Blue Cross Blue Shield, a Multi-State Plan
Major Medical Expense Coverage

This Policy provides benefits for Covered Services received in-Network Only.
If the policy you choose has a coinsurance amount of 25% or more, the policy is considered a limited benefit policy.

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 continue coverage by paying the Premium required by the first of each calendar month or within the grace period. We may non-renew this Policy:
1. For failure to pay the Premiums according to the terms of the Policy or if we have not received timely Premium payments; or
2. For an act or practice that constitutes fraud or an intentional misrepresentation of a material fact under the terms of the Policy; or
3. If we decide to discontinue offering Blue Cross Blue Shield, a Multi-State Plan for everyone who has this Policy form. However, coverage may only be discontinued if we:
   a. Provide notice to each individual covered by this Policy of the discontinuance at least 90 days before the date the Policy is discontinued;
   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 will not decline to renew 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. 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 Schedule of Benefits that is included with the Policy 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 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 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 refund your Premiums minus any amounts paid for claims. We will provide 30 days written notice if your policy is rescinded. 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 constitutes a policy 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 undersigned 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 undersigned 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 agreement.

BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA

[Signature]
Scott Graves
President
Blue Cross and Blue Shield Division
Table of Contents

Introduction ............................................................................................................................................... 4
How to Contact Us if You Have a Question .............................................................................................. 5
Preauthorization ........................................................................................................................................ 7
Your Rights and Responsibilities ............................................................................................................ 10
Eligibility, Renewability, Premiums and When Your Coverage Ends ...................................................... 11
  Medical Loss Ratio ......................................................................................................................... 15
  Qualified Individual Redetermination .............................................................................................. 16
Covered Services.................................................................................................................................... 17
  Pediatric Vision .............................................................................................................................. 27
  Prescription Drug Coverage ........................................................................................................... 28
Additional Covered Services ................................................................................................................. 33
Excluded Services .................................................................................................................................. 34
Providers, Continuation of Care, Out-of-Area Services ........................................................................... 39
How to File Claims .................................................................................................................................. 43
Appeal Procedures .................................................................................................................................. 45
Subrogation ............................................................................................................................................. 47
Certificate of Creditable Coverage ......................................................................................................... 48
General Provisions .................................................................................................................................. 48
Definitions ............................................................................................................................................... 50
Introduction

Welcome to Blue Cross and Blue Shield of South Carolina (BlueCross). BlueEssentials offers Members like you many different ways to save on health care.

Please take time to review your Policy carefully. In this Policy, 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.

This Policy is issued by a Qualified Health Plan. If at any time, this Policy is considered no longer “Qualified,” coverage will end as specified in the Eligibility section.

This BlueEssentials product uses an Exclusive Provider Network (EPN) and 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 Mental Health and Substance Use Disorder services, in order to receive maximum benefits available under this Policy.

The network for this product is the BlueEssentials Exclusive Provider Network. Emergency Services provided outside of South Carolina are provided through the BlueCard Worldwide® Program. Always ask to make sure your Provider is a BlueEssentials Provider. In addition, you should verify that the Provider’s location is within the BlueCard® program.

We offer a variety of wellness programs, including 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.

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.

Benefits are available In-network only.

Benefits are provided at the in-Network Coinsurance amount for an out-of-Network Emergency Room visit for an Emergency Medical Condition. The Allowed Amount for the out-of-Network Provider will be the Medicare Allowance and these Providers can bill you for the difference in the Allowed Amount and his or her actual charge.

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

<table>
<thead>
<tr>
<th>CALL</th>
<th>855-404-6752</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Monday through Friday, 8:30 a.m. to 5:30 p.m. Eastern Standard Time</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TTY</th>
<th>855-889-4325</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.</td>
</tr>
<tr>
<td></td>
<td>Monday through Friday, 8:30 a.m. to 5:30 p.m. Eastern Standard Time</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FAX</th>
<th>803-870-9439</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>WRITE</th>
<th>Marketplace Operations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BlueCross BlueShield of South Carolina</td>
</tr>
<tr>
<td></td>
<td>Post Office Box 100228</td>
</tr>
<tr>
<td></td>
<td>Columbia, SC 29260-6000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E-MAIL</th>
<th><a href="mailto:Myebill@bcbsnc.com">Myebill@bcbsnc.com</a> for Billing Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><a href="mailto:Membership.enrollment@bcbsnc.com">Membership.enrollment@bcbsnc.com</a> for other Membership Questions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WEBSITE</th>
<th><a href="http://www.SouthCarolinaBlues.Com">www.SouthCarolinaBlues.Com</a></th>
</tr>
</thead>
</table>

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 Physician, Hospital or Pharmacy.
  
  To locate a Provider, go to: https://www.SouthCarolinaBlues.com/links/metallic/providerdirectory
- 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
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 appropriate.

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 under the guidelines set out in 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.

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 actual charge.

