South Carolina

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

Business Blue℠ Chamber

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

51+
PPO

Certificate of Coverage

Ord. # 13344M (Rev. 1/2019)

South Carolina

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www.SouthCarolinaBlues.com

Dear Member:

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

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

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

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

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

Sincerely,

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

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How Your Coverage Works

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

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

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

Our plan has free language interpretation services available. We can also give you information in languages other than English, in large print or other alternate formats.

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

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

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

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

Non-Discrimination
Health Status-Related Factors (except for tobacco use), race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency or quality of life will not affect your eligibility for this coverage.

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

How to Contact Us if You Have a Question

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

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

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

Membership or Eligibility Inquiries:

Call:	Monday through Friday, 8:30 a.m. to 5:30 p.m. EST 803-264-1010 (from the Columbia area) 800-868-2500, ext. 41010 (from all other areas)
TTY:	800-735-8583 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Friday, 8:30 a.m. to 5:30 p.m. Eastern Standard Time
Write:	Member Service Center Blue Cross and Blue Shield of South Carolina P.O. Box 100177 Columbia, SC 29260
Email:	Group.membership@bcbssc.com

BlueCross Website Address:	www.SouthCarolinaBlues.com, then log in to My Health Toolkit®

If you have any questions or complaints regarding claims, benefits, quality of care or service concerns, please contact the Member Service Center through Health Claim Inquiries. You may also send us a secure email through the Ask Customer Service feature of My Health Toolkit on our website.

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

Your Fastest Place for Answers – www.SouthCarolinaBlues.com
If you have access to the Internet, you can find quick and easy answers to your health coverage questions any time day or night. When you go to www.SouthCarolinaBlues.com, you'll find useful tools that can help you better understand your coverage.

Here are some of the things you can do on our website:
- Learn more about our products and services.
- Stay informed with all the latest BlueCross news, including press releases.
- Find links to other health-related websites.
- Locate a Network Physician, Hospital or Pharmacy. Go to: https://www.SouthCarolinaBlues.com/links/tools/findadoctorsc
- Use My Health Toolkit.

My Health Toolkit
From SouthCarolinaBlues.Com, click Members, to get to My Health Toolkit to:
- Check your eligibility.
- See how much has been applied toward your Deductible or Out-of-pocket Limit.
- Check on Authorizations.
- Find out if we've processed your claims.
- Order a new ID card.
- See if our records show if you have other health insurance.
- Ask a Customer Advocate a question through secure email.
- View your Explanation of Benefits (EOB).
- View your Contract documents

Preauthorization

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

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

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

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

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

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

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

For all preauthorization requirements for Prescription drugs, please see the Prescription Drug section of this Contract.

Type of service or treatment	Who to call for Preauthorization	Penalty if Preauthorization isn't obtained
• Hospital admission • Skilled Nursing Facility (SNF) admission • Inpatient Hospice Services	In Columbia 803-736-5990 In S.C. 800-327-3238 Outside S.C. 800-334-7287	Room and Board.
• Continuation of a Hospital stay (remaining in the Hospital or SNF for a period longer than we originally approved) for a medical condition		Room and Board for the continued stay period.
• Outpatient chemotherapy or radiation therapy • Outpatient hysterectomy or septoplasty • Home health care or hospice services • Durable Medical Equipment when purchase or rental is $500 or more		No Benefits.
Admissions for Rehabilitation and/or Human Organ and/or Tissue Transplants	In Columbia 803-736-5990 In S.C. 800-327-3238 Outside S.C. 800-334-7287	No benefits will be provided. Also requires use of a Provider we designate.
Treatment for hemophilia	In Columbia 803-736-5990 In S.C. 800-327-3238 Outside S.C. 800-334-7287	If care isn't coordinated through a Center for Disease Control and Prevention (CDC) designated Hemophilia Treatment Center at least once per Benefit Period, no benefits will be provided.
Outpatient/office MRI, MRA, PT scan and CT scan	National Imaging Associates (NIA) 866-500-7664	No benefits will be provided.
• Hospital admissions for Mental Health and Substance Use Disorders • Residential Treatment Center (RTC) Admissions for Mental Health and Substance Use Disorders	Companion Benefit Alternatives, Inc. (CBA) in Columbia 803-699-7308 Outside Columbia 800-868-1032	Room and Board
• Continuation of a Hospital stay or RTC admission (remaining in the Hospital or RTC for a period longer than we originally approved) for Mental Health and Substance Use Disorder		Room and Board for the continued stay period.
• Outpatient psychological testing and repetitive Transcranial Magnetic Stimulation (rTMS) • Outpatient facility: Intensive Outpatient partial hospitalization, electroconvulsive therapy		50% reduction of allowed amount if not preapproved.
• Genetic Counseling and Testing, including Prenatal Screening and Mutation Analysis	Avalon Health Services, LLC 844-227-5769	No benefits will be provided.

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

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

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

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

You have 30 days for most group health plans to add a newborn child to your coverage or to obtain other coverage for the child; see the *Eligibility, Coverage and When your Coverage Ends* section. However, until the newborn is covered under this policy, we cannot process benefits or approve a Preauthorization if the child needs a continued stay in the Hospital. We recommend that you add the newborn to this coverage (or other coverage, if you prefer) as soon as possible after birth to ensure benefits for that child are processed timely.

Emergency Hospital Admissions – If you experience an emergency illness or injury; seek medical assistance.

Since your admission will be unexpected, we allow time to be notified of the admission. Our medical services personnel must be notified within 24 hours or by 5 p.m. of the next working day or as soon as reasonably possible, if you're admitted to the Hospital. Otherwise, we won't provide benefits for the hospitalization. If Emergency Admission review isn't obtained within this timeframe due to circumstances beyond your control, an appeal can be made and the admission will be reviewed to determine if medically appropriate.

A Provider may be considered an Authorized Representative without a specific designation by you when the approval request is for Urgent Care Claims (medical conditions which require immediate treatment). A Provider may be an Authorized Representative with regard to non-Urgent Care Claims only when you give us or the Provider a specific designation to act as an Authorized Representative. If you have designated an Authorized Representative, all information and notifications will be directed to that representative unless you give contrary directions.

Your Rights and Responsibilities

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

You have the right to:

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

You have the responsibility to:

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

Summary of Benefits and Coverage

A Summary of Benefits and Coverage (SBC) summarize the benefit options of your insurance plan. All insurance companies are required to provide you with an SBC. You can request your SBC by going to your employer. You may also contact a Customer Advocate and ask us to send you a copy of the SBC. We can send it to you electronically or mail a paper copy (free of charge).

Eligibility and Coverage

Eligibility

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

- A full-time Employee working an average of 30 hours a week.
- Performing the normal duties of the job at one of the Employer's normal places of business or at a location to which the Employee must travel to perform the job; and
- Actively-at-work unless the absence is due to a Health Status-related Factor, such as: health status, medical condition (including both physical and mental illness), claims experience, receipt of health care, medical history, Genetic Information, evidence of insurability, and conditions arising out of the acts of domestic violence or disability.

