WELCOME TO BLUE CROSS BLUE SHIELD OF SOUTH CAROLINA

South Carolina Dental Association

Preferred Blue®
Plan 4

SouthCarolinaBlues.com

February 1, 2020

PREFERRED BLUE®
PLAN OF BENEFITS

South Carolina

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

MGPBint-NGF (Rev. 01/20)

Dear Member:

BlueCross BlueShield of South Carolina (BlueCross) is pleased to provide your Preferred Blue® Plan of Benefits. BlueCross provides you and your covered family members with cost-effective health care coverage both locally and on a nationwide basis.

Please refer to the Benefits outlined in this Plan of Benefits for all your healthcare coverage.

The BlueCross networks offer the best geographic access to Providers and Hospitals of any Preferred Provider Organization (PPO) in the nation. This national coverage is available through the BlueCard® Program in which all BlueCross Plans participate. For more Provider information visit our website at www.SouthCarolinaBlues.com.

Blue Medicare Solutions:
Medicare is a federal program to help people age 65 and over (or under 65 for those who qualify) cover healthcare costs. Today, many people are working longer and delaying retirement. Just because you continue to work doesn't mean you can't take advantage of the savings available through the Medicare program. BlueCross BlueShield of South Carolina offers a portfolio of Medicare products with low premiums and rich benefits. Once you turn 65, the Corporation wants you to consider all of your Medicare options, and potentially save money. Call the Corporation at 855-542-4376 for more information.

We welcome you to our family of healthcare coverage through BlueCross and look forward to meeting your health care needs.

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VISIT OUR WEBSITE AND MOBILE SITE

Through our Member website, www.SouthCarolinaBlues.com, you can access My Health Toolkit®, a source for instant, personalized Benefits and health information. As a Member, you can take full advantage of this interactive website to complete a variety of self-service transactions online from wherever you have Internet access. ***Need to access your Member ID card digitally or order a replacement? Need to check the status of a claim or download claim forms? Need to print an Explanation of Benefits (EOB)?***

You also can use such self-help tools as:

View **real-time status** of your eligibility, deductible, out-of-pocket and any healthcare account balances.

The **Doctor and Hospital Finder** is where you get the most recent information on our network of medical Providers and Hospitals. Search by name, address, gender, specialty and Hospital affiliation. You can also get information about medical schools attended, board certification status, languages spoken, handicap access, maps and driving directions.

With **Shopping for Care**, you can find health care Providers and services within our vast Provider network, check out cost information (where available) to make sure you're getting the care you need at the best possible price and see reviews from other patients who have rated a Provider you're considering. You can also identify Blue Distinction® Specialty Care Hospitals.

Our **Shopping for Care** feature also includes cost estimates to help you find the right care at the right price. Estimates help you avoid surprises when the bills come as costs for a medical procedure – like an ultrasound, a checkup, X-rays or joint replacement – can vary by hundreds of dollars. From My Health Toolkit®, under the Resources tab, click Find a Doctor or Hospital under Shopping for Care. As you explore the Find Care categories further, you'll see a Cost Estimates tab that's loaded with price information about hundreds of procedures, from mammograms and MRIs to allergy testing, sleep studies, physical therapy and various types of surgery.

On the go? The My Health Toolkit® mobile app is available in both the App Store and Google Play. With your personal account you can:

- Check the status of your claims
- View and share your digital ID card
- Confirm your coverage for services
- Find a Provider or Hospital in your network
- Manage your medical spending accounts, if applicable

IMPORTANT INFORMATION ABOUT YOUR HEALTH COVERAGE:

The Benefits you receive will depend on whether the Provider of medical services is a Participating or Non-Participating Provider. You will receive the maximum Benefits that can be paid if you use Participating Providers and you get Preauthorization, when required, before getting medical care. The amount you have to pay will increase when you do not use Participating Providers and if you do not get Preauthorization.

BlueCross makes every effort to contract with Providers that practice at participating Hospitals. Members of the Blue Cross and Blue Shield Association (BCBSA) also attempt to contract with Providers that practice at participating Hospitals. For various reasons, some Providers may elect not to contract as Participating Providers. If you use a Non-Participating Provider, you have no protection from balance billing from the Provider.

HOW TO GET HELP

How to get help with claims or Benefit questions:

- From Columbia, South Carolina, dial 264-0015
- From anywhere else in or out of South Carolina, dial 800-760-9290

How to get help on Preauthorization:

For radiation oncology Services, Magnetic Resonance Imaging (MRIs), Magnetic Resonance Angiography (MRAs), Computerized Axial Tomography (CAT) scans or Positron Emission Tomography (PET) scans and musculoskeletal care in an outpatient facility:

- 866-500-7664

For all other medical care:

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

Please do not call these numbers for claims inquiries.

Please note that Preauthorization is required for certain procedures. Please contact your Provider for additional information.

Preauthorization for Mental Health Services and Substance Use Disorder Services:

- 699-7308 from the Columbia, South Carolina area
- 800-868-1032 from all other areas

Drug coverage is handled by OptumRx, an independent company that provides pharmacy Benefits on behalf of BlueCross.

For assistance outside the United States:

You may also call 800-810-BLUE (2583) when traveling outside the United States for assistance with locating an international Provider, in translating foreign languages and submitting claims.

Blue CareOnDemand:
The Corporation provides you with access to ***Blue CareOnDemand***, a Telehealth service. Blue CareOnDemand is powered by American Well. American Well is an independent company that provides Telehealth hosting and software services on behalf of BlueCross. Blue CareOnDemand licensed health care professionals can treat many of the most common health issues such as cold and flu symptoms and other specialties. Telehealth is not a replacement for primary care doctors. Members should maintain relationships with their primary care doctors and continue scheduling office visits for preventive care. We encourage Members to use the convenience of Blue CareOnDemand for treating unexpected, non-emergency health issues. Members can use Blue CareOnDemand to seek treatment from U.S. licensed healthcare professionals twenty-four (24) hours per day, seven (7) days per week and three hundred sixty-five (365) days per year through the convenience of video consultation.

There are two (2) ways for Members to register and create their patient profiles:

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

2. Visit www.BlueCareOnDemandSC.com.

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

Complex Care Management:
The Corporation provides you with access to ***Complex Care Management***, a unique patient support and education program which provides you with a registered nurse case manager to assist you in making informed decisions about your health care when you're seriously ill or injured. Participation in the program is voluntary and at no cost to Members. For more information, call: 800-868-2500, extension 42648.

Essential Advocate:
The Corporation provides you and your Dependents with access to ***Essential Advocate***, a program that includes immediate care with the 24-hour Nurse Advisor plus the unique service of our health advocacy program tailored to bridge the gap between care and Benefits, Provider and patient, and Hospital and home. Members will experience personal support and receive individualized assistance provided by experienced healthcare and Benefit experts. The health advocates assist Members:

- Locating Providers through the BlueCross Doctor & Hospital Finder.
- Using online tools for treatment options and cost estimates.
- Educating Members on health plan Benefits and how they work.
- Researching current treatments.
- Resolution of health care claims.
- Preparing Members and family members for medical appointments.
- Understanding eldercare issues.
- Arranging transportation relating to medical needs.
- Navigating the BlueCross website, including cost estimator and quality tools.
- And much more.

Call 888-521-2583 to speak with a registered nurse or health advocate.

Health Coaching – Chronic Condition:
The Corporation provides you with access to ***Health Coaching – Chronic Condition***, a program designed to help Members with the following conditions live healthier lives:

- Attention deficit hyperactivity disorder
- Asthma (pediatric and adult)
- Bipolar disorder
- Coronary artery disease
- Chronic heart failure
- Chronic obstructive pulmonary disease
- Depression
- Diabetes (pediatric and adult)
- Hypertension (high blood pressure)
- Hyperlipidemia (high cholesterol)
- Metabolic health
- Migraine
- Recovery support
- Stress Management

As a participant in ***Health Coaching – Chronic Condition***, you will receive personalized information and tools to help you learn more about your condition and ways to improve your health. You will also have access to a personal health coach – a healthcare professional who can help you reach your health goals.

If you are identified as someone with one of the conditions listed above who could benefit from the program, you will be automatically enrolled. If you do not wish to participate, you can disenroll by calling 855-838-5897.

Health Coaching – Lifestyle:
The Corporation provides you with access to the ***Health Coaching – Lifestyle*** bundle, a collection of programs designed to help you improve your health and wellness lifestyle such as kicking a habit, exercising more or switching up your diet. You may also receive guidance as you adjust to a major change in your life, such as pregnancy. A health coach will provide support and help you create an action plan to meet your personal goals. The bundle includes the following programs:

- Back care
- Maternity (preconception, maternity and postpartum care)
- Tobacco-free living
- Weight management (adults and Children)

To participate, call 855-838-5897.

Proactive Member Messaging:
The Corporation provides you with access to ***Proactive Member Messaging***, a program that offers wellness reminders and program specific promotions. Proactive Member Messaging is offered through Relay®, a text marketing communications channel. Relay Network, LLC is an independent company that provides the ***Proactive Member Messaging*** program on behalf of BlueCross. To participate, call 844-206-0623.

Rally:

The Corporation provides you with access to ***Rally***, a program that can help guide you toward positive lifestyle choices. Once you have completed the confidential ***Rally*** Health Survey, you will receive your ***Rally*** age which may be higher or lower than your physical age based on risk factors and healthy behaviors. This program provides missions and challenges that improve overall health and wellbeing. Along the way, you will earn chances to enter prize sweepstakes. Rally is a product of Rally Health Inc. Rally Health Inc. is an independent company that provides the Rally program on behalf of BlueCross. To access the ***Rally*** Health Survey, login to My Health Toolkit. For more information, call 844-334-4944.

HOW TO FILE CLAIMS

Participating Providers have agreed to file claims for healthcare services they rendered to you. However, in the event a Provider does not file a claim for such services, it is your responsibility to file the claim. If you choose to use a Non-Participating Provider, you are responsible for filing your claim.

Once the claim has been processed, you will have quick access to an EOB through our website or by contacting customer service. The EOB explains who provided the care, the kind of service or supply received, the amount billed, the Allowable Charge, the Coinsurance rate and the amount paid. It also shows Benefit Year Deductible information and the reasons for denying or reducing a claim. Please see this Plan of Benefits for more information.

The only time you must pay a Participating Provider is when you have a Benefit Year Deductible, Coinsurance, Copayment or when you have services or supplies that are not Covered Expenses under your Plan of Benefits.

If you need a claim form, you may obtain one from us at the address below or print a copy from the website. You can also call us at the telephone numbers listed on the previous page, and we will send you a form. After filling out the claim form, send it to the address below:

BlueCross BlueShield of South Carolina
Claims Service Center
Post Office Box 100300
Columbia, South Carolina 29202

Please refer to Article XI of this Plan of Benefits for more information on filing a claim.

SCHEDULE OF BENEFITS

Employer: South Carolina Dental Association
Plan 4
Plan of Benefits Effective Date: February 1, 2020

This Schedule of Benefits and the Benefits described herein are subject to all terms and conditions of this Plan of Benefits. In the event of a conflict between this Plan of Benefits and this Schedule of Benefits, this Schedule of Benefits shall control. Capitalized terms used in this Schedule of Benefits have the meaning given to such terms in this Plan of Benefits.

To maximize your Benefits, seek medical services from a Participating Provider. Please call 800-810-BLUE (2583) or access our website at www.SouthCarolinaBlues.com to find out if your Provider is a Participating Provider.

GENERAL PROVISIONS **When a Benefit is listed below and has a dollar or percentage amount associated with it then the Benefit will be provided to Members subject to the terms of this Plan of Benefits. When a Benefit has a "Covered" notation associated with it, the Benefit will pay based on the location of the service (e.g. inpatient, outpatient, office). When a Benefit has a "Non-Covered" notation associated with it, the Benefit is not available to the Member. All Benefits are subject to the dollar or percentage amount limitation associated with each Benefit in this Schedule of Benefits.**	
Probationary Period:	Coverage for new Employees hired following the Effective Date of the Plan of Benefits will commence on the first of the month following the probationary period designated by each Employer.
In addition to meeting the requirements contained in this Plan of Benefits; the maximum age limitation to qualify as a Dependent Child is:	A Child under the age of twenty-six (26).
Actively at Work: **Minimum hours per week:** **Minimum weeks per year:**	 At least thirty (30) hours per week. At least forty-eight (48) weeks per year.
Benefit Year Deductible:	$4,000 per family with no one Member meeting more than $2,000 for Participating Providers. $8,000 per family with no one Member meeting more than $4,000 for Non-Participating Providers. Covered Expenses for services rendered by Participating or Non-Participating Providers will be applied only to the Participating Provider Benefit Year Deductible or the Non-Participating Provider Benefit Year Deductible, respectively.

Out-of-Pocket Maximums for Participating Providers:	**Standard Out-of-Pocket Maximums:** $9,000 per family with no one Member meeting more than $4,500. Benefit Year Deductibles and Coinsurance contribute to the Standard Out-of-Pocket Maximum, with the exception of chiropractic services. Allowable Charges for Coinsurance are paid at 100% after the Standard Out-of-Pocket Maximum is met, except as specified above. The Member will still be responsible for any applicable Copayments until the Out-of-Pocket Maximum is met. **Out-of-Pocket Maximums:** $14,700 per family with no one Member meeting more than $7,350. All Benefit Year Deductibles, Coinsurance and Copayments incurred, with the exception of chiropractic services, will contribute to the Out-of-Pocket Maximum. All Allowable Charges are paid at 100% after the Out-of-Pocket Maximum is met. If Coinsurance does not contribute to the Out-of-Pocket Maximum, the percentage of reimbursement does not change from the amount indicated on the Schedule of Benefits. Coinsurance, Benefit Year Deductibles and Copayments for services rendered at a Participating Provider will apply to the Standard Out-of-Pocket Maximum or Out-of-Pocket Maximum as listed above and will not be applied to the Non-Participating Provider Out-of-Pocket Maximum.
Out-of-Pocket Maximums for Non-Participating Providers:	$18,000 per family with no one Member meeting more than $9,000. Coinsurance for chiropractic services and Copayments do not contribute to the Out-of-Pocket Maximum determination. Allowable Charges are paid at 100% after the Out-of-Pocket Maximum is met. If Coinsurance does not contribute to the Out-of-Pocket Maximum, the percentage of reimbursement does not change from the amount indicated on the Schedule of Benefits. Coinsurance and Benefit Year Deductibles for services rendered at a Non-Participating Provider will apply to the Non-Participating Provider Out-of-Pocket Maximum only and will not be applied to either the Standard Out-of-Pocket Maximum or Out-of-Pocket Maximum for Participating Providers.

Benefit Year Deductibles and any Copayments must be met before any Covered Expenses can be paid.
This Schedule of Benefits applies during the 01/01 through 12/31 Benefit Year. The Anniversary Date is 02/01.
There are no annual or lifetime dollar limitations on essential health Benefits as defined by the Affordable Care Act (ACA).

PREAUTHORIZATION	
Inpatient	**All Admissions require Preauthorization** If Preauthorization is not obtained, room and board charges will be denied. Other services may also require preauthorization. All charges will be denied for human organ and tissue transplant services not performed at a Blue Distinction® Center of Excellence or a transplant center approved by the Corporation in writing.
Outpatient	Preauthorization is required for certain outpatient Benefits. Please contact your Provider for additional information. Benefits for outpatient services that require Preauthorization will be reduced by 50% of the Allowable Charge when Preauthorization is not obtained or approved by the Corporation.
Mental Health Services and Substance Use Disorder Services	Preauthorization is required for certain Mental Health Services and Substance Use Disorder Services. Please contact your Provider for additional information. Benefits for ABA related to Autism Spectrum Disorder will be denied when Preauthorization is not obtained or approved by the Corporation. If Preauthorization is not obtained or approved by the Corporation for facility-based inpatient services, charges for room and board will be denied. Benefits for psychological testing, rTMS and facility-based outpatient services will be reduced by 50% of the Allowable Charge when Preauthorization is not obtained or approved by the Corporation.
Pharmacy	Please refer to the Corporation's website for a complete list of Prescription Drugs and Specialty Drugs that require Preauthorization.

ADMISSIONS/INPATIENT BENEFITS OTHER THAN MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES		
	Participating Provider	**Non-Participating Provider**
Hospital charges for room and board related to Admissions	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
All other Benefits in a Hospital during an Admission (including for example, facility charges related to the administration of anesthesia, obstetrical services including labor and delivery rooms, drugs, medicine, lab and X-ray services)	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Inpatient physical rehabilitation services when Preauthorized by the Corporation and performed by a Provider designated by the Corporation	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Hospital Admission resulting from an emergency room visit	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Skilled Nursing Facility Admissions, limited to sixty (60) days per Member per Benefit Year	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

OUTPATIENT BENEFITS OTHER THAN MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES		
	Participating Provider	**Non-Participating Provider**
Hospital and Ambulatory Surgical Center charges for Benefits provided on an outpatient basis, including: lab, X-ray and other diagnostic services	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Outpatient emergency room services (Copayment waived if admitted)	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $300 Copayment The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible and Copayment	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $300 Copayment The Member must pay the balance of the Provider's charge
All other covered outpatient Benefits	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

PROVIDER SERVICES OTHER THAN MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES		
	Participating Provider	**Non-Participating Provider**
Provider Services in a Hospital	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Surgical Services, when rendered in a Hospital or Ambulatory Surgical Center	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider Services for treatment in a Hospital outpatient department or Ambulatory Surgical Center	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Services in the Provider's office, including contraceptives and birth control devices(other than maternity care, physical therapy, dialysis treatment and Second Surgical Opinion) This Benefit does not include preventive Benefits offered under the ACA. See the preventive Benefits section in this Schedule of Benefits for payment of preventive Benefits under the ACA.	The Corporation pays 100% of the Allowable Charge after the Member pays a $25 Copayment Office services by a Specialist will be paid at 100% of the Allowable Charge after a $40 Copayment	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	**Non-Participating Provider**
Provider Services in the Member's home	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Second Surgical Opinion	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
All other Provider Services	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES		
	Participating Provider	**Non-Participating Provider**
Inpatient Hospital charges for Mental Health Services and Substance Use Disorder Services	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Inpatient Hospital Admission resulting from an emergency room visit for Mental Health Services and Substance Use Disorder Services	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Residential Treatment Center Admissions for Mental Health Services and Substance Use Disorder Services	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Outpatient Hospital or clinic charges for Mental Health Services and Substance Use Disorder Services	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Inpatient Provider charges for Mental Health Services and Substance Use Disorder Services	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	**Non-Participating Provider**
Outpatient Provider charges for Mental Health Services and Substance Use Disorder Services	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Office Provider charges for Mental Health Services and Substance Use Disorder Services	The Corporation pays 100% of the Allowable Charge after the Member pays a $25 Copayment	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Outpatient emergency room services for Mental Health and Substance Use Disorder Services	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $300 Copayment The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible and Copayment	The Corporation pays 80% of the Allowable Charge after the Participating Provider Benefit Year Deductible and after the Member pays a $300 Copayment The Member must pay the balance of the Provider's charge

OTHER SERVICES		
	Participating Provider	**Non-Participating Provider**
Ambulance service (including air ambulance)	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 80% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member must pay the balance of the Provider's charge
Durable Medical Equipment, Prosthetics and Orthopedic Devices	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	Non-Covered
Medical Supplies	Covered	Covered
Home Health Care, limited to sixty (60) visits per Benefit Year	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Hospice Care, limited to six (6) months per episode	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Colorectal cancer screenings limited to: • One (1) fecal occult blood testing of three (3) consecutive stool samples per Benefit Year • One (1) flexible sigmoidoscopy every five (5) years • One (1) double contrast barium enema every five (5) years • One (1) colonoscopy every ten (10) years	Covered	Covered
ABA related to Autism Spectrum Disorder	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	Non-Covered
Provider charges for rehabilitation related to physical therapy and occupational therapy (Limited to a combined thirty (30) visits per Member per Benefit Year)	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Provider charges for habilitation related to physical therapy and occupational therapy (Limited to a combined thirty (30) visits per Member per Benefit Year)	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Rehabilitation related to speech therapy (Limited to twenty (20) visits per Member per Benefit Year)	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Participating Provider	Non-Participating Provider
Habilitation related to speech therapy (Limited to twenty (20) visits per Member per Benefit Year)	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Human organ and tissue transplant services Human organ and tissue transplant services are only covered if provided at a Blue Distinction® Center of Excellence or a transplant center approved by the Corporation in writing Provider charges are subject to the Benefit Year Deductible	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible	Non-Covered
Allergy injections	The Corporation pays 100% of the Allowable Charge after the Member pays a $25 Copayment Office services by a Specialist will be paid at 100% of the Allowable Charge after a $40 Copayment	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Chiropractic services, including modalities and spinal manipulation/subluxation, limited to $500 per Member per Benefit Year	The Corporation pays 100% of the Allowable Charge after the Member pays a $40 Copayment	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Oxygen	Covered	Covered

	Participating Provider	**Non-Participating Provider**
Urgent care	The Corporation pays 100% of the Allowable Charge after the Member pays a $50 Copayment	The Corporation pays 60% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Sustained Health services related to an annual physical exam (limited to $500 per Member per Benefit Year) This Benefit does not include preventive Benefits offered under the ACA. Payment will be made for the ACA preventive Benefits prior to Sustained Health services. See the preventive Benefits section in this Schedule of Benefits for payment of preventive Benefits under the ACA.	The Corporation pays 100% of the Allowable Charge after the Member pays a $25 Copayment	Non-Covered

VISION BENEFITS		
	Participating Provider	**Non-Participating Provider**
Vision exams, including Refractions, limited to $150 per Member per Benefit Year	The Corporation pays 100% of the Allowable Charge	The Corporation pays 100% of the Allowable Charge The Member must pay the balance of the Provider's charge

