South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

2023

Business BlueEssentials℠

Benefits are available In-Network and Out-of-Network

Small Group
PPO

Certificate of Coverage

South Carolina

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www.SouthCarolinaBlues.com

Dear Member:

I would like to take this opportunity to welcome you to Blue Cross® and Blue Shield® of South Carolina's most flexible and complete health plan — Business BlueEssentials.

Business BlueEssentials offers members like you many different ways to save on health care. This plan is a Preferred Provider Organization (PPO) from Blue Cross and Blue Shield of South Carolina (also referred to as BlueCross). A PPO is an independent network of Hospitals, Physicians and other health care Providers who have agreements with a health plan to provide services to members at less than their normal charges. This plan features a large and diverse network of physicians and hospitals known as Preferred Blue® Providers.

In this Certificate, you will find a complete list of benefits, instructions on how to use your benefits wisely, tips on how to make the most of your coverage, how to file claims and who to call when you have a question. There also are important sections explaining your benefits and commonly used terms.

This Certificate is part of a Contract between the Group Employer and the Corporation. The Corporation is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. The "Association" permits the Corporation to use the Blue Cross and Blue Shield service marks in the State of South Carolina, and that the Corporation is not contracting as the agent of the Association.

Please take time to review your Certificate carefully — especially the section, *How Your Coverage Works*.

Again, welcome. We are happy to have you as a member of BlueCross.

Sincerely,

Scott Graves
President
Blue Cross and Blue Shield Division
Blue Cross and Blue Shield of South Carolina

Table of Contents

How Your Coverage Works

This Certificate summarizes and explains the benefits available to you from BlueCross. It includes as few legal and technical terms as possible. The terms "we," "us" and "our" refer to BlueCross or the "Corporation." The terms "you" and "your" refer to the Employee and any covered Dependents.

This Certificate becomes part of the Master Contract between BlueCross and your Employer. If you wish to review the Contract, you can arrange to do so by contacting your company's personnel office or health insurance administrator. Defined terms appearing in this Certificate begin with a capital letter. You can find most of these terms in the *Definitions* section.

The insurance benefits provided under the Contract are fully insured by BlueCross. **There are no dollar limits on Essential Health Benefits.**

Important Things to Remember About Your Coverage
This plan gives you the freedom to choose where you receive health care services — whether it is a trusted family Physician or a favorite local Hospital. What's important to remember is we pay your benefits at a higher percentage when you receive medical, surgical, or Behavioral Health services from a Network Provider. This can easily add up to major savings for you. The section on Providers will give you a better understanding.

To make sure you receive services that are Medically Necessary, this plan has built-in cost saving features that also control unnecessary costs. These cost-saving features require that you file a Pre-service Claim to get approval from us on certain services, hospitalizations, supplies and equipment. To avoid having your benefits reduced or not covered at all, please get all necessary approvals as outlined in this Certificate. **Preauthorization or approval of a Pre-service Claim, however, is not a guarantee that we will pay benefits**. To make sure you get the most benefits from this plan, please read the section, *Preauthorization*. This section explains exactly when and how to get an approval.

BlueCross offers a variety of wellness programs, including a smoking cessation program to assist a Member in making a positive lifestyle change. Please call a Customer Service Advocate or go to our website for more information about our programs.

If you perform an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage, we may have grounds to rescind the Contract. A rescission does not include a retroactive cancellation or discontinuance of your coverage due to the failure to timely pay Premiums. If the Contract is rescinded, we will provide 30 days written notice and refund Premiums; your refund may be reduced by any claims that have been paid. After this Contract has been in force for two years, we cannot use any statement made in any Application (unless fraudulent) to void the Contract or deny any claim incurred after the two-year period.

If you have any questions about your coverage, please write or call our Member Service Center. You can find the address and telephone numbers in the section – *How to Contact Us if You Have a Question*.

Non-Discrimination
Blue Cross does not discriminate on the basis of Health Status-Related Factors, race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency or quality of life in the administration of the plan, including enrollment and benefit determination. If you are an individual living with disabilities or have limited English proficiency, we have free interpretive services available. If you have questions about your coverage, please contact Member Services at the number shown in the "How to Contact Us" section for more information.

Premiums may not be increased, coverage cannot be denied and wellness incentives may not be reduced or withheld based on the lawful ownership, possession, use or storage of a firearm or ammunition.

How to Contact Us if You Have a Question

It is only natural to have questions about your coverage and we are committed to helping you understand your coverage so you can make the most of your benefits.

Your Fastest Place for Answers – www.SouthCarolinaBlues.com
If you have access to the Internet, you can find quick and easy answers to your health coverage questions any time day or night. When you go toour website, you will find useful tools that can help you better understand your coverage.
Here are some of the things you can do on our website:

- Learn more about our products and services.
- Stay informed with all the latest BlueCross news, including press releases.
- Find links to other health-related websites.
- Locate a Network Provider, including a Physician, Hospital or Pharmacy. To locate a Provider, go to: https://www.SouthCarolinaBlues.com/links/providers/PreferredBlue
- Use My Health Toolkit®.

My Health Toolkit
Visit SouthCarolinaBlues.com and access My Health Toolkit to:

- Check your eligibility.
- Check HRA information.
- See how much has been applied toward your Deductible or Maximum Out-of-pocket Limit.
- Check on Authorizations.
- Check the status of your claims.
- Order a new ID card
- See if our records show if you have other Health Insurance.
- Ask a Customer Advocate a question through secure email.
- View your Explanation of Benefits (EOB).
- Go paperless with our online bills and Explanations of Benefits
- Pay your bill
- Estimate cost for certain prescription drugs.
- Rate your doctor.

For Customer Service Inquiries

When writing to us, please include your name, address, ID number and phone number in the letter. You may also contact the Member Service Center as shown below

Call:	Monday through Friday, 8:30 a.m. to 5:30 p.m. EST 803-264-3475 (from the Columbia area) 800-868-2500, ext. 43475 (from all other areas)
Write:	Member Service Center Blue Cross and Blue Shield of South Carolina P.O. Box 100300 Columbia, SC 29202-3300
TTY:	800-735-8583 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Friday, 8:30 a.m. to 5:30 p.m. Eastern Standard Time
BlueCross Website Address:	www.SouthCarolinaBlues.com, then log in to My Health Toolkit®

Your Rights and Responsibilities

As a Member, you have certain rights. You also have some responsibilities. As part of our ongoing efforts to keep you informed, we've listed your rights and responsibilities below.

You have the right to:

- Be treated with respect and recognition of your dignity and right to privacy.
- Get the information you need to make thoughtful decisions before choosing a Provider or treatment plan.
- Constructively share your opinion, concerns or complaints.
- Receive information from BlueCross regarding services provided or care received.

You have the responsibility to:

- Carefully read all health plan materials provided by BlueCross.
- Ask questions and make sure you understand the information given to you.
- Present your BlueCross ID card prior to receiving services or care.
- Inform BlueCross of any information that affects your coverage, including any other insurance you may have.
- Select a representative to act on your behalf in the event you are unable to represent yourself.
- Tell us if you move.

Summary of Benefits and Coverage

A Summary of Benefits and Coverage (SBC) gives an overview of the benefit options of your insurance plan. All insurance companies are required to provide you with an SBC, which is in a format required by the government. You can find your SBC by going to My Health Toolkit.

You may also contact a Customer Service Advocate and ask us to send you a copy of the SBC. We can send it to you electronically or mail a paper copy (free of charge). Please note: the format and content of an SBC is controlled by federal agencies. In the event of an inconsistency between the SBC and this Certificate or other documents, these Contract documents are controlling.

Preauthorization

Preauthorization is also called prior authorization, prior approval or precertification. It is important to understand what Preauthorization means. It means the service has been determined to be medically appropriate for the patient's condition. **A Preauthorization does not guarantee that we will pay benefits.**

Preauthorization must be obtained for certain categories of benefits; a failure to get preauthorization may result in benefits being denied. We will make our final benefit determination when we process your claims. Even when a service is preauthorized, we review each claim to make sure:

- The patient is a Member under the Contract at the time service is provided, and
- The service is a Covered Service. Contract limitations or exclusions may apply, and
- The service provided was Medically Necessary as defined by your Contract, including appropriateness, health care setting, level of care, and effectiveness.

A Preauthorization may only be for a specific period of time or number of visits/treatments. If you have any questions about this, please contact Member Service Center.

If your request for Preauthorization of services is denied, you can request further review; see the Appeal Procedures Section of this Contract. Preauthorization denials are considered denied claims for purposes of appeals and grievances.

Network Providers in South Carolina will be familiar with the requirement to obtain Preauthorization and will get the necessary approvals. If a Network Provider in South Carolina does not get Preauthorization, it cannot Balance-Bill you.

If you use an Out-of-Network Provider, it is your responsibility to contact us before receiving services and/or supplies. An Out-of-Network Provider can Balance-Bill you for the difference unless prohibited by law. This is also true for Network Providers through the BlueCard® program.

If you are outside the Business BlueEssentials service area and receive benefits through the BlueCard® program (see the Out-of-Area Services section of the Contract), you may need to request approval for any service you receive. A BlueCard Provider is not required to obtain approvals for you. It is your responsibility to make sure Preauthorization is obtained. In addition, a BlueCard Provider may charge you for any additional costs if the required Preauthorization is not obtained.

For some services to be covered, you will be required to use a Provider we designate, who may or may not be a Network Provider. These services may include mammography, Habilitation, Rehabilitation and vision care. If the Provider we designate is not an in-Network Provider, benefits will be provided at the in-Network Coinsurance amount. The Allowed Amount for these Providers will be the Medicare allowance and these Providers can bill you the difference between the Allowed Amount and the billed charges.

For transplant services to be covered (in-Network or out-of-Network), you will be required to use the Provider we designate, and they perform the transplant at a Blue Distinction® Centers for Transplant Designation.

To use the BlueCross Preauthorization process, call the numbers listed in the table below to reach the appropriate medical services personnel. Below is the list of services that must be Preauthorized.

For all Preauthorizations requirements for Prescription drugs, please see the Prescription Drug section of this Certificate.
The following services or benefits require preauthorization. Your in-Network Provider should obtain any needed authorization; however, you remain responsible for any unauthorized charges or services. If a required preauthorization is not obtained, no benefits will be provided.

Types of services	Who to Call:
Non-Emergency Hospital Services (not required for maternity/newborns; see next page) Habilitation or Rehabilitation (including Inpatient Rehabilitation) Human Organ and/or Tissue Transplants Skilled Nursing Facility (SNF) Continuation of Inpatient or Skilled Nursing Facility admission (remaining as Inpatient longer than originally approved) Cardiac rehabilitation (Phase 1 and 2) Pulmonary rehabilitation	In Columbia 803-736-5990 In S.C. 800-327-3238 Outside S.C. 800-334-7287
Outpatient facility admissions for services Surgery (including pre-authorization for anesthesia) Dialysis (hemodialysis/peritoneal), including home dialysis when required criteria are met	
Home Health Care or Hospice Services	
Durable Medical Equipment when purchase price or rental is $500 or more; supplies used with the DME must be Preauthorized every 90 days.	
Treatment for hemophilia - care must be coordinated through a Center for Disease Control and Prevention (CDC) designated Hemophilia Treatment Center. You must see a Provider at the designated Hemophilia Treatment Center within 60 days of the beginning of your Benefit Period.	
Treatments for Varicose Veins and Venous Insufficiency	
Colonoscopies when not for screening/preventive purposes	
Virtual colonoscopies and capsule endoscopies	
Inter-Disciplinary Pain Management Program	
Ambulance Services for non-Emergency transport	
Inpatient admissions for Behavioral Health treatment Residential Treatment Center (RTC) admission Continuation of an Inpatient or RTC admission (remaining as Inpatient longer than originally approved) Outpatient/office diagnostic and therapeutic: Psychological testing, rTMS, ECT Outpatient facility admissions for services: Intensive outpatient and Partial Hospitalization Programs Applied Behavioral Analysis (ABA) Therapy related to Autism Spectrum Disorder	Companion Benefit Alternatives, Inc. (CBA) – In Columbia 803-699-7308 Outside Columbia 800-868-1032
Outpatient/office diagnostic MRI, MRA, PET scans and CT scans Radiation oncology Musculoskeletal/spine management (interventional pain management, lumbar and cervical spine surgery) services. Virtual colonoscopy or CT Colonography	National Imaging Associates (NIA) 866-500-7664
Genetic Counseling and Testing, including Prenatal Screening and Mutation Analysis	Avalon Health Services, LLC 1-844-227-5769.
Prescription Drugs, Specialty Pharmacy medications, Injections/ Injectable drugs; medications that require special handling, Preauthorization, or exceed allowed quantities (See Prescription Drug section for details.)	Optum Rx Customer Service 855-823-0387

National Imaging Associates is an independent company that preauthorizes certain radiological procedures on behalf of Blue Cross.

Companion Benefit Alternatives, Inc. is a separate company that preauthorizes Mental Health and Substance Use Disorder services on behalf of Blue Cross.

Avalon Health Services, LLC is an independent company that preauthorizes certain laboratory services and procedures on behalf of Blue Cross.

Optum Rx is an independent company that provides pharmacy benefit management services on behalf of BlueCross

Hospital Admission for Maternity/Newborns – No Preauthorization is required for a mother's admission or hospitalization related to the delivery of a newborn child when the hospital stay is 48 hours or less for a vaginal birth or 96 hours or less for a cesarean section. The day of delivery, Surgery or birth is not counted in the 48 or 96 hours. If you or the newborn are not released within these timeframes, you or your Provider should contact BlueCross for authorization for a continued stay. If you are in a Network Hospital, the Hospital should contact us for this authorization.

You have 31 days to add a newborn child to your coverage or to obtain other coverage for the child; see the *Eligibility, Coverage and When your Coverage Ends* section. However, coverage is not automatic and until the newborn is covered under this Contract, we cannot process benefits or approve a Preauthorization if the child needs a continued stay in the Hospital. We recommend that you add the newborn to this coverage (or other coverage, if you prefer) as soon as possible after birth to ensure benefits for that child are processed timely.

Emergency Hospital Admissions – If you experience an emergency illness or injury, seek immediate medical assistance. An Emergency is an unexpected and usually dangerous situation that requires immediate medical attention at a Hospital Emergency Room. An Emergency Medical Condition is an illness, symptom or condition so serious that a reasonable person would seek medical care immediately to avoid serious harm, including illness or injury to an unborn child. If you are Admitted to a Hospital due to an Emergency Medical Condition, your Admission will be unexpected, so no preapproval or preauthorization is required; however, we should be notified of the Admission as soon as possible. Our medical services personnel must be notified within 24 hours or by 5 p.m. of the next working day or as soon as reasonably possible, if you are admitted to the Hospital. Otherwise, we will not provide benefits for the hospitalization. If an Emergency Admission approval is not obtained within this timeframe due to circumstances beyond your control, an appeal can be made and the Admission will be reviewed to determine if it was Medically Necessary to admit you to the Hospital for an Emergency Medical Condition.

A Provider may be considered an Authorized Representative without a specific designation by you only when the approval request is for Urgent Care Claims (medical conditions which require immediate treatment). For all other types of claims, a Provider can appeal an adverse determination only when you give us or the Provider a specific designation to act as an Authorized Representative.

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."

Eligibility and Coverage

Eligibility

An employee is eligible to enroll in this coverage if he or she is:

- A full-time Employee working an average of 30 hours a week;
- Performing the normal duties of the job at one of the Employer's normal places of business or at a location to which the Employee must travel to perform the job; and
- Actively-at-work - An Employee is considered Actively-at-work if he or she has begun working and is not absent from work due to a leave of absence or temporary layoff. The Employee remains eligible to enroll, and coverage will begin, if the absence is due to a Health Status-related Factor, such as the Employee's health status or medical condition (including both physical and mental illness).

This coverage is also available to your legal spouse and to your Dependent children through age 25. Employees and Dependents are eligible for coverage regardless of claims experience, receipt of health care, medical history, Genetic Information, evidence of insurability, or conditions arising out of the acts of domestic violence or disability. They must meet your Employer's eligibility requirements for Dependent coverage.

The types of coverage you may choose are:

- Single coverage
- Employee/spouse coverage
- Employee/child coverage
- Family coverage

In all cases, you will have to pay the required premium.

Enrollment

An Actively-at-work Employee is eligible for coverage as of the first day of full-time employment, and will be enrolled following the applicable Waiting Period of one month, two months, or 90 days.If the Employee completes a Membership Application during the Waiting Period, he or she will be covered on the first day of the Contract Month following the end of the Waiting Period. If an Employee is not Actively-at-work on that date, coverage for the Employee and eligible Dependents will not begin until the first day of the next Contract Month after the Employee has returned to work and the required premium is paid. When the Waiting Period is 90 days, coverage will begin on the 91st day or, if the Employee is not Actively-at-work, on the next day the Employee is Actively-at-work.

New Dependents can enroll within 31 days of the date on which they first become eligible. Note: You can also enroll, if eligible, under the Special Enrollment terms of the Contract.

Special Enrollment

As a qualified Employee or Employee's Dependent, you may enroll only during an initial or annual Open Enrollment Period, unless you qualify for a Special Enrollment Period. We may request documentation to confirm you had a qualifying event and that you are entitled to a Special Enrollment Period. You or your Dependent will have 31 days to enroll in or change from one Qualified Health Plan to another as a result of the following events, if you:

Situation	Details about qualifying for a Special Enrollment Period
1. If you lose qualifying health coverage, such as:	• Coverage through a job, or through another person's job. This also applies if you are now eligible for help paying for coverage because your employer stops offering coverage or the coverage is not considered qualifying coverage. • Medicare. • Coverage under your parent's health plan (if you are on it). If you turn 26 or the maximum dependent age allowed in your state and lose coverage, you can qualify for this Special Enrollment Period. • You became ineligible for help paying for coverage or became eligible for a different amount of help paying for out-of-pocket costs, like copayments. **Note:** This Special Enrollment Period does not include loss of coverage because you did not pay your premiums, you voluntarily dropped coverage, your prior coverage did not qualify as Minimum Essential Coverage, or the issuer finds fraud or misrepresentation.
2. Gaining or losing eligibility for Medicaid or Children's Health Insurance Program	If you gain or lose eligibility for Medicaid or the Children's Health Insurance Program (CHIP) coverage, including pregnancy-related coverage and medically needy coverage, you are entitled to a 60-day Special Enrollment Period
3. Change in household size, if you:	• Got married. • Had a baby, adopted a child, or placement for adoption or foster care. • Got divorced, legally separated, or had a death in the family and lost health coverage. • Gained or became a dependent due to a child support or other court order.

