2017

Business BlueEssentials^{SM} PPO

Master Contract

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

Blue Cross and Blue Shield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

MASTER CONTRACT BODY

ARTICLE I – DEFINITIONS

Words and phrases that are capitalized in this Contract or Certificate have specific defined meanings. Any term which has a different medical and nonmedical meaning and which is undefined in this Contract or Certificate is intended to have the medical meaning.

1. **Actively-at-work:** To be considered Actively-at-work, the Employee must: 1) have begun work and not be absent from work because of leave of absence or temporary lay-off, unless the absence is due to a Health Status-related Factor; and 2) be performing the normal duties of his or her occupation at one of the Employer's places of business or at a location to which the Employee must travel to do his or her job. If the Employee does not meet this requirement, coverage will begin on the first day of the next Contract Month after the Employee has returned to active, full-time work.
2. **Care Coordination:** Organized, information-driven patient care activities intended to facilitate the appropriate responses to a member's healthcare needs across the continuum of care.
3. **Care Coordinator:** An individual within a Provider organization who facilitates Care Coordination for patients.
4. **Care Coordinator Fee:** A fixed amount paid by Blue Cross and Blue Shield of South Carolina to Providers periodically for Care Coordination under a Value-Based Program.
5. **Contract:** The agreement between the Corporation and the Employer, including the Application, Master Contract, Certificate, Schedule of Benefits and any attached endorsements, amendments, riders and addenda.
6. **Contract Month:** A one-month period for which the premium is due and payable beginning with the Contract Effective Date and, thereafter, the corresponding day of each Contract Month.
7. **Employee:** Any person working for an Employer who is eligible for coverage.
8. **Employer:** A business, trust or other entity listed on the Face Page of this Contract, which has entered into a contract with the Corporation and acts on behalf of Employees and Dependents who are enrolled as Members in the health plan.
9. **FF-SHOP or SHOP:** the Federally Facilitated Small Business Health Options Program.
10. **Member's Effective Date:** The date (beginning at 12:01 a.m.) on which the Member became covered under the terms of this Contract. See Article II for further details.
11. **Membership Application:** A form agreed upon by the Corporation and the Employer for transmitting the necessary enrollment information from its Employee to the Corporation.
12. **Provider:** Any of the following: A facility, Hospital, Skilled Nursing Facility, Rehabilitation/Habilitation facility, Mental Health or Substance Use Disorder facility, Residential Treatment Facility, Physician or other Clinician, Psychologist, and other mental health clinicians, clinic, Ambulatory Surgical Center, or supplier licensed as required by the state where located, performing within the scope of the license, and acceptable to us or as listed. 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

13. **Small Employer:** As defined in Section 3(5) of the Employee Retirement Income Security Act of 1974, an employer who employed no more than 50 eligible employees or employed an average of not more than 50 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the Benefit Period:

    a. In determining the number of eligible employees, companies that are affiliated companies, that are eligible to file a combined tax return for purposes of state taxation, or that are treated as a single employer under subsection (b), (c), (m) or (o) of Section 414 of the Internal Revenue Code of 1986 will be considered one employer; and
    b. In the case of an employer which was not in existence throughout the prior calendar year, the determination of whether such employer is a Small Employer, or a large employer, will be based on the average number of employees that the employer reasonably expected to employ on business days in the current calendar year; and
    c. Any reference in this Contract to an employer includes a reference to any predecessor of the employer.

14. **Value-Based Program (VBP):** An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

ARTICLE II – ELIGIBILITY FOR COVERAGE

1. **Eligibility**
   Every Employee is eligible for coverage if permanently employed and working an average of 30 hours a week. The Employee will be eligible for coverage for himself and his Dependents if the Employee has completed the Waiting Period shown in the Benefit Request Form. Neither an Employee nor his Dependents will be covered until the Employee is Actively-at-work.

   In all cases, the required premium will have to be paid.

   An Employee and all Dependents are no longer eligible if any of the following occurs:
   a. This Contract is no longer in effect;
   b. The Employee retires;
   c. The Member ceases to be a Member eligible for coverage under the Contract;
   d. The period ends for which the last contribution is made;
   e. The Employee's active employment with the Employer ends.

