



South Carolina

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

## **Business BlueEssentials<sup>SM</sup>**

# **Small Group Certificate of Coverage**

Group and Individual Division



# South Carolina

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

[www.SouthCarolinaBlues.com](http://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'll 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.

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

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

Sincerely,

A handwritten signature in black ink, appearing to read 'J. Deyling', written in a cursive style.

James A. Deyling  
President  
Blue Cross and Blue Shield Division  
Blue Cross and Blue Shield of South Carolina

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## 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. 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.

### Important Things to Remember About Your Coverage

As mentioned earlier, this plan gives you the freedom to choose where you receive health care services — whether it’s 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, Mental Health services or Substance Use Disorder care from a 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 Medically Necessary services, 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’ll 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 Advocate or go to our website for more information about our programs.

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

Receiving an advance Premium tax credit does not affect your eligibility for this coverage or the amount of your Premiums, nor does this tax credit prevent you from taking any action to enforce your rights under applicable law.

Health Status-Related Factors (except for tobacco use), race, color, national origin, disability, age, sex, gender identity or sexual orientation will not affect your eligibility for this coverage.

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

Whenever you call us, please have your BlueCross ID card handy. Our Customer Advocate will ask for the ID number on the front of your card. When writing to us, please include your name, address, ID number and phone number in the letter. We recommend you keep your card with you at all times because you never know when you may need to contact us.

**Health Claim Inquiries:** The mailing address is also on the back of your ID card.

<b>Call:</b>	Monday through Friday, 8:30 a.m. to 5:30 p.m. EST  <u>803-264-3475</u> (from the Columbia area) <u>800-868-2500, ext. 43475</u> (from all other areas)
<b>Write:</b>	<u>Member Service Center</u> <u>Blue Cross and Blue Shield of South Carolina</u> <u>P.O. Box 100300</u> <u>Columbia, SC 29202-3300</u>

### Membership or Eligibility Inquiries:

<b>Call:</b>	Monday through Friday, 8:30 a.m. to 5:30 p.m. EST  <u>803-264-1010</u> (from the Columbia area) <u>800-868-2500, ext. 41010</u> (from all other areas)
<b>Write:</b>	<u>Member Service Center</u> <u>Blue Cross and Blue Shield of South Carolina</u> <u>P.O. Box 100177</u> <u>Columbia, SC 29260</u>
<b>Email:</b>	<u>Group.membership@bcbssc.com</u>

<b>BlueCross Website Address:</b>	<u>www.SouthCarolinaBlues.com</u> , then log in to My Health Toolkit®
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If you have any questions or complaints regarding claims, benefits, quality of care or service concerns, please contact the Member Service Center through Health Claim Inquiries. You may also send us a secure email through the Ask Customer Service feature of My Health Toolkit on our website.

Any complaints or disagreements you have regarding a Preauthorization or prior approval can be directed to us at the numbers listed in the *Preauthorization* section.

## **Your Fastest Place for Answers – [www.SouthCarolinaBlues.com](http://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 to [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com), you'll 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 Physician, Hospital or Pharmacy.
- Use My Health Toolkit.

## **My Health Toolkit**

From [SouthCarolinaBlues.Com](http://SouthCarolinaBlues.Com), click Members, to get to My Health Toolkit to:

- Check your eligibility.
- See how much has been applied toward your Deductible or Out-of-pocket Limit.
- Check on Authorizations.
- Find out if we've processed 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).

## 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 doesn't guarantee that we'll provide benefits. **Along with the service needing to be medically appropriate, the patient must be a Member under this Certificate at the time the service is provided and the service must be a Covered Service. This isn't a guarantee that the service will be covered. Benefits are subject to patient eligibility (whether you're covered under the Plan at the time the service is provided) and contract limitations or exclusions may also apply.** Preauthorization must be obtained for certain categories of benefits; a failure to get preauthorization may result in benefits being denied or a lower level of benefits for the services you receive. We'll make our final benefit determination when we process your claims.

Network Providers in South Carolina will be familiar with this requirement and will get the necessary Preauthorizations. If a Network Provider in South Carolina doesn't get Preauthorization, it can't bill you for the penalty.

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 penalty. This is also true for Network Providers through the BlueCard program.

For some services to be covered, you'll be required to use a Provider we designate, who may or may not be a Network Provider. We'll consider these Providers to be Network Providers. The services include transplants, mammography, habilitation and rehabilitation.

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 the Member Service Center.

*If your request for Preauthorization of services is denied, you can request further review under the guidelines set out in the Appeal Procedures Section of this Certificate. Preauthorization denials are considered denied claims for purposes of appeals and grievances.*

To use the BlueCross Preauthorization process, call the numbers listed below to reach the appropriate medical services personnel. The following are types of services or treatment that must be preauthorized:

Type of service or treatment	Who to call for Preauthorization	Penalty if Preauthorization isn't obtained
<ul style="list-style-type: none"> <li>• Hospital admission</li> <li>• Skilled Nursing Facility (SNF) admission</li> <li>• Continuation of a Hospital stay (remaining in the Hospital or SNF for a period longer than we originally approved) for a medical condition</li> <li>• Outpatient chemotherapy or radiation therapy</li> <li>• Outpatient hysterectomy or septoplasty</li> <li>• Home health care or hospice services</li> <li>• Durable Medical Equipment when purchase or rental is <u>\$500</u> or more</li> </ul>	In Columbia 803-736-5990 In S.C. 800-327-3238 Outside S.C. 800-334-7287	No benefits will be provided.
Admissions for Habilitation, Rehabilitation and/or Human Organ and/or Tissue Transplants	In Columbia 803-736-5990 In S.C. 800-327-3238 Outside S.C. 800-334-7287	No benefits will be provided. Also requires use of a Provider we designate.

Type of service or treatment	Who to call for Preauthorization	Penalty if Preauthorization isn't obtained
Treatment for hemophilia	In Columbia 803-736-5990 In S.C. 800-327-3238 Outside S.C. 800-334-7287	If care isn't coordinated through a Center for Disease Control and Prevention (CDC) designated Hemophilia Treatment Center at least once per Benefit Period, no benefits will be provided.
Certain Prescription Drugs	Log into My Health Toolkit on our website for details	No benefits will be provided.
Specialty Drugs	Log into My Health Toolkit on our website for details	No benefits will be provided. Also requires use of a Provider we designate.
Outpatient/office MRI, MRA, PT scan and CT scan	National Imaging Associates (NIA) 866-500-7664	No benefits will be provided.
Mental Health and Substance Use Disorders	Companion Benefit Alternatives, Inc. (CBA) in Columbia 803-699-7308 Outside Columbia 800-868-1032	No benefits will be provided.

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

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

Hospital Admission for Maternity – When you have a baby, the newborn is included under your Preauthorization. If your baby must stay in the Hospital after you're discharged, a separate Preauthorization must be obtained for your newborn within 24 hours of your discharge or as soon as reasonably possible. You must add your newborn to your coverage before a Preauthorization will be given.

Emergency Hospital Admissions — If you experience an emergency illness or injury, go to the nearest emergency room right away or call 911 for help. We don't expect you to wait for approval before you go to the Hospital.

Since your admission will be unexpected, we allow time to be notified of the admission. 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're admitted to the Hospital. Otherwise, we won't provide benefits for the hospitalization. If Emergency Admission review isn't obtained within this timeframe due to circumstances beyond your control, an appeal can be made and the admission will be reviewed to determine if medically appropriate.

**You can also find these numbers on your ID card.**

*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). A Provider may be an authorized representative with regard to non-Urgent Care Claims only when you give us or the Provider a specific designation to act as an authorized representative. If you have designated an authorized representative, all information and notifications should be directed to that representative unless you give contrary directions.*

## 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 after we accept you as a member.
- 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're unable to represent yourself.
- Pay your cost share amounts, including your premium.
- Tell us if you move.

## 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 unless the absence is due to a Health Status-related Factor, such as: health status, medical condition (including both physical and mental illness), claims experience, receipt of health care, medical history, Genetic Information, evidence of insurability, and conditions arising out of the acts of domestic violence or disability.

This coverage is also available to your legal spouse and to your Dependent children through age 25. 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

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

You're no longer eligible for the group health coverage on the last day of the Contract Month that your active employment with your Employer ends. If you're on disability leave of absence, you may be considered remaining in active employment under the Family and Medical Leave Act if your Employer has 50 or more employees.

