WELCOME TO BLUE CROSS BLUE SHIELD OF SOUTH CAROLINA

CLEMSON UNIVERSITY

Preferred Blue®
Student Health Plan

SouthCarolinaBlues.com

January 1, 2019

INTRODUCTION

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 healthcare coverage.

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

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

BlueCross BlueShield 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 download claim forms? Need to print an Explanation of Benefits (EOB)?***

You also can use such self-help tools as:

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

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

Through our **Treatment Cost Estimator**, you can see your estimated out-of-pocket costs for over four hundred (400) treatment cost categories. Treatment cost categories include inpatient and outpatient procedures like Magnetic Resonance Imaging (MRIs) and Surgical Services. Costs are displayed by place of service and you can compare up to three (3) facilities on cost and quality. Your out-of-pocket costs displayed on the website are based on your Plan design and your real-time Benefit Year Deductible and Out-of-Pocket Maximum status. Your estimated costs will include any Copayment, Benefit Year Deductible and Coinsurance you would owe.

On the go? The My Health Toolkit® mobile website offers Members features designed for smaller smartphone screens. Unlike some mobile tools, as a BlueCross Member, you do not need to download an app. When you want to access the mobile site, simply navigate to www.SouthCarolinaBlues.com on your smartphone or tablet.

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 will 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 have no protection from balance billing from the Provider.

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:

- 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 the procedures on the Schedule of Benefits that have a "Preauthorization" note.

Preauthorization for Mental Health Services and Substance Use Disorder Services:

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

How to get information on drug coverage:

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

For inquiries regarding the Prescription Drug Benefit, please call:

- 888-963-7290

For prior authorization on Prescription Drugs, please call:

- 800-294-5979

For inquiries regarding Specialty Drugs, please call:

- 800-237-2767

For inquiries regarding the status of prior authorization on Specialty Drugs, please call:

- 800-237-2767

For Preauthorization for the Try-Generics Program, please call:

- 800-294-5979

You can also access Caremark from My Health Toolkit.

For information regarding Quantity versus Time Limits or Step Therapy Programs, contact your Customer Service Representative.

The Corporation provides you with an incentive program where you are eligible for rewards based on your completion of certain criteria. For more information, contact your Customer Service Representative or access My Health Toolkit.

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.

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

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

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

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

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

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

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

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

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

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

To participate, call 855-838-5897.

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

Quit for Life:
The Corporation provides you and your covered Dependent eighteen (18) years of age or older with access to ***Quit for Life,*** an aggressive tobacco cessation program that provides counseling and nicotine replacement therapy (NRT). Quit for Life is offered through Optum. Optum is an independent company that provides the Quit for Life program on behalf of BlueCross.

When tobacco users enroll in the Quit for Life program, they will receive:

- Five (5) individualized, telephone-counseling sessions from a tobacco treatment specialist or Quit Coach.
- Unlimited toll free telephone access to the Quit Coaches for the duration of treatment.
- An 8-week supply of NRT shipped directly to your home, if appropriate. The Quit Coach will make NRT recommendations of type and dosing.
- A Quit Kit of materials designed to help you or your Dependent quit tobacco through active self-management, as well as advice so family and friends are able support the tobacco user.

To participate, call: *866-QUIT-4-LIFE*.

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

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

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

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

2. Visit www.BlueCareOnDemandSC.com.

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

Actuarial Value:

This Policy constitutes an ACA-compliant Student Health Plan that provides comprehensive Benefits with an actuarial value of 78.42%, with the applicable "metal level" being gold.

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. An EOB will also be mailed to you. 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 telephone numbers listed on the previous page, and we will send you a form. After filling out the claim form, send it to the address below:

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

Please refer to Article XI 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:

Blue Cross and Blue Shield 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: 25-85558-00, 02 through 06 and 08 through 13
Member Institution: Clemson University
Student Health Plan
Policy Effective Date: January 1, 2019

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 and undergraduate Students enrolled in a minimum of six (6) or more semester hours and subject to a hard-waiver requirement at a Member Institution;

2. All graduate Students enrolled in one (1) semester hour and/or that have a graduate assistance (GA) position within the institution;

3. All international Students (includes special programs i.e. English Programs for International-EPI student internships, Co-ops and Student Teaching); and,

4. Post-doctorate Students who are not eligible for the institution's employee health insurance plan and are eligible to pay the health services fee who are subject to a hard-waiver requirement at a Member Institution.

Undergraduate and graduate Students who do not fall under the hard waiver plan are eligible to purchase the Voluntary Plan if:

1. The Student is eligible to pay the student health services health fee (includes undergraduate and graduate students as applicable);

2. The Student is enrolled in a degree-seeking program; and,

3. The Student is enrolled in a minimum number of semester hours as required by the Member Institution.

Degree-seeking Students participating in campus-sponsored internships, a co-op semester, or student teaching that is required as part of the academic degree program of the campus are eligible for, but are not required to have, the Hard Waiver Plan, including:

1. Enrolled Students for which the proposer and Member Institution agree should be eligible to participate; and,

2. Eligible Dependents.

GENERAL PROVISIONS **When a Benefit is listed below and has a dollar or percentage amount associated with it, 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. $1,500 per family with no one Member meeting more than $750 for Participating Providers. $3,000 per family with no one Member meeting more than $1,500 for Non-Participating Providers. 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 Student Health Center:	There are no Out-of-Pocket Maximums for services performed at a Student Health Center.

Out-of-Pocket Maximums for Participating Providers:	**Standard Out-of-Pocket Maximums:** $11,200 per family with no one Member meeting more than $5,600. Benefit Year Deductibles and Coinsurance contribute to the Standard Out-of-Pocket Maximum, with the exception of chiropractic services and adult dental care services. Allowable Charges for Coinsurance are paid at 100% after the Standard Out-of-Pocket Maximum is met, except as specified above. The Member will still be responsible for any applicable Copayments until the Out-of-Pocket Maximum is met. **Out-of-Pocket Maximums:** $12,700 per family with no one Member meeting more than $6,350. All Benefit Year Deductibles, Coinsurance and Copayments incurred, with the exception of chiropractic services and adult dental care services, will contribute to the Out-of-Pocket Maximum. All Allowable Charges are paid at 100% after the Out-of-Pocket Maximum is met. If Coinsurance does not contribute to the Out-of-Pocket Maximum, the percentage of reimbursement does not change from the amount indicated on the Schedule of Benefits. Coinsurance, Benefit Year Deductibles and Copayments for services rendered at a Participating Provider will apply to the Standard Out-of-Pocket Maximum or Out-of-Pocket Maximum as listed above and will not be applied to the Non-Participating Provider Out-of-Pocket Maximum.
Out-of-Pocket Maximums for Non-Participating Providers:	$30,000 per family with no one Member meeting more than $15,000. Benefit Year Deductibles, Coinsurance for chiropractic services, coinsurance for adult dental care services and Copayments do not contribute to the Out-of-Pocket Maximum determination. Allowable Charges are paid at 100% after the Out-of-Pocket Maximum is met. If Coinsurance does not contribute to the Out-of-Pocket Maximum, the percentage of reimbursement does not change from the amount indicated on the Schedule of Benefits. Coinsurance and Benefit Year Deductibles for services rendered at a Non-Participating Provider will apply to the Non-Participating Provider Out-of-Pocket Maximum only and will not be applied to either the Standard Out-of-Pocket Maximum or Out-of-Pocket Maximum for Participating Providers.

Benefit Year Deductibles and any Copayments must be met before any Covered Expenses can be paid.

If a Student does not pay the Student Health fee as part of his or her tuition, he or she 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 initial Benefit Year is 08/01/18 through 07/31/19. 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	
Inpatient	**All Admissions require Preauthorization** If Preauthorization is not obtained, room and board charges will be denied. Other services may also require preauthorization. All charges will be denied for human organ and tissue transplant services not performed at a Blue Distinction Center of Excellence or a transplant center approved by the Corporation in writing.
Outpatient	Preauthorization is required for the following outpatient Benefits: • Any surgical procedure that may be potentially cosmetic: i.e., blepharoplasty, reduction mammoplasty • Cancer chemotherapy • Hysterectomy • Investigational procedures • Septoplasty • Radiation therapy Benefits for outpatient services that require Preauthorization will be reduced by 50% of the Allowable Charge when Preauthorization is not obtained or approved by the Corporation.
Mental Health Services and Substance Use Disorder Services	Preauthorization is required for the following Mental Health Services and Substance Use Disorder Services: • Applied Behavioral Analysis (ABA) related to Autism Spectrum Disorder (Preauthorization requests and treatment plans must be submitted to CBA) • Facility-based inpatient services • Facility-based outpatient services (partial hospitalization, electroconvulsive therapy (ECT) and intensive outpatient programs) • Psychological testing • Repetitive transcranial magnetic stimulation (rTMS) Benefits for ABA related to Autism Spectrum Disorder will be denied when Preauthorization is not obtained or approved by the Corporation. If Preauthorization is not obtained or approved by the Corporation for facility-based inpatient services, charges for room and board will be denied. Benefits for psychological testing and rTMS performed in the office and for the facility-based outpatient services listed above will be reduced by 50% of the Allowable Charge when Preauthorization is not obtained or approved by the Corporation.

