University of South Carolina



STUDENT HEALTH PLAN

Preferred Blue & Dental Coverage

August 1, 2026

PREFERRED BLUE® POLICY



South Carolina

Dear Member:

Blue Cross and Blue Shield of South Carolina (BlueCross) is pleased to provide your Preferred Blue® Policy. 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 Policy for all your health care coverage.

The Blue Cross and Blue Shield 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.

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

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

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 submit claim forms? Need to print an Explanation of Benefits (EOB)?***

You also can use such self-help tools as:

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

Shopping for Care 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 facilities and 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 Providers & Services tab, click Find 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
- View your healthcare spending account balances, if applicable
- View your Summaries of Benefits and Coverage (SBCs)
- Access health and wellness programs available to you through your plan, including mental and behavioral health support.

Scan the below QR code with your smartphone camera for quick access to our Member website.

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. The amount you have to pay may increase when you do not use the Student Health Center or 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 may have no protection from balance billing from the Provider, except where prohibited by applicable law.

HOW TO GET HELP

How to get help with claims or Benefit questions:

- 855-823-0319

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:

- 803-736-5990 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:

- 803-699-7308 from the Columbia, South Carolina area
- 800-868-1032 from all other areas

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.

Academic HealthPlans, Inc. (AHP) is an independent company that provides program management and administrative services for the student health plans on behalf of BlueCross BlueShield of South Carolina. For contact information or enrollment support:

University of South Carolina: sc.myahpcare.com or 1-855-844-3015

Medical University of South Carolina: musc.myahpcare.com or 1-855-850-4302

Clemson University: clemson.myahpcare.com or 1-855-856-2384

Coastal Carolina University: coastal.myahpcare.com or 1-855-306-9474

Winthrop University: winthrop.myahpcare.com or 1-855-824-9684

The Citadel: citadel.myahpcare.com or 1-855-850-4174

College of Charleston: cofcvol.myahpcare.com or 1-833-213-1083

Comprehensive Case Management:
The Corporation provides you with access to ***Comprehensive Case 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, however, is voluntary and at no cost to Members.

Connect Your Way:
Occasional communications from your Policy can help you stay healthy, save money and make the most of your Benefits. Just let us know the best way to reach you – through email, text or push notifications. We'll notify you when it's time for your annual checkup, for example, or if there's an update on a prior authorization request. Updating your contact preferences is easy. Simply log in to My Health Toolkit® from your computer, then on the Profile dropdown in the top navigation, select *Contact Preferences* to update your preferred contact method for each category. You may withdraw your consent to receive electronic communications and request paper copies of communication at any time. You can also update your preferences through the app by logging in and visiting the *My Profile* section.

Essential Advocate:
The Corporation provides you and your Dependents with access to ***Essential Advocate***, a program that includes access to a Care Coordinator and Registered Nurse, 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 with:

- Identifying and coordinating a range of wellness services.
- Using online tools for treatment options and cost estimates.
- Educating Members on health plan Benefits and how they work.
- Assistance in negotiating fees with healthcare Providers to lower the Members' out-of-pocket costs.
- Providing advice or assistance to Members when filing a complaint or grievance.
- Preparing Members and family members for medical appointments.
- Arranging transportation relating to medical needs.
- Navigating the BlueCross website, including cost estimator and quality tools.
- And much more.

Call 855-638-5839 to speak with a Care Coordinator, 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:

- Anxiety disorder
- 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

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)
- Stress Management
- Tobacco-free living
- Weight Management (adults and children)

To participate, call 855-838-5897.

My Diabetes Discount Program:
The Corporation provides you with access to the ***My Diabetes Discount Program***, a program which gives Members access to more affordable insulin to help manage their Type 1 or Type 2 diabetes. Members who meet the eligibility criteria will be automatically enrolled in the program. Eligible Members will receive communication welcoming them to the program as well as advising them of the ongoing requirements they must meet to remain enrolled in the program. While enrolled in the My Diabetes Discount Program, Members will receive their insulin at a reduced Copayment.

My Health Novel:
The Corporation provides you with access to ***My Health Novel***. If you wish to make healthy lifestyle changes and need assistance in managing your health goals, log onto My Health Toolkit to complete a brief one (1) minute assessment. Members will be matched to programs based on their risk factors, interests and preferred method of participation (i.e., in person or on-line).

Oncology Management:
The Corporation provides you with access to ***Oncology Management***, a program that develops a personalized care plan for Members who are in active treatment for cancer. As a participant in ***Oncology Management***, you will receive:

- A program welcome packet.
- Educational materials related to identified needs.
- Coaching, counseling and telephonic care management by a registered nurse specialized in oncology management.
- Access to a Case Manager via a toll free number.
- A secure, digital application used to record and track health data, access information and facilitate communication with the Case Manager.

Members identified as being in an approved course of treatment will receive a letter and phone call from Companion Benefit Alternatives Companion Care Solutions team. Companion Benefit Alternatives is a subsidiary of Blue Cross and Blue Shield of South Carolina that provides the ***Oncology Management*** program. If the Member needs assistance and agrees to participate, the Member is enrolled in the program.

Personify Health:
The Corporation provides you with access to ***Personify Health***, a comprehensive solution for health and well-being engagement. ***Personify Health*** is designed to help you adopt easy-to-maintain changes in behavior that can lower health risks. Everyone has different health goals and needs. You deserve better than a one-size-fits-all platform. Whether you just want to stay healthy or you need to manage certain health issues, ***Personify Health*** helps you get on a path to success. ***Personify Health*** is user-friendly with digital options similar to those that Members already use and enjoy in their daily lives. Features include a brief health survey, challenges, digital coaching, and educational content. ***Personify Health's*** smart technology serves up tailored tips and programming that help members build healthy habits. You can even share features, such as challenges, with friends and family members. Personify Health is an independent company that offers a digital health platform on behalf of your Policy. To access Personify Health, login to My Health Toolkit®.

Renal Management:
The Corporation provides you with access to ***Renal Management***, a program that develops a personalized care plan for Members who are diagnosed with Chronic Kidney Disease (CKD) Stage 4 and Stage 5 and End Stage Renal Disease (ESRD). As a participant in ***Renal Management***, you will receive:

- A program welcome packet.
- Educational materials related to identified needs.
- Coaching, counseling and telephonic care management by a Registered Nurse specialized in renal management.
- Access to a Case Manager via a toll-free number.
- A secure, digital application used to record and track health data, access information and facilitate communication with the Case Manager.

Members identified as being in an approved course of treatment will receive a letter and phone call from the Companion Benefit Alternatives Companion Care Solutions team. Companion Benefit Alternatives is a subsidiary of Blue Cross and Blue Shield of South Carolina that provides the ***Renal Management*** program. If the Member needs assistance and agrees to participate, the Member is enrolled in the program.

Actuarial Value:

This Policy constitutes an ACA-compliant Student Health Plan that provides comprehensive Benefits with an actuarial value of 73.17%, with the applicable "metal level" being silver.

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 Policy 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 Policy.

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 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:

Blue Cross and Blue Shield of South Carolina
Claims Service Center
Post Office Box 100300
Columbia, South Carolina 29202

Please refer to Article X of this Policy for more information on filing a claim.

PREDETERMINATION OF DENTAL BENEFITS

Except in an emergency, you should discuss fees with your dentist before treatment begins. If recommended dental treatment will cost $100 or more, your dentist should file a Predetermination of Benefits to the Corporation. By doing this, both you and your dentist will know up front how much the Corporation will pay for the recommended treatment. Here's how it works:

Your dentist should list, on a claim form, the treatment planned and its cost and send the form to:

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

After the Corporation determines the amount eligible for payment, the Corporation will let you and your dentist know. If your dentist does not ask for Predetermination of Benefits, the Corporation will pay Benefits according to the information on the claim form. Predetermination of Benefits is not necessary for emergency care, routine oral examinations, X-rays, fluoride treatments, cleaning, scaling or polishing teeth.

SCHEDULE OF BENEFITS

Member Institution Contract Number: 25-85557-00 through 21
Member Institution: University of South Carolina
Student Health Plan
Member Institution's Effective Date: August 1, 2026

This Schedule of Benefits and the Benefits described herein are subject to all terms and conditions of this Policy. In the event of a conflict between this Policy 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 Policy.

To maximize your Benefits, seek medical services from the Student Health Center or 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.

Students who are required to participate under the Hard Waiver Plan:

1. All graduate Students enrolled in six (6) or more credit hours in an on-campus or blended delivery program;
2. All graduate Students with assistantships at all campus locations;
3. USC School of Medicine Students enrolled in graduate programs;
4. International Students;
5. EPI Students; and,
6. Athletes.

All other students are eligible to enroll in the plan on a voluntary basis.

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 Policy. 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.

In addition to meeting the requirements contained in this Policy; the maximum age limitation to qualify as a Dependent Child is:	Twenty-six (26). When a Child turns age twenty-six (26), the Child's coverage will terminate at the end of the period for which a Premium has been accepted.
The column to the right identifies other group classifications, as defined by the Member Institution, that may participate in this Policy:	Domestic Partners

Benefit Year Deductible:	There are no Benefit Year Deductibles for services performed at a Student Health Center. $1,000 per family with no one Member meeting more than $500 for Participating Providers (includes Non-Participating Providers of air ambulance services, Emergency Services, and non-Emergency Services furnished at certain Participating Provider facilities). $6,000 per family with no one Member meeting more than $3,000 for Non-Participating Providers. Other than as specified above, Covered Expenses for services rendered by the 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 and Student Health Centers (generally includes Non-Participating Providers of air ambulance services, Emergency Services, and non-Emergency Services furnished at certain Participating Provider facilities):	**Standard Out-of-Pocket Maximums:** $11,200 per family with no one Member meeting more than $5,600. Expenses paid towards the following do not contribute to the Out-of-Pocket Maximum determination: • Chiropractic Services **Out-of-Pocket Maximums:** $15,000 per family with no one Member meeting more than $9,200. Expenses paid towards the following do not contribute to the Out-of-Pocket Maximum determination: • Chiropractic Services 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 or Student Health Center 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:	$30,000 per family with no one Member meeting more than $15,000. Expenses paid towards the following do not contribute to the Out-of-Pocket Maximum determination: • Copayments • Chiropractic Services 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. Other than as specified above, 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.

