South Carolina

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

Business Blue℠

Employee Booklet

Group and Individual Division

South Carolina

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

www.SouthCarolinaBlues.com

Dear Member:

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

Business Blue offers members like you many different ways to save on health care. This plan features a large and diverse network of physicians and hospitals known as Preferred Blue® Providers.

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

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

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

Sincerely,

James A. Deyling
President
Blue Cross and Blue Shield Division
Blue Cross and Blue Shield of South Carolina

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How to Contact Us if You Have a Question

It's only natural to have questions about your coverage. Blue Cross wants to help you understand your plan so you can make the most of your benefits.

For health claim inquiries:

Please contact the claims area of the Member Service Center. You can find the telephone numbers, the mailing address and website below. You can also find the mailing address on the back of your Blue Cross identification (ID) card.

Telephone Numbers: (Monday through Friday, 8:30 a.m. to 5:30 p.m. EST)

803-264-1000 (from the Columbia area)
800-868-2500, ext. 41000 (from all other areas)

Mailing Address:

Member Service Center
Blue Cross and Blue Shield of South Carolina
P.O. Box 100300
Columbia, SC 29202-3300

Website Address:

Go to www.SouthCarolinaBlues.com, then log in to My Health Toolkit®.

For membership or eligibility inquiries:

Please contact the membership area of the Member Service Center. You can find the telephone numbers, the mailing address and website below.

Telephone Numbers: (Monday through Friday, 8:30 a.m. to 5:30 p.m. EST)

803-264-1010 (from the Columbia area)
800-868-2500, ext. 41010 (from all other areas)

Mailing Address:

Member Service Center
Blue Cross and Blue Shield of South Carolina
P.O. Box 100177
Columbia, SC 29260

Website Address:

Go to www.SouthCarolinaBlues.com, then log in to My Health Toolkit.

Pre-service Claims and Reviews:

Certain health care services shown in your Schedule of Benefits require a Pre-service Claims review or authorization before you receive services. If you receive any of the referenced services, please call:

- 803-736-5990 (from the Columbia area)
- 800-327-3238 (from all other South Carolina locations)
- 800-334-7287 (from outside South Carolina)

For Preadmission Review and Preauthorization of Mental Health Services and Substance Abuse care, call Companion Benefit Alternatives, Inc. (CBA) at:

- 803-699-7308 (from the Columbia area)
- 800-868-1032 (from all other areas)

On behalf of Blue Cross, Companion Benefit Alternatives preauthorizes Mental Health Services and Substance Abuse services. Companion Benefit Alternatives is a separate company that preauthorizes behavioral health benefits.

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

Introduction

Your Employer has selected Business Blue for your Health Insurance Coverage. This plan is a Preferred Provider Organization (PPO) from Blue Cross and Blue Shield of South Carolina (also referred to as Blue Cross). A PPO is an independent network of Hospitals, Physicians and other health care Providers who have agreements with a health plan to provide services to members at less than their normal charges. If you go outside the PPO network, then you may have to pay more. As long as you're a Member of this plan, you can take comfort in knowing the Benefits in this booklet will be honored — no matter where you travel.

This plan is designed to deliver the protection you and your family need. At the same time it helps hold down the cost of health care for you and your Employer. It also gives you flexibility, your choice of Providers (such as Physicians and Hospitals from a large, independent network of Providers) and ways to reduce your out-of-pocket expenses. It's a plan that encourages you to become more involved both as a patient and as a consumer by giving you options on how to use health care wisely without sacrificing Benefits.

The key to making the most of your Benefits is in the network of Preferred Blue Providers. **When you use Preferred Blue Providers for covered services, you receive a higher level of Benefits. If you choose to visit a Physician or Hospital who is not a Preferred Blue Provider, you can do so. Your Benefits, however, will be lower.** The choice is yours. What's important is that you understand what your plan will cover.

This booklet is not a Contract. It includes as few legal and technical terms as possible. If you wish to review the Contract, you can arrange to do so by contacting your company's personnel office or health insurance administrator. Defined terms appearing in this booklet begin with a capital letter. You can find some of these terms in the *How Your Coverage Works* section or in the *Definitions* section. All definitions of the Contract apply to your coverage, even if they are not defined in the booklet.

The Contract is a legal document that has a complete description of the Benefits and terms of your Health Insurance Coverage. It's also the controlling document for determining all contractual rights.

The insurance Benefits provided under the Contract are fully insured by Blue Cross.

Your Fastest Place for Answers – www.SouthCarolinaBlues.com

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

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

- Learn more about our products and services.
- Stay informed with all the latest Blue Cross news, including press releases.
- Find links to other health-related websites.
- Locate a network Physician, Hospital or Pharmacy.
- Use My Health Toolkit.

My Health Toolkit

Go to My Health Toolkit from www.SouthCarolinaBlues.com to:

- Check your eligibility.
- See how much you've paid toward your Deductible or any Out-of-pocket Maximum if shown in your Schedule of Benefits.
- Check on Authorizations.
- Find out if we've processed your claims.
- Order a new ID card.
- See if our records show if you have other health insurance.
- Ask a Member Service Representative a question through secure email.
- View your Explanation of Benefits (EOB).

Eligibility and Coverage

Eligibility

You must be an Actively-at-work (unless the absence is due to a Health Status-related Factor other than Substance Abuse or chemical dependency), full-time Employee working at least 30 hours a week for at least 48 weeks a year to be eligible for this coverage. You must also be performing the normal duties of your job at one of your Employer's normal places of business or at a location to which you must travel to do your job. This coverage is also available to your legal spouse and to your Dependent children through age 25. They must meet your Employer's eligibility requirements for Dependent coverage.

Here are the types of coverage you may choose:

- Single coverage for just you.
- Employee/Spouse coverage for you and your spouse.
- Employee/Child coverage for you and one or more Dependent children.
- Family coverage for you, your spouse and one or more Dependent children.

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

You are no longer eligible for the group health coverage on the last day of the Contract Month that your active employment with your Employer ends. If you are on disability leave of absence, you may be considered remaining in active employment up to a maximum of 60 days from the date active employment ended due to disability. If your Employer has 50 or more employees, please read the section in this booklet about the Family and Medical Leave Act.

A rescission doesn't include a retroactive cancellation or discontinuance of your coverage due to the failure to timely pay premiums. The Employer is solely responsible for providing you any notice related to retroactive terminations or rescissions that are required by law.

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

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

If you divorce, coverage for your spouse will end after 60 days following the filing of the legal order of the divorce. If your Employer has 20 or more employees, your spouse may be able to continue coverage for a specified period of time under COBRA or Conversion coverage. If your spouse is not eligible for COBRA, your spouse may be able to continue coverage for a specified period of time under State Continuation or Conversion coverage. Please review the *Continuation of Coverage* section of this booklet.

A Dependent child is no longer eligible for the group health coverage when he or she reaches age 26. An Incapacitated Dependent child's coverage, however, will not end simply because he or she is older than age 25.

Enrollment

You can enroll within 31 days of the date you first become eligible for coverage. New Dependents can enroll within 31 days of the date on which they first become eligible. Note: You can also enroll, if eligible, under the Late Enrollment or Special Enrollment terms of the Contract.

Coverage and Enrollment Changes

Newborn or Adopted Children – If you or your spouse gives birth, adopts a child or a child is placed with you or your spouse for the purpose of adoption while this policy is in force for you, then the child is covered from the moment of birth or adoption for Medically Necessary covered services and supplies. This includes any necessary care and treatment of medically diagnosed birth defects, diseases and anomalies or complications due to a premature birth. You must send us a completed Membership Application within 31 days of the birth or adoption and any premium that may be due.

If you enroll your child after 31 days of his or her birth, adoption or placement with you or your spouse for the purpose of adoption, then he or she will be subject to the Pre-existing Condition Limitations.

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

1. From the moment of birth for a child you or your spouse legally adopts within 31 days after the date of the child's birth;
2. From the moment of birth for a child for whom you or your spouse has temporary custody and have begun adoption proceedings within 31 days of the child's birth; or
3. When the adopted child is not a newborn, upon temporary custody with you or your spouse. Coverage will continue as long as you or your spouse has custody of the child.

Late Enrollment

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

Special Enrollment

If you (or your Dependent) are eligible for coverage but have not already enrolled, we will let you enroll if you meet either 1 or 2 below:

1. You must meet each of the following:
   a. You or your Dependent was covered under a Group Health Plan or had Health Insurance Coverage at the time coverage was previously offered to you or your Dependent.
   b. You stated in writing at the time that coverage under a Group Health Plan or Health Insurance Coverage was the reason for declining enrollment, but only if the plan sponsor or issuer (if applicable) required such a statement at the time. The plan sponsor or issuer must have given you a notice of the requirement and the consequences of the requirement at the time.
   c. You or your Dependent's coverage described in paragraph a above:
      i. Was under a COBRA or state continuation provision and that coverage had ended; or
      ii. Was not under a continuation provision and the coverage ended either because you lost eligibility or because employer contributions toward the coverage stopped. Reasons for a loss of eligibility might include legal separation, divorce, death, end of employment or reduction in the number of hours of employment; or
      iii. Was one of multiple health insurance plans offered by an employer and you chose another plan during an open enrollment period.
   d. You request the enrollment no later than 31 days after the date coverage ended due to loss of eligibility or Employer contributions stopped as described above.

2. a. You or your Dependent is covered under a Medicaid plan or under a State Children's Health Insurance Program (S-CHIP) and coverage of you or your Dependent under such plan is terminated due to loss of eligibility for such coverage and you request coverage under the Group Health Plan not later than 60 days after the termination date of such coverage; or
   b. You or your Dependent becomes eligible for assistance, with respect to coverage under the Group Health Plan under such Medicaid plan or State Children's Health Insurance Program (S-CHIP), if you request coverage under the Group Health Plan not later than 60 days after the date you or your Dependent is determined to be eligible for such assistance.

If you're eligible under this plan, but aren't enrolled and you marry, then you and your new spouse can enroll in the plan if enrollment is requested within 31 days of the marriage.

If you're eligible under this plan, but aren't enrolled and you or your spouse has a child, adopts a child or is in the process of adopting a child, the child can receive coverage under the plan. At the time of birth, adoption or placement for adoption, you and your spouse can receive coverage as long as you meet the eligibility requirements of the Contract. You must request coverage within 31 days of the child's birth, adoption or placement for adoption.

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

Qualified Medical Child Support Order (QMCSO)

Your Dependent may be entitled to receive Benefits according to the terms of a "Qualified Medical Child Support Order" (QMCSO) under federal ERISA law.

The order may not require us to provide any type or form of benefit, or any option that we do not already provide.

