

# AMENDMENT TO YOUR BLUE CROSS® AND BLUE SHIELD® OF SOUTH CAROLINA POLICY

(An Independent Licensee of the Blue Cross and Blue Shield Association,  
an association of independent Blue Cross and Blue Shield Plans)  
(www.SouthCarolinasBlues.com)

## Consolidated Appropriations Act (CAA) Amendment

This Amendment is subject to all the provisions of the Policy, Policy Name listed below, which are not otherwise specified in the provisions of this Amendment.

12100M-A (Rev. 1/12), 12126M-A (Rev. 1/12), 12130M-A (Rev. 1/12), 12133M-A (Rev. 1/12), 12099M-A (Rev. 1/12), 12327M-A (Rev. 1/12), 12136M-A (Rev. 1/12), 12139M-A (Rev. 1/12), 12992M-A (Rev. 1/12), 12994M-A (Rev. 1/12), 13034M-A (Rev. 1/12), 13036M-A (Rev. 1/12), 13038M-A (Rev. 1/12) and 13040M-A (Rev. 1/12)

**This Amendment to the Policy is effective on or after the Benefit Period of your Policy starting January 1, 2022.**

**The Policy**, is amended by the addition of the following:

### Special Out-of-Network Rules

If you receive treatment from an out-of-Network Provider as described below, your treatment may be covered and your costs may be comparable to those received from an in-Network Provider, but only if one of the below exceptions applies. The Provider must be an out-of-Network Provider (physician or other clinician, or facility not in our Network) and, in these limited situations, we will treat the Provider as though it was in-Network for purposes of determining your cost share liability, and will pay the Provider our portion of the claim directly. You will still be required to meet any in-Network cost share amounts under all other terms of this coverage, and those in-Network cost share amounts will be based on the Recognized Amount. These are the only circumstances in which BlueCross will allow for out-of-Network services without prior authorization and approval.

- You are treated in the emergency department of a hospital or a free-standing emergency department where the facility or a treating Provider is not in-Network. In emergency situations, no prior authorization is required. For services furnished after your condition has stabilized, as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the emergency department visit where emergency services were furnished, if the Provider or facility provides you (or your authorized representative) with an advance notice, and obtains your (or your authorized representative's) signed consent to be treated on a non-Network basis, these rules will not apply.
- You seek non-Emergency treatment at an in-network hospital, hospital outpatient department, critical access hospital, or ambulatory surgical center, but during your treatment, you receive services from a non-Network Provider. An example of this would be if you have surgery performed in a Network Hospital; your surgeon is in our Network, but the anesthesiologist is not in our Network. In some cases, if the Provider or facility provides you (or your authorized representative) with an advance notice, and obtains your (or your authorized representative's) written consent to be treated on a non-Network basis, these rules will not apply.
- If it is medically necessary for you to be transported by an air ambulance company not in our Network.

If you need assistance because one of the above actions has occurred, please contact us using the information on the back of your ID card or as shown in the section above titled "How to Contact Us."

**D. COVERED SERVICES**, is amended by the addition of the following:

**Ambulance Service** – Benefits are provided for professional ambulance services to the nearest Network Hospital in case of an accident or Emergency Medical Condition. The following requirements apply to all ground and air ambulance transports:

1. The transport is Medically Necessary and reasonable under the circumstances;
2. A BlueCross member is transported;
3. The destination is within the United States; and

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

Non-Emergency Ground Ambulance Transportation: Benefits may be available for non-emergency ground transportation between Hospitals or for a preauthorized admission to another health care facility at a lower level of care, only when all of the following requirements are met:

- Use of a medical transport is medically necessary because the member's condition makes other forms of transportation infeasible (e.g. mechanical ventilation, traction);
- The sending Hospital admission was as an inpatient and was preauthorized;
- The receiving Hospital or facility inpatient admission is preauthorized;
- Use of a medical transport is preauthorized; and
- The receiving Hospital or facility is the closest facility that can provide Covered Services appropriate to the Member's condition.

When all of the above requirements are met, ground transportation may be used in non-emergency transfers for a preauthorized admission for a lower level of care.

An out-of-Network Provider may Balance Bill you in most non-emergency situations. Repatriation is not covered; see the Exclusions section.

Air Ambulance Transportation: Preauthorization is required for transportation as an Inpatient from one Hospital to a second Hospital using an air ambulance. The following requirements must be met:

- The first Hospital does not have needed hospital or skilled nursing care for the member's illness or injury (such as burn care, cardiac care, trauma care, and critical care);
- The second Hospital is the nearest medically appropriate facility;
- A ground ambulance transport endangers the Member's medical condition; and
- The transport is not related to a hospitalization outside the United States.

Cost-Sharing for out-of-Network air ambulance services is at the in-Network level, applied toward the in-Network Deductible and Maximum out-of-pocket, and based on the Recognized Amount.

The Allowed Amount for air ambulance services provided by non-Network Providers will be no less than the minimum amount required by applicable law, and you generally may not be Balance Billed by the Provider. The Allowed Amount for ground ambulance services provided by non-Network Providers will be determined by BlueCross, in its discretion, using methods, including, but not limited to, governmental reimbursement rates such as Medicare, and/or comparable costs for the same or similar transportation services in the same geographic area, and/or other transportation services over comparable distances. See the Special Out-of-Network Rules section for additional information.

## **Emergency Services**

Use of the Emergency Room is intended only for persons who are experiencing an Emergency Medical Condition. See the Definitions section of this Policy for Emergency, Emergency Medical Condition, and Emergency Services for more details.