For services rendered at the Student Health Center, if a Student does not pay the Student Health fee as part of tuition, such Student is subject to a $20 Copayment for services that are paid at 100% for a Student who has paid the Student Health fee.

This Schedule of Benefits applies during the 08/01 through 07/31 Benefit Year. The Anniversary Date is 08/01.

There are no annual or lifetime dollar limitations on essential health Benefits as defined by the Affordable Care Act (ACA).

PREAUTHORIZATION

Any questions about Preauthorization should be directed to either your Provider or to the Corporation at the number on the back of your Identification Card.

Preauthorization is required for the following services:

- All facility Admissions for non-emergent medical and behavioral health services
- Applied Behavioral Analysis (ABA) related to Autism Spectrum Disorder
- Ambulance services (non-emergency)
- Cleft lip and palate
- Dental care for accidental injury (Preauthorization is required for the treatment plan and subsequent visits)
- Rental of Durable Medical Equipment
- Purchase of Durable Medical Equipment over $500
- Home Health Care
- Hospice Care
- Interdisciplinary pain management program
- Orthopedic devices
- Orthotic devices
- Outpatient Services
    - Any surgical procedure that may be potentially cosmetic: i.e., blepharoplasty, reduction mammoplasty
    - Cancer chemotherapy (initial notification)
    - Electroconvulsive therapy (ECT)
    - Hysterectomy
    - Investigational procedures
    - Partial hospitalization and intensive outpatient programs
    - Radiation therapy (initial notification)
    - Sclerotherapy
    - Septoplasty
- Oxygen
- Psychological testing
- Radiology management
    - CAT scan
    - MRI
    - MRA
    - Musculoskeletal care
    - PET scan
    - Radiation treatment plans related to oncology
- Repetitive transcranial magnetic stimulation (rTMS)

Please refer to the Corporation’s website for a complete list of Prescription Drugs and Specialty Drugs that require Preauthorization.

The penalties for not obtaining preauthorization, when required, are as follows:

Denial of room and board charges:

- All facility Admissions for non-emergent medical and behavioral health services

Denial of all charges:

- ABA related to Autism Spectrum Disorder
- DME purchase of $500 or more
- Home Health Care
- Hospice Care
- Radiology management

Benefits reduced by 50% of the Allowable Charge:

- Outpatient services, including partial hospitalization, psychological testing, rTMS, ECT and intensive outpatient programs
- Psychological testing performed in the office
- rTMS performed in the office

ADMISSIONS/INPATIENT BENEFITS The below include services for medical, mental health and substance use disorders				
	Student Health Center	**Participating Provider**	**Non-Participating Provider at a Participating Provider facility** **(unless the Provider satisfies advance patient notice and consent requirements)**	**Non-Participating Provider at a Non-Participating Provider facility** **(or at a Participating Provider facility if advance patient notice and consent requirements are met)**
Inpatient Hospital charges during an Admission (non-emergency)	Not Available	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 pays the remaining 20% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible	The Corporation pays 70% 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	Not Available	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 pays the remaining 20% of the Allowable Charge after meeting the Member's Participating Provider 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

	Student Health Center	**Participating Provider**	**Non-Participating Provider at a Participating Provider facility** **(unless the Provider satisfies advance patient notice and consent requirements)**	**Non-Participating Provider at a Non-Participating Provider facility** **(or at a Participating Provider facility if advance patient notice and consent requirements are met)**
Inpatient physical rehabilitation services when Preauthorized by the Corporation and performed by a Provider designated by the Corporation	Not Available	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 70% 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
Skilled Nursing Facility Admissions (limited to sixty (60) days per Member per Benefit Year) and Residential Treatment Center Admissions	Not Available	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 70% 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) and Residential Treatment Center Admissions

OUTPATIENT BENEFITS The below include services for medical, mental health and substance use disorders				
	Student Health Center	**Participating Provider**	**Non-Participating Provider at a Participating Provider facility** **(unless the Provider satisfies advance patient notice and consent requirements)**	**Non-Participating Provider at a Non-Participating Provider facility** **(or at a Participating Provider facility if advance patient notice and consent requirements are met)**
Outpatient Hospital services (non-emergency)	Not Available	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 pays the remaining 20% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Student Health Center	**Participating Provider**	**Non-Participating Provider**
Lab, X-ray and other diagnostic services	The Corporation pays 100% of the Allowable Charge	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $25 Copayment The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible and Copayment	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $40 Copayment The Member must pay the balance of the Provider's charge

	Student Health Center	Participating Provider	Non-Participating Provider
Outpatient emergency room services (Copayment waived if admitted)	Not Available	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $200 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 $200 Copayment The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible and Copayment
Surgery	Not Available	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	For certain surgeries performed by a Non-Participating Provider at certain Participating Provider facilities (unless the Provider satisfies advance patient notice and consent requirements): The Corporation pays 80% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member generally pays the remaining 20% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible For all other surgeries: The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Student Health Center	Participating Provider	Non-Participating Provider
Maternity	Not Available	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 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Doctor's Care	Not Available	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible and after Member pays a $25 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 Member pays a $25 Copayment The Member must pay the balance of the Provider's charge
Urgent care	Not Available	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $75 Copayment The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible and Copayment	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $75 Copayment The Member must pay the balance of the Provider's charge

PROVIDER SERVICES The below include services for medical, mental health and substance use disorders				
	Student Health Center	**Participating Provider**	**Non-Participating Provider at a Participating Provider facility** **(unless the Provider satisfies advance patient notice and consent requirements)**	**Non-Participating Provider at a Non-Participating Provider facility** **(or at a Participating Provider facility if advance patient notice and consent requirements are met)**
Inpatient Provider Services for an Admission resulting from an emergency room visit	Not Available	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 pays the remaining 20% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Student Health Center	Participating Provider	Non-Participating Provider
Inpatient Provider Services (non-emergency)	Not Available	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	For certain Inpatient Provider Services performed by a Non-Participating Provider at certain Participating Provider facilities (unless the Provider satisfies advance patient notice and consent requirements): The Corporation pays 80% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member generally pays the remaining 20% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible For all other Inpatient Provider Services: The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Student Health Center	Participating Provider	Non-Participating Provider
Surgical Services, when rendered in a Hospital or Ambulatory Surgical Center (non-emergency)	Not Available	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	For certain Surgical Services performed by a Non-Participating Provider at certain Participating Provider facilities (unless the Provider satisfies advance patient notice and consent requirements): The Corporation pays 80% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member generally pays the remaining 20% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible For all other Surgical Services: The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Outpatient Provider Services for lab, X-ray and other diagnostic services	The Corporation pays 100% of the Allowable Charge	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $25 Copayment The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible and Copayment	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $40 Copayment The Member must pay the balance of the Provider's charge

	Student Health Center	Participating Provider	Non-Participating Provider
Provider Services for lab, X-ray and other diagnostic services performed at an independent laboratory facility	Not Available	The Corporation pays 100% of the Allowable Charge	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $40 Copayment The Member must pay the balance of the Provider's charge
Provider Services for treatment in a Hospital outpatient department or Ambulatory Surgical Center	Not Available	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	For certain Provider Services performed by a Non-Participating Provider at certain Participating Provider facilities (unless the Provider satisfies advance patient notice and consent requirements): The Corporation pays 80% of the Allowable Charge after the Participating Provider Benefit Year Deductible The Member generally pays the remaining 20% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible For all other Provider Services for treatment in a Hospital outpatient department or Ambulatory Surgical Center: The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Student Health Center	Participating Provider	Non-Participating Provider
Provider Services for an outpatient emergency room visit	Not Available	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 pays the remaining 20% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible
Services in the Provider's office Copayment includes office visit and consultation only	The Corporation pays 100% of the Allowable Charge after the Member pays a $20 Copayment	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $25 Copayment The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible and Copayment	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $40 Copayment The Member must pay the balance of the Provider's charge
All other Services in the Provider's office	The Corporation pays 100% of the Allowable Charge after the Member pays a $20 Copayment	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 70% 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 for Mental Health Services and Substance Use Disorder Services	The Corporation pays 100% of the Allowable Charge after the Member pays a $20 Copayment	The Corporation pays 100% of the Allowable Charge after the Member pays a $25 Copayment	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $40 Copayment The Member must pay the balance of the Provider's charge

	Student Health Center	Participating Provider	Non-Participating Provider
Allergy injections	The Corporation pays 100% of the Allowable Charge	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 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Second Surgical Opinion	Not Available	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 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

OTHER SERVICES			
	Student Health Center	**Participating Provider**	**Non-Participating Provider**
Air ambulance service	Not Available	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 pays the remaining 20% of the Allowable Charge after meeting the Member's Participating Provider Benefit Year Deductible
Ground ambulance service	Not Available	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 100% of the Allowable Charge after the Member pays a $20 Copayment	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $25 Copayment The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible and Copayment	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $40 Copayment The Member must pay the balance of the Provider's charge
Medical Supplies	Covered	Covered	Covered

	Student Health Center	Participating Provider	Non-Participating Provider
Home Health Care, limited to sixty (60) visits per Member per Benefit Year	Not Available	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 70% 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	Not Available	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 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
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	Not Available	Covered	Covered

	Student Health Center	Participating Provider	Non-Participating Provider
ABA related to Autism Spectrum Disorder	Not Available	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 100% of the Allowable Charge The Corporation pays 100% of the Allowable Charge for the evaluation for physical therapy after the Member pays an initial $20 Copayment per Member per Benefit Year	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $25 Copayment The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible and Copayment	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $40 Copayment 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 100% of the Allowable Charge The Corporation pays 100% of the Allowable Charge for the evaluation for physical therapy after the Member pays an initial $20 Copayment per Member per Benefit Year	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $25 Copayment The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible and Copayment	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $40 Copayment The Member must pay the balance of the Provider's charge