Situations that do not qualify for a Special Enrollment Period:

- Being terminated from other coverage for not paying premiums or for fraud
- Divorce or death of a family member without a resulting loss of coverage
- Moving solely for medical treatment or vacation

Effective Date for Special Enrollment

If you enroll during a Special Enrollment, you will be placed on the coverage on the first day of the month following your qualifying event.

Some Special Enrollments are eligible for other or additional Effective Date options. Examples include:

- For birth, adoption, placement for adoption or placement for foster care, your coverage Effective Date will be the date of the event, unless you specifically choose to begin coverage on the first day of the month following the date of birth, adoption, or placement.

- For a loss of Minimum Essential Coverage, the Effective Date depends on when you request coverage and the date the loss of coverage occurs. You have 60 days before and 60 days after the loss of Minimum Essential Coverage to make a plan selection. The Effective Date, though, will always be the first day of the month after plan selection, or the date you lose coverage, whichever comes last.

Example: You are told on April 3 that you will lose minimum essential coverage on May 31. You can choose a plan at any time prior to May 31 and your new coverage will be effective on June 1. However, if you choose a new plan after you have lost Minimum Essential Coverage, your new plan will take be effective on the first of the month following your plan selection.

Adding your Spouse
You may add your new spouse during a Special or Open Enrollment Period by enrolling and paying the additional full Premium required. Your spouse will not be covered until we receive the enrollment and required Premium.

Birth, Adoption, or Placement for Adoption or Foster Care
If you or your spouse gives birth, adopts a child or a child is placed with you or your spouse for the purpose of adoption or foster care while this Contract is in force, then the child is covered. If you are eligible under this plan, but are not enrolled and you or your spouse has a child, adopts a child or is in the process of adopting or fostering a child, you and your spouse can receive coverage as long as you meet the eligibility requirements of the Contract. In both of these situations, you must request coverage within 31 days of the child's birth, adoption or placement for adoption or foster care and pay any premium that may be due.
For an adopted or fostered child, coverage will start when you pay the appropriate premium, if any, as follows:

1. From the moment of birth for a child you or your spouse legally adopts within 31 days of the child's birth;
2. From the moment of birth for a child for whom you or your spouse has temporary custody and have begun adoption proceedings within 31 days of the child's birth; or
3. When the adopted or fostered child is not a newborn, upon temporary custody with you or your spouse. Coverage will continue as long as you or your spouse has custody of the child.

Termination/End of Eligibility
An Employee and all Dependents are no longer eligible if any of the following occurs:

a. The Group Health Plan Contract is no longer in effect;
b. The Employee retires or active employment with the Employer ends;
c. The period ends for which the last contribution is made;
d. The date an Employee is no longer Actively at Work; however Employees may be considered as remaining in active employment for purposes of Coverage under this Contract during a leave of absence under the Family Medical Leave Act, or for a period not to exceed 90 days from the date of cessation of active work.

If you divorce, coverage for your spouse will end after 60 days following the filing of the legal order of the divorce. Your spouse may be eligible to continue coverage through COBRA or State Continuation and may be eligible for conversion of coverage. Please review the Continuation of Coverage section of this Certificate.

A Dependent child is no longer eligible for the group health coverage when he or she reaches age 26; however, the dependent will be allowed to remain on the group health plan until the end of the birth month. An Incapacitated Dependent's coverage, however, will not end simply because he or she is older than age 25. An Incapacitated Dependent is a Dependent child who is: 1) incapable of self-sustaining employment because of a mental or physical handicap; and 2) mainly dependent upon you or your spouse for support and maintenance. The child must have developed the handicap before he or she reached the age at which coverage would otherwise terminate. To continue coverage for an Incapacitated Dependent, you must give us written proof of the disability from a Physician within 31 days of the Dependent's 26th birthday. For the child to remain covered, we may request a Physician's written report as requested, but no more often than every two years. Coverage must also remain in effect for the Employee.

Employees and Dependents no longer eligible will be terminated at the end of the month in which Employee loses eligibility.

Employer as agent of Members:
By accepting benefits, Member agrees that the Employer is the Member's agent for all purposes of any notice under this Plan. Other than as expressly required by law, if this coverage is terminated for any reason, the Employer is solely responsible for notifying you of such termination and your coverage will not continue beyond the termination date.

Qualified Medical Child Support Order (QMCSO)

Your Dependent may be entitled to receive benefits according to the terms of a "Qualified Medical Child Support Order" (QMCSO) under federal law. The order cannot require us to provide any type or form of benefit, or any option that we do not already provide.

Establishment of Procedures for Determining Qualified Status of Orders.

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

i. Shall be in writing;

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

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

The Employer must notify the Employee and the child that an order has been received, and, within a reasonable time let the Employee and the child know whether or not the court order or submission of an approved form issued by the appropriate state's social services agency is a QMCSO. If the court order or approved social services form is determined to be a QMCSO, the child, age 25 or younger, is considered a beneficiary under the plan. As a beneficiary, the child is entitled to all benefits and services as any other Member.

Except for any coverage continuation rights otherwise available under the Contract and subject to the other termination provisions of the Contract, coverage for the child will end on the earliest of:

- The date your coverage ends.
- The date the QMCSO is no longer in effect.
- The date you get other comparable health coverage through another insurer or plan to cover the child.
- The date your Employer ends family health coverage for all of its Employees under all of the Employer's Group Health Plans.

Medical Loss Ratio

Group contracts must meet certain medical loss ratio requirements as required by federal law. If all small group contracts issued by BlueCross do not meet the medical loss ratio requirement, we will issue medical loss ratio rebates. These rebates may be in the form of a lump-sum check, credit or debit card reimbursement, pre-paid debit or credit cards or premium credits. A premium credit means your Employer will not be required to pay premiums or a portion of premiums for covered Members for a specified period of time. After the specified period of time; however, your Employer must again pay the premiums.

In general, We will issue any rebate to the Employer – with two exceptions. First, we may issue any rebate to a nongovernmental Group Health Plan that is not subject to ERISA (e.g., church plan) only if the Employer first provides a written assurance that the rebate will be used to benefit Members. Otherwise, we must issue any rebate to the Members covered during the time period on which the rebate is based. Second, if the group contract is cancelled as of the date the rebate is to be paid, and we are unable to locate the Employer, We will distribute the rebate directly to Members covered during the time period on which the rebate is based.

Each year by a date determined by Health and Human Services (HHS), you will receive notice if you are due a Medical Loss Ratio rebate for the previous year.

Covered Services

We will provide benefits for Covered Services according to the provisions described in this Certificate and as shown in your Schedule of Benefits. We base benefits on a percentage of the Allowed Amount. Benefits are subject to Deductibles, Copayments, Coinsurance, Benefit Period Maximums, exclusions and limitations. Preauthorization must be obtained on certain services to receive maximum benefits. See the *Preauthorization* section for details.

Please note: Even at an In-Network Hospital or facility, you may be treated by an Out-of-Network Provider. Out-of-Network Providers may Balance Bill you unless prohibited by law; there is no Maximum Out-of-Pocket (no limit) on Out-of-Network charges. See the Special Out-of-Network Rules section for additional information.

All Covered Services must be Medically Necessary and include only the services specifically described in this section unless limited or excluded in other provisions of the Contract or this Certificate. The services must be prescribed by and performed by, or under the direction of, a Physician in the Business BlueEssentials network. Please note: a contract exclusion may apply even if a service is considered Medically Necessary.

The following Essential Health Benefits are described in detail below.

- Ambulatory Patient Services
- Emergency Services
- Habilitation and Rehabilitation Services
- Hospital Services
- Laboratory Services
- Maternity and Newborn Care
- Mental Health & Substance Use Disorder Services
- Pediatric Services
- Prescription Drugs
- Preventive Services

Benefit Period Maximums for Covered Services (per Member per Benefit Period):
60 days for Skilled Nursing Facility
60 visits for Home Health Care
6 months per episode for Inpatient and Outpatient Hospice Care
30 Rehabilitative visits for Physical, Speech and Occupational Therapy Services combined
30 Habilitative (developmental) visits for Physical, Speech and Occupational Therapy Services combined
$500 for Sustained Health Benefit (for physical exam services not included in other Preventive Services)

There are no annual or lifetime dollar limits on the Essential Health Benefits provided.

The following are Covered Services:

Ambulatory Surgical Center – medically necessary services, supplies, and benefits provided at an Ambulatory Surgical Center. When you receive services at an Ambulatory Surgical Center, we may allow additional visits for rehabilitation; you should coordinate a request for increased benefits through our Case Management area.

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 medical transport is medically necessary because the member's condition makes other forms of transportation infeasible (i.e. 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 medical transport is preauthorized.
- The receiving Hospital or facility is the closest facility that can provided 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 unless prohibited by law. 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 beneficiary's illness or injury (such as burn care, cardiac care, trauma care, and critical care); and
- The second Hospital is the nearest medically appropriate facility; and
- 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 Out-of-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 Out-of-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.

Autism Spectrum Disorder – Limited to treatment prescribed by the treating Physician according to a treatment plan. The treatment plan must include all necessary elements such as, but not limited to, a diagnosis, proposed treatment by type, frequency, and duration of treatment, anticipated outcomes stated as goals, the frequency by which the treatment plan will be updated and the treating Physician's signature. Benefits are limited to services rendered by a covered Provider. The child must be diagnosed by age 8 and Benefits end when the child turns 16.

Birth Control – Benefits are provided for the following oral contraceptives and contraceptive devices with no cost-share. Other non-FDA-approved contraceptive methods may be available, but your deductible and coinsurance would be applied unless otherwise required by law. BlueCross will cover at least one option in each of the following categories. See the searchable Covered Drug List to determine if a specific brand or item is covered at no cost-share.

- Cervical cap
- Diaphragms
- Emergency contraception
- Female condom
- Implantable rod
- Intrauterine device (IUD)
- Oral contraceptives (birth control pills)
- Patch
- Shot/injection
- Spermicide
- Sponge
- Vaginal contraceptive ring

Birth control includes female sterilization surgery and surgical sterilization implant for women, including follow-up care.

Blue CareOnDemand℠ – We provide you with access to ***Blue CareOnDemand***, a telehealth service through which you can seek treatment from U.S. licensed healthcare professionals twenty-four (24) hours per day, seven (7) days per week and three hundred sixty-five (365) days per year using the convenience of video consultation. Blue CareOnDemand providers can treat many of the most common health issues, such as treatment for cold and flu symptoms, allergies, skin irritations, pinkeye, ear infections, bronchitis, sinus infections and other specialties. We encourage Members to use the convenience of Blue CareOnDemand for treating unexpected, non-emergency health issues. There are two (2) ways for Members to register and create their patient profiles:

1. Download the "Blue CareOnDemand" mobile app from iTunes or Google Play.
2. Visit www.BlueCareOnDemandSC.com.

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

Blue CareOnDemand is offered through American Well, an independent company that provides telehealth hosting and software services on behalf of BlueCross. Telehealth is not a replacement for primary care doctors. Members should maintain relationships with their primary care doctors and continue scheduling office visits for preventive care.

Breastfeeding Support, Supplies and Counseling – Benefits will be provided for breastfeeding support and counseling. Breastfeeding support includes benefits for breast pumps when purchased through a doctor's office, Pharmacy or DME supplier and is limited to one pump every 12 months or per pregnancy.

Cardiac Rehabilitation – Benefits are provided for Phase 1 and 2 cardiac rehabilitation when provided within 30 days of an acute cardiac event. Preauthorization is required.

Cleft Lip and Palate – Benefits will be provided for the care and treatment of a cleft lip and palate and any condition or illness that is related to or caused by a cleft lip and palate. Cleft lip and palate means a congenital cleft in the lip or palate or both. Care and treatment will include, but are not limited to:

1. Oral and facial Surgery, surgical management and follow-up care;
2. Prosthetic treatment such as obdurators, speech appliances and feeding appliances;
3. Orthodontic treatment and management;
4. Treatment and management for missing teeth (prosthodontics);
5. Ear, nose and throat (otolaryngology) treatment and management;
6. Hearing (audiological) assessment, treatment and management including surgically implanted hearing aids; and
7. Physical therapy assessment and treatment.

If a Member with a cleft lip and palate is also covered by a dental Contract, then teeth capping, prosthodontics and orthodontics will be covered by the dental Contract to the limit of coverage provided and any excess after that will be provided by this Certificate.

Clinical Trials – Benefits are provided for routine Member costs for items and services related to clinical trials when:

1. The Member has cancer or another life-threatening disease or condition;
2. The referring Provider is a Network Provider that has concluded that the Member's participation in such trial would be appropriate;
3. The Member provides medical and scientific information establishing that the Member's participation in such trial would be Medically Necessary; and
4. The services are furnished in connection with an Approved Clinical Trial, defined below.

An Approved Clinical Trial is one that is 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), or the Centers for Medicare & Medicaid Services (CMS); the Department of Defense (DOD), the Department of Veterans Affairs (VA), or the Department of Education (DOE), if the study or investigation has been peer reviewed and approved by U.S. Department of Health and Human Services (HHS); a cooperative group or center of any of these entities (except the DOE); 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).

Dental Services to Sound Natural Teeth Related to Accidental Injury – Benefits are provided for treatment, Surgery or appliances as a result of an accidental bodily injury, but are limited to care completed within six months of an accident and while the patient is still covered under this Contract. Dental injuries occurring through the natural act of chewing are not considered accidental.

Diabetes Management – Benefits are provided for equipment, supplies, Outpatient self-management training and education including nutritional counseling for the treatment of Members with diabetes. A health care professional must follow minimal standards of care for diabetes as adopted and published by the Diabetes Initiative of South Carolina.

Diabetes self-management training and education will be provided on an Outpatient basis when done by a registered or licensed health care professional certified in diabetes education.

Durable Medical Equipment (DME) – Benefits are provided for DME and certain orthotics and supplies. If more than one item can meet your functional needs, Benefits are available only for the item that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, we will pay only the amount that we would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost.

DME is subject to all contract exclusions, whether or not Medically Necessary and Preauthorization is required if the purchase price or rental cost is $500 or more. Note: You are required to obtain Durable Medical Equipment from a Network Provider; no benefits are available at out-of-Network Providers.

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 Contract 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 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 Contract.

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 Emergency Services, and you will be subject to In-Network Cost-Sharing based on the Recognized Amount. The Allowed Amount for benefits for Ememrgency Services for an Emergency Medical Condition when provided by an Out-of-Network will be no less than the amount required under applicable law. See the Special Out-of-Network rules section for addition information.

Please note: At any In-Network Hospital or facility, you may be treated by and Out-of-Network Provider. Out-of-Network Providers may Balance Bill you, even when you are treated for an Emergency Medical Condition.

Out-of-Network Emergency room – We will provide benefits for Emergency Medical Condition received in an Emergency Room at an Out-of-Network Hospital. However, benefits for Covered Services are subject to any in-Network Copayment, Deductible and Coinsurance as shown in the Schedule of Benefits.

The Allowed Amount for benefits for Emergency Services for an Emergency Medical Condition when provided by an out-of-Network Provider will be the greater of: A) the median amount for those Emergency Services, calculated using reimbursement rates of in-Network Providers who participate in the Business BlueEssentials Network; or B) the amount for those Emergency Services calculated using Medicare reimbursement rates, which is the same method BlueCross generally uses to determine payment to out-of-Network Providers who do not participate in the Business BlueEssentials Network.
An Out-of-Network Provider may Balance-Bill you for the difference between the Allowed Amount we pay and its billed charge.

Non-Emergency care outside the Business BlueEssentials Network is not covered; any follow-up care must be provided by an In-Network Provider.

Genetic Counseling – Benefits are provided for Genetic Counseling when Preauthorization is obtained. If Preauthorization is not obtained, no benefits will be provided.

Habilitation Services – Benefits include Physical, Occupational and Speech Therapy for the purpose of assisting a Member with achieving developmental skills, including as a result of developmental speech delay, developmental communication disorder, or a developmental coordination disorder. Benefits are provided when a Physician prescribes therapy and it is performed by a licensed, professional physical, occupational or speech therapist. Preauthorization is required; you must use a Provider we designate, if applicable. If Preauthorization is not obtained and/or you don't use the Provider we designate, no benefits will be provided. All Benefit Period maximums apply.

Home Health Care Services – A variety of services and benefits provided to a homebound Member in a personal residence. Home health care must be provided by or through a community home health agency on a part-time visiting basis and according to a Physician-prescribed course of treatment. We must Preauthorize the care based on an established home health care treatment plan before you are eligible for benefits. If Preauthorization is not obtained, no benefits will be provided. Please refer to your Member Schedule to see what benefit limitations apply. Home health care includes:

1. Services by a registered nurse (RN) or licensed practical nurse (LPN);
2. Services provided by a medical social worker;
3. Nutritional guidance;
4. Diagnostic services;
5. Administration of Prescription Drugs;
6. Medical and surgical supplies;
7. Oxygen and its use; and
8. Durable Medical Equipment (A separate Preauthorization is not needed when the entire Home Health Care plan is approved).