The Employer must notify the Employee and the child that an order has been received, and, within a reasonable time let the Employee and the child know whether or not the court order or submission of an approved form issued by the appropriate state's social services agency is a QMCSO. If the court order or approved social services form is determined to be a QMCSO, the child, age 25 or younger, is an Alternate Recipient and considered a beneficiary under the plan. Reimbursement of Benefit payments under this plan according to a QMCSO may be made to the child, the child's custodial parent or other designated representative, or to the Provider of care if Benefits are assigned.

If Medicaid has paid for the child's medical services that this plan should have paid, the state may seek to recover those paid amounts from this plan.

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

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

How Your Coverage Works

To better understand how your coverage works, it's helpful to know some common insurance terms. One of the most common terms you'll find throughout this booklet is **Benefit**. It refers to the amount this plan pays for Covered Expenses. **Before we pay Benefits on most expenses, you or your insured family Member must meet a Deductible as shown in your Schedule of Benefits each Benefit Period**.

As we process your claims, we'll credit Allowed Charges to the Deductible shown in your Schedule of Benefits. Once you have met the Deductible shown in your Schedule of Benefits, we pay Benefits for covered services at a percentage of the Allowed Charges for the rest of the Benefit Period. This is called the **Benefit percentage**. The difference between the Allowed Charges and the Benefit percentage is called **Coinsurance**. For example, if the Benefit percentage is 80 percent of Allowed Charges, the Coinsurance is 20 percent. Your coverage pays the Benefit percentage, while you are responsible for paying the Coinsurance portion of the bill. The Deductible applies to all Covered Expenses unless otherwise noted.

Another common term is **Maximum Benefits Payable**. This refers to the amount a plan will pay per Member on a yearly or lifetime basis. This plan, like other insurance plans, has limits on the amount payable during a Benefit Period and during the lifetime of your coverage. When we have paid the lifetime maximum Benefits, no additional payments will be made on claims.

Please note, the Benefit percentage will vary based on the Provider you choose. By using a Preferred Blue Provider, you receive a higher Benefit percentage. This helps lower your Coinsurance — an amount you spend out of your own pocket.

Except for any services shown in your Schedule of Benefits, there is a limit to the amount of Coinsurance you must pay each Benefit Period for Preferred Blue Providers and All Other Providers. This is called your **Out-of-pocket Maximum**. It protects you from having to spend large sums of your own money on health care. Once you reach the Out-of-pocket Maximum if shown in your Schedule of Benefits, claims for covered services are paid at the amount shown in the Out-of-pocket Expenses section of your Schedule of Benefits for the rest of the Benefit Period except for any services shown in your Schedule of Benefits.

Important Things to Remember About Your Coverage

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

To make sure you receive Medically Necessary services, this plan has built-in cost saving features that also control unnecessary costs. These cost saving features require that you file a Pre-service Claim to get Approval from us on certain services, Hospital visits, supplies and equipment. That way we can help you identify things that you can have done in a more affordable way and point out other things that you may not necessarily need. To avoid having your Benefits reduced or not paid at all, please get all necessary Approvals as outlined in this booklet. **Approval of a Pre-service Claim, however, is not a guarantee that we'll pay Benefits**. To make sure you get the most Benefits from this plan, please read the section, *Getting Approval from Blue Cross*. This section explains exactly when and how to get Approval.

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

Preferred Blue Providers

The backbone of this plan is the independent network of **Preferred Blue Providers**. These Physicians, Hospitals, Skilled Nursing Facilities, home health agencies, hospices and other Providers have agreed to provide health care services to Blue Cross plan members at a discounted rate. The Preferred Blue Network is one of the largest in South Carolina. Plus, it also will mean less paperwork on your part since Preferred Blue Providers file all claims for you.

There's comfort in knowing we will pay your Benefits at a higher percentage when you receive medical, surgical, Mental Health Services or Substance Abuse care from a Preferred Blue Provider.

Your Preferred Blue Provider has agreed to:
- Bill you only for the network allowance for the covered services.
- File all claims for you.
- Ask you to pay only the required Deductibles, Copayments and Coinsurance for covered amounts.

To find out if your Physician or Hospital is a Preferred Blue Provider, you can check the Preferred Blue Provider directory. You can call the Member Service Center toll free at 800-868-2500, ext. 41000 or in the Columbia area at 803-264-1000 and request a directory if you don't have one. Or visit our website at www.SouthCarolinaBlues.com. Since the Preferred Blue Provider network changes all the time, it's a good idea to ask your Physician or Hospital if it is a Preferred Blue Provider before you receive care.

To ensure you receive all of the Benefits you're entitled to, be sure to show your ID card whenever you visit your Physician or Hospital.

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.

All Other Providers

Not all Physicians, Hospitals and other health care Providers have contracted with Blue Cross to be Preferred Blue Providers. Those who have not are called **All Other Providers**. Although this plan gives you the freedom to use any provider, the percentage of Benefits we pay will be lower. This means you pay more money out of your own pocket. All Other Provider Benefit percentages are shown in your Schedule of Benefits.

Naturally, we encourage you to use Preferred Blue Providers whenever you can for a number of reasons. All Other Providers may:
- Require you to pay the full amount of their charges at the time you receive services.
- Require you to file your own claims.
- Require you to get all necessary Approvals. Information regarding how and when to get an Approval is in the *Getting Approval from Blue Cross* section of this booklet.
- Charge you more than the Blue Cross Allowed Charge.

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

Claims Filing

How to File a Claim

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

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

1. **Comprehensive Benefits Claim Form for each patient.** You can get these forms from the Member Service Center or from our website at www.SouthCarolinaBlues.com.
2. **Itemized Bills from the Providers.** These bills should include:
   - Provider's name and address.
   - Patient's name and date of birth.

- Employee's Blue Cross ID number.
- Description and cost of each service.
- Date that each service took place.
- Description of the illness or injury (diagnosis).

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

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

The *Prescription Drug Coverage* section explains how to file claims for Prescription Drugs. Please follow those instructions when filing claims for Prescription Drugs.

Time Limits to File a Claim

Claims must be filed no later than 12 months from the end of the Benefit Period in which you or your Dependents receive the medical services or supplies. Exceptions may be made where an Employee shows he or she was not legally competent to file the claim.

Claims Determination

There are three types of claims. They are Pre-service Claims, Urgent Care Claims (a type of Pre-service Claim) and Post-service Claims. The time frames allowed for us to provide a determination for each of these claims are listed below:

1. Pre-service Claim – We must give you our decision in writing or in electronic form within 15 calendar days.

   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.

   If we receive incomplete information from you and need more information to make a determination, we will let you know within five calendar days. You have 60 calendar days to send us the required information. If we do not 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 your Provider.

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. We will defer to the attending Physician with respect to the decision as to whether a claim constitutes "urgent care." A Provider may be considered an authorized representative without a specific designation by you when the Approval request is for Urgent Care Claims (medical conditions which require immediate treatment).

   We will notify you or your authorized representative of the lack of information in which to render a decision within 24 hours from receipt of the original Urgent Care Claim. An extension of 48 hours may be required if we do not receive complete information to make a Medical Necessity decision. If we do not 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. 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.

   If we receive incomplete information from you and need more information to make a determination, we will let you know within 30 calendar days. You have 60 calendar days to send us the required information. If we do not 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 your 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.

If you request Concurrent Care Benefits to 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 booklet. It outlines the terms and conditions of your health coverage.
- Contact the Member Service Center for help.
- Ask your Employer to let you read the Contract it holds with Blue Cross. The Contract is a legal document that provides a complete description of your health coverage.

Time Limit to Question a Claim or File a Lawsuit

You have only 180 days to question or appeal our decision regarding a claim. After that date, we will consider disposition of the claim to be final. You cannot bring any legal action against Blue Cross 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 booklet. You cannot bring any action against Blue Cross after the expiration of any applicable period prescribed by law.

Getting Approval from Blue Cross

To make the most of your Benefits, Blue Cross has an Approval process in place. Our Medical Services personnel (a group of medical professionals employed by us) must give advance Approval for Pre-service Claims, which include all Hospital Admissions and certain other specified services for you to receive maximum Benefits (see the section on *Preauthorization Review*). Their responsibility is to review all requests for prior Approval. Inpatient and Outpatient services you receive for treatment of Mental Health Services and Substance Abuse care require Preauthorization by Companion Benefit Alternatives, Inc. (CBA).

An Approval from Medical Services or Companion Benefit Alternatives, Inc. means only that a service is Medically Necessary for treatment of the Member's condition. **Approval from Medical Services or Companion Benefit Alternatives, Inc. does not verify Benefits or guarantee that we'll pay Benefits. Payment is subject to Member eligibility, Pre-existing Condition Limitations and all other Contract limitations and exclusions. We'll make our final Benefit determination when we process your claims.** If you have any questions about whether a certain service will be covered, please contact a Member Service Representative.

If your Physician recommends these services and/or supplies for you or your Dependent for any reason, make sure you tell your Physician that your health insurance plan requires advance Approval. Preferred Blue Providers will be familiar with this requirement and will get the necessary Approvals.

If you or your Dependent doesn't use a Preferred Blue Provider, it's your responsibility to contact Blue Cross before receiving these services and/or supplies. If you don't get prior Approval, then you'll pay more of your own money for these services and/or supplies.

If you or a Dependent is undergoing a human organ and/or tissue transplant, written Approval from Blue Cross must be obtained in advance and, if shown in the Schedule of Benefits, the procedure must be done at a Designated Provider. **If we don't preapprove these services in writing or, if shown in the Schedule of Benefits, they are not done at a Designated Provider, then we won't pay any Benefits.**

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.

Please note that if your Pre-service Claim for services or Benefits is denied, you can request further review under the guidelines set out in the *Appeal Procedures* section of this booklet. Remember that preauthorization and prior Approval denials are considered denied claims for purposes of appeals. Determinations and appeals regarding Pre-service Claims are subject to the time frames explained in the *Claims Filing* and *Appeal Procedures* sections of this booklet.

Types of Approval

There are five different types of Approval:

1. Preadmission Review
2. Emergency Admission Review
3. Continued Stay Review

4. Preauthorization Review
5. Preauthorization for Mental Health Services and Substance Abuse care

Here are more details about each one:
Preadmission Review — Before you or a Dependent is admitted to a Hospital or Skilled Nursing Facility, Preadmission Review Approval must be obtained. If you've just had a baby and your newborn is sick and must stay in the Hospital, Approval must be obtained within 24 hours of your discharge.

If Approval isn't obtained, or if we don't approve the Admission and you or your Dependent is still admitted, we won't pay Benefits for any part of the room and board charges. If a Preferred Blue Hospital or Skilled Nursing Facility doesn't get Approval, it can't bill you for room and board charges. An All Other Provider, however, can bill you for the penalty.