	Student Health Center	Participating Provider	Non-Participating Provider
Rehabilitation related to speech therapy, limited to twenty (20) visits per Member per Benefit Year	The Corporation pays 100% of the Allowable Charge	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $25 Copayment The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible and Copayment	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $40 Copayment The Member must pay the balance of the Provider's charge
Habilitation related to speech therapy, limited to twenty (20) visits per Member per Benefit Year Habilitative speech therapy (other than approved ABA therapy for Autism Spectrum Disorder) is limited to Members age six (6) and younger	The Corporation pays 100% of the Allowable Charge	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $25 Copayment The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible and Copayment	The Corporation pays 70% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $40 Copayment 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	Not Available	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 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge

	Student Health Center	Participating Provider	Non-Participating Provider
Chiropractic services, including modalities and spinal manipulation/subluxation	Not Available	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 70% of the Allowable Charge after the Benefit Year Deductible The Member must pay the balance of the Provider's charge
Oxygen	Not Available	Covered	Covered
Temporomandibular Joint Disorder (TMJ) including treatment	Not Available	Non-Covered	Non-Covered
Orthognathic Surgery	Not Available	Non-Covered	Non-Covered
Dental care for accidental injury, limited to six (6) months from the date of the accidental injury	Not Covered	Covered	Covered
Supplemental accident Benefits	Not Available	Non-Covered	Non-Covered
Magnetic Resonance Imaging (MRIs), Magnetic Resonance Angiography (MRAs), Computerized Axial Tomography (CAT) scans or Positron Emission Tomography (PET) scans	Not Available	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $150 Copayment The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible and Copayment	The Corporation pays 70% 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

	Student Health Center	Participating Provider	Non-Participating Provider
Nutritional counseling	The Corporation pays 100% of the Allowable Charge	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 70% 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 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	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

DENTAL BENEFITS			
	Student Health Center	**Participating Provider**	**Non-Participating Provider**
Adult dental care preventive services for the following for Members age nineteen (19) and older: • Oral exams, limited to two (2) per Member per Benefit Year • Bitewing X-ray, limited to one (1) per Member per Benefit Year • Full mouth X-ray, limited to one (1) per Member every three (3) years • Prophylaxis, limited to two (2) services per Member per Benefit Year • Emergency treatment for pain	Not Available	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
Adult dental care basic services for Members age nineteen (19) and older, limited to fillings only	Not Available	The Corporation pays 80% of the Allowable Charge The Member pays the remaining 20% of the Allowable Charge	The Corporation pays 80% of the Allowable Charge The Member must pay the balance of the Provider's charge
Pediatric dental care preventive services for Members through age eighteen (18)	Not Available	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
Pediatric dental care, including Basic Dental Services and Major Dental Services for Members through age eighteen (18)	Not Available	The Corporation pays 50% of the Allowable Charge The Member pays the remaining 50% of the Allowable Charge	The Corporation pays 50% of the Allowable Charge The Member must pay the balance of the Provider's charge

	Student Health Center	Participating Provider	Non-Participating Provider
Pediatric Orthodontic Services for Members through age eighteen (18) only when Medically Necessary and approved by the Corporation	Not Available	The Corporation pays 50% of the Allowable Charge The Member pays the remaining 50% of the Allowable Charge	The Corporation pays 50% of the Allowable Charge The Member must pay the balance of the Provider's charge
The pediatric dental services listed above for Members through age eighteen (18) are limited to the following:	1. Oral examinations are limited to two (2) per Member per Benefit Year; 2. Bitewing X-rays are limited to one (1) per Member per Benefit Year; 3. Prophylaxis is limited to two (2) per Member per Benefit Year; 4. Full mouth X-rays or panoramic films are limited to once per Member every three (3) years; 5. Topical fluoride applications are limited to one (1) application per Member every six (6) months; 6. Space maintainers are limited to one (1) per lifetime for permanent teeth; 7. Sealants are limited to one (1) per tooth per lifetime for permanent teeth and limited to Members from the ages of six (6) through fifteen (15); 8. Prosthodontics may be replaced once per Member every five (5) years; and, 9. Relining of removable dentures is covered once every three (3) years per Member.		
Impacted teeth, including injury to sound natural teeth and removal of impacted teeth, limited to a combined $1,000 per Member per Benefit Year for Members through age eighteen (18)	Not Available	The Corporation pays 80% of the Allowable Charge The Member pays the remaining 20% of the Allowable Charge	The Corporation pays 80% 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			
	Student Health Center	**Participating Provider**	**Non-Participating Provider**
Preventive Benefits under the Affordable Care Act (ACA) (Refer to www.healthcare.gov for guidelines) In the event of a conflict between the terms of preventive Benefits under the ACA (as may be amended from time to time) and the specific preventive Benefits and limits listed below, coverage will be provided in accordance with the more generous terms	Covered	Covered	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	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
Prostate screenings, limited to one (1) per Member per Benefit Year	The Corporation pays 100% of the Allowable Charge	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
Gynecological exam, limited to two (2) per Member per Benefit Year	The Corporation pays 100% of the Allowable Charge	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

In South Carolina:			
	Student Health Center	**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	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
Outside South Carolina:			
	Student Health Center	**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	**T**he Corporation pays 100% of the Allowable Charge	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

PRESCRIPTION DRUG BENEFIT

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

Prescription Drugs	**Student Health Center* (if available)**	**Mail Service/ Home Delivery Pharmacy**	**Participating Pharmacy**	**All Other Pharmacies**
Generic Drugs	The Member pays a $10 Prescription Drug Copayment for each prescription or refill, up to a 90 day supply Member may be responsible for an additional Prescription Drug Copayment amount for day supplies of 31 or more	Non-Covered	The Member pays a $20 Prescription Drug Copayment for each prescription or refill after the Prescription Drug Deductible, up to a 90 day supply Member may be responsible for an additional Prescription Drug Copayment amount for day supplies of 31 or more	The Member will be responsible for 100% of the Allowable Charge at the pharmacy then will be reimbursed at 100% after a $20 Prescription Drug Copayment per Member for each prescription or refill after the Prescription Drug Deductible, up to a 90 day supply Member may be responsible for an additional Prescription Drug Copayment amount for day supplies of 31 or more
Preferred Drugs Members are encouraged to utilize Generic Drugs when available and may be subject to a penalty if not	The Member pays a $20 Prescription Drug Copayment for each prescription or refill, up to a 31 day supply	Non-Covered	The Member pays a $40 Prescription Drug Copayment for each prescription or refill after the Prescription Drug Deductible, 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% after a $40 Prescription Drug Copayment per Member for each prescription or refill after the Prescription Drug Deductible, up to a 31 day supply

Prescription Drugs	Student Health Center* (if available)	Mail Service/ Home Delivery Pharmacy	Participating Pharmacy	All Other Pharmacies
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 $20 Prescription Drug Copayment for each prescription or refill, up to a 31 day supply	Non-Covered	The Member pays a $100 Prescription Drug Copayment for each prescription or refill after the Prescription Drug Deductible, 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% after a $100 Prescription Drug Copayment per Member for each prescription or refill after the Prescription Drug Deductible, up to a 31 day supply

Prescription Drugs	Student Health Center* (if available)	Mail Service/ Home Delivery Pharmacy	Participating Pharmacy	All Other Pharmacies
Contraceptives: oral contraceptives, cervical cap, condoms, diaphragms, digital contraception, emergency contraception, 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 The above contraceptives are covered under the participating medical Benefits at the same payment levels. Refill quantities may vary.	Prescription Drugs will be covered at 100%, up to a 31 day supply	Non-Covered	Prescription Drugs will be covered at 100%, up to a 31 day supply	Non-Covered

Prescription Drugs	Student Health Center* (if available)	Mail Service/ Home Delivery Pharmacy	Participating Pharmacy	All Other Pharmacies
All other contraceptives (Prescription Drugs) All other contraceptives are paid at the Generic, Preferred and Non-Preferred Brand Drug payment levels	Covered	Non-Covered	Covered	Covered
Tobacco cessation Prescription Drugs	Covered	Non-Covered	Covered	Covered
Prescription Drug deductible	$0 (No Prescription Drug deductible)	Non-Covered	$100 per family with no one Member meeting more than $100	$100 per family with no one Member meeting more than $100
Prescription Drug out-of-pocket maximum	$0 (No Prescription Drug out-of-pocket maximum)	Non-Covered	$0 (No Prescription Drug out-of-pocket maximum)	$0 (No Prescription Drug out-of-pocket maximum)
Insulin for Members enrolled in the My Diabetes Discount Program (see the Introduction section for information about the My Diabetes Discount Program)	The Member pays a $10 Prescription Drug Copayment for each prescription or refill, up to a maximum of $20	Non-Covered	The Member pays a $20 Prescription Drug Copayment for each prescription or refill, up to a maximum of $20	The Member will be responsible for 100% of the Allowable Charge at the pharmacy then will be reimbursed at 100% after a $20 Prescription Drug Copayment for each prescription or refill, up to a maximum of $20

Prescription Drugs	Student Health Center* (if available)	Mail Service/ Home Delivery Pharmacy	Participating Pharmacy	All Other Pharmacies
Diabetic syringes and supplies (test strips, lancets, syringes, needles, control solution and lancet devices) A separate Prescription Drug Copayment applies for each supply purchase	The Corporation pays 100% of the Allowable Charge for each prescription or refill, up to a 31 day supply	Non-Covered	Covered	Covered
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	Non-Covered
*Certain travel vaccinations and medications are only covered if received at a Student Health Center. Prenatal vitamins are covered at 100% when received at a Student Health Center.				