2. **Election of Coverage**
   a. Any Employee eligible for coverage can elect coverage for himself and his eligible Dependents by completing and filing a Membership Application with the Employer. New Employees can enroll within 31 days of the date they first become eligible for coverage. Dependents can enroll within 31 days of the date on which they first become eligible. **Note:** Persons can also enroll if eligible under terms of Late or Special Enrollment. Except during the time periods set forth in this paragraph, eligible persons cannot enroll without the express written authorization of the Corporation.
   b. The Employer will provide the Corporation a list of eligible Employees and Dependents to be covered, together with any other information required by the Corporation for coverage under this Contract.

3. **Coverage Effective Date**

Unless otherwise provided in the Application for this Contract, coverage will begin as follows:

a. For an Employee eligible prior to the Effective Date of this Contract, coverage will begin on the Effective Date of this Contract if a Membership Application is filed prior to the Effective Date, the required premium is paid and the Employee is Actively-at-work. If an Employee is not Actively-at-work at the time this coverage would otherwise begin, the coverage for the Employee and eligible Dependents will not begin until the first day of the next Contract Month after the Employee has returned to work and the required premium is paid.

b. After this Contract is in effect, an Actively-at-work Employee is eligible for coverage as of the first day of full-time employment. If the Employee completes a Membership Application during the Waiting Period, he or she will be covered on the first day of the Contract Month following the Waiting Period. If an Employee is not Actively-at-work on that date, coverage for the Employee and eligible Dependents will not begin until the first day of the next Contract Month after the Employee has returned to work and the required premium is paid.

4. **Late Enrollment**

Late Enrollees will be subject to a maximum exclusion of 12 months from the date you completed your application for coverage.

5. **Special Enrollment and Effective Date of Coverage**

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:

a. 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.

b. 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.

c. The Employee gains a Dependent or becomes a Dependent through marriage, birth, adoption, placement for adoption or foster care.

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 60 days of the qualifying event.

Birth, Adoption, Placement for Adoption or Foster Care

If the Employee or Employee's spouse gives birth, adopts a child, or a child is placed with the Employee or Employee's spouse for the purpose of adoption or foster care while this policy is in force, then the child is eligible for coverage as of the date of birth. If the Employee is eligible under this plan, but isn't enrolled and the Employee or Employee's spouse has a child, adopts a child, is in the process of adopting a child or has a child placed with them from foster care, the Employee and Employee's spouse can enroll as long as the Employee meets the eligibility requirements of the Contract. In both of these situations, the Employee must request coverage within 31 days of the child's birth, adoption, placement for adoption or foster care and pay any premium that may be due.

For an adopted child, coverage will start when the Employee pays the appropriate premium, if any, as follows:

a. From the moment of birth for a child the Employee or Employee's spouse legally adopts within 31 days of the child's birth;

b. From the moment of birth for a child for whom the Employee or Employee's spouse has temporary custody and have begun adoption proceedings within 31 days of the child's birth; or

c. When the adopted child isn't a newborn, upon temporary custody with the Employee or Employee's spouse. Coverage will continue as long as the Employee or Employee's spouse has custody of the child.

The Employee's Effective Date for Special Enrollment events, except birth, adoption, placement for adoption, marriage or loss of Minimum Essential Coverage is:

Special Enrollment Plan Selection	Effective Date
Between the 1st and 15th of the month (Example: the Employee loses coverage on February 2nd)	The 1st of the following month (Coverage is effective March 1st)
Between the 16th and the end of the month (Example: the Employee loses coverage on February 18th)	The 1st of the month following next month (Coverage is effective April 1st)

6. **Group Replacement Standards**

South Carolina Group Replacement Standards, S.C. Code §38-71-760(m)(5), will apply only if this Contract becomes effective within 62 days after termination of prior Health Insurance Coverage. These Replacement Standards do not apply to changes in benefit options under this Contract.