An admission for physical rehabilitation requires use of Designated Providers and Preauthorization from us. If the admission for physical rehabilitation isn't Preauthorized and/or the service isn't performed at a Designated Provider, we won't pay benefits.

Emergency Admission Review — If you or a Dependent experiences 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.

Medical Services must be notified within 24 hours of the emergency Admission, or by 5:00 p.m. of the next working day following the Admission. (Exceptions may be made for reasons beyond your control.)

If Emergency Admission Review Approval isn't obtained within 24 hours or by the next working day, we won't pay Benefits for any part of the room and board charges. If a Preferred Blue Hospital or Skilled Nursing Facility doesn't get Approval, it can't bill you for room and board charges. An All Other Provider, however, can bill you for the penalty.

Continued Stay Review — It's possible that you or a Dependent has to remain in the Hospital or Skilled Nursing Facility for a period longer than we originally approved. In this case, Continued Stay Review Approval must be obtained from Medical Services.

If Continued Stay Review Approval isn't obtained, or if we don't approve the continued stay, but you or your Dependent remains in the Hospital or Skilled Nursing Facility, we won't pay Benefits for any part of the room and board charges for the period of the continued stay. If a Preferred Blue Hospital or Skilled Nursing Facility doesn't get Approval, it can't bill you for room and board charges for the continued stay. An All Other Provider, however, can bill you for the penalty.

Preauthorization Review — A number of services and medical procedures require Preauthorization Review. Please refer to your Schedule of Benefits for a list of the services or procedures and what penalty will apply if Preauthorization is not obtained.

If a Preferred Blue Provider doesn't get Preauthorization for you, it can't bill you for the denied or reduced Benefits due to Preauthorization not being obtained. An All Other Provider, however, can bill you for the penalty.

For more information about services and supplies that require Preauthorization Review, please see the *Covered Expenses* section. If you have specific questions, please call or write the Member Service Center.

Preauthorization for Mental Health Services and Substance Abuse care – Companion Benefit Alternatives, Inc. (CBA) must preapprove any inpatient or Outpatient treatment for Mental Health Services and Substance Abuse care.

When Approval isn't obtained for inpatient Mental Health Services and Substance Abuse care, we'll deny covered charges for room and board. If a Preferred Blue Hospital doesn't get Approval for you, it can't bill you for room and board charges. When Approval isn't obtained for Outpatient or office Mental Health Services and Substance Abuse care, we'll reduce Benefits as shown in your Schedule of Benefits. If a Preferred Blue Provider doesn't get Approval for you, it can't bill you for the reduction. An All Other Provider, however, can bill you for the penalty.

Where to Call for Approval

For Approval for medical or surgical treatment, call Medical Services at one of the numbers listed in the *How to Contact Us if You Have a Question* section.

You also can find the numbers on the front of your ID card. Be sure to keep your card with you at all times since you never know when you may need to reach us.

For Approval for Mental Health Services and Substance Abuse care, call Companion Benefit Alternatives, Inc. at one of the numbers listed in the *How to Contact Us if You Have a Question* section.

If you call for review and Approval, you'll talk with a medical professional. He or she will ask you for this information:

- Your name and ID number
- The patient's name and relationship to you, the Employee
- The Physician's name, address and phone number
- The Hospital or Skilled Nursing Facility's name, address and phone number
- Reason the Member needs care

After careful review, we'll let your Physician and Hospital know if we approved the Admission or service as Medically Necessary and how long the Approval is valid.

If you need Approval, be sure to call Medical Services or Companion Benefit Alternatives, Inc. Please don't call the Member Service Center. A Member Service Representative cannot give Approval.

Continuation of Care

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

You may get the form for this request by going to our website at www.SouthCarolinaBlues.com or calling 803-264-1000 in Columbia or 800-868-2500, ext. 41000 outside the Columbia area. 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.

If You Receive Emergency Care In An Emergency Room Out-of-network

If you or a Dependent receives Emergency Medical Care in an Emergency Room by an All Other Provider, we will pay Benefits for covered services at the in-network percentage of the **Allowed Charges**. Prior authorization is not required, regardless of the network participating status of the Provider.

For purposes of this section, Allowed Charges will be based on the greatest of the following:

- The Fee Schedule for Preferred Blue Providers
- The Reasonable and Customary Fee Schedule
- The Medicare allowance

Benefits under this provision are subject to the All Other Provider Deductibles and all Contract maximums, limits and exclusions.

Hospital Admission

If you are admitted to the Hospital later, as a result of the emergency visit, approval is required within 24 hours or by 5 p.m. of the next working day, or as soon as reasonably possible.

If You Receive Out-of-area Emergency Care

If you or a Dependent receives Emergency Medical Care from an All Other Provider, we'll pay Benefits for covered services at a higher percentage of the **Allowed Charges** if you meet all of these conditions:

- The Member was traveling for reasons other than seeking medical care when the Emergency Medical Condition occurred.
- The Member was treated for an accident or new Emergency Medical Condition.

Benefits under this provision are subject to the Deductibles or Copayments, Coinsurance and all Contract maximums, limits and exclusions.

Emergency Admission Review Approval is required within 24 hours or by 5:00 p.m. the next working day for all emergency Admissions.

If you have claims that meet all of these conditions, write or call the Member Service Center. We will review your claims to determine if we can provide additional Benefits.

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 referred to generally as "Inter-Plan Programs." Whenever you obtain health care services outside of Blue Cross and Blue Shield of South Carolina's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between us and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside our service area, you will obtain care from health care Providers that have a contractual agreement (i.e., are "Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from nonparticipating health care Providers. Our payment practices in both instances are described below.

a. **BlueCard® Program**

Under the BlueCard Program, when you access covered health care services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care Providers.

Whenever you access 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, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

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

b. **Non-Participating Health Care Providers Outside Our Service Area**

1. Member Liability Calculation

When covered health care services are provided outside of our service area by non-participating health care Providers, the amount you pay for such services will generally be based on either the Host Blue's nonparticipating health care Provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating health care Provider bills and the payment we will make for the covered services as set forth in this paragraph.

2. Exceptions

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the health care services had been obtained within our service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by nonparticipating health care Providers. In these situations, you may be liable for the difference between the amount that the non-participating health care Provider bills and the payment we will make for the covered services as set forth in this paragraph.

Pre-existing Condition Limitations

Pre-existing Conditions are physical or mental conditions (regardless of the cause) for which medical advice, diagnosis, care or treatment was received or recommended within the six-month period ending on your Enrollment Date.

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

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

1. The date on which the Member has not received medical care, treatment or supplies for the Pre-existing Condition for 12 months and that period of 12 months ends on or after the Effective Date of coverage; or
2. 12 months after the Enrollment Date. In the case of a Late Enrollee, 18 months after the date the Member completes the application for coverage (See the Eligibility and Coverage section, Late Enrollment).

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

A period of Creditable Coverage doesn't count if there is at least a 63-day period where you or your Dependent was not covered under any Creditable Coverage.

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

The Pre-existing Condition Limitation does not apply to Members who enroll in the Group Health Plan when they are under the age of 19, to Maternity Services or to Genetic Information when there has been no diagnosis of the condition related to the information.

The Pre-existing Condition Limitation does not apply to a newborn child, a child who is adopted or a child who is placed with you or your spouse for the purpose of adoption before he or she reaches age 18 if you applied for coverage and you paid your premiums within 31 days from the birth, adoption or placement for adoption.

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

If you have single coverage and add Dependents, the Pre-existing Condition Limitations apply to any Dependents as of the Effective Date of the upgraded coverage unless there is Creditable Coverage.

Method of Counting Creditable Coverage

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

Credit for prior coverage will be determined when you provide us with a certificate or other acceptable evidence that shows you had prior coverage with Health Insurance Coverage. You or your Dependent has the right to request a Certificate of Creditable Coverage from any prior plan or issuer. This is based on the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This Act requires that Group Health Plans give credit for prior coverage when applying Pre-existing Condition Limitations. If necessary, Blue Cross will request the certificate with your written authorization.

Blue Cross will notify you of any Pre-existing Condition Limitations period and the basis for the determination. You have the right to submit additional evidence of prior Creditable Coverage. Blue Cross has the right to reconsider its decision if we determine you didn't have the prior Creditable Coverage you say you did.

Definitions

Health insurance is sometimes difficult to understand. Many of the terms are not used in day-to-day conversation. Here are some definitions that should make it easier for you to understand your health coverage.

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

Allowable/Allowed Charges: The Allowable Charge for Preferred Blue Providers is an allowance mutually agreed upon by Preferred Blue Providers and Blue Cross. For all other Providers, the Allowable Charge will be the actual charge submitted or the Maximum Payment, whichever is less.

The Maximum Payment is the total amount eligible for payment by us for the services, supplies or equipment you receive from a Provider. The Maximum Payment that we determine will be the least of 1, 2, 3, 4 or 5:

1. The actual charges made for similar services, supplies or equipment by Providers and filed with us during the last calendar year.
2. The Maximum Payment for the last year increased by an index based on national or local economic factors or indices.
3. The lowest charge level at which any medical services, supplies or equipment is generally available in the area, when in our judgment, a charge for such services, supplies or equipment should not vary significantly from one Provider to another.
4. A set of allowances that has been mutually agreed upon by contracting Providers and Blue Cross.
5. A set of allowances we establish.

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

Ambulatory Surgical Center: A Facility that is licensed for Outpatient Surgery only and doesn't provide inpatient accommodations. It must be operated 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. Ambulatory Surgical Center includes an endoscopy center.

Approval: To approve Pre-service Claims based on Medical Necessity, Medical Services or Companion Benefit Alternatives, Inc. must be called for the following: Preadmission Review, Emergency Admission Review, Continued Stay Review, Preauthorization Review and Preauthorization Review for Mental Health Services and Substance Abuse care.

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

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

Behavioral Therapy does not include educational or alternative programs such as, but not limited to:

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

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

Certificate of Creditable Coverage: A document from a previous health insurance plan or insurer that says you had prior Health Insurance Coverage with them. You should receive a certificate after your prior Health Insurance Coverage ends. By presenting a certificate when you enroll for new health coverage, you may be able to reduce the length of or eliminate any Pre-existing Condition exclusion period under your new health plan.

Clinic: An Outpatient Facility for examining and treating patients who aren't bedridden. It must be operated under the supervision of a Physician.

Coinsurance: The percentage of Allowable Charge you pay as your share of the Covered Expenses. This percentage applies to the negotiated rate or lesser charge when we have negotiated rates with that Provider. Coinsurance amounts apply to the Out-of-pocket Maximum as shown in your Schedule of Benefits.

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

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

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

Coordination of Benefits (COB): You or your Dependents may be covered for Benefits under two or more Group Health Plans. In this case, Blue Cross will coordinate benefits with the other plans to prevent duplicate payments and overpayments.

