Business Blue[SM]

Contract Body

CONTRACT BODY

ARTICLE I - DEFINITIONS

The terms defined in this Article or in the following articles of this Contract will have their defined meaning whenever they are capitalized in this Contract. Any term in this Contract which has a different medical and nonmedical meaning and which is undefined in this Contract is intended to have the medical meaning.

1. **Accidental Injury:** An injury directly and independently caused by specific accidental contact with another body or object. All injuries received in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Accidental Injury does not include loss that results wholly or in part, directly or indirectly, from disease or other illness.

2. **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 other than substance abuse or chemical dependency; 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.

3. **Admission:** The period of time between a Member's entry as a registered bed-patient into a Hospital or Skilled Nursing Facility and the time the Member leaves or is discharged from the Hospital or Skilled Nursing Facility.

4. **Allowable/Allowed Charge:** For Preferred Blue® Providers, it means the allowance mutually agreed upon by the Preferred Blue Provider and the Corporation. For all other Providers, the Allowable Charge will be the actual charge submitted or the Maximum Payment, whichever is less.

   "Maximum Payment" is the total amount eligible for payment by the Corporation for the services, supplies or equipment the Member receives from a Provider. The Maximum Payment that the Corporation determines will be the least of a, b, c, d or e:
   a. The actual charges made for similar services, supplies or equipment by Providers and filed with the Corporation during the last calendar year.
   b. The Maximum Payment for the last year increased by an index based on national or local economic factors or indices.
   c. The lowest charge level at which any medical service, supply or equipment is generally available in the area, when, in the judgment of the Corporation, a charge for such services, supplies or equipment generally should not vary significantly in quality from one Provider to another.
   d. A set of allowances that has been mutually agreed upon by Contracting Providers and the Corporation.
   e. A set of allowances the Corporation establishes.

   Review of the Maximum Payment will occur following each calendar year. If there are no actual or similar charges, as referred to above, the Corporation may, through its medical staff and/or consultants, determine the Maximum Payment based on comparable or similar services or procedures. Allowable Charges may be subject to a Deductible and/or Copayment and Coinsurance, as specified in the Schedule of Benefits.

5. **Ambulatory Surgical Center:** A licensed Facility that: a) has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis; b) provides treatment by or under the supervision of Physicians and provides nursing services when the patient is in the Facility; c) does not provide inpatient accommodations; and d) is not, other than incidentally, a Facility used as an office or Clinic for the private practice of a Physician. Ambulatory Surgical Center includes an endoscopy center.

6. **Approval:** To approve Pre-service Claims based on Medical Necessity, Medical Services or Companion Benefit Alternatives, Inc. must be called for the following: Preadmission Review, Emergency Admission Review, Continued Stay Review, Preauthorization Review and Preauthorization Review for Mental Health Services and Substance Abuse care. On behalf of Blue Cross® and Blue Shield® of South Carolina, Companion Benefit Alternatives preauthorizes Mental Health Services and Substance Abuse services. Companion Benefit Alternatives is a separate company that preauthorizes behavioral health benefits.

7. **Autism Spectrum Disorder:** Autistic Disorder, Asperger's Syndrome and Pervasive Developmental Disorder.

8. **Benefit:** The amount your plan pays for Covered Expenses.

9. **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. The Benefit Period is specified in the Schedule of Benefits. It begins again each year on that date.

10. **Certificate of Creditable Coverage:** A document from a prior health insurance plan or insurer that states the Employee had prior Health Insurance Coverage with them. The Employee should receive a certificate after their prior Health Insurance Coverage ends. By presenting a certificate when the Employee enrolls for new health coverage, the length of any Pre-existing Condition exclusion period under the new health plan may be reduced or eliminated.

11. **Clinic:** A Facility for examination and treatment of ambulatory patients who are not hospitalized. It must be operated under the supervision of a Physician.

12. **Coinsurance:** The percentage of Allowable Charge for Covered Expenses a Member must pay. This percentage applies to the negotiated rate or lesser charge when the Corporation has negotiated rates with that Provider. Coinsurance amounts apply to the Out-of-pocket Maximum if specified in the Schedule of Benefits, except for Mental Health Services, Substance Abuse care and Spinal Subluxation Services.

13. **Concurrent Care:** An ongoing course of treatment to be provided over a period of time or number of treatments.

14. **Continued Stay Review:** The review for Medical Necessity that must be obtained from the Corporation's Medical Personnel for an extension of a previously approved Hospital or other inpatient facility stay.

15. **Contract:** The agreement between the Corporation and the Employer, including the Application, attached endorsements, amendments, riders and addenda, if any, which constitute the entire Contract between both parties.

16. **Contracting Mail-service Pharmacy:** A mail-service Pharmacy that has a written agreement with Blue Cross.

17. **Contracting Mammography Provider:** A Provider with which the Corporation has a written agreement to provide routine mammograms. This is a separate list of Providers specifically for mammograms.

18. **Contracting Provider:** Any Provider with which the Corporation has a Contracting Provider Agreement, including any licensed Hospital meeting the definition of Hospital in this Article, with which any Blue Cross Plan has a written agreement and any Physician, supplier, Pharmacy, Skilled Nursing Facility or home health agency.

19. **Contracting Provider Agreement:** A written agreement between the Corporation and a Provider.

20. **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.

21. **Copayment:** The amount a Member must pay each time the Member receives certain services, if specified in the Schedule of Benefits.

22. **Creditable Coverage:** Benefits or coverage provided under:

    a. A Group Health Plan;
    b. Health Insurance Coverage;
    c. Medicare Part A or B;
    d. Medicaid, other than coverage having only benefits under Section 1928;
    e. Military, TRICARE or CHAMPUS;
    f. A medical care program of the Indian Health Service or of a tribal organization;
    g. A state health benefits risk pool, including the South Carolina Health Insurance Pool (SCHIP);
    h. The Federal Employees Health Benefits Plan (FEHBP);
    i. A public health plan, as defined in regulations;

j. A health benefit plan under the Peace Corps;
k. Short Term Health; or
l. A State Children's Health Insurance Program (S-CHIP).

This term does not include coverage for Excepted Benefits. The Corporation will count a period of Creditable Coverage without regard to specific health benefits covered during the period.

If a Member is no longer eligible for a Group Health Plan and applies for an individual health underwritten policy, the period of Creditable Coverage under the Group Health Plan will not reduce or eliminate any Pre-existing Condition limitations under the individual policy.

23. **Deductible:** The amount the Members must pay for Covered Expenses each Benefit Period before the Corporation pays Benefits, if specified in the Schedule of Benefits.

24. **Dependent:** Any covered Member of the Employee's family: a) spouse; and/or b) unmarried Dependent children through age 18 (or through age 22 if a Full-time Student). A Dependent child can be a natural child, legally adopted child, stepchild, foster child or a child under legal guardianship.

    The child must qualify as a dependent of the Employee or Employee's spouse under the United States Revenue Code and federal tax regulations. This also includes any child of a divorcing/divorced Employee who is recognized under a qualified medical child support order (QMCSO) as having a right to enrollment under this health plan. This means coverage is provided for Dependents of an Employee who is a Member of this Group Health Plan even though this Employee is the noncustodial parent when a QMCSO exists. Once a Dependent child has been married, he or she is not eligible for coverage again as a Dependent child under this Contract.

25. **Designated Provider:** Any Provider with whom the Corporation has a Contracting Provider Agreement, and that the Member is required to use for specialized services in order to receive Benefits for these services. These Providers include, but are not limited to, Rehabilitation Facilities and Contracting Mammography Providers. The Corporation will not pay Benefits unless a Designated Provider performs these services.

26. **Dose**: An approved quantity for a prescription or refill or single treatment of a Specialty Drug. No Dose may exceed a 31-day supply.

27. **Durable Medical Equipment:** A device or other appliance that has exclusive medical use to enhance the recovery of, or to assist a patient in the achievement of, physical independence. A Physician must order such devices or equipment and they must be Medically Necessary for a specific medical need. Such devices must be reusable and medical in nature, such as: wheelchairs, hospital-type beds, prosthetic devices, walkers, oxygen, respirators, etc. Devices such as air conditioners, whirlpool baths, spas, (de)humidifiers, wigs, fitness supplies, vacuum cleaners or air filters do not qualify, as they are not devices that have exclusive medical uses. To qualify as Durable Medical Equipment, the device or equipment's use must be limited to the patient for whom it was ordered. That is, others cannot use the device or equipment.

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

29. **Emergency Admission Review:** The review for Medical Necessity that must be obtained from the Corporation's Medical Personnel within 24 hours of, or by the end of the first working day after, the commencement of an emergency Admission to a Hospital or other inpatient facility. (Exceptions may be made for reasons beyond the Member's control.)

30. **Emergency Medical Care:** Health care services received in a Hospital emergency room to evaluate and treat an Emergency Medical Condition.

31. **Emergency Medical Condition:** An injury or illness so severe that a reasonable person with an average knowledge of health and medicine could reasonably expect that if he or she does not get medical care right away, one of these might occur:

    a. Serious risk to one's health. For a pregnant woman, this includes her health or her unborn child's health; or
    b. Serious damage to any organs, body functions or body parts.

32. **Employee:** Any person, working for or who has worked for an Employer, who is eligible for coverage, and, as provided in Article II of this Contract, who is so designated to the Corporation by the Employer.

33. **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.

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

35. **Excepted Benefits:** Benefits or coverage provided under:
    a. Coverage for accident or disability income insurance, or any combination of the two;
    b. Coverage issued as a supplement to liability insurance;
    c. Liability insurance, including general liability insurance and automobile liability insurance;
    d. Workers' Compensation or similar insurance;
    e. Automobile medical payment insurance;
    f. Credit-only insurance;
    g. Coverage for on-site medical clinics;
    h. Other similar insurance coverage that is specified in regulations where benefits for medical care are secondary or incidental to other insurance benefits;
    i. If offered separately:
        1. Limited scope dental or vision benefits;
        2. Benefits for long-term care, nursing home care, Home Health Care, community-based care or any combination of them;
        3. Such other similar, limited benefits as specified in regulations;
    j. If offered as independent, noncoordinated benefits:
        1. Coverage only for a specified disease or illness;
        2. Hospital indemnity or other fixed indemnity insurance;
    k. If offered as a separate insurance policy:
        1. Medicare supplemental Health Insurance;
        2. Coverage supplement to the coverage provided under Military, TRICARE or CHAMPUS; and
        3. Similar supplemental coverage under a Group Health Plan.

    Prior coverage under any of the Excepted Benefits will not be counted as Creditable Coverage.

36. **Facility:** A Hospital, Skilled Nursing Facility, Ambulatory Surgical Center or Clinic.

37. **Full-time Student:** A Dependent child age 22 or younger and enrolled in and attending one of these:

    a. High school; or
    b. An accredited or licensed school commonly recognized as a vocational, technical or trade school, with attendance qualifying a Dependent child as a full-time student under the rules of the institution; or
    c. A college or university with full enrollment in at least enough regular academic courses to reach the status of a full-time student at the institution. A time period between graduation from high school and college entry, or between college graduation and graduate school entry, will be included only if the Dependent child has applied for admission beginning with the next regular school term immediately following graduation.

    Time periods between school terms, such as summer periods, will be included if the Dependent child was attending as a Full-time Student during the last regular school term session. Correspondence-course participation does not constitute attendance as a Full-time Student for items (a) through (c) above.

    For coverage to remain in effect, the Member must send a letter to the Corporation, at least yearly, stating the Dependent child is a Full-time Student. The Member's letter must include a tuition receipt from the school's Bursar's office or a letter from the school verifying its accreditation and the student's full-time status.

38. **Genetic Information:** Information about genes, gene products or genetic characteristics derived from an individual or a family member of the individual. "Gene product" is a scientific term that means messenger RNA and translated protein. Genetic Information will not include routine physical measurements; chemical, blood and urine analysis, unless purposely done to diagnose a genetic characteristic; tests for drug abuse; and tests for the presence of human immunodeficiency virus (HIV).

39. **Group Health Plan:** Health Insurance Coverage for eligible Employees and their Dependents and/or retirees of the same Employer and their Dependents. Benefits usually include coverage for hospital, medical or other health care services and supplies as defined under the terms of the contract with the health plan.

40. **Health Insurance Coverage:** The benefits for medical care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract or Health Maintenance Organization (HMO) contract that a health insurer offers, except for those types specified in Excepted Benefits.

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

42. **Home Health Care:** An extensive range of Physician-prescribed professional, technical and related medical care services that are Medically Necessary and provided in the Member's home in lieu of inpatient care in a Hospital or Skilled Nursing Facility.

43. **Hospice Care:** A program designed specifically to provide services for care and management of a terminally ill Member with a life expectancy of six months or less. Hospice Care must be provided in lieu of inpatient care at a Hospital or Skilled Nursing Facility to a patient who would otherwise need inpatient care.