This coverage is also available to your legal spouse and to your Dependent children through age 25. They must meet your Employer's eligibility requirements for Dependent coverage.

The types of coverage you may choose are:

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

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

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

Other than as expressly required by law, if this coverage is terminated for any reason, the Employer is solely responsible for notifying you of such termination and your coverage won't continue beyond the termination date.

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

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

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

Enrollment

You can enroll within 30 days of the date you first become eligible for coverage, but may be required to serve a Waiting Period of up to 90 days. New Dependents can enroll within 30 days of the date on which they first become eligible. Note: You can also enroll, if eligible, under the Special Enrollment terms of the Contract.

Special Enrollment
An Employee or Dependent(s) eligible for coverage but not yet enrolled must meet one of the requirements listed below:

1. Had coverage at the time enrollment was previously offered, but lost eligibility for coverage or employer contributions toward the coverage, and the Employee requests the enrollment no later than 30 days after the date coverage ended.
2. The Employee or Dependent gains or loses coverage under a Medicaid plan or under a State Children's Health Insurance Program (S-CHIP) and the Employee requests coverage under the Group Health Plan no more than 60 days after the date the Employee or Dependent is determined to be eligible or ineligible for such assistance.
3. You gain a Dependent or become a Dependent through marriage, birth, adoption, placement for adoption or foster care and request coverage under the Group Health Plans no more than 60 days after the date of the event.

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

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

- Your Effective Date for Special Enrollment for marriage is on the first day of the following month.
- Your Effective Date for Special Enrollment for birth, adoption, placement of adoption or foster care is on the date of the event.

Loss of Minimum Essential Coverage
If you or a Dependent loses Minimum Essential Coverage, the Effective Date of coverage is the first day of the next month after we receive notice of the Special Enrollment. If you're eligible under this plan, but aren't enrolled, you're also eligible for this Special Enrollment. In this situation, you must request coverage within 30 days of the qualifying event.

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

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

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

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

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

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

Certificate of Creditable Coverage
Upon request we will provide you or your Dependent a Certificate of Creditable Coverage at the time coverage stops or at the time the COBRA or state continuation coverage stops. Please write or call our Member Service Center at the address or phone number listed in the *How to Contact Us if You Have a Question* section.

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

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

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

Covered Services

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

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

The following are Covered Services:

Ambulance Service – Benefits are provided for professional ambulance services to the nearest Network Hospital in case of an accident or Emergency Medical Condition.

The following requirements apply to all ground and air ambulance transports:

1. The transport is medically necessary and reasonable;
2. A BlueCross member is transported;
3. The destination is local; and
4. The facility is appropriate.

Benefits for ground transport are also available for transporting the sick and injured (with prior approval for Medical Necessity) between Hospitals when such Hospital is the closest Network facility that can provide Covered Services appropriate to the Member's condition. Benefits are not available when you are transported from one facility to another when the transfer to the new facility is due to you receiving a lower level of care at the new facility. An out-of-Network Provider may Balance Bill you. Repatriation is not covered; see the Exclusions section.

If a member seeks Preauthorization to be transported as an Inpatient from one Hospital to a second Hospital using an air ambulance, the following requirements must be met:

- The first hospital does not have needed hospital or skilled nursing care for the beneficiary's illness or injury (such as burn care, cardiac care, trauma care, and critical care);
- The second hospital is the nearest appropriate facility;
- A ground ambulance transport endangers the beneficiary's health; and
- The transport is not related to a foreign hospitalization.

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

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

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

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

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

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

Clinical Trials – The Corporation will pay for routine Member costs for items and services related to clinical trials when:

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

An Approved Clinical Trial is one that is approved or funded through the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHRQ), the Centers for Medicare & Medicaid Services (CMS), the Department of Defense (DOD), the Department of Veterans Affairs (VA), a qualified non-governmental research entity identified in the guidelines issued by the NIH or is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA).

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

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

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

Durable Medical Equipment (DME) – Benefits are provided toward the purchase price or total rental cost up to the purchase price of DME when it's for therapeutic use outside of a Hospital for the treatment of your condition. If the equipment isn't available for rent, we may approve monthly payments toward the purchase of the equipment. We provide benefits for standard DME only. Benefits don't include: manual or motorized wheelchairs or power operated scooters, unless Medically Necessary for mobility in the patient's home; or bioelectric, microprocessor or computer-programed DME. In addition, supplies used with the DME must be Preauthorized every 90 days. If Preauthorization is not obtained, no benefits will be provided.

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

Emergency Services – If you experience an emergency illness or injury, seek immediate medical attention. Benefits are provided for services and supplies for stabilization and/or initial treatment of an Emergency Medical Condition provided on an outpatient basis at a hospital or Emergency room. Coverage is considered to be for treatment of an Emergency Medical Condition only as long as your condition continues to be considered an Emergency. If you receive care for an Emergency Medical Condition and are treated in the Emergency room at a Hospital, the charges for Emergency services are paid as follows:

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

2. **Emergency services at an Out-of-Network Provider**
   The nearest medical help may be an Out-of-Network Provider. Benefits will be provided for Emergency services at the in-Network rate; however, because the Provider is Out-of-Network, you may have additional cost-sharing or other requirements. This section explains how you receive Emergency medical care from an Out-of-Network Provider and what additional cost-sharing or other requirements you may expect.
   Please note: At any in-Network Hospital or facility, you may be treated by and Out-of-Network Provider. Out-of-Network Providers may Balance Bill you, even when you are treated for an Emergency Medical Condition.

   Out-of-Network Emergency room – We will provide benefits for Emergency medical care in an Emergency room at an Out-of-Network Hospital or Provider. Benefits for Covered Services are subject to any in-Network Copayment, Deductible and Coinsurance as shown in the Schedule of Benefits. As long as you are considered to have an Emergency Medical Condition, we will provide benefits at the in-Network rate and the Allowed Amount will be based on the fee schedule for In-Network Providers. Because the provider is Out-of-Network, you will be reimbursed at the in-Network rate and will need to forward this payment to the Provider. The provider may balance-bill you for the difference between our Allowed Amount and the rate they charge.

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

Home Health Care Services – Benefits are provided to an essentially homebound Member in a personal residence. Home health care must be provided by, or through a community home health agency on a part-time visiting basis and according to a Physician-prescribed course of treatment. We must Preauthorize the care based on an established home health care treatment before you're eligible for benefits. Please refer to your Schedule of Benefits to see what benefit limitations apply. Home health care includes:

1. Services by a registered nurse (RN) or licensed practical nurse (LPN);
2. Physical, speech and occupational therapy (Benefit Period Maximum applies)
3. Services provided by a home health aide or medical social worker;
4. Nutritional guidance;
5. Diagnostic services;
6. Administration of Prescription Drugs;
7. Medical and surgical supplies;
8. Oxygen and its use; and
9. Durable Medical Equipment (A separate Preauthorization isn't needed when we approve the entire home health care plan).