A rescission doesn't include a retroactive cancellation or discontinuance of your coverage due to not paying premiums timely.

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 won't continue beyond the termination date.

NOTE: Dependent coverage automatically ends on the same date that your coverage ends.

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. An Incapacitated Dependent's coverage, however, won't 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 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 26<sup>th</sup> birthday. For the child to remain covered, we must receive a Physician's written report every two years within 31 days of the child's birthday. Coverage must also remain in effect for the Employee.

## **Enrollment**

You can enroll within 31 days of the date you first become eligible for coverage, but may be required to serve a Waiting Period of up to 90 days. 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**

An Employee or Dependent(s) eligible for coverage but not yet enrolled may enroll or change from one Qualified Health Plan to another if each person seeking enrollment meets one of the requirements listed below:

1. Had coverage at the time enrollment was previously offered, but lost eligibility for coverage or employer contributions toward the coverage, and the Employee requests the enrollment no later than 31 days after the date coverage ended.
2. The Employee or Dependent gains or loses coverage under a Medicaid plan or under a State Children's Health Insurance Program (S-CHIP) and the Employee requests coverage under the Group Health Plan no more than 60 days after the date the Employee or Dependent is determined to be eligible or ineligible for such assistance.
3. You or a Dependent loses Minimum Essential Coverage. This doesn't include loss due to failure to pay premiums on a timely basis (including COBRA premiums) or rescission of coverage.
4. You gain a Dependent or become a Dependent through marriage, birth, adoption or placement for adoption.
5. Your enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Marketplace or Health and Human Services (HHS), as evaluated and determined by the Marketplace. In such cases, the Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.
6. You adequately demonstrate to the Marketplace that the Qualified Health Plan you were enrolled in substantially violated a material provision of its contract in relationship to you.
7. You gain access to a new Qualified Health Plan as a result of a permanent move.
8. An Indian, as defined by Section 4 of the Indian Health Care Improvement Act, may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another no more often than one time per month.
9. You demonstrate that you meet certain exceptional circumstances.

For items #5 – 9 above, a Special Enrollment must be requested within 60 days of the triggering event.

## **Marriage**

If you marry, the Effective Date of coverage is the first day of the next month after we receive notice of the Special Enrollment. If you're eligible under this plan, but aren't enrolled and you marry, then you're also eligible to enroll in the plan. You must request coverage within 31 days of the marriage.

## **Loss of Minimum Essential Coverage**

If you or a Dependent loses Minimum Essential Coverage, the Effective Date of coverage is the first day of the next month after we receive notice of the Special Enrollment. If you're eligible under this plan, but aren't enrolled, you're also eligible for this Special Enrollment. In this situation, you must request coverage within 31 days of the qualifying event.

## **Birth, Adoption, or Placement for Adoption**

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 while this policy is in force, then the child is covered. If you're eligible under this plan, but aren't enrolled and you or your spouse has a child, adopts a child or is in the process of adopting 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 and pay any premium that may be due.

For an adopted 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 child isn't 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.

Your Effective Date for Special Enrollment for triggering events, except birth, adoption, placement for adoption, marriage or loss of Minimum Essential Coverage is:

Triggering Event Occurs	Effective Date
Between the 1 <sup>st</sup> and 15 <sup>th</sup> of the month (example you lose coverage on February 2 <sup>nd</sup> )	The 1 <sup>st</sup> of the next month (Coverage is effective March 1 <sup>st</sup> )
Between the 16 <sup>th</sup> and the end of the month (example you lose coverage on February 18 <sup>th</sup> )	The 1 <sup>st</sup> of the month following next month (Coverage is effective April 1 <sup>st</sup> )

### 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 don't already provide.

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.

This coverage will provide benefits according to the applicable requirements of any qualified medical child support order.

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.

### Certificate of Creditable Coverage

We'll provide you or your Dependent a Certificate of Creditable Coverage at the time coverage stops or at the time the COBRA or state continuation coverage stops. If you need a copy of the certificate at a later time, you or your Dependent must request the Certificate of Creditable Coverage within 24 months at the end of coverage, or the end of COBRA or state continuation coverage, whichever occurs first. You or your Dependent may also request a Certificate of Creditable Coverage from us even if your coverage is still in force. To request a Certificate of Creditable Coverage, please write or call our Member Service Center at the address or phone number listed in the *How to Contact Us if You Have a Question* section.

## **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 don't meet the medical loss ratio requirement, we'll 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 won't 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'll issue any rebate to the Employer – with two exceptions. First, we may issue any rebate to a nongovernmental Group Health Plan that isn't 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're unable to locate the Employer, we'll distribute the rebate directly to Members covered during the time period on which the rebate is based.

Each year by August 1<sup>st</sup> or by a different date determined by Health and Human Services (HHS), you will receive notice if you're due a Medical Loss Ratio rebate for the previous year.

## Covered Services

We'll 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 Allowed Amount. Benefits are subject to Deductibles, Copayments, Coinsurance, Benefit Period Maximums and exclusions. Preauthorization must be obtained on certain services to receive maximum benefits. See the *Preauthorization* section for details.

**All Covered Services must be Medically Necessary and include only the services specifically described in this section to the extent the services aren't limited or excluded in other provisions of the Contract or this Certificate. The services must be prescribed by or performed by, or upon the direction of, a Physician.**

The following list of Essential Health Benefits are described in detail below.

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

**There is no annual or lifetime dollar limits on benefits provided.**

The following are Covered Services:

**Ambulance Service** – Benefits are provided for professional ambulance services to the nearest Hospital in case of an accident or Emergency Medical Condition. Benefits are also available for transporting the sick and injured (with prior approval for Medical Necessity) between Hospitals when such Hospital is the closest Facility that can provide Covered Services appropriate to the Member's condition.

**Birth Control** – Benefits are provided for oral contraceptive and contraceptive devices as shown in the Schedule of Benefits. Birth control includes female sterilization.

**Breastfeeding Support, Supplies and Counseling** – Benefits will be provided for breastfeeding support and counseling. Breastfeeding support includes benefits for breast pumps as shown in the Schedule of Benefits.

**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's 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 aren't limited to:

1. Oral and facial Surgery, surgical management and follow-up care;
2. Prosthetic treatment such as obturators, 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 policy, then teeth capping, prosthodontics and orthodontics will be covered by the dental policy to the limit of coverage provided and any excess after that will be provided by this Certificate.

**Clinical Trials** – Benefits are only provided for routine patient costs for items and services furnished in connection with a Phase Three Approved Clinical Trial. For these patient costs to be covered you must have cancer or another life-threatening condition (impending death within six months) and your Provider provides us with medical and scientific information establishing your participation in the trial would be appropriate. Your Provider will need to inform us of your participation in the Approved Clinical Trial. An Approved Clinical Trial is one that's listed on the National Institutes of Health (NIH).

**Dental Care to Sound Natural Teeth Related to Accidental Injury** – Benefits are provided for treatment, Surgery or appliances as a result of an accidental bodily injury and is limited to care completed within six months of such accident and while the patient is still covered under this Policy. 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 toward the purchase price or total rental cost up to the purchase price of DME when it's for therapeutic use outside of a Hospital for the treatment of your condition. If the equipment isn't available for rent, we may approve monthly payments toward the purchase of the equipment. We provide benefits for standard DME only. Benefits don't include manual or motorized wheelchairs or power operated scooters, unless Medically Necessary for mobility in the patient's home.

Preauthorization is required before you get the DME if the cost is \$500 or more. See the *Preauthorization* section.

**Emergency Services** – For emergency services received from an in-Network Provider, benefits are provided as any other service under this Certificate. This section explains how you receive Emergency Medical Care from an out-of-Network Provider and what additional cost-sharing or other requirements you may expect.

1. **Out-of-Network Emergency Room** – We provide benefits for Emergency Medical Care in an Emergency Room from an out-of-Network Provider. Benefits for Covered Services are subject to any in-Network Copayment and Benefit Percentage. For purposes of this paragraph, Allowed Amount will be based on the greatest of the following:

- The Fee Schedule for in-Network Providers
- The Reasonable and Customary Fee Schedule
- The Medicare allowance

2. **Out-of-Area Emergency Services** – We provide benefits for Emergency Medical Care from an out-of-Network Provider at the in-Network Benefit Percentage, Deductible and Copayment (if any) if you meet these conditions:

- The Member was traveling for reasons other than seeking medical care when the Emergency Medical Condition occurred.
- The Member was treated for an accident or new Emergency Medical Condition.