a. If the Employee and/or Dependents had continuous coverage with the Employer's prior Group Health Plan and are now insured by this plan, credit will be given for deductibles and coinsurance to the extent that they were fully or partially met under similar provisions of the prior plan. The credit will apply for the same or overlapping Benefit Periods and for expenses actually incurred and applied against the deductible and coinsurance provisions of the prior plan during the 90 days before the Effective Date of this plan. This applies only if this Contract covers these expenses and these expenses are subject to similar deductible and coinsurance provisions.

b. Each person not eligible for coverage under this Contract because of the Actively-at-work provision (unless due to a Health Status-related Factor) is nevertheless covered under this Contract, based on the following rules if the person had valid coverage (including Extension of Benefits) under the Employer's prior Group Health Plan on the date it ended. Each person must also be eligible for coverage under this Contract. Any reference in the following rules to a person who was or was not totally disabled is a reference to the person's status immediately before the date this Contract became effective.

Rules

1. The level of benefits the Contract provides is the Contract's regular benefits, with credit given for deductibles and coinsurance to the extent stated in paragraph (a) above, reduced by any benefits payable by the prior plan
2. Coverage will be provided pursuant to the South Carolina Group Replacement Standards laws until the earliest of the following dates:
    a. The date the person becomes eligible under this Contract, satisfying the Actively-at-work provision.
    b. The date the Member's coverage would end based on this Contract's provisions regarding individual termination of coverage.
    c. In the case of a person who was totally disabled at the time the prior plan was discontinued and replaced by a Group Health Plan with similar benefits, the minimum level of benefits provided by the succeeding carrier must be the applicable level of benefits of the succeeding carrier's plan. This Benefit may be reduced by any benefits paid by the prior plan.

The Schedule of Benefits will indicate if this Contract is a "qualified high deductible health plan," in which case the below will be in lieu of the above a. and b.

Each person not eligible for coverage under this Contract because of the Actively-at-work provision (unless due to a Health Status-related Factor) is nevertheless covered under this Contract, based on the following rules if the person had valid coverage (including Extension of Benefits) under the Employer's prior Group Health Plan on the date it ended. Each person must also be eligible for coverage under this Contract. Any reference in the following rules to a person who was or was not totally disabled is a reference to the person's status immediately before the date this Contract became effective.

Rules

a. The level of benefits the Contract provides is the Contract's regular benefits, reduced by any benefits payable by the prior plan.

b. Coverage will be provided pursuant to the South Carolina Group Replacement Standards laws until the earliest of the following dates:

   1. The date the person becomes eligible under this Contract, satisfying the Actively-at-work provision.
   2. The date the Member's coverage would end based on this Contract's provisions regarding individual termination of coverage.
   3. In the case of a person who was totally disabled at the time the prior plan was discontinued and replaced by a Group Health Plan with similar benefits, the minimum level of benefits provided by the succeeding carrier must be the applicable level of benefits of the succeeding carrier's plan. This Benefit may be reduced by any benefits paid by the prior plan.

7. **Qualified Medical Child Support Order (QMCSO)** – The Corporation will comply as required by law when the Employer notifies the Corporation that a valid QMCSO has been received.

8. **Family and Medical Leave Act** – The Corporation will comply with any actions requested by the Employer based on an Employee's use of, or protection by, the Act.

   An Employee may be considered as remaining in the active employment for purposes of coverage under this Contract during a disability leave of absence if the Employer is subject to the Family and Medical Leave Act of 1993.

   If an Employee on leave pursuant to the Family and Medical Leave Act fails to pay the Employee portion of the premium within a 31-day grace period and his or her coverage ends, the coverage of the Employee will be reinstated without new Waiting Periods as long as the Employee returns to work immediately after the leave period, re-enrolls and pays his or her portion of the then current premium within 31 days.

ARTICLE III – PAYMENT OF PREMIUM

1. Unless the Employer or the Corporation has given notice of termination of this Contract as provided in Article VI, premiums are due and payable on or before the monthly due date. The Employer must pay all premiums and any additional charges assessed pursuant to federal or state law in full for coverage to continue.