This nationally accepted cost-containment program provides that our Benefit payment, plus any payment due from any other group health coverage you may have, will not exceed the amount that Blue Cross would pay in the absence of other insurance coverage or the amount for which you are responsible after the primary insurer pays. The rules determining which group coverage should pay first (primary) are as follows:

1. The Group Health Plan of the Employee is primary over one that covers the Employee as a dependent spouse, retired, laid off or otherwise inactive Employee.
2. If a person works at several places and each place has a Group Health Plan, the plan he or she has been covered under longest is primary.
3. When a husband and wife work at different places, both of which have group health coverage, the plan of the parent whose birthday falls earlier in the year is primary for the children.
4. In the case of divorce or legal separation, the group plan that covers the parent with custody of the child(ren) generally is considered primary unless otherwise ordered by the court.
5. When a Group Health Plan does not have a coordination of benefit provision, that plan is primary.

If your other group health coverage is responsible for making payments first, Blue Cross can't pay until we know how much the other plan has paid and the amount of your remaining liability. You must tell us of any other group health benefit plan under which you or your Dependents are covered. You must also confirm if there is no other insurance for your Dependents each year. You will receive a notice stating a claim has been denied or that we need information to complete processing the claim. For us to update your files, return the notice with the requested information. If you need more information, please contact a Member Service Representative.

Copayment: A fee you pay each time you receive a certain service or supply, such as a doctor's office visit, a particular medical service, Hospital Admission or prescription. Copayments are shown in your Schedule of Benefits.

Copayments don't go toward reaching your Deductible or Out-of-pocket Maximum shown in your Schedule of Benefits. They will continue to apply even after you meet your Deductible and reach your Out-of-pocket Maximum as shown in your Schedule of Benefits.

Creditable Coverage: Benefits or coverage provided under:

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

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

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

Deductible: The amount of Allowable Charges you are responsible for paying each Benefit Period before Benefits are payable on Covered Expenses. The Deductible applies to all Covered Expenses unless otherwise noted. The Deductible doesn't apply to the Out-of-pocket Maximum shown in your Schedule of Benefits. The Deductible is also shown in your Schedule of Benefits.

Dependent: Your spouse and any children through age 25 who are covered under the Contract. A Dependent child can be a natural or adopted child, stepchild, foster child or a child who is under your legal guardianship.

This also includes any child of a divorcing/divorced Employee who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment under this health plan. This means we provide coverage for Dependents of an Employee who is a Member of this Group Health Plan even though this Employee is the noncustodial parent when a QMCSO exists.

Designated Provider: Any Provider with whom we have a Contracting Provider Agreement, and that we require you to use for specialized services in order to receive Benefits for these services. These Providers include, but are not limited to, Rehabilitation Facilities and Contracting Mammography Providers. We won't pay Benefits unless a Designated Provider performs these services.

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

Durable Medical Equipment: Equipment your doctor orders that has exclusive medical use. These items must be reusable and may include wheelchairs, hospital-type beds, walkers, Prosthetic Devices, oxygen, respirators, etc. To qualify for Benefits, your Physician must order the medical equipment and it must be Medically Necessary for a specific need. Equipment such as air conditioners, whirlpool baths, spas, (de)humidifiers, wigs, fitness supplies, vacuum cleaners or air filters don't qualify because they don't have exclusive medical uses. To be considered Durable Medical Equipment, the device or equipment's use must be limited to the patient for whom it was ordered. This means others can't use the device or equipment.

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

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

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

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

Excepted Benefits: 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 supplement to the coverage provided under Military, TRICARE or CHAMPUS; and
    c. Similar supplemental coverage under a Group Health Plan.

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

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

Genetic Information: Information about genes, gene products or genetic characteristics (hair and eye color, risks for certain diseases, etc.) that are passed down from parents to children. "Gene product" is a scientific term that means messenger RNA and translated protein. Genetic Information doesn't include routine physical measurements; chemical, blood and urine analysis, unless purposely done to diagnose a genetic characteristic; tests for drug abuse; and tests for the presence of HIV.

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

Health Insurance Coverage: Benefits for medical care provided directly, through insurance, reimbursement or otherwise. It includes items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract or Health Maintenance Organization (HMO) contract that a health insurer offers with the exception of those under Excepted Benefits.

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

Home Health Care: Care you get in your home that you would normally receive during an inpatient Admission. You must receive Home Health Care from a home health agency that is licensed by the state in which it operates. We must approve Benefits for Home Health Care in advance.

Hospice Care: A program specifically to provide services for care and management of a terminally ill Member with a life expectancy of six months or less. Hospice Care requires Preauthorization Review.

Hospital: A short-term, 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 and treatment of injured or sick people on an inpatient basis. It must also be under the supervision of a staff of duly licensed Physicians; and
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 that are, other than incidentally:
1. Convalescent, rest or nursing homes or facilities; or
2. Facilities primarily affording custodial, educational or rehabilitory care; or
3. For the treatment of substance or alcohol abuse; or
4. For the treatment of mental conditions.

A Hospital does not include a long-term, chronic-care institution or Facility that mainly provides care for items 1-4 above, whether or not such institution or Facility is affiliated with or part of a Hospital.

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 the Employee.

Investigational or Experimental Services: The use of services or supplies that Blue Cross doesn’t recognize as standard medical care for the treatment of conditions, diseases, illnesses or injuries. These include but aren’t limited to, treatments, procedures, facilities, equipment, drugs or devices. Here are the criteria used to base our decision on whether a service or supply is Investigational or Experimental:

1. Services or supplies requiring Federal or other governmental agency approval such as drugs and devices that have restricted market approval from the Food and Drug Administration (FDA) or from any other governmental regulatory agency for the use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.

   We will, however, allow coverage for a Prescription Drug that hasn’t been approved by the FDA:
   a. For a specific medical condition when there are at least two formal clinical studies recognizing the use of the drug for the medical condition; or
   b. For the treatment of a specific type of cancer, provided the drug is recognized for treatment of that specific cancer in at least one standard reference compendium or the drug is found to be safe and effective in formal clinical studies. These results must have been published in peer-reviewed professional medical journals.
2. There is insufficient or inconclusive scientific evidence in peer-reviewed medical literature to let Blue Cross evaluate the therapeutic value of the service or supply.
3. There is inconclusive evidence that the service or supply has a beneficial effect on a person’s health.
4. The service or supply under consideration is not as beneficial as any established alternatives.

5. There is insufficient information or inconclusive scientific evidence that the service or supply is beneficial to a person's health and is as beneficial as any established alternatives when it's used in a non-investigational setting.

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

Blue Cross' Medical Director, in making such determinations, may use one or more of these sources of information:
1. FDA-approved market rulings
2. *The United States Pharmacopoeia and National Formulary*
3. The annotated publication titled, *Drugs, Facts and Comparisons*, published by J.B. Lippincott Company
4. Available peer-reviewed literature
5. Appropriate consultation with Specialists on a local and national level

Late Enrollee or Late Enrollment: An eligible Member who enrolls under this Contract other than during:
1. The first period in which you or your Dependent is eligible to enroll under the plan if the initial enrollment period is a period of at least 30 days; or
2. A Special Enrollment period.

Legal Intoxication: Legal intoxication means the Member's blood alcohol level was at or in excess of legal limits under applicable state law, when measured by law enforcement or medical personnel.

Maternity Services: Prenatal care, perinatal care and childbirth.

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

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

Member: An enrolled Employee or covered Dependent.

Mental Health Services: The treatment of mental conditions. These conditions are defined, described or classified as psychiatric disorders or conditions in the latest publication of The American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders.* As used in the health plan, this does not include services for the treatment of Substance Abuse.

Non-contracting Facility: Any Facility with which Blue Cross doesn't have a written agreement. We won't pay Benefits for services or supplies provided by a Non-contracting Facility, except for the treatment of an Emergency Medical Condition and services provided outside the state of South Carolina.

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

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

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

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

Coinsurance on certain services shown in your Schedule of Benefits do not apply toward your Out-of-pocket Maximums. These services will be paid as shown in your Schedule of Benefits regardless of Out-of-pocket Maximums.

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

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

Over-the-counter Drug: A drug that doesn't require a prescription.

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

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

Pharmacy Benefit Manager (PBM): A company that has a written contract with Blue Cross to manage the Prescription Drug Benefit program according to your coverage.

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

Post-service Claim: Any claim that is not a Pre-service Claim or any claim that you submit to us after you received the medical care, service or supply.

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

Prescription Drug: A drug that has been approved by the FDA and labeled "Caution: Federal Law Prohibits Dispensing Without Prescription," or labeled in a similar manner. Only a licensed registered pharmacist can dispense it according to a Physician's prescription order. Injectable insulin is also included.

- **Brand-name Drug:** A Brand-name Drug may be a Preferred Drug or a Non-preferred Drug.
- **Generic Drug:** A Prescription Drug that normally has the same active ingredients as the Brand-name Drug but is not manufactured under a registered brand name or trademark.
- **Non-preferred Drug:** A Prescription Drug that has not been chosen by Blue Cross, or its designated Pharmacy Benefit Manager, to be a Preferred Drug. This includes any Brand-name Drug that has an "A" rated Generic Drug available.
- **Preferred Drug:** A Prescription Drug that has been reviewed for cost, clinical effectiveness and quality. The Preferred Drug List is subject to periodic review and updates by Blue Cross or its designated Pharmacy Benefit Manager, without notice.

Specific classes of Over-the-counter Drugs may be covered as Prescription Drugs. If so designated and the Schedule of Benefits reflects Benefits are available, these classes of Over-the-counter Drugs must have a valid prescription.

Prescription Drug Coinsurance: The percentage of Allowable Charges for Prescription Drugs that the Member pays. The Prescription Drug Coinsurance does apply to the Out-of-pocket Maximum shown in your Schedule of Benefits.

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

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

Pre-service Claim: Any claim or request for a Benefit where prior authorization or Approval must be obtained from Blue Cross before receiving the medical care, service or supply. An Approval means only that a service is Medically Necessary for treatment of your condition. It is not a guarantee or verification of Benefits. Payment is subject to your eligibility, Pre-existing Condition Limitations and all other Contract limitations and exclusions. We will make our final Benefit determination when we process your claim.

Prosthetic Devices – Artificial replacement body parts needed to ease or correct a condition caused by an illness, injury or birth defect, disease or anomaly.

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

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

Rehabilitation Facility: A Hospital or other freestanding medical Facility that has a written agreement with Blue Cross, to provide, on an inpatient basis, a multi-disciplinary therapeutic program that includes physical therapy, Occupational Therapy and other therapeutic interventions for patients with neurological or other physical illnesses or injuries.

Second Surgical Opinion: An opinion from a second Physician about the need for Medically Necessary, elective Surgery that has been recommended by another Physician. Second Surgical Opinions should never be used to avoid or delay emergency Surgery.