SPECIALTY DRUG BENEFIT			
	Student Health Center (if available)	**Participating Pharmacy**	**All Other Pharmacies**
Specialty Drugs	The Member pays a $20 Prescription Drug Copayment per Member for each prescription or refill, up to a 31 day supply	The Member pays a $100 Prescription Drug Copayment per Member for each prescription or refill after the Prescription Drug Deductible, up to a 31 day supply	Non-Covered

STUDENT BLANKET HEALTH INSURANCE

Blue Cross and Blue Shield of South Carolina, referred to in this Policy as “Corporation”, issues this Policy to the Policyholder named in the Insurance Information Schedule to insure the Students of a school.

The Effective and Termination Dates for coverage under this Policy are as shown in the Schedule of Benefits and Rates. All time periods begin and end at 12:01 A.M., local time, at the Policyholder’s address.

The following pages form a part of this Policy as fully as if the signatures below were on each page.

This Policy is executed for the Company by its President.

BLUE CROSS BLUE SHIELD
OF SOUTH CAROLINA
An Independent Licensee of the Blue Cross
and Blue Shield Association



By: _____
Title: President
Blue Cross and Blue Shield Division

Address: I-20 East @ Alpine Road
Columbia, South Carolina 29219-0001**]**

Date: August 12, 2026

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Member Institution Name: University of South Carolina
Member Institution Number(s): 25-85557-00, 04, 09, 13, 18 and 19
Member Institution's Effective Date: August 1, 2026

Medical Premiums:	**Types of Membership**	**Monthly Premiums**
	Student:	$426.51
	Student +One	$853.42
	Student +Two	$1,280.00
	Student +Three	$1,705.70
	Student +Four	$2,132.05

Premiums and fees for Hard Waiver Students are paid on a per semester basis.

Contact AHP at the number listed on the How To Get Help page of this Policy for information regarding additional fees that may apply to your Plan.

Reports for certain programs will be provided for a fee as agreed to by the Member Institution and the Corporation.

RATE PAGE

Member Institution Name: University of South Carolina
Member Institution Number(s): 25-85557-01 through 03, 05, 07, 08, 10 through 12, 14, 16, 17, 20 and 21
Member Institution's Effective Date: August 1, 2026

Medical Premiums:	**Types of Membership**	**Monthly Premiums**
	Student:	$306.21
	Student +One	$612.99
	Student +Two	$919.53
	Student +Three	$1,225.02
	Student +Four	$1,531.07

Premiums and fees for Hard Waiver Students are paid on a per semester basis.

Contact AHP at the number listed on the How To Get Help page of this Policy for information regarding additional fees that may apply to your Plan.

Reports for certain programs will be provided for a fee as agreed to by the Member Institution and the Corporation.

RATE PAGE

Member Institution Name: University of South Carolina
Member Institution Number(s): 25-85557-06 and 15
Member Institution's Effective Date: August 1, 2026

Medical Premiums:	**Types of Membership**	**Monthly Premiums**
	Student:	$546.45
	Student +One	$1,092.90
	Student +Two	$1,639.35
	Student +Three	$2,185.80
	Student +Four	$2,732.25

Premiums and fees for Hard Waiver Students are paid on a per semester basis.

Contact AHP at the number listed on the How To Get Help page of this Policy for information regarding additional fees that may apply to your Plan.

Reports for certain programs will be provided for a fee as agreed to by the Member Institution and the Corporation.

ARTICLE I - DEFINITIONS

Capitalized terms that are used in this Policy 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.

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 Policy, 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.

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, unless otherwise required by applicable law;

2. The Allowable Charge for Emergency Services (including air ambulance services) provided by Non-Participating Providers, as well as non-Emergency Services provided by Non-Participating Providers at Participating Hospitals , Hospital outpatient departments, Critical Access Hospitals, or Ambulatory Surgical Centers, will pay in accordance with applicable federal law; 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, except where prohibited by applicable law.

   For covered items and services described in item 2, above, the Allowable Charge will be the Recognized Amount (less any applicable Benefit Year Deductible, Copayment and/or Coinsurance), unless otherwise prescribed under applicable law. If the Provider disputes such Allowable Charge and initiates a 30-day open negotiation and/or independent dispute resolution process in accordance with applicable federal law, the Corporation will administer such processes.

   Notwithstanding anything herein to the contrary, the Member's responsibility for Benefit Year Deductibles, Copayments and/or Coinsurance for covered items and services provided by Non-Participating Providers described in item 2, above, will be calculated as if the item or service was furnished by a Participating Provider, and based on the Recognized Amount (which may differ from the Allowable Charge).

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.

An Ambulatory Surgical Center includes any licensed facility described in section 1833(i)(1)(A) of the Social Security Act.

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 such Member's 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.

Basic Dental Services: the following dental services:

1. Oral surgery (but not periodontal surgery), including the following:

    a. Surgical extractions;

    b. Alveoplasty;

    c. Surgical excision of lesions and tumors;

    d. Removal of cysts and neoplasms;

    e. Excision of bone tissue;

    f. Biopsies of oral tissue;

    g. Treatment of oral fistula;

    h. Excision of hyperplastic tissue; and,

    i. Frenulectomy;

2. Fillings, consisting of amalgam and tooth-colored synthetic materials;

3. Simple extractions;

4. Endodontics, consisting of pulpotomy, pulp capping and root canal treatment;

5. Thirty (30) minutes of IV sedation and general anesthesia if Medically Necessary and rendered in connection with covered oral or dental surgery;

6. Assistant at surgery when Medically Necessary;

7. Hemi-section;

8. Apicoectomy (amputation of apex of a tooth root);

9. Periodontics, that being the diagnosis and treatment of diseases of the tooth-supporting tissues, as follows:

    a. Surgical periodontic examination;

    b. Gingival curettage;

    c. Gingivectomy and gingivoplasty; and,

    d. Osseous surgery, including flap entry and closure;,

10. Periodontal cleanings;

11. Periodontal scaling and root planning;

12. Repair of removable dentures; and,

13. Relining or rebasing of removable dentures (complete and partial).

Behavioral Health Clinician: a Clinician 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 Clinician.

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.

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

1. Medically Necessary;

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

3. Included in Article III of this Policy; and,

4. Not limited or excluded under the terms of this Policy.

Benefit Detail Report: the document (in electronic or hardcopy form) maintained by the Corporation which reflects the benefits selected by the Member Institution and submitted to the Corporation which outlines the Benefits to be offered under the Policy. The Corporation shall administer the Policy in accordance with the terms of the Benefit Detail Report. In the event of any conflict between the Benefit Detail Report and this Policy, the Benefit Detail Report 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 XI.

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: a Student's child, whether a natural child, adopted child, foster child, stepchild or child for whom an Student has custody or legal guardianship. The term "Child" also includes an Incapacitated Dependent, and a child of a divorced or divorcing Student who, under a valid court order, has a right to enroll under the Policy. The term "Child" does not include the Spouse of an eligible child.

Clinical Trials: a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and meets any of the following criteria:

1. 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), or a cooperative group or center of:

    a. Any of the preceding entities;

    b. The Department of Defense (DOD); or,

    c. The Department of Veterans Affairs (VA);

2. Approved or funded by the DOD, VA, or Department of Energy (DOE), provided that the study or investigation has been reviewed and approved through a peer review system that the Secretary of the agency determines to be comparable to the peer review system of studies and investigations used by the NIH, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

3. Approved or funded through a qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants; or,

4. Either conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA), or a drug trial that is exempt from having such an investigational new drug application.

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 Claim: any claim for 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.

Continuing Care Patient: a Member who, with respect to a Provider or facility, is either:

1. Undergoing a course of treatment for a serious and complex condition from the Provider or facility;
2. Undergoing a course of institutional or inpatient care from the Provider or facility;
3. Scheduled to undergo nonelective surgery from the Provider or facility, including receipt of postoperative care;
4. Pregnant and undergoing a course of treatment for the pregnancy from the Provider or facility; or
5. Receiving treatment for a terminal illness from the Provider or facility.

For this purpose, a serious and complex condition means a condition that, in the case of an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm, or in the case of a chronic illness or condition, is life-threatening, degenerative, potentially disability, or congenital and requires specialized medical care over a prolonged period of time.

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 Request For Proposal between the Corporation and the South Carolina Student Health Insurance Consortium (SCSHIC) including the Member Institution Application, Benefit Detail Report, Policy, Schedule of Benefits 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: Blue Cross and Blue Shield 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 Policy and at the percentages set forth on the Schedule of Benefits. Covered Expenses are subject to the limitations and requirements set forth in this Policy 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.

Critical Access Hospital: a facility that is designated by the state in which it is located, and certified by the United States Department of Health and Human Services as a critical access hospital.

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. A Student's Spouse;

2. A Child under the age set forth on the Schedule of Benefits;

3. An Incapacitated Dependent; or,

4. A Domestic Partner, if Domestic Partners are listed as covered on the Schedule of Benefits.

Domestic Partner: a Dependent who:

1. Is unmarried, at least eighteen (18) years of age, mentally competent, resides with the other partner and intends to reside with the other partner for an indefinite amount of time;

2. Is not related to the other partner by adoption or blood;

3. Is the sole Domestic Partner of the other partner, with whom such Domestic Partner has a close committed and personal relationship, and has been a member of the domestic partnership for the last twelve (12) months;

4. Agrees to be jointly responsible for the basic living expenses and welfare of the other partner; and;

5. Is financially interdependent. Financial interdependence is demonstrated by submission of three (3) or more of the following documents:

    a. a joint mortgage or lease;

    b. a designation of one (1) of the partners as beneficiary in the other partner's Will or life insurance policy;

    c. a durable property and health care powers of attorney;

    d. a joint title to an automobile;

    e. a joint bank account or credit account; or;

    f. such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case.

If Domestic Partners are listed as covered on the Schedule of Benefits, the Student and applicant for coverage as a Domestic Partner will be required to sign an Affidavit of Domestic Partnership. The Corporation reserves the right to request documentation of any of the foregoing prior to commencing coverage of the Domestic Partner.