Benefits are available to treat an Emergency Medical Condition at a Hospital Emergency Room or at an Urgent Treatment Center, and only for as long as your condition continues to be considered an Emergency. If you receive care for an Emergency Medical Condition and are treated in the Emergency Room at a Hospital, the charges for Emergency Services are paid as follows:

### **1. Emergency Services provided by an in-Network Provider**

When Emergency Services are received from an in-Network Provider, benefits are provided as any other in-Network service under this Policy.

### **2. Emergency Services by an out-of-Network Provider**

When Emergency Services are received from an out-of-Network Provider or Hospital, benefits will be provided for the Emergency Services, and you will be subject to in-Network Cost-Sharing based on the Recognized Amount. The Allowed Amount for benefits for Emergency Services for an Emergency Medical Condition when provided by an out-of-Network

Provider will be no less than the amount required under applicable law. See the Special Out-of-Network Rules section for additional information.

Non-Emergency care outside the Network, including any follow-up to Emergency Care, is not covered.

**This Policy**, is amended by the addition of the following:

### **Continuation of Care**

If benefits under this Policy are no longer covered due to a change in a Provider's terms of participation in the Network, such as a Network Provider's contract is modified, ends, or is not renewed for any reason other than fraud or failure to meet specified quality standards, including suspension or revocation of the Provider's license, and you are a Continuing Care Patient of the Provider at the time, you may be eligible to continue to receive Network benefits for that Provider's services for a limited period of time. We will attempt to notify you if and when these situations arise with your providers, and explain your right to elect continued Network coverage, but such continued Network coverage is not automatic; please contact us or have your provider contact us in order to receive this continued Network coverage.

We recommend you use a form for this request; this form can be found on our website or by calling 855-404-6752. Your treating Provider should include a statement confirming that you have a Serious and Complex Condition. Upon receipt of your request, we will confirm the last date the Provider is part of our Network and a summary of continuation of care requirements. If additional information is necessary, we may contact you or the Provider.

If you qualify for continued Network status, we will provide in-Network benefits for you from that Provider, for the course of treatment relating to your status as a Continuing Care Patient, for 90 days or until the date you are no longer a Continuing Care Patient with respect to the Provider, whichever occurs earlier. During this time, the Provider will accept the Network Provider allowance as payment in full. Such continued Network status is subject to all other terms and conditions of this Policy, including regular benefit limits.

**Appeals/Grievance Procedures**, is amended by the addition of the following:

#### **Standard External Review**

You can request an external review if we deny your claim, either in whole or in part, and the request relates to a decision involving medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or administration of this Policy's provisions under the section entitled "Special Out-of-Network Rules." You may be held financially responsible for the covered benefits. You can request an external review without completing the appeal process above if:

1. Your Physician has certified in writing that you have a Serious Medical or Behavioral Health Condition, a condition that requires immediate medical attention to avoid serious impairment to body functions, serious harm to an organ or body part, or that would place your health in serious jeopardy or jeopardize your ability to regain maximum function. This may include cancer, acute myocardial infarction, pregnancy, and Behavioral Health conditions.

; or

2. The denial of coverage was based on our determination that the service is Investigational or Experimental and your Physician certifies:

a. Your condition is a serious disability or you have a life-threatening disease; and

i. Standard health care services or treatments have not been effective in improving your condition; or

ii. Standard health care services or treatments are not medically appropriate; or

iii. The recommended or requested service or treatment is more beneficial than the standard health care service or

treatment covered by us; and

b. Medical and scientific evidence shows that treatment that was denied is more beneficial to you than available standard health services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of the standard services or treatments.

We will respond within five business days of your request for an external review, by either notifying the South Carolina Department of Insurance of a request for external review and requesting the South Carolina Department of Insurance to assign the review to an independent review organization (IRO) and forwarding your records to it or telling you in writing that

your situation doesn't meet the requirements for an external review and explaining the reasons. The South Carolina Department of Insurance assigns an IRO on a rotational system. BlueCross does not assign the IRO and is obligated to notify the Department of Insurance if a conflict of interest exists so a different IRO can be assigned.

You have five business days from the date you receive our response to submit additional information to the IRO in writing. The IRO must consider this additional information when conducting its review. The IRO will also forward this information to us within one business day of its receipt.

If your request is assigned to an IRO, the IRO will determine within five business days after receiving your request whether all the information, certifications and forms required to process an external review have been provided. If the IRO needs additional information, you will be allowed to submit additional information in writing to them within seven business days.

If your request is not accepted for external review, the IRO will inform you and us in writing of the reason(s) your request was not accepted.

The IRO will provide written notice of its decision within 45 days after it receives the request.

If the IRO's decision is to allow benefits, we must process the claim subject to applicable Policy exclusions, limitations and other provisions within five business days of our receipt of the notification.

**H. OTHER POLICY PROVISIONS**, is amended by the deletion of **2. Conformity with State Statutes**: in its entirety and the following substituted therefore:

**2. Conformity with State Statutes**: Any provision of this Policy which, at any relevant time, is in conflict with the laws of the state in which it is delivered or in conflict with Federal law on that date is amended to conform to the minimum requirements of such laws. Notwithstanding anything herein to the contrary, no provision of this Policy shall be interpreted as prohibiting any provision, access, use, or disclosure of information to the extent required by applicable law.

**B. DEFINITIONS**, is amended by the addition of the following:

**Recognized Amount**: The lesser of the out-of-Network Provider's billed charges or our median contracted rate for in-Network Providers for the same or similar item or service furnished in the same or similar specialty in the same geographic region; provided that, except in connection with air ambulance services, if there is a recognized amount specified for this purpose under an applicable All-Payer Model Agreement under Section 1115A of the Social Security Act, or if not, under applicable state law, then such amount, as applicable, will instead serve as the Recognized Amount.

Nothing contained in this Amendment will be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the Policy or Member Schedule other than as stated above.

**BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA**



**Scott Graves**  
**President**

**Blue Cross and Blue Shield Division**