South Carolina

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

2019

BlueEssentials℠ Catastrophic

Major Medical Expense Coverage

This Policy provides benefits for Covered Services only when received from in-Network Providers.

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Major Medical Expense Coverage

This contract is based on federal and state laws and regulations. If laws or regulations are updated during a contract year, the contract is revised to be consistent with the updated law or regulation.

We must receive two things to put your Policy into effect: 1) your application; and 2) your portion of the first month's premium paid in full. Your Policy is not effective until your portion of the first Premium is received, even if you have already received your Identification Card.

Guaranteed Renewable Except for Stated Reasons

This Policy renews each calendar year and you can continue coverage by paying the Premium required by the first of each calendar month or within the grace period. We can cancel this Policy if:

1. You fail to pay Premiums according to the terms of the Policy; or
2. We determine you have committed an act or practice that constitutes fraud or an intentional misrepresentation of a material fact under the terms of the Policy; or
3. We decide to discontinue offering BlueEssentials for everyone who has this Policy form. If we discontinue the product, we must:
   a. Provide notice to each individual covered by this Policy of the discontinuance at least 90 days before the date the Policy is discontinued or within time frames as directed by a governmental agency;
   b. Offer to each individual covered by this Policy, the option to purchase other individual Health Insurance Coverage currently offered by us; and
   c. In exercising the option to discontinue the Policy or offering the option to purchase other individual coverage we act uniformly without regard to any Health Status-related Factor.

At the time of renewal, we may modify this Policy for everyone who has it as long as the modification is consistent with federal and state law and effective on a uniform basis. However, we cannot cancel your Policy simply because of a change in your physical or mental health.

Premiums

The benefits described are available as long as the required Premium is paid on time. If you previously had coverage with Blue Cross and Blue Shield of South Carolina or any of its affiliated companies, your policy was cancelled due to nonayment of premiums, and you re-apply for coverage within twelve months, you will be required to pay all past due premiums before you can activate new coverage or begin using benefits.

We base Premiums on coverage selected, tobacco use, age, where you live at the time this Policy is issued and regulatory fees. Regulatory fees are fees and taxes required by the Affordable Care Act. The Member Schedule shows the Premium as of the Effective Date. Premiums may only be changed at the beginning of your Benefit Period. At least 31 days prior to your new Benefit Period, you will receive notice of your new Premium and any benefit charges for the new Benefit Period. If you receive a Special Enrollment Period and select a new benefit option, your premiums may also change as of the date your benefit option changes If you receive an Advance Premium Tax credit, the amount you are billed each month is reduced by the tax credit you receive. If the tax credit changes at any time during the Benefit Period, your billed premium will change. This change will occur as directed by the Health Insurance Marketplace and may occur without notice to you.

If the Member's age, tobacco use or residence has been misstated and if the amount of the Premiums is based on these factors, an adjustment in Premiums, coverage, or both, will be made based on the Member's true age, tobacco usage or residence.

Your Premiums are not affected by Health-Status Related Factors (except for tobacco use), race, color, national origin, present or predicted disability, gender identity, sexual orientation, expected length of life, degree of medical dependency or quality of life.

Right to Examine Policy for Thirty Days

If you aren't satisfied with this Policy, return it to us or our agent within 30 days after it is received. All Premiums will then be refunded minus any claims paid. If the Policy is returned, it will be void from the beginning. The parties will be in the same position as if no Policy had been issued.

Important Notice Concerning Statements in Your Application for Insurance

The Application is a part of your Policy. If a statement on your Application or enrollment records is an intentional misrepresentation of material facts related to your eligibility for coverage, or you perform an act or practice that constitutes fraud, we may have grounds to rescind the Policy. A rescission does not include a retroactive cancellation or discontinuance of your coverage due to the failure to timely pay Premiums. If the Policy is rescinded, we will provide 30 days written notice and refund your Premiums minus any amounts paid for claims. After this Policy has been in force for two years, we cannot use any statement made in any Application (unless fraudulent) to void the Policy or deny any claim incurred after the two-year period.

This Policy contains a requirement for Preauthorization of certain services. See the Preauthorization Section for details.

The Policyholder hereby expressly acknowledges understanding this Policy is solely with Blue Cross and Blue Shield of South Carolina, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. The "Association" permits Blue Cross and Blue Shield of South Carolina to use the Blue Cross and Blue Shield service marks in the State of South Carolina, and Blue Cross and Blue Shield of South Carolina is not contracting as an agent of the Association. The Policyholder further acknowledges and agrees to have not entered into this Policy based on representations by any person other than Blue Cross and Blue Shield of South Carolina. No person, entity or organization other than Blue Cross and Blue Shield of South Carolina shall be held accountable or liable to the Policyholder for any of Blue Cross and Blue Shield of South Carolina's obligations created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of South Carolina other than those obligations created under other provisions of this Policy..

BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA

Scott Graves
President
Blue Cross and Blue Shield Division

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This Policy provides benefits for Covered Services only when received from in-Network Providers.

Introduction

Welcome to Blue Cross and Blue Shield of South Carolina (BlueCross). This BlueEssentials Policy offers Members like you many different ways to save on health care. This Policy is a Qualified Health Plan. If at any time, this Policy is considered no longer "Qualified," coverage will end as specified in the Eligibility section.

Please take time to review this Policy carefully. 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. The terms "we," "us" or "our" refer to BlueCross. The term "you" or "your" refers to the named insured person. No agent, employee or representative of BlueCross has the authority to waive or change any of the requirements within the Application or waive or change any of the provisions within this Policy.

There are no dollar limits on Essential Health Benefits. Except for Emergency Services for an Emergency Medical Condition, benefits are available in-Network only from BlueEssentials Network Providers.

This BlueEssentials product uses an Exclusive Provider Organization (EPO), meaning a more limited, restricted provider network than for other products offered by BlueCross. This Policy only provides benefits for Covered Services received from Providers who contract with BlueCross to specifically participate in the BlueEssentials Network. This Policy does not cover services rendered by out-of-network Providers (except for Emergency Services as defined in this Policy). Services provided outside the BlueEssentials Network are only available to treat an Emergency Medical Condition when those services are received as an Outpatient in a Hospital Emergency Room, and only for as long as your condition continues to be considered an Emergency. Always ask to make sure your Provider is a BlueEssentials Network Provider to ensure benefits are available. In addition, be sure the Provider's location is in the BlueEssentials Network.

For Emergency Services for an Emergency Medical Condition rendered at an out-of–Network Hospital Emergency Room, benefits are provided at the in-Network Coinsurance amount, and the Allowed Amount we pay for the out-of-Network Hospital Emergency Room charges will be the greater of the median amount for those emergency services if rendered by a Network Provider participating in the BlueEssentials Network, or the amount for those emergency services calculated using Medicare allowances, which is the method BlueCross generally uses to determine payment to an out-of-Network Provider who does not participate in the BlueEssentials Network. *An out-of-Network Provider can bill you for the difference between the Allowed Amount we pay and his or her actual charge.*

BlueEssentials encourages early identification and management of health problems to improve health outcomes and help reduce health care costs. In addition, our process involves evaluation and Preauthorization of all Hospital Admissions, whether a scheduled Admission, Emergency Admission or any continuation of a Hospital stay was longer than originally Preauthorized. Preauthorization is also required for certain services, including some Mental Health and Substance Use Disorder services, in order to receive maximum benefits available under this Policy.

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

Blue Cross and Blue Shield of South Carolina does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in the administration of the plan, including enrollment and benefit determination. If you are an individual living with disabilities or have limited English proficiency, we have free interpretive services available. For questions about your coverage, please contact Member Services at the number shown below.

How to Contact Us if You Have a Question

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

For Customer Service Inquiries

If you have any questions or complaints, please contact Marketplace Operations. We can be reached by telephone, mail or through our Website.

CALL	855-404-6752 Monday through Friday, 8:30 a.m. to 5:30 p.m. Eastern Standard Time
TTY	855-889-4325 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
FAX	803-870-9439
WRITE	Marketplace Operations BlueCross BlueShield of South Carolina Post Office Box 100228 Columbia, SC 29260-6000
E-MAIL	Membership.enrollment@bcbssc.com for questions
WEBSITE	www.SouthCarolinaBlues.Com

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 our website, you will find useful tools that can help you better understand your coverage.

Here are some of the things you can do on our website:

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

My Health Toolkit

Visit SouthCarolinaBlues.com and access My Health Toolkit to:

- Check your eligibility.

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

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.
- Notify us if any information on your enrollment is or was incorrect.
- Ask questions and make sure you understand the information given to you.
- Present your BlueCross ID card prior to receiving services or care.
- Inform BlueCross of any information that affects your coverage, including any other insurance you may have.
- Select a representative to act on your behalf in the event you are unable to represent yourself.
- 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) gives an overview of the benefit options of your insurance plan. All insurance companies are required to provide you with an SBC. You can find your SBC by going to My Health Toolkit.

You may also contact a Customer Service Advocate and ask us to send you a copy of the SBC. We can send it to you electronically or mail a paper copy (free of charge). Please note: the format and content of an SBC is controlled by federal agencies and some details may appear inconsistent with information in this Policy or your Schedule of Benefits. If information is inconsistent, the Policy documents are controlling.

Preauthorization

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

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

- The patient is a Member under the Policy at the time service is provided.
- The service is a Covered Service. Policy limitations or exclusions may apply.
- The service provided was Medically Necessary as defined by your Policy.

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 Marketplace Operations.

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

Network Providers in South Carolina will be familiar with the requirement to obtain Preauthorization and will get the necessary approvals. If a Network Provider in South Carolina does not get Preauthorization, it cannot bill you for the penalty (see chart below).

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

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

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

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

Types of services	Who to Call:
Inpatient Admissions generally (does not include maternity/newborns) Habilitation or Rehabilitation, Human Organ and/or Tissue Transplants, Skilled Nursing Facility (SNF) Continuation of Hospital stay (remaining as Inpatient longer than originally approved) Cardiac rehabilitation (Phase 1 and 2) Pulmonary rehabilitation	In Columbia 803-736-5990 In S.C. 800-327-3238 Outside S.C. 800-334-7287
Outpatient admissions for services Surgery (including pre-authorization for anesthesia) Dialysis (hemodialysis or peritoneal)	
Home Health Care or Hospice Services	
Durable Medical Equipment when purchase price or rental is $500 or more	
Treatment for hemophilia - care must be coordinated through a Center for Disease Control and Prevention (CDC) designated Hemophilia Treatment Center. You must see a Provider at the designated Hemophilia Treatment Center within 60 days of the beginning of your Benefit Period.	
Colonoscopies when not for screening/preventive purposes	
Hospital admissions for Mental Health and Substance Use Disorders, including at a Residential Treatment Center (RTC) Admissions for Substance Use recovery and rehabilitation Continuation of a Hospital stay or RTC admission (remaining as Inpatient longer than originally approved) Outpatient psychological testing Repetitive Transcranial Magnetic Stimulation (rTMS) Outpatient facility: Intensive Outpatient partial Hospitalization Electroconvulsive therapy	Companion Benefit Alternatives, Inc. (CBA) – In Columbia 803-699-7308 Outside Columbia 800-868-1032
Outpatient/office MRI, MRA, PET scans and CT scans Radiation oncology Musculoskeltal/spine management (interventional pain management, lumbar and cervical spine surgery) services. Virtual colonoscopy or CT Colonography	National Imaging Associates (NIA) 866-500-7664
Genetic Counseling and Testing, including Prenatal Screening and Mutation Analysis	Avalon Health Services, LLC 1-844-227-5769.
Prescription Drugs, Specialty Pharmacy medications, Injections and Injectable drugs; any medications that require special handling, Prior Authorization, or more than allowed quantities	See Prescription Drug section for detailed information

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

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

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 the hospital stay is 48 hours or less for a vaginal birth or 96 hours or less for a cesarean section. The day of delivery, Surgery or birth is not counted in the 48 or 96 hours. If you or the newborn are not released within these timeframes, you or your Provider should contact BlueCross for authorization for a continued stay. If you are in a Network Hospital, the Hospital should contact us for this authorization.