Hospice Services –Benefits are provided for palliative hospice services. You must obtain Preauthorization for hospice services before you are eligible for this care, and services must be provided according to a Physician prescribed treatment plan. If Preauthorization is not obtained, no benefits will be provided. Hospice services include:

1. Services provided by a registered nurse (RN) or licensed practical nurse (LPN);
2. Physical, speech and occupational therapy (Benefit Period Maximum applies)
3. Services provided by a home health aide or medical social worker;
4. Nutritional guidance;
5. Diagnostic services;
6. Administration of Prescription Drugs;
7. Medical and surgical supplies;

8. Oxygen and its use;
9. Durable Medical Equipment (A separate Preauthorization is not needed when we approved the entire Hospice Service plan);
10. Family counseling concerning the patient's terminal condition.

Hospital Services – Includes Inpatient Admissions, Outpatient care and ancillary services. Preauthorization is required. If Preauthorization is not obtained, no benefits will be provided. Please note: Even at an In-Network Hospital, Ambulatory Surgical Center, or certain other facilities, you may be treated by an Out-of-Network Provider and the provider generally may Balance Bill you unless prohibited by law. There is no Maximum Out-of-Pocket (no limit) on Out-of-Network billed charges. For Emergency Care and services furnished by an Out-of-Network provider at an In-Network Hospital, Ambulatory Surgical Center, or certain other facilities, you generally will be subject to In-Network Cost-Sharing and the In-Network Deductible and Maximum Out-of-Pocket, and the provider generally may not Balance Bill you. See the Special Out-of-Network Rules section for additional information.

Room and board benefits are provided at the most prevalent semi-private room rate. When all rooms in a Hospital are private, the semi-private room rate will be considered the private room allowance.

College or School Infirmary – When you receive care in a college or school infirmary that bills students for its services, benefits will be provided if the infirmary is a Network Provider in the Business BlueEssentials Network, and are limited to the average semi-private room rate for South Carolina Hospitals.

The day you leave a Hospital, with or without permission, is treated as the day of discharge and will not be counted as an Inpatient care day, unless you return to the Hospital and are admitted by midnight of the same day. Please note that services provided on the day of discharge are provided according to the Contract terms and conditions. The day you return to the Hospital and are admitted, if applicable, is treated as the day of Admission and **is counted** as an Inpatient care day. The days during which you are not physically present for Inpatient care **are not counted** as Inpatient days.

Immunizations – Benefits will be provided for immunizations as recommended by the Centers for Disease Control (CDC). The recommendations may include age and/or frequency restrictions. The CDC is an independent organization that offers health information and recommendations; they are not affiliated with Blue Cross.

Laboratory and Diagnostic Services – Benefits will be provided for procedures to identify the nature and/or extent of a condition or disease. We will reduce benefits for Inpatient diagnostic services to the level of benefits for Outpatient services when services could have been safely done on an Outpatient basis. Diagnostic services include, but are not limited to:
1. Radiology, ultrasound and nuclear medicine;
2. Laboratory and pathology;
3. ECG, EEG and other electronic diagnostic medical procedures and physiological medical testing;
4. Surgical pathology — pathological examination of tissue removed surgically, by resection or biopsy. This does not include smear techniques;
5. High technology diagnostic services such as, but not limited to, MRIs, MRAs, PET scans and CT scans; and
6. Gastrointestinal endoscopies.

Mastectomy and Reconstruction – Benefits include Hospitalization for at least 48 hours following a mastectomy. If you are released early, then we will provide benefits for at least one home care visit if the attending Physician orders it.

We will also provide benefits for Prosthetic Devices, reconstruction of the breast on which the mastectomy was performed and physical complications for all stages of mastectomy including lymphedemas. This includes Surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance as determined in consultation with the attending Physician and the patient.

Maternity Care – Benefits are available for all covered female members and are provided for pre- and postnatal care, including the hospitalization and related professional services for at least 48 hours after a vaginal delivery (96 hours following a Cesarean section) or the date of discharge from the Hospital — whichever occurs first. The day of delivery or Surgery is not counted in the 48 hours after vaginal delivery (96 hours for Caesarean Section). Maternity care does not include: payment for a surrogate; artificial insemination and in-vitro fertilization. Benefits may include services of a midwife and/or provided at a birthing facility. All Providers must be licensed or certified as appropriate, and performing services within the license or certification. Reimbursement rates are determined by Network status of the Provider. Coverage is available under this

Contract for a Newborn; see the Eligibility section for how to add your child and see Newborn Child Coverage under Covered Services for the services and benefits available.

Mental Health and Substance Use Disorder Services (Behavioral Health Services) – Benefits are available for the treatment of conditions defined, described or classified as psychiatric disorders or conditions in the latest publication of The American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, including the continued use, abuse and/or dependence of legal or illegal substance(s), despite significant consequences or marked problems associated with that use.

Benefits are provided as shown in the Schedule of Benefits, for Behavioral Services/Mental Health and/or Substance Use Disorders.

Newborn Child Coverage – When you add your newborn to this coverage within 31 days of his or her birth, and pay the appropriate Premium, coverage will be effective on the date of birth and benefits will be provided for the hospitalization and related professional services for the newborn for at least 48 hours after a vaginal delivery (96 hours following a Cesarean section) or the date of discharge from the Hospital — whichever occurs first. The day of birth is not counted in the 48 hours after vaginal delivery (96 hours for Caesarean Section). You may also choose to make coverage effective the first day of the month following the birth, but must give us notice of your choice; if we do not receive specific instructions, the Effective Date of Coverage for the Newborn will be the date of birth. Please Note: although you have 31 days to enroll the child, we cannot process claims until the Newborn Child is enrolled for coverage.

Non-Emergency care when traveling outside the United States – We will provide out-of-country benefits based on our Business BlueEssentials Network Provider allowance or the total charge, whichever is less. Out-of-country benefits consist of all Covered Services provided or supplies received outside the United States. However, services must be provided through Blue Cross Blue Shield Global Core®. Please note that these Global Core Providers may bill you the difference between the allowance and the total charge. To find a BlueCard Provider outside of the United States, visit the BlueCard Doctor and Hospital Finder website (www.BCBS.com), call the Blue Cross Blue Shield Global Core service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. You can also visit www.bcbsglobalcore.com. Also, please review the Out-of-Area Services section for more details.

Pediatric Preventive Services – Benefits will be provided, subject to age and/or condition guidelines/recommendations, as follows:

- The United States Preventive Services Task Force (USPSTF) recommended Grade A or B services.
- Screenings recommended for children by Health Resources and Services and Administration.
- Pediatric oral and vision care as recommended by the United States Preventive Services Task Force (USPSTF) Grade A or B services and Health Resources and Services Administration (HRSA).

The USPSTF and HRSA are independent organizations that provide health information and recommendations; they are not affiliated with Blue Cross. *These services are provided in-Network only.*

Physician Services (Primary Care Physician, Specialist, or other Clinician) – Benefits are provided as outlined below. Please note that Preauthorization is required for all Inpatient admissions and for other services as described in the Preauthorization section . While the benefits described below are Covered Services, care that is in excess of medically necessary treatment criteria is not covered.

1. Office/Outpatient Services – Care and consultation by a Physician or other Clinician in an Outpatient setting for the examination, diagnosis or treatment of an injury, illness, or Behavioral Services treatment.

2. Inpatient Services – Care and consultation provided in an Inpatient setting for the examination, diagnosis or treatment of an injury, illness, or Behavioral Services treatment.
   a. Inpatient and Intensive Care Visits ; may also include diagnostic services and therapy services done concurrently with medical or Behavioral Services care.
   b. Consultation –Limited to one consultation per consulting Physician.

3. Surgery – Benefits include pre- and post-operative care as well as daily care by the Physician who performed the surgery if you are Inpatient.

Benefits are provided at a lower reimbursement percentage if two or more surgical procedures are performed during one operation

a. Surgical Assistant – Services of a Physician or other Clinician who actively assists the operating Physician during an eligible Surgery in a Hospital. are only available if all of the following conditions are met:

- The complexity of the procedure or the patient's condition warrants an assistant surgeon
- An intern, resident or house physician is not available to assist
- Non-Physicians (e.g., physician assistants, first assistants, certified surgical assistants and nurse practitioners) may not serve as an assistant surgeon or Surgical Assistant, unless the non-Physician has separate surgical privileges at the Facility or Hospital.

Benefits are not available when the service or procedure does not require an assistant at surgery (when assistant is not Medically Necessary).

b. Anesthesia – Services provided by a Physician or a certified registered nurse anesthetist, other than the attending surgeon or his assistant. See the Special Out-of-Network Rules section for additional information.

4. Chemotherapy – The treatment of malignant disease by chemical or biological antineoplastic agents that have received full, unrestricted market approval from the FDA.

5. Dialysis Treatment – The treatment of acute renal failure or chronic irreversible renal insufficiency to include hemodialysis or peritoneal dialysis. Dialysis treatment may include home dialysis, when required criteria are met. NOTE: This service requires preauthorization.

6. Radiation Therapy – The treatment of disease by X-ray, radium or radioactive isotopes.

Prescription Drugs – Benefits will be provided for Prescription Drugs under the pharmacy and medical portions of your benefit. More detailed information is noted in the *Prescription Drug Coverage* section. Prescription Drugs and pharmaceuticals that are provided under the Prescription Drug benefit are not provided as a medical benefit. NOTE: When prescription drugs are infused, we may require administration be performed at the most appropriate and efficient site of care.

Preventive Services – A limited number of services are provided as preventive care with no cost share, as follows:
- The United States Preventive Services Task Force (USPSTF) recommended Grade A or B services.
- Screenings recommended for children and women by Health Resources and Services and Administration.
- Preventive prostate screenings and lab work according to the American Cancer Society (ACS) guidelines.
- Pediatric oral and vision care as recommended by the United States Preventive Services Task Force (USPSTF) Grade A or B services and Health Resources and Services Administration (HRSA).

Preventive care (except Preventive Pap Smear) must meet the age and/or condition guidelines/recommendations of the USPSTF, CDC, HRSA or ACS to be covered at no cost to the Member. These organizations and agencies are independent bodies that offer health information and recommendations; they are not affiliated with BlueCross.

Virtual colonoscopies and capsule endoscopies may be covered but are subject to medical management guidelines and are subject to preauthorization. Any services not performed as screening/preventive measures are covered at regular contract terms.

Prosthetics – Benefits are provided for a prosthetic, other than a dental or cranial prosthetic, which meets minimum specifications for the body part it is replacing regardless of the functional activity level. If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

No benefits are provided for duplicate prosthetics. Services related to the repair or replacement of a prosthetic are only considered necessary when due to a change in the Member's medical condition, and with prior authorization from us. Repair or replacement for routine wear and tear is not a Covered Service**.**

Pulmonary Rehabilitation – Benefits are provided when pulmonary rehabilitation is in conjunction with a covered lung transplant. This benefit requires Preauthorization.

Rehabilitation Services – Benefits are provided for Cardiac or Pulmonary Rehabilitation and for Therapy (physical, occupational, and speech). Please see those benefits listed separately in the Covered Services section.

Preauthorization is required for Inpatient Rehabilitation and you must use a Provider we designate. If Preauthorization is not obtained and/or you do not use the Provider we designate, no benefits will be provided.

Preauthorization is required for Inpatient Habilitation and Rehabilitation. In addition, you must use a Provider we designate. If Preauthorization is not obtained and/or you do not use a Provider we designate, no benefits will be provided.

Residential Treatment Center (RTC) – Benefits include room and board, general nursing service, therapy services and other ancillary services. Preauthorization is required. If Preauthorization is not obtained, Room and Board will be denied.

Benefits for Residential Treatment Facility are provided at the semi-private room rate. When you are admitted to a Residential Treatment Facility in which all rooms are private, the most prevalent semi-private room rate, as determined by us, will be considered the private room rate.

The day you go to the Residential Treatment Facility is the Admission day. The day you leave the Residential Treatment Facility, with or without permission, is the discharge day. Please note that services provided on the day of discharge are provided according to the Contract terms and conditions.

Benefits are not provided for days in which you are not physically present in the Residential Treatment Facility.

Skilled Nursing Facility – Benefits include room and board, special diets, general nursing services, therapy services and other ancillary services. The Member must be admitted within 14 days after being discharged from a Hospital following an authorized hospitalization.

Benefits for a Skilled Nursing Facility are provided at the semi-private room rate. When you are admitted to a Skilled Nursing Facility in which all rooms are private, the most prevalent semi-private room rate, as determined by us, will be considered the private room rate.

The day you go to the Skilled Nursing Facility is the admission day. The day you leave the Skilled Nursing Facility, with or without permission, is the discharge day. Please note that services provided on the day of discharge are provided according to the Contract terms and conditions.

Benefits are not provided for days in which you are not physically present in the Skilled Nursing Facility.

Telehealth – Benefits will be provided for Telehealth services which are initiated by either a Member or Provider and are provided by Network Providers who have been credentialed as eligible Telehealth Providers.

Telemedicine – Benefits will be provided for Telemedicine services such as: consultation, diagnosis and treatment where the services would otherwise be covered if you were "in person." Office and outpatient visits that are conducted via Telemedicine are counted towards any applicable Benefit limits for these services. Consulting and referring Providers must be Network Providers who have been credentialed as eligible Telemedicine Providers.

Telemedicine services will be covered when the services performed are Covered Services under this Contract and under the following circumstances:

1. The medical care is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the Member's need; and,
2. The medical care can be safely furnished, and there is no equally effective, more conservative and less costly treatment available.

The following are examples of services that are not Telemedicine services and are not covered:

1. E-mail messages
2. Facsimile transmissions

Therapy – Benefits are provided for physical, occupational and speech Therapy when prescribed by a Physician and performed by a licensed, professional physical, occupational or speech therapist. Benefit period maximums apply.

Transplants (Human Organ and/or Tissue) – We provide benefits for covered transplants only when Preauthorized and a Provider we designate performs the transplant at a Blue Distinction® Centers for Transplant Designation.

Organ transplant coverage includes all expenses for medical and surgical services a Member receives for human organ and/or tissue transplants while the Member is covered under this Contract. Organ transplants do not include transplants involving mechanical or animal organs.

1. We provide benefits for certain living donor transplants covered under this Contract, including but not limited to kidney transplants, liver transplants, and specific tissue transplants as pre-authorized. Benefits will be subject to the following conditions:
   a. When both the transplant recipient and the donor are Members, benefits will be provided for both.
   b. When the transplant recipient is a Member and the donor is not, benefits will be provided for both.
   c. When the transplant recipient is not a Member and the donor is, no benefits will be provided to either the donor or the recipient.
   d. We will also provide benefits to transport the donor organ or tissue to the location where the transplant will be performed, if the transplant is a covered benefit under this Contract.

The following transplants are not Covered Services:

- Uses of allogeneic bone marrow transplantation (between two related or unrelated people), syngeneic bone marrow transplantation (from one identical twin to the other), or other forms of stem cell transplant (with or without high doses of chemotherapy or radiation) where use of the transplant is not consistent with evidence-based guidance or standard medical practice;
- Adrenal tissue to brain transplants;
- Islet cell transplants;
- Procedures that involve the transplantation of fetal tissues into a living recipient.
- Service and supplies related to transplants involving mechanical or animal organs.

Urgent Care – Benefits are provided when you seek treatment at an in-Network Urgent Treatment center. Urgent Care centers provide care and/or treatment outside normal business hours.

Varicose Vein and Venous Insufficiency Treatment – When medically necessary, benefits will be paid for services, supplies or treatment for varicose veins and/or venous insufficiency, including but not limited to endovenous ablation, vein stripping or the injection of sclerosing solutions.

Pediatric Vision Services

Vision Services – We provide Pediatric Vision Services as shown in the schedule of benefits. Pediatric Vision Services are available from birth through end of the Benefit Period in which the member turns age 19. Pediatric Vision Services are provided through VSP. VSP is a separate company that provides Pediatric Vision Services on behalf of BlueCross. To find a VSP Provider, go to www.vsp.com/advantage and enter your ZIP code. (This link leads to a third party site. That company is solely responsible for the contents and privacy policies on its site.)

Any copayment made for Pediatric Vision Services will be applied to your Maximum Out-of-pocket.

Additional Covered Services

Sustained Health Benefit – Benefits are provided as indicated below for routine tests and services that are not part of the United States Preventive Services Task Force (USPSTF) recommended Grade A or B services, screenings recommended for children and women by Health Resources and Services Administration, or preventive prostate screenings and lab work according to the American Cancer Society (ACS) guidelines.

Services that are covered for you	What we must pay when you get these services	
	Network	Out-of-Network
Services related to a physical exam not included in other covered Preventive Services (limited to $500 per Benefit Period). Services may be subject to age and visit limits.	100% up to $500	No Benefits

Prescription Drug Coverage

Prescription Drugs
Prescription Drugs are medications that, by federal law, require a prescription and can only be dispensed by a licensed pharmacy. Injectable insulin and diabetic supplies may also be also considered Prescription Drugs.

BlueCross works with a team of health care Providers to choose drugs that provide quality treatment. We cover drugs on the Business BlueEssentials Covered Drug List (formulary), as long as:

- The drug is Medically Necessary and
- The prescription is filled at one of our network pharmacies and
- Other plan rules are followed where applicable, including but not limited to: Prior Authorization, Quantity Limits and Step Therapy.

The Business BlueEssentials Covered Drug List gives information about Prescription Drugs covered under the Business BlueEssentials plans which has five coverage levels, called Tiers. Benefits are limited to a 90-day supply at a retail pharmacy or a 90-day supply by mail. A 90-day supply is not available for Specialty Drugs or for any prescription filled at a retail pharmacy. More information about the Covered Drug List or Network Pharmacies can be found in the Prescription Drug Information section at https://www.SouthCarolinaBlues.com/links/pharmacy/BusinessBlueEssentials.

How your Drug Benefits are paid
To receive benefits for Prescription Drugs, you must fill them through our Network Pharmacies, simply show the pharmacist your BlueCross ID card.