44. **Hospital:** A short-term, acute-care Facility that:

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

    The term "Hospital" does not include long-term, chronic-care institutions or institutions that are, other than incidentally:

    a. Convalescent, rest or nursing homes or facilities; or
    b. Facilities primarily affording custodial, educational or rehabilitory care; or
    c. For the treatment of substance or alcohol abuse; or
    d. For the treatment of mental or nervous conditions.

    A Hospital does not include a long-term, chronic-care institution or Facility that mainly provides care for items (a) through (d) above, whether or not such institution or Facility is affiliated with or part of a Hospital.

45. **Incapacitated Dependent:** An unmarried child who becomes or continues to be: a) incapable of self-sustaining employment because of mental or physical handicap; and b) mainly dependent upon the Employee or Employee's 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, the Member must provide the Corporation written proof of the disability from a Physician within 31 days of the Dependent's 19^{th} (or 23^{rd} birthday if a Full-time Student). For the child to remain covered, a Physician's written report must be submitted every two years within 31 days of the child's birthday. Coverage must also remain in force for the Employee.

46. **Investigational or Experimental Services:** The use of services or supplies that the Corporation does not recognize as standard medical care for the treatment of conditions, diseases, illnesses or injuries. These include, but are not limited to: treatments, procedures, facilities, equipment, drugs or devices. The following criteria are the basis for the Corporation's determination that a service or supply is Investigational or Experimental:

    a. 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 is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.

       The Corporation will, however, allow coverage for a Prescription Drug that has not been approved by the FDA:

       1. For a specific medical condition when there are at least two formal clinical studies recognizing the use of the drug for the medical condition; or

2. For the treatment of a specific type of cancer, provided the drug is recognized for treatment of that specific cancer in at least one standard 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.

b. There is insufficient or inconclusive scientific evidence in peer-reviewed medical literature to let the Corporation evaluate the therapeutic value of the service or supply.
c. There is inconclusive evidence that the service or supply has a beneficial effect on a person's health.
d. The service or supply under consideration is not as beneficial as any established alternatives.
e. There is 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 used in a noninvestigational setting.

If a service or supply meets one or more of these criteria, it is Investigational or Experimental. The Corporation solely makes the determinations after independent review of scientific data. The Corporation may consider opinions of professionals in a particular field and/or opinions and assessments of nationally recognized review organizations, but they are not determinative, nor conclusive.

The Corporation's Medical Director, in making such determinations, may use one or more of these sources of information:

a. FDA-approved market rulings;
b. *The United States Pharmacopoeia and National Formulary*;
c. The American Medical Association's Drug Evaluation publications;
d. The annotated publication titled, *Drugs, Facts, and Comparisons*, published by J. B. Lippincott Company;
e. Available peer review literature; and
f. Appropriate consultation with specialists on a local and national level.

47. **Late Enrollee** or **Late Enrollment:** An eligible Employee or Dependent who enrolls under this Contract other than during:

a. The first period in which the Employee or Dependent is eligible to enroll under the plan if the initial enrollment period is a period of at least 30 days; or
b. A Special Enrollment period.

48. **Legal Intoxication**: 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.

49. **Maternity Services:** Prenatal care, perinatal care and childbirth.

50. **Medical Personnel:** Professionally qualified persons who are competent to conduct initial reviews, data analysis and other functions involved in Pre-service Claims such as Preadmission Reviews, Emergency Admission Reviews and Preauthorizations performed pursuant to this agreement.

51. **Medically Necessary** or **Medical Necessity:** Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating diagnosing or treating an illness, injury, disease or its symptoms, and that are:
a. In accordance with generally accepted standards of medical practice;
b. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;
c. Not primarily for the convenience of the patient, Physician, or other health care Provider; and
d. 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.

52. **Member:** A covered Employee or covered Dependent.

53. **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.

54. **Membership Application:** A form agreed upon by the Corporation and the Employer for transmitting the necessary enrollment information from its Employee to the Corporation.

55. **Mental Health Services:** The treatment of mental and nervous conditions. These conditions are 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*. Substance Abuse care or treatment is not included.

56. **Non-contracting Facility:** Any Facility with which the Corporation does not have a written agreement. No Benefits are payable for services or supplies provided by a Non-contracting Facility, except for the treatment of an Emergency Medical Condition and services provided outside the state of South Carolina.

57. **Orthotic Devices:** Special devices such as splints, cervical collars, back braces or hip-knee-ankle or foot orthosis used to treat problems of the muscles, ligaments or bones of the skeletal system.

58. **Ostomy Supplies:** Includes, but isn't limited to, pouches, skin barriers, adhesives, belts and filters.

59. **Out-of-pocket Covered Expenses:** Coinsurance amounts a Member must pay, if an Out-of-pocket Maximum is specified in the Schedule of Benefits.

60. **Out-of-pocket Maximum:** The maximum amount of Coinsurance for Covered Expenses the Member will have to pay during a Benefit Period for certain services if specified in the Schedule of Benefits.

    Coinsurance on Mental Health Services, Substance Abuse care and Spinal Subluxation Services do not apply toward the Out-of-pocket Maximums. These services will be paid as shown in the Schedule of Benefits regardless of Out-of-pocket Maximums.

    Certain other expenses also do not qualify toward the Out-of-pocket Maximums. They include the difference in an All Other Provider's fee and the Corporation's Allowed Charge, the Deductible, Copayments and charges for non-covered services by any Provider.

61. **Outpatient:** A Member who receives services or supplies at a Hospital, Skilled Nursing Facility or Ambulatory Surgical Center that does not require an overnight stay.

62. **Over-the-counter Drug:** A drug that does not require a prescription.

63. **Participating Network Pharmacy:** A Pharmacy that has a written agreement with the Corporation or its Pharmacy Benefit Manager (PBM) not to charge a Member more than the Allowable Charge for Prescription Drugs.

64. **Pharmacy:** A Provider that is licensed to dispense medications a doctor prescribes. It does not include a Physician's office or a Pharmacy affiliated with or part of a Hospital, Skilled Nursing Facility or other similar type of institution.

65. **Pharmacy Benefit Manager (PBM):** An organization that has a written contract with the Corporation and is responsible for the administration of the Prescription Drug Benefit program according to the plan.

66. **Physician:** A person (other than an intern, resident or house Physician), duly licensed as a medical doctor, oral surgeon, dentist, osteopath, podiatrist, chiropractor, optometrist, ophthalmologist 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.

67. **Post-service Claim:** Any claim that is not a Pre-service Claim or any claim that is submitted to the Corporation after the medical care, service or supply has been provided.

68. **Preadmission Review:** A Pre-service Claim involving a review for Medical Necessity that must be obtained from the Corporation's Medical Personnel prior to all non-emergency Admissions to a Hospital or other inpatient facility.

69. **Preauthorization:** A Pre-service Claim for which the Approval must be obtained from the Corporation's Medical Personnel prior to receiving certain Covered Services which are specified in the Schedule of Benefits.

70. **Pre-existing Condition(s):** A physical or mental condition for which any medical advice, diagnosis, care or treatment was received or recommended within the six-month period ending on the Enrollment Date.

71. **Preferred Blue Provider:** Includes the following types of persons or facilities which furnish health care services to a Member and have a written agreement with the Corporation to participate in the Preferred Blue program: Hospitals, Skilled Nursing Facilities, home health agencies, Hospice Care programs, independent laboratories, Physicians, Pharmacies, and vendors of Durable Medical Equipment. A Preferred Blue Provider will see that all necessary Pre-service Claims are filed and Approvals obtained from the Corporation before rendering services or any other provisions met that may be mutually agreed upon in the Contracting Provider Agreement. A Preferred Blue Provider also agrees to accept the Corporation's allowance as payment in full for Covered Expenses, except for any Deductibles, Copayments and Coinsurance due from the Member.

72. **Prescription Drug:** A drug that has been approved by the FDA and labeled "Caution: Federal Law Prohibits Dispensing Without Prescription," or labeled in a similar manner. Only a licensed registered pharmacist can dispense it according to a Physician's prescription order. Injectable insulin is also included.
    a. **Brand-name Drug:** A Prescription Drug that is manufactured under a registered trade name or trademark. A Brand-name Drug may be a Preferred Drug or a Non-preferred Drug.
    b. **Generic Drug:** A Prescription Drug that has the same active ingredients as the Brand-name Drug but is not manufactured under a registered brand name or trademark.
    c. **Non-preferred Drug:** A Prescription Drug that has not been chosen by the Corporation, or its designated Pharmacy Benefit Manager, to be a Preferred Drug. This includes any Brand-name Drug with an "A" rated Generic Drug available.
    d. **Preferred Drug:** A Prescription Drug that has been reviewed for cost, clinical effectiveness and quality. Preferred Drugs are Brand-name Drugs and Generic Drugs that are preferred by the Corporation, or its designated Pharmacy Benefit Manager, for dispensing to Members when appropriate. The Preferred Drug List is subject to periodic review and updates by the Corporation, or its designated Pharmacy Benefit Manager, without notice.

73. **Prescription Drug Coinsurance:** The percentage of Allowable Charges for Prescription Drugs payable by the Member. The Prescription Drug Coinsurance does apply to the Out-of-pocket Maximum specified in the Schedule of Benefits.

74. **Prescription Drug Copayment:** The amount payable (if any) by the Member for each Prescription Drug filled or refilled, as specified in the Schedule of Benefits. This amount will not be applied to the Deductible or the Out-of-pocket Maximum specified in the Schedule of Benefits.

75. **Prescription Drug Deductible:** The amount (if any) specified in the Schedule of Benefits of all covered Prescription Drug charges each Member is responsible for paying each Benefit Period before Prescription Drug Benefits are payable. This amount will not be applied to the Deductible or the Out-of-pocket Maximum specified in the Schedule of Benefits.

76. **Prescription Drug Maximum:** The maximum amount, if specified in the Schedule of Benefits, that will be paid for Prescription Drugs for each Member, each Benefit Period. The charges applied to the Prescription Drug Maximum will be applied to the lifetime maximum payment specified in the Schedule of Benefits.

77. **Pre-service Claim:** Any claim or request for a Benefit where prior authorization or Approval must be obtained from the Corporation before receiving the medical care, service or supply. An Approval means only that a service is Medically Necessary for treatment of a Member's condition, but is not a guarantee or verification of Benefits. Payment is subject to Member's eligibility, Pre-existing Condition Limitations and all other Contract limitations and exclusions. Final Benefit determination will be made when the Corporation processes the Member's claim.

78. **Prosthetic Devices:** Artificial replacement body parts needed to alleviate or correct conditions caused by an illness, injury or birth defect, disease or anomaly.

79. **Provider:** Any of the following: a Facility, Hospital, Skilled Nursing Facility, Rehabilitation Facility, mental health or Substance Abuse 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 or as listed:

    a. Durable Medical Equipment supplier
    b. Independent clinical laboratory
    c. Occupational, Physical and Speech therapist

d. Pharmacy
e. Home Health Care provider
f. Hospice Care provider

80. **Qualified Trade Adjustment (TAA) Eligible Individual:** A person who is 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:

    a. Eligible TAA recipient; or
    b. Eligible ATAA (Alternate TAA) recipient.

81. **Rehabilitation Facility:** A Hospital or other freestanding medical Facility that has a written agreement with the Corporation that specifies allowable reimbursement rates, to provide, on an inpatient basis, a multidisciplinary therapeutic program that includes physical therapy, occupational therapy and other therapeutic interventions directed toward the restoration of full function and independent living for patients who have experienced neurologic or other physical illnesses or injuries.

82. **Schedule of Benefits:** The pages so titled in this Contract that specify the amount of coverage provided and the applicable Copayments, Coinsurance, Deductibles and limitations.

83. **Second Surgical Opinion:** An opinion from a second Physician regarding a Medically Necessary, elective non-emergency surgical procedure recommended by another Physician.

84. **Skilled Nursing Facility:** A licensed institution, other than a Hospital, that has a written agreement with the Corporation or with any other Blue Cross Plan, which meets all six of these requirements:

    a. Maintains permanent and full-time facilities for bed care of resident patients; and
    b. Has the services of a Physician available at all times; and
    c. Has a registered nurse (RN) or Physician on full-time duty in charge of patient care and one or more RNs or licensed practical nurses (LPNs) on duty at all times; and
    d. Keeps a daily medical record for each patient; and
    e. Is primarily providing continuous skilled nursing care for sick or injured patients during the recovery stage of their illnesses or injuries and is not, other than incidentally, a rest home or a home for custodial care for the aged; and
    f. 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 of substance or alcohol abuse.

85. **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 two employees 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.

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

87. **Special Enrollment:** Special circumstances listed in Article II that allow an Employee or Dependent who is eligible but not enrolled, to enroll for coverage under the terms of the Contract.

88. **Specialist:** A Physician who has received advanced training related to treatment of diseases or injury of particular parts of the body and who limits his or her practice to that area of medicine.