To use the BlueCross Preauthorization process, call the numbers listed below to reach the appropriate medical services personnel. Below is the list of services that must be Preauthorized.
<table>
<thead>
<tr>
<th>Type of service or treatment</th>
<th>Who to call for Preauthorization</th>
<th>Penalty if Preauthorization is not obtained</th>
</tr>
</thead>
</table>
| • Hospital Admissions, not including maternity/newborns – See below for information on      | In Columbia 803-736-5990  
In S.C. 800-327-3238  
Outside S.C. 800-334-7287                      | No benefits will be provided.                                        |
| • Skilled Nursing Facility (SNF) Admission                                                  |                                                                       |                                        |
| • Continuation of a Hospital stay (remaining in the Hospital or SNF for a period longer     |                                                                       |                                        |
| than we originally approved) for a medical condition                                       |                                                                       |                                        |
| • Outpatient chemotherapy or radiation therapy                                              |                                                                       |                                        |
| • Outpatient hysterectomy or septoplasty                                                    |                                                                       |                                        |
| • Home Health Care or Hospice Services                                                      |                                                                       |                                        |
| • Durable Medical Equipment when the purchase price or rental is $500 or more               |                                                                       |                                        |
| • Admissions for Habilitation, Rehabilitation and/or Human Organ and/or Tissue Transplants | In Columbia 803-736-5990  
In S.C. 800-327-3238  
Outside S.C. 800-334-7287                      | No benefits will be provided. Also requires use of a Provider we      |
|                                                                                          |                                                                       | designate.                                 |
| • Treatment for hemophilia                                                                 | In Columbia 803-736-5990  
In S.C. 800-327-3238  
Outside S.C. 800-334-7287                      | If care is not coordinated through a Center for Disease Control and   |
|                                                                                          |                                                                       | Prevention (CDC) designated Hemophilia   |
|                                                                                          |                                                                       | Treatment Center at least once per      |
|                                                                                          |                                                                       | Benefit Period, no benefits will        |
|                                                                                          |                                                                       | be provided.                             |
| • Certain Prescription Drugs                                                                | Log into My Health Toolkit on our website for details                | No benefits will be provided.            |
| • Specialty Drugs                                                                           | Log into My Health Toolkit on our website for details                | No benefits will be provided.            |
| • Outpatient/office MRI, MRA, PT scan and CT scan                                           | National Imaging Associates (NIA) 866-500-7664                          | No benefits will be provided.            |
| • Hospital admissions for Mental Health and Substance Use Disorders                        | Companion Benefit Alternatives, Inc. (CBA) in Columbia 803-699-7308   | No benefits will be provided.            |
| • Residential Treatment Center (RTC) Admissions for Mental Health and Substance Use          |                                                                       |                                        |
| Disorders                                                                                    |                                                                       |                                        |
| • Continuation of a Hospital stay or RTC admission (remaining in the Hospital or RTC for    |                                                                       |                                        |
| a period longer than we originally approved) for Mental Health and Substance Use Disorder   |                                                                       |                                        |
| • Outpatient psychological testing and repetitive Transcranial Magnetic Stimulation (rTMS) |                                                                       |                                        |
| • Outpatient facility: Intensive Outpatient partial Hospitalization, electroconvulsive       |                                                                       |                                        |
| therapy                                                                                     |                                                                       |                                        |
| • Genetic Counseling and Testing                                                            | Avalon Health Services, LLC 1-844-227-5769.                          | No benefits will be provided.            |
You can also find these numbers on your ID card.

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 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.

Benefits for a newborn child will be available only if the newborn child is added to this coverage as described in the Eligibility, Coverage and When your Coverage Ends section. You must add your newborn child to your coverage or purchase a Policy for the newborn before a Preauthorization will be given.

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

Since your Admission will be unexpected, we allow time to be notified of the Admission. Our medical services personnel must be notified within 24 hours or by 5 p.m. of the next working day, or as soon as reasonably possible, if you are admitted to the Hospital. Otherwise, we will not provide benefits for the hospitalization. If Emergency Admission review 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 medically appropriate.

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

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

You have the right to:

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

You have the responsibility to:

- Carefully read all health Plan materials provided by BlueCross after we accept you as a Member.
- Ask questions and make sure you understand the information given to you.
- Present your BlueCross ID card prior to receiving services or care.
- Inform BlueCross of any information that affects your coverage, including any other insurance you may have.
- Select a representative to act on your behalf in the event you 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) summarizes the benefit options of your insurance plan. All insurance companies are required to provide you with a SBC. You can find your SBC by going to www.SouthCarolinaBlues.com/links/metallic/SBC and clicking the link for your Plan.

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).
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. Dependent children are eligible for coverage 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.

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 Schedule of Benefits.

You may enroll in coverage every year during the annual Open Enrollment. You may enroll at other times during the year only if you have a Special Enrollment. A Special Enrollment occurs when you fall into one of the situations described below.

Special Enrollment
You may only enroll in this coverage during an annual Open Enrollment Period unless you qualify for a Special Enrollment. In all situations, you must be Qualified Individual(s) to enroll. You or your dependent may enroll in or change from one Qualified Health Plan to another as a result of the following events, if:

1. You lose minimum essential coverage. Loss of minimum essential coverage does not include loss due to: 1) failure to pay Premiums on a timely basis (including COBRA Premiums, even if the premium is unaffordable); 2) rescission; or 3) voluntarily dropping coverage.
2. You gain or become a dependent through marriage, birth, adoption, court order, placement for adoption or placement in foster care.
3. You gain status as a United States citizen, a national, or lawfully present in the United States.
4. You show your enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Health Insurance Marketplace and Health and Human Services (HHS), as evaluated and determined by the Health Insurance Marketplace. In such cases, the Health Insurance Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.
5. You adequately demonstrate that the Qualified Health Plan you were enrolled in substantially violated a material provision of its contract in relationship to you.
6. i. You or your Dependent are already enrolled in a Qualified Health Plan, but are determined to be newly eligible or ineligible for advance payments of the Premium tax credit or have a change in eligibility for cost-sharing reductions;
   ii. You or your Dependent was enrolled in an eligible employer-sponsored plan and is determined to be newly eligible for advance payment of the Premium tax credit based in part because the employer is discontinuing or changing available coverage within the next 60 days and you or Your Dependent will no longer be eligible for that plan. If you or your Dependent is allowed to terminate the eligible employer-sponsored plan, you may access this Special Enrollment period prior to the end of the existing coverage even though you or your Dependent will not be eligible for advance payments of the Premium tax credit until the end of your existing coverage.
7. You gain access to a new Qualified Health Plan as a result of a permanent move.
8. You are an Indian, as defined by Section 4 of the Indian Health Care Improvement Act; you may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another no more often than one time per month.
9. You meet certain exceptional circumstances as the Health Insurance Marketplace may provide.
10. The Health Insurance Marketplace determines that you or your Dependent was not enrolled in a Qualified Health Plan; was not enrolled in the Qualified Health Plan selected by you or your Dependent; or is eligible for but not is not receiving advance payments of the Premium tax credit or cost-sharing reductions as a result of misconduct on the part of a non-Health Insurance Marketplace entity providing enrollment assistance or conducting enrollment activities. For the purposes of this provision, misconduct includes, but is not limited to, the failure of the non-Health Insurance Marketplace entity to comply with applicable standards under the law, as determined by the Health Insurance Marketplace.