2. All premiums are payable by the Employer at the Home Office of Blue Cross and Blue Shield of South Carolina, Columbia, South Carolina 29219, or to an authorized agent of the Corporation. The payment of any premium will not maintain the coverage under this Contract in force beyond the date immediately preceding the next premium due date except as provided in paragraph 3 of this Article and in the *Continuation of Coverage* section of the Certificate.

3. A 31-day grace period will be granted for the payment of premiums, other than premiums for the initial month, during which grace period this Contract will continue in force and the Employer will be liable to the Corporation for all premiums due and unpaid for the period this Contract continues in force. If premiums are not received by the end of the grace period, this Contract will automatically terminate. Any claims paid after the last paid date of coverage does not extend this coverage.

   For coverage purchased through the FF-SHOP, an Employer terminated for non-payment of premiums may request reinstatement if, within 30 days of the termination, the Employer pays all premiums owed including prior premiums for the grace period and pays the premium for the next month's coverage.

4. The Corporation may change the monthly amount of premium each quarter, as specified on Schedule A of this Contract, with a 31-day prior written notice to the Employer.

5. On occasion, the Corporation may, at its option, choose to provide a "premium holiday" to an Employer. A premium holiday means that the Corporation has chosen to forgive the required Employer's premium or a portion of the premium for a specific period of time. Such a decision does not mean the Corporation waives or changes the normal Employer's premium amount in the future.
6. The Employer agrees to properly handle any Medical Loss Ratio (MLR) rebates it may receive from the Corporation.

ARTICLE IV – EMPLOYER'S PERSONNEL DATA

1. The Employer, as plan administrator, is solely responsible in a timely fashion for furnishing the information that the Corporation requires for the purpose of enrolling Employees under this Contract, processing applications and terminations and effecting changes in family and membership status.

   The Employer is responsible for the accuracy of the information it transmits to the Corporation and/or the FF-SHOP and understands that the Corporation and FF-SHOP will rely on this information. The Employer further agrees to indemnify the Corporation for all expenses it incurs, if any, as a result of the Employer's failure to transmit the information, failure to transmit it in the time period required by the Corporation and/or failure to transmit the correct information. As used here the term "expenses" includes, without limitation, any benefits the Corporation may be required to pay beyond those required according to the information the Employer furnished to the Corporation, attorney's fees, court costs, penalties and uncollected premiums.

   Nothing contained in this Article will be construed to expand or otherwise alter the benefits provided for Members under this Contract.
2. An Employer is liable for any penalty that may be imposed on the Corporation by a federal or state regulatory body when the Employer fails to provide required information on a timely basis.
3. Any agent assisting an Employer with enrollment or other transactions, including that of its Employees, is representing the Employer, not the Corporation.
4. The Certificate is not a Summary Plan Document. The Corporation provides the Certificate to the Employer for distribution to its Employees. The Employer, as plan administrator, is responsible for providing employees with all information as mandated by state or federal law. Both federal and state regulatory agencies require various notices be given to employee's upon hire or enrollment, annually, and at other times. The Employer is advised to regularly review information maintained by state and federal agencies to ensure compliance with all requirements placed on the Employer by state and federal law.
5. The Employer agrees to keep the Corporation accurately informed regarding the number of employees and to comply with requests for information related to the group size.

ARTICLE V – OUT OF AREA SERVICES

Overview

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 Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association").

Whenever employees or members access healthcare services outside the geographic area Blue Cross and Blue Shield of South Carolina serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the geographic area Blue Cross and Blue Shield of South Carolina serves, members obtain care from healthcare Providers that have a contractual agreement ("participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, members may obtain care from healthcare Providers in the Host Blue geographic area that do not have a contractual agreement

("nonparticipating Providers") with the Host Blue. Blue Cross and Blue Shield of South Carolina remains responsible for fulfilling our contractual obligations to you. Our payment practices in both instances are described below.

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

A. BlueCard® Program
The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when members access Covered Services outside the geographic area we serve, the Host Blue will be responsible for contracting and handling all interactions with its participating healthcare Providers. The financial terms of the BlueCard Program are described generally below.