If a Physician or other Clinician prescribes a Brand-name Drug and there is an equivalent Generic Drug available (whether or not the Physician allows substitution of the Brand-name Drug), then the Member must pay any difference between the cost of the Generic Drug and the higher cost of the Brand-name Drug. The difference you must pay between the cost of the Generic Drug and the higher cost of the Brand-name Drug does not apply to your Deductible or your Maximum Out-of-pocket.

Maximum pharmacy benefits are available when provided by a Network Pharmacy. Of course, not all pharmacies are part of this Business BlueEssentials Network. When you receive benefits at an Out-of-Network pharmacy, your benefits will be paid with a 50% Coinsurance. Exceptions may be made in case of an Emergency Medical Condition. Please contact a Customer Advocate, if you need to file a Prescription Drug claim for an Emergency Medical Condition.

We will provide benefits for off-label use of Prescription Drugs that have not been approved by the FDA for the treatment of a specific type of cancer for which the drug was prescribed, provided the drug is recognized for treatment of that specific cancer in at least one standard reference compendium or the drug is found to be safe and effective in formal clinical studies. These results must have been published in peer-reviewed professional medical journals.

Until your Maximum Out-of-pocket is met, you will pay one or more of the following for each Prescription Drug, depending upon your plan type: Prescription Drug Deductible, Copayment, Deductible and/or Coinsurance. Once you have met your Maximum Out-of-pocket, you will no longer have to pay Maximum Out-of-pocket for covered benefits until a new Benefit Period begins. Please refer to your Schedule of Benefits for specific plan costs for each Tier referenced below. No Tier is restricted to a specific class of prescription drugs. Any Tier may contain a mix of generic, brand or non-brand name drugs or specialty medications, including infusible or injectible drugs.

- **Tier 0:** Drugs on this tier are considered preventive medications under the Affordable Care Act (ACA) and are covered at no cost to you.
- **Tier 1:** These drugs are most often generic and will generally cost you the least amount of money out of your pocket (other than those on Tier 0). Generic drugs have the same active ingredient(s) as brand-name drugs, may have different inactive ingredients and are not manufactured under a registered brand name or trademark.
- **Tier 2:** Tier 2 drugs are most often brand-name drugs and are sometimes referred to as “preferred” drugs because they usually cost you less than brand-name drugs in higher tier levels.
- **Tier 3:** Drugs on this tier are most often brand-name drugs that may have generic equivalents. They are sometimes referred to as non-preferred because there is usually a lower cost alternative available.

- **Tier 4:** These are typically drugs that are used in the management of chronic or genetic disease, including but not limited to injectable, infused or oral medications; or, products that otherwise require special handling, refrigeration and special training. You will usually pay more for drugs in this tier than drugs in lower tiers.

How to file a Prescription Drug Claim
Network Pharmacies will file all claims for you. If you receive Prescription Drugs from a non-Network Pharmacy due to an Emergency Medical Condition, please refer to *How to Contact Us if You Have a Question* section.

If you fill a Prescription Drug before the effective date of your coverage or before you pay the premium for your coverage, you will have to pay the full retail price of the Prescription Drug. The charge will not be refunded and will not apply to your Deductible or Maximum Out-of-pocket.

Mail-order Pharmacy
We have contracted with a pharmacy that will provide up to a 90-day supply of Prescription Drugs straight to your door when you set up this service. Our Mail-order Pharmacy order form may be used to set up Mail-order service and is located on our website at www.SouthCarolinaBlues.com.

Specialty Pharmacy
Drugs that are designated to be specialty medications will be filled by Optum® Specialty Pharmacy, when using your pharmacy benefits. If a covered specialty drug is not available from Optum Specialty Pharmacy, we will arrange to have the prescription filled from another Specialty Pharmacy. The list of drugs that must be filled by our Specialty Pharmacy is included as part of the Covered Drug List. This Specialty Pharmacy has also agreed to accept our allowance as payment in full for Covered Services except for any Deductibles, Copayments or Coinsurance you owe. Specialty medications are limited to a 31-day supply. Optum Specialty Pharmacy is a service provided by Optum Rx, an independent company that provides pharmacy benefit management services on behalf of BlueCross. Specialty drugs administered under the medical benefit may or may not be available from our Specialty Pharmacy. Certain specialty drugs can be billed and administered in the providers office, in network infusion centers or home.

Over-the-counter (OTC) Drug
These are drugs that do not require a prescription. We do not generally pay benefits for over-the-counter drugs but may designate specific classes of over-the-counter drugs to be covered as Prescription Drugs. A prescription for an included drug must be presented at the Pharmacy or the drug will not be covered.

Additional Requirements/Limits
There may be additional requirements or limits on some medications on the Business BlueEssentials Covered Drug List. These requirements and/or limits may include:

- **Prior Authorization (PA):** If your drug needs prior authorization, your doctor will have to get approval before we will cover your drug. Your doctor should contact our prior authorization center for drugs filled under the pharmacy benefit. There are different reasons a drug might require prior authorization. One is to make sure it is being used for the condition(s) it was approved for by the United States Food and Drug Administration (FDA). Another is because there are covered drugs that usually work just as well, but cost lessif your Provider does not obtain prior authorization, no benefits will be provided.

- **Quantity Limits (QL):** If your drug has a quantity limit, we will only cover a certain amount of the drug in a specified period of time; unless your Provider requests a quantity in excess of this amount and gives evidence supporting this request which is approved prior to the prescription being filled. This is to make sure you are using the drug safely and based on the FDA guidelines. If we determine a member has used multiple doctors or pharmacies to obtain quantities of prescription medication in excess of what is allowed or recommended, we reserve the right to require the use of a designated provider for prescribing the medication and/or a specific pharmacy to fill prescriptions of that medication.

- **Step Therapy (ST):** If your drug has a step therapy requirement, we will only cover second choice drugs if you have already tried a first choice drug and it did not work for you. The reason for a particular step therapy requirement may be because there are covered drugs that usually work just as well, but will cost you less. It may

also be because some drugs are approved by the FDA specifically as second-choice drugs or as add-ons to other medication.

Pharmacy Appeals:
If a member requests a prescription drug that is on the formulary (covered drug), but the request is denied, the member can file an appeal. Appeal information will be included on the notice of denial. If the first appeal is denied, you can request a second-level appeal. If the second appeal is denied, the member can request an external review using information included in the appeal denial notice.

Formulary Exception Request (standard or expedited): If a drug is not on the formulary (not covered), it may be helpful to discuss with your Physician covered alternatives he or she may prescribe; or, if not medically viable, you may request a formulary exception. An exception request may be made by the Member, the Member's designee, or the Member's prescribing Provider (or other prescriber, as appropriate) to request and gain access to clinically appropriate drugs not otherwise covered by the health plan (i.e. non formulary) by contacting us at (855) 811-2218. We will work with the prescribing physician to obtain any medical records or other necessary information to process the request. We must act on a standard request within 72 hours and on an expedited request within 24 hours after we receive your request for a formulary exception. Expedited requests are available only when you have exigent circumstances: a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or when you are undergoing a current course of treatment using a non-formulary drug.

For a standard formulary exception, we will notify you no later than 72 hours following receipt of the request, and if approved, will provide coverage of the approved non-formulary drug for the duration of the prescription, including refills. For an expedited formulary exception, the determination will be made no later than 24 hours following receipt of the request and, if approved, will provide coverage of the non-formulary drug only for the duration of the exigent circumstances.

If your formulary exception request is denied, you can ask for an appeal or an external exception review. This request can be made by you, your designee, or your prescribing Provider. You can ask for an external exception review by contacting us to begin the process at:

Optum Rx
Prior Authorization Department
P.O. Box 25183
Santa Ana, CA 92799
Fax: (844) 403-1029

External exception reviews are available. The external exception request will be assigned to an independent review organization that will make a determination on your external exception request. We will notify you or your designee, along with the prescribing Provider, of the coverage determination. If the original request was a standard formulary exception request, we will notify you no later than 72 hours following receipt of the request, and if approved, will provide coverage of the approved non-formulary drug for the duration of the prescription. If the original formulary exception request was an expedited request, the determination will be made no later than 24 hours following receipt of the request and, if approved, will provide coverage of the non-formulary drug only for the duration of the exigency.

Pharmacy Exclusions: What's Not Covered?

We will not provide benefits for the following Prescription Drugs:

a. That are used for or related to Non-Covered Services or conditions, such as, but not limited to, weight control, obesity, erectile dysfunction (unless indicated for confirmed diagnosis of Benign Prostatic Hypertrophy), cosmetic purposes (such as Tretinoin or Retin-A), hair growth and hair removal.
b. That are used for infertility.
c. More than the number of days' supply allowed as shown in your Schedule of Benefits.
d. Refills in excess of the number specified on your Physician's prescription order.
e. More than the recommended daily dosage defined by BlueCross, unless prior authorization is sought and approved.
f. When administered or dispensed in a Physician's office, Skilled Nursing Facility, Residential Treatment Center, Hospital or any other place that is not licensed to dispense drugs.
g. When there is an Over-the-counter Drug equivalent including any over-the-counter supplies, devices or supplements.
h. When not consistent with the diagnosis and treatment of an illness, injury or condition or that is excessive in terms of the scope, duration or intensity of drug therapy that is needed to provide safe, adequate and appropriate care.
i. When not provided in the appropriate place of service; i.e., some medications are classified as self-administered drugs; when obtained and administered at a doctor's office or in an outpatient setting
j. That require Prior Authorization, and the Prior Authorization is not received.
k. That requires step therapy when a Step Therapy Program is not followed.
l. That are not on the Business BlueEssentials Covered Drug List. (certain drugs administered under the medical benefit are exempt).
m. Any medication or drugs for which some or all of the cost sharing is paid by a drug manufacturer in any form of direct support (cash, reimbursement, coupon, voucher, debit card, etc.) that reduces or eliminates immediate out-of-pocket costs for a specific prescription brand drug. Although the drug remains a covered prescription drug, cost sharing amounts provided by the drug manufacturer will not be counted toward the member's annual limitation on cost sharing.
n. Food or nutritional substances, such as orthomolecular therapy, infant formula, nutrients, vitamins, food supplements, and enteral feedings, whether or not obtained with a prescription.
o. Prescription Drugs that are new to the market and under clinical review by the Corporation shall be listed on the Prescription Drug List as excluded until the clinical review has been completed and a final determination has been made as to whether the Drug should be included.
p. Prescription Drugs and pharmaceuticals under the medical portion of this Contract when benefits are available under the Prescription Drug benefit.

We contract with a pharmacy benefit manager to manage the pharmacy Network, and/or Specialty Drug Network Providers, and to perform other administrative services, including negotiating prices with the pharmacies in this Network. Optum Rx is an independent company that offers a pharmacy network on behalf of BlueCross.

We receive financial credits directly from drug manufacturers and through this pharmacy benefits manager. These credits are used to help stabilize overall rates and to offset costs. Reimbursements to pharmacies and Specialty Drug Network Providers or discounted prices charged by pharmacies and Specialty Drug Network Providers are not affected by these credits.
Any cost-sharing that you must pay for Prescription Drugs is based on the Allowed Amount at the pharmacy or Specialty Drug Network Provider. Copayments are flat amounts and likewise do not change due to receipt of drug manufacturer credits.

Note: If you have other insurance coverage that is primary to this coverage (see Coordination of Benefits section), your primary insurance must pay pharmacy claims before this coverage.

Excluded Services

All Exclusions apply even if the service is deemed Medically Necessary. Notwithstanding any provision of the Contract to the contrary, if the Contract generally provides benefits for any type of injury, then we will not apply an exclusion to an otherwise covered service simply because a medical, physical or mental health condition arises out of an act of domestic violence, whether or not the condition was diagnosed prior to the Contract Effective Date.

We will not provide benefits for:

1. General Exclusions

a. Services and supplies that are:
- not Medically Necessary,
- not needed for the diagnoses or treatment of an illness or injury; or
- not specifically listed in Covered Services.

b. Services and supplies you received before you had coverage under this Certificate or after you no longer have this coverage except as described in Extension of Benefits under the Eligibility, Coverage and When Your Coverage Ends section of this Certificate.

c. Services or benefits received from any Provider not in the Network, unless we have directed you to receive care at the Provider, or if the care results from an Emergency Medical Condition and was received in the emergency department of a Hospital or free-standing Emergency Room. See the Special Out-of-Network Rules section for additional information.

d. Illness contracted or injury sustained as the result of: war or act of war (whether declared or undeclared); participation in a riot or insurrection; service in the armed forces or an auxiliary unit.

e. Any loss that results from you committing, or attempting to commit a crime, felony or misdemeanor or from engaging in an illegal occupation.

f. Any service, supply or treatment for complications resulting from any non-covered service, procedure, condition or drug.

2. Abortion Services

Services or supplies related to an abortion, except:
- For an abortion performed when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused or arising from the pregnancy; or
- When the pregnancy is the result of rape or incest.

3. Administrative Charges

a. Services for which no charge is normally made in the absence of insurance.

b. Any type of fee or charge for handling medical records, filing a claim or missing a scheduled appointment.

c. Separate charges for services or supplies from an employee of a Hospital, laboratory or other institution; or an independent health care professional whose services are normally included in facility charges.

4. Alternative Treatments, Pain Management, Wellness Programs

Charges for acupuncture, massage therapy, hypnotism and TENS unit, or services for chronic pain management programs.

5. Ambulance Charges

a. Ambulance services that meet the following criteria are excluded:
1. That do not meet coverage guidelines outlined in the Ambulance Services description in Covered Services; or
2. That are not Medically Necessary and reasonable; or
3. Transport to a more distant Hospital solely for the member's convenience, regardless of the reason, or to allow the Member to use the services of a specific Physician or Specialist. BlueCross will pay the base rate and mileage for a Medically Necessary ambulance transport to the nearest medically appropriate facility. If the transport is to a facility that is not the nearest medically appropriate facility, the member is responsible for additional cost incurred to go to the Member's preferred facility; or
4. If the member is medically stable and the situation does not involve an Emergency; or
5. Transport from a Hospital in connection with a hospitalization outside the United States.

b. Any and all travel expenses such as, but not limited to: transportation, lodging and repatriation. For persons travelling outside the BlueCross network area, and particularly if you travel outside the United States, we recommend you purchase travel insurance that covers medical expenses and, where possible, the cost of repatriation.

6. Behavioral, Educational, or Alternate Therapy Programs

Any behavioral, educational or alternative therapy techniques to target cognition, behavior language and social skills modification, including:

a. ABA therapy unless Medically Necessary for the treatment of Autism Spectrum Disorder;
b. Teaching, Expanding, Appreciating, Collaborating and Holistic (TEACCH) programs;
c. Higashi schools/daily life;
d. Facilitated communication;
e. Floor time;
f. Developmental Individual-Difference Relationship-based model (DIR);
g. Relationship Development Intervention (RDI);
h. Holding therapy;
i. Movement therapies;
j. Primal therapy
k. Group socialization
l. Art therapy
m. Music therapy; and,
n. Animal assisted therapy.

7. Benefits Available from other Sources

a. Services for which no charge is normally made in the absence of insurance.
b. Services or supplies for which you are entitled to benefits under a governmental program (except Medicaid).
c. Injuries or diseases paid by Workers' Compensation or settlement of a Workers' Compensation claim.
d. Treatment provided in a government Hospital for which you are not legally responsible.
e. Charges by the Department of Veterans Affairs (VA) for a service-related disability.
f. Services or supplies you or a member of your immediate family provides; a member of your family means spouse, parents, grandparents, brothers, sisters, aunts, uncles, children or in-laws.
g. Separate charges for services or supplies from an employee of a Hospital, laboratory or other institution; or an independent health care professional whose services are normally included in facility charges.
h. Services provided when there is a site of care or location that is more appropriate and cost-effective for the condition of the Member or the care required.

8. Chiropractic Care

Services, care, or supplies used to detect and correct, by manual or mechanical means, structural imbalance, distortion or subluxation in your body for the purpose of removing nerve interference and its effects when this interference is the result of or related to distortion, misalignment or subluxation of, or in, the spinal column, unless the Optional Endorsement is purchased.

9. Clinical Trials

a. Services that are not covered routine patient care costs or services, including the following:
    1. The investigational drug, device item or service that is provided solely to satisfy data collection and analysis needs;
    2. An item or service that is not used in the direct clinical management of the Member; and
    3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis
b. An item or service provided by the research sponsors free of charge for any person enrolled in the Clinical Trial
c. Travel and transportation expenses unless otherwise covered under the Policy, including, but not limited to:
    1. Fees for personal vehicle, rental car, taxi, medical van, ambulance, commercial airline or train;
    2. Mileage reimbursement for driving a personal vehicle;
    3. Lodging; and
    4. Meals

10. Cosmetic Services (These services are excluded even if deemed medically necessary.)

a. Cosmetic Surgery: any plastic or reconstructive Surgery done mainly to improve the appearance or shape of any body part and for which no improvement in physiological or body function is reasonably expected. Cosmetic Surgery does not include reconstructive Surgery incidental to or following Surgery resulting from unexpected or unforeseen physical trauma, infection or other diseases of the involved part, or reconstructive Surgery because of congenital disease or anomaly of a covered child which has resulted in a functional defect. Complications arising from Cosmetic Surgery are also not covered.
b. Breast augmentation except after treatment for breast cancer.
c. Reduction mammoplasty for macromastia unless your Body Mass Index (BMI) is less that or equal to 30.
d. Any treatment or Surgery for obesity (even if morbid obesity is present), weight reduction or weight control, such as any gastric by-pass, insertion of stomach (gastric) banding, intestinal bypass, wiring mouth shut, liposuction or complications related to any of these treatments or surgeries. This also includes any reversal or reconstructive procedures from such treatments.
e. Adjustable cranial orthosis (band or helmet) for positional plagiocephaly or craniosynostoses in the absence of cranial vault remodeling Surgery.