Other Services	Preauthorization is required for the following services:
	
	• Ambulance services (when reasonable under the circumstances)
	• Cleft lip and palate
	• Dental care for accidental injury (Preauthorization is required for the treatment plan and subsequent visits)
	• Durable Medical Equipment if purchase or rental is $500 or more
	• Home Health Care
	• Hospice Care
	• Orthopedic devices
	• Orthotic devices
	• Oxygen
	• Radiology Management
	  • CAT scans
	  • MRI
	  • MRA
	  • Musculoskeletal care
	  • PET scans
	  • Radiation treatment plans related to oncology
	
	Benefits for durable medical equipment, Home Health Care, Hospice Care, radiation treatment plans related to oncology, musculoskeletal care, MRIs, MRAs, CAT scans and PET scans performed in an outpatient facility will be denied when Preauthorization is not obtained or approved by the Corporation. Preauthorization may be required for outpatient rehabilitation services.

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

ADMISSIONS/INPATIENT BENEFITS OTHER THAN MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES			
	Student Health Center	**Participating Provider**	**Non-Participating Provider**
Hospital charges for room and board related to 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
All other Benefits in a Hospital during an Admission (including for example, facility charges related to the administration of anesthesia, obstetrical services, including labor and delivery rooms, drugs, medicine, lab and X-ray services)	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	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 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

OUTPATIENT BENEFITS OTHER THAN MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES			
	Student Health Center	**Participating Provider**	**Non-Participating Provider**
Hospital and Ambulatory Surgical Center charges for Benefits provided on an outpatient basis	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
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 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
True emergency room visits (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 $450 Copayment The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible and Copayment	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $450 Copayment The Member must pay the balance of the Provider's charge
Non-true emergency room visits (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 $450 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 $450 Copayment The Member must pay the balance of the Provider's charge

	Student Health Center	Participating Provider	Non-Participating Provider
All other covered outpatient Benefits	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

PROVIDER SERVICES OTHER THAN MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES			
	Student Health Center	**Participating Provider**	**Non-Participating Provider**
Provider Services in a Hospital	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
Surgical Services, when rendered in a Hospital 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	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 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
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 The Member must pay the balance of the Provider's charge

	Student Health Center	Participating Provider	Non-Participating Provider
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	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, including contraceptives and birth control devices (other than Surgical Services, maternity care, physical therapy, dialysis treatment and Second Surgical Opinion) This Benefit does not include preventive Benefits offered under the ACA. See the preventive Benefits section in this Schedule of Benefits for payment of preventive Benefits under the ACA.	The Corporation pays 100% of the Allowable Charge after the Member pays a $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
Provider Services in the Member's home	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
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
All other Provider Services	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

MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES			
	Student Health Center	**Participating Provider**	**Non-Participating Provider**
Inpatient Hospital charges for Mental Health Services and Substance Use Disorder Services	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
Residential Treatment Center Admissions for Mental Health Services and Substance Use Disorder Services	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
Outpatient Hospital or clinic charges for Mental Health Services and Substance Use Disorder Services	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 Provider charges for Mental Health Services and Substance Use Disorder Services	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
Outpatient Provider charges for Mental Health Services and Substance Use Disorder Services	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
Office Provider charges for Mental Health Services and Substance Use Disorder Services	The Corporation pays 100% of the Allowable Charge after the Member pays a $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
Outpatient Hospital emergency room charges for Mental Health Services and Substance Use Disorder Services	Not Available	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $450 Copayment The Member pays the remaining 20% of the Allowable Charge after meeting the Member's Benefit Year Deductible and Copayment	The Corporation pays 80% of the Allowable Charge after the Benefit Year Deductible and after the Member pays a $450 Copayment The Member must pay the balance of the Provider's charge

OTHER SERVICES			
	Student Health Center	**Participating Provider**	**Non-Participating Provider**
Ambulance service (including air ambulance)	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
Home Health Care, limited to sixty (60) visits 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

	Student Health Center	Participating Provider	Non-Participating Provider
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
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

	Student Health Center	Participating Provider	Non-Participating Provider
Provider charges for rehabilitation related to physical therapy and occupational therapy (Limited to a combined thirty (30) visits per Member per Benefit Year. Please see the "Outpatient Rehabilitation" section in Article III of the Policy for limitations)	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
Provider charges for habilitation related to physical therapy and occupational therapy (Limited to a combined thirty (30) visits per Member per Benefit Year. Please see the "Outpatient Rehabilitation" section in Article III of the Policy for limitations)	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
Rehabilitation related to speech therapy (Limited to twenty (20) visits per Member per Benefit Year. Please see the "Outpatient Rehabilitation" section in Article III of the Policy for limitations)	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
Habilitation related to speech therapy (Limited to twenty (20) visits per Member per Benefit Year. Please see the "Outpatient Rehabilitation" section in Article III of the Policy for limitations)	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

	Student Health Center	Participating Provider	Non-Participating Provider
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	Non-Covered
Allergy injections	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 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
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
Supplemental accident Benefits	Not Available	Non-Covered	Non-Covered

	Student Health Center	Participating Provider	Non-Participating Provider
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 • Biopsy of oral tissue • Prophylaxis, limited to two (2) services per Member per Benefit Year	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	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 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, Major Dental Services and Orthodontic 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
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 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	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

VISION BENEFITS			
	Student Health Center	**Participating Provider**	**Non-Participating Provider**
Adult eye exam and glasses, limited to one (1) routine eye exam and one (1) pair of prescribed lenses, frames or contact lenses per Member per Benefit Year for Members age nineteen (19) and older	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 $20 Copayment	The Corporation pays 100% of the Allowable Charge after the Member pays a $20 Copayment The Member must pay the balance of the Provider's charge
Children's eye exam and glasses, limited to one (1) routine eye exam and one (1) pair of prescribed lenses, frames or contact lenses per Member per Benefit Year for Members through age eighteen (18)	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

PREVENTIVE BENEFITS The Benefit Year Deductible does not apply to these Benefits			
	Student Health Center	**Participating Provider**	**Non-Participating Provider**
Preventive Benefits under the 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	Non-Covered
Pap smear screenings (the report and interpretation only, limited to one (1) per Member per Benefit Year)	The Corporation pays 100% of the Allowable Charge	The Corporation pays 100% of the Allowable Charge	Non-Covered
Prostate screenings (limited to one (1) per Member per Benefit Year)	The Corporation pays 100% of the Allowable Charge	The Corporation pays 100% of the Allowable Charge	Non-Covered
Gynecological exam (limited to two (2) per Member per Benefit Year)	The Corporation pays 100% of the Allowable Charge	The Corporation pays 100% of the Allowable Charge	Non-Covered
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	Non-Covered

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)	The Corporation pays 100% of the Allowable Charge	The Corporation pays 100% of the Allowable Charge	Non-Covered

PRESCRIPTION DRUG BENEFIT				
Prescription Drugs	**Student Health Center**	**Mail Service Pharmacy**	**Participating Pharmacy**	**All Other Pharmacies**
Generic Drugs	The Member pays a $10 Prescription Drug Copayment for each monthly prescription or refill, up to a 90 day supply	Non-Covered	The Member pays a $20 Prescription Drug Copayment for each monthly prescription or refill after the Prescription Drug Deductible, up to a 90 day supply	The Member will be responsible for 100% of the Allowable Charge at the pharmacy then will be reimbursed at 100% after a $20 Prescription Drug Copayment per Member for each monthly prescription or refill after the Prescription Drug Deductible, up to a 90 day supply
Preferred Brand Drug	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	Mail Service Pharmacy	Participating Pharmacy	All Other Pharmacies
Non-Preferred Brand Drug	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
*Contraceptives: oral contraceptives, cervical cap, diaphragms, emergency contraception, female condom, implantable rod, intrauterine device (IUD), patch, shot/injection, spermicide, sponge, vaginal contraceptive ring and approved sterilization procedures for women A complete list of specific Prescription Drugs or supplies covered at 100% is available at www.SouthCarolinaBlues.com	Prescription Drugs will be covered at 100%, up to a 31 day supply	Prescription Drugs will be covered at 100%, up to a 31 day supply	Prescription Drugs will be covered at 100%, up to a 31 day supply	Non-Covered
**All other contraceptives (Prescription Drugs)	Covered	Non-Covered	Covered	Covered