89. **Specialty Drugs:** FDA approved Prescription Drugs that treat a complex clinical condition and/or require special handling such as refrigeration. They normally require unusual/complex clinical monitoring and special training. Specialty Drugs include but are not 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.

90. **Specialty Drug Copayment:** The amount payable (if any) by the Member for each Specialty Drug, as specified in the Schedule of Benefits if Specialty Drug coverage is provided. The Specialty Drug Copayment will not apply to the Deductible or the Out-of-pocket Maximum specified in the Schedule of Benefits and will continue to apply even after the Out-of-pocket Maximum is met.

91. **Specialty Drug Network Provider**: A Provider that has a written agreement to participate in a special pharmaceutical network with the Corporation to provide Specialty Drugs. A Specialty Drug Network Provider also agrees to accept the Corporation's allowance as payment in full for Covered Expenses except for any Deductibles, Copayments and Coinsurance due from the Member if Specialty Drug coverage is provided. A Specialty Drug Network Provider may be different from a Preferred Blue Provider.

92. **Substance Abuse:** The use of drugs or alcohol where medical services are required, that are 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.* As used in the health plan, this does not include services for treatment of Mental Health Services.

93. **Surgery:** a) The performance of generally accepted operative and cutting procedures including endoscopic examinations and other invasive procedures; b) the correction or treatment of fractures and dislocations; and c) other procedures as reasonable and as approved by the Corporation. This includes the usual, necessary and related pre- and post-operative care.

94. **Transplant Benefit Period:** For an organ, the period begins on the Admission date for the transplant Surgery and continues for 12 months. For bone marrow, the period begins on the first date of mobilization therapy, marrow/stem cell harvest date or inpatient Admission date for the transplant procedure, whichever occurs first, and will continue for 12 months.

95. **Transplant Lifetime Maximum:** The maximum amount of Benefits provided in a lifetime for each Member for each of the transplants listed in the Schedule of Benefits. Once the Transplant Lifetime Maximum has been met, no additional transplant Benefits will be provided for that type of transplant.

96. **Urgent Care Claim:** Any claim made by the Member or by a Provider or Physician (with knowledge of the Member's current medical condition), where, if the normal Pre-service Claim review time frames of this Contract were used:
    a. The Member's life, health or ability to regain maximum function could be seriously jeopardized; or
    b. The Member, in the opinion of the Physician, would be subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

97. **Urgent Treatment Care:** Care for an illness or injury that is serious or acute and requires immediate care, but is not life- or limb threatening.

98. **Urgent Treatment Center:** A medical Facility, other than a Hospital emergency room, where ambulatory patients can be treated on a walk-in basis, without appointment, and receive immediate, non-emergency care.

99. **Waiting Period:** The period that must pass with respect to the individual before the individual is eligible to be covered for Benefits under the terms of this Contract with the Employer.

ARTICLE II - ELIGIBILITY FOR COVERAGE

1. **Eligibility**

Every Employee eligible as set forth in the attached Application by the Employer. The Employee must be permanently working full-time at least 30 hours a week at least 48 weeks a year. The Employee will be eligible for coverage for himself and his Dependents if, on or after the Member's Effective Date, such Employee is Actively-at-work and has completed the period of continuous employment commonly referred to as the Waiting Period with the Employer, as set forth in the Application. Neither an Employee nor his Dependents will be covered until the Employee is Actively-at-work.

To be eligible for membership, the Dependent must meet the Employer's eligibility requirements for Dependent coverage and either be married to the Employee or be the Employee's unmarried Dependent child age 18 or younger or (age 22 or younger, if a Full-time Student).

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.

During a disability leave of absence, an Employee may be considered as remaining in active employment for purposes of insurance under this Contract for a period not to exceed 60 days from the date of cessation of active work or, for a qualified Employee, during a leave pursuant to the Family and Medical Leave Act of 1993.

Note: Dependent coverage automatically ends on the same date that the Employee coverage ends.

Unless otherwise required by the Consolidated Omnibus Budget Reconciliation Act (COBRA), a spouse is no longer an eligible Dependent at the end of 60 days from entry of a valid decree of legal termination of marriage to the Employee. A child is no longer an eligible Dependent as specified in Article I, or upon his or her marriage, whichever occurs first. Once a Dependent child has been married, he or she is not eligible for coverage again as a Dependent child under this Contract. An Incapacitated Dependent's coverage, however, will not terminate under this Contract by merely reaching the age limit as specified in Article I.

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 can not 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 such data, other than evidence of insurability, as may be required by the Corporation as a prerequisite to coverage under this Contract.

3. **Commencement of Coverage**

Coverage hereunder, unless otherwise provided in this Application for this Contract, will commence as follows:

a. For an Employee eligible prior to the Effective Date of this Contract, if then eligible and if coverage is elected, 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, however, 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 active, full-time 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 as specified on the attached Master Group Application. If an Employee is not Actively-at-work at the time this coverage would otherwise begin, however, 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 active, full-time work and the required premium is paid.
c. When an Employee marries, coverage for the spouse will be effective from the date of marriage with the required premium payment. An Employee has 31 days from the date of marriage to apply for coverage.
d. Coverage will become effective at birth for newborn children of the Employee or Employee's spouse when the Employee enrolls the newborn within 31 days of the newborn's birth and the appropriate premium payment, if any, has been made.

If the Employee enrolls the newborn after 31 days of the newborn's birth, the newborn will be subject to the Pre-existing Condition Limitations.

e. For adopted children of the Employee or Employee's spouse, coverage will begin with the appropriate premium payment, if any, as follows:

1. From the moment of birth for a child the Employee or Employee's spouse legally adopts within 31 days of the child's birth.
2. From the moment of birth for a child for whom the Employee or Employee's spouse has temporary custody and has begun adoption proceedings within 31 days of the child's birth.
3. For adopted children other than newborns, upon temporary custody and may continue for up to a year. The court may also extend coverage.

If the Employee enrolls an adopted child after 31 days of the adoption or placement with the Employee or Employee's spouse for the purpose of adoption, the adopted child will be subject to the Pre-existing Condition Limitations.

4. **Late Enrollment**

Late Enrollees will be subject to a combination of a 12-month exclusion period and an additional 6-month Pre-existing Condition Limitations period. This combination will not be more than a total of 18 months starting from the date the Member completed the application for coverage.

5. **Special Enrollment**

If the Employee (or a Dependent) is eligible for coverage but has not already enrolled, the Corporation will allow the Employee or Dependent to enroll if each of the following is met:

a. The Employee or Dependent was covered under a Group Health Plan or had Health Insurance Coverage at the time coverage was previously offered to the Employee or Dependent; and
b. The Employee stated in writing at the time that coverage under a Group Health Plan or Health Insurance Coverage was the reason for declining enrollment, but only if the plan sponsor or issuer (if applicable) required such a statement at the time. The plan sponsor or issuer must have given the Employee a notice of the requirement and the consequences of the requirement at the time; and
c. The Employee's or Dependent's coverage described in paragraph (a) above:
    1. Was under a COBRA or state continuation provision and that coverage had ended; or
    2. Was not under a continuation provision and either the coverage was terminated as a result of loss of eligibility for the coverage or employer contribution toward the coverage stopped. Reasons for a loss of eligibility might include legal separation, divorce, death, termination of employment or reduction in the number of hours of employment; or
    3. Was one of multiple health insurance plans offered by an employer and the Employee chose another plan during an open enrollment period.
d. The Employee requests the enrollment not later than 31 days after the date coverage ended due to loss of eligibility or Employer contribution stopped as described above.

If the Employee is eligible under the plan but is not enrolled, and he or she marries, the Employee and the new spouse can enroll in the plan if enrollment is requested within 31 days of the marriage.

If the Employee is eligible under the plan but not enrolled and the Employee or Employee's spouse has a child, adopts a child or is in the process of adopting a child, the child can receive coverage under the plan. At the time of birth, adoption or placement for adoption, the Employee and Employee's spouse can also receive coverage as long as the eligibility requirements of this Contract are met. Coverage must be requested within 31 days of the child's birth, adoption or placement for adoption.

Special Enrollees other than newborns, adopted children or children placed for adoption may be subject to the Pre-existing Condition exclusion period up to 12 months.

6. **Group Replacement Standards**

South Carolina Group Replacement Standards, S.C. Code §38-71-760(m)(5), 1976 as amended, 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. Except for Pre-existing Conditions, 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.

7. **Qualified Medical Child Support Order (QMCSO)**

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

a. **Definitions** – For purposes of this subsection:

1. Medical Child Support Order – The term "medical child support order" means any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction, or submission of an approved form issued by the appropriate state social services agency, which:
   (i) Provides child support with respect to a child of a Member or provides for health benefit coverage to such child, is made pursuant to a State domestic relations law (including a community property law) and relates to Benefits under this Contract; or
   (ii) Enforces a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a Group Health Plan.

2. Qualified Medical Child Support Order – The term "Qualified Medical Child Support Order" means a medical child support order:
   (i) Which creates or recognizes the existence of an Alternate Recipient's right to, or assigns an Alternate Recipient the right to receive Benefits for which an Employee is eligible under this Contract; and
   (ii) With respect to which the requirements of paragraphs (b) and (c) are met.

3. Alternate Recipient – The term "Alternate Recipient" means any child, age 18 or younger or (age 22 or younger, if a Full-time Student), of an Employee who is recognized under a medical child support order as having a right to enrollment under this Contract with respect to such participant.

b. **Restriction on New Types or Forms of Benefits** – A medical child support order meets the requirements of this paragraph only if such order does not require a plan to provide any type or form of Benefit, or any option, not otherwise provided under the plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993).

c. **Procedural Requirements**
Timely Notifications and Determinations – The Employer, as the plan administrator, will promptly notify the Employee and each Alternate Recipient of the receipt of such order and the plan's procedures for determining whether medical child support orders are QMCSOs. The Employer will then determine whether such order is a QMCSO and notify the Employee and each Alternate Recipient within a reasonable period of the determination after receipt of such order.

d. **Treatment of Alternate Recipients**
1. Treatment as Member generally – An Alternate Recipient under any medical child support order will be considered a Member under the plan for purposes of any provision of ERISA.
2. Treatment as Participant for Purposes of Reporting and Disclosure Requirements – An Alternate Recipient under any medical child support order will be considered a participant under the plan for purposes of the reporting and disclosure requirements of ERISA.

e. **Direct Provision of Benefits Provided to Alternate Recipients** – Any payment for Benefits made by this Group Health Plan pursuant to a medical child support order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian will be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

f. **Termination of Coverage** – Except for any coverage continuation rights otherwise available under this Contract and subject to the other termination provisions in this Contract, the coverage for the Alternate Recipient will end on the earliest of:
1. The date the Employee's coverage ends; or
2. The date the QMCSO is no longer in effect; or
3. The date the Employee obtains other comparable health coverage through another insurer or plan to cover the Alternate Recipient; or
4. The date the Employer eliminates family health coverage for all of its Employees under all of the Employer's Group Health Plan.

8. **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. Employees are eligible if they have been employed for at least one year and worked at least 1,250 hours during the last 12 months.

FMLA requires employers to provide up to 12 weeks of unpaid leave to eligible employees for: a) the birth of the employee's child; b) the placement of a child with the employee for adoption or foster care; c) the care of a seriously ill spouse, child or parent; or d) a serious health condition that leaves the employee unable to perform his or her job.

During leave, the employer must keep the same health benefits as provided to employees not on leave. The employee would continue to pay his or her portion of the premium and the employer would continue to pay the same portion the employer would have paid had the employee been Actively-at-work. If premiums are not paid by an employee within 31 days of the premium due date, coverage ends as of the due date of that premium contribution.

If an employee on FMLA leave fails to pay the employee portion of the premiums and the employee's health benefit coverage ends, the coverage 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 current premium within 31 days.

ARTICLE III - COVERED SERVICES

1. **Benefits Provided**
Subject to all provisions of this Contract, including but not limited to, ARTICLE V, EXCLUSIONS AND LIMITATIONS and the provision of ARTICLE III, paragraph 2, relating to Pre-service Claims such as Preadmission, Emergency Admission, Continued Stay Review and Preauthorization, the Corporation will pay Benefits based upon the Allowable Charges for Covered Expenses for services provided by Hospitals (including Skilled Nursing Facilities), Physicians, other health facilities or suppliers, on or after a Member's Effective Date of coverage. Covered Expenses are subject to the Deductible, Coinsurance, Copayment and other specific limitations specified in the Schedule of Benefits.