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

1. Services provided by a registered nurse (RN) or licensed practical nurse (LPN);
2. Physical, speech and occupational therapy (Benefit Period Maximum applies)
3. Services provided by a home health aide or medical social worker;
4. Nutritional guidance;
5. Diagnostic services;
6. Administration of Prescription Drugs;
7. Medical and surgical supplies;
8. Oxygen and its use;
9. Durable Medical Equipment (A separate Preauthorization isn't needed when we approved the entire hospice service plan);
10. Respite care; and
11. Family counseling concerning the patient's terminal condition.

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

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

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

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

Immunizations – Benefits will be provided as recommended by the Center for Disease Control (CDC). The recommendations may include age and/or frequency restrictions. The CDC is an independent organization that offers health information on behalf of Blue Cross and Blue Shield of South Carolina.

Laboratory Services – Benefits will be provided for procedures to identify the nature and/or extent of a condition or disease. We'll reduce benefits for Inpatient diagnostic services to the level of benefits for Outpatient services when services could have been safely done on an Outpatient basis. Diagnostic services include, but aren't limited to:

1. Radiology, ultrasound and nuclear medicine;
2. Laboratory and pathology;
3. ECG, EEG and other electronic diagnostic medical procedures and physiological medical testing;
4. Surgical pathology — pathological examination of tissue removed surgically, by resection or biopsy. This doesn't include smear techniques;
5. High technology diagnostic services such as, but not limited to, MRIs, MRAs, PET scans and CT scans; and
6. Gastrointestinal endoscopies.

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

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

Maternity Care – Benefits will be provided to an employee or spouse for pre- and postnatal care, including the hospitalization and related professional services for at least 48 hours after a vaginal delivery (96 hours following a Cesarean section) or the date of discharge from the Hospital — whichever occurs first. The day of delivery or Surgery is not counted in the 48 hours after vaginal delivery (96 hours following a Cesarean section). Maternity care does not include: surrogate parenting; artificial insemination and in-vitro fertilization. Coverage is available under this Policy for a Newborn; please see sections on Eligibility for how to add your child and Covered Services: Newborn Child Coverage for the services and benefits available.

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

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

See the Preauthorization Section to see which services that require Preauthorization. No benefits for those services are provided when Preauthorization is not obtained.

Newborn Child Coverage – Benefits for a newborn child will be available only if the child is added to this coverage as described in the *Eligibility and Coverage* section. If the child is added to this coverage, benefits will be provided for the hospitalization and related professional services for at least 48 hours after a vaginal delivery (96 hours following a Cesarean section) or the date of discharge from the Hospital — whichever occurs first. The date of birth is not counted in the 48 hours after vaginal delivery (96 hours following a Cesarean section). Benefits will also be provided for the first medical exam of a newborn done by a Physician who didn't deliver the baby or serve as the assistant to the Physician who delivered the baby or as the anesthesiologist.

Non-Emergency care when traveling outside the United States – We will provide out-of-country benefits based on the in-Network Provider allowance or the total charge, whichever is less. Out-of-country benefits consist of all Covered Services provided or supplies received outside the United States. However, services must be provided by a Network Provider. Please note that these Network Providers may bill you the difference between the allowance and the total charge. To find a Provider, go to https://www.bluecardworldwide.com.

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

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

The USPSTF and HRSA are independent organizations that provide health information on behalf of Blue Cross and Blue Shield of South Carolina. Benefits will be provided for pediatric vision services as shown in the *Pediatric Vision* section and the Schedule of Benefits.

These services are provided in-Network only.

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

1. Office/Outpatient Medical Services – Medical care and consultation by a Physician to a Member in an Outpatient setting for the examination, diagnosis or treatment of an injury or illness.
2. Inpatient Services – Medical care and consultation provided by a Physician in an Inpatient setting for the examination, diagnosis or treatment of an injury or illness.
   a. Inpatient and Intensive Medical Care Visits – Visits are limited to one per day. Inpatient medical services also include diagnostic services and therapy services done concurrently with medical care.
   b. Consultation – If a consultation with another Physician is ordered by a patient's attending Physician, benefits are provided for one consultation per consulting Physician.

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

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

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

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

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

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

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

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

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

   c. Surgical Assistant –Services of one Physician who actively assists the operating Physician when an eligible Surgery is performed in a Hospital, and when such surgical assistant service isn't available by an intern, resident or house Physician. We'll provide a predetermined percent not more than 20 percent of the Allowable Charges, not to exceed the Physician's actual charge.

   d. Anesthesia – Services provided by a Physician or a certified registered nurse anesthetist, other than the attending surgeon or his assistant.

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

5. Dialysis Treatment – The treatment of acute renal failure or chronic irreversible renal insufficiency to include hemodialysis or retinol dialysis. Dialysis treatment includes home dialysis.

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

Prescription Drugs – Benefits will be provided for Prescription Drugs. More detailed information is noted in the *Prescription Drug Coverage* section. Prescription Drugs and pharmaceuticals that are provided under the Prescription Drug benefit are not provided as a medical benefit.

Preventive Screenings – Benefits will be provided as follows:

- The United States Preventive Services Task Force (USPSTF) recommended Grade A or B screenings.
- Screenings recommended for children and women by Health Resources and Services and Administration.
- Preventive prostate screenings and lab work according to the American Cancer Society (ACS) guidelines.
- Pediatric oral and vision care as recommended by the United States Preventive Services Task Force (USPSTF) Grade A or B screenings and Health Resources and Services Administration (HRSA).

Preventive care (except Preventive Pap Smear) must meet the age and/or condition guidelines/recommendations of the USPSTF, CDC, HRSA or ACS to be covered at no cost to the Member. The ACS is an independent organization that offers health information on behalf of Blue Cross and Blue Shield of South Carolina.

Prosthetics – Benefits are provided for a prosthetic, other than a dental or cranial prosthetic, which meets minimum specifications for the body part it is replacing regardless of the functional activity level. The item must be a standard, non-luxury item as determined by us. Specialty items such as bionics or microprocessor components aren't covered. Benefits are provided only for the initial temporary and permanent prosthesis. No benefits are provided for repair, replacement or duplicates, nor for services related to the repair or replacement of such prosthetics, except when necessary due to a change in the Member's medical condition, and with prior authorization from us. Repair or replacement for routine wear and tear isn't a Covered Service.

Rehabilitation Services – Include:

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

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

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

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

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

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

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

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

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

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

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

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

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

Telemedicine – Benefits will be provided for Telemedicine services as specified herein; consultation, diagnosis and treatment where the services would otherwise be covered if you were "in person."