Liability Calculation Method Per Claim
Unless subject to a fixed dollar copayment, the calculation of the member liability on claims for Covered Services will be based on the lower of the participating provider's billed charges for Covered Services or the negotiated price made available to us by the Host Blue.

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

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

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

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

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

C. Special Cases: Value-Based Programs

BlueCard Program

We have included a factor for bulk distributions from Host Blues in your group's premium for Value-Based Programs when applicable under this contract.

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

In some instances federal or state laws or regulations may impose a surcharge, tax or other fee that applies to insured accounts. If applicable, we will include any such surcharge, tax or other fee in determining your group's premium.

E. Nonparticipating Providers Outside Our Service Area

Member Liability Calculation

When Covered Services are provided outside of our service area by nonparticipating Providers, information regarding the amount you pay for such services is contained in the Covered Services section of the Booklet. Payments for out-of-Network emergency services are governed by applicable federal and state law.

F. BlueCard Worldwide® Program

General Information

If members are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard service area"), they may be able to take advantage of the BlueCard Worldwide Program when accessing Covered Services. The BlueCard Worldwide Program is not served by a Host Blue. As such, when members receive care from Providers outside the BlueCard service area, the members will typically have to pay the Providers and submit the claims themselves to obtain reimbursement for these services.

Inpatient Services

In most cases, if members contact the BlueCard Worldwide Service Center for assistance, hospitals will not require members to pay for covered inpatient services, except for their cost-share amounts/deductibles, coinsurance, etc.. In such cases, the hospital will submit member claims to the BlueCard Worldwide Service Center to initiate claims processing. However, if the member paid in full at the time of service, the member must submit a claim to obtain reimbursement for Covered Services. **Members must contact us to obtain precertification for non-emergency inpatient services.**

Outpatient Services

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

Submitting a BlueCard Worldwide Claim

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

ARTICLE VI – TERMINATION AND RENEWAL OF THIS CONTRACT

1. This Contract may be terminated by the Employer at any time by giving written notice to the Corporation at least 31 days prior to a monthly due date of the premium. The Contract will be renewed automatically from year-to-year unless terminated pursuant to this paragraph or to the following paragraphs of this Article or pursuant to Article III.
2. If any of the following occurs, coverage will end for an Employee and/or his or her Dependent(s) on the last day of the month specified by the Employer, except as provided in this Article and the *Continuation of Coverage* section of the Certificate:
    - A Member ceases to be eligible.
    - The Employer notifies the Corporation that coverage of a Member is to be terminated.
    - This Contract is cancelled by the Employer or non-renewed by the Corporation.

    If the Employer notifies the Corporation of the termination of an Employee's coverage other than on a timely basis, there will be no retroactive credit adjustment. The Employee's rights to carry Creditable Coverage forward must not be compromised.

i. It is the Employer's responsibility to ensure any retroactive Member termination forwarded to the Corporation is in compliance with federal law, specifically, that such termination was due to either:
   a. A Member's fraudulent act, practice or omission, or
   b. A Member's intentional misrepresentation of material fact, or
   c. A Member's failure to timely pay required premiums or contributions towards the cost of coverage.

   The Employer is solely responsible for providing the Member with any notice related to retroactive terminations or rescissions that are required by law.

ii. Other than as expressly required by law, if this Contract is terminated for any reason, the Employer is solely responsible for notifying all Members of such termination and coverage of Members will not continue beyond the termination date.

iii. The Employer agrees to indemnify and hold the Corporation harmless for all damages, claims, causes of action, costs and expenses (including a reasonable attorney's fee) arising out of or relating to the Employer's failure to notify Members of termination of this Contract, or any other notification required to be given to Members by the Employer.