11. Dental Care, Oral Surgery

a. Physician services directly related to the care, filling, removal or replacement of teeth; the removal of impacted teeth; and the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth. This includes, but is not limited to: apicoectomy (dental root resection), root canal treatment, alveolectomy (Surgery for fitting dentures) and treatment of gum disease.
b. Services for or related to dental care except as follows:
    1. Within six months of an accident, a member may receive benefits for medically necessary, non-cosmetic dental treatment to teeth that were damaged in the accident;
    2. When a Member requires dental anesthesia because the Member is unable to cooperate for dental treatment and the service or benefit is approved by us prior to any dental procedure; and
    3. For Medically Necessary Cleft Lip and Palate services.
c. Any service or supply related to dysfunctional conditions of the chewing muscles, wrong position or deformities of the jaw bone(s), jaw muscles, orthognathic deformities or temporomandibular joint syndrome (headache, facial pain and jaw tenderness) caused by jaw problems usually known as TMJ, regardless of cause.

12. Durable Medical Equipment

a. Durable medical equipment or Prosthetic Devices when the cost is in excess of $500 and preauthorization is not obtained.
b. Equipment available over the counter such as, but not limited to, air conditioners, air filters, whirlpool baths, spas, (de)humidifiers, wigs, fitness supplies, vacuum cleaners or common first aid supplies.
c. Items purchased that exceed the minimum specifications for your needs; we will pay only the amount that we would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost.
d. No benefits are provided for duplicate prosthetics. Services related to the repair or replacement of a prosthetic are only considered necessary when due to a change in the Member's medical condition, and with prior authorization from us. Repair or replacement for routine wear and tear is not a Covered Service.
e. A penile prosthesis will be considered as a benefit under Durable Medical Equipment only after Medically Necessary prostate Surgery.

13. Excessive sweating

Any services, supplies or treatment for excessive sweating.

14. Family Planning

a. Any services or supplies for the diagnosis or treatment of infertility.
b. Pre-conception testing or pre-conception genetic testing; limited testing is available but must be pre-authorized by Avalon Health Services. See Preauthorization section.

15. Food or Nutrition
Orthomolecular therapy including infant formula, nutrients, vitamins and food supplements, and enteral feedings.

16. Foot Care
Services and supplies related to non-surgical treatment of the feet, except when related to diabetes

17. Genetic testing or counseling
Limited services are available for genetic testing or counseling, and must be preauthorized by Avalon Health Services. See Preauthorization section.

18. Hearing Assistance
Hearing aids and exams for the prescription or fitting of them.

19. Infertility
a. Any services, supplies, or prescription drugs for the diagnosis or treatment of infertility. This includes, but is not limited to: fertility drugs, lab and X-ray tests, reversals of sterilization, surrogate parenting, artificial insemination and in-vitro fertilization.
b. Pre-conception testing or pre-conception genetic testing (limited testing is available but only when pre-authorized; see Preauthorization section).

20. Investigational or Experimental Services
Investigational or Experimental Services, as determined by us, including but not limited to the following:
a. Relating to transplants:
    1. Uses of allogeneic bone marrow transplantation (between two related or unrelated people), syngeneic bone marrow transplantation (from one identical twin to the other), or other forms of stem cell transplant (with or without high doses of chemotherapy or radiation) where use of the transplant is not consistent with evidence-based guidance or standard medical practice;
    2. Adrenal tissue to brain transplants;
    3. Procedures that involve the transplantation of fetal tissues into a living recipient.
b. Biofeedback, except when used for migraines and tension headaches, unless preauthorized under BlueCross medical management guidelines;
c. Vagal Nerve Stimulation (VGS)
d. Rapid opiate detoxification

Other services and supplies may be determined to be Investigational and/or Experimental when the service or supply does not meet medical management criteria under the definition of Investigation or Experimental in this Contract.

21. Long Term Care
Admissions or portions thereof for long-term care, including:
    a. Rest care;
    b. Care to assist a Member 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);
    c. Custodial or long-term care; or,
    d. Psychiatric or Substance Use Disorder treatment, including, but not limited to, therapeutic schools, wilderness /boot camps, therapeutic boarding homes, half-way houses and therapeutic group homes.
    e. Admissions or portions thereof for long-term or chronic care for medical or psychiatric conditions.

22. Maternity and Newborn Care
a. Limited pre-conception testing or pre-conception genetic testing is available and only as Pre-Authorized. See Pre-Authorization section.
b. Newborn care as an Inpatient, Outpatient, or Office Visit, unless the Newborn is added to the Contract within 31 days, and the appropriate Premium paid.

23. Physician Charges

a. Any type of fee or charge for handling medical records, filing a claim or missing a scheduled appointment.
b. Physician charges for drugs, appliances, supplies, blood and blood products.
c. Surgical assistant when not medically necessary

24. Preauthorization Required

a. Benefits will be denied for procedures, services or pharmaceuticals when you do not get the required Preauthorization.
b. Hospital or Skilled Nursing Facility charges when Preauthorization is not obtained. Please refer to the *Preauthorization* section of this Certificate.
c. All Non-emergent Admissions to Hospitals or freestanding Rehabilitation Facilities for physical Rehabilitation when the services are not done at a Provider we designate and/or you do not receive the required Preauthorization.
d. Any medical social services, visual therapy or private duty nursing, except when part of a Preauthorized home health care or hospice services program.

25. Prescription Drugs and Medications

a. That are used for or related to Non-Covered Services or conditions, such as, but not limited to, weight control, obesity, erectile dysfunction (unless indicated to treat confirmed Benign Prostatic Hypertrophy), cosmetic purposes (such as Tretinoin or Retin-A, Kybella for chin fat), hair growth and hair removal.
b. That are used for infertility.
c. More than the number of days' supply allowed as shown in your Member Schedule.
d. Refills in excess of the number specified on your Physician's prescription order.
e. More than the recommended daily dosage defined by BlueCross, unless prior authorization is sought and approved.
f. When administered or dispensed in a Physician's office, Skilled Nursing Facility, Hospital or any other place that is not licensed to dispense drugs.
g. That are available over-the-counter or when there is an over-the-counter equivalent containing the same active ingredients as the prescription/Rx version including any over-the-counter supplies, devices or supplements.
h. When not consistent with diagnosis and treatment of an illness, injury or condition or that is excessive in terms of the scope, duration or intensity of drug therapy that is needed to provide safe, adequate and appropriate care.
i. Some medications classified as self-administered drugs; when obtained, purchased, and/or administered at a doctor's office or in an outpatient setting.
j. That require Prior Authorization, and the Prior Authorization is not received.
k. That requires step therapy when the Step Therapy Program is not followed.
l. That are received Out-of-network, unless due to an Emergency Medical Condition.
m. That are not on the Business BlueEssentials Covered Drug List (certain drugs administered under the medical benefit are exempt).
n. Any medication or drugs for which some or all of the cost sharing is paid by a drug manufacturer in any form of direct support(cash, reimbursement, coupon, voucher, debit card, etc.) that reduces or eliminates immediate out-of-pocket costs for a specific prescription brand drug. Although the drug remains a covered prescription drug, cost sharing amounts provided by the drug manufacturer will not be counted toward the member's annual limitation on cost sharing.
o. Food or nutritional substances, such as orthomolecular therapy, infant formula, nutrients, vitamins, food supplements, and enteral feedings, whether or not obtained with a prescription.
p. Prescription Drugs that are new to the market and under clinical review by BlueCross or its Pharmacy Benefit Manager shall be listed on the Prescription Drug List as excluded until the clinical review has been completed and a final determination has been made as to whether the Drug should be included.
q. Prescription Drugs and pharmaceuticals under the medical portion of this Contract when benefits are available under the Prescription Drug benefit.

26. Preventive services

Preventive Services other than those specifically described under Covered Services, or otherwise required by law to be covered. Some tests may be used for screening (preventive) purposes or for diagnostic purposes; when filed by the Provider for a diagnostic purpose, the claim will not be paid under the Preventive Care provisions. Normal contract terms will apply. If coverage for Preventive Services requires use of a Network Provider, benefits will not be paid for services received out-of-Network.

27. 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

28. Services for Certain Diagnoses or Disorders
Medical Supplies, services or charges for the diagnosis or treatment of learning disorders, communication disorders, motor skills disorders, relational problems, intellectual disabilities, vocational rehabilitation, except as specified on the Schedule of Benefits.

29. Services for Counseling or Psychotherapy
Counseling and psychotherapy services for the following conditions are not covered:

a. Tic disorders, except when related to Tourette's disorder;
b. Mental disorders due to a general medical condition;
c. Medication induced movement disorders; or,
d. Nicotine dependence, except as specified on the Schedule of Benefits.

30. Sexual Dysfunction

a. Any services or supplies for the diagnosis or treatment of sexual dysfunction. This includes, but is not limited to: drugs, lab and X-ray tests, counseling, procedures to correct sexual dysfunction, or penile prostheses due to any medical condition or organic disease, except after Medically Necessary prostate Surgery.
b. Testing, counseling, therapy or psychotherapy for sexual function disorder.

31. Telehealth Services

a. Telehealth services which are initiated by either a Member or Provider (including, but not limited to a medical doctor) in which the method of web-based or video communication is not secure, does not occur in real-time and/or is not provided by Network Providers who have been credentialed as eligible Telehealth Providers.
b. Telemedicine services which do not comply with all requirements specified in the Covered Services section of this Certificate.

32. Telemonitoring
Telemonitoring services are not Covered Services.

33. Transplants

a. Human organ and tissue transplants when a Preauthorization is not obtained or when you do not use the Provider we designate.
b. Transplants involving:
    1. The use of allogeneic bone marrow transplantation (between two related or unrelated people), syngeneic bone marrow transplantation (from one identical twin to the other), or other forms of stem cell transplant (with or without high doses of chemotherapy or radiation) where use of the transplant is not consistent with evidence-based guidance or standard medical practice;
    2. Adrenal tissue to brain transplants;
    3. Islet cell transplants;
    4. Procedures that involve the transplantation of fetal tissues into a living recipient.
    5. Services and supplies related to transplants involving mechanical or animal organs,
c. Travel or transportation to obtain a Transplant.

34. Travel
Any and all travel expenses including, but not limited to, those related to a transplant, CAR-T therapy, gene therapy; and transportation, lodging and repatriation, unless specifically included in Covered Services. For persons travelling outside the BlueCross network area, and particularly if you travel outside the United States, we recommend you purchase travel insurance that covers medical expenses and, where possible, the cost of repatriation.

35. Vision Care

a. Eyeglasses, contact lenses (except after cataract Surgery), and exams for the prescription or fitting of them except as shown in the Pediatric Vision section and the Additional Covered Services section.
b. Any Hospital or Physician charges related to refractive care such as radial keratotomy (Surgery to correct nearsightedness), or keratomileusis (laser eye Surgery or LASIK), lamellar keratoplasty (corneal grafting) or any such procedures that are designed to alter the refractive properties of the cornea.

Providers

This Contract encourages you to use our Network Providers in the Preferred Blue Network. The Preferred Blue Network includes Physicians and Clinicians, Hospitals, Skilled Nursing Facilities, home health agencies, hospices and other Providers who have agreed to provide health care services to our Members at a discounted rate. Benefits will also be payable at a higher percentage when you receive care from a Network Provider.

To find a Network Provider, go to https://www.SouthCarolinaBlues.com/links/tools/PreferredBlue

To ensure you receive all of the benefits you are entitled to, be sure to show your ID card whenever you visit your Provider. This way your Provider will know you have this coverage.

It is important to use a Preferred Blue Network Provider because the Provider has agreed to:

- Bill you no more than the Network allowance for Covered Services.
- File all claims for you when this Certificate is your primary insurance.
- Ask you to pay only the required Deductibles, Copayments and Coinsurance for covered amounts.
- Obtain necessary Preauthorization

Out-of-Network Providers

Not all Physicians, Hospitals and other health care Providers have contracted with us to be Network Providers. Although this plan gives you the freedom to use any Provider, the Benefit Percentage we pay will be lower. This means you pay more money out of your own pocket. These Providers may:

- Require you to pay the full amount of their charges at the time you receive services.
- Require you to file your own claims.
- Require you to get all necessary approvals. Information regarding how and when to get an approval is in the *Preauthorization* section of this Certificate.
- Charge you more than the BlueCross-Allowed Amount. With the exception of Emergency Services, and certain out-of-Network Providers furnishing services at an in-Network Hospital, Ambulatory Surgical Center, or certain other facilities, an out-of-Network Provider can also Balance-Bill you for any amount BlueCross does not pay unless prohibited by law. This may be true even when BlueCross agrees that you can receive services from an out-of-Network Provider.and can Balance-Bill you for any amount BlueCross does not pay. This is true even when BlueCross agrees that you can receive services from an out-of-Network Provider. See the Special Out-of-Network Rules section for additional information.

For some services to be covered, such as transplants, mammography, habilitation, rehabilitation and vision care, you will be required to use a Provider we designate, who may or may not be a Preferred Blue Provider. We may also designate a Provider if you need a Specialist and there is no Preferred Blue Provider with that specialty in your area. If the Provider is not an in-Network provider, benefits will be provided at the in-Network coinsurance amount. The Allowed Amount for these Providers will be the Medicare allowance and these Providers can bill you the difference in the Allowed Amount and the actual charge.

It is always a good idea to ask your Provider if it is a Preferred Blue Provider before you receive care. To find out if your Physician or Hospital is a Preferred Blue Provider, see the *How to Contact Us if You Have a Question* section to request a directory or visit our website. The Preferred Blue Provider Network may change. If you see a *BlueCard* Provider outside South Carolina, that Provider may require you to pay the full charge at the time you receive services and may require you to request any needed Preauthorizations.

BlueCross makes every effort to contract with Physicians who practice at Network Hospitals. Some Physicians, however, choose not to be Network Providers even though they may practice at Network Hospitals. It is important to understand that while you can still use these Physicians, the Benefit Percentage we pay will be lower.

Please note that you may be seen in a teaching Facility or by a Provider who has a teaching program. This means that a medical student, intern or resident participating in a teaching program may see you. Please ask your Provider if you have questions about your care.

Continuation of Care

If a Network Provider's contract is modified, ends, or is not renewed for any reason other than suspension or revocation of the Provider's license, you may be eligible to continue to receive in-Network benefits for that Provider's services.

If you are receiving treatment for a Serious Medical Condition at the time a Network Provider's contract ends, you may be eligible to continue to receive treatment from that Provider. In order to receive this continuation of care for a Serious Medical Condition, you must submit a request to us on the appropriate form.
You may get the form for this request by going to our website or calling 803-264-3475 in Columbia or 800-868-2500, ext. 43475 outside the Columbia area. You will l also need to have the treating Provider include a statement on the form confirming that you have a Serious Medical Condition. Upon receipt of your request, We will notify you and the Provider of the last date the Provider is part of our network and a summary of continuation of care requirements. We will review your request to determine if you qualify for the continuation of care. If additional information is necessary to make a determination, we may contact you or the Provider for such information.

If we approve your request, 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 thedate you are no longer a Continuing Care Patient with respect to the Provider, whicheveroccurs earlier. During this time, the Provider will accept the network allowance as payment in full. Continuation of care is subject to all other terms and conditions of this Contract, including regular benefit limits.

Services Provided Outside the State of South Carolina

Because the Group Health Plan has contracted with BlueCross BlueShield of South Carolina, you have acess to healthcare at In-Network prices when you use the BlueCard network of Providers around the United States or if you travel outside the country. The following section describes how to find a Provider when you are outside the Preferred Blue service area. Please note: non-emergency services may require a Preauthorization when received outside the service area.

Out-of-Area Services

Blue Cross and Blue Shield of South Carolina has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area Blue Cross and Blue Shield of South Carolina serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside our service area, you will receive it from one of two kinds of Providers. Most Providers ("participating Providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("non-participating Providers") do not contract with the Host Blue. We explain below how we pay both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claims Types

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

1. **BlueCard® Program**
   Under the BlueCard® Program, when you receive covered healthcare services within the geographic area served by a Host Blue, we will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

   When you receive Covered Services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:
   - The billed charges for your Covered Services; or
   - The negotiated price that the Host Blue makes available to us.

   Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

   Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims as noted above. However, such adjustment will not affect the price we have used for your claim because they will not be applied after a claim had already paid.

2. **Special Cases: Value-Based Programs**
   BlueCard® Program
   If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to us through average pricing or fee schedule adjustments.

3. **Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees**
   Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

4. **Nonparticipating Providers Outside Our Service Area**
   Member Liability Calculation
   When Covered Services are provided outside of our service area by non-participating Providers, information regarding the amount you pay for such services is contained in the Covered Services section of this Booklet. Federal or state law, as applicable, will govern payments for out-of-Network emergency services.

   Blue Cross Blue Shield Global® Core If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

   If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

   - **Inpatient Services**
     In most cases, if you contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts, deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the Blue Cross Blue Shield Global Core Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Healthcare Services. **You must contact Blue Cross and Blue Shield of South Carolina to obtain precertification for non-emergency inpatient services.**

   - **Outpatient Services**
     Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

   - **Submitting a Blue Cross Blue Shield Global Core Claim**
     When you pay for Covered Healthcare Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from Blue Cross and Blue Shield of South Carolina, the Blue Cross Blue Shield Global Core Service Center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, and seven days a week.

How to File a Claim

By accepting this certificate, you authorize release to BlueCross or its representatives: (1) All past and future medical records and other information deemed necessary by us to process claims; and (2) All Medicare Part A and Part B claims information from the effective date of coverage for the purpose of processing claims.

Claims filed by Network Providers:
If you receive health care services or supplies from a Network Provider, the Provider will file your claims for you.

