BlueChoice HealthPlan South Carolina

An independent licensee of the Blue Cross and Blue Shield Association

Blue Option

Outline of Coverage

Major Medical Expense Coverage
Policy Form No. Blue Option (Rev. 1/23)

BlueChoice HealthPlan of South Carolina, Inc.
Post Office Box 6170
Columbia, South Carolina 29260-6170

If you need information about this health coverage – Call BlueChoice HealthPlan of South Carolina, Inc.'s (BlueChoice) Member Services Department. From Columbia, dial 786-8476, from anywhere else in the state, dial 855-816-7636 toll free. You may also send your inquiries through the Web site at www.BlueOptionSC.com.

Blue Option is an Exclusive Provider Organization (EPO) plan. An EPO is a managed care plan where services are covered only if you go to Providers in the Blue Option Network (except in an Emergency). The Blue Option Network is only within South Carolina and benefits are provided in-Network only.

No benefits are provided for services received out-of-Network unless the services are (1) due to an Emergency Medical Condition and provided at an Urgent Care Center or Hospital or Freestanding Emergency Room, (2) medically necessary air ambulance services, or (3) except where the Provider satisfies advance patient notice and consent requirements, services rendered by an out-of-Network Provider at certain in-Network facilities, or specified out-of-Network post-Stabilization services resulting from an Emergency Medical Condition.

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in the administration of the plan, including enrollment and benefit determination. If you are an individual living with disabilities or have limited English proficiency, we have free interpretive services available. We can also give you information in languages other than English or other alternate formats.

Read Your Contract Carefully

Blue Option is a non-grandfathered health plan. This Outline of Coverage provides a very brief description of the important features of Blue Option. This is not the insurance Policy and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of you and BlueChoice HealthPlan of South Carolina, Inc. Please READ YOUR POLICY CAREFULLY. It accompanies this Outline of Coverage. It gives special instructions on how to get authorization and how to handle an emergency.

Major Medical Expense Coverage
Policies of this category are designed to provide coverage to persons insured for major Hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily Hospital room and board, miscellaneous Hospital services, surgical services, anesthesia services, in-Hospital medical services and out-of-Hospital care subject to any Deductibles, Copayments or other limitations that may be set forth in the Policy.

Individual Coverage
You do not need prior Authorization from BlueChoice or from any other person (including your primary care Provider) in order to access to a pediatrician for children or gynecological care (from a Provider who specializes in gynecology) for women from a health care professional in our Network. The health care professional, however, may be required to comply with certain procedures, including obtaining prior Authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of Participating health care professionals who specialize in gynecology, contact BlueChoice at 786-8476 in Columbia or 855-816-7636, toll free from anywhere else. You can also visit our website at www.BlueOptionSC.com/Findcare for the most current list of Participating Physicians.

Important

The following items require prior Authorization in order for any benefits to be covered:

- All Inpatient Admissions, except for Emergency Admissions
  - For emergency admissions, you or someone acting on your behalf must notify BlueChoice no later than 24 hours after the admission or the next working day, whichever is later.
- Continued Inpatient Admissions.
- Outpatient facility admissions, except for Emergency Admissions
  - For emergency admissions, you or someone acting on your behalf must notify BlueChoice no later than 24 hours after the admission or the next working day, whichever is later.
- All Inpatient, Outpatient/office psychological testing, Intensive Outpatient and/or Partial Hospitalization programs, Repetitive Transcranial magnetic Stimulation (rTMS) and Electroconvulsive therapy and certain Prescription Drugs for Behavioral Health Disorders.
- Dental Services to Sound Natural Teeth Related to Accidental Injury after initial visit.
- Genetic counseling.
- Habilitation Services.
- Home Health Services
- Hospice Services.
- Covered transplants.
- Durable Medical Equipment (DME) that has a purchase price or rental cost of $500 or more. Any supplies used with DME must be Authorized every 90 days.
- Virtual colonoscopies, subject to medical management guidelines.
- Treatment of varicose veins.
- Services, supplies, or charges for a covered multi-disciplinary Pain Management Program, regardless of the state of location of the provider.
- Varicose vein procedures.
- Prescription Drugs as listed in the Prescription Drug List.
- Cardiac rehabilitation.
- Pulmonary rehabilitation.
- Dialysis.
- Radiation oncology.
- Injectable/infusible chemotherapy.
- Treatment of hemophilia.
- Advanced radiology.
- Nuclear cardiology.
- Musculoskeletal care
- Home infusion therapy.
- Home occupational therapy
- Home physical therapy.
- Home speech therapy.
- Biofeedback.