PREVENTIVE BENEFITS The Benefit Year Deductible does not apply to these Benefits		
	Participating Provider	**Non-Participating Provider**
Preventive Benefits under the Affordable Care Act (ACA) (Refer to www.healthcare.gov for guidelines)	Covered	Non-Covered
Pap smear screenings (the report and interpretation only, limited to one (1) per Member per Benefit Year)	The Corporation pays 100% of the Allowable Charge	Non-Covered
Prostate screenings, limited to one (1) per Member per Benefit Year	The Corporation pays 100% of the Allowable Charge	Non-Covered
Gynecological exam (limited to two (2) per Member per Benefit Year)	The Corporation pays 100% of the Allowable Charge	Non-Covered
In South Carolina:		
	SC Mammography Network	**All Other Providers**
Mammography screenings (limited to one (1) per Benefit Year for any female Member age forty (40) or older)	The Corporation pays 100% of the Allowable Charge	Non-Covered
Outside South Carolina:		
	Out-of-State Participating Providers	**All Other Providers**
Mammography screenings (limited to one (1) per Benefit Year for any female Member age forty (40) or older)	The Corporation pays 100% of the Allowable Charge	Non-Covered

PRESCRIPTION DRUG BENEFIT			
Prescription Drugs	**Mail Service/Home Delivery Pharmacy**	**Participating Pharmacy**	**All Other Pharmacies**
Generic Drugs	The Member pays a $25 Prescription Drug Copayment for each prescription or refill, up to a 90 day supply	The Member pays a $15 Prescription Drug Copayment for each monthly prescription or refill, up to a 90 day supply	The Member will be responsible for 100% of the Allowable Charge at the pharmacy then will be reimbursed at 60% after a $15 Prescription Drug Copayment per Member for each monthly prescription or refill, up to a 90 day supply
Preferred Drugs Members are encouraged to utilize Generic Drugs when available and may be subject to a penalty if not	The Member pays a $90 Prescription Drug Copayment for each prescription or refill, up to a 90 day supply	The Member pays a $40 Prescription Drug Copayment for each prescription or refill, up to a 31 day supply	The Member will be responsible for 100% of the Allowable Charge at the pharmacy then will be reimbursed at 60% after a $40 Prescription Drug Copayment per Member for each prescription or refill, up to a 31 day supply
Non-Preferred Brand Drugs Members are encouraged to utilize Generic Drugs when available and may be subject to a penalty if not	The Member pays a $175 Prescription Drug Copayment for each prescription or refill, up to a 90 day supply	The Member pays a $70 Prescription Drug Copayment for each prescription or refill, up to a 31 day supply	The Member will be responsible for 100% of the Allowable Charge at the pharmacy then will be reimbursed at 60% after a $70 Prescription Drug Copayment per Member for each prescription or refill, up to a 31 day supply

Prescription Drugs	Mail Service/Home Delivery Pharmacy	Participating Pharmacy	All Other Pharmacies
*Contraceptives: oral contraceptives, cervical cap, diaphragms, Emergency contraception, female condom, implantable rod, intrauterine device (IUD), patch, shot/injection, spermicide, sponge, vaginal contraceptive ring and approved sterilization procedures for women A complete list of specific Prescription Drugs or supplies covered at 100% is available at www.SouthCarolinaBlues.com	Prescription Drugs will be covered at 100%, up to a 90 day supply	Prescription Drugs will be covered at 100%, up to a 31 day supply	The Member will be responsible for 100% of the Allowable Charge at the pharmacy then will be reimbursed at 100%, up to a 31 day supply
**All other contraceptives (Prescription Drugs)	Covered	Covered	Covered
Sexual dysfunction Prescription Drugs	Non-Covered	Non-Covered	Non-Covered
Tobacco cessation Prescription Drugs	Covered	Covered	Covered
Obesity/weight control Prescription Drugs	Non-Covered	Non-Covered	Non-Covered
Infertility Prescription Drugs	Non-Covered	Non-Covered	Non-Covered
Cosmetic Prescription Drugs	Non-Covered	Non-Covered	Non-Covered
Travel vaccinations	Non-Covered	Non-Covered	Non-Covered
Prescription Drug deductible	$0 (No Prescription Drug deductible)	$0 (No Prescription Drug deductible)	$0 (No Prescription Drug deductible)
Prescription Drug out-of-pocket	$0 (No Prescription Drug out-of-pocket)	$0 (No Prescription Drug out-of-pocket)	$0 (No Prescription Drug out-of-pocket)
Diabetic syringes and supplies***	Covered	Covered	Covered

Prescription Drugs	**Mail Service/Home Delivery Pharmacy**	**Participating Pharmacy**	**All Other Pharmacies**
Syringes and related supplies for conditions such as cancer or burns, test tape, surgical trays and renal dialysis supplies	Non-Covered	Non-Covered	Non-Covered
*Contraceptives listed above are covered under the participating medical Benefits at the same payment levels. Refill quantities for the contraceptives listed above may vary. **All other contraceptives are paid at the Generic, Preferred and Non-Preferred Brand Drug payment levels. ***One Prescription Drug Copayment applies for all supplies purchased on the same day.			

SPECIALTY DRUG BENEFIT		
	Participating Pharmacy	**All Other Pharmacies**
Specialty Drugs	The Member pays a $125 Prescription Drug Copayment for each prescription or refill, up to a 31 day supply	Non-Covered

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ARTICLE I - DEFINITIONS

Capitalized terms that are used in this Plan of Benefits shall have the following defined meanings:

ACA: the Affordable Care Act of 2010, as amended.

Accountable Care Organization (ACO): a group of healthcare Providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their Member populations.

Actively at Work: a permanent, full-time Employee who works at least the minimum number of hours per week and the minimum number of weeks per year (each as set forth on the Schedule of Benefits) and who is not absent from work during the initial enrollment period because of a leave of absence or temporary layoff. An absence during the initial enrollment period due to a Health Status-Related Factor will not keep an Employee from qualifying for Actively at Work status.

Admission: the period of time between a Member's admission as a patient into a Hospital or Skilled Nursing Facility and the time the Member leaves or is discharged.

Adverse Benefit Determination: any denial, reduction or termination of, or failure to provide or make (in whole or in part) payment for a claim for Benefits, including any such denial reduction, termination, or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in a Plan, and including a denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for a Benefit which results from the application of any utilization review as well as a failure to cover an item or services for which Benefits are otherwise provided because it is determined to be Investigational or Experimental or not Medically Necessary or appropriate. An Adverse Benefit Determination includes any cancellation or discontinuance of coverage that has retroactive effect (whether or not there is an adverse effect on any particular Benefit), except to the extent attributable to a failure to pay any required Premiums or Employee contributions.

Allowable Charge: the amount the Corporation or a licensee of the Blue Cross and Blue Shield Association (BCBSA) agrees to pay a Provider as payment in full for a service, procedure, supply or equipment. Additionally:

1. The Allowable Charge shall not exceed the Maximum Payment;

2. The Allowable Charge for Emergency Services provided by Non-Participating Providers will pay in accordance with the definition of Maximum Payment; and,

3. In addition to the Member's liability for Benefit Year Deductibles, Copayments and/or Coinsurance, the Member may be balance billed by the Non-Participating Provider for any difference between the Allowable Charge and the billed charges.

Alternate Recipient: any Child who is recognized under a Medical Child Support Order as having a right to enroll in this Plan of Benefits.

Ambulatory Surgical Center: a licensed facility that:

1. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;

2. Provides treatment by or under the supervision of licensed medical doctors or oral surgeons and provides nursing services when the Member is in the facility;

3. Does not provide inpatient accommodations; and,

4. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a licensed medical doctor or oral surgeon.

Applied Behavioral Analysis (ABA): behavioral modification to target cognition, language and social skills for Autism Spectrum Disorder.

Authorized Representative: an individual (including a Provider) whom the Member designates in writing to act on his or her behalf.

Autism Spectrum Disorder: the diagnoses designated as such in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Behavioral Health Provider: a Provider who renders Mental Health Services and/or Substance Use Disorder Services and is licensed to practice independently.

Behavioral Health Services: all Mental Health Services and/or Substance Use Disorder Services performed by a licensed Behavioral Health Provider.

Benefit Year: the period of time set forth on the Schedule of Benefits. The initial Benefit Year may be more or less than twelve (12) months.

Benefit Year Deductible: the amount, if any, listed on the Schedule of Benefits that must be paid by the Member each Benefit Year before the Corporation will pay Covered Expenses. The Benefit Year Deductible is subtracted from the Allowable Charge before Coinsurance is calculated. Members must refer to the Schedule of Benefits to determine if the Benefit Year Deductible applies to the Out-of-Pocket Maximum.

Benefit(s): medical services or Medical Supplies that are:

1. Medically Necessary;

2. Preauthorized (when required under this Plan of Benefits or the Schedule of Benefits);

3. Included in Article III of this Plan of Benefits; and,

4. Not limited or excluded under the terms of this Plan of Benefits.

Benefits Checklist: the document (in electronic or hardcopy form) maintained by the Corporation which reflects the benefits selected by the Employer and submitted to the Corporation which outlines the Benefits to be offered under the Group Health Plan. The Corporation shall administer the Plan of Benefits in accordance with the terms of the Benefits Checklist. In the event of any conflict between the Benefits Checklist and this Plan of Benefits or the Schedule of Benefits, the Benefits Checklist shall control.

BlueCard Program: a program in which all members of the BCBSA participate. Details of the BlueCard Program are more fully set forth in Article XII.

Brand Name Drug: a Prescription Drug that is manufactured under a registered trade name or trademark.

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

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

Care Coordinator Fee: a fixed amount paid by a Blue Cross and/or Blue Shield Licensee to Providers periodically for Care Coordination under a VBP.

Child: an Employee's child, whether a natural child, adopted child, foster child, stepchild or child for whom an Employee has custody or legal guardianship. The term "Child" also includes an Incapacitated Dependent, and a child of a divorced or divorcing Employee who, under a Qualified Medical Child Support Order, has a right to enroll under the Employer's Group Health Plan. The term "Child" does not include the Spouse of an eligible child.

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

COBRA: those provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended, which require certain Employers to offer continuation of healthcare coverage to Employees and Dependents of Employees who would otherwise lose coverage.

COBRA Administrator: the Corporation or its designated subcontractor that provides administrative services related to COBRA.

Coinsurance: the sharing of the Allowable Charge between the Member and the Corporation. After the Member's Benefit Year Deductible requirement is met, the Corporation will pay the percentage of Allowable Charges as set forth on the Schedule of Benefits. The Member is responsible for the remaining percentage of the Allowable Charge. Coinsurance is calculated after any applicable Benefit Year Deductible or Copayment is subtracted from the Allowable Charge based upon the network charge or the lesser charge of the Provider.

For Prescription Drug Benefits, Coinsurance means the amount payable by the Member calculated by multiplying the percentage listed on the Schedule of Benefits and the negotiated pharmacy price for that item at the time of the sale.

Companion Benefit Alternatives (CBA): a separate company that is responsible for managing Behavioral Healthcare Services (including Preauthorization) on behalf of BlueCross.

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

Congenital Disorder/Congenital Disease: a condition documented as existing at birth, regardless of cause.

Continuation of Care: the payment of Participating Provider level of Benefits for services rendered by certain Non-Participating Providers for a definite period of time in order to ensure continuity of care for covered Members for a Serious Medical Condition.

Continued Stay Review: the review that must be obtained by a Member (or the Member's Authorized Representative) regarding an extension of an Admission to determine if an Admission for longer than the time that was originally Preauthorized is Medically Necessary. The Continued Stay Review process is outlined in Article III.

Contract: the Master Group Contract between the Corporation and the Employer including the Employer Application, Benefits Checklist, Plan of Benefits, Schedule of Benefits, Schedule A and all endorsements, amendments, riders or addenda.

Copayment: the amount, if any, specified on the Schedule of Benefits that the Member must pay directly to the Provider each time the Member receives Benefits.

Corporation: BlueCross BlueShield of South Carolina.

Covered Expenses: the amount payable by the Corporation for Benefits. The amount of Covered Expenses payable for Benefits is determined as set forth in this Plan of Benefits and at the percentages set forth on the Schedule of Benefits. Covered Expenses are subject to the limitations and requirements set forth in this Plan of Benefits and on the Schedule of Benefits. Covered Expenses will not exceed the Allowable Charge.

Credit(s): rebates and/or other amounts which may be received by the Corporation from drug manufacturers, a Pharmacy Benefit Manager and/or another third party. Credits are not payable to Members and will be retained by the Corporation to help stabilize overall rates and to offset expenses.

Reimbursements to a Participating Pharmacy or discounted prices charged at pharmacies are not affected by these Credits. Any Coinsurance or Copayment that a Member must pay for Prescription Drugs or Specialty Drugs does not change due to receipt of any Credit by the Corporation.

Custodial Care: non-skilled services that are primarily for the purpose of assisting an individual with daily living activities or personal needs (e.g., bathing, dressing and/or eating), which is not specific therapy for any illness or injury.

Dependent(s): an individual who is:

1. An Employee's Spouse;
2. A Child under the age set forth on the Schedule of Benefits; or,
3. An Incapacitated Dependent.

Durable Medical Equipment: medical equipment that:

1. Can withstand repeated use;
2. Is Medically Necessary;
3. Is customarily used for the treatment of a Member’s illness, injury, disease or disorder;
4. Is appropriate for use in the home;
5. Is not useful to a Member in the absence of illness or injury;
6. Does not include appliances that are provided solely for the Member’s comfort or convenience;
7. Is a standard, non-luxury item; and,
8. Is ordered by a licensed medical doctor, oral surgeon, podiatrist or osteopath.

Prosthetic Devices, Orthopedic Devices and Orthotic Devices are considered Durable Medical Equipment.

Emergency Admission Review: the review that must be obtained by a Member (or the Member's Authorized Representative) within twenty-four (24) hours of or by the end of the first working day after the commencement of an Admission to a Hospital to treat an Emergency Medical Condition. The Emergency Admission Review process is outlined in Article III.

Emergency Medical Condition: a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the Member, or with respect to a pregnant Member, the health of the Member or her unborn Child, in serious jeopardy;

2. Serious impairment to bodily functions; or,

3. Serious dysfunction of any bodily organ or part.

Emergency Services: services, supplies and treatment for stabilization, evaluation and/or initial treatment of an Emergency Medical Condition when provided on an outpatient basis at a Hospital emergency room or department.

Employee: any employee of the Employer who is eligible for coverage, as provided in Article II of this Plan of Benefits, and who is so designated to the Corporation by the Employer.

Employer: the entity identified as the Employer in the Contract.

Employer's Effective Date: the date the Corporation begins to provide Services under the Contract.

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

ERISA: the Employee Retirement Income Security Act of 1974, as amended.

Excepted Benefits:

1. Coverage only for accident, disability income insurance or any combination thereof;

2. Coverage issued as a supplement to liability insurance;

3. Liability insurance, including general liability insurance and automobile liability insurance;

4. Worker's compensation or similar insurance;

5. Automobile medical payment insurance;

6. Credit-only insurance;

7. Coverage for on-site medical clinics; or,

8. Other similar insurance coverage specified in regulations, under which 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 thereof; or,

    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; or,

    b. Hospital indemnity or other fixed indemnity insurance.

11. If offered as a separate insurance policy:

    a. Medicare supplemental health insurance (as defined under Section 1882(g)(l) of the Social Security Act);

    b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code; or,

    c. Similar supplemental coverage under a Group Health Plan.

Generic Drug: a Prescription Drug that has a chemical structure that is identical to and has the same bio-equivalence as a Brand Name Drug but is not manufactured under a registered brand name or trademark or sold under a brand name.

Genetic Information: information about genes, gene products (messenger ribonucleic acid (RNA) and transplanted protein) or genetic characteristics derived from an individual or family member of the individual. Genetic Information includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes. However, Genetic Information shall not include routine physical measurements; chemical, blood, and urine analyses unless conducted purposefully to diagnose a genetic characteristic; tests for abuse of drugs and tests for the presence of human immunodeficiency virus.

Global Payment/Total Cost of Care: a payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient such as outpatient, physician, ancillary, hospital services and Prescription Drugs.

Grace Period: the thirty-one (31) day period for the payment of any Premium due, except the first Premium, during which time the Covered Expenses are paid by the Corporation, unless the Employer gives the Corporation written notice of intent to discontinue the Contract or this Plan of Benefits prior to the date the next Premium is due in accordance with the terms of the Contract. There is no Grace Period for the payment of the first Premium.

Group Health Plan: the employee welfare benefit plan established, administered and/or sponsored by the Employer to provide health Benefits to Employees and/or their Dependents directly or through insurance, reimbursement or otherwise.

Health Status-Related Factor: information about a Member's health, including:

1. Health status;
2. Medical conditions (including both physical and mental illnesses);
3. Claims experience;
4. Receipt of healthcare;
5. Medical history;
6. Genetic Information;
7. Evidence of insurability (including conditions arising out of acts of domestic violence); or,
8. Disability.

HIPAA: the Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Agency: an agency or organization licensed by the appropriate state regulatory agency to provide Home Health Care.

Home Health Care: part-time or intermittent nursing care; health aide services; or physical, occupational or speech therapy provided or supervised by a Home Health Agency and provided to a home-bound Member in such Member's private residence.

Hospice Care: care for terminally ill patients under the supervision of a licensed medical doctor and provided by an agency that is licensed or certified as a hospice or hospice care agency by the appropriate state regulatory agency.

Hospital: a short-term, acute care facility licensed as a hospital by the state in which it operates. A Hospital is primarily engaged in providing medical, surgical, or acute behavioral health diagnosis and treatment of injured or sick persons by or under the supervision of a staff of licensed Providers and continuous twenty-four (24) hour-a-day services by licensed, registered, graduate nurses physically present and on duty. The term Hospital does not include Long-Term Acute Care Hospitals; chronic care institutions or facilities that principally provide custodial, rehabilitative or long-term care, whether or not such institutions or facilities are affiliated with or are part of a Hospital. A Hospital may participate in a teaching program. This means medical students, interns or residents participating in a teaching program may treat Members.

Identification Card: the card issued by the Corporation to a Member that contains the Member's identification number.

Incapacitated Dependent: a Child who is:

1. Incapable of financial self-sufficiency by reason of Total Disability; and,
2. Dependent upon the Employee for at least fifty-one (51) percent of his or her support and maintenance.

A Child must meet both of these requirements to qualify as an Incapacitated Dependent. A Child who is not incapacitated by the maximum Dependent Child age listed on the Schedule of Benefits will not be covered.

Investigational or Experimental: surgical or medical procedures, supplies, devices or drugs which, at the time provided or sought to be provided, are, in the judgment of the Corporation, not recognized as conforming to generally accepted medical or behavioral health practice in the United States, or the procedure, drug or device:

1. Has not received required final approval in the United States to market from appropriate government bodies;

2. Is one about which the peer-reviewed medical literature in the United States does not permit conclusions concerning its effect on health outcomes;

3. Is not demonstrated in the United States to be superior to established alternatives;

4. Has not been demonstrated in the United States to improve net health outcomes; or,

5. Is one in which the improvement claimed is not demonstrated in the United States to be obtainable outside the Investigational or Experimental setting.

Late Enrollee: an Employee or Dependent who enrolls for coverage under this Plan of Benefits other than during:

1. The first period in which the Employee or Dependent is eligible to enroll if such initial enrollment period is at least thirty (30) days; or,

2. A special enrollment period (as set forth in Article II(C)(6)).

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

Long-Term Acute Care Hospital: a long-term, acute care facility licensed as a long-term care Hospital by the state in which it operates and which meets the other requirements of this definition. A Long-Term Acute Care Hospital provides highly skilled nursing, therapy and medical treatment to Members (typically over an extended period of time) although such Members may no longer need general acute care typically provided in a Hospital. A Long-Term Acute Care Hospital is primarily engaged in providing diagnostic services and medical treatment to Members with chronic diseases or complex medical conditions. The term Long-Term Acute Care Hospital does not include chronic care institutions or facilities that principally provide custodial, rehabilitative or long-term care, whether or not such institutions or facilities are affiliated with or are part of a long-term acute care hospital. A Long-Term Acute Care Hospital may participate in a teaching program. This means medical students, interns or residents participating in a teaching program may treat Members.

Mail Service/Home Delivery Pharmacy: a pharmacy maintained by the Pharmacy Benefit Manager that fills prescriptions and sends Prescription Drugs by mail.

Maximum Payment: the maximum amount the Corporation will pay for a particular Benefit. The Maximum Payment will not be affected by any Credit. The Maximum Payment will be one of the following as determined by the Corporation in its discretion:

1. The actual charge submitted to the Corporation for the service, procedure, supply or equipment by a Provider;

2. An amount based upon the reimbursement rates in its Benefits Checklist;

3. An amount that has been agreed upon in writing by a Provider and the Corporation or a licensee of the BCBSA;

4. An amount established by the Corporation, based upon factors including, but not limited to:

    a. Governmental reimbursement rates applicable to the service, procedure, supply or equipment; or,

    b. Reimbursement for a comparable or similar service, procedure, supply or equipment, taking into consideration the degree of skill, time and complexity involved; geographic location and circumstances giving rise to the need for the service, procedure, supply or equipment; or,

5. The lowest amount of reimbursement the Corporation allows for the same or similar service, procedure, supply or equipment when provided by a Participating Provider.

In addition, the Maximum Payment for Emergency Services by a Non-Participating Provider will be the greatest of the following:

1. The amount negotiated with Participating Providers for the particular Emergency Services (reduced by any in-network Copayment or Coinsurance);

2. The amount for Emergency Services calculated using same method the Corporation uses for out-of-network services, but substituting the relevant in-network Copayment or Coinsurance for the out-of-network Copayment or Coinsurance requirements; or,

3. The amount for Emergency Services that would be paid under Medicare, reduced by any in-network Copayment or Coinsurance for the services.

Medical Child Support Order: any judgment, decree or order (including an approved settlement agreement) issued by a court of competent jurisdiction or a national medical support notice issued by the applicable state agency which:

1. Provides Child support with respect to a Child or provides for health benefit coverage to a Child, is made pursuant to a state domestic relations law (including a community property law) and relates to this Plan of Benefits; or,

2. Enforces a law relating to medical Child support described in Section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a Group Health Plan.