Office and outpatient visits that are conducted via Telemedicine are counted towards any applicable Benefit limits for these services.

Consulting and Referring Providers must be Participating/Contracting Providers who have been credentialed as eligible Telemedicine Providers.

Telemedicine services will be covered by the Employer's Group Health Plan when they are Covered Services under the terms of this Plan of Benefits and under the following circumstances:

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

Examples of interactions that are not reimbursable Telemedicine services and will not be reimbursed are:

1. Telephone conversations;
2. E-mail messages;
3. Facsimile transmissions; or
4. Internet-based audio-video communication that is not secure and HIPAA-compliant (e.g., Skype).

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

Organ transplant coverage includes all expenses for medical and surgical services a Member receives for human organ and/or tissue transplants while the Member is covered under this Certificate. This includes donor organ procurement. Organ transplants don't include transplants involving mechanical or animal organs.

1. The only living donor transplants covered under this Certificate are kidney transplants for Members with dialysis-dependent kidney failure and liver transplants. All other living donor transplants aren't covered. Benefits will be subject to the following conditions:
   a. When both the transplant recipient and the donor are Members, benefits will be provided for both.
   b. When the transplant recipient is a Member and the donor isn't, benefits will be provided for the recipient only.
   c. When the transplant recipient isn't a Member and the donor is, no benefits will be provided to either the donor or the recipient.
2. Benefits are provided for the specified transplants listed below. These benefits are subject to all other provisions of the Contract.
   a. Single/double kidney
   b. Pancreas and kidney
   c. Heart
   d. Single/double lung
   e. Liver
   f. Pancreas
   g. Heart and single/double lung
   h. Bone marrow transplants

3. Benefits may be available when a malignancy is present for high-dose chemotherapy followed by hematopoietic stem support, either autologous (the patient is the donor) bone marrow transplant, peripheral stem cell or allogeneic bone marrow transplant.

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

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

The following transplants are not Covered Services:

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

Additional Covered Services

The following benefit is available to you however; this additional Covered Service is not an Essential Health Benefit and does not apply to your Deductible or Maximum Out-of-pocket.

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

Prescription Drug Coverage

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

Blue Cross Blue Shield of South Carolina works with a team of health care providers to choose drugs that provide quality treatment. We cover drugs on the plans Drug List (formulary), as long as:

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

The plans Drug List gives information about Prescription Drugs covered under the Business Blue Chamber plans which has five coverage levels, called Tiers. Benefits are limited to a 31-day supply at a retail pharmacy or a 90-day supply by mail. Caremark is an independent company that offers a pharmacy network on behalf of Blue Cross and Blue Shield of South Carolina.

How your Drug Benefits are paid
To receive benefits for Prescription Drugs, you must fill them through our Network Pharmacies. A Network Pharmacy has contracted with our pharmacy benefit manager to provide Prescription Drugs. When you fill a prescription at a Network Pharmacy, you must show the pharmacist your BlueCross ID card.

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

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

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

Until your Maximum Out-of-pocket is met, you will pay one or more of the following for each Prescription Drug, depending upon your plan type: Copayment, Deductible and/or Coinsurance. Once you have met your Maximum Out-of-pocket, you will no longer have to pay Maximum Out-of-pocket for covered benefits until a new Benefit Period begins. Please refer to your Schedule of Benefits for specific plan costs for each Tier referenced below.

- **Tier 1:** These drugs are most often generic and will generally cost you the least amount of money out of your pocket. Generic drugs have the same active ingredient(s) as brand-name drugs, may have different inactive ingredients and are not manufactured under a registered brand name or trademark.
- **Tier 2:** Tier 2 drugs are most often brand-name drugs and are sometimes referred to as "preferred" drugs because they usually cost you less than brand-name drugs in higher tier levels.
- **Tier 3:** Drugs on this tier are most often brand-name drugs that may have generic equivalents. They are sometimes referred to as non-preferred because there is usually a lower cost alternative available.
- **Tier 4:** These are typically drugs that are used in the management of chronic or genetic disease, including but not limited to injectable, infused or oral medications; or, products that otherwise require special handling, refrigeration and special training. You will usually pay more for drugs in this tier than drugs in lower tiers.

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

Specialty Pharmacy
Drugs that are designated to be specialty medications must be filled at our Specialty Pharmacy. Although most Specialty drugs are found in Tier 4, they could also be categorized in any of the Tiers above. The list of drugs that must be filled with the Specialty Pharmacy is included as part of the Plans Covered Drug List. This Specialty Pharmacy has also agreed to accept our allowance as payment in full for Covered Services except for any Deductibles, Copayments or Coinsurance you owe. Specialty medications are limited to a 31-day supply. The Specialty Pharmacy can overnight to your home, provider's office or your local CVS/Caremark pharmacy. Caremark is an independent company that offers specialty pharmacy services on behalf of Blue Cross and Blue Shield of South Carolina.

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

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

- **Prior Authorization (PA):** If your drug needs prior authorization, your doctor will have to get approval before we will cover your drug. There are different reasons a drug might require prior authorization. One is to make sure it's being used for the condition(s) it was approved for by the United States Food and Drug Administration (FDA). Another is because there are covered drugs that usually work just as well, but cost less.
- **Quantity Limits (QL):** If your drug has a quantity limit, we will only cover a certain amount of the drug in a specified period of time; unless your Provider requests a quantity in excess of this amount and gives evidence supporting this request which is approved by our Pharmacy Benefit Manager. This is to make sure you are using the drug safely and based on the FDA guidelines.
- **Step Therapy (ST):** If your drug has a step therapy requirement, we will only cover second choice drugs if you have already tried a first choice drug and it didn't work for you. The reason for a particular step therapy requirement may be because there are covered drugs that usually work just as well, but will cost you less. It may also be because some drugs are approved by the FDA specifically as second-choice drugs or as add-ons to other medication.
- **Formulary Exception Request:** If a drug is not covered, it may be helpful to discuss with your Physician covered alternatives he or she may prescribe; or, if not medically viable, you may request a formulary exception. An exception request may be made by the Member or prescribing Provider by contacting our Pharmacy Benefit Manager (PBM), reach Prior Authorization line at 855-582-2022 to acquire an exception request form. After completing the necessary information, the form can be faxed to 855-245-2134. Caremark will work with the prescribing physician to obtain any medical records or other necessary information to process the request.

If your formulary exception request is denied, you may request a free copy of the criteria or guidelines used in making the decision and any other information related to the determination by calling the toll-free Customer Care number on your benefit ID card. You may also choose to receive the medication at your own expense.

Type of service or treatment	Who to call for Preauthorization	Penalty if Preauthorization is not obtained
Certain Prescription Drugs	Log into My Health Toolkit on our website for details	No benefits will be provided.
Specialty Drugs	Log into My Health Toolkit on our website for details	No benefits will be provided. Also requires use of a Provider we designate.