2. **Approval from the Corporation**
All Admissions and some outpatient services require prior Approval. Requests for prior Approval are Pre-service Claims and the initial determinations and appeals are subject to the time frames for Pre-service Claims set forth in Article XIII, paragraphs 7 and 8. An Approval is not a guarantee or verification of Benefits. The Approvals are listed below:

   a. **Preadmission Review** – In the case of a non-emergency Admission, the Member, the Member's family or the Physician, the Hospital or Skilled Nursing Facility (if a Preferred Blue Provider) must call the Corporation at the number given on the ID card prior to such Admission and obtain a determination as to whether the Admission is approved based on Medical Necessity only and the length of the expected stay.
   b. **Emergency Admission Review** – In the case of an emergency Admission, the Member, the Member's family or the Physician, the Hospital or Skilled Nursing Facility (if a Preferred Blue Provider) must call the Corporation at the number given on the ID card within 24 hours of, or by the end of, the first working day after the Member's Admission and obtain a determination as to whether the Admission is approved based on Medical Necessity only. "Emergency" means the sudden onset of an illness or injury requiring an unplanned or unscheduled Admission to a Hospital.
   c. **Continued Stay Review** – If the emergency or non-emergency Admission requires continuation of hospitalization or an extension of the Hospital stay, the Member, the Member's family or the Physician, the Hospital or Skilled Nursing Facility (if a Preferred Blue Provider) must call the Corporation at the number given on the ID card prior to the expiration of the original discharge date as determined through previous Preadmission Review or Emergency Admission Review (paragraphs (a) and (b) above) and obtain a new determination as to whether the continuation of hospitalization or extension of the Hospital or Skilled Nursing Facility stay is approved based on Medical Necessity only.
   d. **Preauthorization Review** – This includes prior Approval based on Medical Necessity for services specified in the Schedule of Benefits. The Corporation must be called at the number given on the ID card.
   e. **Preauthorization for Mental Health Services and Substance Abuse care** – Companion Benefit Alternatives, Inc. (CBA) must preapprove for Medical Necessity all inpatient or outpatient treatment. The Member, the Member's family or the Physician or the Hospital (if a Preferred Blue Provider) must call Companion Benefit Alternatives, Inc. at the number given on the ID card.

3. **Covered Expenses**
Charges for Medically Necessary services or supplies not otherwise excluded by any term, condition, limitation or exclusion of this Contract that a Physician performs or prescribes for treatment and diagnosis of an illness or injury, as follows:

   a. **Ambulance Service** – Professional ambulance services to the nearest local Hospital in case of an accident or Emergency Medical Condition and to or from a Hospital in connection with inpatient care.

   b. **Ambulatory Surgical Center and Clinic Expenses** – Not specified elsewhere or limited by the Schedule of Benefits.

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

   d. **Blood Transfusions** – Including cost of blood, blood plasma and blood plasma expanders.

e. **Cleft Lip and Palate** – Medically Necessary care and treatment of any condition or illness that is related to or caused by 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 is not limited to these types of Medically Necessary care:

1. Oral and facial Surgery, surgical management and follow-up care made necessary because of a Cleft Lip and Palate;
2. Prosthetic treatment such as obdurators, speech appliances and feeding appliances;
3. Orthodontic treatment and management;
4. Prosthodontic treatment and management;
5. Otolaryngology treatment and management;
6. Audiological assessment, treatment and management performed by or under the supervision of a licensed doctor of medicine, which includes surgically implanted hearing aids; and
7. Physical therapy assessment and treatment.

Benefits will be provided as for any other condition or illness. For Members covered by a dental policy, the dental policy will cover teeth capping, prosthodontics and orthodontics to the limit of coverage provided and any excess after that will be provided by this Contract.

f. **Diabetes** – Equipment, supplies, and outpatient self-management training and education for the treatment of Members with diabetes if it is Medically Necessary and a health care professional prescribes it. This health care professional must be legally authorized to prescribe such items and follow minimal standards of care for diabetes. These minimal standards of care are 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 that is certified in diabetes.

g. **Diagnostic X-ray and Laboratory Procedures** – Benefits are payable as specified in the Schedule of Benefits when ordered by a health care Provider.

h. **Durable Medical Equipment** – Purchase price or rental cost up to the purchase price of Medically Necessary Durable Medical Equipment as specified in the Schedule of Benefits, as required for therapeutic use outside of a Hospital by a Member for a specific condition when ordered or directed by a Physician. If the equipment is not available for rent, the Corporation may approve the monthly payments toward the purchase of the equipment. If deluxe equipment is used, Benefits will be reduced to that available for standard equipment, which in the judgment of the Corporation, is most appropriate to the Member's medical needs. Written prior Approval from the Corporation is required for Durable Medical Equipment Benefits if the cost is more than the amount specified in the Schedule of Benefits.

i. **Home Health Care** – When rendered to an essentially homebound Member in the Member's home. Home Health Care must be rendered by, or through a community home health agency, must be provided on a part-time visiting basis and must be provided according to a Physician-prescribed course of treatment. Preauthorization based on established Home Health Care treatment must be obtained from the Corporation before a Member is eligible, if Benefits are specified in the Schedule of Benefits.

Benefits for Home Health Care include these services and supplies that are usually provided inpatient by a Hospital or Skilled Nursing Facility:

1. Registered or licensed practical nurse care
2. Physical, respiratory, speech and occupational therapy (the physical therapy Benefit Period maximum applies)
3. Medical social service
4. Home health aide service
5. Nutritional guidance
6. Diagnostic services
7. Administration of Prescription Drugs
8. Medical and surgical supplies
9. Oxygen and its administration
10. Durable Medical Equipment

j. **Hospice Care** – The services must be provided according to a Physician prescribed treatment plan. The Corporation must Preauthorize Hospice Care before a Member is eligible, if Benefits are specified in the Schedule of Benefits.

Hospice Care Benefits include these services and supplies:

1. Registered or licensed practical nurse care
2. Physical, respiratory, speech and occupational therapy (the physical therapy Benefit Period maximum applies)
3. Medical social service
4. Home health aide service
5. Nutritional guidance
6. Diagnostic services
7. Administration of Prescription Drugs
8. Medical and surgical supplies
9. Oxygen and its administration
10. Durable Medical Equipment
11. Respite care
12. Family counseling related to the patient's terminal condition

k. **Hospital Services** – Subject to the following:

1. Inpatient Hospital Services include:
When a Member is admitted to a Hospital that contracts with another Blue Cross Plan with which the Corporation has a reciprocal agreement, Benefits will be provided as set forth in Article III, paragraph 1.

When care is rendered in a non-contracting Hospital accredited by the Joint Commission on Accreditation of Hospitals, the Corporation will pay the percentage of Covered Expenses specified in the Schedule of Benefits for services listed in this Article when they are customarily provided by the Hospital and to the extent they are consistent with diagnosis and treatment.

When care is rendered in another Hospital or in a School or College Infirmary that customarily bills students for its services, payment for all services will be limited to an amount not to exceed the average semi-private room rate in South Carolina Hospitals, as determined by the Corporation, for each day of inpatient care. In no case will the total payment exceed the total charges.

a. Semi-private room and special care unit – When a Member is admitted to a Hospital in which all rooms are private, the most prevalent semi-private room rate, as determined by the Corporation, will be considered the private room.
b. Bed and board – including meals, special diets, general nursing services, therapy services and other ancillary services.

The day the Member leaves a Hospital, with or without permission, is the discharge day and will not be counted as an inpatient care day, unless he or she returns to the Hospital by midnight of the same day. The day the Member returns to the Hospital is treated as the Admission day and is counted as an inpatient care day. Benefits are not payable for days in which the Member is not physically present for inpatient care.

2. Outpatient Hospital Services include:
a. Emergency Medical Care.
b. Surgery.
c. Other services not specified above or in the Schedule of Benefits and not specifically excluded in Article V.

l. **Human Organ and/or Tissue Transplants** – Except as otherwise excluded, Benefits will be provided under this Contract as specified in subparagraphs (1), (2), (3), (4) and (5) and will be provided according to the Benefits and Transplant Lifetime Maximum specified in the Schedule of Benefits.

The Corporation must preapprove any covered human organ and/or tissue transplant procedure in writing and, if specified in the Schedule of Benefits, the transplant must be performed by a Designated Provider.

The Benefits payable for human organ and/or tissue transplants include all expenses for all medical and surgical services and supplies the Member receives while covered under this Contract. Organ transplant coverage includes expenses for the donor organ procurement. All Benefits provided during a Transplant Benefit Period (not exceeding 12 months) will apply toward the Transplant Lifetime Maximum. To the extent payable under this Contract, Prescription Drugs do not apply toward the Transplant Lifetime Maximum.

1. The only living donor, human organ transplants covered under this Contract are kidney transplants for Members with dialysis-dependent kidney failure and liver transplants. All other living donor, human organ transplants are not 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 is not, Benefits will be provided for both the recipient and the donor to the extent that Benefits to the donor are not provided by any other source. This includes, but is not limited to, other insurance coverage, any government program or any employee welfare plan. Benefits provided to the donor will be charged against the recipient's coverage under this Contract;
    c. When the transplant recipient is not a Member and the donor is, no Benefits will be provided to either the donor or the recipient.

2. Limited Benefits are provided for the specified major human organ transplant procedures listed below. These Benefits are subject to all other provisions of the Contract.
    - Kidney single/double, liver, heart, heart and lung single/double, lung single/double, pancreas and pancreas and kidney 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 when the procedure is considered Medically Necessary.

4. Benefits may be available for allogeneic bone marrow transplantation in the treatment of developmental and non-malignant diseases of bone marrow when the procedure is considered Medically Necessary.

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

5. Transplants of tissue (rather than whole major organs), except fetal tissue, are Covered Expenses under this Contract, subject to all the provisions of this Contract only as follows:
    - Blood transfusions (but not whole blood and blood plasma);
    - Autologous parathyroid transplants;
    - Corneal transplants;
    - Bone and cartilage grafting; or
    - Skin grafting.

m. **Mastectomy** – Hospitalization will be provided for at least 48 hours following a mastectomy. If the Member is released early, Benefits will be provided for at least one home care visit if the attending Physician orders it.

Benefits will also be provided for prosthetic devices, reconstruction of the breast on which the mastectomy was performed and physical complications for all stages of a 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.

n. **Maternity Services** – For the Employee or covered spouse only, as specified in the Schedule of Benefits. Benefits for the newborn child will be available only if the child is added to the Contract as described in Article II.

Benefits for the hospitalization and related professional services for the mother and newborn child, if added to the Contract, will be provided for at least 48 hours after a vaginal delivery or the date of discharge from the Hospital — whichever occurs first. This does not include the day of delivery. Benefits for the hospitalization and attending professional services for the mother and newborn child, if added to the Contract, will be provided for at least 96 hours following a Cesarean section or the date of discharge from the Hospital — whichever occurs first. This does not include the day of Surgery.

o. **Medical Supplies** – Limited to the following: 1) syringes and related supplies for conditions such as diabetes; 2) dressings for conditions such as cancer or burns; 3) catheters; 4) test tape; 5) necessary supplies for renal dialysis equipment or machines; and 6) surgical trays. Supplies and equipment that have non-therapeutic uses, over-the-counter supplies and bandages are not covered medical expenses.

p. **Mental Health Services** – As specified in the Schedule of Benefits for Covered Expenses, and all terms and conditions, limitations and exclusions in Article V, as follows:
   1. Inpatient Care – inpatient care in a Hospital provided in those State institutions with which the Corporation has a written agreement are limited, as specified in the Schedule of Benefits.
   2. Outpatient Care – treatment by a psychiatrist or licensed mental health Provider when the Member is not confined in a Hospital, as specified in the Schedule of Benefits.

q. **Optional Preventive Benefits –** Benefits are available for these services when specified in the Schedule of Benefits:
   1. **Routine physical exam** – Limited to one per Benefit Period and to the amount specified in the Schedule of Benefits. A Preferred Blue Provider must provide the services.
   2. **Well-baby care and immunizations** – For well-baby care as specified in the Schedule of Benefits. This also includes immunizations as recommended by the American Academy of Pediatrics for a Dependent. A Preferred Blue Provider must provide the services.

r. **Orthotic Devices –** Benefits will be provided as specified in the Schedule of Benefits.

s. **Ostomy Supplies –** External opening (ostomy) bags and related supplies as specified in the Schedule of Benefits.

t. **Out-of-country** – Benefits will be provided based on the lesser of the plan's Allowable Charge or the total charge, payable as specified in the Schedule of Benefits. Out-of-country Benefits consist of all services or supplies covered under this Contract and received from outside the United States.

u. **Physical Therapy** – As specified in the Schedule of Benefits, when prescribed by a Physician and performed by a licensed professional physical therapist.

v. **Physicians services –** As described below:

   1. **Dental care to Sound Natural Teeth** – Only when such care is for treatment, Surgery or appliances, made necessary by accidental bodily injury (except dental injuries occurring through the natural act of chewing). Benefits are limited to any amount specified in the Schedule of Benefits, to care completed within one year of such accident and while the Member is still insured under this Contract.
   2. **Pediatric medical care** – The initial examination of a newborn when the care is given by a Physician other than the delivering Physician or the Physician who administered anesthesia during delivery.
   3. **Surgery** – subject to the following:
      a. If two or more operations or procedures are performed at the same time, through the same surgical opening, or by the same surgical approach, the total amount payable for such operations or procedures will be paid according to the Allowable Charges for the major procedure only;
      b. If two or more operations or procedures are performed at the same time, through different surgical openings or by different surgical approaches, the total amount covered will be paid according to the Allowable Charges for the operation or procedure bearing the highest allowance, plus one-half of the amount according to the Allowable Charges for all other operations or procedures performed;

c. If an operation consists of the excision of multiple skin lesions, the total amount covered will be paid according to the Allowable Charges for the procedure bearing the highest allowance, 50% for the procedures bearing the second and third highest allowance, 25% for the procedures bearing the fourth through the eighth highest allowance, and 10% for all other procedures;
d. If an operation or procedure is performed in two or more steps or stages, coverage for the entire operation or procedure will be limited according to the Allowable Charges for such operation or procedure;
e. If two or more Physicians perform operations or procedures in conjunction with one another, other than as an assistant at Surgery or anesthesiologist, the amount payable according to the Allowable Charges, subject to the above paragraphs, will be prorated between them by the Corporation when so required by the Physician in charge of the case;
f. Certain surgical procedures, which are normally exploratory in nature, are designated as "Independent Procedures" by the Corporation, and the Allowable Charge is payable when such a procedure is performed as a separate and single entity. However, when an Independent Procedure is performed as an integral part of another Surgery, the total amount covered will be paid according to the Allowable Charge for the major procedure only.