Prescription Drugs	Student Health Center	Mail Service Pharmacy	Participating Pharmacy	All Other Pharmacies
Sexual dysfunction Prescription Drugs	Non-Covered	Non-Covered	Non-Covered	Non-Covered
Tobacco cessation Prescription Drugs	Covered	Non-Covered	Covered	Covered
Obesity/weight control Prescription Drugs	Non-Covered	Non-Covered	Non-Covered	Non-Covered
Infertility Prescription Drugs	Non-Covered	Non-Covered	Non-Covered	Non-Covered
Cosmetic Prescription Drugs	Non-Covered	Non-Covered	Non-Covered	Non-Covered
Prescription Drug deductible	$0 (No Prescription Drug deductible)	Non-Covered	$100 per Member per Benefit Year	$100 per Member per Benefit Year
Prescription Drug out-of-pocket	$0 (No Prescription Drug out-of-pocket)	Non-Covered	$0 (No Prescription Drug out-of-pocket)	$0 (No Prescription Drug out-of-pocket)
Maximum Prescription Drug Benefit	$0 (No maximum Prescription Drug Benefit)	Non-Covered	$0 (No maximum Prescription Drug Benefit)	$0 (No maximum Prescription Drug Benefit)
Diabetic syringes and supplies (test strips, lancets, syringes, needles, control solution and lancet devices)	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
*Contraceptives listed above are covered under the participating medical Benefits at the same payment levels. Refill quantities for the contraceptives listed above may vary. **All other contraceptives are paid at the Generic, Preferred Brand and Non-Preferred Brand Drug payment levels.				

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

PREFERRED BLUE®
POLICY

South Carolina

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

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 AND 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: **January 17, 2019**

TABLE OF CONTENTS

RATE PAGE **1**

ARTICLE I - DEFINITIONS **5**

ARTICLE II – ELIGIBILITY FOR COVERAGE **23**

A. ELIGIBILITY **23**
B. ELECTION OF COVERAGE **23**
C. COMMENCEMENT OF COVERAGE **23**
D. DEPENDENT CHILD'S ENROLLMENT **25**
E. MEMBERSHIP APPLICATION **25**
F. MEMBER CONTRIBUTIONS **25**
G. DISCLOSURE OF MEDICAL INFORMATION **25**

ARTICLE III – BENEFITS **26**

A. PAYMENT **26**
B. PREAUTHORIZATION **26**
C. SPECIFIC COVERED BENEFITS **27**
D. BENEFITS **27**
ABA RELATED TO AUTISM SPECTRUM DISORDER **27**
ALLERGY INJECTIONS **27**
AMBULANCE SERVICES **28**
CHIROPRACTIC SERVICES **28**
CLEFT LIP OR PALATE **29**
CLINICAL TRIALS **29**
COLORECTAL CANCER SCREENING **29**
DENTAL CARE FOR ACCIDENTAL INJURY **30**
DIABETIC SUPPLIES **30**
DIABETES EDUCATION **30**
DURABLE MEDICAL EQUIPMENT **30**
EMERGENCY SERVICES **30**
GENDER DYSPHORIA **31**
GYNECOLOGICAL EXAMINATION **31**
HABILITATION **31**
HOME HEALTH CARE **31**
HOSPICE CARE **31**
HOSPITAL AND SKILLED NURSING FACILITY SERVICES **31**
HUMAN ORGAN AND TISSUE TRANSPLANTS **32**
IN-HOSPITAL MEDICAL SERVICE **32**
MAMMOGRAPHY TESTING **33**
MEDICAL SUPPLIES **33**
MENTAL HEALTH SERVICES **33**
OBSTETRICAL SERVICES **33**

ORTHOPEDIC DEVICES 34
ORTHOTIC DEVICES 34
OUTPATIENT HOSPITAL AND AMBULATORY SURGICAL CENTER SERVICES 34
OUTPATIENT REHABILITATION SERVICES 34
OXYGEN 34
PAP SMEAR 34
PHYSICAL EXAMINATION 34
PRESCRIPTION DRUGS 34
PREVENTIVE SERVICES 35
PROSTATE EXAMINATION 35
PROSTHETIC DEVICES 35
PROVIDER SERVICES 36
RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES 36
REHABILITATION 36
RESIDENTIAL TREATMENT CENTER 36
SPECIALTY DRUGS 37
SUBSTANCE USE DISORDER SERVICES 37
SURGICAL SERVICES 37
TELEHEALTH 38
TELEMEDICINE 38

ARTICLE IV - EXCLUSIONS AND LIMITATIONS 39

ACUPUNCTURE 39
ACTS OF WAR 39
ADMISSIONS THAT ARE NOT PREAUTHORIZED 39
BEHAVIORAL, EDUCATIONAL OR ALTERNATE THERAPY PROGRAMS 39
BENEFITS PROVIDED BY STATE OR FEDERAL PROGRAMS 40
BIO-FEEDBACK SERVICES 40
COMPLICATIONS FROM FAILURE TO COMPLETE TREATMENT 40
COMPLICATIONS FROM NON-COVERED SERVICES 40
CONTRACEPTIVES 40
COPYING CHARGES 40
COSMETIC AND RECONSTRUCTIVE SERVICES 40
CRANIAL ORTHOTICS 41
CUSTODIAL CARE 41
DENTAL SERVICES 41
DISCOUNT SERVICES 43
EYEGLASSES 43
FOOT CARE 43
GROWTH HORMONE THERAPY 44
HEARING AIDS 44
HEMOPHILIA SERVICES 44
HUMAN ORGAN AND TISSUE TRANSPLANTS 44
HYPNOTISM 44
ILLEGAL ACTS 44
IMMUNIZATIONS 44
IMPACTED TOOTH REMOVAL 44
IMPOTENCE 44
INCAPACITATED DEPENDENTS 45

INFERTILITY 45
INPATIENT DIAGNOSTIC AND EVALUATIVE PROCEDURES 45
INVESTIGATIONAL OR EXPERIMENTAL SERVICES 45
LIFESTYLE IMPROVEMENT SERVICES 45
LONG-TERM CARE SERVICES 45
MASSAGE THERAPY 45
MEMBERSHIP DUES AND OTHER FEES 46
MISSED PROVIDER APPOINTMENTS 46
NO LEGAL OBLIGATION TO PAY 46
NOT MEDICALLY NECESSARY SERVICES OR SUPPLIES 46
OBESITY RELATED PROCEDURES 46
ORTHOGNATHIC SURGERY 46
OUTPATIENT SERVICES THAT ARE NOT PREAUTHORIZED 46
OVER-THE-COUNTER DRUGS 46
PAIN MANAGEMENT PROGRAMS 47
PARTICIPATING PROVIDER CHARGES NOT PREAUTHORIZED 47
PHYSICAL THERAPY ADMISSIONS 47
PRECONCEPTION SERVICES 47
PREMARITAL AND PRE-EMPLOYMENT EXAMINATIONS 47
PREOPERATIVE ANESTHESIA CONSULTATION 47
PRESCRIPTION DRUG COPAY CARD 47
PRESCRIPTION DRUG EXCLUSIONS 47
PRIVATE DUTY NURSING 49
PROSTHETIC DEVICES 49
PROVIDER CHARGES 49
PSYCHOLOGICAL AND EDUCATIONAL TESTING 49
PULMONARY REHABILITATION 49
RADIOLOGY MANAGEMENT 49
RELATIONSHIP COUNSELING 49
SELF-INFLICTED INJURY 50
SERVICES FOR CERTAIN DIAGNOSES OR DISORDERS 50
SERVICES FOR COUNSELING OR PSYCHOTHERAPY 50
SERVICES NOT LISTED AS COVERED BENEFITS 50
SERVICES PRIOR TO MEMBER EFFECTIVE DATE OR MEMBER INSTITUTION'S EFFECTIVE DATE 50
SERVICES RENDERED BY AN INDEPENDENT HEALTHCARE PROFESSIONAL 50
SERVICES RENDERED BY FAMILY 51
SEX CHANGE 51
TELEMONITORING 51
TEMPOROMANDIBULAR JOINT (TMJ) DISORDER 51
TOBACCO CESSATION TREATMENT 51
TRAVEL 51
VARICOSE VEIN AND VENOUS INSUFFICIENCY TREATMENT 51
VISION CARE 51
WHEELCHAIRS OR POWER OPERATED VEHICLES 51
WORKERS' COMPENSATION 52