A Medical Child Support Order must clearly specify:

1. The name and the last known mailing address (if any) of each participant Employee and the name and mailing address of each Alternate Recipient covered by the order;

2. A reasonable description of the type of coverage to be provided by the Group Health Plan to each such Alternate Recipient or the manner in which such type of coverage is to be determined;

3. The period to which such order applies; and,

4. Each Group Health Plan to which such order applies.

If the Medical Child Support Order is a national medical support notice, the order must also include:

1. The name of the issuing agency;

2. The name and mailing address of an official or agency that has been substituted for the mailing address of any Alternate Recipient; and,

3. The identification of the underlying medical Child support order.

A Medical Child Support Order meets the requirement of this definition only if such order does not require a Group Health Plan to provide any type or form of benefit, or any option, not otherwise provided under this Plan of Benefits, except to the extent necessary to meet the requirements of a law relating to medical Child support described in Section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993).

Medical Supplies: supplies that are:

1. Medically Necessary;

2. Prescribed by a Provider acting within the scope of his or her license;

3. Are not available on an over-the-counter basis (unless such supplies are provided to a Member in a Provider's office and should not be included as part of the treatment received by the Member); and,

4. Are not prescribed in connection with any treatment or Benefit that is excluded under this Plan of Benefits.

Medically Necessary/Medical Necessity: using United States standards, healthcare services and/or Behavioral Health Services that a Provider, 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 or behavioral health 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, patient's caregiver(s) or 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.

All requirements of the above-referenced definition must be met in order for a health care service or Behavioral Health Service to be deemed Medically Necessary. The failure of a health care service or Behavioral Health Service to meet any one of the above referenced requirements means, in the discretion of the Corporation or CBA, the health care service or Behavioral Health Service does not meet the definition of Medically Necessary.

For the purposes of determining Medical Necessity:

1. The Corporation and CBA have the discretion to utilize and rely upon any medical and behavioral health (which includes substance use and mental health) standards, policies, guidelines, criteria, protocols, manuals, publications, studies or literature (herein collectively referred to as "criteria"), whether developed by them or others, which, in their discretion, are determined to be generally accepted standards by the medical and/or behavioral health community;

2. "Generally accepted standards of medical or behavioral health practice" means United States standards that are based on credible scientific evidence published in peer-reviewed medical and/or behavioral health literature generally recognized by the relevant United States medical or behavioral health community, physician or behavioral health specialty society recommendations, and/or any other factors deemed relevant in the discretion of the Corporation or CBA; and,

3. The Corporation and CBA may, in their discretion, use the following materials, including but not limited to, Corporate Administrative Medical ("CAM") Policies, Technology Evaluation Center ("TEC") Assessments, Behavioral Health Care Utilization Management Criteria and/or any Care Guidelines or criteria by MCG Health, LLC, its affiliated companies, or other entities generally recognized as providing industry guidance and expertise, which reflect clinically appropriate health care services and Behavioral Health Services and generally accepted standards of medical and behavioral health practice. MCG Health, LLC, its affiliated companies and/or other entities are independent companies that develop evidence based guidelines and criteria for medical, behavioral health and insurance industries to interpret clinical determinations and determine the Medical Necessity and appropriateness of requested services, procedures, devices and supplies.

Member: an Employee or Dependent who has enrolled under the Group Health Plan.

Member Effective Date: the date on which an Employee or Dependent is covered for Benefits under the terms of Article II of this Plan of Benefits.

Membership Application: any mechanism agreed upon by the Corporation and the Employer for transmitting necessary Member enrollment information from the Employer to the Corporation.

Mental Health Services: treatment (except Substance Use Disorder Services) for a condition that is defined, described or classified as a psychiatric disorder or condition in the most current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association and which is not otherwise excluded by the terms and conditions of this Plan of Benefits.

Natural Teeth: teeth that:

1. Are free of active or chronic clinical decay;

2. Have at least fifty percent (50%) bony support;

3. Are functional in the arch; and,

4. Have not been excessively weakened by multiple dental procedures; or,

5. Teeth that have been treated for one (1) or more of the conditions referenced in 1-4 above and, as a result of such treatment, have been restored to normal function.

Negotiated Arrangement/Negotiated National Account Arrangement: an agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard Program.

Non-Participating Provider: any Provider who does not have a current, valid Provider Agreement.

Non-Preferred Drug: a Prescription Drug that does not appear on the list of Preferred Drugs.

Orthopedic Device: any ridged or semi-ridged leg, arm, back or neck brace and casting materials that are directly used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.

Orthotic Device: any device used to mechanically assist, restrict or control function of a moving part of the Member's body.

Out-of-Pocket Maximum: the maximum amount (listed on the Schedule of Benefits) incurred during a Benefit Year that a Member will be required to pay.

Over-the-Counter Drug: a drug that does not require a prescription.

Participating Pharmacy: a pharmacy that has a contract with the Corporation or with the Pharmacy Benefit Manager to provide Prescription Drugs or Specialty Drugs to Members.

Participating Provider: a Provider who has a current, valid Provider Agreement.

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

Pharmacy Benefit Manager (PBM): the pharmacy benefit manager with whom the Corporation contracts to perform PBM services.

Plan: any program that provides benefits or services for medical or dental care or treatment, including:

1. Group coverage, whether insured or self-insured. This includes, but is not limited to, prepayment, group practice or individual practice coverage; and,

2. Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Each contract or other arrangement for coverage is a separate Plan for purposes of this Plan of Benefits. If a Plan has two (2) or more parts and the coordination of benefit rules in Article V apply only to one (1) of the parts, each part is considered a separate Plan.

Plan Administrator: the entity charged with the administration of the Group Health Plan. The Employer is the Plan Administrator of the Group Health Plan.

Plan of Benefits: this document which reflects the Benefits offered under the Group Health Plan based on the Benefits Checklist. The Plan of Benefits includes the Schedule of Benefits. Employer agrees that the Plan of Benefits will, at a minimum, be incorporated as a part of the Group Health Plan.

Plan of Benefits Effective Date: 12:01 a.m. EST on the date listed on the Schedule of Benefits.

Plan Sponsor: the party sponsoring the Group Health Plan. The Employer is the Plan Sponsor of the Group Health Plan.

Post-Service Claim: any claim for a Benefit that is not a Pre-Service Claim.

Preadmission Review: the review that must be obtained by a Member (or the Member's Authorized Representative) prior to all Admissions that are not related to an Emergency Medical Condition. The Preadmission Review process is outlined in Article III.

Preauthorized/Preauthorization: the Corporation's approval of Benefits based on Medical Necessity prior to the rendering of such Benefits to a Member. The Preauthorization process is outlined in Article III.

Preferred Drug: a Prescription Drug that has been reviewed for cost effectiveness, clinical efficacy and quality that is preferred by the Corporation or Pharmacy Benefit Manager. Preferred Drugs are subject to periodic review and modification by the Corporation, or its designated Pharmacy Benefit Manager, and include Brand Name Drugs and Generic Drugs.

Premium: the amount paid to the Corporation by the Employer for coverage under this Plan of Benefits. Payment of Premiums by the Employer constitutes acceptance by the Employer of the terms of this Plan of Benefits and the Contract.

Prescription Drug: a drug or medicine that is:

1. Required to be labeled that it has been approved by the FDA; and,

2. Bears the legend "Caution: Federal Law prohibits dispensing without a prescription" prior to being dispensed or delivered, or labeled in a similar manner.

Additionally, to qualify as a Prescription Drug, the drug must be prescribed by a licensed Provider acting within the scope of his or her license.
Certain Over-the-Counter Drugs may be designated as Prescription Drugs, at the discretion of the Corporation. Such designated Over-the-Counter Drugs will be listed on the PDL.

Prescription Drug Copayment: the amount payable, if any, set forth on the Schedule of Benefits, by the Member for each Prescription Drug filled or refilled. This amount will not be applied to the Benefit Year Deductible.

Prescription Drug List (PDL)/Formulary: a listing of drugs approved for a specified level of Benefits by the Corporation under the Plan of Benefits. This list shall be developed and subject to periodic review and modification by the Corporation. The most up-to-date version of the PDL is available on the Corporation's website.

Pre-Service Claim: any request for a Benefit where Preauthorization must be obtained before receiving the medical care, service or supply.

Primary Plan: a Plan whose Benefits must be determined without taking into consideration the existence of another Plan.

Private Duty Nursing (PDN): hourly or shift skilled nursing care provided in a patient's home. PDN provides more individual and continuous skilled care than can be provided in a skilled nurse visit through a Home Health Agency. The intent of PDN is to assist the patient with complex direct skilled nursing care, to develop caregiver competencies through training and education and to optimize patient health status and outcomes. The frequency and duration of PDN services is intermittent and temporary in nature and is not intended to be provided on a permanent ongoing basis. PDN is not long-term care.

Probationary Period: the period of continuous employment (if included on the Schedule of Benefits) with the Employer that an Employee must complete before becoming eligible to enroll in this Plan of Benefits. The Employer may require an additional orientation period.

Prosthetic Device: any device that replaces all or part of a missing body organ or body member, except a wig, hairpiece or any other artificial substitute for scalp hair.

Protected Health Information (PHI): has the same meaning as the term is defined under HIPAA.

Provider: any person or entity licensed by the appropriate state regulatory agency and legally entitled to practice within the scope of such person or entity's license in the practice of any of the following:

1. Medicine;
2. Dentistry;
3. Optometry;
4. Podiatry;
5. Chiropractic services;
6. Behavioral health;
7. Physical therapy;
8. Oral surgery;
9. Speech therapy;
10. Occupational therapy; or,
11. Osteopathy.

The term Provider also includes a Hospital; a Rehabilitation Facility; a Skilled Nursing Facility; a physician assistant; nurses practicing in expanded roles (such as pediatric nurse practitioners, family practice nurse practitioners and certified nurse midwives) when supervised by a licensed medical doctor or oral surgeon; and Behavioral Health Services when performed by a Behavioral Health Provider, licensed professional counselor, masters level licensed social worker, licensed marriage and family therapist or other licensed Behavioral Health Provider approved by the Corporation. The term Provider does not include interns, residents, physical trainers, lay midwives or masseuses.

Provider Agreement: an agreement between the Corporation (or another BCBSA licensee) and a Provider under which the Provider has agreed to accept the Corporation's allowance as payment in full for Benefits (subject to the Member liability amounts).

Provider Incentive: an additional amount of compensation paid to a healthcare Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.

Provider Services: includes the following services:

A. When performed by a Provider or a Behavioral Health Provider within the scope of his or her license, training and specialty and within the scope of generally acceptable medical standards:

   1. Office visits, which are for the purpose of seeking or receiving care for a preventive service, illness or injury;
   2. Basic diagnostic services and machine tests; or,

3. Behavioral Health Services.

B. When performed by a licensed medical doctor, osteopath, podiatrist or oral surgeon, but specifically excluding such services when performed by a chiropractor, optometrist, dentist, physical therapist, speech therapist, occupational therapist or licensed psychologist with a doctoral degree:

1. Benefits rendered to a Member in a Hospital or Skilled Nursing Facility;

2. Benefits rendered in a Member's home;

3. Surgical Services;

4. Anesthesia services, including the administration of general or spinal block anesthesia;

5. Radiological examinations;

6. Laboratory tests; and,

7. Maternity services, including consultation; prenatal care; conditions directly related to pregnancy, delivery and postpartum care and delivery of one (1) or more infants. Provider Services also include maternity services performed by certified nurse midwives when supervised by a licensed medical doctor.

Qualified Medical Child Support Order: a Medical Child Support Order that:

1. Creates or recognizes the existence of an Alternate Recipient's right to enroll under this Plan of Benefits; or,

2. Assigns to an Alternate Recipient the right to enroll under this Plan of Benefits.

Qualifying Event: for continuation of coverage purposes under Article VII, a Qualifying Event is any one of the following:

1. Termination of the Employee's employment (other than for gross misconduct) or reduction of hours worked;

2. Death of the Employee;

3. Divorce or legal separation of the Employee from his or her Spouse;

4. A Child ceasing to qualify as a Dependent under this Plan of Benefits;

5. Entitlement to Medicare by an Employee or by a parent of a Child; or,

6. A proceeding in bankruptcy under Title 11 of the United States Code with respect to an Employer from whose employment an Employee retired at any time.

Rehabilitation Facility: licensed facility operated for the purpose of assisting Members with neurological or other physical injuries to recover as much restoration of function as possible.

Residential Treatment Center (RTC): a licensed institution, other than a Hospital, which meets all six (6) of these requirements:

1. Maintains permanent and full-time facilities for bed care of resident patients;

2. Has the services of a psychiatrist (addictionologist, when applicable) or physician extender available at all times and is responsible for the diagnostic evaluation and provides face-to-face evaluation services with documentation a minimum of once/week and as needed as indicated;

3. Has a registered nurse (RN) present onsite who is in charge of patient care along with one (1) or more RNs or licensed practical nurses (LPNs) onsite at all times twenty-four (24) hours per day and seven (7) days per week;

4. Keeps a daily medical record for each patient;

5. Is primarily providing a continuous structured therapeutic program specifically designed to treat behavioral health disorders and is not a group or boarding home, boarding or therapeutic school, half-way house, sober living residence, wilderness camp or any other facility that provides Custodial Care; and,

6. Is operating lawfully as a residential treatment center in the area where it is located.

Schedule of Benefits: the pages of this Plan of Benefits, so titled, which specify the coverage provided and the applicable Copayments, Coinsurance, Benefit Year Deductibles and Benefit limitations.

Second Surgical Opinion: the medical opinion of a board-certified surgeon regarding an elective surgical procedure. The opinion must be based on the surgeon's examination of the patient. The examination must be performed after another licensed medical doctor has proposed to perform surgery but before the surgery is performed. The second licensed medical doctor must not be associated with the primary licensed medical doctor.

Secondary Plan: a Plan that is not a Primary Plan. When this Plan of Benefits constitutes a Secondary Plan, availability of Benefits are determined after those of the other Plan and may be reduced because of benefits payable under the other Plan.

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 the Member's health in serious jeopardy. This includes cancer, acute myocardial infarction and pregnancy.

Skilled Nursing Facility: an institution other than a Hospital that is certified and licensed by the appropriate state regulatory agency as a skilled nursing facility.

Special Care Unit: a specially equipped unit of a Hospital, set aside as a distinct care area, staffed and equipped to handle seriously ill Members requiring extraordinary care on a concentrated and continuous basis, such as burn, intensive or coronary care units.

Special Enrollment: the time period during which an Employee or eligible Dependent who is not enrolled for coverage under this Plan of Benefits may enroll for coverage due to the involuntary loss of other coverage or under permitted circumstances described in Article II of this Plan of Benefits.

Specialist: a licensed medical doctor who specializes in a particular branch of medicine.

Specialty Drugs: Prescription Drugs, as identified by the Corporation, that treat a complex clinical condition and/or require special handling, such as refrigeration. They generally require complex clinical monitoring, training and expertise. Specialty Drugs include, but are not limited to, infusible Specialty Drugs for chronic diseases, injectable and self-injectable drugs for acute and chronic diseases and specialty oral drugs. Specialty Drugs are used to treat acute and chronic disease states (e.g., growth deficiencies, Hemophilia, Multiple Sclerosis, Rheumatoid Arthritis, Gaucher's Disease, Hepatitis, cancer, organ transplantation, Alpha 1-Antitrypsin Disease and immune deficiencies).

Spouse: any individual who is legally married under any state law.

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

Substance Use Disorder Services: services or treatment relating to Substance Use Disorder.

Surgical Services: an operative or cutting procedure, including the usual, necessary and related pre-operative and post-operative care when performed by a licensed medical doctor.

Telehealth: the exchange of Member information during which Members can have a telephone or video consultation with a licensed health care professional.

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

Totally Disabled/Total Disability: the Member is able to perform none of the usual and customary duties of such Member's occupation. With respect to a Member who is a Dependent, the terms refer to disability to the extent that such Member can perform none of the usual and customary duties or activities of a person in good health of the same age. The Member must provide a licensed medical doctor's statement of disability upon periodic request by the Corporation.

Urgent Care Claim: any claim for medical care or treatment where making a determination under other than normal time frames could seriously jeopardize the Member's life or health or the Member's ability to regain maximum function, or, in the opinion of a licensed medical doctor or oral surgeon with knowledge of the Member's medical condition, would subject the Member to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.

USERRA: the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

Utilization Management: the use of techniques, such as step therapy, that allow the Corporation to manage the cost of Benefits by assessing their appropriateness using evidence-based criteria or guidelines before they are provided.

Value-Based Program (VBP): a healthcare delivery model such as a patient-centered medical home ("PCMH"), accountable care organization ("ACO"), capitation arrangements or episode-based arrangements aimed at improving patient health quality and outcomes with respect to certain diseases and/or conditions. These services are facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment. The VBP is described further in this Contract and the Plan of Benefits.

Value-Based Shared Savings: a payment mechanism in which the Provider and payer share cost savings achieved against a target cost budget based upon agreed upon terms and may include downside risk.

ARTICLE II – ELIGIBILITY FOR COVERAGE

A. ELIGIBILITY

1. Every Employee who is Actively at Work and who has completed the Probationary Period on or after the Employer's Effective Date is eligible to enroll (and to enroll his or her Dependents) for coverage under this Plan of Benefits.

2. If an Employee is not Actively at Work or has not completed the Probationary Period such Employee is eligible to enroll (and to enroll his or her Dependents) beginning on the next day that the Employee:

   a. Is Actively at Work; and,

   b. Has completed the Probationary Period.

3. Dependents are not eligible to enroll for coverage under this Plan of Benefits without the sponsorship of an Employee who is enrolled under this Plan of Benefits.

4. The Employee must furnish written proof of the requirements for an Incapacitated Dependent, as outlined in Article I, to the Employer no later than thirty-one (31) days after the Child's attainment of the maximum age listed on the Schedule of Benefits. The Employee will provide proof upon request.

5. Probationary Periods and/or contribution levels will not be based on any factor which discriminates in favor of higher wage Employees as required under federal law.

B. ELECTION OF COVERAGE

Any Employee may enroll for coverage under this Plan of Benefits for such Employee and such Employee's Dependents by completing and filing a Membership Application with the Employer. Dependents must be enrolled within thirty-one (31) days of the date on which they first become Dependents. Employees and Dependents may also enroll if eligible under the terms of any late enrollment or Special Enrollment procedure.

The Employee is required to submit a marriage license and file it with the Employer. The Corporation reserves the right to request documentation of such marriage.

C. COMMENCEMENT OF COVERAGE

Coverage under this Plan of Benefits will commence as follows, provided that coverage will not be effective more than sixty (60) days before the Corporation receives such Employee's Membership Application:

1. Employees and Dependents Eligible on the Employer's Effective Date.

   For Employees (and such Employee's Dependents for whom such Employee has elected coverage) who are Actively at Work prior to and on the Employer's Effective Date, coverage will generally commence on this Plan of Benefits Effective Date.

   If the Corporation receives an Employee's Membership Application dated after the Employer's Effective Date, coverage will commence on the date chosen by the Employer.

2. Employees and Dependents Eligible After this Plan of Benefits Effective Date.

   Employees and Dependents who become eligible for coverage after this Plan of Benefits Effective Date and have elected coverage will have coverage after they have completed the Probationary Period.

3. Dependents Resulting from Marriage.

   Dependents resulting from the marriage of an Employee will have coverage upon enrollment provided they have been enrolled for coverage within thirty-one (31) days after marriage and appropriate Premiums must be paid to the Corporation for such Dependents to have coverage from the date of the marriage.

4. Newborn Children.

   A newborn Child will have coverage upon the date of the Child's birth provided he or she has been enrolled for coverage (and the coverage has been paid for) within thirty-one (31) days after the Child's birth.

5. Adopted Children.

   For an adopted Child of an Employee, coverage shall commence as follows:

   a. Coverage shall be retroactive to the Child's date of birth when a decree of adoption is entered within thirty-one (31) days after the date of the Child's birth;

   b. Coverage shall be retroactive to the Child's date of birth when adoption proceedings have been instituted by the Employee within thirty-one (31) days after the date of the Child's birth and if the Employee has obtained temporary custody of the Child; or,

   c. For an adopted Child other than a newborn, coverage shall begin when temporary custody of the Child begins. However, such coverage shall only continue for one (1) year unless a decree of adoption is entered, in which case coverage shall be extended so long as such Child is otherwise eligible for coverage under the terms of this Plan of Benefits.

   If an adopted Child is not enrolled within the time frame set forth in (a)-(c) above, coverage will begin on the date chosen by the Employer and upon the payment of the applicable Premium.

6. Special Enrollment.

   In addition to enrollment under Article II (C)(2-5), the Corporation shall permit an Employee or Dependent who is not enrolled to enroll if each of the following is met:

   a. The Employee or Dependent was covered under a Group Health Plan at the time coverage was previously offered to the Employee or Dependent;

   b. The Employee stated in writing at the time of enrollment that the reason for declining enrollment was because the Employee or Dependent was covered under a Group Health Plan at that time. This requirement shall only apply if the Employer required such a statement at the time the Employee declined coverage and provided the Employee with notice of the requirement and the consequences of the requirement at the time; and,

   c. The Employee or Dependent's coverage described above:

i. Was under a COBRA continuation provision and the coverage under the provision was exhausted;

ii. Was not under a COBRA continuation provision described in Article II (C)(6)(c)(i) and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death or termination of employment), reduction in the number of hours of employment or if the Employer's contributions toward the coverage were terminated;

iii. Was one of multiple Plans offered by an Employer and the Employee elected a different plan during an open enrollment period or when an Employer terminates all similarly situated individuals;

iv. Was under a Health Maintenance Organization (HMO) that no longer serves the area in which the Employee lives, works or resides; or,

v. Under the terms of the Plan, the Employee requests the enrollment not later than thirty-one (31) days after date of exhaustion described in Article II (C)(6)(c)(i), termination of coverage or Employer contribution described in Article II (C)(6)(c)(ii).

d. Medicaid or State Children's Health Insurance Program (SCHIP) Coverage

i. The Employee or Dependent was covered under a Medicaid or SCHIP plan and coverage was terminated due to loss of eligibility; or,

ii. The Employee or Dependent becomes eligible for Premium assistance under a Medicaid or SCHIP plan; and,

iii. The Employee or Dependent requests such enrollment not more than sixty (60) days after either:

aa. Date of termination of Medicaid or SCHIP coverage; or,

bb. Determination that the Employee or Dependent is eligible for such assistance.

A Member whose Child becomes eligible to enroll in and receive child health assistance under a SCHIP plan also may disenroll the Child from the Plan of Benefits, pursuant to applicable procedures and deadlines established by the state.