Claims from Out-of-Network Providers:
If you receive health care services or supplies from an Out-of-Network Provider, the Provider may file your claims directly to BlueCross; however, you may have to file your own claims. Please follow the instructions below when you have claims for expenses other than Prescription Drugs. When filing your own claims, here are some things you willl need:

1. **Comprehensive Benefits Claim Form for each patient.** You can get these forms from the Member Service Center or from our website.
2. **Itemized Bills From the Providers.**

Complete the front of each claim form and attach the itemized bills from the Provider to it. If the patient has other insurance that has already processed the claim, be sure to attach a copy of the other plan's Explanation of Benefits (EOB) notice. This will speed up our claims processing.

Before you submit your claims, we suggest you make copies of all claim forms and itemized bills for your records since we cannot return them to you. Send your claims to the Member Service Center at the address found in the *How to Contact Us if You Have a Question* section.

Prescription Drug Claims:
Please refer to the *Prescription Drug Coverage* section if you need to file a claim for Prescription Drugs.

How Long You Have to File a Claim
We must receive your claim no later than 12 months from the date in which you or your Dependents received the services or supplies. Exceptions may be made if you show you were not legally competent to file the claim. Claims will be processed in the order we receive them.

How Long We Have to Process a Claim
The time frames we are allowed to provide a determination for each of these claims are listed below:

1. Pre-service Claim – We must give you our decision, based on Medical Necessity, in writing or in electronic form within 15 calendar days of receipt. A **Pre-service Claim** is any claim or request for a benefit where Preauthorization must be obtained from us before receiving the medical care, service or supply.

   An extension of 15 calendar days may be provided if we determine that, for reasons beyond our control, an extension is necessary. If an extension is required, we will notify you within the initial 15-day time period that an extension is necessary. When we require an extension due to incomplete information, we are entitled to the rest of the initial determination period to reach a benefit determination after the additional information is received from you or the Provider.

   We will let you know within five calendar days if we receive incomplete information from you and additional information is required to make a determination. You have 60 calendar days to send us required information. If we do not receive the required information within the 60-day time period, we may deny the claim.

2. Urgent Care Claim – We must provide you a determination, based on Medical Necessity, in writing or in electronic form within 72 hours of receipt of the original Urgent Care Claim. An **Urgent Care Claim** is any claim, where, if the normal Preauthorization review time frames were used, your life, health or ability to regain maximum function could be seriously jeopardized; or you would be subject to severe pain that cannot be adequately managed without the care or treatment. We will defer to the attending Provider with respect to the decision as to whether a claim constitutes "urgent care." A

Provider may be considered an authorized representative without a specific designation by you when the approval request is for Urgent Care Claims (medical conditions which require immediate treatment).

We will notify you or your authorized representative within 24 hours from receipt of the original Urgent Care Claim if we do not have enough information to make a decision. An extension of 48 hours may be required if we do not receive complete information in which to make a Medical Necessity decision. If we do not receive the required information from you within 48 hours after notifying you, we may deny the claim.

3. Post-service Claim – We must give you our decision in writing or in electronic form within 30 calendar days if the decision is adverse to you. A **Post-service Claim** is any claim for which you are not required to obtain Preauthorization before obtaining the medical care, service or supply. An adverse decision includes any rescission of coverage or any amount due that you may be held responsible for other than Copayment amounts previously paid to the Provider.

   An extension of 15 calendar days may be provided if we determine that for reasons beyond our control, an extension is necessary. If an extension is required, we will notify you within the initial 30-day time period that an extension is necessary.

   We will let you know within 30 calendar days if we receive incomplete information from you and additional information is required to make a determination. You have 60 calendar days to provide the required information. If we do not receive the required information within the 60-day time period, we may deny the claim.

   When we require an extension due to incomplete information, we are entitled to the rest of the initial determination period to reach a benefit determination once we get the additional information from you or the Provider.

4. Concurrent Care Decision – If we make a decision to reduce or stop benefits for Concurrent Care that had previously been approved, you must be notified sufficiently in advance of the reduction or termination of benefits to allow you time to appeal the decision before the benefits are reduced or terminated. **Concurrent Care** is an approved ongoing course of treatment to be provided over a period of time or number of treatments.

   If you request that Concurrent Care Benefits be extended and the request involves Urgent Care, the request to extend a course of treatment beyond the initially approved period of time or number of treatments must be made at least 24 hours prior to the expiration of the initially approved period. We must make a decision within 24 hours.

Time Payment of Claim: We will pay completed clean claims received via paper within forty business days and completed electronic claims within twenty business days following the later of 1) date the clean claim is received; or 2) the date on which the insurer receives all of the information needed in the format required for the claim to constitute a "clean" claim as defined in the South Carolina Health Care Financial Recovery and Protection Act.

Denial of Claims
If we deny any part or all of a claim, you will receive an Explanation of Benefits (EOB) explaining the reason(s).

If you do not understand why we denied your claim, you can:
- Read the information in this Certificate. It outlines the terms and conditions of your health coverage.
- Contact the Member Service Center for help.
- Ask your Employer to let you read the Contract it holds with BlueCross. The Contract is a legal document that provides a complete description of your health coverage.

Right of Recovery
We have the right to recover any overpayments or mistakes made in payment. The recovery can be from any person to or for with respect to which such payments were made. Recovery will be by check, wire transfer or as an offset against existing or future benefits payable under this Certificate, and from any other insurance companies or any other organizations.

Time Limit to Question a Claim or File a Lawsuit
You have only 180 days to question or appeal our decision regarding a claim. After that date, We will consider disposition of the claim to be final. You cannot bring any Legal Action against us until 60 days after we receive a claim (proof of loss) and you have exhausted the appeal process as described in the *Appeal Procedures* section of this Certificate. You cannot bring any action against us after the expiration of any applicable period prescribed by law.

Appeal Procedures

Please direct any complaints or disagreements you have regarding claims for services or benefits to us at 803-264-3475 from Columbia, South Carolina, or 800-868-2500, ext. 43475 from anywhere else. You can also send us a secure email through the Ask Customer Service feature of My Health Toolkit on our website at www.SouthCarolinaBlues.com.

A Preauthorization denial will be considered a denied claim for purposes of this provision. You can direct any complaints or disagreements you have regarding a Preauthorization to us at 803-736-5990 in Columbia, South Carolina, or 855-895-1682 in South Carolina, or 800-334-7287 outside of South Carolina.

Appeals
An appeal is a request for us to review a claim denial. A member can appeal a claim denial or the appeal can be requested by a member's Authorized Representative. Except in an Urgent Care situation, no person can act as a member's Authorized Representative unless the member has designated that person as the Authorized Representative in writing. If your Provider appeals a claim denial for a Prescription Drug or any medical service, but you have not expressly authorized the Provider to serve as your Authorized Representative, the Provider's actions cannot be used to deny you an Appeal.

How to File an Appeal
If you wish to file a formal **appeal**, you must write to Blue Cross and Blue Shield of South Carolina, Member Service Center, P.O. Box 100300, Columbia, SC 29202. The appeal must state that you are requesting a formal appeal and include all pertinent information regarding the claim in question that you wish to be considered in the appeal. Claims and appeals for services and supplies which are specifically excluded in the Contract are not eligible for external review.

The following guidelines apply for each type of claim (including the appropriate claim with regard to a Concurrent Care decision), unless both parties agree to the extension:

1. Pre-service or Concurrent Care Claim – You have 180 days to appeal our decision on a Pre-service Claim or a Concurrent Care decision. We must complete the appeal process within 30 calendar days after receiving the appeal.
2. Urgent Care Claim – You have 180 days to appeal our decision on an Urgent Care Claim. You may request an expedited review for an Urgent Care Claim either orally or in writing, and all necessary information pertaining to the appeal must be transmitted by telephone, facsimile or other expeditious method. We must complete the appeal process within 72 hours after we receive your appeal.
3. Post-service Claim – You have 180 days to appeal our decision on a Post-service Claim. We must complete the appeal process within 60 calendar days after receiving the appeal.

You will have the opportunity to submit written comments, documents or other information in support of the appeal and you will have access to all documents that are relevant to your claim. If we consider or present additional evidence in connection with the appeal or use new or additional reasons as the basis of the appeal decision, you will be notified of the new evidence or rationale in the appeal decision and have an opportunity to respond. The appeal will be conducted by someone other than the person who made the initial decision, or his or her subordinate. No deference will be afforded to the initial determination. Individuals involved in the decision-making for claims and appeals are not compensated or rewarded based on the outcome of the appeals.

You will be considered to have exhausted the internal appeal process if we fail to strictly adhere to the internal appeal process, unless the error was:

a. De minimis;
b. Non-prejudicial;
c. Attributable to good cause or matters beyond our control;
d. In the context of an ongoing good-faith exchange of information; and
e. Not reflective of a pattern or practice of non-compliance.

You may write to us and request an explanation of our basis for stating we meet the above standard.

External Reviews
Requests to cover services, benefits, or supplies which are specifically excluded in the Contract are not eligible for external review. You will be notified in writing of your right to request an external review. You should file a request for external review within four months of receiving that notice; your request for external review must be in writing. You will be required to authorize the release of any medical records that may be needed for the external review. If you need assistance during the external review process, you can contact the South Carolina Department of Insurance at the following address and telephone number:

South Carolina Department of Insurance
Post Office Box 100105
Columbia, SC 29202-3105
800-768-3467

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 Contract'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 does not 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 Contract exclusions, limitations and other provisions within five business days of our receipt of the notification.

Expedited External Reviews
You can request an expedited external review at the same time as requesting an expedited internal review and there is no deadline on when you can make this request.

When we receive your request for an expedited external review, the South Carolina Department of Insurance will assign your review to an IRO and we will forward our records by overnight delivery, or tell you in writing that your situation does not meet the requirements for an expedited external review and explain the reasons.

The IRO must make its decision as fast as possible but within no more than 72 hours after it receives the request for expedited review. If the IRO's decision is to allow benefits, we must approve the benefit as covered, but it remains subject to applicable Contract exclusions, limitations and other provisions.

All requests for external review and the subsequent review will be at our expense.

If your Physician certifies that you have a "Serious Medical or Behavioral Health Condition," as described above, you are entitled to an expedited external review.

Coordination of Benefits (COB)

Coordination of Benefits occurs when a person is covered by two insurance Plans. When you are covered under two or more types of insurance, one Plan will be considered "primary" and will pay your health care claims first. The other Plan will be considered "secondary," and will process your claims after the primary Plan has processed your claims. You must tell us of any other health coverage you have for yourself or your Dependents. You must also confirm each year that you have no other insurance for you or your Dependents. All benefits provided under this Contract are subject to this section.

How We Pay Claims When We Are Primary
When we are the primary Plan, we will pay benefits as we describe in this Certificate, just as if you had no other health care coverage under any other Plan.

How We Pay Claims When We Are Secondary
We will be secondary whenever the rules do not require us to be primary.

When we are the secondary Plan, we do not pay until after the primary Plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid, as explained below. An "allowable expense" is a health care expense covered by one of the Plans, including copayments, coinsurance and deductibles.

If your other health coverage is responsible for making payments first, BlueCross cannot pay until we know how much the other Plan has paid and the amount of your remaining liability.
Whether BlueCross is primary or secondary, we may need information about your other insurance. You may receive a notice stating a claim has been denied or that we need information to complete processing the claim. For us to update your files, return the notice with the requested information as quickly as possible. If you need more information, please contact a Customer Advocate.

As used in this Section, Plan means any of the following types of coverage that provide benefits or services for your care or treatment:

1. Health Insurance Coverage;
2. Uninsured arrangements of group coverage;
3. Other type of prepayment coverage, including group practice and individual practice plans;
4. Medical benefits coverage in group and individual "no fault" contract and traditional automobile "fault" type contracts;
5. Group hospital indemnity benefits payments in excess of $100 per day.

Effects on Benefits

1. If you are also covered for health or medical benefits or services under any other Plans, we will coordinate benefits with each of your other Plans. If we are the secondary Plan, We will determine our payment by subtracting the amount the primary Plan paid from the amount we would have paid if we had been primary. We may reduce our payment by any amount so that, when combined with the amount paid by the primary Plan, the total benefits paid do not exceed the total Allowed Amount for your claim. We will credit any amount we would have paid in the absence of your other health care coverage toward our own Plan Deductible.

2. We will not pay an amount the primary Plan did not cover because you did not follow its rules and procedures. For example, if your Plan has reduced its benefit because you did not obtain Preauthorization, as required by that Plan, we will not pay the amount of the reduction, because it is not an allowable expense.

3. The rules for Coordination of Benefits follow. If a rule applies to your situation, then you do not need to consider any rules that follow it. For example, if the first rule applies, you do not need to consider the second rule.

   a. If a Plan does not have a Coordination of Benefits provision, then that Plan is presumed to be primary.

   b. The Plan of the Employee is primary over one that covers the Employee as a dependent or inactive Employee.

   c. The Plan of the Employee is primary over one that covers the Employee as a laid off or otherwise inactive Employee.

      If the other Plan does not contain this rule, and, as a result, the Plans do not agree on the order of benefits determination, the order of liability will be determined according to rule #d.

   d. When the prior rules do not establish an order of benefit determination, the Plan under which you have been covered the longest is primary.

   e. A Plan sometimes states that it is always secondary or is always the excess coverage. When a Plan makes that statement, this Certificate will coordinate benefits as follows:
      1. If we determine this Certificate is primary, it will pay or provide benefits on a primary basis;
      2. If we determine this Certificate is secondary, We will provide benefits, but the amount of benefits payable will be determined as if this Certificate were the secondary Plan;
      3. If the other Plan fails to furnish the information needed for us to determine Benefits within a reasonable time after we request the information, We will assume the benefits of the other Plan are the same as those provided under this Certificate and will pay benefits accordingly. If the other Plan makes information available about the actual benefits of the other Plan, any benefit payment we've made under this Certificate will be adjusted accordingly;
      4. If the other Plan refuses to pay as the primary Plan, We will advance you an amount equal to what the other Plan should have paid; however we will not advance more than what we would have paid if we had been the primary Plan and We will be subrogated to all your rights against the other Plan.

         In no event will this Certificate advance more than it would have paid as the primary Plan less any amount it previously paid. In consideration of such advance, this Certificate will be subrogated to all your rights against the other Plan. Such advance under this Certificate will also be without prejudice to any claim it may have against the other Plan in the absence of such subrogation.

   f. If your Dependent children have coverage under this Certificate and as Dependents under other health coverage, the following order of liability will be used:
      1. The Plan covering the parent whose birthday falls earlier in the year (month and day in a calendar year) are determined before those of the Plan of the parent whose birthday falls later in the year;
      2. If both parents have the same birthday, the benefits of the Plan that covered the parent for a longer period of time are determined first;
      3. If the other Plan always considers the father's coverage as primary (gender rule), and as a result, the Plans do not agree on the order of benefits, the gender rule will apply.

   g. In the case of divorce or legal separation, we look first to any court order. If a court order requires one of the parents to be financially responsible for the health care of the child, and the Plan for that parent has actual knowledge of the court order, that Plan becomes primary. If a court says that the parents will share joint custody, without stating that one of the

parents is financially responsible for the health care of the child, we follow the rules above as if the parents are not separated or divorced.

When no court order exists, we determine the primary Plan for a Dependent child as follows:

1. The Plan of the custodial parent;
2. The Plan of the spouse of the custodial parent;
3. The Plan of the non-custodial parent.
4. The Plan of the spouse of the non-custodial parent.

If this Certificate is secondary to Medicare as mandated by Federal law, but the covered Member did not elect coverage under Medicare Part B, Benefits under this Certificate may be reduced by the amount that would have been paid by Medicare Part B had the person elected such coverage.

Facility of Payment

If another Plan mistakenly pays as the primary Plan, we have the right to reimburse that Plan directly for its overpayment; any amount paid to reimburse the other Plan will be considered paid Benefits under this Certificate.

Right of Recovery

If we pay more than we should have paid under this COB provision, we are entitled to receive the overpayment from the person or company that received the overpayment.

Right to Receive and Release Necessary Information

BlueCross may need to release information to, or obtain information from, another Plan, other organization or person for the purpose of determining whether COB applies or processing benefits using the COB provision. No authorization or prior notice is required to release or obtain this information. Any person claiming benefits under this Plan will furnish information upon request. If another Plan or Provider requires an authorization to release information, the Member (or personal representative if the Member is a minor) will provide this upon request.

Subrogation and Reimbursement

Subrogation

The Member agrees, as a condition of receiving Benefits, to transfer to the Corporation all rights to recover for the amount paid for such Benefits when the need for Benefits results from an injury occurring through the act or omission of a third party (including another person, firm, corporation, organization or business entity). The Corporation shall be subrogated, at its expense, to the rights of recovery of such Member against any third party who is liable, responsible or otherwise makes a payment for the injury.

Reimbursement

The Member agrees, as a condition of receiving Benefits, to reimburse the Corporation for the amount paid for Benefits which are related to an injury caused by an act or omission of a liable third party when the Member receives a settlement, judgment or other payment relating to the injury from another person, firm, corporation, organization or business entity. However, under no circumstances will the amount of reimbursement exceed the amount of the Member's recovery.

For purposes of this Article, a liable third party and/or liable insurance coverage include parties and coverages that are responsible or otherwise make a payment for the Member's injury even though liability or other culpability may be denied.

General Provisions

The Corporation's subrogation/reimbursement rights apply to any judgment and/or settlement proceeds received by the Member from or on behalf of the liable third party.

The Corporation's subrogation/reimbursement interest extends to all Benefits paid or payable relating to the injury even if claims for those Benefits were not submitted to the Corporation for payment at the time the Member received the settlement, judgment or payment.

The Corporation's right of recovery may be from any available source, including the liable third party, any liability or other insurance covering the liable third party, malpractice insurance, the Member's own uninsured motorist insurance and/or underinsured motorist insurance.