You have 60 days to add a newborn child to your coverage or to obtain other coverage for the child; see the *Eligibility, Coverage and When your Coverage Ends* section. However, 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 immediate medical assistance. An Emergency is an unexpected and usually dangerous situation that requires immediate medical attention at a Hospital Emergency Room. An Emergency Medical Condition is an illness, symptom or condition so serious that a reasonable person would seek medical care immediately to avoid serious harm, including illness or injury to an unborn child. If you are Admitted to a Hospital due to an Emergency Medical Condition, your Admission will be unexpected, so no pre-approval or preauthorization is required; however, we allow shouldtime to be notified of the Admission as soon as possible. Our medical services personnel must be notified within 24 hours or by 5 p.m. of the next working day, or as soon as reasonably possible, if you are admitted to the Hospital. Otherwise, we will not provide benefits for the hospitalization. If an Emergency Admission approval is not obtained within this timeframe due to circumstances beyond your control, an appeal can be made and the Admission will be reviewed to determine if it was Medically Necessary to admit you to the Hospital for an Emergency Medical Condition.

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

Eligibility, Coverage, and When Your Coverage Ends

Eligibility

Every Qualified Individual who applies for coverage during a special or open enrollment period will be accepted for coverage if the applicant is a South Carolina Resident. Children are eligible to enroll for coverage as a dependent through age 25. Gaining or losing a Dependent in your household may affect your eligibility for premium tax credits and your eligibility for a Special Enrollment. A Catastrophic plan may not be purchased unless the applicant meets the requirements of federal law; you must be under the age of 30 on the first day of your plan year or effective date, or you must have received a certificate of exemption and provide that certificate at the time of application or upon request.

This product is considered to be duplication of Medicare coverage. If you are entitled to or enrolled in Medicare coverage, you cannot lawfully purchase this product.

Effective Date of Coverage

The date on which coverage for a Member begins under this Policy is called the **Effective Date**. Your Effective Date is shown on your Member Schedule.

You may enroll in coverage every year during the annual Open Enrollment. You may enroll at other times during the year only if you qualify for a **Special Enrollment** such as one of the situations described below.

Special Enrollment

A **Special Enrollment** occurs when you fall into one of the situations described below. In all situations, you must be Qualified Individual(s) to enroll; your dependent may also qualify to enroll in or change from one Qualified Health Plan to another. If you believe you meet the requirements for a Special Enrollment, you can:

- Contact the Health Insurance Marketplace
- Enroll on Healthcare.gov
- Contact your agent
- Visit a Blue Retail Center

Note: Special Enrollment Periods (SEP) are defined and regulated by federal regulation. Changes to the regulations may override the information shown below. This is not an all-inclusive list. You are not entitled to an SEP if your prior coverage did not qualify as minimum essential coverage or if you did not have coverage within 60 days of the triggering event.

Triggering Event	Details about qualifying for a Special Enrollment Period
1. If you lose qualifying health coverage, such as:	• Coverage through a job, or through another person's job. This also applies if you're now eligible for help paying for coverage because your employer stops offering coverage or the coverage isn't considered qualifying coverage. • Loss of qualifying COBRA contributions by an employer or former employer. • Medicaid or Children's Health Insurance Program (CHIP) coverage (including pregnancy-related coverage and medically needy coverage). • Medicare. • Individual or group health plan coverage that ends during the year, including student health insurance if it was a qualifying health plan. • Coverage under your parent's health plan (if you're on it), including when you turn 26 or the maximum dependent age allowed in your state and lose coverage. Note: This Special Enrollment Period doesn't include loss of coverage because you didn't pay your premiums, you voluntarily dropped coverage, your prior coverage did not qualify as Minimum Essential Coverage, or the issuer finds fraud or misrepresentation.

2. Change in household size, if you:	• Got married. One spouse must have had qualifying health coverage for at least one day in the 60 days prior to the marriage or have been living outside the United States, in a U.S. territory, or in a service area where no qualified health plan was available. • Had a baby, adopted a child, or placed a child for foster care. • Got divorced, legally separated, or had a death in the family and lost health coverage. • Gained or became a dependent due to a child support or other court order.
3. Change in primary place of living so that you now have access to new Marketplace plans, including: *You must show qualifying health coverage for at least one day in the 60 days before your move, unless no QHP was available, such as a foreign country, US territory, or service area where no QHP was sold.*	• Moving to a new home. • Moving to the U.S. from a foreign country or United States territory (prior coverage requirement does not apply). • Moving from a service area where no qualified health plan was available to an area where one is available. • A student moving to or from the place he or she attends school. • A seasonal worker moving to or from the place he or she lives and works. • Moving to or from a shelter or other transitional housing. Notes: Moving only for medical treatment or staying somewhere for vacation doesn't qualify you for a Special Enrollment Period.
4. Change in eligibility for Marketplace coverage or help paying for coverage, if you: .	• Are enrolled in Marketplace coverage and report a change that makes you: o Newly eligible for help paying for coverage. o Newly ineligible for help paying for coverage. o Eligible for a different amount of help paying for out-of-pocket costs, like copayments. • Become newly eligible for Marketplace coverage because you've become a U.S. citizen, U.S. national, or lawfully present individual. • Become newly eligible for Marketplace coverage after being released from incarceration (detention, jail, or prison). • Gain or maintain status as a member of a federally recognized tribe or Alaska Native Claim Settlement Act (ANCSA) Corporation shareholders (you can change plans once per month). • Become newly eligible for help paying for Marketplace coverage because you had a change in household income or moved to a different state and you were previously both of these: o Ineligible for Medicaid coverage because you lived in a state that hasn't expanded Medicaid. o Ineligible for help paying for coverage because your household income was below 100% of the Federal Poverty Level (FPL).
5. Enrollment or plan problems, such as if you:	• Weren't enrolled in a plan or were enrolled in the wrong plan because of: o Misinformation, misrepresentation, misconduct, or inaction of someone working in an official capacity to help you enroll (like an insurance company, navigator, certified application counselor, agent, or broker). o A technical error or another Marketplace-related enrollment delay. o The wrong plan data (like benefit or cost-sharing information) was displayed on HealthCare.gov at the time that you selected your health plan. • Can demonstrate your Marketplace plan has violated a key part (called a "material provision") of its contract.
6. Other qualifying changes	• You applied for Medicaid or Children's Health Insurance Program (CHIP) coverage during the Marketplace Open Enrollment Period, or after a qualifying life event, and your state Medicaid or CHIP agency determined you or they weren't eligible. • You are a victim of domestic abuse or spousal abandonment and want to enroll in a health plan separate from your abuser or abandoner.

	• You submitted documents to clear a data matching issue after your prior coverage was ended. • Are below 100% of the federal poverty level (FPL), submitted documents to prove your eligibility and didn't enroll in coverage while waiting for documents to be reviewed. • You are an AmeriCorps service member starting or ending AmeriCorps service. • You can show you had an exceptional circumstance that kept you from enrolling in coverage, like being incapacitated or a victim of a natural disaster.

A Special Enrollment must be requested within 60 days of the triggering event. We may request documentation to confirm you had a qualifying event and that you are entitled to a Special Enrollment Period.

Situations that do not qualify for a Special Enrollment Period:

- Being terminated from other coverage for not paying premiums or for fraud
- Divorce or death of a family member without a resulting loss of coverage
- Moving solely for medical treatment or vacation
- Changing from one legally present status to another (e.g. consumer who becomes a U.S. citizen who was previously a lawfully present individual)

Effective Date for Special Enrollment –

Most Special Enrollments are eligible for a "Regular Effective Date" as described in this chart:

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)

** Where the Effective Date is delayed due to the need for verification of your right to a Special Enrollment Period and the delay results in a premium due of two or more months retroactive premium, you can request an Effective Date later than shown above.

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

- For birth, adoption, placement for adoption or foster care, or as a result of a court order, your coverage Effective Date will be the date of the event, unless you specifically choose to begin coverage on the first day of the month following the date of birth, adoption, placement, or court order. You may also choose a Regular Effective date, as shown in the chart above.
- For marriage, your coverage Effective Date is the first of the month following your selection of a plan; for example, if you get married on January 31st and immediately request coverage, your coverage will be effective February 1st. If you wait to request coverage until February 1st, coverage will be effective March 1st.
- For a loss of Minimum Essential Coverage, the Effective Date depends on when you request coverage and the date the loss of coverage occurs. You have 60 days before and 60 days after the loss of Minimum Essential Coverage to make a plan selection. The Effective Date, though, will always be the first day of the month after plan selection, or the date you lose coverage, whichever comes last.

Example: You are told on April 3 that you will lose minimum essential coverage on May 31. You can choose a plan at any time prior to May 31 and your new coverage will be effective on June 1. However, if you choose a new plan after

you have lost Minimum Essential Coverage, your new plan will take be effective on the first of the month following your plan selection.

Adding your Spouse

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

Adding a Child

If you or your spouse gives birth, adopts a child or a child is placed with you or your spouse for foster care or legal guardianship while this Policy is in force, or if you are ordered to provide coverage as the result of a court order, then the child is eligible to receive benefits for Medically Necessary covered services and supplies from the moment of birth, adoption, placement, or court order. This includes any necessary care and treatment of medically diagnosed birth defects, diseases and anomalies or complications arising from a premature birth. You must add the child within 60 days of the birth, adoption or placement along with payment of the appropriate Premium in order for the coverage to be effective from the moment of birth, adoption or placement. Claims for services or benefits cannot be processed until the child is added to the coverage and the applicable premium has been received.

Dependents added to your coverage during a special enrollment will be covered on the same basis as any other dependent, from these dates:

1) from the moment of birth when born or when a decree of adoption has been entered into by you or your spouse within 60 days after the date of the child's birth and you or your spouse has temporary custody;
2) on the date the adoption proceedings have been completed and a decree of adoption is entered into within one year from the institution of proceedings, unless extended by order of the court by reason of special needs of the child;
3) from the date of placement for adoption or foster care;
4) on the date the court enters the child support or other court order (may be the date the judge signed the order, or the date the clerk of court enters the order);
5) the first of the month following plan selection;
6) on the Effective Date of this Policy, if plan selection occurs after the above dates.

A child is considered "adopted" or as being under legal guardianship (foster care) on the date the child is placed in your home. The child is no longer considered "adopted" or under your legal guardianship on the date placement is disrupted and the child is removed from placement with you or your spouse. A dependent covered under a court order is no longer eligible for coverage if a later court order transfers responsibility for coverage to any other person. Terminations will be effective as outlined below.

Premium Payment

The Premium is the amount that must be paid for your health insurance or plan. The Premium for this Policy is due on the 1st of each month. If you are eligible for an Advance Premium Tax Credit, the amount you are billed each month may be reduced by the tax credit. If your tax credit changes during the Benefit Period, the amount you are billed will change to reflect the new tax credit.

You are responsible for all Premiums due for your coverage, including for dependents included on your coverage. *We will not accept payment of your premiums from any health care provider, health agency, health entity, public*

or private institution or any other person or entity which does not have an insurable interest. We accept premium payments and co-payments only from you or
(a) Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
(b) Indian tribes, tribal organizations or urban Indian organizations; and
(c) State and Federal Government programs.

You may pay your Premiums electronically or we will bill you monthly. At any time, we may notify you that no premium is due for coverage for a certain period of time. The notification will include the reason for the waiver of premium and the length of time the waiver is in effect. This can occur when we need to refund money to you or in situations involving a medical loss ratio rebate (see the *Medical Loss Ratio* section). We are under no obligation to waive your premium and the fact that we may do so does not obligate us to waive premium in the future.