If your Provider requests an additional review of these processes, that review will not be considered an appeal unless you expressly designate the Provider as an Authorized Representative.

How to file a Prescription Drug Claim

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

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

Appeals of Pharmacy Claims

You may also appeal this decision. If you choose to submit an appeal for coverage, it can be requested in writing or by telephone; but, must be received within 180 days of the date of your denial letter. You or your authorized representative (who may be your doctor) may submit an appeal and should include documentation that will support your appeal. That documentation should include any information that you or your doctor believe supports your claim. This information could include a letter from your doctor describing why the requested medication is necessary, clinical notes, test results or any other supporting documentation. Please mail or fax your appeal and/or supporting documentation to our PBM at:

CVS/Caremark
PA Exchanges Department
1300 East Campbell Road
Richardson, TX 75081
Fax: 1-855-245-8333
Phone: 1-855-582-2022

CVS/Caremark is an independent company that offers pharmacy benefits management services on behalf of Blue Cross and Blue Shield of South Carolina. If our PBM does not get all the information it needs to make a decision about your appeal, it will send you a letter to tell you what information it needs and how you can get that information to it. The PBM will review your standard appeal request within 30 days after receiving it. You will get a letter that explains its decision.

If you or your doctor believe your situation is urgent as defined by law (that is, your health is in serious jeopardy or, in the opinion of your doctor, you will experience pain that cannot be adequately controlled while you wait for a decision on your appeal), you or your authorized representative (who may be your doctor) may request an expedited appeal by calling the PBM toll-free at 1-855-582-2022 or by faxing your appeal to 1-855-245-8333.

A determination on an expedited appeal will be made and you will be notified within 72 hours from receipt of the appeal and the supporting information necessary to review the appeal. You will receive a letter explaining its decision.

If your appeal is denied, you may have the right to ask for another review of this decision by someone outside of CVS/Caremark, also known as an External Review. You also may contact the Department of Insurance with questions by writing or calling:

Consumer Services Division
South Carolina Department of Insurance
Post Office Box 100105
Columbia, South Carolina 29202-3105
1-803-737-6180
1-800-768-3467

External Review

If you are eligible for an external review, an Independent Review Organization (IRO) will review the denial of your appeal. The South Carolina Department of Insurance approves all IROs. You cannot ask for an external review if your Health Carrier does not cover the service.

Eligibility

You can have an external review only if you meet the following items:

1. The service or payment for service was denied, reduced or terminated because:
   a. The service does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness; or
   b. The service was experimental or investigational and involves a life-threatening or seriously disabling condition, and
2. You have completed your health carrier's internal appeals process.
   a. You do not have to complete the internal appeals process if:
      i. Your treating physician has certified in writing that you have a serious medical condition;
      ii. The service is experimental or investigational and your treating physician has provided the required certifications;
      iii. The health carrier has not issued a written decision within the time frames set forth in the health carrier's internal appeals process. It must have received all the information from you that it needs to complete the appeal. You or your authorized representative must not have agreed to a delay; or
      iv. The health carrier agrees to waive the internal appeals process.
3. You always have to complete the internal appeals process if you have already received the service.

What's Not Covered?

We will not provide benefits for the following Prescription Drugs:

- That are used for or related to Non-Covered Services or conditions, such as, but not limited to, weight control, obesity, erectile dysfunction, cosmetic purposes (such as Tretinoin or Retin-A), hair growth and hair removal.
- That are used for infertility.
- More than the number of days' supply allowed as shown in your Schedule of Benefits.
- Refills in excess of the number specified on your Physician's prescription order.
- More than the recommended daily dosage defined by BlueCross, unless prior authorization is sought and approved.
- When administered or dispensed in a Physician's office, Skilled Nursing Facility, Residential Treatment Center, Hospital or any other place that is not licensed to dispense drugs.
- When there is an Over-the-counter Drug equivalent including any over-the-counter supplies, devices or supplements.
- When not consistent with the diagnosis and treatment of an illness, injury or condition or that is excessive in terms of the scope, duration or intensity of drug therapy that is needed to provide safe, adequate and appropriate care.
- When not provided in the appropriate place of service; i.e., some medications are classified as self-administered drugs; when obtained and administered at a doctor's office or in an outpatient setting, these medications are not covered.
- When you don't receive Prior Authorization.
- That requires step therapy when a Step Therapy Program is not followed.
- That are not on the plans Drug List.
- The cost of medications or drugs which are covered by a discount card or coupon.
- Prescription Drugs which are new to the market and which are under clinical review by the Corporation shall be listed on the Prescription Drug List as excluded until the clinical review has been completed and a final determination has been made as to whether the Drug should be included.
- Prescription Drugs and pharmaceuticals under the medical portion of this Policy when benefits are available under the Prescription Drug benefit.

We contract with a pharmacy benefit manager to manage the pharmacy Network, and/or Specialty Drug Network Providers, and to perform other administrative services, including negotiating prices with the pharmacies in this Network. We receive financial credits directly from drug manufacturers and through our pharmacy benefit manager. These credits are used to help stabilize overall rates and to offset costs. Reimbursements to pharmacies and Specialty Drug Network Providers or discounted prices charged by pharmacies and Specialty Drug Network Providers are not affected by these credits.

Any cost-sharing that you must pay for Prescription Drugs is based on the Allowed Amount at the pharmacy or Specialty Drug Network Provider. Copayments are flat amounts and likewise don't change due to receipt of drug manufacturer credits.

Excluded Services

EXCEPT AS SPECIFICALLY PROVIDED IN THIS POLICY, EVEN IF MEDICALLY NECESSARY, NO BENEFITS WILL BE PROVIDED FOR THE SERVICES AND PRODUCTS LISTED IN THIS "EXCLUDED SERVICES" SECTION EXCEPT: (1) SERVICES RENDERED BY A PROVIDER AS PART OF A VALUE-BASED PROGRAM OR (2) IF REQUIRED BY LAW:

We won't provide benefits for:

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

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

  Relating to other conditions or services:

- Dorsal Rhizotomy (cutting the back of spinal nerve roots) in the treatment of spasticity (increased tone or tension in a muscle such as a leg);

- Services and supplies related to transplants involving mechanical or animal organs, human organ and/or tissue transplant procedures when you don't get the required prior Preauthorization, it's not done at a Provider we designate, or unless specifically listed in Covered Services.
- Services and supplies related to cosmetic Surgery, as determined by us. This means any plastic or reconstructive Surgery done mainly to improve the appearance of any body part, and from which no improvement in physiologic function is reasonably expected, unless performed either to correct functional disorder or as a result of an injury. Cosmetic Surgery excluded includes, but isn't limited to:
  - Surgery for sagging or extra skin;
  - Any augmentation, reduction, reshaping or injection procedures;
  - Rhinoplasty, abdominoplasty, liposuction and other associated Surgery; and
  - Any procedures using an implant that doesn't alter physiologic function or isn't incidental to a surgical procedure.