As a condition of being entitled to Benefits, the Member must:

1. Immediately notify the Corporation of an injury for which another party may be liable, legally responsible or otherwise makes a payment in connection with the injuries;
2. Execute and deliver an accident questionnaire within one hundred eighty (180) days of the accident questionnaire being mailed to the Member;
3. Deliver to the Corporation a copy of the police report, incident or accident report or any other reports issued as a result of the injuries within ninety (90) days of being requested to do so;
4. Authorize the Corporation to sue, compromise and settle in the Member's name to the extent of the amount of medical or other Benefits paid for the injuries under the Plan and the expenses incurred by the Corporation in collecting this amount and assign to the Corporation the Member's rights to recovery when this provision applies;
5. Include the amount paid for Benefits as a part of the damages sought against a liable third party and/or liability insurance company;
6. Immediately reimburse the Corporation, out of any recovery made from a liable third party, the amount of medical Benefits paid for the injuries by the Corporation up to the amount of the recovery;
7. Immediately notify the Corporation in writing of any proposed settlement and obtain the Corporation's written consent before signing any release or agreeing to any settlement; and,
8. Cooperate fully with the Corporation in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Corporation.

The Corporation will pay reasonable attorney's fees and costs from the amount recovered.
If the Director of Insurance, or his or her designee, upon being petitioned by the Member, determines that the exercise of subrogation and/or reimbursement by the Corporation is inequitable and commits an injustice to the Member, subrogation

and/or reimbursement will not be allowed. This determination by the director or his or her designee may be appealed to the Administrative Law Judge Division as provided by law.

Certificate of Creditable Coverage

A Certificate of Creditable Coverage is a document from a health plan or insurer that says you had Health Insurance coverage with that health plan or insurer. To request a Certificate of Creditable Coverage, please write or call our Claims Service Center at the address or phone number listed in the *How to Contact Us if You Have a Question* section.

Continuation of Coverage

If you or your covered Dependents are no longer eligible for coverage or you have ended your employment with your company, you have certain rights to continue your coverage. An explanation follows.

Conversion of Coverage
If a spouse covered under this coverage is no longer eligible because of a legal divorce, he or she may get another Contract from BlueCross without written proof of insurability. The spouse must send us a written application and the required premium within 60 days after the legal divorce. Your Personnel or Human Resources representative will help your spouse apply for conversion of coverage.

The new Contract will provide coverage from BlueCross similar to, but not greater than, this coverage. Credit will be given for any Waiting Periods met under the Contract.

Continuation Under State Law
South Carolina law allows continuation of group coverage for the rest of a month plus six full months after your insurance ends. You must pay the full cost of this Continuation of Coverage in advance to your Employer each month.

Continuation of Coverage is subject to the Contract or a successor Contract remaining in force. And, it is subject to you paying the entire group premium before the date each month that the group Contract begins. This includes any portion usually paid by your former Employer.

Continuation of Coverage is not available if any of these conditions apply:
1. Coverage ended because you did not make timely payments of any required premium contributions.
2. You become eligible for other group coverage including COBRA.
3. You become eligible for Medicare benefits.
4. You were not continuously covered under your Employer's Group Health Plan for a period of at least six months immediately before its end. (Prior Group Health Plan coverage can be counted toward the six-month period as long as there were no more than 62 days between coverage.)
5. The Contract ends for the group. (You may be entitled to Continuation of Coverage under the replacement carrier, if the Employer gets new group coverage.)
6. You are entitled under federal law to Continuation of Coverage for a period of greater length than already provided here.

Continuation Under COBRA (Employers with 20 or More Employees)
The Consolidated Omnibus Budget Reconciliation Act (COBRA) does not apply to churches, religious organizations or federal employees. You must apply for COBRA through your Employer within 60 days of loss of coverage.

Please read this Continuation of Coverage information carefully.
Depending on the circumstances, COBRA requires Employers to let the following people continue their coverage after they normally are no longer eligible for a period of up to 18, 29 or 36 months:

Reason for Loss of Coverage	Eligible Persons	Number of Months of Extended Coverage
1. Employee's working hours reduced from full-time to part-time (for any reason).	Employee Dependents	18 months
2. Employee quits work, is laid off or is fired for any reason other than gross misconduct.	Employee Dependents	18 months
3. Member establishes through the Social Security Administration (SSA) that a disability began within 60 days of a qualifying event for COBRA. **Employee must notify Employer within 60 days of the SSA disability determination and within the original period of COBRA coverage.**	Employee Dependents	29 months
4. Employee dies.	Dependents	36 months
5. Employee and spouse divorce or separate (only when this results in a loss of coverage but also applies if Employee drops spouse's coverage in anticipation of separation or divorce). **Employee must notify Employer within 60 days.**	Dependents	36 months
6. Dependent child who no longer meets plan definition of dependent child. **Employee must notify Employer within 60 days.**	Dependent child	36 months
7. Employee becomes eligible for Medicare and no longer has the group health coverage (applies only if spouse and Dependents are also not eligible for Medicare).	Dependents	36 months
8. If Employee retires, still has the group coverage and the Employer files for Chapter 11 bankruptcy.	Employee Dependents	Until retiree dies, then 36 months for surviving spouse and Dependents

Except for items 3, 5 and 6 above, your Employer must get the proper form to you so you can apply for Continuation of Coverage. This form is called a Membership Application.

For items 3, 5 and 6, you or your eligible Dependents must let your Employer know within 60 days that the situation has occurred. If you or your Dependent, however, does not give the required notice of a divorce or a change in a Dependent child's status, we cannot extend the election period beyond the 60 days after the date coverage ends.

If you or your spouse applies for Continuation of Coverage, it will also apply to any other Dependents who lose coverage for the same reason. Each family Member, however, who loses coverage for the same reason, is entitled to make a separate application for Continuation of Coverage. If there is a choice among types of coverage under the plan, each family Member can make a separate selection from what is available.

During an 18-month Continuation of Coverage period, you may have another situation occur from among items 2 and 4 through 7. If so, then you are entitled to Continuation of Coverage for an overall total of up to 36 months. For items 5 and 6, notify your Employer within 60 days of your situation.

Pay your Premiums for Continuation of Coverage to your Employer.
If you chose Continuation of Coverage, you must pay the first premium to your Employer by the 45th day after your Employer receives the Membership Application. After that, you must pay premiums each month in advance. There is a 31-day grace period for payment of the monthly premiums; however, you will be responsible for any claims incurred during the grace period.

Continuation of Coverage ends earlier than the maximum continuation period under these circumstances:

- When premiums are not paid on time. You will be billed by your provider for any benefits or services.
- When the person who has the Continuation of Coverage becomes covered under another Group Health Plan. (Enrolling in Medicare will not end coverage for people continuing coverage under item (8)
- When a disabled person covered under the extended 29-month COBRA continuation period has been determined by the SSA to be no longer disabled, coverage ends for the disabled person and any covered family Members. (You must notify the Employer within 30 days of final determination.)
- When your Employer no longer has health coverage for its Employees.

Under the Trade Adjustment Assistance Act (TAA) of 2002, an eligible Employee may be entitled to a special 60-day COBRA election period. You must not have previously elected COBRA and must be deemed eligible for the tax credit, but only if the eligibility determination occurs within six months of losing the group health coverage. The special election period begins on the first day of the month you become a Qualified TAA Eligible Individual. If coverage is elected, it begins on the first day of the special election period. There is no required "reach-back" to the date coverage terminated under the group. The total COBRA time period is measured from the initial qualifying event.

Extension of Benefits
If you or a Dependent is in the Hospital or if you or a Dependent is totally disabled on the day your coverage ends, then coverage for the Member will continue while the Member remains totally disabled, subject to all contract limits, from the same or related cause until one of these occurs: 1) the date of recovery from total disability; or 2) the Member receives eligible benefits for up to 365 days from the date coverage ends; or 3) the date the Contract ends and is replaced by another Group Health Plan with similar benefits and the other Group Health Plan makes reasonable provision for continuity of care for the disabling condition.

Important Note: We recommend that you notify BlueCross if you wish to exercise Extension of Benefits rights. We will then determine if the Member is eligible for benefits. Benefits are only payable for Covered Services listed in the Contract that are directly related to the disabling condition. Premium payments are waived for Members receiving Extension of Benefits. There are no continuation rights or any conversion rights available to the Member at the end of the Extension of Benefits period.

"Totally disabled" means you are receiving ongoing medical care by a Physician and are not able to do the material and substantial duties of your regular job. A totally disabled Dependent means the Dependent is receiving ongoing medical care by a Physician and is not able to do the normal activities of a person of the same age and sex who is in good health.

For BlueCross to recognize Extension of Benefits and ensure proper processing, you must send us a Physician's statement of disability.

Your Provider may charge you the full amount for any benefits or services you receive during the grace period.

Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) covers employers with 50 or more employees in each working day during 20 or more workweeks in the current or past year. You may be eligible for FMLA if you worked for your employer for at least one year and have worked at least 1,250 hours during the last 12 months.

During leave, your Employer must keep the same health benefits as provided to other employees who are not on leave. You will continue to pay your portion of the premium and your employer will continue to pay the same portion they would have paid if you had been Actively-at-work. If you do not pay your premiums within 31 days of the due date, your coverage will end on that premium due date.

If you are on FMLA leave and fail to pay the Employee portion of the premiums and your health benefit coverage ends, the coverage will be reinstated without new Waiting Periods as long as you return to work immediately after the leave period, re-enroll and pay your portion of the current premium within 31 days.

Statement of Your ERISA Rights

If your benefit plan is an integral part of an employee welfare benefit plan subject to the provisions of ERISA, then BlueCross is a claim fiduciary. As a claim fiduciary, BlueCross has the discretionary authority to determine eligibility for benefits and to interpret the terms of that part of the ERISA plan represented by your Contract. Any judicial review of a decision made by BlueCross will be done under the arbitrary and capricious standard of review with respect given to the claim fiduciary's decision.

Definitions

Health insurance is sometimes difficult to understand. Many of the terms are not used in day-to-day conversation. Words beginning with **capital letters** have special definitions. We have included the definitions of these terms under this section to help you understand your coverage. More definitions are shown in other parts of this Certificate.

Accidental Injury: An injury directly and independently caused by a specific accidental contact with another body or object such as a car accident or blow by a moving object. All injuries you receive in one accident, including all related conditions and recurrent symptoms of these injuries, will be considered one injury. Accidental Injury does not include indirect or direct loss that results in whole or partially from a disease or other illness.

Admission: The period of time between your entry as a registered bed-patient in a Hospital or Skilled Nursing Facility or long-term acute care Hospital and the time you leave or are discharged from the Hospital or Skilled Nursing Facility. The Admission may be on an Inpatient or Outpatient basis as determined by the Provider.

Allowed Amount: The amount we or a member of the Blue Cross and Blue Shield Association agrees to pay a Network or Participating Provider or a out-of-Network or Non-participating Provider as payment in full for a service, procedure, supply or equipment. For a out-of-Network Provider, (i) the Allowed Amount shall not exceed the Maximum Payment and (ii) in addition to the Member's liability for Benefit Year Deductibles, Copayments and/or Coinsurance, the Member may be Balance Billed unless prohibited by law by the out-of-Network Provider, except as described in the Special Out-of-Network Rules section, for any difference between the Allowed Amount and the Billed Charge.

Alternative Recipient/Alternate Participant: The child of an Employee who is the subject of a Qualified Medical Child Support Order (QMCSO). The child has the same rights as the other participants of the plan.

Ambulatory Surgical Center: A free-standing facility not affiliated with a health system that is licensed for Outpatient Services only and does not provide overnight accommodations or around-the-clock care. The care must be provided under the supervision of a Physician. It also must provide nursing services by or under the supervision of an on duty registered nurse (RN). The facility must not be an office or clinic for the private practice of a Physician.

Anniversary Date: A date selected by your group health plan, on which the contract of insurance renews. This date may be the same as the Effective Date of each Benefit Period, but may be any other date selected by the Group Health Plan.

Authorized Representative: A person you designate in writing to act on your behalf to appeal a particular adverse determination or claim denial.. A Provider may act without written permission when seeking an approval request for Urgent Care Claims (medical conditions which require immediate treatment). In other situations, a person, including a Provider, must have written permission to act as your Authorized Representative. If you have designated an Authorized Representative, all information and notifications will be directed to that representative unless you give contrary directions.

Autism Spectrum Disorder – Autistic Disorder, Asperger's Syndrome and Pervasive Developmental Disorder.

Balance Bill(ing): The process when a Provider bills you for the difference between the Provider's billed charge and the Allowed Amount we pay or for the penalties for not obtaining Preauthorization. For example, if the Provider's billed charge is $100 and the Allowed Amount we pay is $70, in many cases the Provider may bill you for the remaining $30. A Network Provider may *not* Balance-Bill you for Covered Services, except as noted in the *Preauthorization* Section.

Behavioral Health: The comprehensive medical term to include Mental Health and Substance Use Disorders services.

Benefit Percentage: The percentage of the Allowed Charges we pay once you have met the Benefit Period Deductible and/or Copayment**.** For example, you pay 20 percent as Coinsurance; the 80 percent we pay is the Benefit Percentage.

Benefit Period: A 12-month period that begins on the Effective Date of the group coverage or a calendar year. If the group coverage has a calendar year Benefit Period, the first Benefit Period may not be 12 months. It begins again each year on that date. Your Benefit Period is shown in your Schedule of Benefits.

Benefit Period Maximum: The maximum number of days, items or visits that benefits will be provided for a Covered Service in a Benefit Period.

Coinsurance: A percentage of the Allowed Amount that you pay. This percentage applies to the negotiated rate or lesser billed charge when we have negotiated rates with that Provider. For example, you pay 20 percent of the Allowed Amount and we pay 80 percent.

Continuing Care Patient: An individual who is (1) undergoing a course or treatment for a Serious and Complex Condition, (2) undergoing a course of institutional or inpatient care, (3) is scheduled to undergo nonelective surgery, including receipt of postoperative care with respect to such a surgery, (4) pregnant and undergoing a course of treatment for the pregnancy, or (5) determined to be terminally ill (under section 1861(dd)(3)(A) of the Social Security Act) and receiving treatment for such illness.

Copayment: A set amount you pay (for example, $50 for an office visit) for some services. Please refer to your Schedule of Benefits to see if Copayments apply to your coverage.

Cost Sharing: The general term that refers to the share of costs for services covered by a plan or health insurance that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of types of Cost Sharing include copayments, deductibles, and coinsurance. Other costs, including your premiums, Balance Billing amounts, penalties you may have to pay**,** or the cost of care not allowed by a plan or policy are usually not considered Cost Sharing.

Creditable Coverage: Benefits or coverage provided under:

1. A Group Health Plan;
2. Health Insurance Coverage;
3. Medicare Part A or B;
4. Medicaid, other than coverage having only benefits under Section 1928;
5. Military, TRICARE or CHAMPUS;
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool, including the South Carolina Health Insurance Pool (SCHIP);
8. The Federal Employees Health Benefits Plan (FEHBP);
9. A public health plan, as defined in regulations;
10. A health benefit plan of the Peace Corps;
11. Short Term Health; or
12. A State Children's Health Insurance Program (S-CHIP).

This term does not include coverage for coverage excepted under Health Insurance Coverage. We will count a period of Creditable Coverage without regard to specific health benefits covered during that time.

Custodial Care: Care that we determine is provided primarily to assist the patient in the activities of daily living and does not require a person with medical training to provide the services. Custodial Care includes, but is not limited to, activities bathing, eating, dressing, toileting, continence, preparation of special diets and supervision over self-administered medications.

Deductible: The amount you are responsible for paying for most Covered Services before we begin to pay each Benefit Period. The Deductible may not apply to all Covered Services. If you have family coverage, the family Deductible is either aggregate or embedded (noted on your Schedule of Benefits). An **Aggregate Deductible** means the entire family Deductible must be met before benefits begin to pay for any family member each year. An **Embedded Deductible** means that benefits will begin paying for a member once that member meets single Deductible for that yearor, if the family Deductible is met by adding together the amounts of all family members, benefits will begin to pay for all members.

Dependent: Your legal spouse and any children through age 25 who are covered under the Contract. A Dependent child can be a natural, adopted child, stepchild, foster child or a child who is under legal guardianship.
This also includes any child of a divorcing/divorced Employee who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment under this health plan.

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care Provider that has exclusive medical use. These items must be reusable and may include wheelchairs, hospital-type beds, walkers, Prosthetic Devices, orthotic devices, oxygen, respirators, etc. To be considered DME eligible for coverage, the device or equipment's use must be limited to the patient for whom it was ordered.

Effective Date: The date on which coverage for a Member begins under this Certificate and the Master Group Contract.

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

Emergency Medical Care: Health care services you receive in a Hospital emergency room to evaluate and treat an Emergency Medical Condition.

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm, including an illness or injury to an unborn child.

Emergency Services: Services, supplies and treatment for stabilization and/or initial treatment of an Emergency Medical Condition when provided at a Hospital Emergency Room.

Enrollment Date: The date of enrollment in the Group Health Plan or the first day of the Waiting Period for enrollment, whichever is earlier.

Excluded Services: Health care services for which this Plan does not provide or cover.

Formulary: A list of drugs your health insurance plan covers. A formulary may include how much you pay for each drug. If the plan uses "tiers," the formulary may list which drugs are in which tiers. For example, a formulary may include generic drug and brand name drug tiers.

Genetic Information: Information about your genetic tests or the genetic tests of your family members, or any request of or receipt by you or your family members of genetic services. Genetic Information does not include the age or sex of any individual.

Group Health Plan: Health Insurance Coverage offered by an Employer for eligible retirees, Employees and their Dependents.

Habilitation Services: Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech language pathology, and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings. All services must be provided by a licensed physical, occupational or speech therapist.