Benefits are provided in-network only. No benefits are provided for services received out-of-network unless the services are (1) due to an Emergency Medical Condition and provided at an Urgent Care Center or Hospital or Freestanding Emergency Room, (2) medically necessary air ambulance services, or (3) except where the Provider satisfies advance patient notice and consent requirements, services rendered by an out-of-Network Provider at certain in-Network facilities, or specified out-of-Network post-Stabilization services resulting from an Emergency Medical Condition. The Blue Option Network is only within the State of South Carolina.

Benefit Description

All Copayments, Deductible and Coinsurance will apply toward the Maximum Out-of-pocket. Copayments do not apply toward your Deductible. Covered Services will be provided at 100% once you reach your Out-of-pocket Maximum. The Out-of-pocket Maximum does not include Premiums, Balance-billed charges or health care the Policy doesn't cover.

Benefits are subject to all terms, conditions, limitations, and exclusions outlined the Policy.

Bronze Plan Options

Plan Benefits	Bronze 6500	Bronze 8000	Bronze 7000 HD
Deductible:			
Individual	$6,500	$8,000	$7,000
Family	$13,000	$16,000	$14,000
Coinsurance	30%	50%	0%
Out-of-Pocket Maximum:			
Individual	$8,700	$8,900	$7,000
Family	$17,400	$17,800	$14,000
Copayments:			
PCP/Doctors Care	$60	$60	Copayments not Applicable to this Plan. All Covered Services are subject to the Deductible
Blue CareOnDemand	$30	$30	
Specialist	$110	$100	
Urgent Care	$75	$75	
Free-Standing Ambulatory Surgery Center	$200	$200	
Emergency Room*	$300	Subject to Deductible	
Inpatient Admissions*	$300		
Outpatient Professional Services* for:			
Surgery	$300		
Prescription Drugs – Retail:			
Tier 1	$30	$30	0%
Tier 2	$30	$30	0%
Tier 3	30%	50%	0%
Tier 4	30%	50%	0%
Tier 5	30%	50%	0%
Tier 6	30%	50%	0%
Prescription Drugs – Mail Order:			
Tier 1	$60	$60	0%
Tier 2	$60	$60	0%
Tier 3	30%	50%	0%
Tier 4	30%	50%	0%
Tier 5	30%	50%	0%
Tier 6	30%	50%	0%

* These services are also subject to the Deductible and Coinsurance in addition to the Copayment.

Silver Plan Options

Plan Benefits	Silver 2250	Silver 3200	Silver 4500	Silver 4900 HD
Deductible:				
Individual	$2,250	$3,200	$4,500	$4,900
Family	$4,500	$6,400	$9,000	$9,800
Coinsurance	50%	50%	50%	0%
Out-of-Pocket Maximum:				
Individual	$7,500	$7,900	$8,900	$4,900
Family	$15,000	$15,800	$17,800	$9,800
Copayments:				
PCP/Doctors Care	$45	$45	$35	
Blue CareOnDemand	$23	$23	$18	
Specialist	$85	$90	$80	
Urgent Care	$50	$50	$50	
Free-Standing Ambulatory Surgery Center	$200	$200	$200	Copayments not Applicable to this Plan. All Covered Services are subject to the Deductible
Emergency Room*	$400	$400	$300	
Inpatient Admissions*	$400			
Skilled Nursing Facility/Residential Treatment Center*	Subject to Deductible	Subject to Deductible	Subject to Deductible	
Outpatient Professional Services* for:				
Surgery	$100	$100	$100	
Prescription Drugs – Retail:				
Tier 1	$25	$25	$25	0%
Tier 2	$25	$25	$25	0%
Tier 3	50%	$50	$50	0%
Tier 4	50%	$90	$90	0%
Tier 5	50%	$300	$300	0%
Tier 6	50%	$300	$300	0%
Prescription Drugs – Mail Order:				
Tier 1	$50	$50	$50	0%
Tier 2	$50	$50	$50	0%
Tier 3	50%	$100	$100	0%
Tier 4	50%	$180	$180	0%
Tier 5	50%	$600	$600	0%
Tier 6	50%	$600	$600	0%

* These services are also subject to the Deductible and Coinsurance in addition to the Copayment.