The above list is not an all-inclusive list of situations when an Employee or Dependent loses eligibility. For situations other than those listed above, see the Employer.

D. DEPENDENT CHILD'S ENROLLMENT

1. A Dependent's eligibility for or receipt of Medicaid assistance will not be considered in enrolling that Dependent for coverage under this Plan of Benefits. For a Dependent to be covered under this Plan of Benefits, the required Premium must be paid.

2. Absent the sponsorship of an Employee, Dependents are not eligible to enroll for coverage under this Plan of Benefits.

3. A Dependent Child will not be denied enrollment for any of the following reasons:

a. Being born out of wedlock;

b. Not being claimed as a Dependent on the Employee's federal tax return; or,

c. Not residing with the Employee.

E. MEMBERSHIP APPLICATION

The Corporation will only accept a Membership Application submitted by the Employer on behalf of each Employee. The Corporation will not accept a Membership Application directly from an Employee or Dependent.

F. MEMBER CONTRIBUTIONS

The Member is solely responsible for making all payments for any Premium.

G. DISCLOSURE OF MEDICAL INFORMATION

The Member agrees that the Corporation may obtain claims information, medical records and other information necessary for the Corporation to consider a request for Preauthorization, a Continued Stay Review, an Emergency Admission Review, a Preadmission Review or to process a claim for Benefits under this Plan of Benefits.

ARTICLE III – BENEFITS

A. PAYMENT

The payment for Benefits is subject to all terms and conditions of this Plan of Benefits. In the event of a conflict between this Plan of Benefits and the Schedule of Benefits, the Schedule of Benefits controls. Oral statements cannot alter the terms of the Plan of Benefits or Schedule of Benefits. The Corporation will only pay for Benefits:

1. Performed or provided on or after the Member Effective Date;

2. Performed or provided prior to termination of coverage;

3. Provided by a Provider, within the scope of his or her license;

4. For which the required Preadmission Review, Emergency Admission Review, Preauthorization and/or Continued Stay Review has been requested and Preauthorization was received from the Corporation;

5. That are Medically Necessary;

6. That are not subject to an exclusion under Article IV of this Plan of Benefits;

7. After the payment of all required Benefit Year Deductibles, Coinsurance and Copayments; and,

8. That comply with the Corporation's corporate medical policy.

The amount payable for Benefits is determined as set forth in this Plan of Benefits and on the Schedule of Benefits. Benefits are subject to the limitations and requirements set forth in this Plan of Benefits and on the Schedule of Benefits. Payment for Benefits will not exceed the Allowable Charge.

B. PREAUTHORIZATION

All Admissions and some Benefits require Preauthorization to determine the Medical Necessity. The Corporation reserves the right to add or remove items from the list of Benefits that are subject to Preauthorization. If Preauthorization is not obtained, Benefits may be reduced. Specific penalties are listed on the Schedule of Benefits. Preauthorization is obtained through the following procedures:

1. For all Admissions that are not the result of an Emergency Medical Condition, Preauthorization is granted or denied in the course of the Preadmission Review;

2. For all Admissions that result from an Emergency Medical Condition, Preauthorization is granted or denied in the course of the Emergency Admission Review;

3. For Admissions that are anticipated to require more days than approved through the initial review process, Preauthorization for additional days is granted or denied in the course of the Continued Stay Review;

4. For specific Benefits that require Preauthorization, Preauthorization is granted or denied in the course of the Preauthorization process; and,

5. For items requiring Preauthorization, the Corporation must be called at the numbers given on the Identification Card.

Preauthorization means only that the Corporation has determined that the Benefit is Medically Necessary. Preauthorization is not a guarantee of payment or a verification that Benefits will be paid or are available to the Member. Notwithstanding Preauthorization, payment for Benefits is subject to a Member's eligibility and all other limitations and exclusions contained in this Plan of Benefits. A Member's entitlement to Benefits is not determined until the Member's claim is processed.

C. SPECIFIC COVERED BENEFITS

If all of the following requirements are met, the Corporation will pay for the Benefits described in Article III (D):

1. All of the requirements of Article III must be met;

2. The Benefit must be listed in Article III;

3. The Benefit must not have a "**Non-Covered**" notation associated with it on the Schedule of Benefits;

4. The Benefit (separately or collectively) must not exceed the dollar or other limitations contained on the Schedule of Benefits; and,

5. The Benefit must not be subject to one (1) or more of the exclusions set forth in Article IV.

D. BENEFITS

ABA RELATED TO AUTISM SPECTRUM DISORDER

Benefits will be paid for ABA related to Autism Spectrum Disorder as set forth on the Schedule of Benefits. Services must be provided by or under direction of an approved Participating Provider**.**

AMBULANCE SERVICES

Benefits will be paid for professional ground and air ambulance services to the nearest network Hospital in case of an accident or Emergency Medical Condition. The following requirements apply to all ground and air ambulance services and transports:

1. The transport is Medically Necessary and reasonable under the circumstances;

2. A Member is transported;

3. The destination is local within the United States; and,

4. The facility is medically appropriate to treat the Member's condition.

Benefits will be paid for ground ambulance transport between two Hospitals only when such ground ambulance transport has been Preauthorized and the Corporation confirms that the receiving Hospital is the closest facility that can provide medically appropriate care to treat the Member's condition. Transport from one facility to a new facility for the purpose of the Member obtaining a lower level of care at the new receiving facility must be Preauthorized. Repatriation for Member convenience is excluded and is not a Benefit for which Covered Expenses are payable.

Preauthorization is required for transportation as an inpatient from one Hospital to a second Hospital using an air ambulance. The following requirements must be met:

1. The first Hospital does not have the needed Hospital or skilled nursing care to treat the Member's illness or injury (such as burn care, cardiac care, trauma care, and critical care);

2. The second Hospital is the nearest medically appropriate facility to treat the Member's illness or injury;

3. A ground ambulance transport would endanger the Member's medical condition; and,

4. The transport is not related to a hospitalization outside the United States.

CHIROPRACTIC SERVICES

If specifically included on the Schedule of Benefits as a Benefit, Benefits will be paid for services and Medical Supplies required in connection with the detection and correction, by manual or mechanical means, of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects of such nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

CLEFT LIP OR PALATE

Benefits will be paid for the care and treatment of a congenital cleft lip or palate, or both, and any physical condition or illness that is related to or developed as a result of a cleft lip or palate.

Benefits shall include, but not be limited to:

1. Oral and facial Surgical Services, surgical management and follow-up care;

2. Prosthetic Device treatment, such as obturators, speech appliances and feeding appliances;

3. Orthodontic treatment and management;

4. Prosthodontia treatment and management;

5. Otolaryngology treatment and management;

6. Audiological assessment, treatment, and management, including surgically implanted amplification devices; and,

7. Physical therapy assessment and treatment.

If a Member with a cleft lip or palate is covered by a dental policy, then teeth capping, prosthodontics, and orthodontics shall be covered by the dental policy to the limit of coverage provided under such dental policy prior to coverage under this Plan of Benefits. Excess medical expenses (after coverage under any dental policy is exhausted) shall be provided as for any other condition or illness under the terms and conditions of this Plan of Benefits.

CLINICAL TRIALS

Benefits will be paid for routine Member costs for items and services related to Clinical Trials when:

1. The Member has cancer or other life-threatening disease or condition; and,

2. Either:

   a. the referring Provider is a Participating Provider that has concluded that the Member's participation in such trial would be appropriate; or,

   b. the Member provides medical and scientific information establishing that the Member's participation in such trial would be appropriate; and,

3. The services are furnished in connection with an approved Clinical Trial.

COLORECTAL CANCER SCREENING

Benefits will be paid for colorectal cancer screening as outlined on the Schedule of Benefits.

CRANIAL ORTHOTICS

Benefits will be paid for adjustable cranial orthoses (band or helmet) for positional plagiocephaly or craniosynostoses in the absence of cranial vault remodeling surgery when Medically Necessary.

DENTAL CARE FOR ACCIDENTAL INJURY

Benefits will be paid for dental services to Natural Teeth required because of accidental injury. For purposes of this section, an accidental injury is defined as an injury caused by a traumatic force, such as a car accident or a blow by a moving object. No Benefits will be paid for injuries that occur while the Member is in the act of chewing or biting. Services for conditions that are not directly related to the accidental injury are not covered. The first visit to a dentist does not require Preauthorization; however, the dentist must submit a plan for any future treatment to the Corporation for review and Preauthorization before such treatment is rendered if Benefits are to be paid. Benefits are limited to treatment for only six (6) months from the date of the accidental injury.

DIABETES EDUCATION

Benefits will be paid for outpatient self-management training and education for Members with diabetes mellitus provided that such training and educational Benefits are rendered by a Provider whose program:

1. Is recognized by the American Diabetes Association; or,

2. Is certified by the Diabetes Initiative of South Carolina.

DIABETIC SUPPLIES

Benefits will be paid for diabetic supplies as set forth on the Schedule of Benefits.

DURABLE MEDICAL EQUIPMENT

Benefits will be paid for standard, non-luxury Durable Medical Equipment. The Corporation will decide whether to buy or rent equipment and whether to repair or replace damaged or worn Durable Medical Equipment. The Corporation will not pay Benefits for Durable Medical Equipment that is solely used by a Member in a Hospital or that the Corporation determines is included in any Hospital room charge.

EMERGENCY SERVICES

Benefits will be paid for the treatment of Emergency Medical Conditions. Benefits are only available to treat an Emergency Medical Condition provided on an outpatient basis at a Hospital emergency room or department and only for as long as the condition continues to be considered an Emergency Medical Condition.

GENDER DYSPHORIA

Benefits will be paid for Medical Supplies, services or charges related to the diagnosis or treatment of gender dysphoria as outlined in the Corporation's medical policy.

GYNECOLOGICAL EXAMINATION

Benefits will be paid for routine gynecological examinations each Benefit Year for female Members.

HABILITATION

Benefits will be paid for habilitation, including assisting a Child with achieving developmental skills when impairments have caused delaying or blocking of initial acquisition of the skills. Habilitation can include fine motor, gross motor or other skills that contribute to mobility communication and performance of activities of daily living. The services will be described in an individual's plan of care.

HOME HEALTH CARE

Benefits will be paid for Home Health Care when rendered to a homebound Member in the Member's current place of residence.

HOSPICE CARE

Benefits will be paid for Hospice Care.

HOSPITAL AND SKILLED NURSING FACILITY SERVICES

Benefits will be paid for Admissions as follows:

1. Semiprivate room, board and general nursing care;

2. Private room, at semiprivate rate;

3. Services performed in a Special Care Unit when it is Medically Necessary that such services be performed in such unit rather than in another portion of the Hospital;

4. Ancillary services and Medical Supplies including services performed in operating, recovery and delivery rooms;

5. Diagnostic services, including interpretation of radiological and laboratory examinations, electrocardiograms and electroencephalograms; and,

6. In a Long-Term Acute Care Hospital.

Benefits for Admissions may be subject to the requirements for Preadmission Review, Emergency Admission Review and Continued Stay Review.

The day on which a Member leaves a Hospital or Skilled Nursing Facility, with or without permission, is treated as a day of discharge and will not be counted as a day of Admission, unless such Member returns to the Hospital or Skilled Nursing Facility by midnight of the same day. The day a Member enters a Hospital or Skilled Nursing Facility is treated as a day of Admission. The days during which a Member is not physically present for inpatient care are not counted as Admission days.

HUMAN ORGAN AND TISSUE TRANSPLANTS

1. Benefits will be paid for certain human organ and tissue transplants. To be covered, such transplants must be provided from a human donor to a Member and provided at a transplant center approved by the Corporation. Benefits shall only be paid for the human organ and tissue transplants as set forth on the Schedule of Benefits.

2. The payment of Benefits for living donor transplants will be subject to the following conditions:

    a. When both the transplant recipient and the donor are Members, Benefits will be paid for both.

    b. When the transplant recipient is a Member and the donor is not, Benefits will be paid for both the recipient and the donor to the extent that the donor does not have health benefits provided by any other source.

    c. When the donor is a Member and the transplant recipient is not, no Benefits will be paid for either the donor or the recipient.

3. Human organ and tissue transplant coverage includes expenses incurred for legal donor organ and tissue procurement and all inpatient and outpatient Hospital and medical expenses for the transplant procedure and related pre-operative and post-operative care, including immunosuppressive drug therapy and air ambulance expenses.

IN-HOSPITAL MEDICAL SERVICE

Benefits will be paid for a licensed medical doctor or Behavioral Health Provider's visits to a Member during a Medically Necessary Admission for treatment of a condition other than that for which Surgical Service or obstetrical service is required as follows:

1. In-Hospital medical Benefits primarily for Mental Health Services and Substance Use Disorder Services;

2. In-Hospital medical Benefits in a Skilled Nursing Facility will be provided for visits of a Provider, limited to one (1) visit per day, not to exceed the number of visits if set forth on the Schedule of Benefits.

3. Where two (2) or more Providers of the same general specialty render in-Hospital medical visits on the same day, payment for such services will be made only to one (1) Provider.

4. Concurrent medical and surgical Benefits for in-Hospital medical services are only provided:

    a. When the condition for which in-Hospital medical services requires medical care not related to Surgical Services or obstetrical service and does not constitute a part of the usual, necessary and related pre-operative or post-operative care but requires supplemental skills not possessed by the attending surgeon or his or her assistant; and,

    b. When the surgical procedure performed is designated by the Corporation as a warranted diagnostic procedure or as a minor surgical procedure.

5. When the same Provider renders different levels of care on the same day, Benefits will only be provided for the highest level of care.

MAMMOGRAPHY TESTING

Benefits will be paid for mammography testing. Benefits will be paid for additional mammograms during a Benefit Year based on Medical Necessity.

MASTECTOMIES AND RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES

Benefits will paid for mastectomies. The Corporation may not restrict Benefits for a Hospital length of stay following a mastectomy to less than forty-eight (48) hours. Nothing in this paragraph prohibits the attending Provider, after consulting with the Member, from discharging the Member earlier than forty-eight (48) hours. In the case of an early release, Benefits will be paid for one (1) home care visit if ordered by the attending Provider.

In the case of a Member who is receiving Benefits in connection with a mastectomy, Benefits will be paid for each of the following (if requested by such Member):

1. Reconstruction of the breast on which the mastectomy has been performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and,

3. Prosthetic Devices and treatment of physical complications at all stages of the mastectomy, including lymphedema.

MEDICAL SUPPLIES

Benefits will be paid for Medical Supplies, provided that the Corporation will not pay Benefits separately for Medical Supplies that are or should be provided as part of another Benefit.

MENTAL HEALTH SERVICES

Benefits will be paid for Mental Health Services provided on an inpatient or outpatient basis.

OBSTETRICAL SERVICES

Benefits will be paid for obstetrical services. Notwithstanding the preceding, Benefits for maternity or obstetrical services will not be paid for a Member who is a Child. Midwives licensed and practicing in compliance with the Nurse Practices Act in a Hospital will be covered under this Benefit.

Under the terms of the Newborn and Mother's Health Act of 1996, the Corporation generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than forty-eight (48) hours following a vaginal delivery (not including the day of delivery) or less than ninety-six (96) hours following a cesarean section (not including the day of surgery). Nothing in this paragraph prohibits the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than the specified time frames or from requesting additional time for hospitalization. In any case, the Corporation may not require that a Provider obtain authorization from the Corporation for prescribing a length of stay not in excess of forty-eight (48) or ninety-six (96) hours as applicable. However, Preauthorization is required to use certain Providers or facilities or to reduce out-of-pocket costs.

ORTHOPEDIC DEVICES

Benefits will be paid for Orthopedic Devices.

ORTHOTIC DEVICES

Benefits will be paid for Orthotic Devices that are not available on an over-the-counter basis and are not otherwise excluded under this Plan of Benefits.

OUTPATIENT HOSPITAL AND AMBULATORY SURGICAL CENTER SERVICES

Benefits will be paid for Surgical Services and diagnostic services, including radiological examinations, laboratory tests and machine tests, performed in an outpatient Hospital setting or an Ambulatory Surgical Center.

OUTPATIENT REHABILITATION SERVICES

Benefits will be paid, subject to the following paragraph, for physical therapy, occupational therapy, speech therapy and rehabilitation services as set forth on the Schedule of Benefits.

Benefits for outpatient rehabilitation services will be paid only following an acute incident involving disease, trauma or surgery that requires such care.

OXYGEN

Benefits will be paid for oxygen. Durable Medical Equipment for oxygen use in a Member's home is covered under the Durable Medical Equipment Benefit.

PAP SMEAR

Benefits will be paid for a Pap smear as part of a gynecological examination regardless of Medical Necessity. Benefits will be paid for additional Pap smears during a Benefit Year based on Medical Necessity.

PHYSICAL EXAMINATION

Benefits will be paid for physical examinations for Members.

PRESCRIPTION DRUGS

1. Unless expressly excluded under Article IV, Benefits will be paid for Prescription Drugs (as specified on the Schedule of Benefits) that are listed as covered on the PDL and are used to treat a condition for which Benefits are otherwise available. This may include certain Over-the-Counter Drugs designated by the Corporation as Prescription Drugs and listed as covered on the PDL. If so designated, these Over-the-Counter Drugs must be prescribed by a Provider. Any Coinsurance percentage or Copayment for Prescription Drugs does not change due to receipt of any Credits by the Corporation.

   For more information about Prescription Drugs, please refer to the PDL which can be found on the Corporation's website. A list of drugs that are not covered by the Corporation is also on the PDL.

   In certain instances, the Corporation provides for an exception process that allows a Member or his or her designee (or the prescribing Provider) to request and obtain access to clinically appropriate drugs that otherwise are not covered on the PDL. For more information about this exception process, please contact the Corporation at the number provided on your Identification Card.

2. The Corporation may use Utilization Management programs for Prescription Drugs.

PREVENTIVE SERVICES

Benefits will be paid for preventive health services required under the ACA as follows:

1. Evidence based services that have a rating of A or B in the current United States Preventive Services Task Force (USPSTF) recommendations;

2. Immunizations as recommended by the CDC; and,

3. Preventive care and screenings for children and women as recommended by the Health Resources and Services Administration (HRSA).

These Benefits are paid without any cost-sharing by the Member when the services are provided by a Participating Provider. Any other covered preventive screenings will be provided as set forth on the Schedule of Benefits.

PROSTATE EXAMINATION

Benefits will be paid for prostate examinations per Benefit Year regardless of Medical Necessity as set forth on the Schedule of Benefits. Benefits will be paid for additional prostate examinations during a Benefit Year based on Medical Necessity.

PROSTHETIC DEVICES

Benefits will be paid for a Prosthetic Device, other than a dental or cranial prosthetic, which is a replacement for a body part and which meets minimum specifications for the body part it is replacing regardless of the functional activity level. Coverage is provided for the cost of the standard, non-luxury item only. Components that are considered deluxe or upgraded over a standard model are not a covered service. Except as provided below, Benefits are provided for only the initial temporary prosthesis and one (1) permanent prosthesis. 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 the Corporation.

Prosthetic Devices do not include bioelectric, microprocessor or computer programmed prosthetic components.

PROVIDER SERVICES

Benefits will be paid for Provider Services, provided that when different levels of Provider Services are provided on the same day, Benefits will only be paid for the highest level of Provider Services.

REHABILITATION

Benefits will be paid, as specified on the Schedule of Benefits, for participation in a multidisciplinary team rehabilitation program only following severe neurologic or physical impairment if the following criteria are met:

1. All such treatment must be ordered by a licensed medical doctor;

2. All such treatment may require Preauthorization and must be performed by a Provider and at a location designated by the Corporation;

3. The documentation that accompanies a request for rehabilitation meets the criteria outlined in the Corporation's medical policy; and,

4. All such rehabilitation Benefits are subject to periodic review by the Corporation.

After the initial rehabilitation period, continuation of rehabilitation Benefits will require documentation that the Member is making substantial progress and that there continues to be significant potential for the achievement of the established rehabilitation goals.

RESIDENTIAL TREATMENT CENTER

Benefits will be paid for Residential Treatment Centers as set forth on the Schedule of Benefits.

SPECIALTY DRUGS

Benefits will be paid for Specialty Drugs as set forth on the Schedule of Benefits. Covered Expenses for Specialty Drugs dispensed to a Member shall not exceed the quantity and Benefit maximum set by the Corporation. Certain Specialty Drugs may be considered medical Benefits and may:

1. Require Preauthorization; and/or,

2. Be subject to certain place of service requirements.

For any Specialty Drugs paid as medical Benefits, the Benefit Year Deductible, Out-of-Pocket Maximum and/or Benefit maximum will apply as set forth on the Schedule of Benefits. A list of Specialty Drugs as well as information about any related requirements and/or restrictions may be obtained by contacting the Corporation at the number listed on the Identification Card or at www.SouthCarolinaBlues.com.

Any Coinsurance percentage or Copayment for Specialty Drugs does not change due to receipt of any Credits by the Corporation.

SUBSTANCE USE DISORDER SERVICES

Benefits will be paid for Substance Use Disorder Services as set forth on the Schedule of Benefits.

SURGICAL SERVICES

Benefits will be paid for Surgical Services performed by a licensed medical doctor or oral surgeon, as applicable, for treatment and diagnosis of disease or injury or for obstetrical services, as follows:

1. Surgical Services, subject to the following:

    a. If two (2) or more operations or procedures are performed at the same time, through the same surgical opening or by the same surgical approach, the total amount covered for such operations or procedures will be the Allowable Charge for the major procedure only.

    b. If two (2) or more operations or procedures are performed at the same time, through different surgical openings or by different surgical approaches, the total amount covered will be the Allowable Charge for the operation or procedure bearing the highest Allowable Charge plus one-half (1/2) of the Allowable Charge for all other operations or procedures performed.

    c. If an operation consists of the excision of multiple skin lesions, the total amount covered will be the Allowable Charge for the procedure bearing the highest Allowable Charge, fifty percent (50%) for the procedure bearing the second and third highest Allowable Charges, twenty-five percent (25%) for the procedures bearing the fourth through the eighth highest Allowable Charges and ten percent (10%) for all other procedures. Provided, however, if the operation consists of the excision of multiple malignant lesions, the total amount covered will be the Allowable Charge for the procedure bearing the highest Allowable Charge and fifty percent (50%) of the charge for each subsequent procedure.

    d. If an operation or procedure is performed in two (2) or more steps or stages, coverage for the entire operation or procedure will be limited to the Allowable Charge set forth for such operation or procedure.

    e. If two (2) or more licensed medical doctors or oral surgeons perform operations or procedures in conjunction with one another, other than as an assistant surgeon or anesthesiologist, the Allowable Charge, subject to the above paragraphs, will be coverage for the services of only one (1) licensed medical doctor or oral surgeon (as applicable) or will be prorated between them by the Corporation when so requested by the licensed medical doctor or oral surgeon in charge of the case.

    f. Certain surgical procedures are designated as separate procedures by the Corporation. The Allowable Charge is payable when such procedure is performed as a separate and single entity; however, when a separate procedure is performed as an integral part of another surgical procedure, the total amount covered will be the Allowable Charge for the major procedure only.