3. The Corporation may terminate coverage under this Contract for any one or more of the following reasons:
   a. Non-payment of premiums or the Corporation has not received timely premium payments according to the terms of the Contract. Benefits under the Contract will automatically terminate without notice on the 31st day following the premium due date retroactive to the last paid date;
   b. The Employer has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage or, intentional misrepresentation by the insured individual or the individual's representative. If coverage is denied and premiums are affected, premiums will be recalculated back to the date the fraud or intentional misrepresentation occurred;
   c. The Employer has failed to comply with a material plan provision relating to employer contribution or group participation rules which requires at least two active Employees on the first day of the new plan year, and as specified on the Application page of this Contract;
   d. The Corporation is ceasing to offer coverage in such market according to applicable state law; or
   e. There are no longer any enrollees in connection with this plan who live, reside or work in the service area of the Corporation or in any area for which the Corporation is authorized to do business; or
   f. If the membership of an Employer in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this paragraph uniformly without regard to any Health Status-related Factor relating to any covered individual.

4. The Corporation may discontinue this particular type of coverage in South Carolina according to applicable state law only if the Corporation: a) provides notice to each plan sponsor provided coverage of this type (and participants and beneficiaries covered under the coverage) of the discontinuation at least 90 days prior to the discontinuation of this coverage; b) offers each plan sponsor the option to purchase all other Health Insurance Coverage currently being offered by the Corporation in such market; and c) the Corporation will act uniformly without regard to the claims experience of those Employers or any Health Status-related Factor of any new or currently enrolled Members.

5. If coverage is terminated for any cause, the Corporation will return the unearned portion of any premium paid.

   The Corporation will provide a Certificate of Creditable Coverage upon request by the Employee or Dependent. To request a Certificate of Creditable Coverage, the Employee or Dependent must contact the Corporation.

ARTICLE VII – REINSTATEMENT

If coverage under this Contract is terminated for any reason, the Corporation has discretion to reinstate the Contract and determine the terms and conditions of the reinstatement.

For coverage purchased through the FF-SHOP, an Employer terminated for non-payment of premiums may request reinstatement if, within 30 days of the termination, the Employer pays all premiums owed including prior premiums for the grace period and pays the premium for the next month's coverage.

ARTICLE VIII – CLAIMS FILING

1. A Member will present an ID card when applying for services covered under this Contract.

2. A Member must give written notice of care on which a claim is based to the Corporation, at its address given in Article IX, paragraph 12, within 20 days of the beginning of care, or as soon thereafter as is reasonably possible. If the Member needs a claim form, he or she should contact the Corporation. If the Member does not receive this form within 15 days, he or she will meet the proof of loss requirements by sending the Corporation copies of bills or statements showing the diagnosis, treatment or other procedures, which are the basis of the claim. The Member will need to provide this documentation within the time limits stated in the Contract.

5. The Corporation must receive the claim within 90 days after the beginning of care. Failure to file the claim within the 90-day period will not prevent payment of benefits if the Member shows that it was not reasonably possible to file the claim timely, provided the claim is filed as soon as is reasonably possible. Except in the absence of legal capacity, claims must be filed no later than 12 months following the end of the Benefit Period in which the services were received. Claims will be processed in the order received by the Corporation and will not be reprocessed due to out of sequence dates of services.

6. Submission of a claim will be deemed written proof of loss and will serve as written authorization from the Member to the Corporation to obtain any medical or financial records and documents useful to the Corporation. The Corporation, however, is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at the time the claim was processed. Any party who submits medical or financial reports and documents to the Corporation in support of a Member's claim will be deemed to be acting as the agent of the Member.

ARTICLE VIIII – GENERAL PROVISIONS

1. **Authorized Representatives**
   A Provider may be considered an authorized representative without a specific designation by the Member when the approval request is for Urgent Care Claims. A Provider may be an authorized representative with regard to non-Urgent Care Claims only when the Member gives the Corporation or the Provider a specific designation to act as an authorized representative. If the Member has designated an authorized representative, all information and notifications should be directed to that representative unless the Member gives contrary directions.

2. **Clerical Errors**
   Clerical errors in keeping records for this Contract by the Corporation will not cause a denial of insurance that should otherwise have been granted, nor will clerical errors extend coverage that should otherwise have ended. Clerical errors may require an adjustment of premiums.

3. **Confidentiality**
   Information from the Member's medical records and information about the Member's doctor-patient and Hospital-patient relationships will be kept confidential. Such information will not be revealed without the Member's authorization, except: a) use in medical research according to government regulations; b) use in administering this Contract; or c) disclosure required or permitted by law.