A Special Enrollment must be requested within 60 days of the triggering event.

Your Effective Date for Special Enrollment for birth, adoption, placement for adoption or placement for foster care is the date of the event.

Your Effective Date for Special Enrollment for marriage 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 2nd, coverage will be effective March 1st.

Your Effective Date for Special Enrollment for a loss of Minimum Essential Coverage 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 required effective date, though, will always be the first of the month following your plan selection, or the loss of coverage, whichever comes last. For example, if 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.

Your Effective Date for all other Special Enrollment events are as follows:

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

**Adding your Spouse**

You may add your new spouse by submitting an application and paying the additional full Premium required. Your spouse will not be covered until we receive the 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, then the child is covered for Medically Necessary covered services and supplies from the moment of birth, adoption or placement. This includes any necessary care and treatment of medically diagnosed birth defects, diseases and anomalies or complications arising from a premature birth. You must provide us with a completed application within 60 days of the birth, adoption or placement along with the appropriate full Premium payment in order for the coverage to be effective from the moment of birth, adoption or placement.

An adopted child will be covered on the same basis as other covered children either: 1) from the moment of birth 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; or 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; or 3) on the Effective Date of this Policy, whichever is later.

A child is considered “adopted” on the date the child is placed in your home for the purpose of adoption. The child is no longer considered “adopted” on the date placement is disrupted prior to legal adoption and the child is removed from placement with you or your spouse.

A foster child or a child in your legal guardianship will be covered on the same basis as other covered children either: 1) on the date of placement; or 2) on the Effective Date of this Policy, whichever is later. The child is no longer considered a foster child or in your legal guardianship if you or your spouse no longer has legal guardianship or the child has been removed from the home.

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 may pay your Premiums electronically or we will bill you monthly. 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. This doesn't apply to premium payments and co-payment assistance from (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.

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.

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 Advanced Premium Tax Credit – If you 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.

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.

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

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

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

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, the end of the month in which the Dependent reaches age 26. An Incapacitated child’s coverage, however, will not end simply because he or she reaches age 26.

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 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.

In the event of your death, your spouse or a Dependent covered under this Policy, will become the Policyholder.
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.

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.

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.

If your request is approved, the Policy will be reinstated on the date it lapsed. If we fail to act on our request within 45 days, your policy will be reinstated. 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.

After the Policy is reinstated, both parties will have the same rights as existed just before the due date. Any amendments to the Policy will still apply and remain effective after reinstatement.

Extension of Benefits
In the event your Policy is terminated, coverage may be extended for any Member who is in a Hospital, Skilled Nursing Facility, Residential Treatment Center or is Totally Disabled on the day coverage ends. The Member's coverage may be continued for the duration of the Benefit Period while the Member remains Totally Disabled from the same or related cause until one of these occurs: 1) the date the hospitalization ends or the date of recovery from the Total Disability, whichever is later; or 2) the date the Policy ends and is replaced by another Health Plan with similar benefits. We will provide benefits only for Covered Services as listed in this Policy that are related to the treatment of the disabling medical condition.

The terms Totally Disabled/Total Disability mean 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 Totally 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.

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.

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.
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 re-determination 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 re-determination notice. The Health Insurance Marketplace may establish a cut-off date for a re-determination 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.
Covered Services

We will provide benefits for Covered Services according to the provisions described in this Policy and as shown in your Schedule of Benefits. We base benefits on a percentage of 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.

Benefits are available at an out-of-Network Emergency Room for an Emergency Medical Condition. Benefits will provided at the in-Network Coinsurance amount. The Allowed Amount for the out-of-Network Provider will be the Medicare Allowance and these Providers can bill you for the difference in the Allowed Amount and the actual charge.

All Covered Services must be Medically Necessary and include only the services specifically described in this section to the extent the services are not limited or excluded in other provisions of the Policy. The services must be prescribed by, performed by, or under the direction of a Physician. However, these are not Covered Services even if prescribed by a Physician: luxury or convenience items; services and supplies not needed for the diagnosis or treatment of an illness or injury; services, supplies and treatment for complications resulting from any non-covered procedure or condition; services considered Investigational or Experimental, such as but not limited to: Dorsal Rhizotomy (cutting the back of the spinal nerve roots) in the treatment of spasticity (increased tone or tension in a muscle such as a leg); medical social services, visual therapy or private duty nursing (unless a part of an approved Home Health Care or Hospice program); orthomolecular therapy including infant formula, nutrients, vitamins, food supplements and enteral feedings (when not the sole source of nutrition); and devices of any type, such as but not limited to: therapeutic devices, artificial appliances or similar devices.

Services and supplies you received before you had coverage under this Policy 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 Policy are not Covered Services. In addition, any services, supplies or drugs, a member of your immediate family provides are not considered Covered Services. A member of your family means spouse, parent, grandparent, brother, sister, aunt, uncle, child or in-law.

Any and all travel expenses (including those related to a transplant) such as, but not limited to: transportation, lodging and repatriation are only covered if specifically listed as a Covered Service.

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

There are no annual or lifetime dollar limits on Essential Health Benefits provided.
The following are Covered Services:

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

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

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

**Cleft Lip and Palate** – Benefits will be provided for the care and treatment of a cleft lip and palate and any condition or illness that 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

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 other 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 appropriate; and
4. The services are furnished in connection with an Approved Clinical Trial.

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

**Dental 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.

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 is not considered Durable Medical Equipment.

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
If you experience an emergency illness or injury, go to the nearest emergency room right away or call 911 for help. Benefits are provided for services and supplies for stabilization and/or initial treatment of an Emergency Medical Condition provided on an outpatient basis at a hospital Emergency room. Coverage is considered to be for treatment of an Emergency Medical Condition only as long as your condition continues to be considered an Emergency. If you receive care for an Emergency Medical Condition and are treated in the Emergency room at a Hospital, the charges for Emergency services are paid as follows:

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

2. **Emergency services at an out-of-Network Provider**
   The nearest medical help may be an out-of-Network Provider. Benefits will be provided for Emergency services at the in-Network rate; however, because the Provider is out-of-Network, you may have additional cost-sharing or other requirements. This section explains how you receive Emergency medical care from an out-of-Network Provider and what additional cost-sharing or other requirements you may expect.