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 after, or if later, by the end of the first business day after the commencement of an Admission to a Hospital resulting from an Emergency Medical Condition. The Emergency Admission Review process is outlined in Article III.

Emergency Medical Condition: a medical condition, including a mental health condition or Substance Use Disorder, 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 the Member's unborn Child, in serious jeopardy;
2. Serious impairment to bodily functions; or,
3. Serious dysfunction of any bodily organ or part.

Emergency Services: an appropriate medical screening examination, 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 or an independent freestanding emergency department, as well as post-stabilization services provided as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services are furnished.

Enrollment Date: the date of enrollment in the Policy.

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 Member Institution gives the Corporation written notice of intent to discontinue the Contract or this Policy 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.

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.

Hospice Services: services provided in the Member's home or in the home of a family member. Generally, Hospice Services are not available to Members who are inpatients in a Hospital or nursing home facility.

Hospice Services include:

1. Services provided by a registered nurse (RN) or licensed practical nurse (LPN);

2. Physical, speech and occupational therapy;

3. Services provided by a home health aide or medical social worker;

4. Nutritional guidance;

5. Diagnostic services;

6. Administration of Prescription Drugs;

7. Medical and surgical supplies;

8. Oxygen and its use;

9. Durable Medical Equipment;

10. Family counseling concerning the patient's terminal condition.

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 Student for at least fifty-one (51) percent of the Dependent's support and maintenance.

A Child must meet both of these requirements to qualify as an Incapacitated Dependent. The Student will furnish written proof of items (1) and (2) no later than thirty-one (31) days after the Child's attainment of the maximum age listed on the Schedule of Benefits. The Student will update items (1) and (2) each year after the two (2) year period. 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 Enrollment: the time period during which a Student or eligible Dependent enrolls for coverage under this Policy other than during:

1. The first period in which the Student 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)).

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.

Major Dental Services: the restoration and maintenance of oral function by the replacement of missing teeth and structures by artificial appliances, as follows:

1. Inlays (not part of a bridge);

2. Permanent crowns (not part of a bridge);

3. Onlays (not part of a bridge);

4. Removable dentures, complete and partial, and bridges, fixed and removable with the exception of:

    a. Any denture replacement inlay, crown or onlays made less than the timeframe, if any, set forth on the Schedule of Benefits after a placement or replacement which was covered under this Policy; or,

    b. Any replacement made necessary by reason of loss or theft; and,

5. Fixed bridge repairs.

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, subject to any different amount that may be required under applicable law:

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 Benefit Detail Report;

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 or air ambulance services by a Non-Participating Provider, or non-Emergency Services by a Non-Participating Provider at a Participating Hospital, Hospital outpatient department, Critical Access Hospital, or Ambulatory Surgical Center, will be the Recognized Amount, unless a different Maximum Payment amount is permitted or required under applicable law.

Medical Supplies: supplies that are:

1. Medically Necessary;

2. Prescribed by a Provider acting within the scope of such Provider's 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 Policy.

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: a person insured under this Policy.

Member Effective Date: the date on which a Student or Dependent is covered for Benefits under the terms of Article II of this Policy.

Member Institution: the entity participating in the SCSHIC whose Students and their Dependents are eligible for coverage under this Policy and who is identified as the member institution on the Schedule of Benefits.

Member Institution’s Effective Date: 12:01 a.m. EST on the Effective Date listed on the Schedule of Benefits.

Membership Application: any mechanism agreed upon by the Corporation and the Member Institution or SCSHIC for transmitting necessary Member enrollment information from the Member Institution or SCSHIC 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 Policy.

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.

Orthodontic Services: the prevention or correction of irregularities in the alignment of the teeth and the prevention or correction of the malocclusion, as follows:

The correction of dysfunctional malocclusion consisting of the following:

1. Diagnosis, including models and radiographs;

2. Active treatment, including necessary appliances; and,

3. Retention treatment following active treatment, limited to ten (10) visits in an eighteen (18) month period.

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 for Covered Expenses.

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. Notwithstanding anything herein to the contrary, for purposes of this Policy, the Student Health Center is a Participating Provider.

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. Individual or group coverage, whether insured or self-insured;

2. Health insurance coverage offered in the individual market; and,

3. 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 Policy. 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.

Policy: this document which reflects the Benefits offered based on the Benefit Detail Report. The Policy includes the Schedule of Benefits.

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 Student for coverage under this Policy. Payment of Premiums by the Student, or the Member Institution or SCSHIC on such Student's behalf, constitutes acceptance by the parties of the terms of this Policy 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 such Provider's 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 Policy. 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.

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 Student Health Center; 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 Clinician, licensed professional counselor, masters level licensed social worker, licensed marriage and family therapist or other licensed Behavioral Health Clinician 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 Clinician within the scope of such Provider or Clinician's 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, Student Health Center 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.

Recognized Amount: the lesser of the Non-Participating Provider's billed charges or the Corporation's median contracted rate for Participating Providers for the same or similar item or service furnished in the same or similar specialty in the same geographic region; provided that, except in connection with air ambulance services, if there is a recognized amount specified for this purpose under an applicable All-Payer Model Agreement under Section 1115A of the Social Security Act, or if not, under applicable state law, then such amount, as applicable, will instead serve as the Recognized Amount.

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: 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. The facility is licensed and/or accredited by the appropriate agency;

3. Has the services of a psychiatrist and/or addictionologist, for Substance Use Disorder (SUD) admissions, 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 or as indicated;

4. Has a RN, who oversees patient care, present onsite twenty-four (24) hours/day seven (7) days per week OR a RN onsite a minimum of eight (8) hours/day seven (7) days a week and on call twenty-four (24) hours per day/seven (7) days per week. The response time to the facility must be sixty (60) minutes or less when on call. Registered nursing personnel for residential facilities performing detoxification must be on-site twenty-four (24) hours/day seven (7) days per week;

5. Keeps a daily medical record for each patient; and,

6. Is primarily providing a continuous structured therapeutic program specifically designed to treat behavioral health disorders with an awake licensed clinician onsite twenty-four (24) hours/day seven (7) days per week 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.,

Schedule of Benefits: the pages of this Policy, so titled, which specify the coverage provided and the applicable Copayments, Coinsurance, Benefit Year Deductibles, Out-of-Pocket Maximums 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 Policy 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: a licensed and accredited 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 physician available at all times and is responsible for the diagnostic evaluation, provides face-to-face evaluation services with documentation a minimum of once per week and PRN as indicated;

3. Has a physician or RN on full-time duty who is in charge of patient care, along with one (1) or more RNs or LPNs on duty at all times (twenty-four (24) hours a day; seven (7) days a week);

4. Keeps a daily medical record for each patient;

5. Is primarily providing continuous skilled nursing care for sick or injured patients during the recovery stage of their illnesses or injuries and isn't, other than incidentally, a rest home or a home for Custodial Care for the aged; and,

6. Is operating lawfully as a skilled nursing facility in the area where it is located.

South Carolina Student Health Insurance Consortium (SCSHIC): the entity contracted with the Member Institutions.

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 a Student or eligible Dependent who is not enrolled for coverage under this Policy may enroll for coverage due to the involuntary loss of other coverage or under permitted circumstances described in Article II of this Policy.

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.

Student: a student of the Member Institution who is eligible and insured for coverage under the Policy.

Student Health Center: an on-campus facility of the Member Institution that provides:

1. Medical care and treatment to sick or injured Students; and,

2. Nursing services.

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.

Teledentistry: the use of information technology and telecommunications to exchange Member information from one Provider to another or between Member and Provider for the purpose of providing dental care, consultation or education. This includes virtual office visits in which a Member is not physically seen or examined by a Provider.

Telehealth: the exchange of Member information during which Members can have a telephone or video consultation with a licensed health care professional. For Members utilizing Blue CareOnDemand. Telehealth services may include E-treatment services through which information is communicated to the Provider through a questionnaire.

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, asynchronous, electronic audio and video telecommunications systems.

Totally Disabled/Total Disability: the individual is able to perform none of the usual and customary duties of such individual's occupation or if the individual is not employed in an occupation. The individual can perform none of the usual and customary duties or activities of a person in good health of the same age. The individual 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.

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 Policy.

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 Student is eligible to enroll (and to enroll such Student's Dependents) for coverage under this Policy.

2. Dependents are not eligible to enroll for coverage under this Policy without the sponsorship of a Student covered under this Policy.

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

For hard waiver and voluntary plan information, please refer to the Schedule of Benefits.

B. ELECTION OF COVERAGE

Any Student may enroll for coverage under this Policy for such Student and such Student's Dependents by completing and filing a Membership Application with the Member Institution. Dependents must be enrolled within sixty (60) days of the date on which they first become Dependents. Students and Dependents may also enroll if eligible under the terms of any Late Enrollment or Special Enrollment procedure.

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

If Domestic Partners are listed as covered on the Schedule of Benefits, the Student and Domestic Partner are required to complete an Affidavit of Domestic Partnership and file it with the Member Institution. The Member Institution and/or Student will submit the affidavit with the Membership Application to the Corporation.

C. COMMENCEMENT OF COVERAGE

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

1. Students and Dependents Eligible After the Member Institution's Effective Date.

   Students and Dependents who become eligible for coverage after the Member Institution's Effective Date and have elected coverage within sixty (60) days of such eligibility will have coverage as of the date of such eligibility.

2. Dependents Resulting from Marriage.

   Dependents resulting from the marriage of a Student will have coverage upon enrollment provided they have been enrolled for coverage within sixty (60) days after marriage and appropriate Premiums must be paid to the Corporation for such Dependents to have coverage from the date of the marriage.

3. Dependents Resulting from Domestic Partnership.

   If Domestic Partners are listed as covered on the Schedule of Benefits, Dependent(s) resulting from the creation of a domestic partnership must apply for coverage within thirty-one (31) days after domestic partnership and appropriate Premiums must be paid to the Corporation for such Dependent(s) to have coverage from the date of the domestic partnership. If a Dependent resulting from a domestic partnership is not enrolled within thirty-one (31) days after the domestic partnership, coverage will begin on the date chosen by the Member Institution and after the payment of the applicable Premium.