If you previously had coverage with Blue Cross and Blue Shield of South Carolina or any of its affiliated companies, the policy was cancelled due to nonpayment of premiums, and you re-apply for coverage within twelve months, you will be required to pay all past due premiums before you can activate new coverage or begin using benefits.

Grace Period

This Policy has a Grace Period for Premium payments. This means if your Premium is not paid on or before the date it is due, it may be paid during the Grace Period. If the Premium has not been paid by 12:01 a.m. of the day following the end of the Grace period, your coverage will automatically terminate without further notice to you. Any claims paid after the last Premium paid date does not extend this coverage.

Grace Period for Coverage with an Advance Premium Tax Credit (APTC) – If you have paid at least one month's Premium and received the Advanced Premium Tax Credit, your Grace period is three months. Benefits will be provided according to your coverage during the first month of the Grace Period. Benefits are not allowed for services provided during the second and third month of the Grace Period until your Premium is paid in full. Premiums not fully paid by the end of the Grace Period will cause this Policy to terminate. Coverage will end on the first day of the second month of the three-month Grace Period. In order for your account to be considered out of the Grace Period, you must pay your total premium due. Any claims you incurred during the period Premiums were unpaid may be submitted to us for processing under the benefits of this Policy. If your coverage is cancelled for non-payment of Premium, you will not be eligible to purchase a Marketplace plan until the next Open Enrollment, unless you have a qualifying event that allows you a Special Enrollment Period, such as marriage, the birth of a child, or a similar event. During this period, you will be responsible for paying your medical bills.

Example: You enroll in coverage on January 1. You miss your April Premium payment, but on May 15, you send in one month's Premium. You are not able to make another Premium payment. On July 1, your coverage will be cancelled back to April 1. You have a Grace Period of three months, but at the end of three months, your Premiums must be paid in full or coverage is cancelled.

Grace Period for Coverage without an Advance Premium Tax Credit – If you did not receive an Advanced Premium Tax Credit, the Grace Period is 31 days. Benefits will not be allowed during the grace period until Premiums are paid. Premiums not fully paid by the end of the 31-day Grace Period will cause this Policy to terminate. Coverage will end on the Premium due date for the 31-day Grace Period.

Reinstatement

If any Premium is not paid within the Grace Period, the Policy will lapse automatically without further notice to you.

If you purchased your Policy through the federal Health Insurance Marketplace, you are not eligible for reinstatement. If your coverage is cancelled for non-payment of Premium, you will not be eligible to purchase a Marketplace plan until the next Open Enrollment, unless you have a qualifying event that allows you a Special Enrollment Period, such as marriage, the birth of a child, or a similar event. During this period, you will be responsible for paying your medical bills.

For all other Members, we may reinstate the Policy, if:

a. You request reinstatement; and
b. The unpaid Premium is not more than 60 days overdue; and
c. You pay all overdue and currently due Premiums (note: you will be given a conditional receipt for the Premiums); and
d. We approve your request for reinstatement.

The Policy will be reinstated on the date the Policy lapsed, if requirements (a) through (d) above have been met. If your request is disapproved, we will refund the Premium submitted. If we fail to act on our request within 45 days, your Policy will be reinstated. After the Policy is reinstated, both parties will have the same rights as existed just before the due date. Any claims you incurred during the period Premiums were unpaid may be submitted to us for processing under the benefits of this Policy. Any amendments to the Policy will still apply and remain effective after reinstatement.

Non-Discrimination

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

Health Status-Related Factors (except for tobacco use), race, color, national origin, 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. If you are an individual living with disabilities or have limited English proficiency, we have free interpretive services available. If you have questions about your coverage, please contact Member Services at the number shown in the "How to Contact Us" section for more information.

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

Termination of Insurance

Coverage will end at 12:01 a.m. Eastern Standard Time:

1. 14 days after we receive your request or on the date you request, if later; or
2. The last day of the month following the month you receive notice from the Health Insurance Marketplace you or a dependent is no longer eligible for coverage offered through the Health Insurance Marketplace;
3. On the date this Policy is no longer considered a Qualified Health Plan or is non-renewed;
4. On the date the Policy lapses due to non-payment of Premiums as determined by the Grace Period;
5. On the Policy Effective Date if rescinded; or
6. If you are determined to be no longer eligible for coverage, your coverage in the plan will end on the last day of the month following the month in which you received notice of your ineligibility.
7. If you and your spouse divorce, your spouse's coverage will end on the Premium due date following the date of divorce.
8. For a Dependent other than a spouse who reaches age 26, coverage will terminate at the end of the benefit period in which the Dependent reaches age 26. An Incapacitated child's coverage, however, will not end simply because he or she reaches age 26.
9. If we receive a termination from the Health Insurance Marketplace/FFM, the termination will be effective as of the date specified by the Marketplace/FFM.
10. If you move out of the State of South Carolina.

For this coverage to be considered a Qualified Health Plan, BlueCross must be determined to be a Qualified Health Plan issuer and the plan must be certified that it meets all the requirements of the Health Insurance Marketplace regulations. If BlueCross receives notification either that it is no longer certified or the plan is no longer considered qualified, your coverage will not end until we have notified you and you have had the opportunity to enroll in other coverage. If we decide to not seek recertification of this Plan, we will give you 90-days written notice and coverage will not end until the end of your Benefit Period.

We will provide benefits to the end of the period for which we accepted Premiums or as required by the Health Insurance Marketplace.

We will not cancel this Policy retroactively and refund any Premium, whether or not you had any claims during that period of time except in case of death or when coverage is rescinded.

Continuation of Coverage for Your Former Spouse and non-Incapacitated Dependent Child

If your spouse covered under this Policy is no longer eligible because of a legal divorce, or if a non-Incapacitated child covered under this Policy is no longer eligible because of reaching the age limit, then he or she qualifies for a Special Enrollment and may apply for a new Policy under the Special Enrollment rights.

Extension of Benefits

Termination of the Policy shall be without prejudice to losses incurred for one period of confinement or to any continuous loss which began while the Policy was in force, but the extension of benefits beyond the period the Policy was in force may be predicated upon the continuous disability of the insured, and is limited to the duration of the Policy Period or payment of the Maximum Payable Benefit. One period of confinement means consecutive days of inpatient services for a Member in a Hospital, Skilled Nursing Facility, or Residential Treatment Center that begins before the Termination Date of the Policy and continues past that date. The term continuous disability means the Member is unable to perform the duties of his or her occupation and is under the ongoing care of a Physician. A child who is continuously disabled is receiving ongoing medical care by a Physician and unable to perform the normal activities of a child in good health of the same age and sex. We will provide benefits only for Covered Services as listed in this Policy that are related to the treatment of the disabling medical condition.

Important Note: We recommend that you notify us if you wish to exercise the Extension of Benefits rights. We will then determine if you are eligible for benefits. In order for us to recognize Extension of Benefits and ensure proper processing, we must receive a Physician's statement of disability.

The BlueCard® Program.

As a Blue Cross® and Blue Shield® Licensee, BlueCross participates in a national program called the BlueCard Program. *This program benefits you when you receive Covered Services for an Emergency Medical Condition or an Urgent Condition while traveling outside the Company's service area*. The "BlueCard" is your BlueCross identification card. Your card tells participating BlueCard hospitals and/or Physicians which independent Blue Cross and Blue Shield Licensee is yours.

If you need care for an urgent condition while away from home, follow these easy steps:

- Always carry your current BlueCross ID card for easy reference and access to service.
- To find names and addresses of nearby doctors and hospitals, visit the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or call BlueCard Access at 800-810-BLUE.
- When you arrive at the participating doctor's office or Hospital, simply present your BlueCross ID card.

After you receive care, you should not have to complete any claim forms. Nor should you have to pay for medical services other than your usual out-of-pocket expenses (non-Covered Services, Deductible, Copayment, and Coinsurance). You should see your primary care Physician for any follow-up care.

Blue Cross and Blue Shield of South Carolina underwrites the BlueCard program.

Qualified Individual Redetermination

The Health Insurance Marketplace must re-determine your eligibility periodically during the benefit year if (1) updated information is reported to and verified by the Health Insurance Marketplace; or (2) the Health Insurance Marketplace identified updated information through its own data matching process. If this redetermination results in a change in eligibility, then the change will generally be effective for the first day of the month following the date of the eligibility redetermination notice. The Health Insurance Marketplace may establish a cut-off date for a redetermination notice (which cannot be earlier than the 16th of the month) on or after which a change due to the redetermination will be effective as of the first day of the second month following the notice.

Medical Loss Ratio

Individual contracts must meet certain medical loss ratio requirements as required by federal law. If all individual coverage issued by Blue Cross and Blue Shield of South Carolina does not meet the medical loss ratio requirement, we will issue medical loss ratio rebates. These rebates may be in the form of a lump-sum check, credit or debit card reimbursement, pre-paid debit or credit cards or Premium credits. A Premium credit means you will not be required to pay your Premium or a portion of your Premium for a specified period of time. However, after the specified time, you must again pay your Premiums.

Each year by a date determined by Health and Human Services, you will receive notice if you are due a Medical Loss Ratio rebate for the previous year. Every Member's rebate will be in the same form, unless the Member is no longer active. If the Member is no longer active, the rebate will always be in the form of a lump-sum check.

Covered Services

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

Benefits are provided in-Network only. Please note: Even at an in-Network Hospital or facility, you may be treated by an out-of-Network Provider. Out-of-Network Providers may Balance Bill you, even when you are treated for an Emergency Medical Condition, and there is no Maximum out-of-pocket (no limit) on out-of-Network charges. Benefits are available at an out-of-Network Hospital Emergency Room for an Emergency Medical Condition. Benefits will provided at the in-Network Coinsurance amount, and the Allowed Amount we pay for Emergency Services by an out-of-Network Provider will be the greater of: A) the median amount for those emergency services if rendered by an in-Network Provider participating in the BlueEssentials Network; and B) the amount for emergency services calculated using Medicare allowances, which is the method used by BlueCross generally to determine payment to an out-of-Network Provider who does not participate in the BlueEssentials Network. Out-of-Network Providers can Balance-Bill you for the difference between the Allowed Amount we pay and his or her actual charge.

All Covered Services must be Medically Necessary and include only the services specifically described in this section unless limited or excluded in other provisions of the Policy. The services must be prescribed by and performed by, or under the direction of, a Physician in the BlueEssentials network; however, a contract exclusion applies even if a service may be considered Medically Necessary.

The following list of Essential Health Benefits is described in detail below:

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

Benefit Period Maximums for Covered Services (per Member per Benefit Period):
60 days for Skilled Nursing Facility
60 visits for Home Health Care
6 months per episode for Inpatient and Outpatient Hospice Care
15 Rehabilitative visits for Physical, Speech and Occupational Therapy Services combined
15 Habilitative (developmental) visits for Physical, Speech and Occupational Therapy Services combined

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

The following are Covered Services:

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

Ambulance Service – Benefits are provided for professional ambulance services to the nearest Network Hospital in case of an accident or Emergency Medical Condition. The following requirements apply to all ground and air ambulance transports:

1. The transport is Medically Necessary and reasonable under the circumstances;
2. A BlueCross member is transported;
3. The destination is local within the United States; and
4. The facility is medically appropriate to treat the Member's condition.

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 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 member's illness or injury (such as burn care, cardiac care, trauma care, and critical care); and
- The second Hospital is the nearest medically appropriate facility; and
- A ground ambulance transport endangers the Member's medical condition; and
- The transport is not related to a hospitalization outside the United States.

Birth Control – Benefits are provided for the following oral contraceptives and contraceptive devices with no cost-share. Other contraceptives may be available, but your deductible and coinsurance would be applied.