4. **Surgical assistant** – Medically Necessary service of one Physician who actively assists the operating surgeon when an eligible Surgery is performed in a Hospital, and when such surgical assistant service is not available by an intern, resident or house Physician. The Corporation will provide a predetermined percent not more than 20% of the Allowable Charges, not to exceed the Physician's actual charge.
5. **Anesthesia** – Services rendered by a Physician or a certified registered nurse anesthetist, other than the attending surgeon or his assistant and includes the administration of spinal or rectal anesthesia, or a drug or other anesthetic agent by injection or inhalation, except by local infiltration, the purpose and effect of which administration is the obtaining of muscular relaxation, loss of sensation, or loss of consciousness. Additional Benefits will not be provided for pre-operative anesthesia consultation.
6. **In-Hospital medical care** – A Physician's visit or visits to a Member who is a registered bed-patient in a Hospital or Skilled Nursing Facility for treatment of a condition other than that for which Surgery or Maternity Services are required, as follows:
   a. In-Hospital medical care will be provided limited to one visit per day. In-Hospital medical care also includes therapy services performed concurrently with medical care;
   b. In-Hospital medical care in a Skilled Nursing Facility will be provided if the Member is admitted within 14 days following discharge from a Hospital for the continued care of the condition for which inpatient care was required;
   c. When two or more Physicians render in-Hospital medical care at the same time, payment for such service will be made only to one Physician;
   d. Concurrent medical/surgical care Benefits for in-Hospital medical care, in addition to Benefits for Surgery, will be provided only: 1) when the condition for which in-Hospital medical care requires medical care not related to Surgery or Maternity Services and does not constitute a part of the usual, necessary and related pre-operative and post-operative care but requires supplemental skills not possessed by the attending surgeon or his assistant; 2) when a Physician, other than a surgeon, admits a Member to the Hospital for medical treatment and it later develops that Surgery becomes necessary, such Benefits cease on the date of Surgery; or 3) when the surgical procedure performed is designated by the Corporation as a "warranted diagnostic procedure" or as a "minor surgical procedure".
7. **Intensive medical care** – Medical care rendered by the attending Physician to a Member who is eligible for in-Hospital medical care or medical care in the outpatient department of a Hospital immediately prior to an Admission, and who is confined with a serious disease or injury requiring additional time and study over and above the usual in-Hospital medical care.
8. **Consultation** – Services of a consulting Physician requested by the attending Physician and provided during an Admission. This service is limited to one consultation per consulting Physician for each Admission and includes discussion with the attending Physician and/or family, and a written expression of opinion by the consultant based on examination of the Member. A consultation does not include radiological consultations and staff consultations required by institutional rules and regulations, nor when primary care of the Member is transferred to the Physician providing the Consultation.
9. **Outpatient and office medical care** – Benefits are provided as specified in the Schedule of Benefits.

w. **Prescription Drugs** – As specified in the Schedule of Benefits. Insulin will be treated as a Prescription Drug whether injectable or otherwise.

The Corporation receives financial credits directly from drug manufacturers and through a Pharmacy Benefit Manager (PBM). The credits are used to help stabilize overall rates and to offset costs. Reimbursements to pharmacies, or discounted prices charged at pharmacies, are not affected by these credits.

Any Coinsurance percentage that an Employee must pay for Prescription Drugs is based on the Allowable Charge at the Pharmacy, and does not change due to receipt of any financial credit by the Corporation. Copayments are flat amounts and likewise do not change due to receipt of drug manufacturer or PBM credits.

Specialty Drugs are covered only as specified in the Schedule of Benefits.

x. **Preventive Benefits –** Benefits will be provided for the following routine services:

1. **Mammography Services** – According to the most recently published American Cancer Society (ACS) guidelines. A Contracting Mammography Provider must provide the services. These Providers are listed separately from the regular Preferred Blue Providers in the directory.
2. **OB/GYN (gynecological) Exam** – Limited to two annually. A Preferred Blue Provider must provide the services.
3. **Pap Smear Services** – Limited to one annually, or more often if recommended by a medical doctor. A Preferred Blue Provider must provide the services. A Pap smear means an examination of cervical cells for the purpose of detecting cancer.
4. **Prostate Exams, Screenings and Lab Work** – According to the most recently published American Cancer Society (ACS) guidelines. A Preferred Blue Provider must provide the services.
5. **Routine Colorectal Cancer Screening/testing** – According to the most recently published American Cancer Society (ASC) guidelines. A Preferred Blue Provider must provide the services.

y. **Reconstructive Surgery** – Reconstructive Surgery that is deemed a Covered Expense is limited to Surgery:

1. To correct a functional defect that results from a birth defect, disease or anomaly;
2. Performed to correct a seriously disfiguring condition resulting from injury; or
3. For breast reconstruction after a mastectomy.

For Benefits to be available for the reconstructive Surgery, the Corporation must preapprove coverage for the planned services prior to the Surgery date.

z. **Rehabilitation** – Admissions for inpatient care in a Rehabilitation Facility for taking part in a multi-disciplinary team-structured rehabilitation program following severe neurologic or physical impairment. Benefits are available as specified in the Schedule of Benefits.

In order for these Benefits to be available, the following criteria must be met:

1. A Physician must order all such Admissions; and
2. The Corporation must preapprove all such Admissions and the services must be performed at a Designated Provider; and
3. The documentation that goes with a request for Preadmission Review must have a detailed patient evaluation from a Physician. This evaluation must document that, to a reasonable degree of medical certainty, the Member has rehabilitation potential such that there is a belief that the Member will be able to provide self-care and conduct his or her activities of daily living.

In order for Benefits to continue, all Admissions are subject to periodic review. This review will require documentation that the Member is making substantial progress toward set goals and that there continues to be significant potential for the achievement of the stated rehabilitation goals.

aa. **Skilled Nursing Facility Services** – Subject to the following:

When a Member is admitted to a Skilled Nursing Facility that contracts with another Blue Cross Plan with which the Corporation has a reciprocal agreement, Benefits will be provided as set forth in Article III, paragraph 1 and as specified in the Schedule of Benefits.

1. Semi-private room – When a Member is admitted to a Skilled Nursing Facility in which all rooms are private, the most prevalent semi-private room rate, as determined by the Corporation, will be considered the private room.
2. Bed and board – including meals, 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.

The day the Member leaves the Skilled Nursing Facility, with or without permission, is the discharge day. The day the Member returns to the Skilled Nursing Facility is treated as the Admission day and is counted as an inpatient care day. Benefits are not payable for days in which the Member is not physically present in the Skilled Nursing Facility for inpatient care.

ab. **Specialty Drugs –** A Physician must prescribe Specialty Drugs. The prescription must be filled by a Specialty Drug Network Provider. If Specialty Drug coverage is provided, Benefits for covered Specialty Drugs dispensed to a Member shall not exceed the quantity and Benefit maximum, if any, specified in the Schedule of Benefits. The Member may obtain a list of Specialty Drugs by contacting the Corporation. **Preauthorization is required for Benefits to be available**.

The Corporation receives financial credits directly from drug manufacturers and through a Pharmacy Benefit Manager (PBM). The credits are used to help stabilize overall rates and to offset costs. Reimbursements to Specialty Drug Network Providers or discounted prices charged by Specialty Drug Network Providers are not affected by these credits.

Any Coinsurance percentage that an Employee must pay for Specialty Drugs is based on the negotiated rate or lesser charge at the Specialty Drug Network Provider, and does not change due to receipt of any financial credit by the Corporation. Copayments are flat amounts and likewise do not change due to receipt of drug manufacturer or PBM credits.

ac. **Spinal subluxation services (if available and purchased separately)** – Services or care used to detect and correct, by manual or mechanical means, structural imbalance, distortion, or subluxation in the human 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. Benefits are limited to the amount specified in the Schedule of Benefits.

ad. **Substance Abuse Treatment** – As specified in the Schedule of Benefits for Covered Expenses, and all terms and conditions, limitations and exclusions in Article V, as follows:

1. Inpatient Care – Inpatient care in a Hospital provided in those State institutions with which the Corporation has a written agreement are limited, as specified in the Schedule of Benefits.
2. Outpatient Care – Treatment by a psychiatrist or licensed mental health Provider when the Member is not confined in a Hospital, as specified in the Schedule of Benefits.

ae. **Supplemental Accidental Injury (if available and purchased separately)** – Benefits are limited to the amount specified in the Schedule of Benefits.

af. **Therapeutic Services** – Benefits will be provided for radiation therapy, chemotherapy and dialysis treatment.

2. **Optional Limited Dental/Vision Coverage**

Benefits are limited as specified in the Schedule of Benefits if the optional limited dental/vision coverage is available and selected. This Benefit is not available if a separate Dental Benefits Option is available.

Dental Coverage

Class I – Preventive Care

a. Oral and periodontal exams, limited to once every six months.
b. Periapical, occlusal, extraoral X-rays, as required; bitewing X-rays limited to four X-rays, once per Benefit Period, full mouth X-rays or panoramic film with up to four additional bitewing X-rays taken on the same day is limited to one in any 36 month period, unless a special need for these services at more frequent intervals is documented as Medically Necessary by the dentist.
c. Topical fluoride applications of stannous fluoride or acid fluoride phosphate for an Employee under age 19 and/or Dependents under age 19, limited to two applications per Benefit Period.
d. Prophylaxis, including cleaning, scaling and polishing, limited to two per Benefit Period.
e. Space maintainers for prematurely lost deciduous teeth, provided for Employees who have not attained age 19 or Dependents who have not attained age 19.
f. Emergency palliative treatment for the relief of pain.
g. Pulp vitality tests.
h. Diagnostic casts.
i. Sealants on permanent teeth that have not had any fillings; covered on children from the ages of 6 through 15.

Class II – Restorative Care

a. Repair of removable dentures.
b. Oral Surgery including the following:
   Surgical extractions (does not include removal of impacted teeth);
   Stomatoplasty;
   Alveoplasty;
   Removal of cysts and neoplasms;
   Excision of bone tissue;
   Biopsies of oral tissue;
   Treatment of oral fistula;
   Excision of hyperplastic tissue; and
   Frenulectomy.
c. Fillings, consisting of amalgam and tooth-colored synthetic materials.
d. Simple extractions.
e. Endodontics, consisting of pulpotomy, pulp capping and root canal treatment.
f. General anesthesia or IV sedation if Medically Necessary and provided in connection with covered oral or dental Surgery.
g. Hemi-section.
h. Apicoectomy (amputation of apex of a tooth root).
i. Assistant at Surgery when Medically Necessary.
j. Periodontics, that being the diagnosis and treatment of diseases of the tooth-supporting tissues, as follows:
   Surgical periodontic examination;
   Gingival curettage;
   Gingivectomy and gingivoplasty;
   Osseous Surgery, including flap entry and closure;
   Mucogingivoplastic Surgery; and
   Management of acute infection and oral lesion.
k. Periodontal cleanings (payable only once every three months after the initial periodontal treatment is documented).

Vision Coverage

Benefits are available for an eye exam and frames/lenses or contact lenses if specified in the Schedule of Benefits.

3. **BlueCard® Program**

The BlueCard Program is a program in which all Blue Cross and Blue Shield Plans participate. This program benefits Blue Cross and Blue Shield members who receive covered services outside the geographic area that Blue Cross and Blue Shield of South Carolina serves. Blue Cross and Blue Shield of South Carolina is the Employer's home plan, the entity having a contract with the Employer. The Blue Cross and Blue Shield Plan where the Member is treated is the "Host Plan."