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

Non-Emergency care outside the Blue Essentials Network is not covered, so any follow-up care must be provided by an in-Network provider.

**Genetic Counseling** – Benefits are provided for Genetic Counseling. Preauthorization is required and, if Preauthorization is not obtained, no benefits will be provided.
Habilitation and Rehabilitation Services – Include:

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

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

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

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

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

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

Hospice Services – Benefits are provided for hospice services. We must Preauthorize hospice services before you 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. Please refer to your Schedule of Benefits to see what benefit limitations apply. 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 approve the entire Hospice Service plan);
10. Respite care; and
11. Family counseling concerning the patient’s terminal condition.

Hospital Services – Include Inpatient Admissions, Outpatient care and ancillary services. Preauthorization is required. If Preauthorization is not obtained, no benefits will be provided. Hospital services do not include: Admissions or portions thereof for long-term or chronic care due to medical conditions or Behavioral Health conditions or; or any service or supply related to dysfunctional conditions of the chewing muscles, wrong position or deformities of the jaw bone(s), orthognathic deformities or temporomandibular joint syndrome (headache, facial pain and jaw tenderness) caused by jaw problems usually known as TMJ is not covered.
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 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. Lab services don’t include: pre-conception testing, pre-conception genetic testing or any services related to infertility. 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

Mastectomy and Reconstruction – Benefits include Hospitalization for at least 48 hours following a 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.
Mental Health & Substance Use Disorder Services – We will provide benefits as shown in the Schedule of Benefits, for Mental Health and/or Substance Use Disorders. Mental Health and Substance Use Disorder Services does not include: Admissions for long-term or chronic care for psychiatric conditions; marriage counseling; recreational, educational or play therapy; biofeedback; psychological or educational diagnostic testing to determine job or occupational placement or for other educational purposes, or to determine if a learning disorder exists; therapy for learning disorders, development speech delay, communication disorder, developmental coordination disorder, the intellectual disability, dissociative disorder, sexual and gender identity disorder, personality disorder and vocational rehabilitation unless specifically included in your Schedule of Benefits; 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; Any behavioral, educational or alternative therapy techniques to target cognition, behavior, language, and social skills modification, including: 1) Applied behavioral analysis therapy; 2) Teaching, Expanding, Appreciating, Collaborating and Holistic 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; and Services for animal assisted therapy, Vagal Nerve Stimulation (VNS), Eye Movement Desensitization and Reprocessing (EMDR) or rapid opiate detoxification. See the Preauthorization Section to see which services require Preauthorization. No benefits for those 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).

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

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

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

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

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

   We 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.

4. 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 don't include any Surgery for: reversals of sterilization or obesity, weight reduction or weight control such as but not limited to, gastric bypass, insertion of stomach (gastric) banding, intestinal bypass, wiring the mouth shut, liposuction, complications from any such procedure and reversal of or reconstruction procedures from such treatments. Reduction mammoplasty for macromastia is covered only when you are within 20 percent of your ideal body weight.

   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.

   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.

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

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

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

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

Physician Services benefits don’t include services or supplies for: pre-conception testing or pre-conception genetic testing; infertility; acupuncture; massage therapy; hypnosis; TENS unit or services for chronic pain management programs (including any program developed by centers with multidisciplinary staffs intended to provide the interventions needed to allow the development of pain coping skills and freedom from analgesic medication dependence); excessive sweating; diagnosis or treatment of sexual dysfunction or transsexual procedures, including, but not limited to, drugs, lab and x-ray test and counseling or such procedures; or treatment for varicose veins and/or venous incompetence, including but not limited to: endovenous ablation, vein stripping or sclerosing solutions injection. Benefits also do not include Physician charges for drugs, appliances, supplies, blood and blood products, or any type of fee or charge for handling medical records, filing a claim or missing a scheduled appointment.

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

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

Prosthetics – Benefits are provided for a prosthetic, other than a dental or cranial prosthetic, which meets minimum specifications for the body part it is replacing regardless of the functional activity level. The item must be a standard, non-luxury item as determined by us. Specialty items such as bionics/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. Prosthetics don't include; adjustable cranial orthosis (band or helmet) for positional plagiocephaly or craniosynostoses in the absence of cranial vault remodeling Surgery or a penile prosthesis necessary due to any medical condition or organic disease. A Penile prosthesis will be considered for benefit only after prostate Surgery.

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.

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

1. The only living donor transplants covered under this Policy are kidney transplants for Members with dialysis-dependent kidney failure and liver transplants. All other living donor transplants are not covered. Benefits will be subject to the following conditions:
   a. When both the transplant recipient and the donor are Members, benefits will be provided for both.
   b. When the transplant recipient is a Member and the donor is not, benefits will be provided for both.
   c. When the transplant recipient is not a Member and the donor is, no benefits will be provided to either the donor or the recipient.

2. 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.

Benefits for allogeneic or syngeneic bone marrow transplants as described in items 3 and 4 above are available only if there are at least six of eight histocompatibility complex antigen matches between the patient and the donor and the mixed lymphocyte culture is nonreactive.
5. The following services related to tissue transplants, except fetal tissue, are covered:
   a. Blood transfusions (but not whole blood and blood plasma);
   b. Autologous parathyroid transplants;
   c. Corneal transplants;
   d. Bone and cartilage grafting; or
   e. Skin grafting.

The following transplants are not Covered Services:

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

Vision Services – We provide Pediatric Vision Services as shown in the schedule of benefits. 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 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
- The prescription is filled at one of our Network pharmacies
- Other Plan rules are followed, including but not limited to: Prior Authorization, Quantity Limits and Step Therapy.