<table>
<tr><th>Oral Contraceptives
(birth control pills)</th><th colspan="2">Other Female Contraceptives</th></tr>
<tr><td rowspan="5">All generic oral contraceptives (birth control pills) are available at $0 if your plan has ACA benefits. Some brand oral contraceptives that do not have a generic alternative are also covered, such as Lo Loestrin.</td><td>Female Condom: FC2 Female Condom</td><td>Implantable Rod: Nexplanon</td></tr>
<tr><td>Diaphragms: Omniflex Diaphragm, Ortho Coil Spring Kit, Ortho Flat Spring Kit, Ortho Flex, Wide-Seal</td><td>Spermicide: Conceptrol Gel , Gynol II Gel, Encare Suppositories, Shur-Seal Gel, VCF Vaginal Contraceptive Film</td></tr>
<tr><td>Cervical Cap: FemCap, Prentif, Prentif Fitting Kit</td><td>Shot/Injection: Medroxyprogesterone AC (generic Depo-Provera)</td></tr>
<tr><td>Vaginal Contraceptive Ring: NuvaRing</td><td>Patch: Xulane</td></tr>
<tr><td>Emergency Contraception:
Ella, Next Choice</td><td>Intrauterine Device (IUD): Mirena, Paragard, copper IUD</td></tr>
</table>

Birth control includes female sterilization, including follow-up care.

Blue CareonDemand℠ –

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

1. Download the "Blue CareOnDemand" mobile app from iTunes or Google Play.

2. Visit www.BlueCareOnDemandSC.com.

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

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

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

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

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

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

If a Member with a cleft lip and palate is also covered by a dental 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 Policy.

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

1. The Member has cancer or another life-threatening disease or condition; and
2. The referring Provider is a Network 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 Medically Necessary; and
4. The services are furnished in connection with an Approved Clinical Trial, defined below.

An Approved Clinical Trial is one that is approved or funded through the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHRQ), 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 Services to Sound Natural Teeth Related to Accidental Injury – Benefits are provided for treatment, Surgery or appliances as a result of an accidental bodily injury, but are limited to care completed with six months of an 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 is not 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.

Preauthorization is required before you get the DME if the purchase price or rental cost is $500 or more. In addition, supplies used with the DME must be Preauthorized every 90 days. If Preauthorization is not obtained, no benefits will be provided. See the *Preauthorization* section.

Emergency Services

Use of the Emergency Room is intended only for persons who are experiencing an Emergency Medical Condition, as defined in this Policy. We will review requests for benefits after an Emergency Room visit to determine if the illness or injury was sudden or unexpected or would be expected to cause a serious risk to your health, or your unborn child's health, if not treated immediately. Requests for services that do not meet this standard will be denied as not covered. See the Definitions section of this Policy for Emergency, Emergency Medical Condition, and Emergency Services for more details.

Benefits are available to treat an Emergency Medical Condition only when provided on an Outpatient basis at a Hospital Emergency Room or at an Urgent Treatment Center, and only for as long as your condition continues to be considered an Emergency. No pre-authorization or pre-approval is required. If you receive care for an Emergency Medical Condition and are treated in the Emergency Room at a Hospital, the charges for Emergency Services are paid as follows:

1. Emergency Services provided by an in-Network Provider

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

2. Emergency Services by an out-of-Network Provider

When Emergency Services are received from an out-of-Network Provider, benefits will be provided for Emergency Services, but you may have additional cost-sharing because an out-of-Network Provider rendered the services.

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

The Allowed Amount for benefits for Emergency Services for an Emergency Medical Condition when provided by an out-of-Network Provider will be the greater of: A) the median amount for those Emergency Services, calculated using reimbursement rates of in-Network Providers who participate in the BlueEssentials Network; or B) the amount for those Emergency Services calculated using Medicare reimbursement rates, which is the same method BlueCross generally uses to determine payment to out-of-Network Providers who do not participate in the BlueEssentials Network.

An out-of-Network Provider may Balance-Bill you for the difference between the Allowed Amount we pay and its billed charge.

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

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

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

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

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

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

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

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

Hospital Services – Includes Inpatient Admissions, Outpatient care and ancillary services. Preauthorization is required. If Preauthorization is not obtained, no benefits will be provided. Please note: Even at a Network Hospital or facility, you may be treated by an out-of-Network Provider. Out-of-Network Providers may Balance Bill you, even when you are treated for an Emergency Medical Condition, and there is no Maximum out-of-pocket (no limit) on out-of-Network billed charges.

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

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

The day you leave a Hospital, with or without permission, is treated as the day of discharge and will not be counted as an Inpatient care day, unless you return to the Hospital 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 for immunizations as recommended by the Centers for Disease Control (CDC). The recommendations may include age and/or frequency restrictions. The CDC is an independent organization that offers health information on behalf of Blue Cross and Blue Shield of South Carolina.

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

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

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

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

Mental Health & Substance Use Disorder Services – We will provide benefits as shown in the Member Schedule, for Behavioral Services/Mental Health and/or Substance Use Disorders.

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

Newborn Child Coverage – When you purchase this Policy for your newborn, or add your newborn to your Policy within 60 days of his or her birth, coverage will be effective on the date of birth and benefits will be provided for the hospitalization and related professional services for the newborn for at least 48 hours after a vaginal delivery (96 hours following a Cesarean section) or the date of discharge from the Hospital — whichever occurs first. The day of birth is not counted in the 48 hours after vaginal delivery (96 hours for Caesarean Section). You may also choose to make coverage effective the first day of the month following the birth, but must give us notice of your choice; if we do not receive specific instructions, the Effective Date of Coverage for the Newborn will be the date of birth. Please Note: although you have 60 days to enroll the child, we cannot process claims until the Newborn Child is enrolled for coverage.

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 and recommendations; they are not affiliated with Blue Cross and Blue Shield of South Carolina.

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 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 will not provide benefits for daily medical visits by more than one Physician unless the Member has a separate medical condition the attending Physician cannot 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 are Inpatient.

Benefits are provided for medical visits by another Physician when you have a condition the Physician who performed the Surgery cannot 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 an assistant at Surgery or anesthesiologist, perform procedures in conjunction with one another, we will 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 Allowed Amount 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 Allowed Amount for the major procedure will be covered.

c. Surgical Assistant – Services of a Physician or other Clinician who actively assists the operating Physician during an eligible Surgery in a Hospital. We will provide a predetermined percent not more than 20 percent of the Allowed Amounts, not to exceed the Physician's actual charge. The following conditions must be met:

- The complexity of the procedure or the patient's condition warrants an assistant surgeon
- An intern, resident or house physician is not available to assist
- Non-physicians (e.g., physician assistants, first assistants, certified surgical assistants and nurse practitioners) are considered ancillary support for the surgeon and will not be considered an assistant at surgery, unless the non-physician is credentialed for the procedure and at the Hospital where it is performed.

Some surgical procedures do not require an assistant at surgery and benefits for an Assistant Surgeon will be denied as not Medically Necessary. A Physician Assistant or Nurse Practitioner may not serve as an assistant surgeon or Surgical Assistant, unless the Physician Assistant or Nurse Practitioner has separate surgical privileges at the Facility or Hospital.

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

Note: If you receive services at an In-network Hospital or from another In-network Provider, you may also receive ancillary services that are incidental to the primary benefit/service from an Out-of-network Provider. When this happens, you may be required to pay the full cost of those services or benefits you received from the Out-of-network Provider. For example, if you have surgery at an In-network Hospital, performed by an In-network Physician, but the anesthesiologist is not in the Blue Essentials network, charges billed by the Out-of-network anesthesiologist are not covered and will be your responsibility.

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

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

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

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

Preventive Screenings – A limited number of services are provided as preventive care with no cost share. Services not specifically covered remain member liability and are generally covered at the Coinsurance amount after you reach your Deductible. 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 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. These organizations and agencies are independent bodies that offers health information and recommendations; they are not affiliated with Blue Cross and Blue Shield of South Carolina.

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

Prosthetics – Benefits are provided for a prosthetic, other than a dental or cranial prosthetic, which meets minimum specifications for the body part it is replacing regardless of the functional activity level. The item must be a standard, non-luxury item as determined by us. Specialty items including, but not limited to, bionics/bioelectric, microprocessor components or computer programed prosthetics are not 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 is not a Covered Service.

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

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

Preauthorization is required for Inpatient Rehabilitation and you must use a Provider we designate. If Preauthorization is not obtained and/or you don't use the 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, benefits will be denied.

Benefits for a Residential Treatment Center are provided at the semi-private room rate. When you are admitted to a Residential Treatment Center 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 Center is the Admission day. The day you leave the Residential Treatment Center, 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 Center.

Skilled Nursing Facility – Benefits include room and board, special diets, general nursing services, therapy services and other ancillary services. You must be admitted within 14 days after being discharged from a Hospital following an authorized hospitalization. Preauthorization is required. If Preauthorization is not obtained, benefits will be denied.

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

The day you go to the Skilled Nursing Facility is the Admission day. The day you leave the Skilled Nursing Facility, with or without permission, is the discharge day. Please note that services provided on the day of discharge are provided according to the 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 Network Providers who have been credentialed as eligible Telehealth Providers. See Blue CareonDemand℠ (above).

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

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

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

The following are examples of services that are not Telemedicine services and are not covered:
1. 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).

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

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

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 Policy. Organ transplants don't include transplants involving mechanical or animal organs.

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

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, and
   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. All services must meet evidence-based guidance and standard medical practice.

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), syngeneic bone marrow transplantation (from one identical twin to the other), or other forms of stem cell transplant (with or without high doses of chemotherapy or radiation) where use of the transplant is not consistent with evidence-based guidance or standard medical practice;
- Adrenal tissue to brain transplants;
- Islet cell transplants;
- Procedures that involve the transplantation of fetal tissues into a living recipient.

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

Pediatric Vision Services

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

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

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 BlueEssentials Covered Drug List (formulary), as long as:

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

The BlueEssentials Covered Drug List gives information about Prescription Drugs covered under this Plan 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. More information about the Covered Drug List and Network Pharmacies can be found under the Prescription Drug Information section at: https://www.SouthCarolinaBlues.com/links/metallic/pharmacy.

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.

Pharmacy benefits are only available when provided by a Network Pharmacy. Not all pharmacies are part of the BlueEssentials Network. 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 Limit is met, you will pay one or more of the following for each Prescription Drug, depending upon your Plan type: Prescription Drug Deductible, Copayment, Deductible and/or Coinsurance. Once you have met your Maximum out-of-pocket, you will no longer have to pay out-of-pocket for covered benefits until a new Benefit Period begins. Please refer to your Member Schedule for specific Plan costs for each Tier referenced below.

- Tier 0: Drugs on this tier are considered preventive medications under the Affordable Care Act (ACA) and are covered at no cost to you.

- Tier 1: These drugs are most often generic and will generally cost you the least amount of money out of your pocket. 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 medication available.
- Tier 4: These are typically drugs that are used in the management of chronic or genetic disease, including but not limited to injectable, infused or oral medications; or, products that otherwise require special handling, refrigeration and special training. You will usually pay more for drugs in this tier than drugs in lower tiers.

How to file a Prescription Drug Claim

Network Pharmacies will file all claims for you. No benefits are available from non-Network Pharmacies. If you receive Prescription Drugs from a non-Network Pharmacy due to an Emergency Medical Condition, please refer to *How to Contact Us if You Have a Question* section.

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

Mail-order Pharmacy

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

Specialty Pharmacy

Drugs that are designated to be specialty medications must be filled by our Specialty Pharmacy. Although most Specialty drugs are found in Tier 4, they could also be categorized in any of the Tiers. The list of drugs that must be filled by our Specialty Pharmacy is included as part of the BlueEssentials 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. Our Specialty Pharmacy can overnight medications 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 Member Schedule 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 BlueEssentials Covered Drug List. These requirements and/or limits may include:

- Prior Authorization (PA): If your drug needs prior authorization, your doctor will have to get approval before we will cover your drug. 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.

