AMENDMENT TO YOUR BLUE CROSS® AND BLUE SHIELD® OF SOUTH CAROLINA POLICY

(An Independent Licensee of the Blue Cross and Blue Shield Association,
an association of independent Blue Cross and Blue Shield Plans)
(www.SouthCarolinasBlues.com)

Consolidated Appropriations Act (CAA) Amendment

This Amendment is subject to all the provisions of the Policy, Policy Name listed below, which are not otherwise specified in the provisions of this Amendment.

11159; 11401 (Rev. 7/94); 10097 (Rev. 7/94); 11505 (7/94); 11504 (Rev. 7/94); 11507 (Re. 7/94) and 11506 (Rev. 7/94)

This Amendment to the Policy is effective on or after the Benefit Period of your Policy starting January 1, 2022.

The Policy, is amended by the addition of the following:

Special Out-of-Network Rules

If you receive treatment from an out-of-Network Provider as described below, your treatment may be covered and your costs may be comparable to those received from an in-Network Provider, but only if one of the below exceptions applies. The Provider must be an out-of-Network Provider (physician or other clinician, or facility not in our Network) and, in these limited situations, we will treat the Provider as though it was in-Network for purposes of determining your cost share liability, and will pay the Provider our portion of the claim directly. You will still be required to meet any in-Network cost share amounts under all other terms of this coverage, and those in-Network cost share amounts will be based on the Recognized Amount. These are the only circumstances in which BlueCross will allow for out-of-Network services without prior authorization and approval.

- You are treated in the emergency department of a hospital or a free-standing emergency department where the facility or a treating Provider is not in-Network. In emergency situations, no prior authorization is required. For services furnished after your condition has stabilized, as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the emergency department visit where emergency services were furnished, if the Provider or facility provides you (or your authorized representative) with an advance notice, and obtains your (or your authorized representative's) signed consent to be treated on a non-Network basis, these rules will not apply.
- You seek non-Emergency treatment at an in-network hospital, hospital outpatient department, critical access hospital, or ambulatory surgical center, but during your treatment, you receive services from a non-Network Provider. An example of this would be if you have surgery performed in a Network Hospital; your surgeon is in our Network, but the anesthesiologist is not in our Network. In some cases, if the Provider or facility provides you (or your authorized representative) with an advance notice, and obtains your (or your authorized representative's) written consent to be treated on a non-Network basis, these rules will not apply.
- If it is medically necessary for you to be transported by an air ambulance company not in our Network.

If you need assistance because one of the above actions has occurred, please contact us using the information on the back of your ID card or as shown in the section above titled "How to Contact Us."

CONTINUATION OF CARE, is amended by the deletion of **Continuation of Care** in its entirety and the following substituted therefore:

CONTINUATION OF CARE

If benefits under this Policy are no longer covered due to a change in a Provider's terms of participation in the Network, such as a Network Provider's contract is modified, ends, or is not renewed for any reason other than fraud or failure to meet specified quality standards, including suspension or revocation of the Provider's license, and you are a Continuing Care Patient of the Provider at the time, you may be eligible to continue to receive Network benefits for that Provider's services for a limited period of time. We will attempt to notify you if and when these situations arise with your providers, and explain your right to elect continued Network coverage, but such continued Network coverage is not automatic; please contact us or have your provider contact us in order to receive this continued Network coverage.

We recommend you use a form for this request; this form can be found on our website or by calling 855-404-6752. Your treating Provider should include a statement confirming that you have a Serious and Complex Condition. Upon receipt of your request, we will confirm the last date the Provider is part of our Network and a summary of continuation of care requirements. If additional information is necessary, we may contact you or the Provider.

If you qualify for continued Network status, we will provide in-Network benefits for you from that Provider, for the course of treatment relating to your status as a Continuing Care Patient, for 90 days or until the date you are no longer a Continuing Care Patient with respect to the Provider, whichever occurs earlier. During this time, the Provider will accept the Network Provider allowance as payment in full. Such continued Network status is subject to all other terms and conditions of this Policy, including regular benefit limits.

