Plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may terminate you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or Federal court after you have exhausted all administrative remedies.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting

your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HIPAA Amendment

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that, in part, requires group health plans to protect the privacy and security of your confidential health information. As an employee welfare plan under ERISA, the Plan is subject to the HIPAA privacy and security rules. Pursuant to the HIPAA request a description of the Plan's uses and disclosures of your protected health information and your rights and protections under the HIPAA privacy and security rules as set forth in the plan's Notice of Privacy Practices, the Plan will not use or disclose your protected health information without your Authorization, except for purposes of payment, health care operations, Plan administration or as required or permitted by law. You may request a description of the Plan's uses and disclosures of your protected health information and your rights and protections under the HIPAA privacy rules as set forth in the plan's Notice of Privacy Practices, by contacting:

SCANA Privacy Officer
SCANA Corporation Mail Code B111
220 Operation Way
Cayce, SC 29033

Plan Information

Retiree Healthcare

Plan Name	SCANA Corporation Retiree Welfare Benefits Plan
Plan Sponsor / Employer	SCANA Corporation 220 Operation Way Cayce, SC 29033 803-217-4444
Employer ID Number	57-0784499
Type of Plan	Welfare benefit plan providing medical, dental, pharmacy and vision benefits.
Plan Number	521
Plan Fiscal Year	January 1 - December 31
Plan Effective Date	January 1, 2015; this summary plan description is effective January 1, 2015
Plan Administrator and Named Fiduciary	Vice President of Human Resources The plan administrator shall have the full discretionary authority and power to control and manage all aspects of the Plan and determine eligibility for benefits under the Plan in accordance with its terms and all applicable laws. The plan administrator may allocate or delegate its responsibilities for the administration of the Plan to others and employ others to carry out or give advice with respect to its responsibilities under the Plan. The plan administrator has delegated various aspects of the Plan administration to BlueCross BlueShield of South Carolina.
Claims Administration and Funding	SCANA Corporation has entered into an administrative services agreement with BlueCross BlueShield of South Carolina, who in turn contracts with administrators for the pharmacy and vision portions of the plan.
Claims Fiduciary	See table below.
Agent for Service of Process	Corporation Service Company 1703 Laurel Street Columbia, SC 29201
Plan Trustee	State Street Corporation Specialized Trust service 200 Newport Avenue JQB-7N North Quincy, MA 02171
Reservation of Rights	Although SCANA currently intends to continue the Plan indefinitely, SCANA reserves the right to modify, amend or terminate any and all provisions of the Plan at any time. No employee has any vested right to any benefit or coverage under the Plan. SCANA intends that any changes to the Plan will apply to all participants receiving benefits under the Plan on the effective date of the change.

Administrator	Benefit	Contact Information
BlueCross BlueShield of South Carolina	Retiree Share medical	P.O. Box 100300 Columbia, SC 29202
EyeMed	Retiree Share vision benefit	4000 Luxottica Place Mason, OH 45040 (866) 723-0513
PayFlex Systems USA, Inc. OneExchange HRA	Health Reimbursement Account (HRA) benefit	P.O. Box 3039 Omaha, NE 68103-3039 Fax: (402) 231-4310
Transamerica Life Insurance Company	NEBCO medical benefit	P.O. Box 3350 Cedar Rapids, IA 52406-3350
Sterling Life Insurance Company	NEBCO prescription drug benefit	AmWINS Rx 50 Whitecap Drive North Kingstown, RI 02852
Companion Life	Dental benefit	P.O. Box 100102 Columbia, SC 29202 (800) 765-9603


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