The 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. If a prescribing Physician specifies 90-day supply on certain Prescription Drugs, they can also be filled at certain retail pharmacies that are part of the Retail 90 Pharmacy Network. More information about the Retail 90 Pharmacy Network, the Covered Drug List and Network Pharmacies can be found under the Prescription Drug Information section at: [https://www.SouthCarolinaBlues.com/links/metallic/pharmacy](https://www.SouthCarolinaBlues.com/links/metallic/pharmacy). Retail 90 is a product of Caremark. Caremark is an independent company that offers a pharmacy network on behalf of Blue Cross and Blue Shield of South Carolina.

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

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

Pharmacy benefits are only available when provided by a Network Pharmacy. Not all pharmacies are part of this 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 Schedule of Benefits 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 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.

**Retail 90**

You may save money and have the convenience of purchasing 90-day supplies of eligible prescription medications at participating retail pharmacies for mail-order prices through our Retail 90 benefit. Sign-up is not necessary; you will only need to verify the pharmacy is part of the network.

**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](http://www.SouthCarolinaBlues.com). Select “Insurance Basics” then “Forms” and then “Prescription Drug Mail Service.”

**Specialty Pharmacy**

Drugs that are designated to be specialty medications must be filled at our Specialty Pharmacy. Although most Specialty drugs are found in Tier 4, they could also be categorized in any of the Tiers. The list of drugs that must be filled with the 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. The Specialty Pharmacy can overnight to your home, provider's office or your local CVS/Caremark pharmacy. Caremark is an independent company that offers specialty pharmacy services on behalf of Blue Cross and Blue Shield of South Carolina.

**Over-the-counter (OTC) Drug**

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

**Additional Requirements/Limits**

There may be additional requirements or limits on some medications on the 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.

- **Quantity Limits (QL):** If your drug has a quantity limit, we will only cover a certain amount of the drug in a specified period of time; unless your Provider requests a quantity in excess of this amount and gives evidence supporting this request which is approved by our Pharmacy Benefit Manager. This is to make sure you are using the drug safely and based on the FDA guidelines.
- **Step Therapy (ST):** If your drug has a step therapy requirement, we will only cover second choice drugs if you have already tried a first choice drug and it didn’t work for you. The reason for a particular step therapy requirement may be because there are covered drugs that usually work just as well, but will cost you less. It may also be because some drugs are approved by the FDA specifically as second-choice drugs or as add-ons to other medication.

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.

**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.

**Formulary Exception Request**

If a drug is not covered, it may be helpful to discuss with your Physician covered alternatives he or she may prescribe; or, if not medically viable, you may request a formulary exception. An exception request may be made by the Member or prescribing Provider by contacting our Pharmacy Benefit Manager (PBM), reach Prior Authorization line at 855-582-2022 to acquire an exception request form. After completing the necessary information, the form can be faxed to 855-245-2134. Caremark will work with the prescribing physician to obtain any medical records or other necessary information to process the request.

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

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

CVS/Caremark
PA Exchanges Department
1300 East Campbell Road
Richardson, TX 75081
Fax: 1-855-245-8333
Phone: 1-855-582-2022
If our PBM does not get all the information it needs to make a decision about your appeal, it will send you a letter to tell you what information it needs and how you can get that information to it. The PBM will review your standard appeal request within 30 days after receiving it. You will get a letter that explains its decision.

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

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

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

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

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

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

1. The service or payment for service was denied, reduced or terminated because:
   a. The service does not meet the health carrier’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness; or
   b. The service was experimental or investigational and involves a life-threatening or seriously disabling condition, and

2. You have completed your health carrier’s internal appeals process.
   a. You do not have to complete the internal appeals process if:
      i. Your treating physician has certified in writing that you have a serious medical condition;
      ii. The service is experimental or investigational and your treating physician has provided the required certifications;
      iii. The health carrier has not issued a written decision within the time frames set forth in the health carrier’s internal appeals process. It must have received all the information from you that it needs to complete the appeal. You or your authorized representative must not have agreed to a delay; or
      iv. The health carrier agrees to waive the internal appeals process.

3. You always have to complete the internal appeals process if you have already received the service.
What's Not Covered?
We will not provide benefits for the following Prescription Drugs:
- That are used for or related to Non-Covered Services or conditions, such as, but not limited to, weight control, obesity, erectile dysfunction, cosmetic purposes (such as Tretinoin or Retin-A), hair growth and hair removal.
- That are used for infertility.
- More than the number of days’ supply allowed as shown in your Schedule of Benefits.
- Refills in excess of the number specified on your Physician’s prescription order.
- More than the recommended daily dosage defined by BlueCross, unless prior authorization is sought and approved.
- When administered or dispensed in a Physician’s office, Skilled Nursing Facility, Residential Treatment Center, Hospital or any other place that is not licensed to dispense drugs.
- When there is an Over-the-counter Drug equivalent including any over-the-counter supplies, devices or supplements.
- When not consistent with the diagnosis and treatment of an illness, injury or condition or that is excessive in terms of the scope, duration or intensity of drug therapy that is needed to provide safe, adequate and appropriate care.
- When you don’t receive Prior Authorization.
- That requires step therapy when a Step Therapy Program is not followed.
- That are received Out-of-network, unless due to an Emergency Medical Condition.
- That are not on the BlueEssentials Covered Drug List.
Additional Covered Services

The following benefits are available to you. These additional Covered Services are not Essential Health Benefits and do not apply to your Deductible or Maximum out-of-pocket.

Adult Vision Care (Ages 19 years and older) – Benefits are provided as shown in the Schedule of Benefits. Adult vision care benefits are provided through VSP. 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.)

Dental Care – Benefits are available for one cleaning and one exam every six months by any licensed dentist as shown in the Schedule of Benefits. You will pay the dentist at the time services are received. You will need to submit a claim to us to receive payment for these services.

No other dental services are covered, except as shown in Covered Services.

Claims may be submitted by mail or by fax to:

BlueCross BlueShield of South Carolina
Group & Individual Claims, AX-F25
P.O. Box 100300
Columbia, SC 29202
Or
FAX: 1-803-264-0172

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

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.