ARTICLE V - COORDINATION OF BENEFITS 52

A. APPLICABILITY 52

B. COORDINATION OF BENEFITS WITH AUTO INSURANCE 52
C. ORDER OF DETERMINATION RULES FOR MEMBERS 52
D. ADDITIONAL ORDER OF DETERMINATION RULES 52
E. EFFECT ON BENEFITS OF THIS POLICY 54
F. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION 54
G. PAYMENT 55
H. RIGHT OF RECOVERY 55

ARTICLE VI – TERMINATION OF THIS POLICY 55

A. GENERALLY 55
B. TERMINATION FOR FAILURE TO PAY PREMIUMS 56
C. UNIFORM TERMINATION OF COVERAGE 56
D. EXTENSION OF BENEFITS FOLLOWING TERMINATION 57
E. MEMBER INSTITUTION AND SCSHIC ARE AGENTS OF MEMBERS 57

ARTICLE VII – CONVERSION AND CONTINUATION OF COVERAGE 57

A. CONVERSION FOR DIVORCED SPOUSES 57
B. CONTINUATION OF COVERAGE FOR A NON-INCAPACITATED DEPENDENT CHILD 57
C. VOLUNTARY MEDIGAP 58

ARTICLE VIII – SUBROGATION AND REIMBURSEMENT 58

A. SUBROGATION 58
B. REIMBURSEMENT 58
C. GENERAL PROVISIONS 58

ARTICLE IX - WORKERS' COMPENSATION PROVISION 59

ARTICLE XI - CLAIMS FILING AND APPEAL PROCEDURES 60

A. CLAIMS FILING PROCEDURES 60
B. APPEAL PROCEDURES FOR AN ADVERSE BENEFIT DETERMINATION 64
C. EXTERNAL REVIEW PROCEDURES 66

ARTICLE XII - GENERAL PROVISIONS 67

AMENDMENT 67
AUTHORIZED REPRESENTATIVES 68
BLUECARD PROGRAM 68
CLERICAL ERRORS 71
CONTINUATION OF CARE 71
EXAMINATION AND SURRENDER OF POLICY FOR RETURN OF PREMIUM 72
GOVERNING LAW 72

IDENTIFICATION CARD **72**
INCONTESTABILITY **72**
INFORMATION AND RECORDS **72**
LEGAL ACTIONS **73**
MEMBERSHIP APPLICATION **73**
NEGLIGENCE OR MALPRACTICE **73**
NOTICES **73**
NO WAIVER OF THE CORPORATION'S RIGHTS **73**
OTHER INSURANCE **73**
PAYMENT OF CLAIMS **74**
PHYSICAL EXAMINATION AND AUTOPSY **74**
TIME OF PAYMENT OF CLAIM **74**

INDEX **75**

RATE PAGE

Member Institution Name: Clemson University
Member Institution Number(s): 25-85558-00, 02, 08 and 09
Effective Date: January 1, 2019

Medical Premiums:	**Types of Membership**	**Monthly Premiums**
	Student	$151.92
	Student +One	$303.84
	Student +Two	$455.76
	Student +Three	$607.68
	Student +Four or more	$759.60
Fees:		
Blue Marketplace[SM]:	$1.00 per Student per month	
Quit for Life: Offered by Optum, an independent company that offers a smoking cessation program on behalf of BlueCross.	$250.00 per enrolled participant plus the cost of the Nicotine Replacement Therapy (NRT)	

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: Clemson University
Member Institution Number(s): 25-85558-03, 04, 10 and 11
Effective Date: January 1, 2019

Medical Premiums:	**Types of Membership**	**Monthly Premiums**
	Student	$211.76
	Student +One	$423.52
	Student +Two	$635.28
	Student +Three	$847.04
	Student +Four or more	$1,058.80
Fees:		
Blue Marketplace[SM]:	$1.00 per Student per month	
Quit for Life: Offered by Optum, an independent company that offers a smoking cessation program on behalf of BlueCross.	$250.00 per enrolled participant plus the cost of the Nicotine Replacement Therapy (NRT)	

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: Clemson University
Member Institution Number(s): 25-85558-05 and 12
Effective Date: January 1, 2019

Medical Premiums:	**Types of Membership**	**Monthly Premiums**
	Student	$262.56
	Student +One	$525.12
	Student +Two	$787.68
	Student +Three	$1,050.24
	Student +Four or more	$1,312.80
Fees:		
Blue Marketplace[SM]:	$1.00 per Student per month	
Quit for Life: Offered by Optum, an independent company that offers a smoking cessation program on behalf of BlueCross.	$250.00 per enrolled participant plus the cost of the Nicotine Replacement Therapy (NRT)	

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: Clemson University
Member Institution Number(s): 25-85558-06 and 13
Effective Date: January 1, 2019

Medical Premiums:	**Types of Membership**	**Monthly Premiums**
	Student	$152.64
	Student +One	$305.28
	Student +Two	$457.92
	Student +Three	$610.56
	Student +Four or more	$763.20
Fees:		
Blue Marketplace℠:	$1.00 per Student per month	
Quit for Life: Offered by Optum, an independent company that offers a smoking cessation program on behalf of BlueCross.	$250.00 per enrolled participant plus the cost of the Nicotine Replacement Therapy (NRT)	

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

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; and,

2. 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.

Ambulatory Surgical Center: a licensed facility that:

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

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

3. Does not provide inpatient accommodations; and,

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

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

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

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

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;

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

e. Management of acute infection and oral lesions;

10. Periodontal cleanings; and,

11. Repair of removable dentures.

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

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

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

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

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

1. Medically Necessary;

2. Preauthorized (when required under this 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.

Benefits Checklist: 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 Benefits Checklist.

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

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

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

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

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

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

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 as follows:

1. The percentage listed on the Schedule of Benefits; multiplied by,

2. The amount listed in the Participating Provider's schedule of allowance for that item calculated at the time of sale; and,

3. Without regard to any Credit or allowance that may be received by the Corporation.

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

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

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

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

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

Contract: the Request For Proposal between the Corporation and the South Carolina Student Health Insurance Consortium (SCSHIC) including the Member Institution Application, Benefits Checklist, Policy 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.

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.

Discount Services: from time to time Benefits in the form of discounts for certain Provider Services or products will be provided to Members by networks of complementary healthcare Providers with which the administrator has an agreement for various programs. This discount applies to services the Policy does not cover. The Corporation will not be responsible for any costs associated with these programs. The services available may include, but are not limited to, chiropractors, massage therapists, acupuncturists, fitness clubs and hearing aids.

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 he or she 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 (as determined by the Corporation); and,

8. Is ordered by a licensed medical doctor, oral surgeon, podiatrist or osteopath.

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

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

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

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

2. Serious impairment to bodily functions; or,

3. Serious dysfunction of any bodily organ or part.

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

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. The Pharmacy Benefit Manager has the discretion to determine if a Prescription Drug is a Generic Drug.

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.

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 his or her support and maintenance.

A Child must meet <u>both</u> 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 Enrollee: a Student or Dependent who 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 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;

5. Fixed bridge repairs; and,

6. Relining or rebasing of removable dentures.

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

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

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

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

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

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

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

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

Medical Supplies: supplies that are:

1. Medically Necessary;

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

3. Are not available on an over-the-counter basis (unless such supplies are provided to a Member in a Provider's office and should not (in the Corporation's discretion) 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 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 to be deemed Medically Necessary. The failure of a health care service to meet any one of the above referenced requirements means, in the discretion of the Corporation or CBA, the health care 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 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 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 or affiliated companies which reflect clinically appropriate health care services and generally accepted standards of medical and behavioral health practice. MCG Health, LLC and/or its affiliated companies 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 bears a recognized brand name of a particular manufacturer but does not appear on the list of Preferred Brand Drugs and has not been chosen by the Corporation or its designated Pharmacy Benefit Manager to be a Preferred Drug, including any Brand Name Drug with an "A" rated Generic Drug available.