   A Domestic Partner's Child, who has not been legally adopted by the Student, must be living with the Student and Student's Domestic Partner on a full-time basis in a permanent parent-child relationship. In addition, the Child must meet the qualifications of Dependent and Child as described in the Policy.

   The Student and/or Student's Domestic Partner may be required to furnish written proof of a Child's eligibility for coverage as a Domestic Partner's Child.

   Domestic Partners are not considered to be tax-qualified dependents by the Internal Revenue Service (IRS) unless they satisfy specific statutory requirements and the Student declares the Domestic Partner or their children on the Student's tax return. Therefore if the Student elects Domestic Partner coverage, the IRS may tax the Student for the value of Benefits provided. The Student should consult such Student's own personal tax advisor to determine how these tax implications affect the Student.

4. Newborn Children.

   A newborn Child will have coverage upon the date of the Child's birth provided the Child has been enrolled for coverage (and the coverage has been paid for) within sixty (60) days after the Child's birth.

5. Adopted Children.

   For an adopted Child of a Student, coverage shall commence as follows, provided that the Child has been enrolled for coverage (and the coverage has been paid for) within sixty (60) days after the applicable event:

   a. Coverage shall be retroactive to the Child's date of birth when a decree of adoption is entered within sixty (60) 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 Student within sixty (60) days after the date of the Child's birth and if the Student has obtained temporary custody of the Child; or,

   c. For an adopted Child other than a newborn, coverage shall begin as of the date of adoption or placement for adoption or, if earlier, when temporary custody of the Child begins. However, such coverage in connection with temporary custody 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 Policy.

   If an adopted Child is not enrolled within sixty (60) days after the applicable event set forth in (a)-(c) above, coverage will begin on the date chosen by the Member Institution 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 a Student or Dependent who is not enrolled to enroll within sixty (60) days of when the Student or Dependent loses other coverage that qualifies as “minimum essential coverage” under federal law, or certain pregnancy-related or medically needy coverage under the Medicaid program, or otherwise qualifies for a Special Enrollment period under federal law. Contact the Corporation for more information.

D. DEPENDENT CHILD’S ENROLLMENT

1. 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 Student’s federal tax return; or,

   c. Not residing with the Student.

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

3. Absent the sponsorship of a Student, Dependents are not eligible to enroll for coverage under this Policy.

E. MEMBERSHIP APPLICATION

The Corporation will only accept a Membership Application submitted by the Member Institution on behalf of each Student. The Corporation will not accept a Membership Application directly from a Student 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 Policy.

ARTICLE III – BENEFITS

A. PAYMENT

The payment for Benefits is subject to all terms and conditions of this Policy. In the event of a conflict between this Policy and the Schedule of Benefits, the Schedule of Benefits controls. Oral statements cannot alter the terms of the Policy 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 such Provider's 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 Policy;

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 Policy and on the Schedule of Benefits. Benefits are subject to the limitations and requirements set forth in this Policy and on the Schedule of Benefits. Payment for Benefits will not exceed the Allowable Charge.

B. PREAUTHORIZATION

All non-Emergency 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 or denied. 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 Policy. A Member's entitlement to Benefits is not determined until the Member's claim is processed.

C. SPECIFIC COVERED BENEFITS

In order for the Corporation to 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 and/or palate 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 Policy. 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 Policy.

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.

Examples of routine Member costs include, but are not limited to, radiological services, laboratory services, intravenous therapy, anesthesia services, Hospital services, Provider services, office visits, room and board, and Medical Supplies that typically would be covered under the Policy for a Member who is not enrolled in a 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 BENEFITS

Benefits will be paid for certain dental Benefits as set forth on the Schedule of Benefits.

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 within the timeframes set forth on the Schedule of Benefits.

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 Durable Medical Equipment, certain orthotics and supplies. Coverage is provided only for the cost of the item that meets minimum specifications and any amount that exceeds that cost will be the Member's responsibility. 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, unless otherwise required by applicable law.

GENDER DYSPHORIA

Benefits will be paid for non-surgical services related to the diagnosis and/or treatment, including hormone replacement therapy, of gender dysphoria.

GYNECOLOGICAL EXAMINATION

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

HABILITATION

Benefits will be paid for habilitation which are healthcare services and devices that help the Member keep, learn or improve skills and functioning for daily living, including physical therapy, occupational therapy, speech-language pathology and other services to assist a Child with achieving developmental skills such as walking or talking at the expected age when impairments have caused delaying or blocking of initial acquisition of the skills. 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 with the exception of Skilled Nursing Facilities;

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 Clinician'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 such attending surgeon's 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, regardless of Medical Necessity, as set forth on the Schedule of Benefits. Benefits will be paid for additional mammograms during a Benefit Year based on Medical Necessity.

MASTECTOMIES AND RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES

Benefits will be 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, except for life-threatening pregnancy complications to either the mother or fetus. 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 the mother's 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 Policy.

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 to the extent necessary for chronic and pulmonary rehabilitation based on Medical Necessity.

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 the Member's 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 the 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 only the cost of the item that meets minimum specifications and any amount that exceeds that cost will be the Member's responsibility.

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 must be performed by a Provider and at a location designated by the Corporation;

3. Preauthorization must be obtained, if required;

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

5. 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 and may:

1. Require Preauthorization; and/or,

2. Be subject to certain place of service requirements.

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.

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 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 consist of services rendered by a licensed medical doctor, oral surgeon or a certified registered nurse anesthetist, other than the attending surgeon or such attending surgeon's 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.

ABORTIONS

Abortions when not compliant with applicable 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.

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

2. Higashi schools/daily life;

3. Facilitated communication;

4. Group socialization;

5. Primal therapy;

6. Holding therapy;

7. Movement therapy;

8. Art therapy;

9. Dance therapy;

10. Music therapy;

11. Animal assisted therapy;

12. Sexual conversion therapy; and,

13. Cranial electrical stimulation (CES).

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.

CLINICAL TRIAL

Any of the following:

1. Services that are not covered routine patient care costs or services, including the following:

    a. The investigational drug, device, item or service that is provided solely to satisfy data collection and analysis needs;

    b. An item or service that is not used in the direct clinical management of the Member; and,

    c. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

2. An item or service provided by the research sponsors free of charge for any person enrolled in the Clinical Trial; and,

3. Travel and transportation expenses unless otherwise covered under the Policy including, but not limited to:

    a. Fees for personal vehicle, rental car, taxi, medical van, ambulance, commercial airline or train;

    b. Mileage reimbursement for driving a personal vehicle;

    c. Lodging; and,

    d. Meals.

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 Policy 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

Charges for:

1. 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 in the discretion of the Corporation if the need for dental services results from an accidental injury to Natural Teeth within the timeframes set forth on the Schedule of Benefits;

2. Dental services received from a dental or medical department maintained by or on behalf of an Member Institution, a mutual benefit association, labor union, trustee or similar person or group;

3. Dental services for which the Member incurs no charge;

4. Dental services or supplies primarily for cosmetic or aesthetic purposes, including personalization or characterization of dentures;

5. Services rendered by a Provider beyond the scope of such Provider's license;

6. Dental services to the extent that charges for such services exceed the charge that would have been made and actually collected if no coverage hereunder;

7. Charges for completion of claim forms;

8. Charges for visits at home or in the Hospital, except in connection with emergency care;

9. Dental care or treatment not specified on the Schedule of Benefits;

10. Implants and crowns, bridges and/or dentures involving implants;

11. Services related to teeth missing prior to a Member's Effective Date of coverage under this Policy are not eligible for payment of Benefits, except as specified on the Schedule of Benefits;

12. Any service for the treatment of dysfunctions or derangements of the TMJ, regardless of cause, including orthognathic surgery for the treatment of dysfunctions or derangements of the TMJ, regardless of cause, except as specified on the Schedule of Benefits;

13. Appliances or restorations necessary to increase vertical dimensions or restore the occlusion, including management of TMJ disorders, except as specified on the Schedule of Benefits;

14. 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 specific on the Schedule of Benefits;

15. Consultations;

16. Non-IV sedation (nitrous oxide and non-conscious sedation);

17. Services for the excision or extraction of impacted teeth, except as specified on the Schedule of Benefits;

18. Replacement Prosthodontics made necessary by loss or theft, except as specified on the Schedule of Benefits;

19. Temporary crowns and partials;

20. Services or charges resulting from the use of Teledentistry;

21. Dental services or supplies received as the result of any intentionally self-inflicted injury that does not result from a medical condition or domestic violence;

22. Dental services or supplies or other items not specifically listed as a Benefit in Article III of this Policy or on the Schedule of Benefits;

23. Orthodontics

    The following will apply:

    a. Benefits for these services will be limited to Members to the age set forth on the Schedule of Benefits, if any;

    b. Benefits payable per Member are limited to the maximum amount specified on the Schedule of Benefits and to services rendered within a period not to exceed thirty-six (36) consecutive months;

    c. The initial payment will be equal to no more than twenty-five percent (25%) of the total liability of the Corporation, with the following sequential payments payable no more frequently than once a month. If, for any reason, the orthodontic services are terminated before completion of the approved treatment plan, the responsibility of the Corporation will cease with payment through the month of termination; and,

    d. The replacement of any appliances made necessary by reason of loss or theft is not covered by this Policy.

24. Payment for dental services shall be limited as follows:

    a. In all cases involving covered services or supplies in which the Provider and Member selected a more expensive or personalized course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned, payment under this agreement will be based on the charge allowed for the lesser procedure as determined by the Corporation. In the event multiple X-rays are performed on the same date of service, the benefit may be based on the allowed charge of a full mouth X-ray;

    b. In the event a Member transfers from the care of one Provider to that of another Provider during the course of treatment or if more than one Provider performs services for one dental procedure, the Corporation shall be liable not more than the amount it would have been liable for had but one Provider performed the service;

c. Any additional treatment that is necessitated by lack of Member cooperation with the Provider or non-compliance with prescribed dental care that results in additional liability will be the responsibility of the Member; or,

d. In the event that a Provider performs different levels of services on the same day, Benefits will only be paid for the highest level of service.