Health Insurance Coverage: Benefits for medical care provided directly, through insurance, reimbursement or otherwise. It does not include benefits or coverage provided under:

1. Coverage for accident or disability income insurance, or any combination of the two;
2. Coverage issued as a supplement to liability insurance;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Workers' Compensation or similar insurance;
5. Automobile medical payment insurance;
6. Credit-only insurance;
7. Coverage for on-site medical clinics;
8. Other similar insurance coverage that is specified in regulations where benefits for medical care are secondary or incidental to other insurance benefits;
9. If offered separately:
    a. Limited scope dental or vision benefits;
    b. Benefits for Long-term Care, nursing home care, home health care, community-based care or any combination of them;
    c. Such other similar, limited benefits as specified in regulations;
10. If offered as independent, non-coordinated benefits:
    a. Coverage only for a specified disease or illness;
    b. Hospital indemnity or other fixed indemnity insurance;
11. If offered as a separate insurance Contract:
    a. Medicare supplemental Health Insurance;

b. Coverage to supplement coverage provided under Military, TRICARE or CHAMPUS; and
c. Coverage to supplement coverage under a Group Health Plan.

Health Status-related Factor: Any of these: health status, medical condition (including both physical and mental conditions), claims experience, receipt of health care, medical history, Genetic Information, evidence of insurability, including conditions arising out of the acts of domestic violence.

Hospital: An acute-care facility that:

1. Is licensed and operated according to the law; and
2. Primarily and continuously provides or operates medical, diagnostic, therapeutic and major surgical facilities for the medical and Behavioral Health care and treatment of injured or sick people on an Inpatient basis. Care must be provided under the supervision of a staff of duly licensed Physicians; and
3. Provides 24-hour nursing services by or under the supervision of registered nurses (RNs).

The term "Hospital" does not include long-term, chronic-care institutions or institutions (even when these are affiliated with or part of a Hospital) that are, other than incidentally:
1. Convalescent, rest or nursing homes or facilities; or
2. Facilities primarily affording custodial, educational or rehabilitory care.

Incapacitated Dependent: A Dependent child who is: 1) incapable of self-sustaining employment because of a mental or physical handicap; and 2) mainly dependent upon you or your spouse for support and maintenance. The child must have developed the handicap before he or she reached the age at which coverage would otherwise terminate. To keep coverage for an Incapacitated Dependent, you must give us written proof of the disability from a Physician within 31 days of the Dependent's 26th birthday. Records must reflect the dependents current medical condition, including an evaluation within the last 12 months. For the child to remain covered, we may request a Physician's written report no more often than every two years. Coverage must also remain in effect for you.

Inpatient: A Member who is a registered bed patient in a Hospital, Skilled Nursing Facility, Rehabilitation Facility or Psychiatric/Substance Abuse facility for whom a room and board charge is made. (This does not include Outpatient observation which may require an overnight stay.)

Inter-disciplinary Pain Management Program: A program that includes physicians of different specialties and non-physician Providers, who specialize in the assessment and management of patients with a range of painful diagnoses and chronic pain, to provide the interventions needed to allow the patients to develop pain coping skills and discontinue analgesic medication.

Investigational or Experimental Services: The use of services or supplies that we don't recognize in the United States as standard medical care for the treatment of conditions, diseases, illnesses or injuries. We may use the following criteria to determine whether a service or supply is Investigational or Experimental:

1. The service does not have final unrestricted market approval from the FDA or final approval from any other governmental regulatory body for the use in treatment of a specified condition.
2. The service does not have scientific evidence that permits conclusions concerning the effect of the technology on health outcomes.
3. The service does not improve the net health outcome.
4. The service has not been found to be as beneficial as any established alternatives.
5. The service does not show improvement outside the investigational settings.

If a service or supply meets one or more of these criteria, it is Investigational or Experimental. We may consider opinions of professionals in a particular field and/or opinions and assessments of nationally recognized review organizations, but they are not determinative or conclusive.

BlueCross' Medical Director, in making such determinations, may use medical and/or science industry references, including but not limited to the following sources of information:

1. FDA-approved market rulings

2. *The United States Pharmacopoeia and National Formulary*
3. The annotated publication titled, *Drugs, Facts and Comparisons*, published by J.B. Lippincott Company
4. Available peer-reviewed literature
5. Appropriate Consultation with professionals and/or Specialists on a local and national level

Legal Action: No action at law or in equity may be brought to recover on the policy before the expiration of sixty days after written proof of loss has been filed in accordance with the requirements of the policy and that no such action may be brought at all unless brought within six years after the time written proof of loss is required to be furnished.

Long-term Care: Services that are not reasonably expected to result in measurable functional improvement in a reasonable and predictable period of time.

Maximum Out-of-Pocket: The most you pay for Covered Services in a Benefit Period before your Plan begins to pay 100 percent of the Allowed Amount. This limit never includes your premium, Balance Billed charges or health care your Plan does not cover.

Maximum Payment: The maximum amount we will pay (as determined by us) for a particular benefit. The Maximum Payment will be the lesser of the following:

1. The actual charge submitted to us for the service, procedure, supply or equipment by a Provider; or
2. An amount that has been agreed upon in writing by a Provider and us or a member of the Blue Cross and Blue Shield Association; or
3. An amount established by us, based upon factors including, but not limited to, (i) Medicare reimbursement rates applicable to the service, procedure, supply or equipment, or (ii) reimbursement for a comparable or similar service, procedure, supply or equipment, taking into consideration the degree of skill, time and complexity involved; geographic location and circumstances giving rise to the need for the service, procedure, supply or equipment ; or
4. The lowest amount of reimbursement we allow for the same or similar service, procedure, supply or equipment when provided by a Network Provider.

Medically Necessary or Medical Necessity: Health care services that a Physician, exercising prudent clinical judgment, would provide to prevent, evaluate, diagnose or treat an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice; and
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
3. Not primarily for the convenience of the patient, Physician or other health care Provider; and
4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Member: An enrolled Employee or covered Dependent.

Mental Health: Conditions defined, described or classified as behavioral or psychiatric disorders or conditions in the latest publication of The American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders.*

Minimum Essential Coverage: Any of the following:

1. Coverage under certain government-sponsored plans
2. Employer-sponsored plans, with respect to any employee
3. Plans in the individual market
4. Grandfathered health plans
5. Any other health benefits coverage, such as a state health benefits risk pool, as recognized by the HHS Secretary.

Minimum Essential Coverage does not include Health Insurance Coverage consisting of excepted benefits, such as dental-only coverage.

Network: The facilities, providers and suppliers we have contracted with to provide health care services.

Newborn: Typically, a child who is 0 to 28 days of age.

Open Enrollment Period: A period of 30 days immediately after an Employee is hired, when the Employee and his or her Dependents have an initial Open Enrollment Period and may enroll in the Group Health Plan.

Outpatient: A Member who receives services or supplies in a facility setting that does not require an overnight stay.

Physician and other Clinicians: A person (other than an intern, resident or house Physician) duly licensed as a medical doctor, dentist, oral surgeon, podiatrist, osteopath, optometrist, ophthalmologist, Physician's assistant, Nurse Practitioner, midwife, licensed independent social worker or licensed doctoral psychologist, legally entitled to practice within the scope of his or her license and who normally bills for his or her services. Additionally, a chiropractor will be considered a Clinician when the spinal subluxation endorsement is purchased.

Prescription Drug Deductible: The amount you are responsible for paying for Prescription Drugs before we begin to pay each year. The Prescription Drug Deductible must be met in addition to any applicable Copayments.

Primary Care Physician (PCP) – A family doctor, general Physician, OB-GYN, pediatrician, osteopath or internal medicine Physician.

Prosthetic Devices – Artificial replacement body parts needed to ease or correct a condition caused by an illness, injury or birth defect, disease or anomaly. A physician must order the appliance or device. Prosthetics do not include bioelectric microprocessor or computer programmed prosthetic components.

Provider: Any of the following: A facility, Hospital, Skilled Nursing Facility, Rehabilitation/Habilitation facility, Mental Health or Substance Use Disorder facility, Residential Treatment Facility, Physician or other clinician, Psychologist, other mental health clinicians, clinic, Ambulatory Surgical Center, or supplier licensed as required by the state where located, performing within the scope of the license, and acceptable to us. Providers also include:

1. Durable Medical Equipment supplier
2. Independent clinical laboratory
3. Occupational, Physical and Speech therapist
4. Pharmacy
5. Home Health Care Provider
6. Hospice Services Provider
7. Behavioral Health

Qualified Employee: An individual who has been offered health insurance coverage by his or her employer.

Qualified Trade Adjustment (TAA) Eligible Individual: A person who iseligible for credit for health insurance costs under Section 35 of the Internal Revenue Code of 1986, which includes the following persons as defined in Section 35:

1. Eligible TAA recipient; or
2. Eligible ATAA (Alternate TAA) recipient.

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.

Rehabilitation Facility: A Hospital or other freestanding medical facility that has a written agreement with BlueCross, to provide services directed toward restoring full function and independent living for patients with neurological or other physical illnesses or injuries. These services consist of a multi-disciplinary therapeutic program that includes physical therapy, occupational therapy and other therapeutic interventions on an Inpatient basis.

Rehabilitation Services: Health care services that help a person improve skills and functioning that have been lost or impaired due to an illness or injury. These services may include physical and occupational therapy and speech therapy in a variety of Inpatient and/or Outpatient settings ifprovided by a licensed physical, speech or occupational therapist.

Residential Treatment Center: A licensed institution, other than a Hospital, which meets all six of these requirements:

1. Maintains permanent and full-time facilities for bed care of resident patients; and
2. Has the services of a Psychiatrist (Addictionologist, when applicable), Physician, Nurse Practitioner, or Physician Assistant available at all times and is responsible for the diagnostic evaluation, provides face-to-face evaluation services with documentation a minimum of once per week or as indicated; and
3. Has a registered nurse (RN) or Physician on full-time duty who is in charge of patient care, along with one or more RNs or licensed practical nurses (LPNs) on duty at all times; and
4. Keeps a daily medical record for each patient; and
5. Is primarily providing continuous structured therapeutic program specifically designed to treat behavioral health disorders and is not a group or boarding home, boarding or therapeutic school, half-way house, sober living residence, wilderness camp or any other facility that provides Custodial Care; and
6. Is operating lawfully as a nursing home in the area where it is located.

Schedule of Benefits: The attachment to this Certificate that specify the amount of coverage provided, applicable Copayments, Coinsurance, Deductibles and limitations.

Serious and Complex Condition: A condition that is —
1. In the case of an acute illness, serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
2. In the case of a chronic illness, (a) life-threatening, degenerative, potentially disabling, or congenital; and (b) requires specialized medical care over a prolonged period of time.

Examples of a Serious and Complex Condition include cancer, acute myocardial infarction and pregnancy, but may also include other medical or behavioral health conditions that meet the above definitions.

Skilled Nursing Facility: A licensed institution, other than a Hospital, that has a written agreement with BlueCross or with another BlueCross and/or BlueShield Plan which meets all six of these requirements:

1. Maintains permanent and full-time facilities for bed care of resident patients; and
2. Has the services of a Physician available at all times; and
3. Has a registered nurse (RN) or Physician on full-time duty who is in charge of patient care, along with one or more RNs or licensed practical nurses (LPNs) on duty at all times; and
4. Keeps a daily medical record for each patient; and
5. Is primarily providing continuous skilled nursing care for sick or injured patients during the recovery stage of their illnesses or injuries and is not, other than incidentally, a rest home or a home for custodial care for the aged; and
6. Is operating lawfully as a nursing home in the area where it is located.

   In no event, will the term “Skilled Nursing Facility” include an institution, such as a Residential Treatment Center, that mainly provides care and treatment for Substance Use Disorder, alcohol abuse, or Mental Health.

Sound Natural Teeth: Teeth that are free of active or chronic decay, have at least 50 percent bony support, are functional in the arch and have not been excessively weakened by multiple dental procedures. Also includes teeth that have been restored to normal function.

Specialist: A Physician who is not a Primary Care Physician.

Substance Use Disorders: The continued use, abuse and/or dependence of legal or illegal substance(s), despite significant consequences or marked problems associated with the use as defined, described or classified as in the latest publication of The American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders.*

Surgery: 1) A procedure performed on a living body, usually with instruments for the repair of damage or defect or the restoration of health, including endoscopic examinations and other invasive procedures; 2) the correction or treatment of fractures and dislocations; and 3) other procedures as reasonable and as approved by us. This includes the usual, necessary and related pre- and post-operative care.

Telehealth: The exchange of Member information during which Members can have a telephone, video or web-based appointment with a licensed Provider. TeleHealth does not require two-way audio or video consultations between a Referring Provider and/or Specialist. Teleheath services are not covered.

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

Telemonitoring: Services where a Member transmits, whether by facsimile, e-mail, telephone or any other format, his or her specific health data (e.g. blood pressure, weight, etc.) to a health care Provider.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Room care.

Urgent Treatment Center: A medical facility where ambulatory patients can be treated on a walk-in basis, without appointment, and receive immediate, non-emergency care. It does not include a Hospital emergency room.

Waiting Period: The period that must pass before you or your family members are eligible to be covered for benefits under the terms of the Contract with your Employer. Your Waiting Period will be one month, two months, or 90 days (exact), as selected by the Employer.

Summary of the South Carolina Life and Accident and Health Insurance Guaranty Association Act and Notice Concerning Coverage Limitations and Exclusions

Residents of South Carolina who hold life insurance, annuities, or health insurance policies should know that the insurance companies and health maintenance organizations (HMOs) licensed in this state to write these types of insurance are required by law to be members of the South Carolina Life and Accident and Health Insurance Guaranty Association (SCLAHIGA). The purpose of SCLAHIGA is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, SCLAHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through SCLAHIGA is limited. Consumers should shop around for insurance coverage and exercise care and diligence when selecting insurance coverage.

Disclaimer

Under South Carolina law, the South Carolina Life and Accident and Health Insurance Guaranty Association (SCLAHIGA) may provide coverage of certain direct life insurance policies, accident and health insurance policies, annuity contracts and contracts supplemental to life, accident and health insurance policies and annuity contract claims (covered claims) if the insurer becomes impaired or insolvent. South Carolina law does not require the SCLAHIGA to provide coverage for every policy. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.

Coverage is generally conditioned upon residence in this state. Other conditions that may preclude or exclude coverage are described in this notice. Even if coverage is provided, there are significant limits and exclusions. Please read the entire notice for further details on limitations and exclusions.

Insurance companies and insurance agents are prohibited by law from using the existence of the SCLAHIGA or its coverage to sell you an insurance policy. You should not rely on the availability of coverage under SCLAHIGA when selecting an insurer. The South Carolina Life and Accident and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

If you think the law has been violated, you may file a written complaint with the SCLAHIGA or the South Carolina Department of Insurance at the addresses listed below:

South Carolina Life and Accident and Health Insurance Guaranty Association	South Carolina Department of Insurance
Attention: Executive Director P.O. Box 8625 Columbia, SC 29202	Attention: Office of Consumer Services 1201 Main Street, Suite 1000 Columbia, SC 29201 Electronic complaint submission via www.doi.sc.gov/complaint

Please attach copies of all pertinent documentation. You may submit a written complaint or a complaint electronically to the Department through submission of the electronic form on the Department's website at www.doi.sc.gov/complaint. You should receive a response to your complaint within 10 days.

This safety-net coverage is provided for in the South Carolina Life and Accident and Health Insurance Guaranty Association Act (the Act). The following summary of the Act's coverages, exclusions and limits does not cover all provisions of the Act; nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the SCLAHIGA.

COVERAGE

Generally, individuals will be protected by the SCLAHIGA if they live in this state and hold a covered life, accident, health or annuity policy, plan or contract issued by an insurer (including a health maintenance organization) authorized to conduct business in South Carolina. The beneficiaries, payees or assignees of insured persons may also be protected if they live in another state unless circumstances described under the Act exclude coverage.

EXCLUSIONS FROM COVERAGE

Persons who hold a covered life, accident, health or annuity policy, plan or contract are not protected by SCLAHIGA if:

- They are eligible for protection under the laws of another state (This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.);
- The insurer was not authorized to do business in this state; or
- They acquired rights to receive payments through a structured settlement factoring agreement.

SCLAHIGA also does not provide coverage for:

- A portion of a policy or contract or part thereof not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner;
- A policy or contract of reinsurance, unless assumption certificates have been issued;
- Interest rate or crediting rate yields or similar factors employed in calculating value changes that exceed an average rate;
- Any policy or contract issued by assessment mutuals, fraternals, and nonprofit hospital and medical service plans;
- Benefits payable by an employer, association or other person under: (a) a multiple employer welfare arrangement; (b) a minimum premium group insurance plan; (c) a stop-loss group insurance plan; or (d) an administrative services contract;
- A portion of a policy or contract to the extent that it provides for (a) dividends or experience rating credits; (b) voting rights; or (c) payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;
- A portion of a policy or contract to the extent that the assessments required by Section 38-29-80 with respect to the policy or contract are preempted by federal or state law;
- An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner or policy owner, including without limitation: (a) Claims based on marketing materials; (b) Claims based on side letters, riders or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements; (c) Misrepresentations of or regarding policy or contract benefits; (d) Extra-contractual claims; or (e) A claim for penalties or consequential or incidental damages;
- An unallocated annuity contract;
- A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Medicare Part C or D or Medicaid; or
- Interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes impaired or insolvent insurer, whichever is earlier.

LIMITS ON AMOUNTS OF COVERAGE

The South Carolina Life and Accident and Health Insurance Guaranty Association Act also limits the amount that SCLAHIGA is obligated to pay for covered claims. The benefits for which SCLAHIGA may become liable shall in no event exceed the lesser of the following:

- With respect to one life, regardless of the number of policies or contracts: $300,000 in life insurance death benefits, or not more than $300,000 in net cash surrender and net cash withdrawal values for life insurance;
- For health insurance benefits: (a) $300,000 for coverages not defined as disability income insurance or health benefit plans or long-term care insurance, including any net cash surrender and net cash withdrawal values; (b) $300,000 for disability income insurance; (c) $300,000 for long-term care insurance; (d) $500,000 for health benefit plans; or
- $300,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.