If you have claims that meet all of these conditions, write or call the Member Service Center. We'll review your claims to determine if we can provide additional benefits.

Benefits under either of these provisions are subject to all Contract maximums and exclusions. Please note that out-of-Network Providers may Balance Bill you even when an Emergency exists.

If you're admitted to the Hospital as the result of the emergency visit, Preauthorization is required within 24 hours or by 5 p.m. the next working day or as soon as reasonably possible.

**Genetic Counseling** – Benefits are provided for Genetic Counseling.

**Habilitation and Rehabilitation Services** – Include:

**Cardiac Rehabilitation** – Benefit are provided for Phase 1 and 2 cardiac rehabilitation within 30 days of an acute cardiac event.

**Physical, Occupational and Speech Therapy** – Benefits are provided when a Physician prescribes therapy and it is performed by a licensed, professional physical, occupational or speech therapist.

**Pulmonary Rehabilitation** – Benefits are provided when pulmonary rehabilitation is in conjunction with a covered lung transplant.

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

**Home Health Care Services** – Benefits are provided to an essentially 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 before you're eligible for benefits. Please refer to your Schedule of Benefits to see what benefit limitations apply. Home health care includes:

1. Services 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; and
9. Durable Medical Equipment (A separate Preauthorization isn't needed when we approve the entire home health care plan).

**Hospice Services** – Benefits are provided for hospice services. We must Preauthorize hospice services before you're eligible for this care. The services must be provided according to a Physician prescribed treatment plan. Please refer to your Schedule of Benefits to see what benefit limitations apply. Hospice services includes:

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 isn't needed when we approved the entire hospice service plan);
10. Respite care; and
11. Family counseling concerning the patient's terminal condition.

**Hospital Services** – Include Inpatient admissions, Outpatient care and ancillary services. Preauthorization is required. If Preauthorization is not obtained, no benefits will be provided.

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 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 by midnight of the same day. Please note that services provided on the day of discharge are provided according to the policy terms and conditions. The day you return to the Hospital is treated as the day of admission and **is counted** as an Inpatient care day. The days during which you aren't physically present for Inpatient care **are not counted** as Inpatient days.

**Immunizations** – Benefits will be provided as recommended by the Center for Disease Control (CDC).

**Laboratory Services** – Benefits will be provided for procedures to identify the nature and/or extent of a condition or disease. We'll 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 aren't 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 doesn't 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** – Hospitalization will be provided for at least 48 hours following a mastectomy. If you're released early, then we'll provide benefits for at least one home care visit if the attending Physician orders it.

We'll 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 will be 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. This doesn't include the day of delivery or Surgery.

**Medical Supplies** – Benefits will be provided for items you need for treatment of an illness or injury. Supplies include syringes and related supplies for conditions such as diabetes, dressings for cancer or burns, catheters, external opening (ostomy) bags, test tapes, kidney (renal) dialysis supplies and surgical trays. Supplies and equipment that have non-therapeutic uses, over-the-counter supplies and bandages aren't covered.

**Mental Health & Substance Use Disorder Services** – We'll provide benefits as shown in the Schedule of Benefits, for Mental Health and/or Substance Use Disorders.

All Mental Health and/or Substance Use Disorders care must be Preauthorized.

**Newborn Child Coverage** – Benefits will be provided for 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. This doesn't include the day of birth. Benefits will also be provided for the first medical exam of a newborn done by a Physician who didn't deliver the baby or serve as the assistant to the Physician who delivered the baby or as the anesthesiologist. Benefits for the newborn child, however, will be available only if the child is added to the coverage as described in the *Eligibility and Coverage* section.

**Out-of-country** – We'll provide out-of-country benefits based on the in-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.

**Pediatric Services** – Benefits will be provided as follows:

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

Benefits will be provided for pediatric dental/vision services as shown in the *Pediatric Dental/Vision* section and the Schedule of Benefits.

These services are provided in-Network only.

**Physician Services (Primary Care Physician and Specialist)** – Benefits are provided for the following:

1. Office/Outpatient Medical Services – Medical care and consultation by a Physician to a Member in an Outpatient setting for the examination, diagnosis or treatment of an injury or illness.
2. Telemedicine – Benefits will be provided for telemedicine consultation, diagnosis and treatment where the services would otherwise be covered if you were "in person." Telemedicine does not include Telehealth or Telemonitoring.
3. Inpatient Services – Medical care and consultation provided by a Physician in an Inpatient setting for the examination, diagnosis or treatment of an injury or illness.
  - a. Inpatient and Intensive Medical Care Visits – Visits are limited to one per day. Inpatient medical services also include diagnostic services and therapy services done concurrently with medical care.
  - b. Consultation – If a consultation with another Physician is ordered by a patient's attending Physician, benefits are provided for one consultation per consulting Physician.

We won't provide benefits for daily medical visits by more than one Physician unless the Member has a separate medical condition the attending Physician can't treat. In this type of situation, benefits may be provided for one daily visit by each Physician.

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

Benefits are provided for medical visits by another Physician when you have a condition the Physician who performed the surgery can't treat.

- a. Multiple Surgical Procedures – when multiple surgical procedures are performed through the same incision or body opening during one operation, benefits are provided only for the primary procedure unless more than one body system is involved or the procedures are required for management of multiple trauma.

If two or more surgical procedures are performed through different incisions or body openings during one operation, benefits are provided for the additional procedures at 50 percent of the Allowed Amount for each procedure.

If a procedure is performed in two or more steps or stages, benefits will be limited to the Allowed Amount for the entire procedure.

If two or more Physicians, other than as an assistant at Surgery or anesthesiologist, perform procedures in conjunction with one another, we'll prorate the Allowed Amount between them when so required by the Physician in charge of the case. This benefit is subject to the above paragraphs.

When more than one skin lesion is removed at one time, we provide full benefits for the largest lesion, 50 percent of the Allowed Amount is covered for the removal of the second largest lesion and 25 percent of the Allowed Amount is covered for removing any other lesions.

We designate certain surgical procedures that are normally exploratory in nature as "Independent Procedures." The Allowable Charge is covered when such a procedure is performed as a separate and single procedure. However, when an Independent Procedure is performed as an integral part of another surgical service, only the Allowable Charge for the major procedure will be covered.

- b. Surgical Assistant – Services of one Physician who actively assists the operating Physician when an eligible Surgery is performed in a Hospital, and when such surgical assistant service isn't available by an intern, resident or house Physician. We'll provide a predetermined percent not more than 20 percent of the Allowable Charges, not to exceed the Physician's actual charge.
  - c. Anesthesia – Services provided by a Physician or a certified registered nurse anesthetist, other than the attending surgeon or his assistant.
5. Chemotherapy – The treatment of malignant disease by chemical or biological antineoplastic agents that have received full, unrestricted market approval from the FDA.
  6. Dialysis Treatment – The treatment of acute renal failure or chronic irreversible renal insufficiency to include hemodialysis or retinol dialysis. Dialysis treatment includes home dialysis.
  7. Radiation Therapy – The treatment of disease by X-ray, radium or radioactive isotopes.

**Prescription Drugs** – Benefits will be provided for Prescription Drugs. More detailed information is noted in the *Prescription Drug Coverage* section.

**Preventive Screenings** – Benefits will be provided as follows:

- The United States Preventive Services Task Force (USPSTF) recommended Grade A or B screenings.
- Screenings recommended for children and women by Health Resources and Services 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 screenings and Health Resources and Services Administration (HRSA).

These services are provided in-Network only.

**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. The item must be a standard, non-luxury item as determined by us. Specialty items such as bionics or microprocessor components aren't covered. Benefits are provided only for the initial temporary and permanent prosthesis. No benefits are provided for repair, replacement or duplicates, nor for services related to the repair or replacement of such prosthetics, except when necessary due to a change in the Member's medical condition, and with prior authorization from us. Repair or replacement for routine wear and tear isn't a Covered Service.

**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're 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.

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 policy terms and conditions.

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

**Transplants (Human Organ and/or Tissue)** – We provide benefits for covered transplants only when Preauthorized and a Provider we designate performs the transplant.

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 Certificate. This includes donor organ procurement. Organ transplants don't include transplants involving mechanical or animal organs.