Preauthorization/Prior Authorization Contact Information:

Type of request	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.

Novologix is an independent company that preauthorizes certain prescription drugs and medications on behalf of Blue Cross and Blue Shield of South Carolina.

- 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. If we determine a member has used multiple doctors or pharmacies to obtain quantities of prescription medication in excess of what is allowed or recommended, we reserve the right to require the use of a designated provider for prescribing the medication and/or a specific pharmacy to fill prescriptions of that medication.

- Step Therapy (ST): If your drug has a step therapy requirement, we will only cover second choice drugs if you have already tried a first choice drug and it 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** (standard or expedited): If a drug is not covered, it may be helpful to discuss other covered alternatives with your Physician; or, if not medically viable, you may request a formulary exception. An exception request may be made by the Member,the Member's designee, or the Member's prescribing Provider (or other prescriber, as appropriate) to request and gain access to clinically appropriate drugs not otherwise covered by the health plan by contacting our Pharmacy Benefit Manager (PBM). You may also contact the 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. Our Pharmacy Benefit Manager will work with the prescribing physician to obtain any medical records or other necessary information to process the request. We must act on a standard request within 72 hours and on an expedited request within 24 hours after we receive your request for a formulary exception. Expedited requests are available only when you have exigent circumstances: a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or when you are undergoing a current course of treatment using a non-formulary drug. For a standard formulary exception, we will notify you no later than 72 hours following receipt of the request, and if approved, will provide coverage of the approved non-formulary drug for the duration of the prescription, including refills. For an expedited formulary exception, the determination will be made no later than 24 hours following receipt of the request and, if approved, will provide coverage of the non-formulary drug only for the duration of the exigent circumstances.

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

CVS/Caremark
Appeals Department, MC 109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax: 1-866-443-1172

The independent review organization will make a determination on your exception review and we will notify you or your designee, along with the prescribing Provider, of the coverage determination. If the original request was a standard formulary exception request, we will notify you no later than 72 hours following receipt of the request, and if approved, will provide coverage of the approved non-formulary drug for the duration of the prescription. If the original formulary exception request was an expedited request, the determination will be made no later than 24 hours following receipt of the request and, if approved, will provide coverage of the non-formulary drug only for the duration of the exigency. If you still disagree with the decision in your case, see the Appeals section of this Policy.

Pharmacy Exclusions: What's Not Covered?

We will not provide benefits for the following Prescription Drugs:

a. That are used for or related to Non-Covered Services or conditions, such as, but not limited to, weight control, obesity, erectile dysfunction, cosmetic purposes (such as Tretinoin or Retin-A, Kybella for chin fat), hair growth and hair removal.
b. That are used for infertility.
c. More than the number of days' supply allowed as shown in your Member Schedule.
d. Refills in excess of the number specified on your Physician's prescription order.
e. More than the recommended daily dosage defined by BlueCross, unless prior authorization is sought and approved.
f. When administered or dispensed in a Physician's office, Skilled Nursing Facility, Hospital or any other place that is not licensed to dispense drugs.
g. That are available over-the-counter or when there is an over-the-counter equivalent containing the same active ingredients as the prescription/Rx version including any over-the-counter supplies, devices or supplements.
h. When not consistent with diagnosis and treatment of an illness, injury or condition or that is excessive in terms of the scope, duration or intensity of drug therapy that is needed to provide safe, adequate and appropriate care.
i. Some medications classified as self-administered drugs; when obtained, purchased, and/or administered at a doctor's office or in an outpatient setting.
j. That require Prior Authorization, and the Prior Authorization is not received.
k. That requires step therapy when the Step Therapy Program is not followed.
l. That are received Out-of-network, unless due to an Emergency Medical Condition.
m. That are not on the BlueEssentials Covered Drug List.
n. Any medications or drugs in which the costs and associated services for said drugs or medications are in any way paid for through or under a pharmaceutical manufacturer or other discount card or coupon program on behalf of the member (excluding members who qualify or enroll in patient assistance programs designed to assist members based on financial need or hardship).
o. Food or nutritional substances, such as orthomolecular therapy, infant formula, nutrients, vitamins, food supplements, and enteral feedings, whether or not obtained with a prescription.
p. Prescription Drugs that are new to the market and under clinical review by 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.

q. 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.

Exclusions and Limitations

All Exclusions apply even if the service is deemed Medically Necessary. Notwithstanding any provision of the policy to the contrary, if the policy generally provides benefits for any type of injury, then in no event shall an exclusion or limitation of benefits be applied to deny coverage for such injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health condition), even if the medical condition is not diagnosed before the injury.

1. General Exclusions

a. Services and supplies that are:

- not Medically Necessary
- not needed for the diagnoses or treatment of an illness or injury; or
- not specifically listed in Covered Services.

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

c. Services or benefits received from any Provider not in the Network, unless we have directed you to receive care at the Provider, or if the care results from an Emergency Medical Condition and was received in the emergency department of a Hospital.

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

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

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

2. Abortion Services

a. Services or supplies related to an abortion, except:

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

3. Administrative Charges

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

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

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

4. Alternative Treatments, Pain Management, Wellness Programs

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

5. Ambulance Charges

a. Ambulance services that meet the following criteria:

1. That do not meet coverage guidelines outlined in the Ambulance Services description in Covered Services; or

2. That are not Medically Necessary and reasonable; or

3. To a more distant Hospital solely for the member's convenience, regardless of the reason, or to allow the Member to use the services of a specific Physician or Specialist. BlueCross will pay the base rate and mileage for a Medically Necessary ambulance transport to the nearest medically appropriate facility. If the transport is to a facility that is not the nearest medically appropriate facility, the member is responsible for additional cost incurred to go to the Member's preferred facility; or

4. If the member is medically stable and the situation does not involve an Emergency; or

5. Transport from a Hospital in connection with a hospitalization outside the United States.

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

6. Benefits Available from other Sources

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

b. Services or supplies for which you are entitled to benefits under a governmental program (except Medicaid).

c. Injuries or diseases paid by Workers' Compensation or settlement of a Workers' Compensation claim.

d. Treatment provided in a government Hospital for which you are not legally responsible.

e. Charges by the Department of Veterans Affairs (VA) for a service-related disability.

f. Services or supplies you or a member of your immediate family provides; a member of your family means spouse, parents, grandparents, brothers, sisters, aunts, uncles, children or in-laws.

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

7. Chiropractic Care

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

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

a. Cosmetic Surgery: any plastic or reconstructive Surgery done mainly to improve the appearance or shape of any body part and for which no improvement in physiological or body function is reasonably expected. Cosmetic Surgery does not include reconstructive Surgery incidental to or following Surgery resulting from unexpected or unforeseen physical trauma, infection or other diseases of the involved part, or reconstructive Surgery because of congenital disease or anomaly of a covered child which has resulted in a functional defect. Complications arising from Cosmetic Surgery are also not covered.

b. Breast augmentation except after treatment for breast cancer.

c. Reduction mammoplasty for macromastia unless you are within 20 percent of your ideal body weight.

d. Any treatment or Surgery for obesity (even if morbid obesity is present), weight reduction or weight control, such as gastric by-pass, 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.

e. Adjustable cranial orthosis (band or helmet) for positional plagiocephaly or craniosynostoses in the absence of cranial vault remodeling Surgery.

f. Unless preauthorized under BlueCross medical management guidelines, services, supplies or treatment for any venous insufficiency or venous incompetence, including but not limited to, varicose veins, endovenous ablation, vein stripping or sclerosing solutions injection, whether or not medically necessary.

9. Custodial Care or Long Term Care

a. Rest care or Custodial Care

b. Admissions or portions thereof for long-term or chronic care for medical or psychiatric conditions.

10. Dental Care, Oral Surgery

a. Physician services directly related to the care, filling, removal or replacement of teeth; the removal of impacted teeth; and the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth. This includes, but is not limited to: apicoectomy (dental root resection), root canal treatment, alveolectomy (Surgery for fitting dentures) and treatment of gum disease.

b. Services for or related to dental care except as follows:

- Within six months of an accident, a member may receive benefits for medically necessary, non-cosmetic dental treatment to teeth that were damaged in the accident;
- When a Member requires dental anesthesia because the Member is unable to cooperate for dental treatment, and the service or benefit is approved by us prior to any dental procedure; and
- For Medically Necessary Cleft Lip and Palate services.

c. Any service or supply related to dysfunctional conditions of the chewing muscles, wrong position or deformities of the jaw bone(s), jaw muscles, orthognathic deformities or temporomandibular joint syndrome (headache, facial pain and jaw tenderness) caused by jaw problems usually known as TMJ, regardless of cause.

11. Durable Medical Equipment

a. Durable medical equipment or prosthetic devices when the cost is in excess of $500 and preauthorization is not obtained.

b. Equipment available over the counter such as, but not limited to, air conditioners, air filters, whirlpool baths, spas, (de)humidifiers, wigs, fitness supplies, vacuum cleaners or common first aid supplies.

c. Luxury or convenience items whether or not a Physician recommends or prescribes them.

d. 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.

e. Bioelectric, microprocessor or computer-programmed prosthetic components.

f. A penile prosthesis will be considered as a benefit under Durable Medical Equipment only after Medically Necessary prostate Surgery.

12. Excessive sweating

Any services, supplies or treatment for excessive sweating.

13. Family Planning

a. Any services or supplies for the diagnosis or treatment of infertility.

b. Pre-conception testing or pre-conception genetic testing; limited testing is available but must be pre-authorized by Avalon Health Services. See Preauthorization section.

14. Food or Nutrition

Orthomolecular therapy including infant formula, nutrients, vitamins and food supplements, and enteral feedings.

15. Foot Care

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

16. Genetic testing or counseling

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

17. Hearing Assistance

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

18. Infertility

a. Any services, supplies, or prescription drugs for the diagnosis or treatment of infertility. This includes, but is not limited to: fertility drugs, lab and X-ray tests, reversals of sterilization, surrogate parenting, artificial insemination and in-vitro fertilization.

b. Pre-conception testing or pre-conception genetic testing (limited testing is available but only when pre-authorized; see Preauthorization section).

19. Investigational or Experimental Services

Investigational or Experimental Services, as determined by us, including but not limited to the following:

a. Relating to transplants:

1) Uses of allogeneic bone marrow transplantation (between two related or unrelated people), syngeneic bone marrow transplantation (from one identical twin to the other), or other forms of stem cell transplant (with or without high doses of chemotherapy or radiation) where use of the transplant is not consistent with evidence-based guidance or standard medical practice;

2) Adrenal tissue to brain transplants;

3) Procedures that involve the transplantation of fetal tissues into a living recipient.

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

20. Maternity and Newborn Care

a. Limited pre-conception testing or pre-conception genetic testing is available and only as Pre-Authorized. See Pre-Authorization section.

b. Newborn care as an Inpatient, Outpatient, or Office Visit, unless the Newborn is added to the Policy within 60 days, and the appropriate Premium paid.

21. Mental Health

The following services are excluded, whether received as an Inpatient, Outpatient, or during an Office Visit.

a. Schools, camps and/or boarding homes including therapeutic schools; wilderness/boot camps; therapeutic boarding homes; half-way houses; and therapeutic group homes.

b. 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, the intellectually disabled, dissociative disorder, sexual disorder, personality disorder and vocational rehabilitation.

c. Marriage counseling.

d. 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 Policy.

e. 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.

f. Any behavioral, educational or alternative therapy techniques to target cognition, behavior, language, and social skills modification, including but not limited to:

1. Applied behavioral analysis therapy;
2. Teaching, Expanding, Appreciating, Collaborating and Holistic programs (TEACCH);
3. Higashi schools/daily life;
4. Facilitated communication;
5. Floor time;
6. Developmental Individual-Difference Relationship-based model (DIR);
7. Relationship Development Intervention (RDI);
8. Holding therapy;
9. Movement therapies;
10. Music therapy; and
11. Animal-assisted therapy.

g. Services, treatment or medications for autism spectrum disorder.