4. **The Contract**
   a. This Master Contract, the Certificate, the Schedule of Benefits, the Application of the Employer and the attached endorsements, amendments and riders, if any, constitute the entire Contract between the parties. The Contract is the controlling document for determining all contractual rights. In the event of differences or errors, the provisions of the Contract control.
   b. Except as specifically provided herein, this Contract will not make the Corporation liable or responsible for any duty or obligation that is imposed on the Employer by Federal or State law or regulations. To the extent that this Contract may be an integral part of a welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 (ERISA), as amended, the Employer will be the plan administrator of such welfare benefit plan and will be solely responsible for meeting any obligations imposed by law or regulation on the plan administrator of the welfare benefit plan, except those specifically undertaken by the Corporation herein.
   c. All statements made by the Employer or by any of the Employees will be deemed representations and not warranties, and no statement made by an Employee may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the person or, in the event of the death or incapacity of the Employee, to the individual's beneficiary or personal representative.
   d. No agent of the Corporation has authority to change this Contract or to waive any of its provisions. No change in this Contract will be valid unless approved by an executive officer of the Corporation and such approval is endorsed thereon.
   e. If this Contract is an integral part of an employee welfare benefit plan subject to the provision of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, the Corporation is a claim fiduciary. As claim fiduciary, the Corporation will have the discretionary authority to determine eligibility for benefits and to construe the terms of that part of the ERISA plan represented by your Contract. Any judicial review of a decision of the Corporation will be conducted under the arbitrary and capricious standard of review with deference given to the claim fiduciary's decision.

5. **Disclosure**
   The Employee must provide information regarding all other health coverage to which the Employee or Dependent is entitled.

6. **Discontinuance Notice**
   If the Corporation discontinues this particular type of coverage in the State of South Carolina, the Corporation will provide notice to each plan sponsor (and participants and beneficiaries covered under the coverage) of the discontinuation at least 90 days prior to the discontinuation of this coverage. Any notice of discontinuance by the Corporation will include a request to the Employer to notify Employees covered under the Contract of the date when the group Contract will discontinue and advise that, unless otherwise provided in the Contract, the Corporation is not liable for claims for losses incurred after such date. The notice also will advise, when the plan involves Employee contributions, that if the Employer continues to collect contributions for the coverage beyond the date of discontinuance, the Employer may be held solely liable for the benefits for which the contributions are collected.

7. **Fees**
   We may charge you a fee to reinstate your Policy and a fee if your Premium payment is returned for non-sufficient funds (NSF). The Reinstatement fee is $10. The NSF fee is $25.

8. **Governing Law**
   This Contract and all Certificates will be construed according to and controlled by the applicable laws and regulations of the State of South Carolina and the Federal Government. Any provision that is in conflict with the applicable laws and regulations of South Carolina or the Federal Government is hereby amended to conform to the minimum requirements.

9. **Identification Cards and Certificates**

The Corporation will issue an ID card and an individual Certificate either to the Employer for delivery to each Employee covered or to the Employee.

ID cards are for identification only. Having an ID card gives no right to services or other benefits. To be entitled to Covered Services, the cardholder must be a Member whose premium has been paid. Any person receiving services or benefits to which the person is not entitled will be responsible for the charges. Loss or theft of an ID card must be reported within five days of the discovery of such an occurrence.

A Certificate summarizes the benefits to which a Member is entitled. If any amendment to this Contract shall materially affect any benefits described in such Certificate, new Certificates or endorsements describing the changes will be issued.

9. **Incontestability**

After two years from the issue date, the validity of the Contract may not be contested except that fraudulent misstatements on the Membership Application may be used to void the Contract or deny any claim.

Any statements made by the Employer or the Employee are considered representations, not warranties. No statements may be contested unless a copy of the instrument containing the statement is provided to the parties.