1. The only living donor transplants covered under this Certificate are kidney transplants for Members with dialysis-dependent kidney failure and liver transplants. All other living donor transplants aren't covered. 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 isn't, benefits will be provided for the recipient only.
  - c. When the transplant recipient isn't a Member and the donor is, no benefits will be provided to either the donor or the recipient.
2. Benefits are provided for the specified transplants listed below. These benefits are subject to all other provisions of the Contract.
  - Single/double kidney, pancreas and kidney, heart, single/double lung, liver, pancreas, heart and single/double lung and bone marrow transplants.
3. Benefits may be available when a malignancy is present for high-dose chemotherapy followed by hematopoietic stem support, either autologous (the patient is the donor) bone marrow transplant, peripheral stem cell or allogeneic bone marrow transplant.
4. Benefits may be available for allogeneic bone marrow transplantation in the treatment of developmental and non-malignant diseases of bone marrow.

Benefits for allogeneic or syngeneic bone marrow transplants as described in items 3 and 4 above are available only if there are at least six out of eight histocompatibility complex antigen matches between the patient and the donor and the mixed lymphocyte culture is nonreactive.

5. The following services related to tissue transplants (except fetal tissue) are covered:
  - a. Blood transfusions (but not whole blood and blood plasma);
  - b. Autologous parathyroid transplants;
  - c. Corneal transplants;
  - d. Bone and cartilage grafting; or
  - e. Skin grafting.

The following transplants are not Covered Services:

- Uses of allogeneic bone marrow transplantation (between two related or unrelated people) or syngeneic bone marrow transplantation (from one identical twin to the other) along with other forms of stem cell transplant (with or without high doses of chemotherapy or radiation) in cases in which less than four of the six complex antigens match; cases in which mixed leukocyte culture is reactive; and AIDS and HIV infection;
- Adrenal tissue to brain transplants;
- Islet cell transplants;
- Procedures that involve the transplantation of fetal tissues into a living recipient.

## Pediatric Dental/Vision Services

**Pediatric Dental Services** – We provide Pediatric Dental Services as shown in the Schedule of Benefits and described below. Pediatric Dental Services are available from birth through age 18.

### Predetermination of Benefits

Except in an emergency, you should discuss fees with your Dentist before treatment begins. If recommended dental treatment will cost \$100 or more, your Dentist should file a Predetermination of Benefits to BlueCross. By doing this, both you and the Dentist will know up front how much we will pay for treatment recommended. Here's how it works.

Your Dentist should list, on a claim form, the treatment planned and its cost, and send the form to Post Office Box 100300, Columbia, SC 29202. After we determine the amount eligible for payment, we will let you and your Dentist know.

If your Dentist does not ask for Predetermination of Benefits, we will pay benefits according to the information on the claim form. Predetermination of Benefits is not necessary for emergency care, routine oral examinations, X-rays, fluoride treatments, cleaning, scaling or polishing teeth.

### Class I — Preventive Care

We pay benefits for the following services:

1. Oral exams and periodontal exams (exams of the bones, tissues and gums around the teeth), twice per year;
2. Full mouth/Panorex x-rays, with up to 4 additional bitewing x-rays taken on the same day, every three years;
3. Supplementary bitewing x-rays limited to 4 x-rays, twice per year, unless your Dentist feels they are Medically Necessary more often;
4. Cleaning, scaling and polishing teeth, twice per year;
5. Fluoride treatment;
6. Emergency treatment for pain;
7. Space maintainers for prematurely lost baby teeth;
8. Diagnostic casts (only if unrelated to any type prosthodontics);
9. Pulp vitality tests;
10. Sealants on permanent teeth that have not had any fillings through age 13.

### Class II — Restorative Care

We pay benefits for the following services:

1. Fillings with amalgam and tooth-colored synthetic materials;
2. Simple extractions or removal of impacted teeth;
3. Pulp capping and root canal treatment;
4. General anesthesia or IV sedation when Medically Necessary and given with covered dental surgery;
5. Oral surgery;
6. Assistant at surgery when Medically Necessary;
7. Hemi-section;
8. Apicoectomy (removal of the apex of a tooth root);
9. Surgical periodontal exam (for gum disease);
10. Gingival curettage (removal of diseased gum tissue);
11. Gingivectomy and gingivoplasty (gum surgery);
12. Osseous surgery, including flap entry and closure (for gum tissue or bone);
13. Mucogingivoplastic surgery;
14. Management of acute infection and oral lesions;
15. Periodontal cleanings (payable only once every three months after the initial gum disease treatment);
16. Repair of removable dentures.

### **Class III — Major Restorative Care**

We pay benefits for the following services:

1. Inlays that are not part of a bridge;
2. Crowns that are not part of a bridge;
3. Onlays that are not part of a bridge;
4. Removable dentures (complete and partial) and bridges (fixed and removable) every five years;
5. Fixed bridge repairs;
6. Relining or rebasing of removable dentures payable once within six months after initial placement, then, once every three years thereafter.

### **Class IV — Orthodontics – There is a one year waiting period for orthodontic services.**

We pay benefits for the following services:

1. Diagnosis, including models and radiographs;
2. Active treatment, including necessary appliances.

### **Pediatric Dental Services Exclusions and Limitations**

We will not pay benefits for the following:

- Services or supplies that are not Medically Necessary.
- Charges for services or supplies that are investigational/experimental in nature.
- Services or supplies that you get before the Effective Date of coverage.
- Dental services received from a dental or medical department maintained by or on behalf of an Employer, a mutual benefit association, labor union, trustee or similar person or group.
- Services and supplies for which the Dentist does not charge.
- Services or supplies paid by Workers' Compensation or similar legislation (if a Workers' Compensation claim is settled, treatment will be considered paid for by Workers' Compensation).
- Services and supplies primarily for cosmetic or aesthetic purposes, including personalization or characterization of dentures.
- Services and supplies for which a Member is entitled to payment or benefits (whether or not any such payment or benefits have been applied for or paid) under the law of the United States (including Medicare), or any state or political subdivision thereof, except for Medicaid.
- Services or supplies related to chewing or bite problems, pain in the face, ears, jaws, or neck resulting from problems of the jaw joint(s), also known as Temporomandibular Joint Disorders (TMJ). Benefits are limited to the x-rays and exam only.
- Services that a Dentist provides that are beyond the scope of his or her license.
- Dental services that cost more than they would have if no coverage had existed.
- Charges for a missed appointment or for filling out claim forms.
- Charges for visits at home or in the hospital, except in connection with emergency care.
- Dental care not specifically listed in the Schedule of Benefits.
- Any service or supply provided by a member of the patient's family or by the patient, including the dispensing of drugs. This means the spouse, parent, grandparent, brother, sister, child or spouse's parent.
- Illness contracted or injury sustained as a result of declared or undeclared war or any act of war, or while in the military service or unit auxiliary.
- Services related to teeth that were missing before the Effective Date of a Member's coverage.
- Services or supplies that do not meet accepted standards of dental practice.
- Claims submitted after the time limit for filing claims has been exceeded.
- Replacement of a denture that could have been repaired or extended.

- Habitual appliances.
- Sterilization fee charged by the Dentist.
- Facility fees filed in conjunction with dental work being performed.
- Mechanical toothbrushes such as the sonic care varieties, rotary head types, or any variety of Water Pic, even if prescribed by a Dentist as Medically Necessary.
- Non-covered forms of anesthesia, including, but not limited to, Nitrous Oxide.
- Appliances or restoration necessary to increase vertical dimensions or to restore an occlusion.
- Treatment after a Member is no longer covered by this insurance, even though treatment began before coverage ended. If dentures were ordered and fitted while coverage was still in force, we still will pay if the dentures are delivered within 31 days after coverage ended.
- More expensive treatment than is Medically Necessary — if a Dentist and patient select a treatment that costs more than treatment other Dentists usually provide, we will pay benefits for the less costly procedure.
- Dental services done by more than one Dentist. If a Member transfers his or her care from one Dentist to another Dentist during the same course of treatment, or if more than one Dentist provides services for the same procedure, we will pay benefits as if only one Dentist had performed the service.
- Any additional treatment because the Member did not cooperate with the Dentist or comply with the dental care prescribed.

**Vision Services** – We provide Pediatric Vision Services as shown in the schedule of benefits. Pediatric Vision Services are available from birth through age 18.