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.

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: an entity that has contracted with the Corporation and is responsible for the administration of the Prescription Drug Benefit in accordance with this Policy.

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

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

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 benefit booklet which reflects the Benefits offered based on the Benefits Checklist. The Policy includes the Schedule of Benefits and all endorsements, amendments, riders or addenda.

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 Brand Drug: a Preferred Drug that bears a recognized brand name of a particular manufacturer and appears on the list of preferred brand drugs.

Preferred Drug: a Prescription Drug that has been reviewed for cost effectiveness, clinical efficacy and quality that is preferred by the 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 his or her 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:

1. Be prescribed by a licensed Provider acting within the scope of his or her license; and,

2. Not be entirely consumed at the time and place where the prescription is dispensed.

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): 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 Provider, licensed professional counselor, masters level licensed social worker, licensed marriage and family therapist or other licensed Behavioral Health Provider approved by the Corporation. The term Provider does not include interns, residents, in-house physicians, physical trainers, lay midwives or masseuses.

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

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

Provider Services: includes the following services:

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

   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.

Quantity versus Time (QVT) Limits: limits that restrict the quantity of Prescription Drugs that are covered under a Member's Benefit within a certain time frame. The limits established for these drugs are based on FDA approved indication.

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

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

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

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

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

4. Keeps a daily medical record for each patient;

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

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

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

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

Secondary Plan: a Plan that is not a Primary Plan. When this 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: an institution other than a Hospital that is certified and licensed by the appropriate state regulatory agency as a skilled nursing facility.

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.

Step Therapy Programs: programs that require a Member to use lower-cost medications that are used to treat the same condition before obtaining higher-cost medication.

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.

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

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

Totally Disabled/Total Disability: the 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.

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 his or her 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 his or her 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 his or her 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 he or she 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.

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 his or her license;

4. For which the required Preadmission Review, Emergency Admission Review, Preauthorization and/or Continued Stay Review has been requested and Preauthorization was received from the Corporation (the Member should refer to the Schedule of Benefits for services that require Preauthorization);

5. That are Medically Necessary;

6. That are not subject to an exclusion under Article IV of this Policy; and,

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

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. Benefits will be administered according to the Corporation's corporate medical policy.

B. PREAUTHORIZATION

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

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

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

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

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

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

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

C. SPECIFIC COVERED BENEFITS

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

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. Any Preauthorization requirements, if applicable, will be listed on the Schedule of Benefits.

ALLERGY INJECTIONS

Benefits will be paid for allergy injections as set forth below:

1. For patients with demonstrated hypersensitivity that cannot be managed by medications or avoidance;

2. To ensure the potency and efficacy of the antigens, the provision of multiple dose vials is restricted to sufficient antigen for twelve (12) weeks at either once per week or twice per week dosing; and,

3. When any of the following conditions are met:

    a. The patient has symptoms of allergic rhinitis and/or asthma after natural exposure to the allergen;

b. The patient has a life threatening allergy to insect stings;

c. The patient has skin test and/or serologic evidence of a potent extract of the antigen; or,

d. Avoidance or pharmacologic (drug) therapy cannot control allergic symptoms.

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 must be Preauthorized where seeking Preauthorization is 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. However, no Benefits are available for ground or air ambulance services or transport if a Member is transferred from one facility to a new facility for the purpose of the Member obtaining a lower level of care at the new receiving facility. Repatriation for Member convenience is excluded and is not a Benefit for which Covered Expenses are payable.

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

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

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

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

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

CHIROPRACTIC SERVICES

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

CLEFT LIP OR PALATE

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

Benefits shall include, but not be limited to:

1. Oral and facial Surgical Services, surgical management and follow-up care;
2. Prosthetic Device treatment, such as obturators, speech appliances and feeding appliances;
3. Orthodontic treatment and management;
4. Prosthodontia treatment and management;
5. Otolaryngology treatment and management;
6. Audiological assessment, treatment, and management, including surgically implanted amplification devices; and,
7. Physical therapy assessment and treatment.

Any Preauthorization requirements, if applicable, will be listed on the Schedule of Benefits. 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.

COLORECTAL CANCER SCREENING

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

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 for only six (6) months from the date of the accidental injury.

DIABETIC SUPPLIES

Benefits will be paid for diabetic supplies as 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.

DURABLE MEDICAL EQUIPMENT

Benefits will be paid for standard, non-luxury (as determined by the Corporation) Durable Medical Equipment. The Corporation will decide (in its discretion) 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. Any Preauthorization requirements, if applicable, will be listed on the Schedule of Benefits.

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.

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

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

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

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

GENDER DYSPHORIA

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

GYNECOLOGICAL EXAMINATION

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

HABILITATION

Benefits will be paid for habilitation 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. Any Preauthorization requirements, if applicable, will be listed on the Schedule of Benefits.

HOSPICE CARE

Benefits will be paid for Hospice Care. Any Preauthorization requirements, if applicable, will be listed on the Schedule of Benefits.

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 as determined by the Corporation;

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

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

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

6. In a Long-Term Acute Care Hospital.

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

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

HUMAN ORGAN AND TISSUE TRANSPLANTS

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

4. Transplants of tissue as set forth below (rather than whole major organs) are Benefits under this Policy, subject to all of the provisions of this Policy as follows:

   a. Blood transfusions;

   b. Autologous parathyroid transplants;

   c. Corneal transplants;

   d. Bone and cartilage grafting; and,

   e. Skin grafting.

IN-HOSPITAL MEDICAL SERVICE

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

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

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

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

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

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

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

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

MAMMOGRAPHY TESTING

Benefits will be paid for mammography testing regardless of Medical Necessity for Members that are within the appropriate age guidelines. Benefits will be paid for additional mammograms during a Benefit Year based on Medical Necessity.

MEDICAL SUPPLIES

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

MENTAL HEALTH SERVICES

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

OBSTETRICAL SERVICES

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

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

ORTHOPEDIC DEVICES

Benefits will be paid for Orthopedic Devices. Any Preauthorization requirements, if applicable, will be listed on the Schedule of Benefits.

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. Any Preauthorization requirements, if applicable, will be listed on the Schedule of Benefits.

OUTPATIENT HOSPITAL AND AMBULATORY SURGICAL CENTER SERVICES

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

OUTPATIENT REHABILITATION SERVICES

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

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

OXYGEN

Benefits will be paid for oxygen. Durable Medical Equipment for oxygen use in a Member's home is covered under the Durable Medical Equipment Benefit. Any Preauthorization requirements, if applicable, will be listed on the Schedule of Benefits.

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 that are within the appropriate age guidelines regardless of Medical Necessity.

PRESCRIPTION DRUGS

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

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

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

2. If a Provider prescribes a Brand Name Drug and an equivalent Generic Drug or Over-the-Counter Drug is available and listed as covered on the PDL (whether or not the Provider indicates in the prescription that the substitution of a Generic Drug or Over-the-Counter Drug is not allowed), and the Member still requests the Brand Name Drug, then any difference between the cost of the covered Generic Drug or Over-the-Counter Drug and the higher cost of the Brand Name Drug shall be the responsibility of the Member. This will be in addition to any Prescription Drug Copayment or Coinsurance appropriate to the Brand Name Drug being purchased. In no instance will the Member be charged more than the actual retail price of the drug.

3. Insulin shall be treated as a Prescription Drug whether injectable or otherwise.

4. The Corporation may, in its discretion, place quantity limits on Prescription Drugs.

PREVENTIVE SERVICES

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

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

2. Immunizations as recommended by the CDC; and,

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

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

PROSTATE EXAMINATION

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

PROSTHETIC DEVICES

Benefits will be paid for a Prosthetic Device, other than a dental or cranial prosthetic, which is a replacement for a body part and which meets minimum specifications for the body part it is replacing regardless of the functional activity level. Coverage is provided for the cost of the standard, non-luxury item only (as determined by the Corporation). Components that are considered deluxe or upgraded over a standard model are not a covered service. Except as provided below, Benefits are provided for only the initial temporary prosthesis and one (1) permanent prosthesis. No Benefits are provided for repair,

replacement or duplicates, nor are Benefits provided for services related to the repair or replacement of such prosthetics, except when necessary due to a change in the Member's medical condition and with prior authorization from the Corporation.

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

PROVIDER SERVICES

Benefits will be paid for Provider Services, provided that when different levels (as determined by the Corporation) of Provider Services are provided on the same day, Benefits will only be paid for the highest level (as determined by the Corporation) of Provider Services.

RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES

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.

REHABILITATION

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

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

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

3. The documentation that accompanies a request for rehabilitation Benefits must contain a detailed Member evaluation from a licensed medical doctor that documents that to a degree of medical certainty the Member has rehabilitation potential such that there is an expectation that the Member will achieve an ability to provide self-care and perform activities of daily living; and,

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

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

RESIDENTIAL TREATMENT CENTER

Benefits will be paid for Residential Treatment Centers as set forth on the Schedule of Benefits. Any Preauthorization requirements, if applicable, will be listed on the Schedule of Benefits.

SPECIALTY DRUGS

Benefits will be paid for Specialty Drugs as set forth on the Schedule of Benefits. Covered Expenses for Specialty Drugs dispensed to a Member shall not exceed the quantity and Benefit maximum set by the Corporation. Certain Specialty Drugs may be considered medical Benefits and may (i) require Preauthorization and/or (ii) be subject to certain place of service requirements. For any Specialty Drugs paid as medical Benefits, the Benefit Year Deductible, Out-of-Pocket Maximum and/or Benefit maximum will apply as set forth on the Schedule of Benefits. A list of Specialty Drugs as well as information about any related requirements and/or restrictions may be obtained by contacting the Corporation at the number listed on the Identification Card or at www.SouthCarolinaBlues.com.

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

SUBSTANCE USE DISORDER SERVICES

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

SURGICAL SERVICES

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

1. Surgical Services, subject to the following:

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

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

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

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

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

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

2. Assistant Surgeon services that consists of the Medically Necessary service of one (1) licensed medical doctor, oral surgeon, 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 consists of services rendered by a licensed medical doctor, oral surgeon or a certified registered nurse anesthetist, other than the attending surgeon or his or her assistant, and includes the administration of spinal or rectal anesthesia, or a drug or other anesthetic agent by injection or inhalation, except by local infiltration, the purpose and effect of which administration is the obtaining of muscular relaxation, loss of sensation or loss of consciousness. Additional Benefits will not be provided for pre-operative anesthesia consultation.

TELEHEALTH

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

TELEMEDICINE

Benefits will be paid for Telemedicine services as follows:

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

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

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

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

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

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

1. Telephone conversations;
2. Email messages;
3. Facsimile transmissions; or,
4. Internet-based audio-video communication that is not secure and HIPAA-compliant (e.g., Skype).

VISION BENEFITS

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

ARTICLE IV - EXCLUSIONS AND LIMITATIONS

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

ACUPUNCTURE

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

ACTS OF WAR

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

ADMISSIONS THAT ARE NOT PREAUTHORIZED

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

BEHAVIORAL, EDUCATIONAL OR ALTERNATE THERAPY PROGRAMS

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

1. ABA therapy unless Medically Necessary for the treatment of Autism Spectrum Disorder;
2. Teaching, Expanding, Appreciating, Collaborating and Holistic (TEACCH) programs;
3. Higashi schools/daily life;
4. Facilitated communication;
5. Floor time;
6. Developmental Individual-Difference Relationship-based model (DIR);

7. Relationship Development Intervention (RDI);

8. Holding therapy;

9. Movement therapies;

10. Music therapy; and,

11. Animal assisted therapy.

BENEFITS PROVIDED BY STATE OR FEDERAL PROGRAMS

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

BIO-FEEDBACK SERVICES

Bio-feedback when related to psychological services.

COMPLICATIONS FROM FAILURE TO COMPLETE TREATMENT

Complications that occur because a Member did not follow the course of treatment prescribed by a Provider, including complications that occur because a Member left a Hospital against medical advice.

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, including complications arising from a Member's use of Discount Services.

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 (in the Corporation's discretion), 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, if required, as set forth on the Schedule of Benefits.

CRANIAL ORTHOTICS

Adjustable cranial orthoses (band or helmet) for positional plagiocephaly or craniosynostoses in the absence of cranial vault remodeling surgery, except as specified on the Schedule of Benefits.

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 six (6) months prior to the date of such services;

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. Dental services for which the Member would have no legal obligation to pay in the absence of dental coverage;

6. 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;

7. Services rendered by a Provider beyond the scope of his or her license;

8. 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;

9. Charges by a Provider for non-dental services such as broken appointments and completion of claim forms;

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

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

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

13. 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;

14. 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;

15. 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;

16. Consultations;

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

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

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

20. Temporary crowns and partials;

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 Plan of Benefits 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;

    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; or,

    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.

DISCOUNT SERVICES

Any charges that result from the use of Discount Services including charges related to any injury or illness that results from a Member's use of Discount Services. Discount Services are not covered under this Policy and Members must pay for Discount Services.

EYEGLASSES

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

FOOT CARE

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

GROWTH HORMONE THERAPY

Growth hormone therapy for patients over eighteen (18) years of age, except as specified on the Schedule of Benefits. Growth hormone therapy for patients eighteen (18) years of age or younger is excluded unless for documented growth hormone deficiency.

HEARING AIDS

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

HEMOPHILIA SERVICES

Services, treatment or medications related to the management of all types of blood clotting or coagulation disorders, including, but not limited to, Hemophilia, unless the Member has received treatment at least once in a given Benefit Year at a Hemophilia Treatment Center (HTC) as designated by the CDC.

HUMAN ORGAN AND TISSUE TRANSPLANTS

Human organ and tissue transplants that are not:

1. Preauthorized, if required, as set forth on the Schedule of Benefits;
2. Performed by a Provider as designated by the Corporation;
3. Listed as covered on the Schedule of Benefits; and,
4. Performed at a Blue Distinction Center of Excellence or a transplant center approved by the Corporation in writing.

HYPNOTISM

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

ILLEGAL ACTS

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

IMMUNIZATIONS

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

IMPACTED TOOTH REMOVAL

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

IMPOTENCE

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

INCAPACITATED DEPENDENTS

Any service, supply or charge for an Incapacitated Dependent that is not enrolled by the maximum Dependent Child age 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, nutrition counseling or 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. Long-term acute or chronic psychiatric care;

3. 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);

4. Custodial or long-term care; or,

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

MASSAGE THERAPY

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

MEMBERSHIP DUES AND OTHER FEES

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

MISSED PROVIDER APPOINTMENTS

Charges for a Member's appointment with a Provider that the Member did not attend.

NO LEGAL OBLIGATION TO PAY

Any service, supply or charge that the Member is not legally obligated to pay.

NOT MEDICALLY NECESSARY SERVICES OR SUPPLIES

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

OBESITY RELATED PROCEDURES

1. Services, supplies, treatment or medication for the management of morbid obesity, obesity, weight reduction, weight control or dietary control (collectively referred to as "obesity-related treatment"), including, but not limited to, gastric bypass or stapling, intestinal bypass and related procedures or gastric restrictive procedures, except as specified on the Schedule of Benefits.

2. Also, the treatment or correction of complications from obesity-related treatment are non-covered services, regardless of Medical Necessity, prescription by a Provider or the passage of time from a Member's obesity-related treatment, except as specified on the Schedule of Benefits. This includes the reversal of obesity-related treatments and reconstructive procedures necessitated by weight loss.

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

ORTHOGNATHIC SURGERY

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

OUTPATIENT SERVICES THAT ARE NOT PREAUTHORIZED

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

OVER-THE-COUNTER DRUGS

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

PAIN MANAGEMENT PROGRAMS

Chronic pain management programs or multi-disciplinary pain management programs, including Transcutaneous Electrical Nerve Stimulation (TENS) units, except as specified on the Schedule of Benefits.

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.

PREMARITAL AND PRE-EMPLOYMENT EXAMINATIONS

Charges for services, supplies or fees for premarital or pre-employment examinations.

PREOPERATIVE ANESTHESIA CONSULTATION

Charges for preoperative anesthesia consultation.

PRESCRIPTION DRUG COPAY CARD

Any Prescription Drugs 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.

PRESCRIPTION DRUG EXCLUSIONS

Charges for:

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

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

3. Prescription Drugs not approved by the FDA;

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

5. 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;

6. More than a thirty-one (31) day supply for Prescription Drugs (ninety (90) day supply for Prescription Drugs obtained through a Mail Service Pharmacy), except as specified on the Schedule of Benefits;

7. Any type of service or handling fee for Prescription Drugs, including fees for the administration or injection of a Prescription Drug;

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

    a. United States Pharmacopeia (USP);

    b. Facts and Comparisons;

    c. Physicians' Desk Reference; and/or,

    d. National Formulary.