22. Out-of-Network Charges

Out-of-Network benefits are not available unless specifically described under Emergency Services, Urgent Care Services, or under Out-of-Area Services, which also provide benefits only for Emergency Services or Urgent Care Services. Even when coverage is available for out-of-Network services, benefits are limited to the in-Network Allowed Amount, and the Member remains liable for all amounts above the Allowed Amount.

23. Physician Charges

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

b. Physician charges for drugs, appliances, supplies, blood and blood products.

24. Preauthorization Required

a. Benefits will be denied for procedures, services or pharmaceuticals when you don't get the required Preauthorization.

b. Hospital or Skilled Nursing Facility charges when Preauthorization is not obtained. Please refer to the *Preauthorization* section of this Policy.

c. All Admissions to Hospitals or freestanding Rehabilitation Facilities for physical Rehabilitation when the services are not done at a Provider we designate and/or you don't receive the required Preauthorization.

d. Any medical social services, visual therapy or private duty nursing, except when part of a Preauthorized home health care or hospice services program.

25. Prescription Drugs and Medications

a. That are used for or related to Non-Covered Services or conditions, such as, but not limited to, weight control, obesity, erectile dysfunction, cosmetic purposes (such as Tretinoin or Retin-A, Kybella for chin fat), hair growth and hair removal.
b. That are used for infertility.
c. More than the number of days' supply allowed as shown in your Member Schedule.
d. Refills in excess of the number specified on your Physician's prescription order.
e. More than the recommended daily dosage defined by BlueCross, unless prior authorization is sought and approved.
f. When administered or dispensed in a Physician's office, Skilled Nursing Facility, Hospital or any other place that is not licensed to dispense drugs.
g. That are available over-the-counter or when there is an over-the-counter equivalent containing the same active ingredients as the prescription/Rx version including any over-the-counter supplies, devices or supplements.
h. When not consistent with diagnosis and treatment of an illness, injury or condition or that is excessive in terms of the scope, duration or intensity of drug therapy that is needed to provide safe, adequate and appropriate care.
i. Some medications classified as self-administered drugs; when obtained, purchased, and/or administered at a doctor's office or in an outpatient setting.
j. That require Prior Authorization, and the Prior Authorization is not received.
k. That requires step therapy when the Step Therapy Program is not followed.
l. That are received Out-of-network, unless due to an Emergency Medical Condition.
m. That are not on the BlueEssentials Covered Drug List.
n. Any medications or drugs in which the costs and associated services for said drugs or medications are in any way paid for through or under a pharmaceutical manufacturer or other discount card or coupon program on behalf of the member (excluding members who qualify or enroll in patient assistance programs designed to assist members based on financial need or hardship).
o. Food or nutritional substances, such as orthomolecular therapy, infant formula, nutrients, vitamins, food supplements, and enteral feedings, whether or not obtained with a prescription.
p. Prescription Drugs that are new to the market and under clinical review by 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.
q. Prescription Drugs and pharmaceuticals under the medical portion of this Policy when benefits are available under the Prescription Drug benefit.

26. Preventive services

Preventive Services other than those specifically described under Covered Services. Some tests may be used for screening (preventive) purposes or for diagnostic purposes; when filed by the Provider for a diagnostic purpose, the claim will not be paid under the Preventive Care provisions. Normal contract terms will apply.

27. Self-inflicted Injuries

Treatment, services or supplies received as a result of intentionally self-inflicted injuries, including suicide, attempted suicide or unless the act results from a medical (physical or mental) condition.

28. Sexual Dysfunction

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

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

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

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

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

Medicare Coverage

If you are enrolled in another insurance coverage, such as Medicare, that offers medical coverage for any of the benefits under this Policy, BlueCross may reduce benefits under this Policy to avoid paying benefits between the two plans that are greater than the cost of the health care service. If you and/or your dependents become eligible for Medicare, you should apply and enroll in Medicare Part A and B, and use Providers who accept Medicare in order to

ensure that you receive full benefit coverage. Based on Medicare Secondary Payor legislation, regulations and Centers for Medicare & Medicaid Services guidance, BlueCross assumes you will enroll in Medicare once you are eligible, and BlueCross may take into account the benefits that you or your dependent are eligible for under Medicare, regardless of whether you have actually enrolled for that coverage. In other words, even if you have not enrolled in Medicare, BlueCross may reduce your claim by the benefits that you are eligible for under Medicare, and then pay the remaining claim amount under the terms of this Policy and in accordance with Medicare coordination rules. As a result, your Maximum out-of-pocket costs may be higher if you do not enroll in Medicare.

The coordination of benefits (COB) process ensures that claims are paid correctly by identifying the health benefits available to a Medicare beneficiary, coordinating the payment process, and ensuring that the primary payer (Medicare) pays first. It also ensures that the amount paid by plans in dual coverage situations does not exceed 100% of the total claim, to avoid duplicate payment. Even if you have not enrolled in Medicare Part B, we will coordinate benefits and reduce your claim(s) by the benefits that you would be eligible for under Medicare Part B. This may result in physicians billing you for services that were only partially covered under your BlueEssentials plan.

If you have Medicare Part A (hospital insurance), Medicare Part B (medical insurance), or Medicare Part C (combined hospital and medical), your Marketplace coverage duplicates your Medicare coverage. This may affect your eligibility for this Policy and any APTC you receive. Contact www.Healthcare.gov or call 800-318-2596 (TTY: 855-889-4325) to discuss how your Medicare eligibility affects this coverage.

Providers

This Policy requires you to use our Network Providers in the BlueEssentials Network. Benefits are covered in-Network only. The BlueEssentials 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.
To find a Network Provider, go to www.SouthCarolinaBlues.com/links/metallic/providers/EPO.

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

It's important to use a BlueEssentials Network Provider because these Providers have agreed to:
- Bill you no more than the BlueEssentials Network allowance for Covered Services.
- File all claims for you when this Policy is your primary insurance.
- Ask you to pay only the required Deductibles, Copayments and Coinsurance for covered amounts.
- Obtain necessary Preauthorization.

Providers not in the BlueEssentials Network:
- Are not limited in the amount you can be charged.
- May require you to file claims.
- May require payment in full before you receive services.
- Can Balance-Bill you for any amount BlueCross does not pay. This is true even when BlueCross agrees that you can receive services from an out-of-Network Provider.

If you have an Emergency Medical Condition and are treated in an Emergency Room at an out-of-Network Hospital, we will provide benefits at the in-Network Coinsurance amount. The Allowed Amount we pay for Emergency Services by an out-of-Network Provider will be the greater of: A) the median amount if such

emergency services were rendered by an in-Network Provider participating in the BlueEssentials Network; or B) the amount for those emergency services calculated using Medicare allowances, which is the method BlueCross generally uses to determine payment to an out-of-Network Provider. However, an out-of-Network Provider can Balance-Bill you for the difference between the Allowed Amount we pay and his or her actual charge.

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

It is always a good idea to ask if your Provider is a BlueEssentials Network Provider before you receive care. To find out if your Physician or Hospital is a BlueEssentials Network Provider, see the *How to Contact Us if You Have a Question* section to request a directory or visit our website. The BlueEssentials Provider Network may change.

We make every effort to contract with Physicians and Clinicians who practice at BlueEssentials Network Hospitals. Some Physicians, however, choose not to be BlueEssentials Network Providers even though they may practice at BlueEssentials Hospitals. It's important to understand that while you can still use these Physicians, we will not provide benefits for any services you receive from that Physician.

Note: If you receive services at an In-network Hospital or from another In-network Provider, you may also receive ancillary services that are incidental to the primary benefit/service from an Out-of-network Provider. When this happens, you may be required to pay the full cost of those services or benefits you received from the Out-of-network Provider. For example, if you have surgery at an In-network Hospital, performed by an In-network Physician, but the anesthesiologist is not in the Blue Essentials network, charges billed by the Out-of-network anesthesiologist are not covered and will be your responsibility.

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

Continuation of Care

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

If you are receiving treatment for a Serious Medical Condition at the time a BlueEssentials Provider's contract ends, you may be eligible to continue to receive treatment from that Provider. In order to receive this continuation of care for a Serious Medical Condition, you must submit a request to us on the appropriate form.

You may get the required form for this request from us by going to our website or by calling 855-404-6752. You will also need to have the treating Provider include a statement on the form confirming that you have a Serious Medical Condition. Upon receipt of your request, we will notify you and the Provider of the last date the Provider is part of our BlueEssentials Network and a summary of continuation of care requirements. We will review your request to

determine if you qualify for the continuation of care. If additional information is necessary to make a determination, we may contact you or the Provider for such information.

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

Services Outside the BlueEssentials Network

The following section describes how services are paid when you are out-of-area and receive services from a Provider that is not in the BlueEssentials Network. This program benefits you when you receive Covered Services for an urgent condition while traveling outside the Company's service area (generally the state of South Carolina).

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 Programs." These Inter-Plan Programs work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area BlueCross serves, the claim for those services may be processed through one of these Inter-Plan Programs.

When you receive care outside of our service area (generally the State of South Carolina), 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.

BlueCross covers only limited healthcare services received outside of our service area. As used in this section, "Out-of-Area Services" for EPO plans refer to emergency care obtained outside the geographic area of our service area. Any other services will not be covered when processed through any Inter-Plan Program unless authorized by us.

As used in this section, "Out-of-Area Covered Healthcare Services" include only those services necessary to treat an Emergency Medical Condition when those services are received as an Outpatient in a Hospital Emergency Room or in an Urgent Treatment Center, and only for as long as your condition continues to be considered an Emergency when obtained outside the geographic area we serve. Any other services will not be covered when processed through any Inter-Plan Program unless authorized by us.

Inter-Plan Programs Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Programs, as described above, except for Dental Care Benefits (unless Dental care Benefits are covered as a medical expense), and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by us to provide the specific service or services.

A. BlueCard® Program

Under the BlueCard Program, when you receive Out-of-Area 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.

The BlueCard Program enables you to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare Provider participating with a Host Blue, where available. The participating Provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the member copayment amount, as stated in your Policy.

B. Emergency Care Services

If you experience an Emergency Medical Condition while traveling outside the Blue Cross and Blue Shield of South Carolina service area, go to the nearest Emergency Room or Urgent Treatment Center. When you receive Out-of-Area Covered Healthcare 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 covered charges for your Covered Services; or
- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your 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 or modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price we have used for your claim because they will not be applied after a claim has already been paid.

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.

C. Non-participating Providers Outside Our Service Area

Your Liability Calculation: When Out-of-Area Covered Healthcare Services are provided outside of our service area by non-participating Providers, the amount you pay for such services will normally be based on either the Host Blue's non-participating Provider local payment or the pricing arrangements required by applicable state law. Additional information is contained under the "Emergency Services" listed in the "Covered Services" section of this policy. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

D. Blue Cross Blue Shield Global® Core

If you are outside the United States, you may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing Covered Services. The Blue Cross Blue Shield Global Core is not served by a Host Blue. As such, when you receive care from Providers outside the BlueCard service are, 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 United States, you should call the Blue Cross Blue Shield Global Core service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

An assistance coordinator, working with a medical professional, will arrange a Physician appointment or hospitalization, if necessary.

- Inpatient Services

In most cases, if you contact the Blue Cross Blue Shield Global Core service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts. In such cases, the Hospital will submit your claims to the Blue Cross Blue Shield Global Core service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Healthcare Services.