## Prescription Drug Coverage

Prescription Drugs are drugs and 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 considered Prescription Drugs. In general, Generic Drugs are the lowest cost-sharing drug, followed by Preferred Drugs, then Non-preferred Drugs and finally Specialty Drugs as the highest cost-sharing drug. The types of Prescription Drugs are described below:

A **Generic Drug** normally has the same active ingredient(s) as a brand-name drug but isn't manufactured under a registered brand name or trademark.

A **Preferred Drug** has been reviewed for clinical effectiveness, quality and cost. It may be either a Generic or brand-name drug that's preferred by us. The Preferred Drug list is reviewed periodically by us, and may be updated without notice.

**Non-Preferred Drugs**, in general, are those drugs (brand or generic, specialty or non-specialty) that aren't included on the BlueCross preferred drug list because they have no distinct clinical or cost advantage.

**Specialty Drugs** are prescription drugs that treat complex clinical conditions and may require special handling such as refrigeration. They normally require unusual/complex clinical monitoring and special training. Specialty Drugs include, but aren't limited to, infusible Specialty Drugs for acute and chronic diseases, injectable and self-injectable drugs for acute and chronic diseases, biotechnology medicines and specialty oral drugs or other dosage forms.

### How Your Drug Benefits are Paid

Your Schedule of Benefits has detailed information about the cost share for each category of Prescription Drugs.

To receive benefits for Prescription Drugs, you must get them through our Network. A Network Pharmacy has contracted with our pharmacy benefit manager to provide Prescription Drugs. When you buy drugs, you must show the pharmacist your BlueCross ID card. You can find Network Pharmacies on our website under the Pharmacy Directory.

Our **Mail-service Pharmacy** is a mail-service pharmacy that we've contracted with to provide Prescription Drugs. Our Mail-service Pharmacy information is located on our website under Prescription Drug Information.

We'll provide benefits for off-label use of Prescription Drugs that haven't 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.

Specialty Drugs must be filled by a Specialty Drug Network Provider. A **Specialty Drug Network Provider** has agreed to participate in a special pharmaceutical network with us to provide Specialty Drugs. They also agree to accept our allowance as payment in full for Covered Services except for any Deductibles, Copayments or Coinsurance you owe. Benefits are limited to a 31-day supply. You can get a list of Specialty Drugs from our website.

**Preauthorization** is required for some Prescription Drugs and some Specialty Drugs.

An **Over-the-counter (OTC) Drug** doesn't require a prescription. BlueCross doesn't generally pay benefits for Over-the-counter Drugs but may designate specific classes of Over-the-counter Drugs to be covered as Prescription Drugs. If the Certificate includes coverage for specific Over-the-counter Drugs, it will be shown in the Schedule of Benefits. We'll allow coverage for specific Over-the-counter Drugs only when use of Over-the-counter Drugs are required as part of a Step Therapy Program. A **Step Therapy Program** is a process in which you're required to try certain drugs to treat a medical condition before we'll cover another drug for that condition. You **must** have a valid prescription for these classes of Over-the-counter Drugs to be covered.

BlueCross contracts 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. We receive financial credits directly from drug manufacturers and through our pharmacy benefit 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 aren't 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 and doesn't change when we receive any financial credit. Copayments are flat amounts and likewise don't change due to receipt of drug manufacturer or pharmacy benefit manager credits.

### **Integrated Drug**

When you buy your Prescription Drugs from a Network Pharmacy, show the pharmacist your ID card. If you buy your Prescription Drugs from our Mail-service Pharmacy, provide the ID number shown on your ID card.

### **Until your Out-of-pocket Limit is met, you'll pay one or more of the following for each Prescription Drug: Copayment, Deductible and/or Coinsurance.**

Please refer to your Schedule of Benefits to see which of the above benefits apply to your coverage. Once you have met your Out-of-pocket Limit, you won't have additional cost-sharing until a new Benefit Period begins. The pharmacy will file your claim for you.

If a Physician 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.

Not all pharmacies are part of this network. If benefits are available, non-Network Pharmacies can charge you more than your coverage allows – an amount you will then have to pay yourself. Benefits for drugs and supplies purchased from a non-Network Pharmacy are also paid at a lower percentage. Please refer to your Schedule of Benefits to see if you have this benefit. If you buy your Prescription Drugs from a non-Network Pharmacy (if benefits are provided), you must pay for your drugs at the time your prescription is filled. You will then have to file your Prescription Drug claim.

To file a claim for Prescription Drugs purchased from a non-Network Pharmacy:

- Use a Prescription Drug Rx claim form. To receive a form, call or write to the Member Service Center or you can get one from our website.
- Fill out the top half of the claim form.
- Sign the claim form.
- Attach a copy of all itemized Pharmacy receipts.
- Mail your claim and copy of receipts to the address shown on the form.

To file a claim for medical supplies, use the Comprehensive Benefits Claim Form. Please refer to the *How to File a Claim* section for information on completing this form.

## **What's Not Covered**

We won't provide benefits for the following Prescription and/or Specialty Drugs:

- That are used for or related to non-covered services or conditions, such as, but not limited to, weight control, obesity, cosmetic purposes (such as Tretinoin or Retin-A), hair growth, smoking cessation (unless part of an approved wellness program) and hair removal. Also excludes all vitamins (except for prenatal vitamins due to pregnancy).
- More than the number of days supply allowed as shown in your Schedule of Benefits.
- Refills in excess of the number specified on your Physician's prescription order.
- More than the recommended daily dosage defined by BlueCross.
- When administered or dispensed in a Physician's office, Skilled Nursing Facility, Hospital or any other place that isn't licensed to dispense drugs.
- When there's an Over-the-counter Drug equivalent including any over-the-counter supplies, devices or supplements.
- When not consistent with the diagnosis and treatment of an illness, injury or condition or that's excessive in terms of the scope, duration or intensity of drug therapy that's needed to provide safe, adequate and appropriate care.
- When you don't receive any required Preauthorization.
- That requires step therapy when a Step Therapy Program isn't followed.

## Excluded Services

Some services and supplies you receive may not be covered under this health coverage. So it's important to read through this list and understand the types of things you'll be required to pay for if you ever need any of these services and supplies.

We won't provide benefits for:

- Hospital or Skilled Nursing Facility charges when you don't get the required authorization. Please refer to the *Preauthorization* section of this Certificate.
- Services and supplies that aren't Medically Necessary, not needed for the diagnosis or treatment of an illness or injury, or not specifically listed in *Covered Services*.
- Services and supplies you received before you had coverage under this Group Contract or after you no longer have this coverage except as described in the *Extension of Coverage* section of this Certificate.
- Services or supplies for which you're entitled to benefits under Medicare or any other governmental program, except for Medicaid; or for which you're not legally responsible for paying.
- Benefits for injuries or diseases paid by Workers' Compensation or settlement of a Workers' Compensation claim.
- Any charges by the Department of Veterans Affairs (VA) for a service-related disability or care in any State or Federal Hospital for which you aren't legally responsible.
- Rest care or custodial care.
- Admissions or portions thereof for long-term or chronic care for medical or psychiatric conditions.
- Psychiatric or Substance Use Disorder care at a Residential Treatment Center.
- All admissions to Hospitals or freestanding Rehabilitation Facilities for physical **Habilitation** or **Rehabilitation** when the services aren't done at a Provider we designate and/or you don't receive the required Preauthorization.
- Treatment resulting from war or acts of war (whether declared or undeclared), while participating in a riot or uprising, or while in the military service or its auxiliary units.
- An illness you get or injury you receive while committing or attempting to commit a crime, felony or misdemeanor or for engaging in an illegal occupation.
- Services and supplies a Member receives from any intentionally self-inflicted injury (or injury resulting from attempted suicide) unless it results from a medical (physical or mental) condition.
- Services provided for injuries sustained as a result of the Member's Legal Intoxication or while under the influence of any narcotic or drug, unless taken on the advice of a Physician. The Member, or Member's representative, must provide any available test results showing blood alcohol levels upon request of BlueCross and, if the Member refuses to provide these test results, no benefits will be provided.
- Investigational or Experimental Services, as determined by us, including but not limited to the following:

Relating to transplants:

- Uses of allogeneic bone marrow transplantation (between two related or unrelated people) or syngeneic bone marrow transplantation (from one identical twin to the other) along with other forms of stem cell transplant (with or without high doses of chemotherapy or radiation) in cases in which less than four of the six complex antigens match; cases in which mixed leukocyte culture is reactive; and AIDS and HIV infection;
- Adrenal tissue to brain transplants;
- Islet cell transplants;
- Procedures that involve the transplantation of fetal tissues into a living recipient.