Except as specifically provided in this Policy, even if Medically Necessary, no benefits will be provided for:

- Services for which no charge is normally made in the absence of insurance.
- Services or supplies for which you are entitled to benefits under Medicare or other governmental programs (except Medicaid).
- Injuries or diseases paid by Workers’ Compensation or settlement of a Workers’ Compensation claim.
- Treatment provided in a government Hospital that you are not legally responsible for.
- Rest care or Custodial Care.
- 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.
- Treatment, services or supplies received as a result of suicide, attempted suicide or intentionally self-inflicted injuries unless it results from a medical (physical or mental) condition.
- 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, also known as Cosmetic Surgery. Cosmetic Surgery includes, but is not limited to, Surgery for saggy or extra skin (regardless of reason); any augmentation, reduction, reshaping or injection procedures of any part of the body; rhinoplasty, abdominoplasty, liposuction and other associated types of Surgery; and any procedures using an implant that doesn’t alter physiologic or body function or isn’t incidental to a surgical procedure. Cosmetic Surgery does not include reconstructive Surgery incidental to or following Surgery resulting from 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 functional defect. Complications arising from Cosmetic Surgery are also not covered.
- Eyeglasses, contact lenses (except after cataract Surgery), and exams for the prescription or fitting of them except as shown in the Pediatric Vision section and the Additional Covered Services section. Any Hospital or Physician charges related to refractive care such as radial keratotomy (Surgery to correct nearsightedness), or keratomileusis (laser eye Surgery or LASIK), lamellar keratoplasty (corneal grafting) or any such procedures that are designed to alter the refractive properties of the cornea.
- Hearing aids and exams for the prescription or fitting of them.
- Procedures, equipment, services, supplies or charges for abortions for which Federal funding is prohibited. Coverage is allowed for abortions:
  - 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.
• 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, except when the Optional Endorsement is purchased.

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

• 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. Exception is made as shown in the Additional Covered Services section; for dental treatment to Sound Natural Teeth for up to six months after an accident; and for Medically Necessary Cleft Lip and Palate services.

• 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.

Other Services This Policy Does Not Cover

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

• 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.

• 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.

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

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

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

• Any service (other than Substance Abuse services), medical supplies, charges or losses resulting from a Member being Legally Intoxicated or under the influence of any drug or other substance, or taking some action the purpose of which is to create a euphoric state or alter consciousness unless taken on the advice of a Physician. The Member, or the Member’s representative, must provide any available test results showing drug/substance levels and/or blood alcohol levels upon our request of and, if the Member refuses to provide these test levels, no benefits will be provided.
• Investigational or Experimental Services, as determined by us, including but not limited to the following:

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

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

• Services and supplies related to transplants involving mechanical or animal organs, human organ and/or tissue transplant procedures when you don't get the required Preauthorization and it is not done at a designated Provider, or unless specifically listed in Covered Services.

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

• 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.

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

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

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

• Recreational, educational or play therapy; biofeedback; psychological or educational diagnostic testing to determine job or occupational placement or for other educational purposes, or to determine if a learning disorder exists; therapy for learning disorders, development speech delay, communication disorder, developmental coordination disorder, the intellectually disabled, dissociative disorder, sexual and gender identity disorder, personality disorder and vocational rehabilitation unless specifically included in your Schedule of Benefits.

• Bioelectric, microprocessor or computer-programmed prosthetic components.

• Marriage counseling.

• Any services or supplies 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.

• 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, transsexual procedures or penile prostheses necessary due to any medical condition or organic disease. If benefits are available for Durable Medical Equipment, a penile prosthesis will be considered for benefits only after Medically Necessary prostate Surgery.
• Counseling and psychotherapy services for: feeding and eating disorders in early childhood and infancy; tic disorder except for Tourette's disorder; elimination disorder; mental disorders due to general medical conditions; sexual function disorder; sleep disorder; medication-induced movement disorder; and nicotine dependence unless specifically covered in this Policy.

• Services for animal-assisted therapy, vagal nerve stimulation (VNS), eye movement desensitization and reprocessing (EMDR), behavioral therapy for solitary maladaptive habits or rapid opiate detoxification.

• Any behavioral, educational or alternative therapy techniques to target cognition, behavior, language, and social skills modification, including:
  1. 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.

• 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.

• Any services, supplies or treatment for excessive sweating.

• Orthomolecular therapy including infant formula, nutrients, vitamins and food supplements, even if the Physician orders or prescribes them; enteral feedings when not a sole source of nutrition.

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

• Telehealth and Telemonitoring, except as shown in Covered Services.

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

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

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

• Any and all travel expenses (including those related to a transplant) such as, but not limited to: transportation, lodging and repatriation, unless specifically included in Covered Services.

• Durable Medical Equipment when you don't get the required Preauthorization.

• Equipment available over the counter such as, but not limited to, air conditioners, air filters, whirlpool baths, spas, (de)humidifiers, wigs, fitness supplies, vacuum cleaners or common first aid supplies.
• Benefits will be denied for procedures, services or pharmaceuticals when you don't get the required Preauthorization.

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

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

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

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

• Services, supplies or treatment for varicose veins and or venous incompetence, including but not limited to, endovenous ablation, vein stripping or sclerosing solutions injection.

• Pre-conception testing or pre-conception genetic testing.

• Prescription Drugs and pharmaceuticals under the medical portion of this Policy when benefits are available under the Prescription Drug benefit.

• The following Prescription Drugs:
  - That are used for or related to Non-Covered Services or conditions, such as, but not limited to, weight control, obesity, erectile dysfunction, cosmetic purposes (such as Tretinoin or Retin-A), hair growth and hair removal.
  - That are used for infertility.
  - More than the number of days' supply allowed as shown in your Schedule of Benefits.
  - Refills in excess of the number specified on your Physician's prescription order.
  - More than the recommended daily dosage defined by BlueCross, unless prior authorization is sought and approved.
  - When administered or dispensed in a Physician’s office, Skilled Nursing Facility, Residential Treatment Center, Hospital or any other place that is not licensed to dispense drugs.
  - When there is an Over-the-counter Drug equivalent including any over-the-counter supplies, devices or supplements.
  - When not consistent with the diagnosis and treatment of an illness, injury or condition or that is excessive in terms of the scope, duration or intensity of drug therapy that is needed to provide safe, adequate and appropriate care.
  - When you don't receive Prior Authorization.
  - That requires step therapy when a Step Therapy Program is not followed.
  - That are received Out-of-network, unless due to an Emergency Medical Condition.
  - That are not on the BlueEssentials Covered Drug List.
Providers

Your coverage requires you to use our 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 Provider, go to https://www.SouthCarolinaBlues.com/links/metallic/providerdirectory.