Serious Medical Condition: A health condition or illness that requires medical attention, and for which failure to provide the current course of treatment through the current Provider would place your health in serious jeopardy. This includes cancer, acute myocardial infarction and pregnancy.

Skilled Nursing Facility: A licensed institution, other than a Hospital, that has a written agreement with Blue Cross or with 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's in charge of patient care, along with one or more RNs or licensed practical nurses (LPNs) on duty at all times; and
4. Keeps a daily medical record for each patient; and
5. Is primarily providing continuous skilled nursing care for sick or injured patients during the recovery stage of their illnesses or injuries and is not, other than incidentally, a rest home or a home for custodial care for the aged; and
6. Is operating lawfully as a nursing home in the area where it is located.

In no event will the term "Skilled Nursing Facility" include an institution that mainly provides care and treatment for substance or alcohol abuse.

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

Special Enrollment: Special circumstances listed in the *Eligibility and Coverage* section that allow you or your Dependent who is eligible but not enrolled, to enroll for coverage under the terms of the Contract.

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

Specialty Drugs: FDA approved Prescription Drugs that treat a complex clinical condition and/or require special handling such as refrigeration. They normally require unusual/complex clinical monitoring and special training. Specialty Drugs include but are not limited to infusible Specialty Drugs for acute and chronic diseases, injectable and self-injectable drugs for acute and chronic diseases, biotechnology medicines and specialty oral drugs or other dosage forms.

Specialty Drug Copayment: The amount payable (if any) by you for each Specialty Drug, as shown in your Schedule of Benefits if Specialty Drug coverage is provided. The Specialty Drug Copayment doesn't apply to the Deductible or the Out-of-pocket Maximum shown in your Schedule of Benefits and will continue to apply even after your Out-of-pocket Maximum is met.

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

Subrogation Right: If you receive medical Benefits under this Contract for an injury caused by the act or omissions of a liable third party and receive a settlement, judgment, or other payment relating to the injury from a liable third party, any other person, firm, corporation, organization or business entity, you agree to reimburse us for Benefits that we have paid relating to the injury. This agreement is a condition to receiving Benefits under this Contract. 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 your place 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 our payment of claims from the liable third party, any liability or other insurance covering the liable third party or from your own uninsured motorist insurance and/or underinsured motorist insurance.

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

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

Substance Abuse: The continued use, abuse and/or dependence of legal or illegal substance(s), despite significant consequences or marked problems associated with the use as defined, described or classified as in the latest publication of The American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders.* As used in your health plan, this does not include services for treatment of Mental Health Services.

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

Urgent Care Claim: Any claim made by you or by a Provider or Physician (with knowledge of your current medical condition), where, if the normal Pre-service Claim review time frames of the Contract were used:

1. Your life, health or ability to regain maximum function could be seriously jeopardized; or
2. You, in the opinion of the Physician, would be subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

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

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

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

Covered Expenses

Covered Expenses are Medically Necessary services or supplies a Physician prescribes for the treatment and diagnosis of an illness or injury. Covered Expenses are subject to provisions of this coverage which include *Services and Supplies not Covered*, *Pre-existing Condition Limitations* and *Getting Approval from Blue Cross*. The Deductible, Coinsurance and other limitations shown in your Schedule of Benefits also apply.

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

Ambulatory Surgical Center – We'll provide Benefits for covered Outpatient Surgery not limited by the Schedule of Benefits.

Anesthesia – Administration of anesthesia an attending Physician orders which is given by a registered nurse anesthetist or Physician other than the surgeon or assistant at Surgery.

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

Cleft Lip and Palate – Medically Necessary care and treatment of a Cleft Lip and Palate, and any condition or illness that is related to or caused by Cleft Lip and Palate. "Cleft Lip and Palate" means a congenital cleft in the lip or palate or both. Care and treatment will include, but is not limited to, these types of Medically Necessary care:

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

If a person with a Cleft Lip and Palate is covered by a dental policy, then the dental policy will cover teeth capping, prosthodontics and orthodontics by the dental policy to the limit of coverage provided and any excess after that will be provided by this plan.

Consultation – A Member's attending Physician may order a consultation from another Physician. An example of this would be when your family doctor seeks advice from a specialist such as a heart specialist or orthopedic surgeon. For each consulting Physician, we'll provide Benefits for one consultation during a single Admission to the Hospital or Skilled Nursing Facility.

Dental Care to Sound Natural Teeth – Only when such care is for treatment, Surgery or appliances caused by accidental bodily injury (except dental injuries occurring through the natural act of chewing). It's limited to care completed within six months of such accident and while the patient is still covered under this Contract.

Diabetes – Equipment, supplies, Outpatient self-management training and education for the treatment of Members with diabetes if it's Medically Necessary and a health care professional prescribes it. This health care professional must be legally authorized to prescribe such items and follow minimal standards of care for diabetes. These minimal standards of care are adopted and published by the Diabetes Initiative of South Carolina.

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

Diagnostic X-rays and Laboratory Procedures – We'll provide Benefits as shown in the Schedule of Benefits when ordered by a health care Provider.

Durable Medical Equipment – If a Physician prescribes Durable Medical Equipment and it's Medically Necessary for the treatment of the Member's condition, then we'll provide Benefits for the purchase price or total rental cost up to the purchase price of the Durable Medical Equipment as shown in your Schedule of Benefits. We provide Benefits for standard Durable Medical Equipment only. We'll provide Benefits for deluxe equipment at standard equipment allowances. Benefits don't include manual or motorized wheelchairs or power operated scooters for mobility outside the home setting. We must determine these devices are Medically Necessary to assist with mobility in the home for Benefits to be available.

A Preauthorization Review is needed before you get the Durable Medical Equipment if the cost is more than the amount shown in your Schedule of Benefits. See the *Getting Approval from Blue Cross* section.

Home Health Care – Refer to your Schedule of Benefits to see if your Group Health Plan includes this coverage and what Benefit limitations apply. If approved, we'll provide Benefits for these services:

1. Services by a registered nurse (RN) or licensed practical nurse (LPN).
2. Physical, respiratory, speech and occupational therapy (the physical therapy Benefit Period maximum applies).
3. Services 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 administration.
9. Durable Medical Equipment (a separate Preauthorization Review isn't needed when we approve the entire Home Health Care plan).

For information on how to get a Preauthorization Review of Home Health Care services, see the *Getting Approval from Blue Cross* section.

Hospice Care – Refer to your Schedule of Benefits to see if your Group Health Plan includes this coverage and what Benefit limitations apply. If approved, we'll provide Benefits for Hospice Care provided by a licensed Hospice Care Provider. Hospice Care includes:

1. Services by a registered nurse (RN) or licensed practical nurse (LPN).
2. Physical, respiratory, speech and occupational therapy (the physical therapy Benefit Period maximum applies).
3. Services 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 administration.
9. Durable Medical Equipment (a separate Preauthorization Review isn't needed when we approve the entire Hospice Care plan).
10. Respite care.
11. Family counseling concerning the patient's terminal condition.

For information on how to get a Preauthorization Review of Hospice Care, See the *Getting Approval from Blue Cross* section.

Hospital Services

1. Inpatient Hospital Services include:
   a. A semi-private room or special care unit, board and general nursing care.
   b. A private room. The private room allowance is the most prevalent semi-private rate as determined by us. If the Member is admitted to a Hospital in which all rooms are private, however, the most prevalent private room rate, as determined by us, will be considered as semi-private for the purpose of providing benefits under the Contract.
   c. Ancillary Services, such as:
      - Use of operating, delivery and treatment rooms.
      - Prescribed drugs.
      - Transfusions, including the cost of blood, blood plasma and blood plasma extenders.
      - Anesthesia, anesthesia supplies and services provided by a Hospital employee.
      - Medical and surgical dressings, supplies, casts and splints.
      - Diagnostic services.
      - Therapy services.
      - Rental of Hospital equipment up to the purchase price during the inpatient stay.

   The day the Member leaves the Hospital, with or without permission, is the discharge day. The day the Member goes to the Hospital is the admission day. Benefits are not payable for days in which the Member is not physically present in the Hospital for inpatient care.

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

Human Organ and/or Tissue Transplants – We'll provide Benefits as shown in your Schedule of Benefits for expenses related to covered human organ and/or tissue transplants. If a Member receives organs from a human donor, the Member transplant recipient is entitled to Benefits for medical expenses of the covered transplants listed in your Schedule of Benefits.

The Benefits payable for human organ and/or tissue transplants include all expenses for medical and surgical services and supplies you receive while covered under the Contract. Organ transplant coverage includes expenses for the donor organ procurement.

We must approve all human organ and/or tissue transplant services in writing and, if shown in your Schedule of Benefits, it must be done by a Designated Provider. If we don't preapprove these services in writing and, if shown in your Schedule of Benefits, they are not provided by a Designated Provider, then we won't pay Benefits.

For prior Approval and information about any type of transplant recommended for you or your Dependents, call Blue Cross' Medical Services personnel at these numbers:

Columbia Area	803-736-5990
Toll free in South Carolina	800-327-3238
Toll free outside South Carolina	800-334-7287

Mastectomy – For hospitalization for at least 48 hours following a mastectomy. If you're released early, then we'll provide Benefits for at least one home care visit if the attending Physician orders it.

We'll also provide Benefits for Prosthetic Devices, reconstruction of the breast on which the mastectomy was done and physical complications for all stages of the 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 Services – Maternity Benefits aren't payable for Dependent children. Benefits for the newborn child will be available only if the child is added to the Contract as described in the *Eligibility and Coverage* section.

We'll provide Benefits for the hospitalization and related professional services for the mother and newborn child, if added to the Contract, for at least 48 hours after a vaginal delivery or the date of discharge from the Hospital — whichever occurs first. This doesn't include the day of delivery. We'll also provide Benefits for the hospitalization and attending professional services for the mother and newborn child, if added to the Contract, for at least 96 hours following a Cesarean section or the date of discharge from the Hospital — whichever occurs first. This doesn't include the day of Surgery.

Blue Cross encourages expectant mothers to seek the proper prenatal care to help give their babies a healthier start in life. To help eligible pregnant Members with this, we offer the *My Health Essentials*SM program. This program gives you access to experienced maternity nurses, free educational materials and helpful advice throughout your pregnancy.

The staff of *My Health Essentials* works with your Physician or OB/GYN to help you identify and prevent any potential risks or complications. That way, you can improve your odds of having a healthier baby.

To enroll in *My Health Essentials* call our Medical Services personnel at the number shown on your ID card. A case manager will be happy to tell you more about the program.