Relating to other conditions or services:

- Dorsal Rhizotomy (cutting the back of spinal nerve roots) in the treatment of spasticity (increased tone or tension in a muscle such as a leg);
- Services and supplies related to transplants involving mechanical or animal organs, human organ and/or tissue transplant procedures when you don't get the required prior Preauthorization, it's not done at a Provider we designate, or unless specifically listed in Covered Services.
- Services and supplies related to cosmetic Surgery, as determined by us. This means any plastic or reconstructive Surgery done mainly to improve the appearance of any body part, and from which no improvement in physiologic function is reasonably expected, unless performed either to correct functional disorder or as a result of an injury. Cosmetic Surgery excluded includes, but isn't limited to:
  - Surgery for sagging or extra skin;
  - Any augmentation, reduction, reshaping or injection procedures;
  - Rhinoplasty, abdominoplasty, liposuction and other associated Surgery; and
  - Any procedures using an implant that doesn't alter physiologic function or isn't incidental to a surgical procedure.Any services a Member receives due to complications of cosmetic Surgery also aren't covered.
- Reduction mammoplasty for macromastia unless the Member is within 20 percent of the ideal body weight.
- Any treatment or Surgery for obesity (even if morbid obesity is present), weight reduction, weight control such as gastric bypass, insertion of stomach (gastric) banding, intestinal bypass, wiring mouth shut, liposuction or complications from it. This includes any reversal or reconstructive procedures from such treatments.
- Eyeglasses, contact lenses (except after cataract Surgery and as shown in the *Pediatric Dental/Vision Coverage* section), hearing aids and exams for the prescription or fitting of them. Any Hospital or Physician charges related to refractive care such as radial keratotomy (Surgery to correct nearsightedness), 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.
- Home health care and hospice services, except as provided in *Covered Services* and with a Preauthorization.
- Any medical social services, visual therapy or Private Duty Nursing services, except when part of a preauthorized home health care plan or hospice services program.
- Recreational, educational or play therapy; biofeedback; psychological or educational diagnostic testing to determine job or occupational placement or for other educational purposes, or to determine if a learning disorder exists; therapy for learning disorders, development speech delay, communication disorder, developmental coordination disorder, mental retardation, dissociative disorder, sexual and gender identity disorder, personality disorder and vocational rehabilitation unless specifically included in your Schedule of Benefits.
- Charges for premarital and pre-employment exams.
- Services or supplies related to an abortion, except:
  - To 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.
- Physician charges for Telehealth and Telemonitoring, except as shown in Covered Services.
- Marriage or family counseling for premarital, marital or family relationship dysfunctions.
- Services or care 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.

- Any services or supplies for the diagnosis or treatment of infertility. This includes, but isn't limited to: fertility drugs, lab and X-ray tests, reversals of tubal ligations or vasectomies, surrogate parenting, artificial insemination and in vitro fertilization.
- Any services or supplies for the diagnosis or treatment of sexual dysfunction. This includes, but isn't limited to: drugs, lab and X-ray tests, counseling, transsexual procedures or penile prostheses necessary due to any medical condition or organic disease. A penile prosthesis will be considered for payment only after Medically Necessary prostate Surgery.
- Counseling and psychotherapy services for: feeding and eating disorders in early childhood and infancy; tic disorder except for Tourette's disorder; elimination disorder; mental disorders due to general medical conditions; sexual function disorder; sleep disorder; medication-induced movement disorder; and nicotine dependence unless specifically covered in this Contract.
- Services for Animal-Assisted Therapy, repetitive Transcranial Magnetic Stimulation (rTMS), Vagal Nerve Stimulation (VNS), Eye Movement Desensitization and Reprocessing (EMDR), Behavioral Therapy for solitary maladaptive habits or Rapid Opiate Detoxification.
- Any behavioral, educational or alternative therapy techniques to target cognition, behavior, language and social skills modification, including:
  1. Applied behavioral analysis therapy;
  2. Teaching, Expanding, Appreciating, Collaborating and Holistic (TEACCH) programs;
  3. Higashi schools/daily life;
  4. Facilitated communication;
  5. Floor time;
  6. Developmental Individual-Difference Relationship-based model (DIR);
  7. Relationship Development Intervention (RDI);
  8. Holding therapy;
  9. Movement therapies;
  10. Music therapy; and
  11. Animal-Assisted therapy.
- Charges for acupuncture, massage therapy, hypnotism and TENS unit. Services for chronic pain management programs. This includes any program developed by centers with multidisciplinary staffs intended to provide the interventions needed to allow the patient to develop pain coping skills and freedom from analgesic medications dependence.
- Any services, supplies or treatment for excessive sweating.
- Services and supplies related to non-surgical treatment of the feet, except when related to diabetes.
- Orthomolecular therapy including infant formula, nutrients, vitamins and food supplements, even if the Physician orders or prescribes them. Enteral feedings when not a sole source of nutrition.
- Adjustable cranial orthosis (band or helmet) for positional plagiocephaly or craniosynostoses in the absence of cranial vault remodeling Surgery.
- Services, supplies or treatment for venous incompetence and/or varicose veins, including but not limited to, endovenous ablation, vein stripping or sclerosing solutions injection.
- Bioelectric, microprocessor or computer-programmed prosthetic components.
- Pre-conception testing or pre-conception genetic testing.
- Physician charges for drugs, appliances, supplies, blood and blood products.

- Services or supplies related to dysfunctional conditions of the chewing muscles, wrong position or deformities of the jaw bone(s), orthognathic deformities or temporomandibular joint syndrome (headache, facial pain and jaw tenderness caused by jaw problems and usually known as TMJ).
- 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 isn't limited to: apicoectomy (dental root resection), root canal treatment, alveolectomy (Surgery for fitting dentures) and treatment of gum disease. Exception is made as shown in the *Pediatric Dental/Vision Coverage* section; for dental care to Sound Natural Teeth for up to six months after an accident; and for cleft lip and palate services.
- Devices of any type, even with a prescription (other than contraceptive devices), such as but not limited to: therapeutic devices, artificial appliances or similar devices.
- Luxury or convenience items whether or not a Physician recommends or prescribes them.
- Any and all travel expenses (including those related to a transplant) such as, but not limited to: transportation, lodging and repatriation unless specifically included in Covered Services.
- Durable Medical Equipment when you don't get the required Preauthorization.
- Equipment available over the counter such as, but not limited to: air conditioners, whirlpool baths, spas, (de)humidifiers, wigs, fitness supplies, vacuum cleaners or air filters and common first aid supplies.
- Benefits will be denied for procedures, services or pharmaceuticals when you don't get the required Preauthorization.
- Prescription Drugs and pharmaceuticals under the medical portion of this coverage when benefits are available under the Prescription Drug benefit.
- Prescription Drugs as shown in the *Prescription Drug Coverage* section.
- 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.
- Any type of fee or charge, for handling medical records, filing a claim or missing a scheduled appointment.
- Any services or supplies a member of your family provides, including the dispensing of drugs. A member of your family means spouse, parents, grandparents, brothers, sisters, aunts, uncles, children or in-laws.
- Any service or treatment for complications resulting from any non-covered procedure or condition.

## Providers

The backbone of this plan is the independent Preferred Blue Provider Network. This 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.

For some services to be covered, you'll be required to use a Provider we designate, who may or may not be a Network Provider. These services include transplants, mammography, Habilitation and rehabilitation.

Your Network 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.

It is a good idea to ask your Provider if it is a Network Provider before you receive care. To find out if your Physician or Hospital is in our Network, see the *How to Contact Us if You Have a Question* section to request a directory or visit our website. *Please note: If you see a BlueCard Provider outside South Carolina, that Provider may charge you more than the Allowed Amount and may require you to request any needed Preauthorizations.*

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

### **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.

**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's 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.**

## 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 referred to generally as “Inter-Plan Programs.” Whenever you obtain health care services outside of Blue Cross and Blue Shield of South Carolina’s service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program.