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.

FOOD SUPPLEMENTS

Orthomolecular therapy, including infant formula, nutrients, vitamins and food supplements administered by mouth. Enteral feedings administered via a feeding tube, including prescription and over-the-counter formulations, when not a sole source of nutrition, 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.

GENDER AFFIRMING SURGICAL SERVICES

Any charges for gender affirming surgical consultation(s) and/or surgical service(s)..

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, directly or indirectly, related to and/or contributed to, in whole or in part, while committing or attempting to commit a felony or while engaging or attempting to engage in an illegal act or occupation.

IMMUNIZATIONS

Immunizations not included on the recommended immunization schedule approved by the CDC.

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 unless the condition is the result of Medically Necessary prostate cancer surgery.

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.

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, behavioral modification facilities, wilderness programs, boot camps, emotional group academies, military schools, therapeutic boarding schools, halfway houses and 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 may be paid in an amount equal to the amount payable had the service been rendered in the least costly setting.

OBESITY RELATED SERVICES

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

2. Surgical procedures for the treatment of morbid obesity, including services, supplies and charges for the treatment of complications from or reversal of such procedures.

3. Membership fees to weight control programs, except as specified 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 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 an interdisciplinary pain management program, as defined herein. An interdisciplinary 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 an interdisciplinary 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 interdisciplinary 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.

PRIVATE DUTY NURSING

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

PROSTHETIC DEVICES

Duplicates and services related to the repair or replacement of such prosthetics, except when Medically Necessary due to routine wear and tear or a change in the Member's medical condition.

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.

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, except as specified on the Schedule of Benefits.

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 such Provider's 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, sexual dysfunction, 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. 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.

9. 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;

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

11. 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);

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

13. 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;

14. 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;

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, 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.

SERVICES FOR CERTAIN DIAGNOSES OR DISORDERS

Medical Supplies, services or charges for the diagnosis or treatment of learning disorders, communication disorders, motor skills disorders, intellectual disabilities, vocational rehabilitation, relational problems, and rapid opiate detoxification, 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 Policy or on the Schedule of Benefits.

SERVICES PRIOR TO MEMBER EFFECTIVE DATE OR MEMBER INSTITUTION'S EFFECTIVE DATE

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

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 themself or rendered by a Member's immediate family (parent, Child, Spouse, brother, sister, grandparent or in-law).

SERVICES REQUIRING PREAUTHORIZATION FOR WHICH SUCH PREAUTHORIZATION IS NOT OBTAINED

If Preauthorization is required for an otherwise Covered Expense and such Preauthorization is not obtained, Benefits may be reduced or denied as set forth on the Schedule of Benefits.

TELEMONITORING

Services where a Member transmits, whether by facsimile, email, telephone or any other format, 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 Policy 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 Policy.

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). 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 Policy secondary.

C. ORDER OF DETERMINATION RULES FOR MEMBERS

When a Member's claim is submitted under both this Policy and another Plan, this Policy 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 Policy;

2. There is a statutory requirement relating to the determination of benefits; or,

3. Both the other Plan's rules and this Policy's rules require that Benefits under this Policy 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 a Student or retiree is the Primary Plan.

2. Dependent Child - Parents not Separated or Divorced.

   When this Policy 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 Students.

The benefits of the Plan that covers a person as a Student who is neither laid off nor retired, or as that Student's Dependent, are determined before those of a Plan that covers that person as a laid off or retired Student or as that Student'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 Policy is a Primary Plan except where federal law mandates that this Policy 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.

E. EFFECT ON BENEFITS OF THIS POLICY

1. This Policy as Primary Plan

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

2. This Policy as Secondary Plan

When this Policy 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 Policy are reduced in this manner, each Benefit is reduced in proportion and then charged against any applicable limit of this Policy.

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 Member Institution 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 Policy. 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 Policy. 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 POLICY

A. GENERALLY

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

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

2. The date a Student ceases to be eligible for coverage as set forth in Article II;

3. In addition to terminating when a Student'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 Student regardless of whether such order or decree is subject to appeal;

4. In addition to terminating when a Student's coverage terminates, a Domestic Partner and the children of the Domestic Partner's coverage terminates when the domestic partnership is dissolved. An Affidavit of Termination of Partnership must be completed by the Student and submitted to the Member Institution and/or the Corporation within thirty (30) days of dissolution, and the Member Institution must send a Membership Application to cancel this person from coverage.

   All other Policy termination of coverage provisions apply to a Domestic Partner and the children of the Domestic Partner;

5. In addition to terminating when a Student's coverage terminates, a Child's coverage terminates when that individual no longer meets the definition of a Child under this Policy;

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

7. Upon the death of the Student.

B. TERMINATION FOR FAILURE TO PAY PREMIUMS

1. If the Premium remains unpaid after the Grace Period, the coverage for the Member's Policy shall automatically terminate, without prior notice to the Member Institution, immediately after the last day of the Grace Period.

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

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

C. UNIFORM TERMINATION OF COVERAGE

1. The Corporation may terminate coverage under this Policy if:

   a. The Corporation ceases to offer coverage of the type of individual health insurance coverage provided by this Policy and provides notice to the Student's Member Institution at least ninety (90) days prior to the date of the discontinuation of such coverage;

   b. The Corporation offers to each Member Institution's Students provided coverage of this type the option to purchase any other individual health insurance currently being offered by the Corporation in the individual market; and,

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

2. If the Corporation elects to discontinue offering all individual health insurance coverage in South Carolina, coverage under this Policy 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 Member Institution of such discontinuation at least one hundred eighty (180) days prior to the date of the discontinuation of such coverage;

c. If all individual 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 individual 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.

D. REINSTATEMENT

The Corporation in its discretion may reinstate coverage under this Policy that has been terminated if:

1. The Member requests reinstatement;

2. The unpaid Premium is not more than sixty (60) days overdue;

3. The Member has paid all overdue and currently due Premiums; and,

4. The Corporation approves the Member's request for reinstatement.

Coverage under this Policy will be reinstated on the date the coverage lapsed if requirements (1) through (4) above have been met. If the request is not approved, the Corporation will refund the Premium submitted. If the Corporation fails to act on the request, coverage under this Policy will be reinstated upon the Corporation's acceptance of the Premium. All terms under this Policy, including any amendments, which existed before the due date will remain in effect. The Member should submit any claims incurred during the period of lapsed coverage to the Corporation for processing under this Policy.

E. EXTENSION OF BENEFITS FOLLOWING TERMINATION

If this Policy is terminated under this Article VI(H), or a Member participating in this Policy 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 Plan with benefits that are similar to the Benefits and such Plan makes a reasonable provision for continuity of care for the disabling condition.

F. MEMBER INSTITUTION AND SCSHIC ARE AGENTS OF MEMBERS

By accepting Benefits, a Member agrees that the Member Institution and SCSHIC are the Member's agents for all purposes of any notice under this Policy. The Member further agrees that notifications received from, or given to, the Member Institution or SCSHIC by the Corporation are notification to the Students 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 a Student and such Student'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 Policy shall be considered as being met to the extent that such probationary periods were met under this Policy.

B. CONTINUATION OF COVERAGE FOR A NON-INCAPACITATED DEPENDENT CHILD

If a non-incapacitated Child covered under this Policy is no longer eligible because of reaching the maximum age limit, such Child may apply for a new policy upon the attainment of the limiting age. The Child is entitled to have issued to him or her, without evidence of insurability, upon application made to the Corporation within thirty-one (31) days following the attainment of the age and upon payment of the appropriate Premium, an individual policy of accident and health insurance, as applicable. The policy shall provide the coverage then being issued by the Corporation which is closest to, but not greater than, the terminated coverage. Any probationary or waiting period set forth in the policy must be considered as met to the extent coverage was in force under the prior Policy. Contact the Corporation for more information.

C. VOLUNTARY MEDIGAP

The Corporation will make voluntary rated health insurance coverage available to any currently insured Student for up to three (3) months from the time the Student either graduates from or discontinues enrollment at a Member Institution.

Premiums for voluntary rated plans are subject to be paid by the Student directly to the Corporation.

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 the Policy 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.

ARTICLE IX - WORKERS' COMPENSATION PROVISION

This Policy 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 Policy, 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 the Member's Member Institution and/or Member Institution's 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 Member Institution and/or Member Institution'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 the Member's Member Institution and/or Member Institution 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 Member Institution and/or Member Institution'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 Member Institution and/or Member Institution'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, Member Institution or the Workers' Compensation carrier; or the medical or healthcare benefits are specifically excluded from the settlement or compromise.

ARTICLE X - 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 Policy 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 X(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 X(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, health care 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 Policy 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 Policy and the time limits applicable to such procedures;

vii. If the reason for denial is based on a lack of Medical Necessity or Investigational or Experimental Services 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; and,

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.

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 X(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, health care 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 Policy 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 Services 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; and,

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.

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. 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 termination or denial or reduction of the claim must be related to:

   a. Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness of a Benefit;

   b. An Investigational or Experimental service that involves a life-threatening or seriously disabling condition; or,

   c. Administration of the provisions related to cost-sharing and surprise billing protections for emergency or air ambulance services by Non-Participating Providers and care provided by Non-Participating Providers at certain Participating Provider facilities.

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 written 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 X(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 will be assigned as expeditiously as reasonably possible and must make its decision within seventy-two (72) hours after it receives the request for expedited review.