2. Assistant Surgeon services that consists of the Medically Necessary service of one (1) licensed medical doctor or oral surgeon or physician assistant or nurse practitioner who actively assists the operating surgeon when a covered Surgical Service is performed in a Hospital and when such surgical assistant service is not available by an intern, resident or in-house physician. The Corporation will pay charges at the percentage of the Allowable Charge set forth on the Schedule of Benefits for the Surgical Service, not to exceed the licensed medical doctor's or oral surgeon's (as applicable) actual charge.

3. Anesthesia services that consists of services rendered by a licensed medical doctor, oral surgeon or a certified registered nurse anesthetist, other than the attending surgeon or his or her assistant, and includes the administration of spinal or rectal anesthesia, or a drug or other anesthetic agent by injection or inhalation, except by local infiltration, the purpose and effect of which administration is the obtaining of muscular relaxation, loss of sensation or loss of consciousness. Additional Benefits will not be provided for pre-operative anesthesia consultation.

TELEHEALTH

Benefits will be paid for Telehealth services which are initiated by either a Member or Provider and are provided by licensed health care professionals who have been credentialed as eligible Telehealth Providers.

TELEMEDICINE

Benefits will be paid for Telemedicine services as follows:

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

Consulting and referring Providers must be Participating Providers who have been credentialed as eligible Telemedicine Providers.

Telemedicine services will be covered by the Corporation under the following circumstances:

1. The medical care is individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and not in excess of the Member's need; and,

2. The medical care can be safely furnished, and there is no equally effective, more conservative and less costly treatment available.

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

1. Telephone conversations;

2. Email messages;

3. Facsimile transmissions; or,

4. Internet-based audio-video communication that is not secure and HIPAA-compliant (e.g., Skype).

VARICOSE VEIN AND VENOUS INSUFFICIENCY TREATMENT

Benefits will be paid for services, supplies or treatment for varicose veins and/or venous insufficiency, including but not limited to endovenous ablation, vein stripping or the injection of sclerosing solutions, as outlined in the Corporation's medical policy.

ARTICLE IV - EXCLUSIONS AND LIMITATIONS

THE CORPORATION WILL NOT PAY ANY AMOUNT FOR THE SERVICES AND PRODUCTS LISTED IN THIS ARTICLE IV EXCEPT: (1) SERVICES ARE RENDERED BY A HEALTH CARE PROVIDER AS PART OF A VALUE-BASED PROGRAM OR (2) IF REQUIRED BY LAW.

ACUPUNCTURE

Acupuncture treatment or services, except as specified on the Schedule of Benefits.

ACTS OF WAR

Illness contracted or injury sustained as a result of a Member's participation as a combatant in a declared or undeclared war, or any act of war, or while in military service.

ADMISSIONS THAT ARE NOT PREAUTHORIZED

If Preauthorization is not received, Benefits may be reduced (or denied) as set forth on the Schedule of Benefits.

AMBULANCE

Ambulance services:

1. That do not meet coverage guidelines outlined in the Ambulance Services description in Article III;

2. That are not Medically Necessary and reasonable;

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

4. If the Member is medically stable and the situation does not involve an emergency, except as specified in Article III; or,

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

Any and all travel expenses including, but not limited to, transportation, lodging and repatriation are excluded.

BEHAVIORAL, EDUCATIONAL OR ALTERNATE THERAPY PROGRAMS

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

1. ABA therapy unless Medically Necessary for the treatment of Autism Spectrum Disorder;

2. Teaching, Expanding, Appreciating, Collaborating and Holistic (TEACCH) programs;

3. Higashi schools/daily life;

4. Facilitated communication;

5. Floor time;

6. Developmental Individual-Difference Relationship-based model (DIR);

7. Relationship Development Intervention (RDI);

8. Holding therapy;

9. Movement therapies;

10. Music therapy; and,

11. Animal assisted therapy.

BENEFITS PROVIDED BY STATE OR FEDERAL PROGRAMS

Any service or charge for a service to the extent that the Member is entitled to payment or benefits relating to such service under any state or federal program that provides healthcare benefits, including, but not limited to, Medicare, TRICARE and Medicaid, but only to the extent that benefits are paid or are payable under such programs. This exclusion includes, but is not limited to, benefits provided by the Veterans Administration for care rendered for a service-related disability or any state or federal Hospital services for which the Member is not legally obligated to pay.

COMPLICATIONS FROM NON-COVERED SERVICES

Complications arising from a Member's receipt or use of services, Medical Supplies or other treatment that are not Benefits .

CONTRACEPTIVES

Medical Supplies, services, devices or Prescription Drugs of any type, even those dispensed by a prescription, for the purpose of contraception, except as specified on the Schedule of Benefits.

COPYING CHARGES

Fees for copying or production of medical records and/or claims filing.

COSMETIC AND RECONSTRUCTIVE SERVICES

A. This Plan of Benefits excludes cosmetic or reconstructive procedures, and any related services or Medical Supplies, which alter appearance but do not restore or improve impaired physical function. Examples of services that are cosmetic or reconstructive which are not covered, include, but are not limited to, the following:

    1. Rhinoplasty (nose);

    2. Mentoplasty (chin);

    3. Rhytidoplasty (face lift);

    4. Glabellar rhytidoplasty (forehead lift);

5. Surgical planing (dermabrasion);

6. Blepharoplasty (eyelid);

7. Mammoplasty (reduction, suspension or augmentation of the breast);

8. Superficial chemosurgery (chemical peel of the face); and,

9. Rhytidectomy (abdomen, legs, hips, buttocks or elsewhere including lipectomy or adipectomy).

B. A cosmetic or reconstructive service may, under certain circumstances, be considered restorative in nature for which Benefits are available but only if the following requirements are met:

1. The service is intended to correct, improve or restore a bodily function; or,

2. The service is intended to correct, improve or restore a malappearance or deformity that was caused by physical injury or accident, congenital anomaly or covered surgical service; and,

3. The proposed service is Preauthorized.

CUSTODIAL CARE

Services or supplies related to Custodial Care, except as specified on the Schedule of Benefits.

DENTAL SERVICES

Any dental procedures involving tooth structures, excision or extraction of teeth, gingival tissue, alveolar process, dental X-rays, preparation of mouth for dentures or other procedures of dental origin. However, that such procedures may be Preauthorized if the need for dental services results from an accidental injury to Natural Teeth within six (6) months prior to the date of such services.

EYEGLASSES

Eyeglasses or contact lenses of any type, even those dispensed by a prescription (except after cataract surgery), except as specified on the Schedule of Benefits.

FOOT CARE

Routine foot care such as paring, trimming or cutting of nails, calluses or corns, except in conjunction with diabetic foot care.

HEARING AIDS

Hearing aids or examinations for the prescription or fitting of hearing aids, except as specified on the Schedule of Benefits.

HUMAN ORGAN AND TISSUE TRANSPLANTS

Human organ and tissue transplants that are not:

1. Preauthorized, if required, as set forth on the Schedule of Benefits;

2. Performed by a Provider as designated by the Corporation;

3. Listed as covered on the Schedule of Benefits; and,

4. Performed at a Blue Distinction Center of Excellence or a transplant center approved by the Corporation in writing.

HYPNOTISM

Hypnotism treatment or services, except as specified on the Schedule of Benefits.

ILLEGAL ACTS

Any illness or injury received while committing or attempting to commit a felony or while engaging in an illegal occupation.

IMMUNIZATIONS

Immunizations are excluded from coverage under this Plan of Benefits, except as specified on the Schedule of Benefits or if otherwise covered as a Preventive service.

IMPACTED TOOTH REMOVAL

Services or Medical Supplies for the removal of impacted teeth, except as specified on the Schedule of Benefits.

IMPOTENCE

Services, supplies or drugs related to any treatment for impotence, including but not limited to penile implants, except as specified on the Schedule of Benefits.

INCAPACITATED DEPENDENTS

Any service, supply or charge for an Incapacitated Dependent that is not enrolled by the maximum Dependent Child age (unless covered under a prior Plan) listed on the Schedule of Benefits.

INFERTILITY

Services, supplies or drugs related to any treatment for infertility, including, but not limited to, fertility drugs, gynecological or urological procedures the purpose of which is primarily to treat infertility, artificial insemination, in-vitro fertilization, reversal of sterilization procedures and surrogate parenting, except as specified on the Schedule of Benefits.

INPATIENT DIAGNOSTIC AND EVALUATIVE PROCEDURES

Inpatient care and related Provider Services rendered in conjunction with an Admission which is principally for diagnostic studies or evaluative procedures that could have been performed on an outpatient basis are not covered unless the Member's medical condition alone required Admission.

INTOXICATION OR DRUG USE

Any service (other than Substance Use Disorder Services), Medical Supplies, charges or losses resulting from a Member being Legally Intoxicated or under the influence of alcohol, any drug or other substance or taking some action the purpose of which is to create a euphoric state or alter consciousness. The Member, or Member's representative, must provide any available test results showing blood alcohol and/or drug/substance levels upon request by the Corporation. If the Member refuses to provide these test results, no Benefits will be provided.

INVESTIGATIONAL OR EXPERIMENTAL SERVICES

Services, supplies or drugs that are Investigational or Experimental.

LIFESTYLE IMPROVEMENT SERVICES

Services or supplies relating to lifestyle improvements, including, but not limited to, physical fitness programs, except as specified on the Schedule of Benefits.

LONG-TERM CARE SERVICES

Admissions or portions thereof for long-term care, including:

1. Rest care;

2. Care to assist a Member in the performance of activities of daily living (including, but not limited to, walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation and taking medication);

3. Custodial or long-term care; or,

4. Psychiatric or Substance Use Disorder treatment, including, but not limited to, therapeutic schools, wilderness/boot camps, therapeutic boarding homes, half-way houses and therapeutic group homes.

MASSAGE THERAPY

Massage therapy treatment or services, except as specified on the Schedule of Benefits.

MEMBERSHIP DUES AND OTHER FEES

Amounts payable (whether in the form of initiation fees, annual dues or otherwise) for membership or use of any gym, workout center, fitness center, club, golf course, wellness center, health club, weight control organization or other similar entity or to a trainer of any type.

MOTORIZED WHEELCHAIRS OR POWER OPERATED VEHICLES

Motorized wheelchairs or power operated vehicles, such as scooters for mobility outside of the home setting, except as specified on the Schedule of Benefits. Coverage for these devices to assist with mobility in the home setting is subject to the establishment of Medical Necessity by the Corporation.

NOT MEDICALLY NECESSARY SERVICES OR SUPPLIES

Any service or supply that is not Medically Necessary. However, if a service is determined to be not Medically Necessary because it was not rendered in the least costly setting, Benefits will be paid in an amount equal to the amount payable had the service been rendered in the least costly setting.

OBESITY RELATED PROCEDURES

1. Services, supplies, treatment or medication for the management of obesity or weight reduction, except as specified on the Schedule of Benefits.

2. Also, the treatment or correction of complications from obesity-related treatment, except as specified on the Schedule of Benefits. This includes the reversal of obesity-related treatments and reconstructive procedures necessitated by weight loss.

3. Membership fees to weight control programs, except as specified on the Schedule of Benefits.

ORTHOGNATHIC SURGERY

Any service related to the treatment of malpositions or deformities of the jaw bone(s), dysfunction of the muscles of mastication or orthognathic deformities, regardless of cause, except as specified on the Schedule of Benefits.

OUTPATIENT SERVICES THAT ARE NOT PREAUTHORIZED

If Preauthorization is not received for an otherwise Covered Expense related to an outpatient service, Benefits may be reduced as set forth on the Schedule of Benefits.

OVER-THE-COUNTER DRUGS

Drugs that are available on an over-the-counter basis or are otherwise available without a prescription, except for Over-the-Counter Drugs that are designated as Prescription Drugs by the Corporation, listed as covered on the PDL accordingly and are prescribed by a Provider.

PAIN MANAGEMENT

Services, supplies or charges for any kind of pain management, including but not limited to, wellness or alternative treatment programs, acupuncture, massage therapy, hypnotism and Transcutaneous Electrical Nerve Stimulation (TENS) unit therapy. The Corporation may, in its discretion under certain limited circumstances, approve services for a multi-disciplinary pain management program, as defined herein. A multi-disciplinary pain management program is a program that includes physicians of different specialties and non-physician Providers, who specialize in the assessment and management of patients with a range of painful diagnoses and chronic pain, the purpose of which is intended to provide the interventions needed to allow the patients to develop pain coping skills and discontinue analgesic medication. Services, supplies or charges for a multi-disciplinary pain management program must be Preauthorized in advance. Preauthorization approval shall be on a case by case basis, in the discretion of the Corporation, and contingent upon such program, and the Providers offering such program, complying with the Corporation's Provider credentialing and medical policy requirements, which may change from time to time based on new evidence-based medical information available to the Corporation. The Member is solely responsible for seeking Preauthorization in advance, regardless of the state of location of the Provider offering the multi-disciplinary pain management program.

PARTICIPATING PROVIDER CHARGES NOT PREAUTHORIZED

For any service that requires Preauthorization, the penalty for not obtaining Preauthorization will vary from state to state, depending on the contractual agreements the BCBSA licensee has with its local Providers in that state. Generally, this is a penalty to the Provider, but in some cases, the Member may be held liable.

PHYSICAL THERAPY ADMISSIONS

All Admissions solely for physical therapy, except as provided in Article III.

PRECONCEPTION SERVICES

Preconception testing, preconception counseling, or preconception genetic testing, except as specified on the Schedule of Benefits or if otherwise covered as a preventive service.

PREOPERATIVE ANESTHESIA CONSULTATION

Charges for preoperative anesthesia consultation.

PRESCRIPTION DRUG COPAY CARD

Prescription Drugs, as determined by the Corporation, for which the costs and associated services are in any way paid for, through or under a pharmaceutical manufacturer or other discount card or coupon program on behalf of the Member.

PRIVATE DUTY NURSING

PDN services, except as specified on the Schedule of Benefits.

PROSTHETIC DEVICES

Repair or replacement for routine wear and tear is not a covered Benefit, except as specified on the Schedule of Benefits.

PROVIDER CHARGES

Charges by a Provider for blood and blood derivatives and for charges for Prescription Drugs or Specialty Drugs that are not consumed at the Provider's office.

PSYCHOLOGICAL AND EDUCATIONAL TESTING

Psychological or educational diagnostic testing to determine job or occupational placement, school placement or for other educational purposes or to determine if a learning disability exists.

PULMONARY REHABILITATION

Pulmonary rehabilitation, except in conjunction with a covered lung transplant, and except as specified on the Schedule of Benefits.

RADIOLOGY MANAGEMENT

All charges for radiation oncology services, MRIs, MRAs, CAT scans or PET scans and musculoskeletal care in an office or outpatient facility when the required Preauthorization is not obtained.

REPATRIATION

Services and supplies received as the result of transporting a Member, regardless of cause, from a foreign country for the convenience of the Member or to the Member's residence in the United States.

RETAIL PRESCRIPTION DRUG EXCLUSIONS

Charges for:

1. Prescription Drugs that are specifically listed on the website as excluded;

2. Prescription Drugs that have not been prescribed by a Provider acting within the scope of his or her license;

3. Prescription Drugs for non-covered therapies, services, devices or conditions;

4. Prescription Drug refills in excess of the number specified on the Provider's prescription order or Prescription Drug refills dispensed more than one (1) year after the original prescription date;

5. Any type of service or handling fee for Prescription Drugs;

6. Dosages that exceed the recommended daily dosage of any Prescription Drug based on the following guidelines as described in the current:

    a. United States Pharmacopeia (USP);

    b. Facts and Comparisons; and/or,

    c. Physicians' Desk Reference.

7. Prescription Drugs used for or related to cosmetic purposes (including hair growth, and skin wrinkles), obesity or weight control, contraceptives, tobacco cessation, travel vaccinations, infertility (including but not limited to fertility drugs) or impotence (except when prescribed for benign prostatic hypertrophy), except as specified on the Schedule of Benefits;

8. Over-the-Counter Drugs and over-the-counter supplies or supplements, except for Over-the-Counter Drugs that are designated by the Corporation as Prescription Drugs and are listed as covered on the PDL and are prescribed by a Provider;

9. Prescription Drugs that are being prescribed for a specific medical condition that are not approved by the FDA for treatment of that condition, except for:

    a. Prescription Drugs for a specific medical condition that have at least two (2) formal clinical studies; or,

    b. Prescription Drugs for the treatment of a specific type of cancer, provided the drug is recognized for treatment of that specific cancer in at least one (1) standard, universally accepted reference compendia or is found to be safe and effective in formal clinical studies, the results of which have been published in peer reviewed professional medical journals.

10. Prescription Drugs that are not consistent with the diagnosis and treatment of a Member's illness, injury or condition, are excessive in terms of the scope, duration, dosage or intensity of drug therapy that is needed to provide safe, adequate and appropriate care or are not provided in compliance with any applicable place of service requirements;

11. Prescription Drugs or services administered or dispensed when the required Preauthorization is not obtained;

12. Prescription Drugs for injury or disease that are paid by worker's compensation benefits (if a worker's compensation claim is settled, it will be considered paid by worker's compensation benefits);

13. Prescription Drugs which are part of a Utilization Management program and do not meet the requirements of such program;

14. Prescription Drugs which are new to the market and which are under clinical review by the Corporation shall be listed on the PDL as excluded until the clinical review has been completed and a final determination has been made as to whether the drug should be covered;

15. Prescription Drugs, regardless of therapeutic class, that are determined to offer no clinical or cost effective advantage over other comparable Prescription Drugs already covered under the PDL; and,

16. Non-prescription mineral supplements, non-prescription vitamins, food supplements or replacements, orthomolecular therapy, including infant formula, nutrients, nutritional or dietary supplements, formulas or special foods of any kind, except for prescription prenatal vitamins or prescription vitamin B-12 injections for anemias, neuropathies or dementias secondary to a vitamin B-12 deficiency. Enteral feedings available on an over-the-counter basis, except as specified on the Schedule of Benefits.

SELF-INFLICTED INJURY

Services and supplies received as the result of any intentionally self-inflicted injury that does not result from a medical condition or domestic violence.

SERVICES FOR CERTAIN DIAGNOSES OR DISORDERS

Medical Supplies, services or charges for the diagnosis or treatment of learning disabilities, perceptual disorders, intellectual disabilities, vocational rehabilitation, animal assisted therapy, behavioral therapy for solitary maladaptive habits or rapid opiate detoxification, except as specified on the Schedule of Benefits.

SERVICES FOR COUNSELING OR PSYCHOTHERAPY

Counseling and psychotherapy services for the following conditions are not covered:

1. Feeding and eating disorders in early childhood and infancy;

2. Tic disorders, except when related to Tourette's disorder;

3. Mental disorders due to a general medical condition;

4. Sexual function disorders;

5. Medication induced movement disorders; or,

6. Nicotine dependence, except as specified on the Schedule of Benefits.

SERVICES NOT LISTED AS COVERED BENEFITS

Medical Supplies or services or other items not specifically listed as a Benefit in Article III of this Plan of Benefits or on the Schedule of Benefits.

SERVICES PRIOR TO MEMBER EFFECTIVE DATE OR PLAN OF BENEFITS EFFECTIVE DATE

Any charges for Medical Supplies or services rendered to the Member prior to the Member's Effective Date, the Employer's Effective Date or after the Member's coverage terminates, except as provided in Articles VI and X.

SERVICES RENDERED BY AN INDEPENDENT HEALTHCARE PROFESSIONAL

Charges for services or supplies from an independent healthcare professional whose services are normally included in facility charges.

SERVICES RENDERED BY FAMILY

Any Medical Supplies or services rendered by a Member to him or herself or rendered by a Member's immediate family (parent, Child, Spouse, brother, sister, grandparent or in-law).

SEX CHANGE

Any Medical Supplies, services or charges incurred for surgery or any procedures related to changing a Member's sex.

TELEMONITORING

Services where a Member transmits, whether by facsimile, email, telephone or any other format, his or her specific health data (e.g. blood pressure, weight, etc.) to a Provider.

TEMPOROMANDIBULAR JOINT (TMJ) DISORDER

Any service for the treatment of dysfunctions or derangements of the temporomandibular joint, regardless of cause. This exclusion also applies to orthognathic surgery for the treatment of dysfunctions or derangements of the temporomandibular joint, regardless of cause, except as specified on the Schedule of Benefits.

TOBACCO CESSATION TREATMENT

Medical Supplies, services or Prescription Drugs for the treatment of tobacco cessation, except as specified on the Schedule of Benefits.

TRAVEL

Travel, whether or not recommended by a Provider, unless directly related to human organ or tissue transplants when Preauthorized by the Corporation, except as specified on the Schedule of Benefits.

VISION CARE

Any Medical Supply or service rendered to a Member for vision care, except as specified on the Schedule of Benefits.

WORKERS' COMPENSATION

This Plan of Benefits does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained or alleged by a Member that arises out of, in connection with, or as the result of any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the Member.

If the Corporation pays Benefits for an injury or illness and the Corporation determines the Member also received Workers' Compensation benefits by means of a settlement, judgment or other payment for the same injury or illness, the Corporation shall have the right of recovery as outlined in Article IX of this Plan of Benefits.