Whenever the Member receives health care services through BlueCard outside Blue Cross and Blue Shield of South Carolina's service area, the amount the Member pays for covered services is calculated on the **lower** of:

- the billed charges for the Member's covered services; or
- the negotiated price that the Host Blue Cross and/or Blue Shield Plan passes on to us.

The Host Plan is only responsible for contracting with its participating out-of-area Providers and handling all interaction with its participating out-of-area Providers under the BlueCard Program.

Often, the negotiated price will be a simple discount that reflects the actual price the Host Plan pays. Sometimes, it is an estimated price that takes into account special arrangements with the Provider or a Provider group that includes settlements, withholds, non-claims transactions (such as provider advances) and other types of variable payments. Occasionally, it may be an average price, based on a discount that results in expected average savings after taking into account the same special arrangements used to obtain an estimated price. Average prices tend to vary more from actual prices than estimated prices.

Negotiated prices may be adjusted going forward to correct for over- or underestimation of past prices. However, the amount the Member pays is considered a final price.

Laws in a small number of states may require the Host Plan to add a surcharge to the Member calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate Member liability for any covered health care services according to the applicable state statute in effect when the Member received care.

ARTICLE IV - COORDINATION OF BENEFITS (REDUCTION OF BENEFITS BECAUSE OF OTHER GROUP COVERAGE)

1. **Benefits Subject to this Article**
   All of the Benefits provided under this Contract are subject to this Article. Confirmation that no other insurance is in effect for Dependents must be submitted yearly.

2. **Definitions**
   a. Plan – Any program providing benefits or services for or by reason of care or treatment, which benefits or services are provided by: 1) group insurance and group subscriber coverage; 2) uninsured arrangements of group coverage; 3) group coverage through HMO's and other prepayment coverage, group practice and individual practice plans; 4) medical benefits coverage in group and individual "no fault" and traditional automobile "fault" type contracts; and 5) group hospital indemnity benefits payments in excess of $100 per day.

      For purposes of this Article, the term "Plan" will also include Medicare Part B when this Contract is secondary to Medicare as mandated by federal law, and the person covered under this Contract did not elect coverage under Medicare Part B.

      The term "Plan" will be construed separately with respect to each policy, Contract or other arrangement for benefits or services and separately with respect to that portion of any such policy, Contract or other arrangement which reserves the right to coordinate benefits or services of other Plans in determining its benefits and that portion which does not.

   b. Covered Services – Any necessary, reasonable and/or customary service or supply specified in this Contract for which Benefits will be provided when provided by a Provider. Payment under this Contract cannot exceed the amount that would normally be paid in the absence of this Article. Personal comfort items provided at the patient's request, such as television, air conditioning and telephone that are listed separately on the Hospital's or Skilled Nursing Facility's regular statement of charges, are not considered covered services. If benefits are reduced under a primary plan because the covered person did not comply with the Plan's provisions, such as Second Surgical Opinions, precertification of Admissions or services, and preferred provider arrangements, the amount of the reduction will not be covered for Benefits under this Contract. When a Plan provides benefits in the form of services, the reasonable cash value of each service provided will be considered a paid benefit.

3. **Effects on Benefits**

a. If a covered Member is also covered for comparable benefits or services under another Plan that should pay first, Benefits payable under this Plan will be reduced so that, for covered services incurred, benefits available under all Plans will not exceed the total Allowable Charge of such covered services. The Member must also confirm if there is no other insurance for their Dependents each year. The Member will receive a notice stating a claim has been denied or that the Corporation needs information to complete processing the claim. For the files to be updated, the Member must return the notice with the requested information.

b. The rules establishing the order of benefits determinations are as follows:

1. The benefits of a Plan that does not contain a Coordination of Benefits provision or other provisions of similar intent will be determined before the Benefits under this Contract.

2. The benefits of a Plan which covers an Employee, contractholder or named insured primarily, will be determined before the benefits of a Plan which covers such persons as a Dependent, or secondarily.

3. For Dependent children whose parents are not separated or divorced, the following order of liability will be used:
   a. The benefits of the Plan of the parent whose birthday (month and day in a calendar year, not the year the parent was born) falls earlier in the year are determined before those of the Plan of the parent whose birthday falls later in the year;
   b. 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;
   c. If the other Plan determines the order of benefits based on the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule based on the gender of the parent will determine the order of benefits.

4. For Dependent children whose parents are separated or divorced, the following order of liability will be used:
   a. The Plan of the natural parent with custody of the child;
   b. The Plan of the stepparent who is married to the natural parent with custody of the child;
   c. The Plan of the natural parent without custody of the child. Anyone who legally adopts the child will assume natural parent status;
   d. If a court order exists stating that one of the parents is financially responsible for the health care of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of the Plan of the parent assigned that responsibility are determined before those of all other Plans that cover the child as a Dependent;
   e. 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, the order of liability will be determined according to the rules for Dependent children whose parents are not separated or divorced.

5. The benefits of a Plan that covers a person as an Employee who is neither laid off nor retired, or as a Dependent of such an Employee, are determined before those of a Plan that covers that person as a laid off, retired Employee or Dependent of that Employee.

   If the other Plan does not contain this rule, and, as a result, the Plans do not agree on the order of benefits determination, the order of liability will be determined according to rule #6.

6. When the prior rules do not establish an order of benefit determination, the benefits of a Plan that has covered the person for the longer period of time will be determined before the benefits of a Plan that has covered the person for the shorter period of time.

7. If a Plan contains order of benefit determination rules that declare that Plan to be excess to or always secondary to all other Plans, this Contract will coordinate benefits as follows:
   a. If this Contract is primary, it will pay or provide Benefits on a primary basis;

   b. If this Contract is secondary, it will pay or provide Benefits first, but the amount of Benefits payable will be determined as if this Contract were the secondary Plan. The liability of this Contract will be limited to such payment;

c. If the other Plan does not furnish the information needed by this Contract to determine Benefits within a reasonable time after such information is requested, this Contract will assume that the benefits of the other Plan are the same as those provided under this Contract and will pay Benefits accordingly. When information becomes available as to the actual benefits of the other Plan, any Benefit payment made under this Contract will be adjusted accordingly;

d. If the other Plan reduces its benefits so that the covered person receives less in benefits than he or she would have received had this Contract paid or provided Benefits as the secondary Plan and the other Plan paid or provided its benefits as the primary Plan and the governing State law allows the right of subrogation, then this Contract will advance an amount equal to such difference to or on behalf of the Member.

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

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

4. **Right to Receive and Release Necessary Information**
For the purpose of determining the applicability of and implementing the terms of this Article or any provision of similar purpose of any other Plan, the Corporation may, without the authorization of or prior notice to any person, release to or obtain from any insurance company or other organization or person any information, with respect to any person, which it deems to be necessary for such purposes. Any person claiming Benefits under this Plan will furnish to the Corporation such information as may be necessary to implement this Article.

5. **Facility of Payment**
Whenever payments which should have been made under this Plan according to this Article have been made under any other Plan, the Corporation will have the right to pay over to any organization making such other payments any amounts it determines to be warranted in order to satisfy the intent of this Article, and amounts paid will be considered paid Benefits under this Plan and, to the extent of such payments for covered services, the Corporation will be fully discharged from liability under this Contract.

6. **Right of Recovery**
If the amount of the payments made by the Corporation is more than it should have paid under this COB provision, it may receive the excess from one or more of the following: the Member it has paid or for who it has paid, the other Plan, or other person or organization.

A Member, or in the case of a minor, the Employee, will, upon request, execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Corporation or any other Plan.

ARTICLE V - EXCLUSIONS AND LIMITATIONS

1. No Benefits will be provided under any Article of this Contract for the following:

a. Room and board charges in any Hospital or Skilled Nursing Facility when the required Preadmission Review, Emergency Admission Review and/or Continued Stay Review were not obtained pursuant to ARTICLE III, paragraph 2, subparagraphs (a), (b) and (c).

b. Service and supplies that are not Medically Necessary; or not specifically listed in Article III inclusive.

c. Any charges for services rendered prior to the Member's Effective Date or after the Member is no longer eligible for coverage, except as provided in Article X.

d. Services or supplies for which a Member is entitled to Benefits under Medicare or any other governmental program, except for Medicaid.

e. Benefits for injuries or diseases paid by Workers' Compensation or settlement of a Workers' Compensation claim.

f. Any charges by the Department of Veterans Affairs (VA) for a service-related disability.

g. Care in any State or Federal Hospital for which the Member is not legally responsible.

h. Inpatient care and related Physicians' services rendered in conjunction with Hospital Admissions which are principally for diagnostic studies or evaluative procedures, as determined by the Corporation, which could have been performed on an outpatient basis, except when medical records are completed in a timely manner to document that the patient's symptoms and physical condition alone warranted hospitalization.

i. Sanitarium care or rest cures; long-term, residential care for the treatment of Mental Health Services or Substance Abuse care; or custodial care (domiciliary care), that being defined as care mainly designed to assist people to meet their daily living activities, such as, but not limited to, services which constitute personal care including: help in walking and getting in and out of bed, assistance in bathing, dressing, feeding, using the toilet, preparation of special diet and supervision of medications which can usually be self-administered and which does not require continuous attention of trained Medical Personnel.

j. All Admissions to Hospitals or freestanding Rehabilitation Facilities for physical rehabilitation, except as provided in Article III when the services are at a Designated Provider and the required Preauthorization is obtained.

k. Treatment resulting from declared or undeclared war or any act of war or while in the military service or units auxiliary thereto.

l. Illness contracted or injury sustained while participating in a riot or uprising, committing a crime, felony or misdemeanor or an illegal occupation.

m. 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.

n. 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 Blue Cross and, if the Member refuses to provide these test results, no Benefits will be paid.

o. Investigational or Experimental Services, as determined by the Corporation, including but not limited to the following:
   - Uses of allogeneic or syngeneic bone marrow transplantation 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 six complex antigens match; cases in which mixed leukocyte culture is reactive; and Acquired Immunodeficiency and Human Immunodeficiency Virus infection;
   - Adrenal tissue to brain transplants;
   - Islet cell transplants;
   - Dorsal Rhizotomy in the treatment of spasticity;
   - Procedures that involve the transplantation of fetal tissues into a living recipient.

p. Services and supplies related to transplants involving mechanical or animal organs, human organ and/or tissue transplant procedures when prior Approval from the Corporation is not obtained and/or, if specified in the Schedule of Benefits, the services and supplies are not obtained from a Designated Provider, or unless specifically listed in Article III.

q. Services and supplies related to cosmetic Surgery, as determined by the Corporation. 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 a functional disorder or as a result of an injury. Cosmetic Surgery excluded includes, but is not limited to:
   - Surgery for sagging or extra skin;
   - Any augmentation or reduction procedures;
   - Rhinoplasty and associated Surgery; and
   - Any procedures using an implant that does not alter physiologic function or is not incidental to a surgical procedure.

   Any services a Member receives due to complications of cosmetic Surgery also are not covered.

r. Reduction mammoplasty for macromastia unless the Member is within 20% of ideal body weight.

s. Any service, supply or drug for the treatment of obesity or other weight control disorders (even if morbid obesity is present) including, but not limited: to gastric by-pass or gastric banding, intestinal bypass, liposuction and any related procedure, including procedures for reversal or complications thereof.

t. Eyeglasses and contact lenses (except after cataract Surgery) when not specified in the Schedule of Benefits as a Covered Expense, hearing aids and examination for the prescription or fitting thereof, any Hospital or Physician charges related to refractive care such as radial keratotomy (Surgery to correct nearsightedness), keratomileusis (laser eye Surgery or LASIK) or lamellar keratoplasty (corneal grafting) and any other such procedures that are designed to alter the refractive properties of the cornea.

u. Home Health Care and Hospice Care except as provided in Article III and the required Preauthorization is obtained when specified in the Schedule of Benefits.

v. Any medical social services, visual, occupational or speech therapy, or Private Duty Nursing, except when specified in the Schedule of Benefits and part of a preauthorized Home Health Care plan or Hospice Care program.

w. Recreational, educational or play therapy; bio-feedback or psychological testing to determine if a learning disability or behavior disorder exists; therapy for learning disabilities and communication delay, perceptual disorders, behavioral disorders, mental retardation and vocational rehabilitation unless specifically included in the Schedule of Benefits.

x. Routine physical examinations or well-baby care (check-up of a healthy baby) and immunizations, except when specified in the Schedule of Benefits, and services, supplies or charges for pre-marital or pre-employment physical examinations.

y. Services or care used to detect and correct, by manual or mechanical means, structural imbalance, distortion, or subluxation in the human 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 when not specified in the Schedule of Benefits as a Covered Expense.

z. Any services or supplies for the diagnosis or treatment of infertility. This includes, but is not limited to: fertility drugs, laboratory and X-ray tests, reversal of tubal ligations and vasectomies, surrogate parenting, artificial insemination and in vitro fertilization.

aa. Any services or supplies a Member receives for the diagnosis or treatment of sexual dysfunction. This includes, but is not limited to: drugs, laboratory 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.