- Outpatient Services

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

- Submitting a Blue Cross Blue Shield Global Core Claim

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

How to File a Claim

By accepting this Policy, you authorize release to Blue Cross and Blue Shield of South Carolina or its representatives of all past and future medical records and other information deemed necessary by BlueCross to review, process or investigate your claims. This authorization for release of past, present and future information includes Medicare Part A and B claims.

If you receive health care services or supplies from a Network Provider, the Provider will file your claims for you. No benefits are available from non-Network Providers. If you receive health care services or supplies for an Emergency Medical Condition from an out-of-Network Provider, you will 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 will need:

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

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

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

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

How Long You Have to File a Claim

We must receive your claim no later than 12 months from the date of service. Exceptions may be made if you show you were not legally competent to file the claim. Claims will be processed in the order we receive them.

How Long We Have to Process a Claim

The time frames we are allowed to provide a determination for each of these claims are listed below:

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

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

We will let you know within five calendar days if we receive incomplete information from you and additional information is required to make a determination. You have 60 calendar days to send us required information. If we 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 receipt of the original Urgent Care Claim. An Urgent Care Claim is any claim, where, if the normal Preauthorization review time frames were used, your life, health or ability to regain maximum function could be seriously jeopardized; or you would be subject to severe pain that cannot be adequately managed without the care or treatment. We will defer to the attending Provider with respect to the decision as to whether a claim constitutes "urgent care." A Provider may be considered an authorized representative without a specific designation by you when the Preauthorization request is for Urgent Care Claims (medical conditions which require immediate treatment).

We will notify you or your authorized representative within 24 hours from receipt of the original Urgent Care Claim if we 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 will notify you within the initial 30-day time period that an extension is necessary.

We will let you know within 30 calendar days if we receive incomplete information from you and additional information is required to make a determination. You have 60 calendar days to provide the required information. If we 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 are entitled to the rest of the initial determination period to reach a benefit determination once we get the additional information from you or the Provider.

4. Concurrent Care Decision – If we make a decision to reduce or stop benefits for Concurrent Care that had previously been approved, you must be notified sufficiently in advance of the reduction or termination of benefits to allow you time to appeal the decision before the benefits are reduced or terminated. Concurrent Care is an 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 will 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 Policy. It outlines the terms and conditions of your health coverage.
- Contact Marketplace Operations for help.

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 Policy, and any from other insurance companies or any other organizations.

Time Limit to Question a Claim or File a Lawsuit (Legal Actions)

You have only 180 days to question or appeal our decision regarding a claim. After that date, we will consider disposition of the claim to be final. You cannot bring any legal action against us until 60 days after we receive a claim (proof of loss) and you have exhausted the appeal process as described in the *Appeal Procedures* section of this Policy. You cannot bring any action against us more than six years after a claim (proof of loss) has been received.

Appeals Procedures

Please direct any complaints or disagreements you have regarding claims for services or benefits to us at 855-404-6752. You can also send us a secure email through the Ask Customer Service feature of My Health Toolkit on our website at www.SouthCarolinaBlues.com.

A Preauthorization denial will be considered a denied claim for purposes of this provision. You can direct any complaints or disagreements you have regarding a Preauthorization to us at 803-736-5990 from Columbia, or 800-327-3238 from anywhere else.

Appeals

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

How to File an Appeal

If you wish to file a formal appeal, you must write to Blue Cross and Blue Shield of South Carolina, Member Services Center, P.O. Box 100300, Columbia, SC 29202. The appeal must state that you are requesting a formal appeal and include all pertinent information regarding the claim in question that you wish to be considered in the appeal.

Requests to cover services and supplies which are specifically excluded in the Policy will be treated as appeals. However, such appeals are not eligible for external review. The following guidelines apply for each type of claim (including the appropriate claim with regard to a Concurrent Care decision), unless both parties agree to an 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 30 calendar days after receiving the appeal.

2. Urgent Care Claim – You have 180 days to appeal our decision on an Urgent Care Claim. You may request an expedited review for an Urgent Care Claim either orally or in writing, and all necessary information pertaining to the appeal must be transmitted by telephone, facsimile, or other expeditious method. We must complete the appeal process within 72 hours after receiving the appeal.

3. Post-service Claim – You have 180 days to appeal our decision on a Post-service Claim. We must complete the appeal process within 60 calendar days after receiving the appeal.

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

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

1. De minimis;
2. Non-prejudicial;
3. Attributable to good cause or matters beyond our control;
4. In the context of an ongoing good-faith exchange of information; and
5. Not reflective of a pattern or practice of non-compliance.

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

External Reviews

You will be notified in writing of your right to request an external review. You should file a request for external review within four months of receiving that notice. You will be required to authorize the release of any medical records that may be needed for the external review. If you need assistance during the external review process, you can contact the South Carolina Department of Insurance at the following address and telephone number:

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

Standard External Review

You can request an external review if we deny your claim, either in whole or in part. You may be held financially responsible for the covered benefits. You can request an external review without completing the appeal process above if:

1. Your Physician has certified in writing that you have a Serious Medical Condition; or
2. The denial of coverage was based on our determination that the service is Investigational or Experimental and your Physician certifies:
    a. Your condition is a serious disability or you have a life-threatening disease; and
        i. Standard health care services or treatments have not been effective in improving your condition; or
        ii. Standard health care services or treatments are not medically appropriate; or
        iii. The recommended or requested service or treatment is more beneficial than the standard health care service or treatment covered by us; and
    b. Medical and scientific evidence shows that treatment that was denied is more beneficial to you than available standard health services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of the standard services or treatments.

We will respond within five business days of your request for an external review, by either notifying the South Carolina Department of Insurance of a request for external review and requesting the South Carolina Department of Insurance to assign the review to an independent review organization (IRO) and forwarding your records to it or telling you in writing that your situation doesn't meet the requirements for an external review and explaining the reasons.

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

If your request is assigned to an IRO, the IRO will determine within five business days after receiving your request whether all the information, certifications and forms required to process an external review have been provided. If the IRO needs additional information, you will be allowed to submit additional information in writing to them within seven business days.

If your request is not accepted for external review, the IRO will inform you and us in writing of the reason(s) your request was not accepted.

The IRO will provide written notice of its decision within 45 days after it receives the request.

If the IRO's decision is to allow benefits, we must process the claim subject to applicable Policy exclusions, limitations and other provisions within five business days of our receipt of the notification.

Expedited External Reviews

You can request an expedited external review at the same time as requesting an expedited internal review.

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

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

All requests for external review will be at our expense.

If your Physician certifies that you have a "serious medical condition," you are entitled to an expedited external review. A serious medical condition, as used in this provision, means 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.

Subrogation and Reimbursement

A. SUBROGATION

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

B. REIMBURSEMENT

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

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

C. GENERAL PROVISIONS

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

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

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

As a condition of receiving Benefits, the Member must:

1. Immediately notify the Corporation of an injury for which another party may be liable, legally responsible or otherwise makes a payment in connection with the injuries;

2. Execute and deliver an accident questionnaire within one hundred eighty (180) days of the accident questionnaire being mailed to the Member;

3. Deliver to the Corporation a copy of the police report, incident or accident report or any other reports issued as a result of the injuries within ninety (90) days of being requested to do so;

4. Authorize the Corporation to sue, compromise and settle in the Member's name to the extent of the amount of medical or other Benefits paid for the injuries under the Plan and the expenses incurred by the Corporation in collecting this amount and assign to the Corporation the Member's rights to recovery when this provision applies;

5. Include the amount paid for Benefits as a part of the damages sought against a liable third party and/or liability insurance company;

6. Immediately reimburse the Corporation, out of any recovery made from a liable third party, the amount of medical Benefits paid for the injuries by the Corporation up to the amount of the recovery;

7. Immediately notify the Corporation in writing of any proposed settlement and obtain the Corporation's written consent before signing any release or agreeing to any settlement; and,

8. Cooperate fully with the Corporation in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Corporation.

The Corporation will pay reasonable attorney's fees and costs from the amount recovered.
If the Director of Insurance, or his or her designee, upon being petitioned by the Member, determines that the exercise of subrogation and/or reimbursement by the Corporation is inequitable and commits an injustice to the Member, subrogation and/or reimbursement will not be allowed. This determination by the director or his or her designee may be appealed to the Administrative Law Judge Division as provided by law.

Certificate of Creditable Coverage

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

General Provisions

1. Claim Forms: When we receive notice of a claim, we will send you forms for filing proof of loss. If these forms are not given to you within 15 days, you can meet the proof of loss by giving us a written statement of the nature and extent of the loss within the time limits stated in the Proofs of Loss section.

2. Conformity with State Statutes: Any provision of this Policy which, on its Effective Date, is in conflict with the laws of the state in which it is delivered or in conflict with Federal law on that date is amended to conform to the minimum requirements of such laws.

3. Entire Policy; Changes: This Policy, together with the Application and any attached papers, is the entire Policy between you and Blue Cross and Blue Shield of South Carolina. No agent can change it in any way. Only an officer of ours can approve a change. That change must be shown on your Policy.

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

5. Governing Law: This Policy and all endorsements and amendments issued hereunder will be construed according to and controlled by the applicable laws and regulations of the State of South Carolina and Federal laws and regulations.

6. Illegal Occupation: We are not liable for any loss that results from the Covered Person committing, or attempting to commit a felony or from a Covered Person engaging in an illegal occupation.

7. Legal Action: No legal action may be brought to recover on this Policy within 60 days after written proof of loss has been given as required by this Policy. No such action may be brought after six years from the time written proof of loss is required to be given.

8. Meetings of Insured Persons: While this Policy is in force, you are a Member of Blue Cross and Blue Shield of South Carolina. You are entitled to vote at any meeting of Members. Our annual meeting is held at our Home Office in Columbia, South Carolina, and notice of the annual meeting is given by mail. We will mail you notice of any special meeting of Members 30 days before such meeting.

9. Non-assessable: This is a Non-assessable Policy. You are not subject to any assessment for any contingent liability. This means that if, for any reason, we owe money, you are not responsible for paying it.

10. Notice of Claim: Written notice of claim must be given within 20 days after a covered loss starts or as soon as reasonably possible. The notice may be given to us at our home office or to our agent. Notice should include the name of the Covered Person and the Policy number.

11. Other Valid Coverage: Proration: This Policy is not meant to duplicate other valid coverage you have with other Health Insurance policies, not including Medicare; see the Medicare Coverage Provision above, on page 37 .

If you have Other Valid Coverage, we will "prorate" benefit payments when your claim is received. We will carefully consider all of the valid Health Insurance that covers your claim. We will determine our responsibility for your

loss in proportion to the responsibility that should be accepted by other insurance companies, and we will pay the portion of your claim we are responsible for.

If your claim is prorated, the portion of the Premiums you paid for coverage that we did not accept as our responsibility will also be prorated. This will be based on Premiums paid during the time both policies were in effect and the treatment was being provided.

12. Payment of Claims: Subject to Member Cost-Sharing, we will pay benefits as follows:

- Where a Member has received Benefits from a Network Provider, we will pay Benefits directly to the Network Provider.
- If a Member receives services from a non-Network Provider, we pay all benefits directly to the Member upon receipt of claims; the Member is responsible for any payment to the Provider. No assignment of Benefits is allowed to a non-Network Provider.
- Payment of benefits related to Emergency Services will be made to the Provider, whether Network or non-Network.
- Any payment of Benefits or refund due after death will be paid to the Member's estate.

13. Physical Examinations and Autopsy: We have the right to have a Physician examine any person as often as reasonably necessary while a claim is pending or after our Medical Services staff has been contacted for review of medical services. We will pay for the cost of these examinations. We may also have an autopsy done during the period of contestability unless prohibited by law. The autopsy must be performed in South Carolina.

14. Proofs of Loss: Written proof of loss must be furnished to us at our said office within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event, except in the absence of legal capacity, will written proofs of loss be furnished later than one year from the time the proof is otherwise required.