Medical Supplies – These are items you need for treatment of an illness or injury, or for use with Durable Medical Equipment or prosthetic devices. Medically Necessary supplies include syringes and related supplies for conditions such as diabetes, dressings for cancer or burns, catheters, external opening (ostomy) bags and related supplies as shown in the Schedule of Benefits, test tapes, kidney (renal) dialysis supplies and surgical trays. Supplies and equipment that have non-therapeutic uses, over-the-counter supplies and bandages are not covered medical expenses.

Medical Care – One inpatient medical visit a day by a Member's attending Physician. Inpatient medical visits also include therapy services done concurrently with medical care. If the Member's condition requires intensive medical care, we'll provide Benefits for one intensive medical visit a day by the attending Physician.

We won't pay Benefits for daily medical visits by more than one Physician unless the Member has a separate medical condition the attending Physician can't treat.

Daily care by the surgeon, as well as pre- and postoperative care, is included in the Benefits for Surgery. Unless a Member has a medical condition a surgeon can't treat, then we will not pay Benefits for medical visits if a Member is hospitalized for Surgery.

We'll also provide Benefits for the first medical exam of a newborn done by a Physician who didn't deliver the baby or assist the Physician who delivered the baby or administered the anesthesia.

Medical care received in the office and Outpatient Hospital for an illness or injury is also payable.

Mental Health Services – We'll provide Benefits as shown in your Schedule of Benefits. To avoid having to pay for these services yourself, be sure to get Preauthorization from Companion Benefit Alternatives, Inc. See the *Getting Approval from Blue Cross* section for more details.

Orthotic Devices – We'll provide Benefits as shown in your Schedule of Benefits.

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

Out-of-country – We'll provide out-of-country Benefits, as shown in your Schedule of Benefits, based on the network Allowance or the total charge, whichever is less. Out-of-country Benefits consist of all services or supplies covered under the Contract and received from outside the United States.

Physical Therapy – We'll provide Benefits as shown in your Schedule of Benefits when a Physician prescribes Physical Therapy and it is performed by a licensed, professional physical therapist.

Prescription Drugs – We'll provide Benefits as shown in your Schedule of Benefits.

We'll treat insulin as a Prescription Drug whether it's injectable or otherwise.

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

Specific classes of Over-the-counter Drugs designated by Blue Cross, or its designated Pharmacy Benefit Manager, may be covered as Prescription Drugs. We will allow coverage for specific Over-the-counter Drugs only when use of Over-the-counter Drugs are required as part of a step therapy program. If so designated and your Schedule of Benefits reflects Benefits are available, these classes of Over-the-counter Drugs must have a valid prescription.

The Pharmacy Benefit Manager (PBM) for Blue Cross and some of its subsidiaries, contracts with and manages the Pharmacy network, negotiates prices with Pharmacies in the network and performs other administrative services. Blue Cross receives a portion of the financial credits directly from drug manufacturers and through the PBM. The credits are used to help stabilize overall rates and to offset costs. Reimbursements to Pharmacies, or discounted prices charged at Pharmacies, are not affected by these credits.

Any Coinsurance percentage that you must pay for Prescription Drugs is based on the Allowable Charge at the Pharmacy. It does not change when we receive any financial credit. Copayments are flat amounts and likewise do not change when we receive drug manufacturer or PBM credits.

Preventive Screenings – Preventive services are covered according to the following:
- United States Preventive Services Task Force (USPSTF) recommendations Grade A or B
- Center for Disease Control and Prevention (CDC) recommendations for immunizations
- Health Resources and Services Administration (HRSA) recommendations for children and women preventive care and screenings

Any other covered preventive screenings will be provided as shown in your Schedule of Benefits. These services are provided in-network only.

Prosthetics – Coverage is provided for a Prosthetic Device, other than a dental or cranial prosthetic, which meets minimum specifications for the body part it is replacing regardless of the functional activity level. Coverage is provided for the standard, non-luxury item only (as determined by us). Coverage for specialty items such as bionics or microprocessor components is also limited to the cost of the standard item. Only the initial temporary and permanent prosthesis is a Covered Expense. No Benefits are provided for repair, replacement or duplicates, nor are Benefits provided 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 Expense.

Reconstructive Surgery – Reconstructive Surgery that is considered a Covered Expense is limited to Surgery:
1. To correct a functional defect that results from a birth defect, disease and anomaly; or
2. Performed to correct a seriously disfiguring condition resulting from injury; or
3. For breast reconstruction after a mastectomy.

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

Rehabilitation – Admissions for inpatient care in a Rehabilitation Facility for taking part in a multi-disciplinary team-structured rehabilitation program following severe neurological or physical disability. Benefits are available as shown in your Schedule of Benefits. The Lifetime Maximum Payment is also shown in your Schedule of Benefits.

For these Benefits to be available, you must meet the following requirements:
1. A Physician must order all such Admissions; and
2. We must preapprove all such Admissions in writing and you must use a Designated Provider; and
3. The documentation that goes with a request for a Preadmission Review must have a detailed patient evaluation from a Physician. This evaluation must document that, to a reasonable degree of medical certainty, the Member has rehabilitation potential, and there is belief that this Member will be able to provide self-care and carry out his or her activities of daily living.

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

Skilled Nursing Facility – We'll provide Benefits as shown in the Schedule of Benefits. Benefits include room and board, special diets, general nursing services, therapy services and other ancillary services. The Member must be admitted within 14 days after being discharged from a Hospital following an authorized hospitalization.

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

Specialty Drugs – A Physician must prescribe Specialty Drugs. The prescription must be filled by a Specialty Drug Network Provider. If Specialty Drug coverage is provided, Benefits for covered Specialty Drugs dispensed to you shall not exceed the quantity and benefit maximum, if any, as shown in your Schedule of Benefits. Please contact the Member Service Center at the phone number listed in the *How to Contact Us if You Have a Question* section to see if a specific drug is a Specialty Drug or you can get the list from our website at www.SouthCarolinaBlues.com. **Preauthorization is required for Benefits to be available**.

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

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

Spinal Subluxation Services – Services or care used to detect and correct 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.

If your Group Health Plan includes optional spinal subluxation coverage, then we will provide Benefits for these services when they are done by a chiropractor. Refer to your Schedule of Benefits to see if your Group Health Plan includes this coverage and what Benefit limitations apply.

Substance Abuse – We'll provide Benefits as shown in your Schedule of Benefits. To avoid having to pay for these services yourself, be sure to get Preauthorization from Companion Benefit Alternatives, Inc. See the *Getting Approval from Blue Cross* section for more details.

Supplemental Accidental Injury – If you receive Covered Expenses due to an Accidental Injury, Benefits received during the Benefit Period will not be subject to the Deductible. Refer to your Schedule of Benefits to see if your Group Health Plan includes this coverage and what Benefit limitations apply.

Surgery Benefits – Benefits for Surgery include payment for pre- and post-operative care.

"Multiple procedures" means more than one procedure done through the same opening or at the same site during one operation. When two or more procedures are done through the same opening or at the same site, we provide full Benefits for the major one. We don't pay Benefits for the lesser operations. If two or more procedures are done at the same time through different openings or at different sites, then we provide full Benefits for the major operation, and 50 percent of full Benefits are payable for all lesser procedures.

When more than one skin lesion is removed during one session, we provide full Benefits on the lesion with the highest Allowed Charge. We provide Benefits for lesions with lower Allowed Charges at 50 percent, 25 percent or 10 percent of the full allowance.

Therapeutic Services – We'll provide Benefits for radiation therapy, chemotherapy and dialysis treatment.

Optional Prescription Drug Coverage

(Your Schedule of Benefits shows which Prescription Drug Coverage option you have. Blue Rx℠ and Drug Card are explained below.)

Blue Rx

When your Physician prescribes medication, you can have it filled at any pharmacy. When you have your prescriptions filled at a Participating Network Pharmacy, however, you will enjoy a higher Benefit percentage and spend less of your own money.

When you buy your Prescription Drugs from a Participating Network Pharmacy, show the pharmacist your ID card. That way the pharmacist will know not to charge you more than the Allowed Charge. You can find a list of Participating Network Pharmacies in your Pharmacy Benefit Manager directory, or go to our online Provider directory at www.SouthCarolinaBlues.com.

Not all pharmacies are part of this network. If Benefits are available, Non-Participating Network Pharmacies can charge you more than your coverage allows — an amount you will then have to pay yourself. Benefits for drugs and supplies purchased from a non-Participating Network Pharmacy are also paid at a lower percentage. Please refer to your Schedule of Benefits to see if you have this Benefit. This increases your share of the cost even more.

If you buy your Prescription Drugs from a Participating Network Pharmacy or our Participating Mail-service Pharmacy, you will have no claims to file. Your claim will automatically be filed by the Pharmacy when you get your prescription filled. If you have met your Deductible, you only have to pay your Coinsurance amount for covered drugs. If you have not met your Deductible yet, you have to pay the Allowed Charge for Prescription Drugs that will be applied towards your Deductible.

If you buy your Prescription Drugs from a non-Participating Network Pharmacy (if Benefits are provided), you must pay for your drugs at the time your prescriptions are filled. You will then have to file your Prescription Drug claim.

To file a Prescription Drug claim:

- Use a Prescription Drug Rx claim form. To receive a form, call or write to the Member Service Center or you can get one from our website at www.SouthCarolinaBlues.com.
- Fill out the top half of the claim form.
- Sign the claim form.
- Attach a copy of all itemized Pharmacy receipts.
- Mail your claim and copy of receipts to the address shown on the form.

Be sure to follow these instructions very closely. Complete all paperwork so your claim can be processed. Then, we'll reimburse you directly at the maximum allowance for covered drugs shown in your Schedule of Benefits after the Deductible is met. We don't assign or pay Benefits directly to the Pharmacy.

To file a claim for medical supplies, use the Comprehensive Benefits Claim Form. Please refer to the *How to File Claims* section for information on completing this form.

Drug Card

If you get your prescription filled at a Participating Network Pharmacy, show the pharmacist your ID card. After you meet the Prescription Drug Deductible (if applicable), you pay the Prescription Drug Copayment amount shown in your Schedule of Benefits. The pharmacist will file the claim for you. Then, we'll pay the balance at the percentage shown in your Schedule of Benefits.

If you don't show your ID card at a Participating Network Pharmacy, you'll have to pay the full cost of the prescription. Then, you file a Prescription Drug claim.

To file a Prescription Drug claim:

- Use a Prescription Drug Rx claim form. To receive a form, call or write to the Member Service Center. You can also get one from our website at www.SouthCarolinaBlues.com.
- Fill out the top half of the claim form.
- Sign the claim form.
- Attach a copy of all itemized Pharmacy receipts.
- Mail your claim and copy of receipts to the address shown on the form.

When your claim is processed, we'll deduct the applicable Prescription Drug Deductible and Prescription Drug Copayment from the prescription cost and we'll pay a percentage of the balance directly to you.