  Any services a Member receives due to complications of cosmetic Surgery also aren't covered.
- Reduction mammoplasty for macromastia unless the Member is within 20 percent of the ideal body weight.
- Any treatment or Surgery for obesity (even if morbid obesity is present), weight reduction, weight control such as gastric bypass, insertion of stomach (gastric) banding, intestinal bypass, wiring mouth shut, liposuction or complications from it. This includes any reversal or reconstructive procedures from such treatments.
- Eyeglasses, contact lenses (except after cataract Surgery), and exams for the prescription or fitting of them except as shown in the Pediatric Vision section and the Additional Covered Services section. Any Hospital or Physician charges related to refractive care such as radial keratotomy (Surgery to correct nearsightedness), or keratomileusis (laser eye Surgery or LASIK), lamellar keratoplasty (corneal grafting) or any such procedures that are designed to alter the refractive properties of the cornea.
- Home health care and hospice services, except as provided in *Covered Services* and with a Preauthorization.
- Any medical social services, visual therapy or Private Duty Nursing services, except when part of a preauthorized home health care plan or hospice services program.
- Recreational, educational or play therapy; biofeedback; psychological or educational diagnostic testing to determine job or occupational placement or for other educational purposes, or to determine if a learning disorder exists; therapy for learning disorders, development speech delay, communication disorder, developmental coordination disorder, intellectually disabled, dissociative disorder, sexual and gender identity disorder, personality disorder and vocational rehabilitation unless specifically included in your Schedule of Benefits.
- Charges for premarital and pre-employment exams.
- Services or supplies related to an abortion, except:
  - To an abortion performed when the life of the mother is endangered by a physical disorder, physical illness or physical injury, including a life-endangering physical condition caused or arising from the pregnancy; or
  - When the pregnancy is the result of rape or incest.
- Marriage counseling.
- Services or care used to detect and correct, by manual or mechanical means, structural imbalance, distortion or subluxation in your body for the purpose of removing nerve interference and its effects when this interference is the result of or related to distortion, misalignment or subluxation of, or in, the spinal column, except when the optional Endorsement is purchased.

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

- Telemedicine services which do not comply all of the requirements specified in the Covered Services section of this Policy.
- Services or supplies related to dysfunctional conditions of the chewing muscles, wrong position or deformities of the jaw bone(s), orthognathic deformities or temporomandibular joint syndrome (headache, facial pain and jaw tenderness caused by jaw problems and usually known as TMJ).
- Physician services directly related to the care, filling, removal or replacement of teeth; the removal of impacted teeth; and the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth. This includes, but isn't limited to: apicoectomy (dental root resection), root canal treatment, alveolectomy (Surgery for fitting dentures) and treatment of gum disease. Exception is made for dental care to Sound Natural Teeth for up to six months after an accident; and for cleft lip and palate services.
- Devices of any type, even with a prescription (other than contraceptive devices), such as but not limited to: therapeutic devices, artificial appliances or similar devices.
- Luxury or convenience items whether or not a Physician recommends or prescribes them.
- Any and all travel expenses (including those related to a transplant) such as, but not limited to: transportation, lodging and repatriation unless specifically included in Covered Services.
- Ambulance services
  1. That does not meet coverage guidelines outlined in the Ambulance Services description in Covered Services.
  2. In which some other means of transportation could be used without endangering the member's health.
  3. To a more distant Hospital solely to allow the member to use the services of a specific physician or physician specialist. BlueCross will pay the base rate and mileage for a medically necessary ambulance transport to the nearest appropriate facility. If the transport is to a facility that is not the nearest appropriate facility, the member is responsible for additional mileage to the preferred facility.
  4. If the member is stable and the situation does not involve an Emergency.
  5. Transports from Hospital in connection with a covered foreign hospitalization.
- Durable Medical Equipment when you don't get the required Preauthorization.
- Equipment available over the counter such as, but not limited to: air conditioners, whirlpool baths, spas, (de)humidifiers, wigs, fitness supplies, vacuum cleaners or air filters and common first aid supplies.
- Benefits will be denied for procedures, services or pharmaceuticals when you don't get the required Preauthorization.
- Prescription Drugs and pharmaceuticals under the medical portion of this coverage when benefits are available under the Prescription Drug benefit.
- Prescription Drugs not on the plans Drug list.
- Separate charges for services or supplies from an employee of a Hospital, laboratory or other institution; or an independent health care professional whose services are normally included in facility charges.
- Any type of fee or charge, for handling medical records, filing a claim or missing a scheduled appointment.
- Any services or supplies a member of your family provides, including the dispensing of drugs. A member of your family means spouse, parents, grandparents, brothers, sisters, aunts, uncles, children or in-laws.
- Any service or treatment for complications resulting from any non-covered procedure or condition.
- Schools, camps and/or boarding homes including: therapeutic schools; wilderness/boot camps; therapeutic boarding homes; half-way houses; and therapeutic group homes.

Providers

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

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

Your Network Provider has agreed to:
- Bill you no more than the Network allowance for Covered Services.
- File all claims for you when this certificate is your primary insurance.
- Ask you to pay only the required Deductibles, Copayments and Coinsurance for covered amounts.

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

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

Out-of-Network Providers
Not all Physicians, Hospitals and other health care Providers have contracted with us to be Network Providers. Although this plan gives you the freedom to use any Provider, the Benefit Percentage we pay will be lower. This means you pay more money out of your own pocket. These Providers may:
- Require you to pay the full amount of their charges at the time you receive services.
- Require you to file your own claims.
- Require you to get all necessary approvals. Information regarding how and when to get an approval is in the *Preauthorization* section of this Certificate.
- Charge you more than the BlueCross-Allowed Amount.

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

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

Out-of-area Services

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

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

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

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

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

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

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

2. **Special Cases: Value-Based Programs**

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

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

4. **Nonparticipating Providers Outside Our Service Area**

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

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

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

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

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

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

Continuation of Care

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

If you're receiving treatment for a Serious Medical Condition at the time a Network Provider's contract ends, you may be eligible to continue to receive treatment from that Provider. In order to receive this continuation of care for a Serious Medical Condition, you must submit a request to us on the appropriate form. A Serious Medical Condition is a health condition or illness that requires medical attention, and for which failure to provide the current course of treatment through the current Provider would place your health in serious jeopardy. This includes cancer, acute myocardial infarction and pregnancy.