15. Right to Transfer: Any person purchasing an individual accident, health or accident and Health Insurance policy, will have the right to transfer to any individual policy of equal or lesser benefits offered for sale by Blue Cross and Blue Shield of South Carolina at the time transfer is sought. Members who purchase this coverage through the Health Insurance Marketplace may be restricted from exercising this right except at the times permitted by the Health Insurance Marketplace (Exchange).

16. Time Limit On Certain Defenses: After two years from the issue date only fraudulent misstatements in the Application may be used to void the Policy or deny any claim for loss incurred or disability that starts after the two year period.

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

Definitions

As you refer to this Policy, please note that the 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 Policy.

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

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

Advanced Premium Tax Credit (APTC): A tax credit provided on an advance basis on behalf of a qualified individual purchasing a qualified health plan through the Health Insurance Marketplace (or FFM).

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

Ambulatory Surgical Center: A free-standing facility not affiliated with a health system that is licensed for Outpatient Services 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.

Application: The electronic or paper form to transmit the necessary information from the Member to us when applying for this Policy. The Application is a part of this Policy.

Authorized Representative: A person you designate in writing to act on your behalf to appeal a particular adverse determination or claim denial. A Provider may act as your Authorized Representative without written permission only when seeking an approval request for Urgent Care Claims (medical conditions which require immediate treatment). In all other situations, a person, including a Provider, must have your written permission to act as your Authorized Representative.

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

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

Benefit Percentage: The percentage of the Allowed Amount 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 period beginning January 1st and continuing through December 31st. Your first Benefit Period begins on your Effective Date of coverage and lasts until December 31st.

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

BlueEssentials Network: The name of the Network of Providers applicable only to this Policy; this Network is an Exclusive Provider Organization (EPO). Only Providers who contract with Blue Cross and Blue Shield of South Carolina to specifically participate in the BlueEssentials Network are considered "in-Network" for purposes of reimbursement under this Policy. This Policy does not cover services rendered by out-of-Network Providers (except Emergency Services for an Emergency Medical Condition as defined by this Policy), who do not contract with Blue Cross and Blue Shield of South Carolina to specifically participate in the BlueEssentials Network. No other provider networks for other products offered by Blue Cross and Blue Shield of South Carolina apply to this Policy.

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 periodically by Blue Cross and Blue Shield of South Carolina to Providers for Care Coordination under a Value-Based Program.

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

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

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

Cost-sharing Reductions: Discounts that lower Cost Sharing for certain services covered by individual health insurance purchased through the Health Insurance Marketplace. You can get these discounts if your income is below a certain level and you choose a Silver level health plan through the Health Insurance Marketplace. If you're a member of a federally recognized Indian tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation, you can qualify for Cost-sharing Reductions under any metal level and may qualify for additional Cost-sharing Reductions depending upon income.

Covered Services: The services that are covered under this Policy. See the Covered Services section.

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

Deductible: The amount you are responsible for paying for Covered Services before we begin to pay each year. The Deductible may not apply to all Covered Services. If you have family coverage, the family Deductible is either aggregate or embedded. Your Member Schedule 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 the single Deductible for that year.

Dependent: Your legal spouse and any children (natural, adopted, step, foster or under legal guardianship) through age 25.

Durable Medical Equipment (DME): Equipment 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, orthotics 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.

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

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

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

Excluded Services: Health care services for which this Policy doesn't provide benefits or cover.

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

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

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 include physical, and occupational therapy and speech language pathology and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings. All services must be provided by a licensed physical, occupational or speech therapist.

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

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

a. Limited scope dental or vision benefits;
b. Benefits for Long-term Care, nursing home care, home health care, community-based care or any combination of them;
c. Such other similar, limited benefits as specified in regulations;

10. If offered as independent, non-coordinated benefits:
    a. Coverage only for a specified disease or illness;
    b. Hospital indemnity or other fixed indemnity insurance;
11. If offered as a separate insurance policy:
    a. Medicare supplemental Health Insurance;
    b. Coverage to supplement coverage provided under Military, TRICARE or CHAMPUS; and
    c. Coverage to supplement coverage under a group health plan.

Health Insurance Marketplace (also known as the Exchange or Federally-Facilitated Marketplace/FFM): The health insurance exchange operated by the federal government at www.healthcare.gov to allow qualified individuals to purchase health care coverage. The Marketplace isa resource where individuals and families can learn about and compare health insurance plans based on costs, benefits, and other important features, as well as enroll in coverage. It also provides information on programs that help people with low to moderate income save on the monthly premiums and out-of-pocket medical expenses (see Premium Tax Credits and Cost-sharing Reductions) . Information about Medicaid and the Children's Health Insurance Program (CHIP) can also be found here. Customers can access the Marketplace through websites, call centers and in-person.

Health Status-Related Factor: Any of these: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, Genetic Information, evidence of insurability, and conditions arising out of 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 care or Behavioral Health care and treatment of injured or sick people on an Inpatient basis. The 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 may include a long-term acute care Hospital or Rehabilitation facility, but does not include long-term, chronic-care institutions, Skilled Nursing Facility, or institutions (even when affiliated with or a part of the Hospital) that are, other than incidentally:

1. Convalescent, rest or nursing homes or facilities; or
2. Facilities primarily affording custodial, educational or rehabilitative care.

Illegal Act or Occupation: We are not liable for any loss that results from the insured covered under this Policy, committing or attempting to commit, a crime, whether a felony or misdemeanor, or engaging or attempting to engage, in an unlawful or illegal occupation, trade or service.

Incapacitated Dependent: A Dependent child who is: 1) incapable of self-sustaining employment because of a mental or physical handicap; and 2) mainly dependent upon you or your spouse for support and maintenance. The child must have developed the handicap before he or she reached the age at which coverage would otherwise terminate. To keep coverage for an Incapacitated Dependent, you must give us written proof of the disability from a Physician within 31 days of the Dependent's 26th birthday. 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 you.

Inpatient: A Member who is a registered bed patient in a Hospital, Skilled Nursing Facility, Rehabilitation Facility or Psychiatric/Substance Abuse facility for whom a room and board charge is made.

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

1. The service requires federal or other governmental agency approval in the United States, including but not limited to, drugs, medical devices, and related technology that have restricted market approval from the Food and Drug Administration (FDA) or from any other governmental regulatory agency for use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval; or
2. There is insufficient information or inconclusive scientific evidence in peer-reviewed medical literature in the Unites States for us to evaluate the therapeutic value of the service; or
3. There is inconclusive evidence in the Unites States that the service has a beneficial effect on a person's health; or
4. The service under consideration is not considered in the United States to be as beneficial as any established alternatives; or
5. There is insufficient information or inconclusive scientific evidence that the service is as beneficial as any established alternatives in the United States when used in a non-investigational or non-experimental setting.

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

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

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

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

Maximum out-of-pocket: The most you pay for Covered Services in a year before this Policy 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.

Maximum Payment: The maximum amount we will pay (as determined by us, and in accordance with the Member Schedule) for a particular benefit. The Maximum Payment will be the lesser of the following:

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

Medically Necessary or Medical Necessity: Health care services that a Physician, exercising prudent clinical judgment, would provide to prevent, evaluate, diagnose or treat an illness, injury, disease or its symptoms, and that are:
1. In accordance with generally accepted standards of medical practice; and
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
3. Not primarily for the convenience of the patient, Physician or other health care Provider; and
4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

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

Member: A person insured under this Policy.

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; and 5) any other health benefits coverage, such as a state health benefits risk pool, as recognized by the Health and Human Services Secretary.

Network: The Providers we have contracted with to specifically participate in the BlueEssentials Network, an Exclusive Provider Organization (EPO), to provide health care services to Members purchasing this Policy only. Only Providers who contract with BlueCross to specifically participate in the BlueEssentials Network are considered part of the Network for purposes of reimbursement under this Policy.

Outpatient: Receiving services or supplies in a facility setting that does not 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, Nurse Practitioner, midwife, licensed independent social worker or licensed doctoral psychologist, legally entitled to practice within the scope of his or her license and who normally bills for his or her services. Additionally, a chiropractor will be considered a Clinician when the spinal subluxation endorsement is purchased.

Policyholder: You, or a parent or a legal guardian, who purchased this insurance Policy to cover you and/or your Dependents and who is the owner of the Policy and payer of the Premiums. The Policyholder is responsible for assuring all Preauthorizations and approvals for services and supplies are obtained.

Premium: The amount that must be paid for your health insurance under this Policy.

Premium Tax Credits: Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

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

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

Prosthetic Devices: Artificial replacement body parts needed to ease or correct a condition caused by an illness, injury or birth defect, disease or anomaly. A Physician must order the appliance or device. Prosthetics 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 Center, Physician or other clinician, Psychologist, other mental health clinicians, clinic, Ambulatory Surgical Center, or supplier licensed as required by the state where located, performing within the scope of the license, and acceptable to us. Providers also include:

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

Qualified Health Plan: A health plan that has been certified by the U.S. Department of Health and Human Services (HHS) to be offered through an Exchange.

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

Rehabilitation Facility: A Hospital or other freestanding medical facility that has a written agreement with us to provide on services directed toward restoring full function and independent living for patients with neurological or other physical illnesses or injuries. These services consist of a multidisciplinary 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, occupational and speech therapy services in a variety of Inpatient and/or Outpatient settings if provided by a licensed physical, occupational or speech therapist.

Resident/South Carolina Resident: Person who resides primarily within the State of South Carolina, typically at least six months of the calendar year. Residency may be shown by possession of a current government identification (such as a South Carolina drivers license, South Carolina voters registration card, etc.), the most recent year's tax return document, or a current utility bill showing the state of South Carolina as residence. For children, residency may be shown by the existence of the above documents for a custodial parent.

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) or Physician extender available at all times and is responsible for the diagnostic evaluation, provides face-to-face evaluation services with documentation a minimum of once per week or as indicated; and
3. Has a Physician or registered nurse (RN) present onsite who is in charge of patient care along with one or more registered nurses (RNs) or licensed practical nurses (LPNs) onsite at all times (24/7); and
4. Keeps a daily medical record for each patient; and
5. Is primarily providing a 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 residential treatment center in the area where it is located.

Schedule: The attachment to the Policy that specifies the amount of coverage provided, your Copayments, Coinsurance, Deductibles and limitations.

Serious Medical Condition: a condition that requires immediate medical attention to avoid serious impairment to body functions, serious harm to an organ or body part, or that would place your health in serious jeopardy or jeopardize your ability to regain maximum function, This includes cancer, acute myocardial infarction and pregnancy.

Skilled Nursing Facility: A licensed institution, other than a Hospital, that has a written agreement with us or another Blue Cross and/or Blue Shield plan, which meets all six of these requirements:
1. Maintains permanent and full-time Facilities for bed care of resident patients; and
2. Has the services of a Physician available at all times; and
3. Has a registered nurse (RN) or Physician on full-time duty who is in charge of patient care along with one or more registered nurses (RNs) or licensed practical nurses (LPNs) on duty at all times; and
4. Keeps a daily medical record for each patient; and
5. Is primarily providing continuous skilled nursing care for sick or injured patients during the recovery stage of their illnesses or injuries and is not, other than incidentally, a rest home or a home for Custodial Care for the aged; and
6. Is operating lawfully as a skilled nursing home in the area where it is located.

In no event, will the term "Skilled Nursing Facility" include an institution that mainly provides care and treatment for Substance Use Disorder, alcohol abuse, or Mental Health.

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

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

Substance Use Disorder: 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 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, including the placement of casts; and 3) other procedures deemed as reasonable and approved by us. This includes the usual, necessary and related pre- and post-operative care.

Telehealth: the exchange of Member information during which a Member 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 Provider. Telemonitoring services are not Covered Services..

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

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

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.