10. **Information and Records**

The Corporation is entitled to obtain authorization for medical and hospital records it may reasonably require from any Provider for the treatment, payment and health care operations for the administration of the benefits hereunder and the attending Physician's certification as to the Medical Necessity for care or treatment. The Corporation will, in every case, hold such records confidential except as authorized in writing by a Member or provided by law.

The Employer shall give the Corporation all information and proof as the Corporation may reasonably require in regard to any matters pertaining to this Contract. All documents given to the Employer by Members in connection with their coverage, together with this Employer's payroll and any other records that may have a bearing on the coverage provided under this Contract, may be inspected by the Corporation, at any reasonable time.

11. **Negligence or Malpractice**

The Corporation and Employer do not practice medicine. Any medical treatment, service or medical supplies provided to or supplied to any Member by a Provider is provided or supplied by such Provider and not by the Corporation or the Employer. The Corporation and Employer are not liable for any improper or negligent act, inaction or act of malfeasance of any Provider in providing such medical treatment, service, medical supply or medication.

12. **Notices**

Except as otherwise provided in this Contract, any notice under this Contract may be given by United States mail, postage paid and addressed:

a. To the Corporation: Blue Cross and Blue Shield of South Carolina, Post Office Box 100300, Columbia, South Carolina 29202.
b. To an Employee: To the last-known name and address listed for the Employee on the Membership Application delivered to the Corporation. The Employee is responsible for notifying the Corporation of any name or address changes within 31 days of the change.
c. To the Employer: To the name and address last given to the Corporation. The Employer is responsible for notifying the Corporation of any name or address changes within 31 days of the change.

13. **Payment of Claims**

The Corporation will pay benefits as described in the *Covered Services* section of the Certificate directly to a Provider if the Corporation has a written agreement with the Provider that allows direct payment of benefits. The Corporation will pay all benefits directly to the Employee upon receipt of due proof of loss and the right to assign any benefits due and payable hereunder is expressly prohibited unless otherwise determined by the Corporation.

14. **Physical Exam & Autopsy**
The Corporation, at our own expense, may examine the person of the individual for whom claim is made as often as reasonably necessary while a claim is pending and in cases of death of the insured the Corporation, at its own expense, also may have an autopsy performed during the period of contestability unless prohibited by law. The autopsy must be performed in this State.

15. **Proof of Loss**
The Corporation will furnish to the person making claim, or to the policyholder for delivery to such person, such forms as are usually furnished by it for filing proof of loss. If the forms are not furnished before the expiration of fifteen days after the Corporation received notice of any claim under the Contract, the person making the claim is considered to have complied with the requirements of the Contract as to proof of loss upon submitting within the time fixed in the Contract for filing proofs of loss, written proof covering the occurrence, character, and the extent of the loss for which claim is made.

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

17. **Replacement Coverage**
If this Contract replaced a prior plan of the Employer, all eligible persons who were validly covered under that plan on its termination date will be covered on the Effective Date of this Contract, provided such persons are enrolled for coverage as stated in Article II.

18. **Right of Recovery**
If the Corporation determines it has paid an Allowed Amount in excess of the maximum amount, it has the right to recover the excess payments from among one or more of the following: 1) any person to or for with respect to which such payments were made, 2) as an offset against future benefits payable under this Contract, and/or 3) any other insurance companies or other organizations.

19. **Right to Amend**
The Corporation may modify the Health Insurance Coverage for a product offered to a Group Health Plan at the time of coverage renewal if the modification is consistent with state and federal law and effective on a uniform basis among Group Health Plans with that product.

20. **Summary of Benefits and Coverage**
The Corporation will comply with Federal Law by providing the applicable Summary of Benefits and Coverage (SBCs) to the Employer. It is the Employer's responsibility to distribute the SBCs to their Employees (and Dependents who live at a different address when it is known).

21. **Waiver of the Corporation's Rights**
The Corporation may choose not to enforce all of the terms and conditions of this Contract. Such decision will not waive the Corporation's future rights under this Contract.

22. **Workers' Compensation**
This Contract is not in lieu of and does not affect any requirements for coverage by Workers' Compensation Insurance or similar laws.

Blue Cross and Blue Shield of South Carolina complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.