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 the Provider has agreed to:

- Bill you no more than the 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 to treat the Provider as in-Network.

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 for the out-of-Network Provider will be the Medicare allowance; however, an out-of-Network Provider can bill you for the difference between the Allowed Amount and the 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 your Provider if it is a BlueEssentials Provider before you receive care. To find out if your Physician or Hospital is a BlueEssentials 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. If you see a BlueCard Provider outside South Carolina, that Provider may require you to pay the full charge at the time you receive services and may require you to request any needed Preauthorizations.

We make every effort to contract with Physicians and Clinicians who practice at BlueEssentials Hospitals. Some Physicians, however, choose not to be BlueEssentials 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.

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

If you 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. A serious medical condition is a condition or illness that requires medical attention and failure to provide the current course of treatment through the current Provider would place your health in serious jeopardy. This includes cancer, acute myocardial infarction and pregnancy. 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 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 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 Network allowance as payment in full. Continuation of care is subject to all other terms and conditions of this Contract, including regular benefit limits.

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 Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association ("Association"). Whenever you access health care services outside the geographic area Blue Cross and Blue Shield of South Carolina serves, the claims for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

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

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

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

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

- The billed covered charges for your Covered Services; or
- The negotiated price that the Host Blue makes available to us.
Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care Providers after taking into account the same types of transactions as with an estimated price.

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

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

3. **Non-Participating Providers Outside Our Service Area**

   **Member Liability Calculation**

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

4. **BlueCard Worldwide® Program**

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

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

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

   **Outpatient Services**
   Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.
• **Submitting a BlueCard Worldwide Claim**
  When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a BlueCard Worldwide International claim form and send the claim form with the provider’s itemized bill(s) to the BlueCard Worldwide Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from Blue Cross and Blue Shield of South Carolina, the BlueCard Worldwide Service Center or online at [www.bluecardworldwide.com](http://www.bluecardworldwide.com). If you need assistance with your claim submission, you should call the BlueCard Worldwide Service Center at 1.800.810.BLUΕ (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. 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. 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 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 803-264-3475 from Columbia, South Carolina, or 800-868-2500, ext. 43475 from anywhere else. 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.

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 letter must state that a formal appeal has been requested and all pertinent information regarding the claim in question must also be included in the letter.

Requests to cover services and supplies which are specifically excluded in the 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 15 calendar days after receiving the appeal.

2. Urgent Care Claim – You have 180 days to appeal our decision on an Urgent Care Claim. An Urgent Care Claim is any claim, where, if the normal Preauthorization or Appeal 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).

You may request an expedited review process for an Urgent Care Claim either orally or in writing, and all necessary information pertaining to the appeal will be transmitted by telephone, facsimile, or other expeditious method. We must complete the appeal process within 72 hours after 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 30 calendar days after receiving the appeal.
You will have the opportunity to present testimony, 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 adverse determination, you will be notified of the new evidence or rationale in advance of the date of the appeal decision. The appeal will be conducted by someone other than the person who made the initial decision, or his or her subordinate. No deference will be afforded to the initial determination. Individuals involved in the decision-making for claims and appeals 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 violation was:

1. De minimis;
2. Non-prejudicial;
3. Attributable to good cause or matters beyond the Company’s 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**

After your internal appeal is completed, you will be notified in writing of your right to request an external review. An external review may be requested for a disputed claim or final denial based on medical judgments or for non-medical judgments related to contract coverage issues, including a rescission of coverage. A claim denied as investigational or experimental is also eligible for external review. You or someone you name to act for you (your authorized representative) may file a request for external review. You may authorize someone to file on your behalf by completing an Authorized Representative Form.

Any request for external review must be filed within one year of our notice to you that a claim was denied, unless you. We must provide you with notice of your right to file an external review through the Office of Personnel Management at the address shown below. If you choose to file an external review, you have the right to submit additional documentation in support of your claim; this documentation will be shared with us. We must also notify you of your rights under the Privacy Act.

Before you can file an external review, you must first exhaust, or complete, all of your internal appeals. Exhaustion of your internal appeals is not required if:

1. We waive this requirement to exhaust appeals;
2. We failed to comply with all requirements of our internal appeals process (except for minor violations); or
3. You requested both an expedited internal appeal and an expedited external review at the same time.

You will not be assessed any fee for filing an external review and there is no minimum dollar amount required for filing an external review.

If you request an external review related to a denied claim based on medical judgment, a contractual dispute or a rescission, your request will be assigned to an independent review organization (IRO). The IRO will be an approved, accredited organization with which OPM contracts and OPM will ensure that neither the IRO nor the reviewer within the IRO has a conflict of interest with any party. For all other denied claims, OPM will consider your external review.

After submitting a request for external review, you will be allowed an additional 20 days in which to submit additional information. OPM also guarantees that any information submitted within 20 days after your request to OPM is accepted will be considered in its review.
The decision by either OPM or the IRO is binding on both the member and us. OPM will notify both the member and us within 30 days of accepting a request for review. The IRO will provide its decision within 15 days of the date OPM assigns the request for review to the IRO; however, the 15 days allowed for the IRO is counted as part of OPM’s 30 days. If necessary to develop the case and ensure sufficient information is gathered and analyzed, OPM may allow more time.

**Expedited External Review**

If OPM receives a valid request for an expedited external review, it will resolve the request with 72 hours after receiving it. An urgent situation is one that concerns an admission, availability of care, continued stay, or health care service for which you have received emergency services, but have not been discharged. A situation is also urgent if the standard external review time frame would seriously jeopardize your life, health, or ability to regain maximum function. You may request an expedited external review by contacting OPM via toll free phone, email, or postal mail as noted above.