9. Prescription Drugs used for or related to cosmetic purposes, including hair growth, and skin wrinkles, except as specified on the Schedule of Benefits;

10. Prescription Drugs related to any treatment for infertility or impotence (except when prescribed for benign prostatic hypertrophy), including but not limited to, fertility drugs, except as specified on the Schedule of Benefits;

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

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

13. 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;

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

15. 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);

16. Prescription Drugs for obesity or weight control, contraceptives or tobacco cessation, except as specified on the Schedule of Benefits with respect to such Prescription Drugs;

17. Prescription Drugs that are not authorized when part of a Step Therapy Program;

18. 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;

19. 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,

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

PRIVATE DUTY NURSING

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

PROSTHETIC DEVICES

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

PROVIDER CHARGES

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

PSYCHOLOGICAL AND EDUCATIONAL TESTING

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

PULMONARY REHABILITATION

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

RADIOLOGY MANAGEMENT

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

RELATIONSHIP COUNSELING

Relationship counseling, including marriage counseling, for the treatment of premarital, marital or relationship dysfunction.

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.

SELF-INFLICTED INJURY

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

SERVICES FOR CERTAIN DIAGNOSES OR DISORDERS

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

SERVICES FOR COUNSELING OR PSYCHOTHERAPY

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

1. Feeding and eating disorders in early childhood and infancy;
2. Tic disorders, except when related to Tourette's disorder;
3. Elimination disorders;
4. Mental disorders due to a general medical condition;
5. Sexual function disorders;
6. Sleep disorders;
7. Medication induced movement disorders; or,
8. Nicotine dependence, except as specified on the Schedule of Benefits.

SERVICES NOT LISTED AS COVERED BENEFITS

Medical Supplies or services or other items not specifically listed as a Benefit in Article III of this 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 him or herself or rendered by a Member's immediate family (parent, Child, Spouse, brother, sister, grandparent or in-law).

SEX CHANGE

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

TELEMONITORING

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

TEMPOROMANDIBULAR JOINT (TMJ) DISORDER

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

TOBACCO CESSATION TREATMENT

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

TRAVEL

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

VARICOSE VEIN AND VENOUS INSUFFICIENCY TREATMENT

Services, supplies or treatment for varicose veins and/or any venous insufficiency condition, including, but not limited to, endovenous ablation, vein stripping or the injection of sclerosing solutions, 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. 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 will not be covered.

WHEELCHAIRS OR POWER OPERATED VEHICLES

Manual or 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.

WORKERS' COMPENSATION

This Plan 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.

   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 under this Coordination of Benefits section, 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. 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.

E. 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, he or she 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 Plan and the expenses incurred by the Corporation in collecting this amount and assign to the Corporation the Member's rights to recovery when this provision applies;

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

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

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

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

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

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

ARTICLE IX - WORKERS' COMPENSATION PROVISION

This Plan 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 his or her 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 his/her 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 XI - CLAIMS FILING AND APPEAL PROCEDURES

A. CLAIMS FILING PROCEDURES

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

2. Written notice of receipt of services on which a claim is based must be furnished to the Corporation, at its address on the Identification Card, within twenty (20) days of the beginning of services or as soon thereafter as is reasonably possible. Failure to give notice within the time does not invalidate nor reduce any claim if the Member can show that it was not reasonably possible to give the notice within the required time frame and if notice was given as soon as reasonably possible. Upon receipt of the notice, the Corporation will furnish or cause a claim form to be furnished to the Member. If the claim form is not furnished within fifteen (15) days after

the Corporation receives the notice, the Member will be deemed to have complied with the requirements of this 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 (as determined by the Corporation). The Corporation, however, is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at the time the claim was processed. Any party who submits medical or financial reports and documents to the Corporation in support of a Member's claim will be deemed to be acting as the agent of the Member. If the Member desires to appoint an Authorized Representative in connection with such Member's claims, the Member should contact the Corporation for an Authorized Representative form.

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

   a. Pre-Service Claim.

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

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

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

   b. Urgent Care Claim.

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

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

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

   c. Post-Service Claim.

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

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

d. Concurrent Care Claim.

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

7. Notice of Determination.

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

i. Include information sufficient to identify the claim involved (including date of service, 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. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request);

viii. 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);

ix. 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);

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

xi. 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 Blue Cross and Blue Shield of South Carolina at the address on the Member's Identification Card;

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

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

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

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

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

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

   a. Pre-Service Claim.

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

   b. Urgent Care Claim.

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

   c. Post-Service Claim.

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

   d. Concurrent Care Claim.

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

6. Notice of Appeals Determination.

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

      i. Include information sufficient to identify the claim involved (including date of service, 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. A Member's claim and appeals will be decided pursuant to a good faith interpretation of the Policy, in the best interest of the Member, without taking into account either the amount of the benefits that will be paid to the Member or the financial impact on the Plan.

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

C. EXTERNAL REVIEW PROCEDURES

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

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

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

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

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

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

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

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

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

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

ARTICLE XII - GENERAL PROVISIONS

AMENDMENT

Upon thirty (30) days prior written notice, the Corporation may unilaterally amend this 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.

C. 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.

D. 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.

E. 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.

F. 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.

G. Blue Cross Blue Shield Global Core® Program

- **General Information**

If Members are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard service area"), they may be able to take advantage of the Blue Cross Blue Shield Global Core Program when accessing covered healthcare services. The Blue Cross Blue Shield Global Core Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core Program assists Members with accessing a network of inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when Members receive care from Providers outside the BlueCard service area, the Members will

typically have to pay the Providers and submit the claims themselves to obtain reimbursement for these services.

- **Inpatient Services**

In most cases, if Members contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require Members to pay for covered inpatient services, except for their cost-share amounts/Benefit Year Deductibles, Coinsurance, etc. In such cases, the hospital will submit Member claims to the Blue Cross Blue Shield Global Core Service Center to initiate claims processing. However, if the Member paid in full at the time of service, the Member must submit a claim to obtain reimbursement for covered healthcare services.

- **Outpatient Services**

Physicians, urgent care centers and other outpatient Providers located outside the BlueCard service area will typically require Members to pay in full at the time of service. Members must submit a claim to obtain reimbursement for covered healthcare services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**

  When Members pay for covered healthcare services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Members should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center address on the form to initiate claims processing. The claim form is available from the Corporation, the Blue Cross Blue Shield Global Core Service Center or online at www.bluecardworldwide.com. If Members need assistance with their claim submissions, they should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

CLERICAL ERRORS

Clerical errors by the Corporation will not cause a denial of Benefits that should otherwise have been granted, nor will clerical errors extend Benefits that should otherwise have ended.

CONTINUATION OF CARE

If a Participating Provider's contract ends or is not renewed for any reason other than suspension or revocation of the Provider's license and the Member is receiving treatment for a Serious Medical Condition, the Member may be eligible to continue to receive in-network Benefits for that Provider's services.

In order to receive this Continuation of Care for a Serious Medical Condition, the Member must submit a request to the Corporation on the appropriate form. The treating Provider should include a statement on the form confirming the Serious Medical Condition. Upon receipt of the request, the Corporation will notify the Member and the Provider of the last date the Provider is part of the network and a summary of Continuation of Care requirements. The Corporation will review the request to determine qualification for the Continuation of Care. If additional information is necessary to make a determination, the Corporation may contact the Member or the Provider for such information. If the Corporation approves the request, in-

network Benefits for that Provider will be provided for ninety (90) days or until the end of the Benefit period, whichever is greater. During this time, the Provider will accept the network allowance as payment in full. Continuation of Care is subject to all other terms and conditions of this Contract, including regular Benefit limits.

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 his or her Identification Card prior to receiving Benefits.

Identification Cards are for identification only. Having an Identification Card creates no right to Benefits or other services. To be entitled to Benefits, the cardholder must be a Member whose Premium has been paid. Any person receiving Covered Expenses to which the person is not entitled will be responsible for the charges.

INCONTESTABILITY

The validity of the 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 XI. 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.

INDEX

This index contains instances of the use of defined terms in this Policy. This index does not include Benefits or excluded items.