Silver Plan Options

Plan Benefits	Silver 5550	Silver 6250	Silver 7350	Silver 8200
Deductible:				
Individual	$5,550	$6,250	$7,350	$8,200
Family	$11,100	$12,500	$14,700	$16,400
Coinsurance	35%	25%	50%	0%
Out-of-Pocket Maximum:				
Individual	$7,400	$8,000	$8,500	$8,200
Family	$14,800	$16,000	$17,000	$16,400
Copayments:				
PCP/Doctors Care	$35	$30	$35	$0
Blue CareOnDemand	$18	$15	$18	$0
Specialist	$85	$65	$80	$60
Urgent Care	$50	$50	$50	$50
Free-Standing Ambulatory Surgery Center	$200	$200	$200	$200
Emergency Room*	$500			$500
Inpatient Admissions*	Subject to Deductible	Subject to Deductible	Subject to Deductible	Subject to Deductible
Skilled Nursing Facility/Residential Treatment Center*	$500			
Outpatient Professional Services* for:	Subject to Deductible			
Surgery		$100		
Prescription Drugs – Retail:				
Tier 1	$35	$25	$30	$30
Tier 2	$35	$25	$30	$30
Tier 3	35%	$40	$60	$50
Tier 4	35%	$90	$75	0%
Tier 5	35%	$300	$300	0%
Tier 6	35%	$300	$300	0%
Prescription Drugs – Mail Order:				
Tier 1	$70	$50	$60	$60
Tier 2	$70	$50	$60	$60
Tier 3	35%	$80	$120	$100
Tier 4	35%	$180	$150	0%
Tier 5	35%	$600	$600	0%
Tier 6	35%	$600	$600	0%

* These services are also subject to the Deductible and Coinsurance in addition to the Copayment.

Gold Plan Option

Plan Benefits	Gold 1500	Gold 3000 HD
Deductible:		
Individual	$1,500	$3,000
Family	$3,000	$6,000
Coinsurance	35%	0%
Out-of-Pocket Maximum:		
Individual	$5,000	$3,000
Family	$10,000	$6,000
Copayments:		
PCP/Doctors Care	$15	Copayments not Applicable to this Plan. All Covered Services are subject to the Deductible
Blue CareOnDemand℠	$8	
Specialist	$50	
Urgent Care	$50	
Free-Standing Ambulatory Surgery Center	$200	
Emergency Room*	$250	
Prescription Drugs – Retail:		
Tier 1	$20	0%
Tier 2	$20	0%
Tier 3	$35	0%
Tier 4	$70	0%
Tier 5	$250	0%
Tier 6	$250	0%
Prescription Drugs – Mail Order:		
Tier 1	$40	0%
Tier 2	$40	0%
Tier 3	$70	0%
Tier 4	$140	0%
Tier 5	$500	0%
Tier 6	$500	0%

* These services are also subject to the Deductible and Coinsurance in addition to the Copayment.

Catastrophic Plan Options

Plan Benefits	Catastrophic
Deductible:	
Individual	$9,100
Family	$18,200
Coinsurance	0%
Out-of-Pocket Maximum:	
Individual	$9,100
Family	$18,200
Copayments:	
PCP/Doctors Care/Blue CareOnDemand Copayments for PCP/Doctors Care/Blue CareOnDemand are limited to the first three visits. Then it is subject to Deductible.	$25
Prescription Drugs – Retail:	
Tier 1	0%
Tier 2	0%
Tier 3	0%
Tier 4	0%
Tier 5	0%
Tier 6	0%
Prescription Drugs – Mail Order:	
Tier 1	0%
Tier 2	0%
Tier 3	0%
Tier 4	0%
Tier 5	0%
Tier 6	0%

COVERED SERVICES

Professional Services (performed outside the office setting) Hospital services [1] Behavioral Health Laboratory Outpatient X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)
Maternity care – Routine Maternity Physician Services (No additional copay for ongoing routine care)
Mandated Preventive Care & Routine Care (includes mammogram and colonoscopy)
Facility Services / Inpatient Hospital[1] Inpatient hospital (includes maternity care and Behavioral Health) Skilled Nursing Facility/Residential Treatment Centers/Long-Term Acute Care Facility
Facility Services / Outpatient Hospital[1] Outpatient services (includes Ambulatory Surgical Center and maternity care) Freestanding Ambulatory Surgical Center (centers not affiliated with Hospital)[2] Outpatient Surgery Physician/Surgical services Behavioral Health Emergency Room (includes Professional Services) in-Network and out-of-Network – In order for Emergency Room care to be covered, care must be for an Emergency Medical Condition.
Prescription Medication Tier 1 Tier 2 Tier 3 Tier 4 Tier 5 Tier 6
Other Services Ambulance (special rules apply to air ambulance) Dental services due to accidental injury Durable Medical Equipment (DME) Habilitative Services Home Health Hospice Initial Prosthetic Devices Rehabilitative Occupational, Physical & Speech Therapy