ab. Marriage, family or child counseling for premarital, marital, family or child relationship dysfunctions.

ac. Acupuncture.

ad. Services and supplies related to non-surgical treatment of the feet.

ae. Food supplements, even if a Physician orders or prescribes the supplements.

af. Physician's charges for medicine, drugs, appliances, supplies, blood and blood products.

ag. Services or supplies related to dysfunctional conditions of the muscles of mastication, malpositions or deformities of the jaw bone(s), orthognathic deformities or temporomandibular joint syndrome (TMJ).

ah. Physician services directly related to the care, filling, removal or replacement of teeth, the excision or extraction of impacted teeth, the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth. This includes but is not limited to: apicoectomy (dental root resection), root canal treatment, alveolectomy and treatment of periodontal disease. Exception is made as specified in the Schedule of Benefits if limited dental coverage is available and has been purchased, for dental treatment for up to a year after an accident to the amount, if any, specified in the Schedule of Benefits and Medically Necessary Cleft Lip and Palate services.

ai. Prescription Drugs used for or related to weight control, obesity, cosmetic purposes (such as Tretinoin or Retin-A), hair growth, hair removal, smoking cessation or promotion of growth (such as growth hormone) unless specified in the Schedule of Benefits; all vitamins, except for prenatal vitamins; immunization agents; injectable drugs other than insulin.

aj. More than the number of days supply specified in the Schedule of Benefits for Prescription Drugs dispensed by prescription.

ak. Prescription refills in excess of the number specified on the Physician's Prescription Order or refills dispensed more than one year after the original prescription date.

al. Devices of any type, even though dispensed through a prescription (other than contraceptive devices), such as, but not limited to: therapeutic devices, artificial appliances or similar devices.

am. More than the recommended daily dosage of any Prescription Drug as described in the current *Physician's Desk Reference* or as recommended under the guidelines of our Pharmacy Benefit Manager, whichever is lower.

an. Drugs administered or dispensed in a Physician's office, Skilled Nursing Facility, Hospital or any other place that is not licensed to dispense drugs.

ao. Drugs for which there is an Over-the-counter (OTC) Drug equal to it along with any OTC supplies or supplements.

ap. Any Prescription Drug or Specialty Drug that is not consistent with the diagnosis and treatment of an illness, injury or condition; or that is excessive in terms of the scope, duration or intensity of drug therapy that is needed to provide safe, adequate and appropriate care.

aq. Drugs that require Preauthorization by the Corporation when Preauthorization is not obtained.

ar. Drugs that require step therapy when step therapy is not done. Step therapy is when a Member is required to try certain drugs to treat a medical condition prior to the Corporation covering another drug for that condition.

as. Charges incurred as the result of virtual office visits including Prescription Drugs. A "virtual office visit" occurs when the Member has never been physically seen or physically examined by the Physician writing or approving the prescription.

at. Prescription Drugs not listed on the Preferred Drug list.

au. Maternity care for a Dependent child.

av. Travel, luxury or convenience items, whether or not a Physician recommends or prescribes them.

aw. Any services performed by a licensed doctoral psychologist that are not preauthorized.

ax. Durable Medical Equipment when Preauthorization is not obtained and the cost is more than the amount specified in the Schedule of Benefits.

ay. Benefits will be denied or reduced for procedures or services as specified in the Schedule of Benefits when the required Preauthorization is not obtained.

az. Any type of service charge, handling or medical records fee, fee for filing a claim or charge incurred due to missing a scheduled appointment.

ba. Any services or supplies a member of the patient's family or the patient provides, including the dispensing of drugs. A member of the patient's family means spouse, parents, grandparents, brothers, sisters, aunts, uncles, children or in-laws.

bb. Any service or treatment for complications resulting from any non-covered procedures or condition.

bc. Services or supplies not needed for the diagnosis or treatment of an illness or injury or for which the Member is not legally obligated to pay.

2. Pre-existing Condition Limitations

Any services or charges for services for Pre-existing Conditions are not covered under this Contract when the treatment relates to a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period prior to the Enrollment Date.

The Pre-existing Condition Exclusion period ends at the earliest of:

a. The date on which the Member has not received medical care, treatment or supplies for the Pre-existing Condition for 12 months and that period of 12 months ends on or after the Effective Date of coverage; or
b. 12 months after the Enrollment Date. In the case of a Late Enrollee, 18 months after the date the Member completes the application for coverage (See Article II, 4 – Late Enrollment).

Creditable Coverage, which is calculated on a day-by-day basis, can reduce or eliminate the Pre-existing Condition Exclusion.

A period of Creditable Coverage does not count if there is at least a 63-day period where the Employee or Dependent was not covered under any Creditable Coverage.

Any period that an Employee or Dependent is in a Waiting Period under a Group Health Plan may not be taken into account in determining the 63-day period.

The Pre-existing Condition Limitations do not apply to Maternity Services or to Genetic Information in the absence of a diagnosis of the condition related to the information.

The Pre-existing Condition Limitations do not apply to a newborn child, a child who is adopted or placed with an Employee or Employee's spouse for the purpose of adoption before he or she reaches age 18 if the Employee applied for coverage and premiums were paid within 31 days from the birth, adoption or placement for adoption.

The newborn and adoption provisions will no longer apply to an Employee or Dependent after the end of the first 63-day period where the Employee or Dependent was not covered under any Creditable Coverage.

If an Employee has single coverage and adds Dependents, the Pre-existing Condition Limitations apply to any Dependents as of the Effective Date of the upgraded coverage unless there is Creditable Coverage.

Method of Counting Creditable Coverage

The Corporation will count a period of Creditable Coverage without regard to the specific health benefits covered during the period.

Credit for prior coverage will be determined through a certificate indicating prior coverage or other acceptable evidence of coverage presented by the Employee. The Employee or Dependent has the right to request a Certificate of Creditable Coverage from any prior plan or issuer. This is based on the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Corporation will request the certificate, if necessary, with written authorization from the Member.

The Corporation will notify the Employee of any Pre-existing Condition Limitations period and the basis for the determination. The Member has the right to submit additional evidence of prior Creditable Coverage. The Corporation has the right to reconsider its decision if it determines that the Member did not have the claimed prior Creditable Coverage.

ARTICLE VI - PAYMENT OF PREMIUM

1. Unless the Employer or the Corporation has given notice of termination of this Contract as provided in Article VIII, premiums are due and payable on or before the monthly due date, provided that the premium due on any due date will not be deemed to have been paid unless the total premium for all coverages in force on such date has been paid.

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 due date except as provided in paragraph 3 of this Article and in Article V, paragraph 1, subparagraph c.

3. A 31-day grace period will be granted for the payment of premiums, other than premiums for the initial month or agreed periodic term, 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.

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

ARTICLE VII - EMPLOYER'S PERSONNEL DATA

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 of the Employer under this Contract, processing terminations and effecting changes in family and membership status and transfers of employment of covered Employees.

Upon the Employer's request, the Corporation will supply the Employer with forms that will present required information in a format convenient for the Corporation's use. Failure of the Employer to request such forms will not relieve the Employer of its duties to transmit the information.

The Employer, after a reasonable investigation, believes the accuracy of the information it transmits to the Corporation to be correct and understands that the Corporation 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, attorneys 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.

ARTICLE VIII - TERMINATION AND RENEWAL OF THIS CONTRACT

The Corporation will provide the Employee or Dependent a Certificate of Creditable Coverage at the time coverage ends or at the time the COBRA or state continuation coverage ends. If a duplicate certificate is needed at a later time, the Employee or Dependent must request the Certificate of Creditable Coverage within 24 months of the coverage ending or the COBRA or state continuation coverage ending, whichever occurs first. The Employee or Dependent may also request the Certificate of Creditable Coverage from the Corporation even if their coverage is still in force. To request the Certificate of Creditable Coverage, the Employee or Dependent must contact the Corporation.

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 VI.

2. In the event a Member ceases to be eligible, or in the event the Employer notifies the Corporation that coverage of a Member is to be terminated, or in the event this Contract is canceled by the Employer or non-renewed by the Corporation, the coverage respecting such Employee and all of his Dependents automatically ends on the last day of the month specified by the Employer, except as provided in this Article and subsequent Articles X and XI.

   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.

   Exception: Employees may be considered as remaining in the active employment for purposes of coverage under this Contract during a disability leave of absence for a period not to exceed 60 days from the date of cessation of active work or for a qualified Employee, during a leave pursuant 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.

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 the fraud or intentional misrepresentation is made by an Employee or Dependent with respect to any person's prior health conditions, the Corporation has the right also to deny coverage to that person or to impose as a condition of continued coverage the exclusion of the conditions misrepresented. 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.

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.

ARTICLE IX - REINSTATEMENT

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

ARTICLE X – EXTENSION OF BENEFITS

If this Contract or coverage thereunder is terminated, all rights to receive Benefits provided in this Contract for services rendered to an Employee or Dependent who was covered under this Contract on the date of that termination will automatically end. An exception is made for an Employee or Dependent confined to a Hospital or Skilled Nursing Facility or totally disabled on the date of such termination. Those Members will be entitled to receive Benefits specified in Article III for each day of that Admission or total disability subject to all contract limits. Benefits provided will be limited to Covered Expenses listed in this Contract that are directly related to the disabling condition on the date of termination. Rights to receive Benefits specified in Article III for services related to the disabling condition will continue until the earliest of the following: 1) the date the hospitalization ends or the date of recovery of the Employee or Dependent from the total disability; or 2) a period of 365 days from the date of termination of this insurance under this Article for Benefits described in Article III of this Contract; or 3) The Contract maximums are met; or 4) the date this Contract is terminated and 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 the Member notify the Corporation if they wish to exercise the Extension of Benefits rights. The Corporation will then determine if the Member is eligible for Benefits. Premium payments are waived for Members receiving Extension of Benefits. There are no continuation rights or any conversion rights available to any Member at the end of the Extension of Benefits period.

As used in this paragraph, the terms "Totally Disabled" and "Total Disability" mean with respect to an Employee, disability to the extent that the Employee is receiving ongoing medical care by a Physician and is unable to perform the material and substantial duties of the Employee's regular job. With respect to a Dependent, the terms mean disability to the extent that the Dependent is receiving ongoing medical care by a Physician and is unable to perform the normal activities of a person of the same age and sex who is in good health. Claims filed under this paragraph must be accompanied by a Physician's statement of disability.

ARTICLE XI - CONTINUATION AND CONVERSION OF COVERAGE

1. **Conversion privilege:** A spouse who is no longer eligible because of a valid decree of divorce may obtain coverage without evidence of insurability if the spouse sends written application and the required premium to the Corporation within 60 days following the valid decree of divorce.

   The new policy will provide coverage then being issued by the Corporation similar to, but not greater than, this coverage. Credit will be given for any Waiting Periods met under this Contract.

2. **Continuation Under State Law:** South Carolina law allows continuation of group coverage for the rest of a month plus six full months after a Member's date of termination of insurance. The Member must pay the full cost of this Continuation of Coverage in advance to the Employer each month.

   Continuation of Coverage is subject to this Contract, or a successor policy, remaining in force and the Member paying the entire group premium, including any portion usually paid by the former Employer, before the date each month that the group policy month begins. The Member is not eligible for State Continuation of Coverage if he or she is eligible for Continuation under COBRA, Medicare or other group coverage.

   Continuation of coverage is not available if any of the following conditions apply:

   a. Coverage ended because the Employee failed to make timely payment of any required premium contribution.
   b. The Member becomes eligible for other group coverage including COBRA.
   c. The Member becomes eligible for Medicare benefits.
   d. The Member was not continuously covered under the Employer's Group Health Plan for a period of at least six months immediately prior to termination.
   e. This Contract ends for the group. (The Member may be entitled to Continuation of Coverage under the replacement carrier, if the Employer gets new group coverage.)
   f. The Member is entitled under federal law to Continuation of Coverage for a period of greater length than already provided here.

3. **Continuation Under COBRA (Employers with 20 or more Employees):** Consolidated Omnibus Budget Reconciliation Act (COBRA) applies to continuation of group health coverage for Employees and their Dependents after they are no longer eligible for group coverage. It does not apply to churches, religious organizations or federal employees.

   Please read the following continuation of coverage information carefully.

   Depending on the circumstances, COBRA requires Employers to let the following people continue their coverage after they normally would not be eligible for it, for a period of up to 18, 29 or 36 months:

Reason for Loss of Coverage	**Eligible Persons**	**Number of Months of Extended Coverage**
a. Employee's working hours reduced from full-time to part-time (for any reason).	Employee Dependents	18 months
b. Employee quits work, is laid off or is fired for any reason other than gross misconduct.	Employee Dependents	18 months
c. Member establishes through the Social Security Administration that a disability began within 60 days of a qualifying event for COBRA. **Employee must notify Employer within 60 days of the disability determination by the Social Security Administration and within the original period of COBRA coverage.**	Disabled Member	29 months
d. Employee dies.	Dependents	36 months
e. Employee and spouse divorce or separate (only when this results in a loss of coverage, but also applies if Employee drops spouse's coverage in anticipation of separation or divorce). **Employee must notify Employer within 60 days.**	Dependents	36 months
f. Dependent child who no longer meets plan definition of Dependent child. **Employee must notify Employer within 60 days.**	Dependent child	36 months

g. 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
h. 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 (c), (e) and (f) above, the Employer must get the proper form to the Employee or eligible Dependent so they can apply for Continuation of Coverage. The form is called a Membership Application.