ARTICLE V - COORDINATION OF BENEFITS

A. APPLICABILITY

Coordination of benefits is designed to avoid the duplication of payments for Benefits. Coordination of benefits under this Article V applies when a Member has health care coverage under one (1) or more Plans that contain a coordination of benefits provision (or are required by law to contain a coordination of benefits provision), excluding individual Plans. Special rules for the Coordination of Benefits with Medicare may also apply.

B. COORDINATION OF BENEFITS WITH AUTO INSURANCE

If the Member resides in a state where automobile no-fault, personal injury protection or medical payments coverage is mandatory or if the Member is involved in an accident in a state where such coverage is mandatory and the Member's automobile insurance carrier provides the state mandated coverage, the Member's automobile coverage is primary and this Plan of Benefits secondary.

C. ORDER OF DETERMINATION RULES FOR EMPLOYEE MEMBERS

When a Member's claim is submitted under both this Plan of Benefits and another Plan, this Plan of Benefits is a Secondary Plan and the availability of Benefits is determined after benefits are determined under the other Plan unless:

1. The other Plan has rules coordinating its benefits with those of this Plan of Benefits;

2. There is a statutory requirement relating to the determination of benefits that is not pre-empted by ERISA; or,

3. Both the other Plan's rules and this Plan of Benefits rules require that Benefits under this Plan of Benefits be determined before those of the other Plan.

D. ADDITIONAL ORDER OF DETERMINATION RULES

The coordination of benefits is determined using the first of the following rules that apply:

1. Dependents.

   The Plan that covers an individual as an Employee or retiree is the Primary Plan.

2. Dependent Child - Parents not Separated or Divorced.

   When this Plan of Benefits and another Plan cover the same Child as a Dependent then benefits are determined in the following order:

   a. The Plan of the parent whose birthday falls earlier in the year (month and date) is the Primary Plan.

b. If both parents have the same birthday, the Plan that has covered a parent longer is the Primary Plan.

c. If the other Plan does not have the rule described in (a) above but instead has a rule based upon the gender of the parent and if, as a result, the Plan and the Corporation do not agree on the order of benefits, the gender rule in the other Plan will apply.

The “birthday rule” does not use the years of the parents’ birth in determining which has the earlier birthday.

3. Dependent Child - Separated or Divorced Parents.

If two (2) or more Plans cover a person as a Dependent Child of divorced, separated or unmarried parents, benefits for the Child are determined in the following order:

a. First, the Plan of the parent with custody of the Child;

b. Second, the Plan of the Spouse of the parent with the custody of the Child;

c. Third, the Plan of the parent not having custody of the Child; or,

d. Fourth, the Plan of the Spouse of the parent not having custody of the Child.

Notwithstanding the foregoing, if the specific terms of a court decree state that one of the parents is responsible for the healthcare expenses of the Child and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any claim determination period or Plan year during which any Benefits are actually paid or provided before the Plan has actual knowledge of the existence of an applicable court decree. Once the Dependent Child reaches the age of eighteen (18) and/or the terms of the court decree are no longer applicable, the Plan which has covered the Dependent for a longer period of time will be primary.

If the specific terms of a court decree state that the parents shall share joint custody without stating that one of the parents is responsible for the healthcare expenses of the Child, the Plans covering the Child shall follow the order of determination rules outlined in Article V (D)(2).

4. Active and Inactive Employees.

The benefits of the Plan that covers a person as an Employee who is neither laid off nor retired, or as that Employee's Dependent, are determined before those of a Plan that covers that person as a laid off or retired Employee or as that Employee's Dependent. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of Covered Expenses, this rule does not apply.

5. Medicare.

This Plan of Benefits is a Primary Plan except where federal law mandates that this Plan of Benefits is the Secondary Plan. Any claims where Medicare is primary must be filed by the Member after Medicare payment is made.

6. Longer and Shorter Length of Coverage.

   If none of the above rules determines the order of benefits, the Plan that has covered the Member longer is the Primary Plan.

7. COBRA.

   COBRA allows coverage to begin or continue under certain circumstances if the Member already has or obtains coverage under a Group Health Plan. In these instances, two policies may cover the Member, and the Plan providing COBRA coverage will be the Secondary Plan.

E. EFFECT ON BENEFITS OF THIS PLAN OF BENEFITS

1. This Plan of Benefits as Primary Plan

   When this Plan of Benefits is the Primary Plan, the Benefits shall be determined without consideration of the benefits of any other Plan.

2. This Plan of Benefits as Secondary Plan

   When this Plan of Benefits is a Secondary Plan, the Benefits will be reduced when the sum of the following exceeds the Covered Expenses in a Benefit Year:

   a. The Covered Expenses in the absence of this coordination of benefits provision; plus

   b. The expenses that would be payable under the other Plan, in the absence of provisions with a purpose like that of this coordination of benefits provision, whether or not a claim is made.

   When the sum of these two (2) amounts exceeds the maximum amount payable for Covered Expenses in a Benefit Year, the Covered Expenses will be reduced so that they and the benefits payable under the Primary Plan do not total more than the Covered Expenses. When the Covered Expenses of this Plan of Benefits are reduced in this manner, each Benefit is reduced in proportion and then charged against any applicable limit of this Plan of Benefits.

3. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered for purposes of determining the appropriate level of coverage available.

4. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not a Covered Expense unless the Member's Admission in a private Hospital room is Medically Necessary. When benefits are reduced under a Primary Plan because a Member does not comply with the Primary Plan's requirements, the amount of such reduction in benefits will not be a Covered Expense.

F. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

The Corporation is entitled to such information as it deems reasonably necessary to apply these coordination of benefit provisions, and the Member and the Employer must provide any such information as reasonably requested.

G. PAYMENT

A payment made under another Plan may include an amount that should have been paid under this Plan of Benefits. In such a case, the Corporation may pay that amount to the organization that made such payment. That amount will then be treated as though it has been paid under this Plan of Benefits. The term "payment" includes providing Benefits in the form of services, in which case "payment" means the reasonable cash value of the Benefits provided in the form of services.

H. RIGHT OF RECOVERY

If the amount of the payments made by the Corporation is more than the Corporation should have paid, the Corporation may recover the excess or overpayment from the Member on whose behalf it has made payments, from a Provider, any group insurer, Plan or any other person or organization contractually obligated to such Member with respect to such overpayments.

ARTICLE VI – TERMINATION OF THIS PLAN OF BENEFITS

A. GENERALLY

TERMINATION OF EMPLOYEE'S COVERAGE AND ALL OF SUCH EMPLOYEE'S DEPENDENTS' COVERAGE WILL OCCUR ON THE EARLIEST OF THE FOLLOWING CONDITIONS:

1. The date this Plan of Benefits is terminated pursuant to Article VI(B)-(I);

2. The date an Employee retires unless this Plan of Benefits covers such individual as a retiree;

3. The date an Employee ceases to be eligible for coverage as set forth in Article II;

4. The date an Employee is no longer Actively at Work, except that an Employee may be considered Actively at Work during a disability leave of absence for a period not to exceed ninety (90) days from the date the Employee is no longer Actively at Work or, for a qualified Employee (as qualified under the Family and Medical Leave Act of 1993), during any leave taken pursuant to the Family and Medical Leave Act of 1993;

5. In addition to terminating when an Employee's coverage terminates, a Dependent Spouse's coverage terminates on the date of entry of an order or decree ending the marriage between the Dependent Spouse and the Employee regardless of whether such order or decree is subject to appeal;

6. In addition to terminating when an Employee's coverage terminates, a Child's coverage terminates when that individual no longer meets the definition of a Child under this Plan of Benefits;

7. In addition to terminating when an Employee's coverage terminates, an Incapacitated Dependent's coverage terminates when that individual no longer meets the definition of an Incapacitated Dependent; or,

8. Upon the death of the Employee.

B. TERMINATION FOR FAILURE TO PAY PREMIUMS

1. If the Premium remains unpaid after the Grace Period, this Plan of Benefits shall automatically terminate, without prior notice to the Employer, or to any Member, immediately after the last day of the Grace Period.

2. If a subgroup fails to pay the Premium after the Grace Period, this Plan of Benefits for that subgroup shall automatically terminate for nonpayment of Premium, without any prior notice to the Employer or Members, immediately after the last day of the Grace Period. Additionally, the Corporation retains the right to terminate this Plan of Benefits for the entire group in the event a subgroup fails to pay their portion of the Premium.

3. During the Grace Period, the Corporation will pay Covered Expenses for Benefits (including Prescription Drugs) obtained by Members during the Grace Period.

4. In the event of termination for failure to pay Premiums, Premiums received by the Corporation after the Grace Period will not automatically reinstate this Plan of Benefits absent written agreement by the Corporation. The Corporation will refund the amount of any late Premium paid if this Plan of Benefits is not reinstated, except that portion relating to coverage provided prior to or during the Grace Period.

C. TERMINATION WHILE ON LEAVE

During an Employee's leave of absence that is taken pursuant to the Family and Medical Leave Act, the Employer must maintain the same health Benefits as provided to Employees not on leave. The Employee must continue to pay his or her portion of the Premium, and the Employer will continue to pay the same Premium the Employer would have paid had the Employee been Actively at Work. If Premiums are not paid by an Employee within thirty-one (31) days of the Premium due date, coverage ends as of the due date of that Premium contribution.

D. TERMINATION FOR LACK OF MEMBERSHIP

If there is no longer any Member who lives, resides or works in South Carolina or in an area for which the Corporation is authorized to do business, the Corporation may terminate this Plan of Benefits and coverage will terminate on the date given by the Corporation in written notice to the Employer.

E. UNIFORM TERMINATION OF COVERAGE

1. The Corporation may terminate coverage under this Plan of Benefits if:

   a. The Corporation ceases to offer coverage of the type of group health insurance coverage provided by this Plan of Benefits and provides notice to the Employer and Members at least ninety (90) days prior to the date of the discontinuation of such coverage;

   b. The Corporation offers to each Employer provided coverage of this type in such market the option to purchase any other group health insurance currently being offered by the Corporation to a group health plan in such market; and,

   c. The Corporation acts uniformly without regard to the claims experience of the Employer or any Health Status-Related Factor relating to any Members, Employees or Dependents who may become eligible for such coverage.

2. If the Corporation elects to discontinue offering all group health insurance coverage in South Carolina, coverage under this Plan of Benefits may be discontinued by the Corporation only:

   a. In accordance with applicable state law;

   b. If the Corporation provides notice to the Department of Insurance (DOI) and to the affected Employer and Members of such discontinuation at least one hundred eighty (180) days prior to the date of the discontinuation of such coverage;

   c. If all group health insurance coverage issued or delivered for issuance in South Carolina is discontinued and coverage under such health benefit coverage in such market is not renewed; and,

   d. If the Corporation will not issue any group health insurance coverage in the market during the five (5) year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

F. NOTICE OF TERMINATION TO MEMBERS

Other than as expressly required by law, if this Plan of Benefits is terminated for any reason, the Employer is solely responsible for notifying all Members of such termination and notifying Members that coverage of Members under this Plan of Benefits will not continue beyond the termination date. The Employer agrees to indemnify and hold the Corporation harmless for all damages, claims, causes of action, penalties, fines, charges, costs and expenses (including a reasonable attorney's fee) arising out of or relating to the Employer's failure to notify Members of termination of this Plan of Benefits.

G. REINSTATEMENT

The Corporation in its discretion (and upon such terms and conditions as the Corporation may determine), may reinstate coverage under this Plan of Benefits that has been terminated for any reason. If a Member's coverage (including coverage for the Member's Dependents) for Covered Expenses under this Plan of Benefits terminates while the Member is on leave pursuant to the Family and Medical Leave Act because the Member fails to pay such Member's portion of the Premium within the Grace Period, the Member's coverage will be reinstated without new Probationary Periods if the Member returns to work immediately after the leave period, re-enrolls and within thirty-one (31) days following such return pays all such Employee's portion of the past due amount and then current Premium.

H. EXTENSION OF BENEFITS FOLLOWING TERMINATION

If this Plan of Benefits is terminated under this Article VI(H), or a Member participating in this Plan of Benefits is terminated, all rights to receive Covered Expenses for Benefits provided on or after the date of termination will automatically cease, except that a Member admitted to a Hospital or Skilled Nursing Facility or Totally Disabled on the date of such termination will be entitled to Covered Expenses for each day of that Admission or Total Disability, but will be limited to Benefits (including Prescription Drugs) directly related to the illness or injury causing the confinement or the Total Disability and will continue until the earlier of:

1. The date of recovery of the Member from the Total Disability;

2. A period of three hundred sixty-five (365) days from the date of termination of this coverage,

3. The date on which the Covered Expenses to which the Member is entitled are exhausted; or,

4. The date the Member has full coverage for the disabling condition under another group health plan with benefits that are similar to the Benefits and such group health plan makes a reasonable provision for continuity of care for the disabling condition.

I. EMPLOYER IS AGENT OF MEMBERS

By accepting Benefits, a Member agrees that the Employer is the Member's agent for all purposes of any notice under this Plan of Benefits. The Member further agrees that notifications received from, or given to, the Employer by the Corporation are notification to the Employees except for any notice required by state or federal law to be given to the Members by the Corporation.

ARTICLE VII – CONVERSION AND CONTINUATION OF COVERAGE

A. CONVERSION FOR DIVORCED SPOUSES

Upon the entry of a valid order or decree of divorce between an Employee and such Employee's Dependent Spouse, the divorced Spouse shall be entitled (upon request) to a conversion policy, without evidence of insurability, upon submission of an application of insurance made to the Corporation within sixty (60) days following the divorce decree and upon payment of the appropriate Premium. Any Probationary Periods set forth in the conversion policy that had previously been met under this Plan of Benefits shall be considered as being met to the extent that such Probationary Periods were met under this Plan of Benefits.

B. CONTINUATION

1. State Law

   In addition to any extension of Benefits or conversion rights a Member may have, each Member has the right, upon request, to continue such Member's coverage under this Plan of Benefits for that portion of the month remaining at termination plus six (6) additional months. The Member must make payment of the appropriate Premium (including any Employer portion) to the Employer in advance for such coverage. To be eligible for such coverage, the Member must have been continuously covered under the Employer's Group Health Plan for at least six (6) months and have been terminated for a reason other than non-payment of Premium. If a Member is entitled to coverage under COBRA for a greater period of time, to Medicare benefits or for other group health coverage, such Member is not entitled to continuation coverage under this section. This Plan of Benefits or a successor Plan must remain in force, and the Member must pay the applicable Premium in advance for the Member to receive this continuation coverage.

2. COBRA

   a. Plan Administrator and Sponsor.

      The Employer is both the Plan Administrator and Plan Sponsor for this Plan of Benefits. The Employer agrees to offer continuation of coverage pursuant to the provisions of COBRA, if required, to eligible Members while this Plan of Benefits is in force. COBRA requires the Employer to allow eligible individuals to continue their health coverage for eighteen (18), twenty-nine (29) or thirty-six (36) months, depending on the Qualifying Event.

b. Disabled Members.

To be eligible for up to twenty-nine (29) months of continuation of coverage due to disability, an Employee or Dependent who:

i. is determined to be disabled under Title II or XVI of the Social Security Act;

ii. with a disability onset date either before the COBRA event or within the first sixty (60) days of the COBRA continuation coverage must provide a copy of the notice of the determination of disability to the Employer within:

aa. sixty (60) days of the determination of disability; and,

bb. before the end of the first eighteen (18) months of COBRA coverage.

Such Employee or Dependent must also notify the Employer within thirty (30) days of any determination that the Employee or Dependent is no longer disabled.

c. Notice of Qualifying Event by the Member.

Each Member is responsible for notifying the Employer within sixty (60) days of such Member's Qualifying Event due to divorce, legal separation or when a Dependent ceases dependency. If the Member does not give such notice, the Member is not entitled to continuation coverage.

d. Notice by the Employer to the Member.

The Employer must notify the COBRA Administrator no later than thirty (30) days after the date the Member loses coverage due to a COBRA event. The COBRA Administrator must send a COBRA Election Notice to each Member no later than fourteen (14) days after receipt of the notice from the Employer. Notice to the Dependent Spouse is deemed notice to any Dependent of the Spouse.

e. Election of Coverage.

Continuation coverage is not automatic. The Member must elect continuation coverage within sixty (60) days of the later of:

i. The date the Member's coverage under this Plan of Benefits ceases because of the Qualifying Event;

ii. The date the Member is sent notice of the right to elect continuation coverage by the Employer; or,

iii. The date the Member becomes an "eligible individual" (as that term is used in the Trade Act of 2002) provided that such election is made not later than six (6) months after the Qualifying Event that gives rise to eligibility under the Trade Act of 2002 (TAA).

f. Premium Required.

The Member will be required to pay a Premium for the continuation coverage and shall have the option to make payment in monthly installments. The Member has forty-five (45) days from the date of election to pay the first Premium, which includes the period when coverage commenced, regardless of the date that the first Premium is due. Subsequent Premiums will be due monthly by the Premium due date. While a Grace Period is allowed, if Premiums are not paid by the end of the Grace Period, coverage will be canceled with no option for reinstatement.

The TAA created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of a percentage of the Premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll free at 866-628-4282. TTD/TTY callers may call toll free at 866-626-4282. More information about the TAA is also available at www.doleta.gov/tradeact/.

g. Length of COBRA Coverage.

The maximum period for continuation coverage for a Qualifying Event involving termination of employment or a reduction in hours is generally eighteen (18) months. An Employee or Dependent who is determined to be disabled under Title II or XVI of the Social Security Act before the COBRA event or within the first sixty (60) days of COBRA continuation coverage is entitled to twenty-nine (29) months of continuation coverage, but only if such Employee or Dependent has provided notice of the determination of disability within sixty (60) days after determination is issued and before the end of eighteen (18) months of coverage. If a second Qualifying Event occurs within this period of continuation coverage, the coverage for any affected Dependent who was a Member under this Plan of Benefits both at the time of the first and the second Qualifying Events may be extended up to thirty-six (36) months from the first Qualifying Event. For all other Qualifying Events, the maximum period of coverage is thirty-six (36) months. Below is a list of circumstances and the period of COBRA coverage for each circumstance.

i. Eighteen (18) months for Employees whose working hours are reduced, from full-time to part-time, for instance, and any Dependents who also lose coverage for this reason.

ii. Eighteen (18) months for Employees who voluntarily quit work and any Dependents who also lose coverage for this reason.

iii. Eighteen (18) months for Employees who are part of a layoff and any Dependents who also lose coverage for this reason.

iv. Eighteen (18) months for Employees who are fired, unless the firing is due to gross misconduct, and any Dependents who also lose coverage for this reason.

v. Twenty-nine (29) months for Employees and all covered Dependents who are determined to be disabled under the Social Security Act during the first sixty (60) days after termination of employment or reduction of hours of employment. Notice of the Social Security Disability determination must be given to the COBRA Administrator within sixty (60) days of the determination of disability and before the end of the first eighteen (18) months of continuation of coverage.

vi. Thirty-six (36) months for Employees' widows or widowers and their Dependent Children.

vii. Thirty-six (36) months for legally separated or divorced husbands or wives and their Dependent Children.

viii. Thirty-six (36) months for Dependent Children who lose coverage because they no longer meet the Plan's definition of a Dependent Child.

ix. Thirty-six (36) months for Dependents who are not eligible for Medicare when the Employee is eligible for Medicare and no longer has coverage with the Employer. This does not apply to any Employees or their Dependents if the Employee voluntarily quit work. See Article VII(B)(2)(g)(ii) of this section for coverage for Employees who voluntarily quit.

x. For Plans providing coverage for retired Employees and their Dependents, a special rule applies for such persons who would lose coverage due to the Employer filing for Title 11 Bankruptcy (loss of coverage includes a substantial reduction of coverage within a year before or after the bankruptcy filing). Upon occurrence of such an event, retired Employees and their eligible Dependents may continue their coverage under the Plan until the date of death of the retiree. If a retiree dies while on this special continued coverage, surviving Dependents may elect to continue coverage for up to thirty-six (36) additional months.

3. USERRA

a. In any case in which an Employee or any of such Employee's Dependents has coverage under this Plan of Benefits and such Employee is not Actively at Work by reason of active duty service in the uniformed services, the Employee may elect to continue coverage under this Plan of Benefits as provided in this Article VII(B)(3). The maximum period of coverage of the Employee and such Employee's Dependents under such an election shall be the lesser of:

i. The twenty-four (24) month period beginning on the date on which the Employee's absence from being Actively at Work by reason of active duty service in the uniformed services begins; or,

ii. The day after the date on which the Employee fails to apply for or return to a position of employment, as determined under USERRA.

The continuation of coverage period under USERRA will be counted toward any continuation of coverage period available under COBRA.

b. An Employee who elects to continue coverage under this section of this Plan of Benefits must pay one hundred and two percent (102%) such Employee's normal Premium. Except that, in the case of an Employee who performs service in the uniformed services for less than thirty-one (31) days, such Employee will pay the normal contribution for the thirty-one (31) days.

c. An Employee who is qualified for re-employment under the provisions of USERRA will be eligible for reinstatement of coverage under this Plan of Benefits upon re-employment. Except as otherwise provided in Article VII(B)(3)(d), upon re-employment and reinstatement of coverage no new exclusion or Probationary Period will be imposed in connection with the reinstatement of such coverage if an exclusion would normally have been imposed. This Article VII(B)(3)(c) applies to the Employee who is re-employed and to a Dependent who is eligible for coverage under this Plan of Benefits by reason of the reinstatement of the coverage of such Employee.

d. Article VII(B)(3)(c) shall not apply to the coverage of any illness or injury determined by the Secretary of Veteran's Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

C. QUALIFIED MEDICAL CHILD SUPPORT ORDER

This Plan of Benefits shall pay Covered Expenses in accordance with the applicable requirements of any Qualified Medical Child Support Order.

1. Procedural Requirements.

   a. Timely Notifications and Determinations.

      In the case of any Medical Child Support Order received by the Corporation:

      i. The Employer shall promptly notify the Employee and each Alternate Recipient of the receipt of the Medical Child Support Order and the Employer's procedures for determining whether Medical Child Support Orders are Qualified Medical Child Support Orders; and,

      ii. Within a reasonable period after receipt of such Qualified Medical Child Support Order, the Employer shall determine whether such order is a Qualified Medical Child Support Order and notify the Employee and each Alternate Recipient of such determination.

   b. Establishment of Procedures for Determining Qualified Status of Orders.