Non-Participating Pharmacies do not have a written agreement with us. If Benefits are available, they can charge more than the Allowed Charge for prescriptions. If you buy drugs from a non-Participating Network Pharmacy, you'll have to pay the entire cost of the prescriptions and file the claim yourself using the Prescription Drug Program claim form. Follow the same procedures listed above to file a claim. We'll pay the balance at the percentage shown in your Schedule of Benefits, if Benefits are provided, after we deduct the applicable Prescription Drug Deductible, Prescription Drug Copayment and/or Prescription Drug Coinsurance.

Optional Limited Dental/Vision Coverage

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

Dental Coverage

Class I – Preventive Care

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

Class II – Restorative Care

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

Vision Coverage

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

Exclusions and Limitations

Some services and supplies you receive may not be covered under this health coverage. So it's important to read through this list and understand the types of things you'll be required to pay for if you ever need any of these services and supplies.

We will not pay Benefits for:

- Room and board charges in a Hospital or Skilled Nursing Facility when you don't get the required Preadmission Review, Emergency Admission Review and/or Continued Stay Review.
- Services and supplies that are not Medically Necessary, not needed for the diagnosis or treatment of an illness or injury, or not specifically listed in *Covered Expenses*.
- Services and supplies you received before you had coverage under this Group Contract or after you no longer have this coverage except as described in the *Extension of Coverage* section of this booklet.
- Services or supplies for which you are entitled to Benefits under Medicare or any other governmental program, except for Medicaid; or for which you're not legally responsible for paying.
- Benefits for injuries or diseases paid by Workers' Compensation or settlement of a Workers' Compensation claim.
- Any charges by the Department of Veterans Affairs (VA) for a service-related disability.
- Care in any State or Federal Hospital for which the Member is not legally responsible.
- Treatment or tests you receive as an inpatient that could have been done safely as an Outpatient.
- Sanitarium care or rest cures; long-term, residential care for the treatment of Mental Health Services or Substance Abuse care, to include: residential treatment centers, therapeutic schools, wilderness/boot camps, therapeutic boarding homes, half-way houses and therapeutic group homes; and custodial care or domiciliary care (care meant simply to help those who can't care for themselves, such as, but not limited to, help in walking and getting in and out of bed, assistance in bathing, dressing, feeding, using the toilet, preparation of special diet and supervision of medications which can usually be self-administered and which does not require continuous attention of trained Medical Personnel).
- All Admissions to Hospitals or freestanding Rehabilitation Facilities for physical rehabilitation when the services are not done at a Designated Provider and/or you don't receive the required Preauthorization.
- Treatment resulting from war or acts of war (whether declared or undeclared) or while in the military service or its auxiliary units.
- An illness you get or injury you receive while participating in a riot or uprising, while committing a crime, felony or misdemeanor or an illegal occupation.
- Services and supplies a Member receives from any intentionally self-inflicted injury (or injury resulting from attempted suicide) unless it results from a medical (physical or mental) condition.
- Services provided for injuries sustained as a result of the Member's Legal Intoxication or while under the influence of any narcotic or drug, unless taken on the advice of a Physician. The Member, or Member's representative, must provide any available test results showing blood alcohol levels upon request of Blue Cross and, if the Member refuses to provide these test results, no Benefits will be paid.
- Investigational or Experimental Services, as determined by us, including but not limited to the following:
  - Uses of allogeneic bone marrow transplantation (between two related or unrelated people) or syngeneic bone marrow transplantation (from one identical twin to the other) along with other forms of stem cell transplant (with or without high doses of chemotherapy or radiation) in cases in which less than four of the six complex antigens match; cases in which mixed leukocyte culture is reactive; and AIDS and HIV infection;
  - Adrenal tissue to brain transplants;
  - Islet cell transplants;
  - 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);
  - Procedures that involve the transplantation of fetal tissues into a living recipient.
- Services and supplies related to transplants involving mechanical or animal organs, human organ and/or tissue transplant procedures when you don't get the required prior Approval, it's not done at a Designated Provider, or unless specifically listed in Covered Expenses.

- Pulmonary rehabilitation, except in conjunction with a covered lung transplant.
- Services and supplies related to cosmetic Surgery, as determined by us. This means any plastic or reconstructive Surgery done mainly to improve the appearance of any body part, and from which no improvement in physiologic function is reasonably expected, unless performed either to correct functional disorder or as a result of an injury. Cosmetic Surgery excluded includes, but isn't limited to:
  - Surgery for sagging or extra skin;
  - Any augmentation or reduction procedures;
  - Rhinoplasty and associated Surgery; and
  - Any procedures using an implant that doesn't alter physiologic function or isn't incidental to a surgical procedure.

  Any services a Member receives due to complications of cosmetic Surgery also aren't covered.
- Reduction mammoplasty for macromastia unless the Member is within 20 percent of the ideal body weight.
- Any treatment or Surgery for obesity (even if morbid obesity is present), weight reduction, weight control such as gastric 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.
- Eyeglasses, contact lenses (except after cataract Surgery) except as shown in your Schedule of Benefits if your Group Health Plan includes limited vision coverage, hearing aids and exams for the prescription or fitting of them. Any Hospital or Physician charges related to refractive care such as radial keratotomy (Surgery to correct nearsightedness), keratomileusis (laser eye Surgery or LASIK), lamellar keratoplasty (corneal grafting) or any such procedures that are designed to alter the refractive properties of the cornea.
- Home Health Care and Hospice Care, except as provided in *Covered Expenses* and with a Preauthorization when shown in your Schedule of Benefits.
- Any medical social services, occupational, visual or speech therapy, or Private Duty Nursing services, except when shown in your Schedule of Benefits and part of a preauthorized Home Health Care plan or Hospice Care program.
- Recreational, educational or play therapy; biofeedback; psychological or educational diagnostic testing to determine job or occupational placement or for other educational purposes, or to determine if a learning disorder exists; therapy for learning disorders, development speech delay, communication disorder, developmental coordination disorder, mental retardation, dissociative disorder, sexual and gender identity disorder, personality disorder and vocational rehabilitation unless specifically included in your Schedule of Benefits.
- Charges for premarital and pre-employment exams.
- Services or care used to detect and correct, by manual or mechanical means, structural imbalance, distortion or subluxation in your body for the purpose of removing nerve interference and its effects when this interference is the result of or related to distortion, misalignment or subluxation of, or in, the spinal column except as shown in your Schedule of Benefits.
- 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 tubal ligations or vasectomies, surrogate parenting, artificial insemination and in vitro fertilization.
- Any services or supplies for the diagnosis or treatment of sexual dysfunction. This includes, but 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. A penile prosthesis will be considered for payment only after Medically Necessary prostate Surgery.
- Marriage or family counseling for premarital, marital or family relationship dysfunctions.
- Counseling and psychotherapy services for: feeding and eating disorders in early childhood and infancy; tic disorder except for Tourette's disorder; elimination disorder; mental disorders due to general medical conditions; sexual function disorder; sleep disorder; medication induced movement disorder; and nicotine dependence unless specifically covered in this Contract.
- Services for Animal Assisted Therapy, rTMS, Eye Movement Desensitization and Reprocessing (EMDR), Behavioral Therapy for solitary maladaptive habits or Rapid Opiate Detoxification.
- Charges for acupuncture, hypnotism and TENS unit. Services for chronic pain management programs. This includes any program developed by centers with multidisciplinary staffs intended to provide the interventions needed to allow the patient to develop pain coping skills and freedom from analgesic medications dependence.
- Services and supplies related to non-surgical treatment of the feet.

- Orthomolecular therapy including infant formula, nutrients, vitamins and food supplements, even if the Physician orders or prescribes them. Enteral feedings when not a sole source of nutrition.
- Adjustable cranial orthosis (band or helmet) for positional plagiocephaly or craniosynostoses in the absence of cranial vault remodeling Surgery.
- Services, supplies or treatment for varicose veins, including but not limited to, endovenous ablation, vein stripping or sclerosing solutions injection.
- Bioelectric, microprocessor or computer programmed prosthetic components.
- Pre-conception testing, pre-conception counseling or pre-conception genetic testing.
- Physician charges for medicine, drugs, appliances, supplies, blood and blood products.
- Services or supplies related to dysfunctional conditions of the chewing muscles, wrong position or deformities of the jaw bone(s), orthognathic deformities or temporomandibular joint syndrome (headache, facial pain and jaw tenderness caused by jaw problems and usually known as TMJ).
- Physician services directly related to the care, filling, removal or replacement of teeth; the removal of impacted teeth; and the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth. This includes, but 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 Schedule of Benefits if your Group Health Plan includes limited dental coverage, for dental treatment to Sound Natural Teeth for up to six months after an accident and Medically Necessary Cleft Lip and Palate services.
- Prescription Drugs used for or related to non-covered services or conditions, such as, but not limited to weight control, obesity, cosmetic purposes (such as Tretinoin or Retin-A), hair growth, hair removal or smoking cessation unless shown in your Schedule of Benefits. Also includes all vitamins, except for prenatal vitamins; and injectable drugs other than insulin.
- More than the number of days supply shown in your Schedule of Benefits for Prescription Drugs a Pharmacy dispenses.
- Prescription refills in excess of the number specified on your Physician's prescription order or refills dispensed more than one year after the original prescription date.
- Devices of any type, even though given through a prescription (other than contraceptive devices), such as but not limited to: therapeutic devices, artificial appliances or similar devices.
- More than the recommended daily dosage of any Prescription Drug as described in the current *Physician's Desk Reference* or as recommended under the guidelines of our Pharmacy Benefit Manager, whichever is lower.
- Drugs administered or dispensed in a Physician's office, Skilled Nursing Facility, Hospital or any other place that is not licensed to dispense drugs.
- Prescription Drugs for which there is an Over-the-counter (OTC) Drug equal to it except for Over-the-counter Drugs considered to be Prescription Drugs if shown in your Schedule of Benefits. Any OTC supplies or supplements.
- Any Prescription Drug or Specialty Drug that is not consistent with the diagnosis and treatment of an illness, injury or condition or that is excessive in terms of the scope, duration or intensity of drug therapy that is needed to provide safe, adequate and appropriate care.
- Drugs that require Preauthorization by Blue Cross when you don't receive Preauthorization. Please contact the Member Service Center at the phone number listed in the *How to Contact Us* section to see if a specific drug requires Preauthorization.
- Prescription Drugs used for or related to growth hormone therapy for patients over 18 years of age. For patients 18 years of age and younger, growth hormone therapy is excluded unless growth hormone deficiency is documented.
- Drugs that require step therapy when step therapy is not done. Step therapy is when you are required to try certain drugs to treat a medical condition before we will cover another drug for that condition.
- Charges incurred as the result of virtual office visits including Prescription Drugs. A virtual office visit occurs when you have never been physically seen or physically examined by the Physician writing or approving the prescription.
- Prescription Drugs not on the Preferred Drug list.