ARTICLE XI - GENERAL PROVISIONS

AMENDMENT

Upon thirty (30) days prior written notice, the Corporation may unilaterally amend this Policy when required by federal or state law. Increases in the Benefits provided or decreases in the Premium are effective without such prior notice. Upon thirty-one (31) days' notice, the Corporation may increase the Premium. Notice of an amendment will be effective when addressed to the Member Institution or SCSHIC. The Corporation has no responsibility to provide individual notices to each Member when an amendment to this Policy 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 Member Institution'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 Member Institution's 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 Member Institution 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 Member Institution'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 fraud or a failure to meet applicable quality standards or this Contract is terminated and the Member is a Continuing Care Patient, the Member may be eligible to continue to receive in-network Benefits from that Provider with respect to the course of treatment relating to the Member's status as a Continuing Care Patient.

In order to receive this Continuation of Care, the Member must submit a request to the Corporation on the appropriate form. 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, with respect to the course of treatment relating to the Member's status as a Continuing Care Patient, for ninety (90) days or until the date the Member is no longer a Continuing Care Patient for the Provider. 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.

EXAMINATION AND SURRENDER OF POLICY FOR RETURN OF PREMIUM

Each Student is entitled to thirty (30) days from the date of the receipt of the Policy to examine its provisions and may for any reason surrender the Policy to the Corporation. Any Premium advanced by the Student, upon appropriate surrender as provided herein, must be immediately returned in full by the Corporation to the Student.

GOVERNING LAW

This Policy (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 Policy 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 Policy conflicts with such law, this Policy 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 the Member's 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 Policy 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 Policy or upon other provision in the Policy.

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 Policy within sixty (60) days after written proof of loss has been given as set forth in Article X of this Policy. No such action may be brought after 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 Member Institution on behalf of its Students and Dependents. The Corporation will not accept Membership Applications directly from Students 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 Policy, any notice under this Policy 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:

   Blue Cross and Blue Shield 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 Student 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 Member Institution or SCSHIC: To the name and address last given to the Corporation. The Member Institution and SCSHIC are 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 Policy. Such a decision does not mean the Corporation waives or gives up any rights under this Policy 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

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. Benefits unpaid at death may be paid, at the Corporation's option, either to the Member's beneficiary or estate.

PHYSICAL EXAMINATION AND AUTOPSY

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. In cases of death of the Member, the Corporation, at its own expense, also may have an autopsy performed during the period of contestability unless prohibited by law. The autopsy must be performed in South Carolina.

TIME OF PAYMENT OF CLAIM

The Corporation will pay completed claims received via paper within forty (40) business days and completed electronic claims within twenty (20) business days following the later of:

1. The date the claim is received; or,

2. The date on which the Corporation receives all of the information needed in the format required for the claim to constitute a “clean” claim as defined in the South Carolina Health Care Financial Recovery and Protection Act.

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ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-832-9686 (TTY: 711) or speak to your provider.

Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-844-396-0183 (TTY: 711) o hable con su proveedor. (Spanish)

中文: 注意：如果您說[中文]，我們可以為您提供免費語言援助服務，也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-844-396-0188（TTY：711）或與您的提供者討論。(Chinese)

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Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, available ang mga libreng serbisyo ng tulong sa wika para sa iyo. Available rin nang walang bayad ang mga naaangkop na auxiliary na tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-844-389-4839 (TTY: 711) o makipag-usap sa iyong provider. (Tagalog)

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ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-844-641-2898 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો. (Gujarati)

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한국어: 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-844-396-0187(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오. (Korean)

العربية: تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-844-396-0189 (خدمة الهاتف النصي: 711) أو تحدث إلى مقدم الخدمة. (Arabic)

Українська мова: УВАГА! Якщо ви розмовляєте українською мовою, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби й послуги для надання інформації в доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1- 844-641-2897 (TTY: 711) або зверніться до свого постачальника. (Ukrainian)

日本語: 注: 日本語を希望する場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰でも利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-844-396-0185（TTY: 711）までお電話ください。または、ご利用の事業者にお問い合わせください。 (Japanese)

ไทย: โปรดทราบ: หากคุณพูดภาษา ไทย เรามีบริการความช่วยเหลือด้านแปลภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อที่ 1-844-641-2896 (TTY: 711) หรือปรึกษาผู้ให้บริการของคุณ (Thai)

ລາວ: ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-844-641-2895 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ. (Lao)

हिंदी: ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-844-641-2894 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें। (Hindi)

Diné SHOOH: Diné bee y1ni[ti'gogo, saad bee an1'awo' bee 1ka'an7da'awo'7t'11 jiik'eh n1 h0l=. Bee ahi[hane'go bee nida'anish7 t'11 1kodaat'4h7g77 d00 bee 1ka'an7da'wo'7 1ko bee baa hane'7 bee hadadilyaa bich'8' ahoot'i'7g77 47 t'11 jiik'eh h0l=. Kohj8' 1-844-516-6328 (TTY: 711) hod7ilnih doodago nika'an1lwo'7 bich'8' hanidziih. (Navajo)

Kiswahili MAKINIKA: Ikiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo ili kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Piga simu 1-844-465-1726 (TTY: 711) au zungumza na mtoa huduma wako. (Swahili)

አማርኛ ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-844-465-1592 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ። (Amharic)

Soomaali FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac 1-844-465-1724 (TTY: 711) ama la hadal bixiyahaaga. (Somali)

ILOCANO PANANGIKASO: No agsasaoka iti Ilocano, magun-odmo dagiti libre a serbisio ti tulong iti pagsasao. Libre met laeng a magun-odan dagiti maitutop a katulongan ken serbisio a mangipaay iti impormasion kadagiti ma-akses a pormat. Awagan ti 1-800-832-9686 (TTY: 711) wenno makisarita iti mangipapaay kenka. (Ilocano)

नेपाली सावधान: यदि तपाईंनेपाली भाषा बोल्नुहुन्छ भनेतपाईंका लादि दन:शुल्क भादषक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रिान ननउपयुक्त सहायता र सेवाहरू पदन दनि:शुल्क उपलब्ध छन्। 1-844-465-1722 (TTY: 711) मा फोन नुनहोस्वा आफ्नो प्रियकसुँ कु रा नुनहोस्। (Nepali)

ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-844-396-0184 (TTY: 711) o parla con il tuo fornitore. (Italian)

বাংলা

মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 1-844-465-1713 (TTY: 711) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন। (Bengali)

Kreyòl Ayisyen ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 1-844-465-1715 (TTY: 711) oswa pale avèk founisè w la. (Haitian Creole)

POLSKI UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-844-396-0186 (TTY: 711) lub porozmawiaj ze swoim dostawcą. (Polish)

తెలుగు

సావధానం: మీరు తెలుగు మాట్లాడితే, మీకు ఉచిత భాషా సహాయ సేవలు అందుబాటులో ఉంటాయి. యాక్సెస్ చేయగల ఫార్మాట్‌లలో సమాచారాన్ని అందించడానికి తగిన సహాయక సహాయాలు మరియు సేవలు కూడా ఉచితంగా అందుబాటులో ఉంటాయి. 1-800-832-9686 (TTY: 711)కి కాల్ చేయండి లేదా మీ ప్రొవైడర్‌తో మాట్లాడండి. (Telugu)

Lus Hmoob

LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 1-844-465-1717 (TTY: 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob. (Hmong)

ਪੰਜਾਬੀ

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੇਂ ਪੂਰਕ ਸਹਾਇਕ ਸਾਧਨ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫ਼ਤ ਵਿੱਚ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। 1-844-465-1723 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ। (Punjabi)

ភាសាខ្មែរសូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយ *ភាសាខ្មែរ* សេវាកម្មជំនួយភាសាឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មនៃលក្ខណៈការប្តូរដ៏សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់នៃលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយឥតគិតថ្លៃផងដែរ។ ហៅទូរសព្ទទៅ 1-844-465-1721 (TTY: 711) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។ (Khmer)

فارسي

توجه: اگر فارسی صحبت می‌کنید، خدمات رایگان پشتیبانی زبان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات جانبی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 1-844-398-6233 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید. (Farsi)

اردو

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے مفت لسانی اعانت کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 1-844-465-1725 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔ (Urdu)

אידיש

אכטונג: אויב איר רעדט אידיש, אומזיסטע שפראך הילף סערוויסעס זענען אוועילעבל פאר אייך. פאסיגע אוקזיליריי הילף און סערוויסעס צוצושטעלן אינפארמאציע אין צוטריטליכע פארמאטן זענען אויך אוועילעבל פריי פון אפצאל. רופן 1-833-584-1829 (TTY: 711) אדער רעדט מיט אייער פראוויידער. (Yiddish)

Deitsch

WICHDICH: Wann du Deitsch schwetzscht, kenne mer dich Schprooch-Hilf griege. Mir kenne dich aa differnti Sadde Hilf griege, wasewwer as brauchscht fer Information griege, unni as es dich ennich eppes koschde zellt. Call 1-833-584-1829 (TTY: 711) uff odder schwetz mit dei Provider. (Pennsylvania Dutch)

Ελληνικά

ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το 1-844-465-1714 (TTY: 711) ή απευθυνθείτε στον πάροχό σας. (Greek)

Oromoo

Afaan Oromoo HUBACHIISA: Yoo Afaan Oromoo dubbattan ta'e, tajaajilloota gargaarsa afaanii bilisaan isiniif ni kennama. Gargaarsoonni fi tajaajilloonni sirrii ta'an namoota dhagahuufi arguun isaan rakkisuuf odeeffannoo dhangii dhaqqabamaa ta'een kennuunis bilisaan niargamu. Gara 1-800-832-9686 (TTY: 711) tti bilbilaa yookiin qopheessaa keessan haasofsiisaa. (Oromo)

Gagana Samoa

FAAALIGA: Afai e te tautala i le Gagana Samoa, o loo maua fua auaunaga lagolago mo gagana. O le a maua fua fo'i mea faalogo, isi faiga tau fesoasoani ma auaunaga talafeagai e tuuina mai ai faamatalaga i auala faigofie ona maua. Vili le 1-800-832-9686 (TTY: 711) pe talanoa i lau fai auaunaga. (Samoan)



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