      The Employer shall establish reasonable procedures to determine whether Medical Child Support Orders are Qualified Medical Child Support Orders and to administer the provision of Covered Expenses under such qualified orders. The Employer's procedures:

      i. Shall be in writing;

      ii. Shall provide for the notification of each person specified in a Medical Child Support Order as eligible to receive Benefits under this Plan of Benefits (at the address included in the Medical Child Support Order) of the Employer's procedures promptly upon receipt by the Plan Administrator of the Medical Child Support Order; and,

      iii. Shall permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

   c. Actions Taken by Fiduciaries.

      If a fiduciary for this Plan of Benefits acts in accordance with these procedural requirements in treating a Medical Child Support Order as being (or not being) a Qualified Medical Child Support Order, then this Plan of Benefits obligation to the Member and each Alternate Recipient shall be discharged to the extent of any payment made pursuant to such act of the fiduciary.

2. Treatment of Alternate Recipients.

   a. Under ERISA.

      A person who is an Alternate Recipient under any Medical Child Support Order shall be considered a beneficiary under this Plan of Benefits for purposes of any provisions of ERISA, as amended, and shall be treated as a participant under the reporting and disclosure requirements of ERISA.

   b. Direct Provision of Benefits Provided to Alternate Recipients.

      Any payment for Covered Expenses made by the Corporation pursuant to a Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

   c. Plan Enrollment and Payroll Deductions.

      If an Employee remains covered under this Plan of Benefits but fails to enroll an Alternate Recipient under this Plan of Benefits after receiving notice of the Qualified Medical Child Support Order from the Employer, the Employer shall enroll the Alternate Recipient and deduct the additional Premium from the Employee's paycheck.

   d. Termination of Coverage.

      Except for any coverage continuation rights otherwise available under this Plan of Benefits, the coverage for the Alternate Recipient shall end on the earliest of:

      i. The date the Employee's coverage ends;

      ii. The date the Qualified Medical Child Support Order is no longer in effect;

      iii. The date the Employee obtains other comparable health coverage through another insurer or Plan to cover the Alternate Recipient; or,

      iv. The date the Employer eliminates family health coverage for all of its Employees.

ARTICLE VIII – SUBROGATION AND REIMBURSEMENT

A. SUBROGATION

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

B. REIMBURSEMENT

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

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

C. GENERAL PROVISIONS

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

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

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

As a condition of receiving Benefits, the Member must:

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

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

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

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

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

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

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

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

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

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

ARTICLE IX - WORKERS' COMPENSATION PROVISION

This Plan of Benefits does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained by a Member that arises out of, in connection with, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the Member.

Although treatment for work-related or alleged work-related injuries or illness is excluded under this Plan of Benefits, the Corporation may, in its discretion, agree to extend coverage to a Member for the injury or illness. In this instance, the Member agrees, as a condition of receiving Benefits, to reimburse the Corporation in full from any workers' compensation recovery as described herein.

As a condition of receiving Benefits, the Member must:

1. Immediately notify the Corporation of an injury or illness for which his or her Employer and/or Employers' Workers' Compensation carrier may be liable, legally responsible or otherwise makes a payment in connection with the injuries or illness;

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

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

4. Assert a claim or lawsuit against the Employer and/or Employer's Workers' Compensation carrier or any other insurance coverage to which the Member may be entitled;

5. Include the amount paid for Benefits as a part of the damages sought against his/her Employer and/or Employer's Workers' Compensation carrier or Second Injury Fund;

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

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

The Corporation has discretion to determine whether claims for Benefits submitted to the Corporation are related to the injuries or illness to the extent this provision applies. If the Corporation pays Benefits for an injury or illness and the Corporation determines the Member also received a recovery from the Employer and/or Employer's Workers' Compensation carrier by means of a settlement, judgment or other payment for the same injury or illness, the Member shall reimburse the Corporation from the recovery for all Benefits paid by the Corporation relating to the injury or illness. However, under no circumstances shall the Member's reimbursement to the Corporation exceed the amount of such recovery.

If the Member receives a recovery from the Employer and/or Employer's Workers' Compensation carrier, the Corporation's right of reimbursement from the recovery will be applied even if: liability is denied, disputed or is made by means of a compromised, doubtful and disputed, clincher or other settlement; no final determination is made that the injury or illness was sustained in the course of or resulted from the Member's employment; the amount of workers' compensation benefits due to medical or healthcare is not agreed upon or defined by the Member, Employer or the Workers' Compensation carrier; or the medical or healthcare benefits are specifically excluded from the settlement or compromise.

ARTICLE X – ERISA RIGHTS

Each Member in this Plan of Benefits is entitled to certain rights and protections under ERISA. ERISA provides that all Members shall be entitled to:

A. RECEIVE INFORMATION ABOUT THE PLAN OF BENEFITS

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing this Plan of Benefits, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of this Plan of Benefits, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may assess a reasonable charge for the copies.

3. Receive, upon request, a summary of this Plan of Benefits' annual financial report. The Plan Administrator is required by law to furnish each Member with a copy of this summary annual report.

B. CONTINUATION COVERAGE

Members are entitled to continue healthcare coverage for themselves and their Dependents if there is a loss of coverage under this Plan of Benefits as a result of a Qualifying Event. The Member or Dependents may have to pay for such continuation coverage. Employee Members should review the documents governing COBRA continuation coverage rights.

C. PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Members, ERISA imposes duties upon the people who are responsible for the operation of an employee welfare benefit plan. The people who administer an employee welfare benefit plan are called "fiduciaries," and have a duty to do so prudently and in the interest of the Members. The Employer is a fiduciary of this Plan of Benefits.

D. ENFORCEMENT OF EMPLOYEE RIGHTS

1. If a Member's claim for a Benefit is denied or ignored, in whole or in part, such Member has a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

2. Under ERISA, there are steps a Member can take to enforce the rights described above. For instance, if a Member requests a copy of Group Health Plan documents or the latest annual report from the Group Health Plan and does not receive them within thirty (30) days, such Member may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay such Member up to $110 a day until such Member receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If a Member has a claim for Benefits that is denied or ignored, in whole or in part, such Member may file suit in a state or federal court. In addition, if a Member disagrees with the Group Health Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, such Member may file suit in federal court. If it should happen that the Group Health Plan fiduciaries misuse the Group Health Plan's money, or if a Member is discriminated against for asserting such Member's rights, such Member may seek assistance from the U.S. Department of Labor, or such Member may file suit in a federal court. The court will decide who should pay court costs and legal fees. If a Member is successful, the court may order the person the Member has sued to pay these costs and fees. If the Member loses, the court may order such Member to pay these costs and fees, for example, if it finds such Member's claim is frivolous.

3. No one, including the Employer, the Members' union or any other person, may fire an Employee or otherwise discriminate against an Employee in any way to prevent an Employee from obtaining a Benefit or exercising the Employee's rights under ERISA.

E. ASSISTANCE WITH QUESTIONS

If a Member has any questions about this Plan of Benefits, the Member should contact the Plan Administrator. If a Member has any questions about this statement or about a Member's rights under ERISA, or if a Member needs assistance in obtaining documents from the Plan Administrator, the Member should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. A Member may also obtain certain publications about the Member's rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ARTICLE XI - CLAIMS FILING AND APPEAL PROCEDURES

A. CLAIMS FILING PROCEDURES

1. When a Participating Provider renders services, generally, the Participating Provider should either file the claim on the Member's behalf or provide an electronic means for the Member to file a claim while the Member is in the Participating Provider's office. However, the Member is responsible for ensuring that the claim is filed.

2. Written notice of receipt of services on which a claim is based must be furnished to the Corporation, at its address on the Identification Card, within twenty (20) days of the beginning of services or as soon thereafter as is reasonably possible. Failure to give notice within the time does not invalidate nor reduce any claim if the Member can show that it was not reasonably possible to give the notice within the required time frame and if notice was given as soon as reasonably possible. Upon receipt of the notice, the Corporation will furnish or cause a claim form to be furnished to the Member. If the claim form is not furnished within fifteen (15) days after the Corporation receives the notice, the Member will be deemed to have complied with the requirements of this Plan of Benefits as to proof of loss. The Member must submit written proof covering the character and extent of the services within the time fixed for filing proof of loss.

3. For Benefits not provided by a Participating Provider, the Member is responsible for filing claims with the Corporation. When filing the claims, the Member will need the following:

    a. A claim form for each Member. Members can get claim forms from a Member services representative at the telephone number indicated on the Identification Card or via the Corporation's website, www.SouthCarolinaBlues.com.

    b. Itemized bills from the Provider(s). These bills should contain all the following:

        i. Provider's name and address;

        ii. Member's name and date of birth;

        iii. Member's Identification Card number;

        iv. Description and cost of each service;

        v. Date that each service took place; and,

        vi. Description of the illness or injury and diagnosis.

    c. Members must complete each claim form and attach the itemized bill(s) to it. If a Member has other insurance that already paid on the claim(s), the Member should also attach a copy of the other Plan's explanation of benefits notice.

    d. Members should make copies of all claim forms and itemized bills for the Member's records since they will not be returned. Claims should be mailed to the Corporation's address listed on the claim form.

4. The Corporation must receive the claim within ninety (90) days after the beginning of services. Failure to file the claim within the ninety (90) day period, however, will not prevent payment of Covered Expenses if the Member shows that it was not reasonably possible to file the claim timely, provided the claim is filed as soon as is reasonably possible. Except in the absence of legal capacity, claims must be filed no later than fifteen (15) months following the date services were received.

5. Receipt of a claim by the Corporation will be deemed written proof of loss and will serve as written authorization from the Member to the Corporation to obtain any medical or financial records and documents useful to the Corporation. The Corporation, however, is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at the time the claim was processed. Any party who submits medical or financial reports and documents to the Corporation in support of a Member's claim will be deemed to be acting as the agent of the Member. If the Member desires to appoint an Authorized Representative in connection with such Member's claims, the Member should contact the Corporation for an Authorized Representative form.

6. There are four (4) types of claims: Pre-Service Claims, Urgent Care Claims, Post-Service Claims and Concurrent Care claims. The Corporation will make a determination for each type of claim within the following time periods:

    a. Pre-Service Claim.

        i. A determination will be provided in writing or in electronic form within a reasonable period of time, appropriate to the medical circumstances, but no later than fifteen (15) days from receipt of the claim.

        ii. If a Pre-Service Claim is improperly filed or otherwise does not follow applicable procedures, the Member will be sent notification within five (5) days of receipt of the claim.

        iii. An extension of fifteen (15) days is permitted if the Corporation determines that, for reasons beyond the control of the Corporation, an extension is necessary. If an extension is necessary, the Corporation will notify the Member within the initial fifteen (15) day time period that an extension is necessary, the circumstances requiring the extension and the date the Corporation expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Member will have at least forty-five (45) days to provide the required information. If the Corporation does not receive the required information within the forty-five (45) day time period, the claim will be denied. The Corporation will make its determination within fifteen (15) days of receipt of the requested information or, if earlier, the deadline to submit the information. If the Corporation receives the requested information after the forty-five (45) days but within two hundred twenty-five (225) days, the claim will be reviewed as a first level appeal. Reference Article XI(B) for details regarding the appeals process.

    b. Urgent Care Claim.

        i. A determination will be sent to the Member in writing or in electronic form as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours from receipt of the claim.

        ii. If the Member's Urgent Care Claim is determined to be incomplete, the Member will be sent a notice to this effect within twenty-four (24) hours of receipt of the claim. The Member will then have forty-eight (48) hours to provide the additional information. Failure to provide the additional information within forty-eight (48) hours may result in the denial of the claim.

        iii. If the Member requests an extension of urgent care Benefits beyond an initially determined period and makes the request at least twenty-four (24) hours prior to the expiration of the original determination period, the Member will be notified within twenty-four (24) hours of receipt of the request for an extension.

    c. Post-Service Claim.

        i. A determination will be sent within a reasonable time period but no later than thirty (30) days from receipt of the claim.

ii. An extension of fifteen (15) days may be necessary if the Corporation determines that, for reasons beyond the control of the Corporation, an extension is necessary. If an extension is necessary, the Corporation will notify the Member within the initial thirty (30) day time period that an extension is necessary, the circumstances requiring the extension and the date the Corporation expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Member will have at least forty-five (45) days to provide the required information. If the Corporation does not receive the required information within the forty-five (45) day time period, the claim will be denied. The Corporation will make its determination within fifteen (15) days of receipt of the requested information or, if earlier, the deadline to submit the information. If the Corporation receives the requested information after the forty-five (45) days but within two hundred twenty-five (225) days, the claim will be reviewed as a first level appeal. Reference Article XI(B) for details regarding the appeals process.

d. Concurrent Care Claim.

The Member will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction or termination to allow the Member time to appeal the decision before the Benefits are reduced or terminated.

7. Notice of Determination.

a. If the Member's claim is filed properly and the claim is in part or wholly denied, the Member will receive notice of an Adverse Benefit Determination, in a culturally and linguistically appropriate manner, that will:

i. Include information sufficient to identify the claim involved (including date of service, healthcare Provider, claim amount (if applicable)) and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings;

ii. State the specific reason(s) for the Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the standard (if any) that was used in denying the claim;

iii. State that the Member is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Member's claim;

iv. Reference the specific Plan of Benefits provisions on which the determination is based;

v. Describe additional material or information, if any, needed to complete the claim and the reasons such material or information is necessary;

vi. Describe the claims review procedures and this Plan of Benefits and the time limits applicable to such procedures, including a statement of the Member's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review;

vii. If the reason for denial is based on a lack of Medical Necessity, Investigational or Experimental exclusion or similar limitation, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);

viii. Disclose any internal rule, guideline or protocol relied on in making the Adverse Benefit Determination (or state that such information will be provided free of charge upon request);

ix. Provide a description of available internal appeals and external review processes, including information regarding how to initiate such appeals;

x. Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under section 2793 of the Public Health Service Act, to assist individuals with the internal claims and appeals and external review processes; and,

xi. Include a statement regarding the Member's right to bring an action under section 502(a) of ERISA.

b. The Member will be provided, as soon as practicable upon request, the diagnosis and treatment codes and their corresponding meanings associated with the Adverse Benefit Determination.

c. No decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual will be made based upon the likelihood that the individual will support the denial of Benefits.

d. The Member will also receive a notice if the claim is approved.

B. APPEAL PROCEDURES FOR AN ADVERSE BENEFIT DETERMINATION

1. The Member has one hundred eighty (180) days from receipt of an Adverse Benefit Determination to file an appeal. An appeal must meet the following requirements:

   a. An appeal must be in writing;

   b. An appeal must be sent (via U.S. mail) to BlueCross BlueShield of South Carolina at the address on the Member's Identification Card;

   c. The appeal request must state that a formal appeal is being requested and include all pertinent information regarding the claim in question; and,

   d. An appeal must include the Member's name, address, identification number and any other information, documentation or materials that support the Member's appeal.

2. The Member may submit written comments, documents or other information in support of the appeal and will (upon request) have access to all documents relevant to the claim. A person other than the person who made the initial decision will conduct the appeal. No deference will be afforded to the initial determination.

3. The Member must raise all issues and grounds for appealing an Adverse Benefit Determination at every stage of the appeals process or such issues and grounds will be deemed permanently waived.

4. If the appealed claim involves an exercise of medical judgment, the Corporation will consult with an appropriately qualified healthcare practitioner with training and experience in the relevant field of medicine. If a healthcare professional was consulted for the initial determination, a different healthcare professional will be consulted on the appeal.

5. The Corporation will make a final decision on the appeal within the time periods specified below:

    a. Pre-Service Claim.

        The Corporation will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than thirty (30) days after receipt of the appeal.

    b. Urgent Care Claim.

        The Member may request an expedited appeal of an Urgent Care Claim. This expedited appeal request may be made orally, and the Corporation will communicate with the Member by telephone or facsimile. The Corporation will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than seventy-two (72) hours after receipt of the request for an expedited appeal.

    c. Post-Service Claim.

        The Corporation will decide the appeal within a reasonable period of time but no later than sixty (60) days after receipt of the appeal.

    d. Concurrent Care Claim.

        The Corporation will decide the appeal of Concurrent Care claims within the time frames set forth in Article XI(B)(4)(a-c) depending on whether such claim is also a Pre-Service Claim, an Urgent Care Claim or a Post-Service Claim.

6. Notice of Appeals Determination.

    a. If a Member's appeal is denied in whole or in part, the Member will receive notice of an Adverse Benefit Determination, in a culturally and linguistically appropriate manner, that will:

        i. Include information sufficient to identify the claim involved (including date of service, healthcare Provider, claim amount (if applicable)) and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings;

        ii. State specific reason(s) for the Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the standard (if any) that was used in denying the claim and a discussion of the decision;

        iii. Reference specific provision(s) of this Plan of Benefits on which the benefit determination is based;

        iv. State that the Member is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits;

        v. Describe any voluntary appeal procedures offered by the Corporation and the Member's right to obtain such information;

        vi. Disclose any internal rule, guideline or protocol relied on in making the Adverse Benefit Determination (or state that such information will be provided free of charge upon request);

vii. If the reason for an Adverse Benefit Determination on appeal is based on a lack of Medical Necessity, Investigational or Experimental or other limitation or exclusion, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);

viii. Provide a description of available internal appeals and external review processes, including information regarding how to initiate such appeals;

ix. Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under section 2793 of the Public Health Service Act, to assist individuals with the internal claims and appeals and external review processes; and,

x. Include a statement regarding the Member's right to bring an action under section 502(a) of ERISA.

b. The Member will also receive, free of charge, any new or additional evidence considered, relied upon or generated in connection with the claim. This evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Benefit Determination is received to give the Member a reasonable opportunity to respond prior to that date.

c. If the Adverse Benefit Determination is based on a new or additional rationale, then the Member will be provided with the rationale, free of charge. The rationale will be provided as soon as possible and sufficiently in advance of the date of the Adverse Benefit Determination to give the Member a reasonable opportunity to respond prior to that date.

d. The Member will be provided, as soon as practicable upon request, the diagnosis and treatment codes and their corresponding meanings associated with the Adverse Benefit Determination.

e. No decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual will be made based upon the likelihood that the individual will support the denial of Benefits.

f. A Member's claim and appeals will be decided pursuant to a good faith interpretation of the Plan of Benefits, in the best interest of the Member, without taking into account either the amount of the Benefits that will be paid to the Member or the financial impact on the Group Health Plan.

g. The Member will also receive a notice if the claim on appeal is approved.

C. EXTERNAL REVIEW PROCEDURES

1. After a Member has completed the appeal process, a Member may be entitled to an additional, external review of the Member's claim at the Corporation's expense. An external review may be used to reconsider the Member's claim if the Corporation has denied, either in whole or in part, the Member's claim. In order to qualify for external review, the claim must have been denied, reduced, or terminated because:

   a. It does not meet the requirements for Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness; or,

   b. It is an Investigational or Experimental service and it involves a life-threatening or seriously disabling condition.

2. After a Member has completed the appeal process (and an Adverse Benefit Determination has been made), such Member will be notified in writing of such Member's right to request an external review. The Member should file a request for external review within four (4) months of receiving the notice of the Corporation's decision on the Member's appeal. In order to receive an external review, the Member will be required to authorize the release of such Member's medical records (if needed in the review for the purpose of reaching a decision on Member's claim). If a Member needs assistance during the external review process, the Member may contact the South Carolina Department of Insurance (DOI) at the following address and telephone number:

   South Carolina Department of Insurance
   P.O. Box 100105
   Columbia, S.C. 29202-3105
   800-768-3467

3. Within five (5) business days of a Member's request for an external review, the Corporation will respond by either:

   a. Notifying the DOI of a request for external review and requesting the DOI assign the review to an independent review organization and then forward the Members records to the DOI; or,

   b. Notifying the Member in writing that the Member's request does not meet the requirements for an external review and the reasons for the Corporation's decision.

4. The external review organization will take action on the Member's request for an external review within forty-five (45) days after it receives the request for external review from the Corporation.

5. Expedited external reviews are available if the Member's Provider certifies that the Member has a Serious Medical Condition. A serious medical condition, as used in this Article XI(C)(5), means one that requires immediate medical attention to avoid serious impairment to body functions, serious harm to an organ or body part, or that would place the Member's health in serious jeopardy. If the Member may be held financially responsible for the treatment, a Member may request an expedited review of the Corporation's decision if the Corporation's denial of Benefits involves Emergency Services and the Member has not been discharged from the treating Hospital. The independent review organization must make its decision within seventy-two (72) hours after it receives the request for expedited review.

ARTICLE XII - GENERAL PROVISIONS

AMENDMENT

Upon thirty (30) days prior written notice, the Corporation may unilaterally amend this Plan of Benefits when required by federal or state law. Increases in the Benefits provided or decreases in the Premium are effective without such prior notice. Notice of an amendment will be effective when addressed to the Employer. The Corporation has no responsibility to provide individual notices to each Member when an amendment to this Plan of Benefits has been made.

AUTHORIZED REPRESENTATIVES

A Provider may be considered a Member's Authorized Representative without a specific designation by the Member when the Preauthorization request is for Urgent Care Claims. A Provider may be a Member's Authorized Representative with regard to non-Urgent Care Claims only when the Member gives the Corporation or the Provider a specific designation, in a format that is reasonably acceptable to the Corporation to act as an Authorized Representative. If the Member has designated an Authorized Representative, all information and notifications will be directed to that representative unless the Member gives contrary directions.

BLUECARD PROGRAM

I. Out-of-Area Services

Overview

The Corporation has a variety of relationships with other Blue Cross and/or Blue Shield Licensees, referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever Members access healthcare services outside the geographic area the Corporation serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the geographic area the Corporation serves, Members obtain care from healthcare Providers that have a contractual agreement ("Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from healthcare Providers in the Host Blue geographic area that do not have a contractual agreement ("Non-Participating Providers") with the Host Blue. The Corporation will remain responsible for fulfilling our contractual obligations to you. The Corporation's payment practices in both instances are described below.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits except when paid as medical claims/Benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party.

A. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Members access covered healthcare services within the geographic area served by a Host Blue, the Host Blue will be responsible for contracting and handling all interactions with its Participating Providers. The financial terms of the BlueCard Program are described generally below.