You may get the form for this request by going to our website or calling 803-264-3475 in Columbia or 800-868-2500, ext. 43475 outside the Columbia area. You'll also need to have the treating Provider include a statement on the form confirming that you have a Serious Medical Condition. Upon receipt of your request, we'll notify you and the Provider of the last date the Provider is part of our network and a summary of continuation of care requirements. We'll review your request to determine if you qualify for the continuation of care. If additional information is necessary to make a determination, we may contact you or the Provider for such information.

If we approve your request, we'll provide in-Network benefits for that Provider for 90 days or until the end of the Benefit Period, whichever is greater. During this time, the Provider will accept the network allowance as payment in full. Continuation of care is subject to all other terms and conditions of this Contract, including regular benefit limits.

How to File a Claim

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

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

If you receive health care services or supplies from an out-of-Network Provider, you'll have to file your own claims. Please follow the instructions below when you have claims for expenses other than Prescription Drugs. When filing your own claims, here are some things you'll need:

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

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

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

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

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

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

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

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

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

2. Urgent Care Claim – We must provide you a determination, based on Medical Necessity, in writing or in electronic form within 72 hours of the original Urgent Care Claim. An **Urgent Care Claim** is any claim, where, if the normal Preauthorization review time frames were used, your life, health or ability to regain maximum function could be seriously jeopardized; or you would be subject to severe pain that can't be adequately managed without the care or treatment. We'll defer to the attending Provider with respect to the decision as to whether a claim constitutes "urgent care." A Provider may be considered an authorized representative without a specific designation by you when the approval request is for Urgent Care Claims (medical conditions which require immediate treatment).

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

3. Post-service Claim – We must give you our decision in writing or in electronic form within 30 calendar days if the decision is adverse to you. A **Post-service Claim** is any claim that you submit after you receive the medical care, service or supply. An adverse decision includes any rescission of coverage or any amount due that you may be held responsible for other than Copayment amounts previously paid to the Provider.

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

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

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

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

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

Denial of Claims

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

If you don't understand why we denied your claim, you can:

- Read the information in this Certificate. It outlines the terms and conditions of your health coverage.
- Contact the Member Service Center for help.
- Ask your Employer to let you read the Contract it holds with BlueCross. The Contract is a legal document that provides a complete description of your health coverage.

Right of Recovery

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

Time Limit to Question a Claim or File a Lawsuit

You have only 180 days to question or appeal our decision regarding a claim. After that date, we'll consider disposition of the claim to be final. You can't bring any legal action against us until 60 days after we receive a claim (proof of loss) and you have exhausted the appeal process as described in the *Appeal Procedures* section of this Certificate. You can't bring any action against us after the expiration of any applicable period prescribed by law.

Appeal Procedures

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

If you wish to file a formal **appeal**, you must write to Blue Cross and Blue Shield of South Carolina, Member Service Center, P.O. Box 100300, Columbia, SC 29202. The letter must state that a formal appeal has been requested and all pertinent information regarding the claim in question must also be included in the letter. Request to cover services and supplies which are specifically excluded in the Contract will be treated as appeals; however, such requests aren't eligible for external review.

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

1. Pre-service Claim – You have 180 days to appeal our decision on a Pre-service Claim or a Concurrent Care decision. We must complete the appeal process within 15 calendar days after receiving the appeal. If you still don't agree with our decision, you can file a second appeal within 90 days after you receive our decision on the first appeal. We must complete the second appeal process within 15 calendar days after we receive your second appeal.
2. Urgent Care Claim – You have 180 days to appeal our decision on an Urgent Care Claim. You may request an expedited review process for an Urgent Care Claim either orally or in writing, and all necessary information pertaining to the appeal will be transmitted by telephone, facsimile or other expeditious method. We must complete the appeal process within 72 hours after we receive your appeal.
3. Post-service Claim – You have 180 days to appeal our decision on a Post-service Claim. We must complete the appeal process within 30 calendar days after receiving the appeal. If you still don't agree with our decision, you can file a second appeal within 90 days after you receive our decision on the first appeal. We must complete the second appeal process within 30 calendar days after we receive your second appeal.

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

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

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

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

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

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

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

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

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

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

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

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

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

Coordination of Benefits (COB)

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

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

How We Pay Claims When We Are Secondary
We'll be secondary whenever the rules don't require us to be primary.

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

If your other health coverage is responsible for making payments first, BlueCross can't pay until we know how much the other Plan has paid and the amount of your remaining liability.

Whether BlueCross is primary or secondary, we may need information about your other insurance. You may receive a notice stating a claim has been denied or that we need information to complete processing the claim. For us to update your files, return the notice with the requested information as quickly as possible. If you need more information, please contact a Customer Advocate.

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

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

Effects on Benefits

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

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

3. The rules for Coordination of Benefits follow. If a rule applies to your situation, then you don't need to consider any rules that follow it. For example, if the first rule applies, you don't need to consider the second rule.
   a. If a Plan doesn't have a Coordination of Benefits provision, then that Plan is presumed to be primary.
   b. The Plan of the Employee is primary over one that covers the Employee as a dependent or inactive Employee.

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

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

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

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

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

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

g. In the case of divorce or legal separation, we look first to any court order. If a court order requires one of the parents to be financially responsible for the health care of the child, and the Plan for that parent has actual knowledge of the court order, that Plan becomes primary. If a court says that the parents will share joint custody, without stating that one of the parents is financially responsible for the health care of the child, we follow the rules above as if the parents aren't separated or divorced.

   When no court order exists, we determine the primary Plan for a Dependent child as follows:
   1. The Plan of the custodial parent;
   2. The Plan of the spouse of the custodial parent;
   3. The Plan of the non-custodial parent.
   4. The Plan of the spouse of the non-custodial parent.

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

Facility of Payment

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

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

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

Subrogation

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

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

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

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

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

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

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

Continuation of Coverage

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

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

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

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

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

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

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

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

Reason for Loss of Coverage	Eligible Persons	Number of Months of Extended Coverage
1. Employee's working hours reduced from full-time to part-time (for any reason).	Employee Dependents	18 months
2. Employee quits work, is laid off or is fired for any reason other than gross misconduct.	Employee Dependents	18 months
3. Member establishes through the Social Security Administration (SSA) that a disability began within 60 days of a qualifying event for COBRA. **Employee must notify Employer within 60 days of the SSA disability determination and within the original period of COBRA coverage.**	Employee Dependents	29 months
4. Employee dies.	Dependents	36 months

Reason for Loss of Coverage	Eligible Persons	Number of Months of Extended Coverage
5. Employee and spouse divorce or separate (only when this results in a loss of coverage but also applies if Employee drops spouse's coverage in anticipation of separation or divorce). **Employee must notify Employer within 60 days.**	Dependents	36 months
6. Dependent child who no longer meets plan definition of dependent child. **Employee must notify Employer within 60 days.**	Dependent child	36 months
7. Employee becomes eligible for Medicare and no longer has the group health coverage (applies only if spouse and Dependents are also not eligible for Medicare).	Dependents	36 months
8. If Employee retires, still has the group coverage and the Employer files for Chapter 11 bankruptcy.	Employee Dependents	Until retiree dies, then 36 months for surviving spouse and Dependents

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

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

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

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

Pay your Premiums for Continuation of Coverage to your Employer.
If you chose Continuation of Coverage, you must pay the first premium to your Employer by the 45th day after your Employer receives the Membership Application. After that, you must pay premiums each month in advance. There's a 31-day grace period for payment of the monthly premiums.