GRIEVANCE/APPEALS PROCEDURES, is amended by the deletion of **Standard External Reviews** in its entirety and the following substituted therefore:

Standard External Reviews

You can request an external review if we deny your claim, either in whole or in part, and the request relates to a decision involving medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or administration of this Policy's provisions under the section entitled "Special Out-of-Network Rules." You may be held financially responsible for the covered benefits. You can request an external review without completing the appeal process above if:

1. Your Physician has certified in writing that you have a Serious Medical or Behavioral Health Condition, a condition that requires immediate medical attention to avoid serious impairment to body functions, serious harm to an organ or body part, or that would place your health in serious jeopardy or jeopardize your ability to regain maximum function. This may include cancer, acute myocardial infarction, pregnancy, and Behavioral Health conditions.

; or

2. The denial of coverage was based on our determination that the service is Investigational or Experimental and your Physician certifies:
    a. Your condition is a serious disability or you have a life-threatening disease; and
        i. Standard health care services or treatments have not been effective in improving your condition; or
        ii. Standard health care services or treatments are not medically appropriate; or
        iii. The recommended or requested service or treatment is more beneficial than the standard health care service or treatment covered by us; and
    b. Medical and scientific evidence shows that treatment that was denied is more beneficial to you than available standard health services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of the standard services or treatments.

We will respond within five business days of your request for an external review, by either notifying the South Carolina Department of Insurance of a request for external review and requesting the South Carolina Department of Insurance to assign the review to an independent review organization (IRO) and forwarding your records to it or telling you in writing that your situation doesn't meet the requirements for an external review and explaining the reasons. The South Carolina

Department of Insurance assigns an IRO on a rotational system. BlueCross does not assign the IRO and is obligated to notify the Department of Insurance if a conflict of interest exists so a different IRO can be assigned.

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

If your request is assigned to an IRO, the IRO will determine within five business days after receiving your request whether all the information, certifications and forms required to process an external review have been provided. If the IRO needs additional information, you will be allowed to submit additional information in writing to them within seven business days.

If your request is not accepted for external review, the IRO will inform you and us in writing of the reason(s) your request was not accepted.

The IRO will provide written notice of its decision within 45 days after it receives the request.

If the IRO's decision is to allow benefits, we must process the claim subject to applicable Policy exclusions, limitations and other provisions within five business days of our receipt of the notification.

Grievances/Appeals Procedures, is amended by the deletion of **External Reviews** in its entirety and the following substituted therefore:

External Reviews
Requests to cover services, benefits, or supplies which are specifically excluded in the Contract are not eligible for external review. You will be notified in writing of your right to request an external review. You should file a request for external review within four months of receiving that notice; your request for external review must be in writing. You will be required to authorize the release of any medical records that may be needed for the external review. If you need assistance during the external review process, you can contact the South Carolina Department of Insurance at the following address and telephone number:

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

Grievances/Appeals Procedures; **Expedited External Reviews** is amended by the addition of:

All requests for external review and the subsequent review will be at our expense.

GENERAL POLICY PROVISIONS, is amended by the deletion of **9. Conformity with State Statutes:** in its entirety and the following substituted therefore:

9. **Conformity with State Statutes:** Any provision of this Policy which, at any relevant time, is in conflict with the laws of the state in which it is delivered or in conflict with Federal law on that date is amended to conform to the minimum requirements of such laws. Notwithstanding anything herein to the contrary, no provision of this Policy shall be interpreted as prohibiting any provision, access, use, or disclosure of information to the extent required by applicable law.

DEFINITIONS AND RELATED COVERAGE REQUIREMENTS, is amended by the addition of the following:

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

Nothing contained in this Amendment will be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the Policy or Member Schedule other than as stated above.

BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA

Scott Graves
President
Blue Cross and Blue Shield Division