- Services and supplies related to pregnancy of a Dependent child except as required by law or for a life-threatening Complication of Pregnancy to either the mother or fetus. An elective abortion is not considered a Complication of Pregnancy.
- Luxury or convenience items and travel expenses, whether or not a Physician recommends or prescribes them.
- Any services done by a licensed doctoral psychologist that are not preauthorized.
- Durable Medical Equipment when you don't get the required Preauthorization and the cost is more than the amount shown in your Schedule of Benefits.
- Benefits will be denied or reduced for procedures or services as shown in your Schedule of Benefits when you don't get the required prior Approval.
- Charges for services or supplies from an independent health care professional whose services are normally included in Facility charges.
- Any type of service charge, handling or medical records fee, fee for filing a claim or charge incurred due to missing a scheduled appointment.
- Any services or supplies a member of your family or the patient provides, including the dispensing of drugs. A member of your family means spouse, parents, grandparents, brothers, sisters, aunts, uncles, children or in-laws.
- Any service or treatment for complications resulting from any non-covered procedure or condition.

Certificate of Creditable Coverage

Blue Cross will provide you or your Dependent a Certificate of Creditable Coverage at the time coverage stops or at the time the COBRA or state continuation coverage stops. If you need a copy of the certificate at a later time, you or your Dependent must request the Certificate of Creditable Coverage within 24 months at the end of coverage, or the end of COBRA or state continuation coverage, whichever occurs first. You or your Dependent may also request a Certificate of Creditable Coverage from us even if your coverage is still in force. To request a Certificate of Creditable Coverage, please write or call our Member Service Center at the address or phone number listed in the *How to Contact Us if You Have a Question* section.

Continuation of Coverage

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

Conversion of Coverage

Your spouse can apply for other coverage when he or she is no longer eligible under your group insurance. This happens if you get a divorce. Your Personnel or Human Resources representative will help your spouse apply for Conversion of Coverage.

If a spouse covered under this coverage is no longer eligible because of a legal divorce, he or she may get another policy from Blue Cross without written proof of insurability, if the spouse sends us a written application and the required premium within 60 days after the legal divorce.

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

Continuation Under State Law

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

Continuation of Coverage is subject to the Contract, or a successor policy, remaining in force. And, it's subject to you paying the entire group premium before the date each month that the group policy begins. This includes any portion usually paid by your former Employer. You are not eligible for State Continuation of Coverage if you're eligible for Continuation under COBRA, Medicare or other group coverage.

Continuation of Coverage is not available if any of these conditions apply:

1. Coverage ended because you didn't make timely payments of any required premium contributions.
2. You become eligible for other group coverage including COBRA.
3. You become eligible for Medicare benefits.

4. You were not continuously covered under your Employer's Group Health Plan for a period of at least six months immediately before its end. (Prior Group Health Plan coverage can be counted toward the six-month period as long as there were no more than 62 days between coverage.)
5. The Contract ends for the group. (You may be entitled to Continuation of Coverage under the replacement carrier, if the Employer gets new group coverage.)
6. You're entitled under federal law to Continuation of Coverage for a period of greater length than already provided here.

Continuation Under COBRA (Employers with 20 or More Employees)

Consolidated Omnibus Budget Reconciliation Act (COBRA) applies to continuation of group health coverage for Employees and their Dependents after they're no longer eligible for group coverage. It does not apply to churches, religious organizations or federal employees. You must apply for COBRA through your Employer within 60 days of loss of coverage.

Please read this Continuation of Coverage information carefully.

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

Reason for Loss of Coverage	Eligible Persons	Number of Months of Extended Coverage
1. Employee's working hours reduced from full-time to part-time (for any reason).	Employee Dependents	18 months
2. Employee quits work, is laid off or is fired for any reason other than gross misconduct.	Employee Dependents	18 months
3. Member establishes through the Social Security Administration that a disability began within 60 days of a qualifying event for COBRA. **Employee must notify Employer within 60 days of the disability determination by the Social Security Administration and within the original period of COBRA coverage.**	Disabled Member	29 months
4. Employee dies.	Dependents	36 months
5. Employee and spouse divorce or separate (only when this results in a loss of coverage but also applies if Employee drops spouse's coverage in anticipation of separation or divorce). **Employee must notify Employer within 60 days.**	Dependents	36 months
6. Dependent child who no longer meets plan definition of dependent child. **Employee must notify Employer within 60 days.**	Dependent child	36 months
7. Employee becomes eligible for Medicare and no longer has the group health coverage (applies only if spouse and Dependents are also not eligible for Medicare).	Dependents	36 months
8. If Employee retires, still has the group coverage and the Employer files for Chapter 11 bankruptcy.	Employee Dependents	Until retiree dies, then 36 months for surviving spouse and Dependents

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

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

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

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

Pay your Premiums for Continuation of Coverage to your Employer.

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

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

- When premiums are not paid on time.
- When the person who has the Continuation of Coverage becomes covered under another Group Health Plan without any pre-existing condition exclusions or limitations that apply to the condition of that person or under Medicare. (Enrolling in Medicare won't end coverage for people continuing coverage under item (8).)
- When a disabled person covered under the extended 29-month COBRA continuation period has been determined by the Social Security Administration to be no longer disabled, coverage ends for the disabled person and any covered family Members. (Notification must be given to the Employer within 30 days of final determination.)
- When your Employer no longer has health coverage for its Employees.

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

Extension of Benefits

If you or a Dependent is in the Hospital or if you or a Dependent is totally disabled on the day your coverage ends, then coverage for the Member will continue while the Member remains totally disabled, subject to all contract limits, from the same or related cause until one of these occurs:

1. The date the hospitalization ends or the date of recovery from total disability; or
2. The Member receives Benefits for covered services and supplies for up to 365 days from the date coverage ends; or
3. The Member uses all Benefits available under the Contract; or
4. The date the Contract ends and is replaced by another Group Health Plan with similar Benefits and the other Group Health Plan makes reasonable provision for continuity of care for the disabling condition.

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

The term "totally disabled" means you are receiving ongoing medical care by a Physician and are not able to do the material and substantial duties of your regular job. A totally disabled Dependent means the Dependent is receiving ongoing medical care by a Physician and is not able to do the normal activities of a person of the same age and sex who is in good health.

For Blue Cross to recognize Extension of Benefits claims and ensure proper payment, claims must include a Physician's statement of disability. Under Extension of Benefits, Benefits are payable only while the Member is in the Hospital or totally disabled as explained above.

Family and Medical Leave Act

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

FMLA requires employers to provide up to 12 weeks of unpaid leave to eligible employees for: 1) the birth of a child; 2) the placement of a child with you for adoption or foster care; 3) the care of a seriously ill spouse, child or parent; or 4) a serious health condition that leaves you unable to work.

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

Contacting Us

If you have any questions or grievances regarding claims for services or benefits, quality of care or service concerns, please call or write the Member Service Center. You may also send us a secure email through the Ask Customer Service feature of My Health Toolkit on our website at www.SouthCarolinaBlues.com. You may call us at 803-264-1000 in Columbia or 800-868-2500, ext. 41000 outside the Columbia area. Or write to us at:

Blue Cross and Blue Shield of South Carolina
Member Service Center
P.O. Box 100300
Columbia, SC 29202

Any complaints or disagreements you have regarding a preauthorization and prior Approval can be directed to us at 803-736-5990 from Columbia or 800-327-3238 from anywhere else.

If the grievance involves the Member Services Representative, it should be addressed to the Vice President of Group and Individual Operations.

Appeal Procedures

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

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

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

1. Pre-service Claim – You have 180 days to appeal our decision on a Pre-service Claim or a Concurrent Care decision. We must complete the appeal process within 15 calendar days after receiving the appeal. If you still do not agree with our decision, you can file a second appeal within 90 days after you receive our decision on the first appeal. We must complete the second appeal process within 15 calendar days after we receive your second appeal.

2. Urgent Care Claim – You have 180 days to appeal our decision on an Urgent Care Claim. We must complete the appeal process within 72 hours after we receive your appeal.

3. Post-service Claim – You have 180 days to appeal our decision on a Post-service Claim. We must complete the appeal process within 30 calendar days after receiving the appeal. If you still do not agree with our decision, you can file a second appeal within 90 days after you receive our decision on the first appeal. We must complete the second appeal process within 30 calendar days after we receive your second appeal.

You 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 your claim. If we consider or present additional evidence in connection with the appeal or use new or additional reasons as the basis of the adverse determination, you 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. No deference will be afforded to the initial determination.

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:

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

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

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

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

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

Within five business days of us receiving your request for an external review, we will respond by either:

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

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

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

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

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

Statement of Your ERISA Rights

As a Member of this plan, you have certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA) and in regulations issued by certain federal agencies, including the U.S. Department of Labor and Internal Revenue Service.

Under ERISA, all plan Members have the right to:

1. Review all plan documents without charge at your plan administrator's office and at other specified locations. This includes insurance contracts and copies of all documents filed with the U.S. Department of Labor such as detailed annual reports and plan descriptions.
2. Receive a summary of the plan's annual financial report. Your plan administrator is required by law to supply each Member with a copy of this summary annual report.

In addition to creating rights for plan Members, ERISA places duties on the people who are responsible for the plan's operation. The people who operate your plan are called fiduciaries or trustees of the plan. Fiduciaries must handle their duties prudently in the best interest of you, other plan Members and beneficiaries.

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

No one, including your Employer or any other person, may fire you or discriminate against you in any way to keep you from receiving a Benefit or from exercising your rights under ERISA. If we deny all or part of your claim for a Benefit, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claims.

Under ERISA, there are steps you can take to enforce the rights explained above. For example, if you request material from the plan and don't receive it within 30 days, you may sue in a federal court. In such a case, the court may require the plan administrator to provide the material and pay up to $100 a day until you receive it, unless it was not sent because of reasons beyond the administrator's control.

If you have a claim that we have denied, you may sue in state or federal court.

If the plan fiduciaries misuse the plan's money, or if you are discriminated against for requesting your rights, you may seek help from the U.S. Department of Labor. Or, you may sue in federal court. The court will decide who should pay the court costs and legal fees.

If you win your suit, the court may order the person you sue to pay these costs and fees. If you lose the suit, the court may order you to pay them. If, for example, it finds your claim is frivolous (not serious enough).

If you have any questions about your plan, you should contact your personnel department or plan administrator. If you have any questions about these statements or about your ERISA rights, contact the nearest area office of the Pension and Welfare Benefits Administration of the U.S. Department of Labor listed in your telephone directory. Or, contact the Division of Technical Assistance and Inquiries at: Pension Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.