Typically, when accessing care outside our service area, you’ll obtain care from health care Providers that have a contractual agreement (i.e., are “Participating Providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, you may obtain care from nonparticipating health care Providers. Our payment practices in both instances are described below.

### a. **BlueCard® Program**

Under the BlueCard Program, when you access covered health care services within the geographic area served by a Host Blue, we’ll remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care Providers.

Whenever you access covered health care services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for covered health care services is calculated based on the lower of:

- The billed covered 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 health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care 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 health care Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustment won’t affect the price we use for your claim because they won’t be applied retroactively to claims already paid.

In some instances, federal law or the law of a small number of states may require the Host Blues either (i) to use a basis for determining your liability for Covered Services that doesn’t reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should either federal law or the law of the state in which health care services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, we would then calculate your liability according to applicable law.

## b. **Non-Participating Health Care Providers Outside Our Service Area**

### 1. Member Liability Calculation

When covered health care services are provided outside of our service area by non-participating health care Providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating health care Provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating health care Provider bills and the payment we'll make for the Covered Services as set forth in this paragraph.

### 2. Exceptions

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the health care services had been obtained within our service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we'll pay for services rendered by nonparticipating health care Providers. In these situations, you may be liable for the difference between the amount that the non-participating health care Provider bills and the payment we'll make for the Covered Services as set forth in this paragraph.

## **Continuation of Care**

If a Network Provider's contract ends or isn't 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're 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. A Serious Medical Condition is a health condition or illness that requires medical attention, and for which failure to provide the current course of treatment through the current Provider would place your health in serious jeopardy. This includes cancer, acute myocardial infarction and pregnancy.

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'll 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'll 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'll 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'll provide in-Network benefits for that Provider for 90 days or until the end of the Benefit Period, whichever is greater. 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.

## How to File a Claim

By accepting this certificate, you authorize release to Blue Cross and Blue Shield of South Carolina 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.

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

If you receive health care services or supplies from an out-of-Network Provider, you'll 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'll 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 can't 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.

Please refer to the *Prescription Drug* 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 weren't 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're 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. 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'll notify you within the initial 15-day time period that an extension is necessary. When we require an extension due to incomplete information, we're 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'll 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 don't 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 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 can't be adequately managed without the care or treatment. We'll 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'll notify you or your authorized representative within 24 hours from receipt of the original Urgent Care Claim if we don't have enough information to make a decision. An extension of 48 hours may be required if we don't receive complete information in which to make a Medical Necessity decision. If we don't 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 that you submit after you receive 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'll notify you within the initial 30-day time period that an extension is necessary.

We'll 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 don't 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're 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 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.

## Denial of Claims

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

If you don't 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 any from 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'll consider disposition of the claim to be final. You can't 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 can't bring any action against us after the expiration of any applicable period prescribed by law.

## Appeal Procedures

A preauthorization or prior approval denial for a service or benefit will be considered a denied claim for purposes of this provision.

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 letter must state that a formal appeal has been requested and all pertinent information regarding the claim in question must also be included in the letter. Request to cover services and supplies which are specifically excluded in the Contract will be treated as appeals; however, such requests aren't 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 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 15 calendar days after receiving the appeal. If you still don't agree with our decision, you can file a second appeal within 90 days after you receive our decision on the first appeal. We must complete the second appeal process within 15 calendar days after we receive your second appeal.
2. Urgent Care Claim – You have 180 days to appeal our decision on an Urgent Care Claim. You may request an expedited review process for an Urgent Care Claim either orally or in writing, and all necessary information pertaining to the appeal will 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 30 calendar days after receiving the appeal. If you still don't agree with our decision, you can file a second appeal within 90 days after you receive our decision on the first appeal. We must complete the second appeal process within 30 calendar days after we receive your second appeal.

You'll have the opportunity to present testimony, submit written comments, documents or other information in support of the appeal and you'll 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 adverse determination, you'll be notified of the new evidence or rationale in advance of the date of the appeal decision. 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 aren't compensated or rewarded based on the outcome of the appeals.

You'll be considered to have exhausted the internal appeal process if we fail to strictly adhere to the internal appeal process, unless the violation 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.

In certain situations, after you have completed the above appeal process, you may be entitled to an additional review of your claim at our expense. You may ask for an **external review** to reconsider your claim if we've denied it, either in whole or in part. The claim must have been denied, reduced or a service terminated because: 1) it doesn't meet our requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness; or 2) it is Investigational or Experimental. You can call or write the Member Service Center listed above to find out what the amount payable would have been.

After your internal appeals are completed, we'll notify you 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. You'll be required to authorize the release of any medical records that may be needed for the purpose of reaching a decision during the external review. If you need assistance during the external review process, you can contact the South Carolina Department of Insurance for assistance at the following address and telephone number:

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

We'll respond within five business days of us receiving your request for an external review by either:

1. Notifying the South Carolina Department of Insurance of a request for external review and requesting the South Carolina Department of Insurance assign the review to an independent review organization and then forward your records to them; or
2. Telling you in writing that your situation doesn't meet the requirements for an external review and the reasons for our decision.

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

The independent review organization will take action on your request for review within 45 days after it receives the request.

If your Physician certifies that you have a serious medical condition, you're entitled to an **expedited external review**. You can request an expedited external review at the same time as requesting an expedited internal review. A serious medical condition, as used in this provision, is one that requires immediate medical attention to avoid serious impairment to body functions, serious harm to an organ or body part or that would place your health in serious jeopardy or jeopardize your ability to regain maximum function.

You can also request an expedited review if our denial involves Emergency Medical Care, if you may be held financially responsible and you haven't been discharged from the facility. The independent review organization must make its decision as fast as possible but within no more than 72 hours after it receives the request for expedited review.

## Coordination of Benefits (COB)

Coordination of Benefits occurs when a person is covered by two insurance Plans. When you're 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're the primary Plan, we'll 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'll be secondary whenever the rules don't require us to be primary.

When we're the secondary Plan, we don't pay until after the primary Plan has paid its benefits. We'll 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 can't 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; and
5. Group hospital indemnity benefits payments in excess of \$100 per day.

### Effects on Benefits

1. If you're also covered for health or medical benefits or services under any other Plans, we'll coordinate benefits with each of your other Plans. If we're the secondary Plan, we'll 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 don't exceed the total Allowed Amount for your claim. We'll credit any amount we would have paid in the absence of your other health care coverage toward our own Plan Deductible.

2. We won't pay an amount the primary Plan didn't cover because you didn't follow its rules and procedures. For example, if your Plan has reduced its benefit because you didn't obtain Preauthorization, as required by that Plan, we won't pay the amount of the reduction, because it isn't an allowable expense.
3. The rules for Coordination of Benefits follow. If a rule applies to your situation, then you don't need to consider any rules that follow it. For example, if the first rule applies, you don't need to consider the second rule.
  - a. If a Plan doesn't 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 doesn't contain this rule, and, as a result, the Plans don't agree on the order of benefits determination, the order of liability will be determined according to rule #d.

- d. When the prior rules don't 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'll 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'll 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'll advance you an amount equal to what the other Plan should have paid; however we won't advance more than what we would have paid if we had been the primary Plan and we'll 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 don't 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 aren't 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 didn't 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're 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**

If you receive medical benefits under this coverage for an injury caused by the act or omissions of a liable third party and receive a settlement, judgment, or other payment relating to the injury from a liable third party, any other person, firm, corporation, organization or business entity, you agree to reimburse us for benefits that we've paid relating to the injury. This agreement is a condition to receiving benefits under this coverage. Our right to subrogation or reimbursement applies to any judgment and/or settlement proceeds, whether or not liability is admitted.

Our interest in subrogation or reimbursement extends to all benefits relating to your injury even if claims for those benefits haven't been submitted to us for payment at the time you receive the settlement, judgment or payment.

You have the right to petition the Director of Insurance, or his designee, to determine if our subrogation action is inequitable or unjust. If the Director makes the determination that allowing subrogation is inequitable or unjust, then it isn't allowed. This determination by the Director may be appealed to the Administrative Law Judge Division as provided by law.

We'll pay attorney's fees and costs from the amount recovered.

If you choose not to pursue an action to recover damages, you agree to transfer all rights to recover damages in full for such benefits to us. At our expense, we lawfully stand in your place to recover the amount of money we've paid for your medical benefits from any third party who's liable, responsible, or otherwise makes a payment for your injury. We may seek recovery for our payment of claims from the liable third party, any liability or other insurance covering the liable third party or from your own uninsured motorist insurance and/or underinsured motorist insurance.