ABA 2, 24, 36
ACA 2, 32
ACO.....2, 19
Admission.. 2, 5, 7, 14, 23, 28, 29, 42, 44, 51, 54
Adverse Benefit Determination ..2, 61, 62, 63, 64
Allowable Charge 2, 4, 5, 6, 23, 34, 35
Ambulatory Surgical Center 2, 31
Authorized Representative..... 3, 5, 7, 14, 58, 65
Autism Spectrum Disorder 3, 24, 36
Basic Dental Services 3
Behavioral Health Provider 4, 16, 29
Behavioral Health Services.....4, 16, 17
Benefit .. 2, 4, 5, 6, 11, 12, 14, 15, 16, 17, 18, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 43, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 64, 65, 68, 69, 71
Benefit Year 4, 14, 28, 30, 31, 32, 41, 51
Benefit Year Deductible ... 2, 4, 5, 15, 18, 23, 34, 68
Benefits 39, 62
Benefits Checklist.....4, 5, 11, 14
BlueCard Program 4, 13, 65, 66, 67
Brand Name Drug 4, 8, 13, 15, 32
Care Coordination 4
Care Coordinator.....4
Care Coordinator Fee 66
CBA 5, 12
Child 5, 6, 8, 9, 20, 21, 22, 28, 30, 42, 48, 50, 52, 54
Clinical Trial.....5, 26
Coinsurance 2, 4, 5, 6, 18, 23, 27, 31, 32, 34, 68
Concurrent Care.....5, 59, 60, 62, 71
Congenital Disease 5
Congenital Disorder 5
Continuation of Care 5, 68
Continued Stay Review.....5, 22, 23, 28
Contract.....5, 8, 15, 69
Copayment..... 2, 5, 6, 18, 23, 27, 31, 34, 65
Corporation. 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 21, 22, 23, 24, 25, 27, 28, 30, 32, 33, 34, 35, 36, 38, 40, 41, 43, 45, 46, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71
Covered Expense .4, 6, 8, 25, 34, 43, 50, 51, 53, 54, 58, 69
Credit 5, 6, 11, 31, 34
Custodial Care 6, 17, 38
Dependent 6, 9, 10, 12, 18, 20, 21, 22, 42, 49, 50, 52, 53, 54, 70
Discount Services 6, 37, 40
Domestic Partner 6, 7, 20, 21, 52
Durable Medical Equipment.....7, 27, 31
Emergency Admission Review 7, 22, 23, 28
Emergency Medical Condition 7, 8, 14, 23, 25, 27
Emergency Services.....8, 27, 64
Enrollment Date 8
ERISA 49
Generic Drug.....8, 13, 15, 32
Genetic Information.....8, 9
Global Payment 8
Grace Period.....8, 53
Health Status-Related Factor 8, 53
HIPAA 9, 15
Home Health Agency.....9, 15
Home Health Care 9, 28
Hospice Care 9, 28
Hospital .2, 7, 8, 9, 10, 16, 17, 18, 25, 27, 28, 29, 30, 31, 35, 37, 51, 54, 64, 69
Identification Card 9, 24, 32, 34, 57, 58, 61, 69
Incapacitated Dependent.....5, 6, 9, 20, 42, 52
Investigational or Experimental.....2, 10, 42, 64
Investigational or Experimental Services.....61
Late Enrollee.....10
Long-Term Acute Care Hospital 9, 10, 28
Mail Service Pharmacy 10, 45
Major Dental Services.....10
Maximum Payment 2, 11, 27
Medical Necessity .12, 14, 23, 30, 31, 32, 43, 48, 63, 69
Medical Supplies.....4, 11, 25, 28, 30, 37, 41, 47, 48, 70
Medically Necessary .2, 3, 4, 5, 7, 11, 12, 23, 24, 28, 29, 35, 36, 43, 51
Member...2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 40, 41,

42, 43, 44, 45, 47, 48, 49, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71
Member Effective Date.....12, 23, 39, 47
Member Institution 4, 5, 8, 12, 13, 15, 18, 20, 21, 22, 38, 51, 52, 53, 54, 55, 56, 57, 64, 66, 67, 70
Member Institution's Effective Date 13, 20, 47
Membership Application.....13, 20, 22, 70
Mental Health Services 4, 13, 29, 30
Natural Teeth 13, 27, 38
Negotiated Arrangement.....13
Negotiated National Account Arrangement.....13
Non-Participating Provider . 5, 13, 27, 65, 66, 67, 71
Non-Preferred Drug.....13
Orthopedic Device.....7, 13, 31
Orthotic Device.....7, 14, 31
Out-of-Pocket Maximum 4, 14, 34
Over-the-Counter Drug 14, 15, 31, 32, 43, 45
Participating Pharmacy 6, 14
Participating Provider ... 5, 11, 14, 24, 26, 27, 32, 35, 57, 58, 65, 67, 68, 71
PCMH.....14, 19
PDL 15, 31, 32, 43, 45, 46
PDN.....15, 46
Pharmacy Benefit Manager... 6, 8, 10, 13, 14, 15
PHI 15
Plan 2, 14, 15, 18, 49, 50, 51, 52, 54, 56, 58
Plan of Benefits 39
Policy 2, 4, 5, 6, 8, 10, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 23, 24, 26, 29, 31, 37, 39, 40, 41, 47, 48, 49, 50, 51, 52, 53, 54, 56, 58, 60, 62, 63, 64, 69, 70
Post-Service Claim.....14, 59, 62, 71
Preadmission Review.....14, 22, 23, 28
Preauthorization 5, 14, 15, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 33, 34, 36, 43, 44, 45, 46, 65, 71
Preauthorized..... 4, 5, 14, 25, 38, 41, 48
Preferred Brand Drug.....13, 14
Preferred Drug 13, 14, 15
Premium . 2, 8, 15, 20, 21, 22, 53, 54, 55, 64, 66, 67, 69
Prescription Drug ... 4, 5, 6, 8, 10, 13, 14, 15, 17, 18, 31, 32, 37, 43, 44, 45, 46, 48, 53, 54, 65
Prescription Drug Copayment.....15, 32
Pre-Service Claim.....14, 15, 59, 62, 71
Primary Plan 15, 18, 49, 50, 51
Prosthetic Device 7, 15, 26, 32, 33
Provider.....2, 3, 4, 5, 6, 9, 11, 12, 13, 14, 15, 16, 18, 19, 23, 26, 27, 30, 31, 32, 33, 35, 36, 37, 39, 40, 41, 43, 44, 45, 46, 48, 58, 64, 65, 66, 67, 68, 69, 70, 71
Provider Agreement.....13, 14, 16
Provider Incentive 16, 66
Provider Services.....6, 16, 17, 33, 42
Qualified Medical Child Support Order 5
QVT Limit 17
Rehabilitation Facility.....16, 17
Residential Treatment Center.....17, 33
Schedule of Benefits.3, 4, 5, 6, 9, 14, 15, 18, 20, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 69
SCSHIC 5, 12, 13, 15, 18, 54, 64, 70
Second Surgical Opinion 18
Secondary Plan.....18, 49, 50, 51
Serious Medical Condition 5, 18, 64, 68
Skilled Nursing Facility...2, 16, 17, 18, 29, 30, 54
Special Care Unit 18, 28
Special Enrollment 18, 20, 22
Specialist.....18
Specialty Drugs.....6, 14, 18, 34, 46
Spouse.....5, 6, 18, 48, 50, 52, 54
Step Therapy Program 18, 45
Student..5, 6, 7, 9, 10, 12, 15, 18, 20, 21, 22, 49, 50, 52, 53, 54, 55, 69, 70
Student Health Center 14, 16, 17, 18
Substance Use Disorder.....19, 42
Substance Use Disorder Services ..4, 13, 19, 29, 34
Surgical Services 17, 19, 26, 30, 31, 34, 35
Telehealth 19, 35
Telemedicine.....19, 35, 36
Total Cost of Care.....8
Total Disability.....9, 19, 54
Totally Disabled 19, 54
Urgent Care Claim 19, 59, 62, 65, 71
Value-Based Shared Savings.....19
VBP 4, 19, 36, 66

AMENDMENT

Member Institution Name: Clemson University
Member Institution Contract Number: 25-85558-00 and appropriate subgroups
Effective Date: January 1, 2019
Amendment: 1

The Policy between the Member Institution and the Corporation is amended as follows:

The **Other Services** section in the **PREAUTHORIZATION** section in the **Schedule of Benefits** is amended by the addition of the following:

Preauthorization and referrals are required for certain services or supplies received outside of the Student Health Center. Benefits will be denied when referrals are not obtained.

THIS IS AN AMENDMENT TO YOUR PRESENT POLICY.

South Carolina

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