Continuation of Coverage ends earlier than the maximum continuation period under these circumstances:
- When premiums aren't paid on time.
- When the person who has the Continuation of Coverage becomes covered under another Group Health Plan. (Enrolling in Medicare won't end coverage for people continuing coverage under item (8).)
- When a disabled person covered under the extended 29-month COBRA continuation period has been determined by the SSA to be no longer disabled, coverage ends for the disabled person and any covered family Members. (You must notify the Employer within 30 days of final determination.)
- When your Employer no longer has health coverage for its Employees.

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

Extension of Benefits

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

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

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

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

Family and Medical Leave Act

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

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

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

Statement of Your ERISA Rights

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

Definitions

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

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

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

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

Ambulatory Surgical Center: A facility that's licensed for Outpatient Surgery only and doesn't provide overnight accommodations or around-the-clock care. The care must be provided under the supervision of a Physician. It also must provide nursing services by or under the supervision of an on duty registered nurse (RN). The facility must not be an office or clinic for the private practice of a Physician.

Authorized Representative: A person you designate to act on your behalf by sending written notice to BlueCross stating you wish the person to act as your Authorized Representative. A Provider may act without written permission when seeking an approval request for Urgent Care Claims (medical conditions which require immediate treatment). In other situations, a person, including a Provider, must have written permission to act as your Authorized Representative. If you have designated an Authorized Representative, all information and notifications will be directed to that representative unless you give contrary directions.

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

Balance Billing: When a Provider bills you for the difference between the Provider's charge and the Allowed Amount or for the penalties for not obtaining Preauthorization. For example, if the Provider's charge is $100 and the Allowed Amount is $70, the Provider may bill you for the remaining $30. A Network Provider may ***not*** Balance Bill you for Covered Services except as noted in the *Preauthorization* Section.

Behavioral Health: Comprehensive term to include Mental Health and Substance Use Disorders.

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

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

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

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

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

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

Care Coordination: Organized, information-driven patient care activities intended to facilitate the appropriate responses to a member's healthcare needs across the continuum of care.

Care Coordinator: An individual within a Provider organization who facilitates Care Coordination for patients.

Care Coordinator Fee: A fixed amount paid by Blue Cross and Blue Shield of South Carolina to providers periodically for Care Coordination under a Value-Based Program.

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

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

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

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

Creditable Coverage: Benefits or coverage provided under:

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

This term doesn't include coverage for coverage excepted under Health Insurance Coverage. We'll count a period of Creditable Coverage without regard to specific health benefits covered during that time.

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

Deductible: The amount you're responsible for paying for Covered Services before we begin to pay each Benefit Period. The Deductible may not apply to all Covered Services. If you have family coverage, the family Deductible is either aggregate or embedded. Your Schedule of Benefits will show whether your Deductible is aggregate or embedded. An **Aggregate Deductible** means the entire family Deductible must be met before benefits begin to pay each year. An **Embedded Deductible** means that benefits will begin paying for a member once that member meets single Deductible for that year.

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

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

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

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

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

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

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

Excluded Services: Health care services that this Plan doesn't provide or cover.

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

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

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

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

1. Coverage for accident or disability income insurance, or any combination of the two;
2. Coverage issued as a supplement to liability insurance;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Workers' Compensation or similar insurance;
5. Automobile medical payment insurance;
6. Credit-only insurance;
7. Coverage for on-site medical clinics;
8. Other similar insurance coverage that's specified in regulations where benefits for medical care are secondary or incidental to other insurance benefits;

9. If offered separately:
    a. Limited scope dental or vision benefits;
    b. Benefits for Long-term Care, nursing home care, home health care, community-based care or any combination of them;
    c. Such other similar, limited benefits as specified in regulations;
10. If offered as independent, non-coordinated benefits:
    a. Coverage only for a specified disease or illness;
    b. Hospital indemnity or other fixed indemnity insurance;
11. If offered as a separate insurance policy:
    a. Medicare supplemental Health Insurance;
    b. Coverage to supplement coverage provided under Military, TRICARE or CHAMPUS; and
    c. Coverage to supplement coverage under a Group Health Plan.

Health Status-related Factor: Any of these: health status, medical condition (including both physical and mental illness), 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.

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

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

Inpatient: A Covered Person who is a registered bed patient in a Hospital, Skilled Nursing Facility, Rehabilitation Facility or Residential Treatment Center for whom a room and board charge is made. (This does not include Outpatient observation which may require an overnight stay.)

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

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

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

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

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

Legally Intoxicated: The Member's blood alcohol level was at or in excess of the amount established under applicable state law to create a presumption and/or inference the member was under the influence of alcohol, when measured by law enforcement or medical personnel.

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

Maximum Out-of-Pocket: The most you pay for Covered Services in a Benefit Period before your Plan begins to pay 100 percent of the Allowed Amount. This limit never includes your premium, Balance Billed charges or health care your Plan doesn't cover. If you have family coverage, the family Out-of-pocket is either aggregate or embedded. Your Schedule of Benefits will show whether your Out-of-pocket is aggregate or embedded. An **Aggregate Out-of-pocket** means the entire family Out-of-pocket must met before benefits begin to pay 100% for the Benefit Period. An **Embedded Out-of-pocket** means that benefits will begin paying at 100% for a member once that member meets single Out-of-pocket for that Benefit Period.

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

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

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

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

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

Member: An enrolled Employee or covered Dependent.

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

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

Minimum Essential Coverage doesn't include Health Insurance Coverage consisting of excepted benefits, such as dental-only coverage.

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

Outpatient: A Member who receives services or supplies in a setting that doesn't require an overnight stay.

Patient-Centered Medical Home (PCMH): A model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified physicians.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Specialist: A Physician who isn't a Primary Care Physician.

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

Surgery: 1) The performance of generally accepted operative and cutting procedures including endoscopic examinations and other invasive procedures; 2) the correction or treatment of fractures and dislocations; and 3) other procedures as reasonable and as approved by us. This includes the usual, necessary and related pre- and post-operative care.

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

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

Telemonitoring: Services where a Member transmits, whether by facsimile, e-mail, telephone or any other format, his or her specific health data (e.g. blood pressure, weight, etc.) to a health care Provider. Telemonitoring services are not covered.

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

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

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

Waiting Period: The period that must pass before you or your family members are eligible to be covered for benefits under the terms of the Contract with your Employer.