In all situations involving subrogation, you shall not do anything to hinder or slow our right to seek reimbursement. You shall cooperate with us, sign any documents, and do all things necessary to protect and secure our subrogation right.

Each time a claim is filed with a diagnosis that could be related to an accident or injury, you may receive either a notice stating that we need information to complete processing the claim along with a questionnaire regarding the claim. For your files to be updated, you must return the questionnaire with the requested information.

## **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 policy 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 policy 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 policy remaining in force. And, it's subject to you paying the entire group premium before the date each month that the group policy begins. This includes any portion usually paid by your former Employer.

Continuation of Coverage isn't available if any of these conditions apply:

1. Coverage ended because you didn't 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 weren't 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're 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) doesn't 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. <b>Employee must notify Employer within 60 days of the SSA disability determination and within the original period of COBRA coverage.</b>	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). <b>Employee must notify Employer within 60 days.</b>	Dependents	36 months
6. Dependent child who no longer meets plan definition of dependent child. <b>Employee must notify Employer within 60 days.</b>	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, doesn't give the required notice of a divorce or a change in a Dependent child's status, we can't 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's a choice among types of coverage under the plan, each family Member can make a separate selection from what's 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're 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 45<sup>th</sup> day after your Employer receives the Membership Application. After that, you must pay premiums each month in advance. There's a 31-day grace period for payment of the monthly premiums.

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

- When premiums aren't paid on time.
- When the person who has the Continuation of Coverage becomes covered under another Group Health Plan. (Enrolling in Medicare won't 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's 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 the hospitalization ends or 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'll 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're receiving ongoing medical care by a Physician and aren't 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 isn't able to do the normal activities of a person of the same age and sex who's in good health.

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

## **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 aren't on leave. You'll 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 don't pay your premiums within 31 days of the due date, your coverage will end on that premium due date.

If you're 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 aren't used in day-to-day conversation. Here are some definitions that should make it easier for you to understand your health coverage.

**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 doesn't include indirect or direct loss that results in whole or partially from a disease or other illness.

**Allowed Amount:** The maximum amount that we may pay for a Covered Service.

**Ambulatory Surgical Center:** A facility that's licensed for Outpatient Surgery only and doesn't 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.

**Balance Billing:** When a Provider bills you for the difference between the Provider's charge and the Allowed Amount or for the penalties for not obtaining Preauthorization. For example, if the Provider's charge is \$100 and the Allowed Amount is \$70, 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:** Comprehensive term to include Mental Health and Substance Use Disorders.

**Behavioral Therapy:** Behavioral modification using applied behavioral analysis (ABA) techniques to target cognition, language and social skills.

Behavioral Therapy doesn't include educational or alternative programs such as, but not limited to:

1. TEACCH
2. Auditory integration therapy
3. Higashi schools/daily life
4. Facilitated communication
5. Floor time (DIR, developmental individual-difference relationship-based model)
6. Relationship development intervention (RDI), holding therapy
7. Movement therapies
8. Music therapy
9. Animal-Assisted therapy

**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 or visits that benefits will be provided for a Covered Service in a Benefit Period.

**Certificate of Creditable Coverage:** A document from a previous health insurance plan or insurer that says you had prior Health Insurance Coverage with them. You should receive a certificate after your prior Health Insurance Coverage ends.

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

**Copayment:** A set amount (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.

**Covered Services:** The services that are covered under the insurance contract. See the *Covered Services* section.

**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 doesn't include coverage for coverage excepted under Health Insurance Coverage. We'll 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're responsible for paying for Covered Services before we begin to pay each Benefit Period. The Deductible may not apply to all Covered Services.

**Dependent:** Your spouse and any children through age 25 who are covered under the Contract. A Dependent child can be a natural or adopted child, stepchild, foster child or a child who's under your legal guardianship.

This also includes any child of a divorcing/divorced Employee who's 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, the device or equipment's use must be limited to the patient for whom it was ordered.

**Effective Date:** 12:01 a.m. on the date that coverage begins.

**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. This includes illness or injury to an unborn child.

**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 that this Plan doesn't provide or cover.

**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 doesn't 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. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech therapy 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, speech or occupational therapist.

**Health Insurance Coverage:** Benefits for medical care provided directly, through insurance, reimbursement or otherwise. It doesn't 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's 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 policy:
  - 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 Insurance Marketplace or Marketplace:** The process through which you're able to purchase a Qualified Health Plan.

**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" doesn't 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.

**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.

**Investigational or Experimental Services:** The use of services or supplies that BlueCross doesn't recognize 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. Services or supplies requiring Federal or other governmental agency approval such as drugs and devices that have restricted market approval from the Food and Drug Administration (FDA) or from any other governmental regulatory agency for the use in treatment of a specified condition. Any approval that's granted as an interim step in the regulatory process isn't a substitute for final or unrestricted market approval.
2. There's insufficient or inconclusive scientific evidence in peer-reviewed medical literature for us to evaluate the therapeutic value of the service or supply.
3. There's inconclusive evidence that the service or supply has a beneficial effect on a person's health.
4. The service or supply under consideration isn't as beneficial as any established alternatives.
5. There's insufficient information or inconclusive scientific evidence that the service or supply is beneficial to a person's health and is as beneficial as any established alternatives when it's used in a non-investigational setting.

If a service or supply meets one or more of these criteria, it is Investigational or Experimental. BlueCross makes these determinations after independent review of scientific data. We may consider opinions of professionals in a particular field and/or opinions and assessments of nationally recognized review organizations, but they aren't determinative or conclusive.

BlueCross' Medical Director, in making such determinations, may use one or more of these 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 Intoxication:** Legal intoxication means the Member's blood alcohol level was at or in excess of legal limits under applicable state law, when measured by law enforcement or medical personnel.

**Long-term Care:** Services that aren't reasonably expected to result in measurable functional improvement in a reasonable and predictable period of time.

**Medically Necessary:** 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;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;
3. Not primarily for the convenience of the patient, 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 and 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 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 doesn't include Health Insurance Coverage consisting of excepted benefits, such as dental-only coverage.

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

**Out-of-Pocket Limit:** 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 doesn't cover.

**Outpatient:** A Member who receives services or supplies in a setting that doesn't 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, chiropractor, optometrist, ophthalmologist, Physician's assistant, 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.

**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 don't 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 facility, Physician, psychologist, other mental health clinicians (when preauthorized) and an Ambulatory Surgical Center 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 Health Plan:** A health plan that has been certified by the U.S. Department of Health and Human Services (HHS) to be offered through the Marketplace.

**Qualified Individual:** An individual who seeks to enroll in a Qualified Health Plan offered through the Marketplace, resides in – or intends to reside in – the state that established the Marketplace, and is determined to be eligible by the Marketplace.

**Qualified Trade Adjustment (TAA) Eligible Individual:** A person who's eligible 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.

**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. All services must be provided by a licensed physical, speech or occupational therapist.

**Residential Treatment Center:** A non-acute, 24 hour-a-day residential treatment setting for Mental Health and Substance Use Disorders including, but not limited to: therapeutic schools, wilderness/boot camps, therapeutic boarding homes, half-way houses and therapeutic group homes.

**Schedule of Benefits:** The pages issued as an attachment to this Contract that specify the amount of coverage provided, applicable Copayments, Coinsurance, Deductibles and limitations.

**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's 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 isn't, 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 that mainly provides care and treatment for substance or alcohol abuse.

**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 haven't been excessively weakened by multiple dental procedures. Also includes teeth that have been restored to normal function.

**Specialist:** A Physician who isn't 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) The performance of generally accepted operative and cutting procedures 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:** Services which are initiated by either a Member or health care Provider (including, but not limited to a Physician) in which the method of communication isn't secure, doesn't occur in real-time, doesn't allow for an actual examination, or doesn't utilize both audio and video communication including coverage for Prescription Drugs obtained through Telehealth or an internet only provider. Telehealth services are not covered.

**Telemedicine:** Providing medical care using an interactive two-way telecommunications system (like real-time audio and video) that is compliant with the Health Insurance Portability and Accountability Act's security rules by an eligible provider who's at a different location than you.

**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. Telemonitoring services are not covered.

**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 doesn't 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.