Liability Calculation Method Per Claim

Unless subject to a fixed dollar Copayment, the calculation of the Member liability on claims for covered healthcare services will be based on the lower of the Participating Provider's billed covered charges or the negotiated price made available to the Corporation by the Host Blue.

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's healthcare Provider contracts. The negotiated price made available to the Corporation by the Host Blue may be represented by one of the following:

(i) An actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases; or

(ii) An estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the Provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or

(iii) An average price. An average price is a percentage of billed covered charges in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare Providers or a similar classification of its Providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues determine whether or not they will use an actual, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over-or underestimation of past prices (i.e., prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid or anticipated to be paid to Providers or refunds received or anticipated to be received from Providers). However, the BlueCard Program requires that the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by the Corporation in determining your Premiums.

B. Special Cases: Value-Based Programs

BlueCard Program

The Corporation has included a factor for bulk distributions from Host Blues in the Employer's Premium for Value-Based Programs when applicable under this contract.

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

C. Return of Overpayments

Recoveries of overpayments/from a Host Blue or its Participating and Non-Participating Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits/healthcare Provider/hospital bill audits, credit balance audits, utilization review refunds and unsolicited refunds. Recoveries will be applied/ so that corrections will be made, in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to the Corporation, they will be credited to the Employer account. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be charged to the Employer as a percentage of the recovery.

D. Inter-Plan Programs: Taxes/Surcharges/Fees

In some instances laws or regulations may impose a surcharge, tax or other fee that applies to insured accounts. If applicable, the Corporation will include any such surcharge, tax or other fee in determining the Employer's Premium.

E. Non-Participating Providers Outside the Corporation's Service Area

1. Member Liability Calculation

When covered healthcare services are provided outside of the Corporation's service area by Non-Participating Providers, the amount(s) a Member pays for such services will generally be based on either the Host Blue's Non-Participating Provider local payment or the pricing arrangements required by applicable law. In these situations, the Member may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment the Corporation will make for the covered services as set forth in this paragraph. Payments for out-of-network emergency services are governed by applicable law.

2. Exceptions

In some exception cases, the Corporation may pay claims from Non-Participating Providers outside of the Corporation's service area based on the Provider's billed charge. This may occur in situations where a Member did not have reasonable access to a Participating Provider, as determined by the Corporation in the Corporation's sole and absolute discretion or by applicable law. In other exception cases, the Corporation may pay such claims based on the payment the Corporation would make if the Corporation were paying a Non-Participating Provider inside of the Corporation's service area. This may occur where the Host Blue's corresponding payment would be more than the Corporation's in-service area Non-Participating Provider payment. The Corporation may choose to negotiate a payment with such a Provider on an exception basis.

Unless otherwise stated, in any of these exception situations, the Member may be responsible for the difference between the amount that the Non-Participating Provider bills and payment the Corporation will make for the covered services as set forth in this paragraph.

F. Blue Cross Blue Shield Global® Core Program

- **General Information**

If Members are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard service area"), they may be able to take advantage of the Blue Cross Blue Shield Global Core Program when accessing covered healthcare services. The Blue Cross Blue Shield Global Core Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core Program assists Members with accessing a network of inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when Members receive care from Providers outside the BlueCard service area, the Members will typically have to pay the Providers and submit the claims themselves to obtain reimbursement for these services.

- **Inpatient Services**

In most cases, if Members contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require Members to pay for covered inpatient services, except for their cost-share amounts/Benefit Year Deductibles, Coinsurance, etc. In such cases, the hospital will submit Member claims to the Blue Cross Blue Shield Global Core Service Center to initiate claims processing. However, if the Member paid in full at the time of service, the Member must submit a claim to obtain reimbursement for covered healthcare services.

- **Outpatient Services**

Physicians, urgent care centers and other outpatient Providers located outside the BlueCard service area will typically require Members to pay in full at the time of service. Members must submit a claim to obtain reimbursement for covered healthcare services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**

  When Members pay for covered healthcare services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Members should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center address on the form to initiate claims processing. The claim form is available from the Corporation, the Blue Cross Blue Shield Global Core Service Center or online at www.bluecardworldwide.com. If Members need assistance with their claim submissions, they should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

CLERICAL ERRORS

Clerical errors by the Corporation will not cause a denial of Benefits that should otherwise have been granted, nor will clerical errors extend Benefits that should otherwise have ended.

CONTINUATION OF CARE

If a Participating Provider's contract ends or is not renewed for any reason other than suspension or revocation of the Provider's license and the Member is receiving treatment for a Serious Medical Condition, the Member may be eligible to continue to receive in-network Benefits for that Provider's services.

In order to receive this Continuation of Care for a Serious Medical Condition, the Member must submit a request to the Corporation on the appropriate form. The treating Provider should include a statement on the form confirming the Serious Medical Condition. Upon receipt of the request, the Corporation will notify the Member and the Provider of the last date the Provider is part of the network and a summary of Continuation of Care requirements. The Corporation will review the request to determine qualification for the Continuation of Care. If additional information is necessary to make a determination, the Corporation may contact the Member or the Provider for such information. If the Corporation approves the request, in-network Benefits for that Provider will be provided for ninety (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.

DISCLOSURE TO EMPLOYER

The Group Health Plan will disclose (or will require the Corporation to disclose) Member's PHI to the Employer only to permit the Employer to carry out Plan administration functions for the Employer's Group Health Plan not inconsistent with the requirements of HIPAA. Any disclosure to and use by the Employer will be subject to and consistent with the provisions of paragraphs A and B of this section.

A. Restrictions on Employer's Use and Disclosure of PHI.

1. The Employer will neither use nor further disclose Member's PHI, except as permitted or required by the Group Health Plan documents, as amended, or required by law.

2. The Employer will ensure that any agent, including any subcontractor, to whom it provides Member PHI agrees to the restrictions and conditions of this Plan of Benefits with respect to Member's PHI.

3. The Employer will not use or disclose Member PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer.

4. The Employer will report to the Group Health Plan any use or disclosure of Member PHI that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.

5. The Employer will make PHI available to the Member who is the subject of the information in accordance with HIPAA.

6. The Employer will make Member PHI available for amendment and will, on notice, amend Member PHI in accordance with HIPAA.

7. The Employer will track disclosures it may make of Member PHI so that it can make available the information required for the Group Health Plan to provide an accounting of disclosures in accordance with HIPAA.

8. The Employer will make its internal practices, books and records relating to its use and disclosure of Member PHI available to the Plan and to the U.S. Department of Health and Human Services to determine compliance with HIPAA.

9. The Employer will, if feasible, return or destroy all Member PHI, in whatever form or medium (including in any electronic medium under the Employer's custody or control), received from the Group Health Plan, including all copies of and any data or compilations derived from and allowing identification of any Member who is the subject of the PHI, when the Member's PHI is no longer needed for the Plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Member PHI, the Employer will limit the use or disclosure of any Member PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

10. The Employer will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that the Employer creates, receives, maintains or transmits on behalf of the Group Health Plan.

11. The Employer will ensure that any agent, including a subcontractor, to whom the Employer provides ePHI (that the Employer creates, receives, maintains or transmits on behalf of the Group Health Plan) agrees to implement reasonable and appropriate security measures to protect this information.

12. The Employer shall report any security incident of which it becomes aware to the Group Health Plan as provided below.

    a. In determining how and how often the Employer shall report security incidents to the Group Health Plan, both the Employer and the Group Health Plan agree that unsuccessful attempts at unauthorized access or system interference occur frequently and that there is no significant benefit for data security from requiring the documentation and reporting of such unsuccessful intrusion attempts. In addition, both parties agree that the cost of documenting and reporting such unsuccessful attempts as they occur outweigh any potential benefit gained from reporting them. Consequently, both the Employer and the Group Health Plan agree that this Contract shall constitute the documentation, notice and written report of any such unsuccessful attempts at unauthorized access or system interference as required above and by 45 C.F.R. Part 164, Subpart C and that no further notice or report of such attempts will be required. By way of example (and not limitation in any way), the parties consider the following to be illustrative (but not exhaustive) of unsuccessful security incidents when they do not result in unauthorized access, use, disclosure, modification or destruction of ePHI or interference with an information system:

        i. Pings on a party's firewall;

        ii. Port scans;

        iii. Attempts to log on to a system or enter a database with an invalid password or username;

        iv. Denial-of-service attacks that do not result in a server being taken offline; and,

        v. Malware (e.g., worms, viruses).

    b. The Employer shall, however, separately report to the Group Health Plan any successful unauthorized access, use, disclosure, modification or destruction of the Group Health Plan's ePHI of which the Employer becomes aware if such security incident (a) results in a breach of confidentiality; (b) results in a breach of integrity but only if such breach results in a significant, unauthorized alteration or destruction of the Group Health Plan's ePHI; or (c) results in a breach of availability of the Group Health Plan's ePHI, but only if said breach results in a significant interruption to normal business operations. Such reports will be provided in writing within ten (10) business days after the Employer becomes aware of the impact of such security incident upon the Group Health Plan's ePHI.

B. Adequate Separation Between the Employer and the Group Health Plan.

1. Only Employees or other workforce members under the control of the Employer ("Employees") who, in the normal course of their duties, assist in the administration of the Employer's Employee Benefits or the Group Health Plan or the Group Health Plan finances or other classes of Employees as designated in writing by the Employer, may be given access to Member PHI received from the Group Health Plan or a third party servicing the Group Health Plan.

2. These Employees will have access to Member PHI only to perform the Plan administration functions that the Employer provides for the Group Health Planor to assist Members.

3. These Employees will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Employer, for any use or disclosure of Member PHI in breach or violation of or noncompliance with the provisions of this section. The Employer will promptly report such breach, violation or noncompliance to the Group Health Plan and will cooperate with the Group Health Plan to correct the breach, violation or noncompliance to impose appropriate disciplinary action or sanctions on each Employee or other workforce member causing the breach, violation or noncompliance and to mitigate any deleterious effect of the breach, violation or noncompliance on any Member, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance.

4. The Employer will ensure that the separation required by the above provisions will be supported by reasonable and appropriate security measures.

The Employer certifies that the Group Health Plan contains the provisions outlined above.

GOVERNING LAW

This Plan of Benefits (including the Schedule of Benefits) is governed by and subject to applicable federal law. If and to the extent that federal law does not apply, this Plan of Benefits is governed by and subject to the laws of the State of South Carolina. If federal law conflicts with any state law, then such federal law shall govern. If any provision of this Plan of Benefits conflicts with such law, this Plan of Benefits shall automatically be amended solely as required to comply with such state or federal law, and the Corporation shall be entitled to adjust the Premium upon thirty-one (31) days written notice.

IDENTIFICATION CARD

A Member must present his or her Identification Card prior to receiving Benefits.

Identification Cards are for identification only. Having an Identification Card creates no right to Benefits or other services. To be entitled to Benefits, the cardholder must be a Member whose Premium has been paid. Any person receiving Covered Expenses to which the person is not entitled will be responsible for the charges.

INCONTESTABILITY

The validity of this Plan of Benefits may not be contested after it has been in force for two (2) years from its date of issue. No statement relating to insurability, except fraudulent misstatements, made by any Member may be used in contesting the validity of the coverage with respect to which the statement was made after the coverage has been in force for a period of two (2) years unless it is contained in a written instrument signed by the person making the statement. The provision does not preclude assertion at any time of defenses based upon the person’s ineligibility for coverage under the Plan of Benefits or upon other provision in the Plan of Benefits.

INFORMATION AND RECORDS

The Corporation is entitled to obtain records and other information as it may reasonably require from any Member or Provider incident to the treatment, payment and healthcare operations for the administration of the Benefits hereunder. This includes medical and Hospital records, the Provider's certification as to the Medical Necessity for care or treatment and/or any other requested documentation or information. Payment for Benefits may be denied until the requested records, documentation or information is received.

LEGAL ACTIONS

No Member may bring an action at law or in equity to recover on this Plan of Benefits until such Member has exhausted the appeal process as set forth in Article XI of this Plan of Benefits. No such action may be brought any later than six (6) years after the time written proof of loss is required to be furnished.

MEMBERSHIP APPLICATION

The Corporation will only accept a Membership Application submitted by the Employer on behalf of its Employees. The Corporation will not accept Membership Applications directly from Employees or Dependents.

NEGLIGENCE OR MALPRACTICE

The Corporation does not practice medicine. Any medical treatment, service or Medical Supplies rendered to or supplied to any Member by a Provider is rendered or supplied by such Provider and not by the Corporation. The Corporation is not liable for any improper or negligent act, inaction or act of malfeasance of any Provider in rendering such medical treatment, service, Medical Supply or medication.

NOTICES

Except as otherwise provided in this Plan of Benefits, any notice under this Plan of Benefits may be given by United States registered or certified mail, postage paid, return receipt requested or nationally recognized carrier and addressed:

1. To the Corporation:

   BlueCross BlueShield of South Carolina
   P.O. Box 100300
   Columbia, South Carolina 29202

2. To a Member: To the last known name and address listed for the Employee related to such Member on the Membership Application. Members are responsible for notifying the Corporation of any name or address changes within thirty-one (31) days of the change.

3. To the Employer: To the name and address last given to the Corporation. The Employer is responsible for notifying the Corporation of any name or address change within thirty-one (31) days of the change.

NO WAIVER OF THE CORPORATION'S RIGHTS

On occasion, the Corporation may, at its option, choose not to enforce all of the terms and conditions of this Plan of Benefits. Such a decision does not mean the Corporation waives or gives up any rights under this Plan of Benefits in the future.

OTHER INSURANCE

Each Member must provide the Corporation with information regarding all other health insurance coverage to which such Member is entitled.

PAYMENT OF CLAIMS

A Member is expressly prohibited from assigning any right to payment of or related to Benefits. The Corporation may pay all Benefits directly to the Member upon receipt of due proof of loss when a Non-Participating Provider renders services. When payment is made directly to the Member, the Member is responsible for any payment to the Provider. Where a Member has received Benefits from a Participating Provider, the Corporation will pay Benefits directly to such Participating Provider.

PHYSICAL EXAMINATION

The Corporation has the right to have examined, at its own expense, a Member whose injury or sickness is the basis of a claim (whether a Pre-Service Claim, Post-Service Claim, Concurrent Care claim or Urgent Care Claim). Such physical examination may be made as often as the Corporation may reasonably require while such claim for Benefits or request for Preauthorization is pending.

REPLACEMENT COVERAGE

If this Plan of Benefits replaced the Employer's prior Plan, all eligible persons who were validly covered under that Plan on its termination date will be covered on the Plan of Benefits Effective Date of this Plan of Benefits, provided such persons are enrolled for coverage as stated in Article II.

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Non-Discrimination Statement and Foreign Language Access

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

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

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

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

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

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

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

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

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

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

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

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

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

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

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

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

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

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ą́ąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíį́ bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)

AMENDMENT

Association Name: South Carolina Dental Association
Association Number: 26-87008, 26-87009, 26-87010, 26-87011, 26-87012, 26-87013, 26-87014, 26-87015, 26-87016, 26-87017, 26-87024 and appropriate subgroups
Effective Date: February 1, 2020
Amendment: 1

The Plan of Benefits between the Employer and the Corporation is amended as follows:

All references to "Employer's Group Health Plan" throughout the Plan of Benefits are replaced with the term "Group Health Plan".

All references to the term "Employer" are replaced with "Association" in the definitions entitled Benefits Checklist, Contract, Grace Period, Membership Application, Plan Administrator, Plan of Benefits, Plan Sponsor and Premium.

ARTICLE I - DEFINITIONS is amended by the addition of the following term:

Association: the professional association in which the Employer participates and which has established and sponsors the Group Health Plan.

The definition entitled **COBRA Administrator** in **Article I – DEFINITIONS** is deleted in its entirety.

The following definitions in **Article I – DEFINITIONS** are deleted in their entirety and the following substituted therefore:

Employee: any employee of the Employer who is eligible for coverage, as provided in Article II of this Plan of Benefits, and who is so designated to the Corporation by the Association.

Employer: the entity which has elected coverage through a written agreement with the Association.

Group Health Plan: the employee welfare benefit plan established, administered and/or sponsored by the Association to provide health Benefits to Employees and/or their Dependents directly or through insurance, reimbursement or otherwise.

Probationary Period: the period of continuous employment (if included on the Schedule of Benefits) with the Employer that an Employee must complete before becoming eligible to enroll in this Plan of Benefits. The Association may require an additional orientation period.

All references to the term "Employer" are replaced with "Association" in the following sections of the Plan of Benefits: Article II(C)(5), Article V(F), Article VI(D), Article VI(F), Article VI(I), Article X(C), the AMENDMENT section of Article XII, the DISCLOSURE TO ASSOCIATION section of Article XII with the exception of Section A(3) and the NOTICES section of Article XII.

Section C(1) in **Article II – ELIGIBILITY FOR COVERAGE** is deleted in its entirety and the following substituted therefore:

1. Employees and Dependents Eligible on the Employer's Effective Date.

   For Employees (and such Employee's Dependents for whom such Employee has elected coverage) who are Actively at Work prior to and on the Employer's Effective Date, coverage will generally commence on this Plan of Benefits Effective Date.

If the Corporation receives an Employee's Membership Application dated after the Employer's Effective Date, coverage will commence on the date chosen by the Association.

Section C(6)(c)(iii) in **Article II – ELIGIBILITY FOR COVERAGE** is deleted in its entirety and the following substituted therefore:

iii. Was one of multiple Plans offered by the Association and the Employee elected a different plan during an open enrollment period or when the Association terminates all similarly situated individuals;

The last paragraph in Section C(6) in **Article II – ELIGIBILITY FOR COVERAGE** is deleted in its entirety and the following substituted therefore:

The above list is not an all-inclusive list of situations when an Employee or Dependent loses eligibility. For situations other than those listed above, see the Association.

Section E in **Article II – ELIGIBILITY FOR COVERAGE** is deleted in its entirety and the following substituted therefore:

E. MEMBERSHIP APPLICATION

The Corporation will only accept a Membership Application submitted by the Association on behalf of each Employee. The Corporation will not accept a Membership Application directly from an Employer, Employee or Dependent.

Sections B(1) and B(2) in **Article VI – TERMINATION OF THIS PLAN OF BENEFITS** are deleted in their entirety and the following substituted therefore:

1. If the Premium remains unpaid after the Grace Period, this Plan of Benefits shall automatically terminate, without prior notice to the Association, Employer, or to any Member, immediately after the last day of the Grace Period.

2. If an Employer fails to pay its Premium after the Grace Period, this Plan of Benefits for that Employer shall terminate at the discretion of the Association for nonpayment of Premium, without any prior notice to the Employer or Members, immediately after the last day of the Grace Period. Additionally, the Corporation retains the right to terminate this Plan of Benefits for the Association, Employer and Members in the event the Association fails to pay any or all the Premium and such amount remains unpaid after the Grace Period.

Section E(1) in **Article VI – TERMINATION OF THIS PLAN OF BENEFITS** is deleted in its entirety and the following substituted therefore:

1. The Corporation may terminate coverage under this Plan of Benefits if:

    a. The Corporation ceases to offer coverage of the type of group health insurance coverage provided by this Plan of Benefits and provides notice to the Association and Members at least ninety (90) days prior to the date of the discontinuation of such coverage;

    b. The Corporation offers to the Association the option to purchase any other group health insurance currently being offered by the Corporation to a group health plan in such market; and,

    c. The Corporation acts uniformly without regard to the claims experience of the Association or any Health Status-Related Factor relating to any Members, Employees or Dependents who may become eligible for such coverage.

Section E(2)(b) in **Article VI – TERMINATION OF THIS PLAN OF BENEFITS** is deleted in its entirety and the following substituted therefore:

b. If the Corporation provides notice to the Department of Insurance (DOI) and to the Association and Members of such discontinuation at least one hundred eighty (180) days prior to the date of the discontinuation of such coverage;

Section B(2) in **Article VII – CONVERSION AND CONTINUATION OF COVERAGE** is deleted in its entirety.

Section C(1)(b) in **Article VII – CONVERSION AND CONTINUATION OF COVERAGE** is deleted in its entirety and the following substituted therefore:

b. Establishment of Procedures for Determining Qualified Status of Orders.

    The Employer shall establish reasonable procedures to determine whether Medical Child Support Orders are Qualified Medical Child Support Orders and to administer the provision of Covered Expenses under such qualified orders. The Employer's procedures:

    i. Shall be in writing;

    ii. Shall provide for the notification of each person specified in a Medical Child Support Order as eligible to receive Benefits under this Plan of Benefits (at the address included in the Medical Child Support Order) of the Employer's procedures promptly upon receipt by the Employer of the Medical Child Support Order; and,

    iii. Shall permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

Section B in **Article X – ERISA RIGHTS** is deleted in its entirety and the following substituted therefore:

B. CONTINUATION COVERAGE

Members are entitled to continue healthcare coverage for themselves and their Dependents if there is a loss of coverage under this Plan of Benefits as a result of a Qualifying Event. The Member or Dependents may have to pay for such continuation coverage. Employee Members should review any documents provided by the Employer or Association outlining COBRA continuation coverage rights.

Section D(3) in **Article X – ERISA RIGHTS** is deleted in its entirety and the following substituted therefore:

3. No one, including the Association, Employer, the Members' union or any other person, may fire an Employee or otherwise discriminate against an Employee in any way to prevent an Employee from obtaining a Benefit or exercising the Employee's rights under ERISA.

The section entitled **MEMBERSHIP APPLICATION** in **Article XII – GENERAL PROVISIONS** is deleted in its entirety and the following substituted therefore:

MEMBERSHIP APPLICATION

The Corporation will only accept a Membership Application submitted by the Association. The Corporation will not accept Membership Applications directly from an Employer, Employee or Dependent.

The section entitled **REPLACEMENT COVERAGE** in **Article XII – GENERAL PROVISIONS** is deleted in its entirety and the following substituted therefore:

REPLACEMENT COVERAGE

If this Plan of Benefits replaced the prior Plan, all eligible persons who were validly covered under that Plan on its termination date will be covered on the Plan of Benefits Effective Date of this Plan of Benefits, provided such persons are enrolled for coverage as stated in Article II.

THIS IS AN AMENDMENT TO YOUR PRESENT PLAN OF BENEFITS.

South Carolina

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