For items (c), (e) and (f) the Employee or eligible Dependent must let the Employer know within 60 days that the situation has occurred. If the Employee or Dependent, however, does not give the required notice of a divorce or change in a Dependent child's status, the election period will not be extended beyond the 60 days after the date coverage ends.

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

During an 18-month Continuation of Coverage period, some people may have another situation occur to them from among items (b) and (d) through (h). They will be entitled to Continuation of Coverage for an overall total of up to 36 months. For items (e) and (f), the Employee should notify the Employer within 60 days that the situation has occurred.

Premiums for Continuation of Coverage Should be Paid to the Employer.

For those who elect Continuation of Coverage, the first premium must be paid to the Employer by the 45th day after the Employer receives the Membership Application. After that, the Employee must pay premiums each month, in advance. There is a 31-day grace period for payment of the monthly premiums. The Corporation will have no obligations for enrolling, premium collection, monitoring or disenrolling COBRA continuees.

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

- When premiums are not paid on time.
- When the person who has Continuation of Coverage becomes covered under another Group Health Plan without any Pre-existing Condition exclusion or limitation that applies to a condition of that person or under Medicare. (Enrolling in Medicare will not end coverage for people continuing coverage under item (#h).)
- When a person covered under the extended 29-month COBRA continuation period has been determined by the Social Security Administration to be no longer disabled. (Notification must be given to the Employer within 30 days of final determination.)
- When the 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. The Employee 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 the Employee becomes a Qualified TAA Eligible Individual. If coverage is elected, it begins on the first day of the special election period. There is no required "reach-back" to the date coverage terminated under the group. The total COBRA time period is measured from the initial qualifying event.

ARTICLE XII – CONTACTING THE CORPORATION

A Member may call, write or send a secure e-mail to the Member Service Center with a question or grievance relating to a claim, quality of care or service concern. If the Member chooses to write, the address is: Blue Cross and Blue Shield of South Carolina, Member Service Center, P.O. Box 100300, Columbia, SC 29202. If the grievance involves the Customer Service Representative, it should be addressed to the Vice President of Group and Individual Operations.

ARTICLE XIII – CLAIMS FILING AND APPEAL PROCEDURES

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 XIV, 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.

3. For covered services provided by a Preferred Blue Provider, the Provider will file the claim, along with all documentation required, to the Corporation. An Explanation of Benefits will be sent to the Employee, not the patient, unless the Corporation has a written request from the patient for Confidential Communication.

4. For covered services not provided by a Preferred Blue Provider, the Member should file the claims to the Corporation. When filing the claims, the Member will need the following:

   a. A Benefits Claim Form for each different patient. The Member can get these forms from a Member Services Representative.

   b. Itemized bills from the Provider(s). These bills should have all the following:
      - Provider's name and address
      - Patient's name and date of birth
      - Employee's Blue Cross ID number
      - Description and cost of each service
      - Date that each service took place
      - Description of the illness or injury (diagnosis)

      The Member should complete the front of each claim form and attach the itemized bill(s) to it. If the patient has other insurance that already paid on the claim(s), the Member should also attach a copy of the other plan's Explanation of Benefits (EOB) notice.

      The Member should make copies of all claim forms and itemized bills for his or her records since they cannot be returned. The claims should be mailed to the Blue Cross address.

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, however, 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.

7. There are three types of claims. They are Pre-service Claims, Urgent Care Claims (a type of Pre-service Claim) and Post-service Claims. The time frames allowed for the Corporation to provide a determination for each of these claims are listed below:
   a. Pre-service Claim – A determination, based on Medical Necessity, must be provided in writing or in electronic form within 15 calendar days.

      An extension of 15 calendar days may be provided if the Corporation determines, that for reasons beyond the control of the Corporation, an extension is necessary. If an extension is required, the Corporation will notify the Member within the initial 15-day time period that an extension is necessary.

      If the Corporation receives incomplete information from the Member and additional information is required to make a determination, the Member will be notified within five calendar days. The Member has 60 calendar days to provide the required information. If the Corporation does not receive the required information within the 60-day time period, the claim may be denied.

When the Corporation requires an extension due to incomplete information, the Corporation is entitled to the rest of the initial determination period to reach a Benefit determination after the additional information is received from a Member or Provider.

b. Urgent Care Claim – A determination, based on Medical Necessity, must be provided to the Member in writing or in electronic form within 72 hours of the original Urgent Care Claim. A Provider may be considered an authorized representative without a specific designation by the Member when the Approval request is for Urgent Care Claims (medical conditions which require immediate treatment).

The Corporation will notify the Member or his authorized representative of the lack of information from which to render a decision within 24 hours from receipt of the original Urgent Care Claim. An extension of 48 hours may be required if the Corporation does not receive complete information in which to make a Medical Necessity decision. If the Corporation does not receive the required information from the Member within 48 hours after notifying the Member, the claim may be denied.

c. Post-service Claim – A determination must be provided to the Member in writing or in electronic form within 30 calendar days if the decision is adverse to the Member. An adverse decision includes any amount due that the Member may be held responsible for other than Copayment amounts previously paid to the Provider.

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

If the Corporation receives incomplete information from the Member and additional information is required to make a determination, the Member will be notified within 30 calendar days. The Member has 60 calendar days to provide the required information. If the Corporation does not receive the required information within the 60-day time period, the claim may be denied.

When the Corporation requires an extension due to incomplete information, the Corporation is entitled to the rest of the initial determination period to reach a Benefit determination after the additional information is received from a Member or the Provider.

d. Concurrent Care Decision – If the Corporation makes a decision to reduce or stop Benefits for Concurrent Care that had previously been approved, the Member must be notified sufficiently in advance of the reduction or termination of Benefits to allow the Member time to appeal the decision before the Benefits are reduced or terminated.

If the Member requests 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. The Corporation must make a decision within 24 hours.

8. **Appeal Process**

If a Member wishes to file a formal **appeal**, the Member 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.

Requests to cover services and supplies which are specifically excluded in the Contract will not be treated as appeals and such requests will not be forwarded to the Claims Review Committee. 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 an extension:

a. Pre-service Claim – The Member has 180 days to appeal the Corporation's decision on a Pre-service Claim or a Concurrent Care decision. The Corporation must complete the appeal process within 15 calendar days after receiving the appeal. If the Member still does not agree with the Corporation's decision, the Member can file a second appeal within 90 days after receiving the Corporation's decision on the first appeal. The Corporation must complete the second appeal process within 15 calendar days after receiving the second appeal.

b. Urgent Care Claim – The Member has 180 days to appeal the Corporation's decision on an Urgent Care Claim. The Corporation must complete the appeal process within 72 hours after receiving the appeal.

c. Post-service Claim – The Member has 180 days to appeal the Corporation's decision on a Post-service Claim. The Corporation must complete the appeal process within 30 calendar days after receiving the appeal. If the Member still does not agree with the Corporation's decision, the Member can file a second appeal within 90 days after receiving the Corporation's decision on the first appeal. The Corporation must complete the second appeal process within 30 calendar days after receiving the second appeal.

In certain situations, after the Member has completed the appeal process above, the Member may be entitled to an additional review of their claim at the Corporation's expense. The Member may ask for an **external review** to reconsider the Member's claim if the Corporation has denied it, either in whole or in part. The claim must have been greater than $500 and denied, reduced, or a service terminated because: 1) it does not meet the Corporation's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness; or 2) it is Investigational or Experimental and it involves a life-threatening or seriously disabling condition.

After the Member's internal appeal is completed, the Member will be notified in writing of their right to request an external review. The Member should file a request for external review within 60 days of receiving that notice. The Member will 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 the Member needs assistance during the external review process, they 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
1-800-768-3467

Within five business days of the receipt of the Member's request for an external review, the Corporation will respond by either:

a. Assigning the Member's review to an independent review organization and forwarding the Member's records to them; or
b. Telling the Member in writing that their situation does not meet the requirements for an external review and the reasons for the Corporation's decision.

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

If the Member's Physician certifies that the Member has a serious medical condition, the Member is entitled to an **expedited external 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 the Member's health in serious jeopardy.

The Member can also request an expedited review if the Corporation's denial involves Emergency Medical Care, if the Member may be held financially responsible and they have not been discharged from the Facility.

9. A Member has only 180 days to question or appeal the Corporation's decision regarding a claim. After that date, the Corporation will consider disposition of the claim to be final. A lawsuit, however, may not be brought to recover on this Contract until 60 days after a claim (proof of loss) has been received and a Member has exhausted the appeal process as described above. No action may be brought after the expiration of any applicable period prescribed by law.

ARTICLE XIV - 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 Contract, the Application of the Employer, the Preferred Blue Provider agreements, and the attached endorsements, amendments and riders, if any, constitute the entire Contract between the parties.
   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 such 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 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. 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. **Governing Law**
This Contract and all benefit booklets issued hereunder will be construed according to and controlled by the applicable laws and regulations of the State of South Carolina. Any provision that is in conflict with the applicable laws and regulations of South Carolina are hereby amended to conform to the minimum requirements.

8. **Identification Cards and Benefit Booklets**
The Corporation will issue an ID card and an individual benefit booklet 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 Expenses, 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 benefit booklet summarizes the Benefits to which a Member is entitled. If any amendment to this Contract shall materially affect any Benefits described in such benefit booklet, new benefit booklets 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 such authorization for medical and Hospital records as it may reasonably require from any Provider of services incident to 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 as 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 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. The Corporation will pay Benefits as described in Article III of this Contract directly to a Provider if the Corporation has a written agreement with the Provider that provides for direct payment of Benefits.

14. **Physical Examination**
The Corporation, at its own expense, has the right to have a Member, for whom a claim is made, examined as often as reasonably required while a claim is pending.

15. **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.

16. **Right of Recovery**
Whenever payments have been made by the Corporation with respect to Allowable Charges in a total amount which is, at any time, in excess of the maximum amount of payment necessary at that time, the Corporation will have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Corporation will determine: any person to or for with respect to which such payments were made, as an offset against future Benefits payable under this Contract, and any other insurance companies or any other organizations.

17. **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 law and effective on a uniform basis among Group Health Plans with that product.

18. **Waiver of the Corporation's Rights**
On occasion, the Corporation may, at its option, choose not to enforce all of the terms and conditions of this Contract. Such a decision does not mean the Corporation waives or gives up any rights under this Contract in the future.

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

ARTICLE XV – SUBROGATION

If a Member receives medical Benefits under this Contract for an injury caused by the act or omissions of a liable third party and receives a settlement, judgment, or other payment relating to the injury from a liable third party, any other person, firm, corporation, organization or business entity, the Member agrees to reimburse the Corporation for Benefits the Corporation has paid relating to the injury. This agreement is a condition to receiving Benefits under this Contract. The Corporation's right to subrogation or reimbursement applies to any judgment and/or settlement proceeds, whether or not liability is admitted.

The Corporation's interest in subrogation or reimbursement extends to all Benefits relating to the Member's injury even if claims for those Benefits have not been submitted to the Corporation for payment at the time the Member receives the settlement, judgment or payment.

The Member has the right to petition the Director of Insurance, or his designee, to determine if the Corporation's subrogation action is inequitable or unjust. If the Director makes the determination that allowing subrogation is inequitable or unjust, then it is not allowed. This determination by the Director may be appealed to the Administrative Law Judge Division as provided by law.

The Corporation will pay attorney's fees and costs from the amount recovered.

If the Member chooses not to pursue an action to recover damages, the Member agrees to transfer all rights to recover damages in full for such Benefits to the Corporation. At its expense, the Corporation lawfully stands in the place of the Member to recover the amount of money it has paid for the Member's medical Benefits from any third party who is liable, responsible, or otherwise makes a payment for the Member's injury. The Corporation may seek recovery for its payment of claims from the liable third party, any liability or other insurance covering the liable third party or from the Member's own uninsured motorist insurance and/or underinsured motorist insurance.

In all situations involving subrogation, the Member shall not do anything to hinder or slow the Corporation's right to seek reimbursement. The Member shall cooperate with the Corporation, sign any documents, and do all things necessary to protect and secure the Corporation's subrogation right.

Each time a claim is filed with a diagnosis that could be related to an accident or injury, the Member may receive either a notice stating that the Corporation needs information to complete processing the claim along with a questionnaire regarding the claim. For the Member's files to be updated, they must return the questionnaire with the requested information.