If you wish to request an external review, contact the U.S. Office of Personnel Management (OPM) toll free at 1-855-318-0714. Information is also available on the web at http://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/.

You may also contact OPM at mspp@opm.gov or by mail:

**MSPP External Review**

National Healthcare Operations

U.S. Office of Personnel Management

1900 E Street, NW

Washington, DC 20415

FAX Number (202) 606-0033

**Subrogation**

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

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

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

We will pay attorney’s fees and costs from the amount recovered.

If you choose not to pursue an action to recover damages, you agree to transfer all rights to recover damages in full for such benefits to us. At our expense, we lawfully stand in the place of you to recover the amount of money we have paid for your medical benefits from any third party who is liable, responsible, or otherwise makes a payment for your injury. We may seek recovery for its payment of claims from the liable third party, any liability or other insurance covering the liable third party or from your own uninsured motorist insurance and/or underinsured motorist insurance.
In all situations involving subrogation, you shall not do anything to hinder or slow our right to seek reimbursement. You shall cooperate with us, sign any documents, and do all things necessary to protect and secure our subrogation and reimbursement rights.

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

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. “Other Valid Coverage” is defined as Health Insurance coverage that is similar to the coverage provided by this Policy, coverage provided by hospital or medical service organizations, coverage provided by union welfare plans or employee benefit organizations, but not group or individual Health Insurance with us.

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:** We will pay all benefits directly to the Member when we receive written proof of loss. The Member is expressly prohibited from assigning any benefits due unless we determine otherwise. We will pay benefits as described in this Policy directly to the Provider only if we have a written agreement for direct payment of benefits with that Provider.

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 and the time you leave or are discharged from the Hospital or Skilled Nursing Facility. The Admission may be on an Inpatient or Outpatient basis as determined by the Provider.

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

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

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

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

**Behavioral Health**: Comprehensive term to include Mental Health and Substance Use Disorder services.

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

**Benefit Period**: A 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.

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

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 Marketplace. You can get these discounts if your income is below a certain level and you choose a Silver level health plan. 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 the insurance contract. 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 Schedule of Benefits will show whether your Deductible is aggregate or embedded. An Aggregate Deductible means the entire family Deductible must be met before benefits begin to pay each year. An Embedded Deductible means that benefits will begin paying for a member once that member meets the single Deductible for that year.

Dependent: Your legal spouse and any children (natural or adopted, step, foster or under your 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. This includes illness or injury to an unborn child.

Excluded Services: Health care services that 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 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 does not include long-term, chronic-care institutions 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 rehabilitory care.
**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 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 such as drugs and devices that have restricted market approval from the Food and Drug Administration (FDA) or from any other governmental regulatory agency for 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.
2. There is insufficient or inconclusive scientific evidence in peer-reviewed medical literature for us to evaluate the therapeutic value of the service.
3. There is inconclusive evidence that the service has a beneficial effect on a person's health.
4. The service under consideration is not as beneficial as any established alternatives.
5. There is insufficient information or inconclusive scientific evidence that the service is beneficial to the person's health and is as beneficial as any established alternatives when used in a noninvestigational setting.

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

Our Medical Director, in making such determinations, may consult with or use one or more of these sources of information:

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

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

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

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

Maximum Payment: The maximum amount we will pay (as determined by us, and in accordance with the Schedule of Benefits) for a particular benefit. The Maximum Payment will be one of the following:
1. The actual charge submitted to us for the service, procedure, supply or equipment by a Provider; or
2. An amount that has been agreed upon in writing by a Provider and us or a member of the Blue Cross and Blue Shield Association; or
3. An amount established by us, based upon factors including, but not limited to, (i) Medicare reimbursement rates applicable to the 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: Health care services that a Physician, exercising prudent clinical judgment, would provide to prevent, evaluate, diagnose or treat an illness, injury, disease or its symptoms, and that are:
1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease;
3. Not primarily for the convenience of the patient, Physician or other health care Provider; and
4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

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

Member: 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 facilities, Providers, and suppliers we have contracted with to provide health care services.

Outpatient: Receiving services or supplies in a setting that does not require an overnight stay.
Physician and other Clinicians: A person (other than an intern, resident or house Physician) duly licensed as a medical doctor, dentist, oral surgeon, podiatrist, osteopath, optometrist, ophthalmologist, Physician’s assistant, Nurse Practitioner, 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 or plan.

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, and other mental health clinicians, clinic and an Ambulatory Surgical Center licensed as required by the state where located, performing within the scope of the license, and acceptable to us or as listed. 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. The services must be provided by a licensed physical, occupational or speech therapist.

**Residential Treatment Center:** A licensed institution, other than a Hospital, which meets all six of these requirements:
1. Maintains permanent and full-time Facilities for bed care of resident patients; and
2. Has the services of a Psychiatrist (Addictionologist, when applicable) 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/week and PRN 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 of Benefits:** The pages issued to you as an attachment to the Policy that specify the amount of coverage provided, your Copayments, Coinsurance, Deductibles and limitations.

**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 or 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**: Services which are initiated by either a Member or Provider (including, but not limited to a Physician) in which the method of communication is not secure, does not occur in real-time, does not allow for an actual examination, or does not utilize both audio and video communication. Telehealth services are not covered.

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

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

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

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

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you’re assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance online at contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-396-0188]。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi về chương trình sức khỏe này, quý vị sẽ được giúp đỡ với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makuasa ang isang tagasalin, tumawag sa 1-844-389-4839. (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعدته أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية ببلغتك من دون أية تكلفة؛ للتحدث مع مترجم اتصل ب 896-396-1-844. (Arabic)
Si ou menm oswa yon moun w ap ede gen ksyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

باکس شما، یا فردی که به این برنامه می‌کنید، سوالاتی درباره این برنامه به‌داشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره 6233-396-844-1 نمایید. (Persian-Farsi)