BENEFITS	MEMBERS PAYS
Pediatric Vision Care – Physicians Eye Plan (PEP) Providers Only **(Refer to Provider Directory)** Pediatric Vision Care is provided under an agreement with Physicians Eyecare Network (PEN) and BlueChoice. PEN is an independent company that provides vision services on behalf of BlueChoice HealthPlan, Inc. of South Carolina.)	
One comprehensive vision exam per Benefit Period	$15 Copayment for all plans except the Catastrophic Plan. Catastrophic Plan – Deductible, then 0%
One standard contact lens fitting per Benefit Period	$49 Copayment for all plans except the Catastrophic Plan. Catastrophic Plan – Deductible, then 0%
$150 will be allowed toward the purchase of frames, lenses, lens options or contacts (Consult your PEP Provider for more information on discounts for which you may be eligible)	$25 Copayment for all plans except the Catastrophic Plan. Catastrophic Plan – Deductible, then 0%

Plan Maximums	Plan Maximum Per Member
Durable Medical Equipment	Up to purchase price
Home Health	60 visits per Benefit Period
Hospice	6 months per episode
Rehabilitative – Occupational Therapy, Physical Therapy,	30 combined visits per Benefit Period
Habilitative Services – Occupational Therapy, Physical Therapy,	30 combined visits per Benefit Period
Prosthetic Devices	1 item per episode
Skilled Nursing Facility/Residential Treatment Center	60 days per Benefit Period
Benefit Period	Calendar Year

The following services are not Essential Health Benefits and Do Not apply to your Deductible or Maximum Out-of-pocket.

BENEFITS	MEMBERS PAYS
Adult Routine Vision Care – Physicians Eye Plan(PEP) Providers Only (Refer to Provider Directory) Adult Routine Vision Care is provided under an agreement with Physicians EyeCare Network (PEN) and BlueChoice. PEN is an independent company that provides adult vision services on behalf of BlueChoice HealthPlan, Inc. of South Carolina.	(Authorization not required)
One comprehensive vision per Benefit Period	$0
One standard contact lens fitting per Benefit Period	$49
$150 will be allowed toward the purchase of frames, lenses, lens options or contacts (Consult your PEP Provider for more information on discounts for which you may be eligible)	
Preventive Dental Care (any licensed dentist)	
One dental exam every six months, a maximum of two per Benefit Period	Balance over $50
One dental cleaning every six months, a maximum of two per Benefit Period	Balance over $50
My Life Consult℠ ◆ Individual & Family Counseling (visits 1-3)	$0
◆ Life Management Services (3 visits)	$0
Benefits are provided under an agreement between First Sun EAP and BlueChoice. First Sun EAP is a separate company that does not offer BlueChoice HealthPlan products. These services are offered by First Sun EAP, not BlueChoice HealthPlan. BlueChoice HealthPlan has no responsibility for these services. For services, please call First Sun EAP at 800-968-8143. First Sun EAP staff is available 24 hours a day, seven days a week.	

[1] Includes post-stabilization services resulting from an Emergency, and services rendered by an out-of-Network Provider at certain in-Network facilities, subject to a limited exception where the Provider satisfies advance patient notice and consent requirements.

[2] Includes services rendered by an out-of-Network Provider at an in-Network Freestanding Ambulatory Surgical Center, subject to a limited exception where the Provider satisfies advance patient notice and consent requirements.

A Summary of Benefits and Coverage, also known as an SBC, is available to you online by using this link http://www.blueoptionsc.com/SBC . You may request a printed copy by calling the Customer Service phone number on the back of your ID card. **Please Note:** The format and content of an SBC is controlled by federal agencies and some details may appear inconsistent with information in the Policy or your Schedule of Benefits. If information is inconsistent, the Policy is the controlling document.
Benefits are available when Covered Services are Medically Necessary.

Benefits are provided In-network only. No benefits are provided for services received Out-of-network, unless the services are (1) due to an Emergency Medical Condition and provided at an Urgent Care Center or Hospital or Freestanding Emergency Room, (2) medically necessary air ambulance services, or (3) except where the Provider satisfies advance patient notice and consent requirements, services rendered by an out-of-Network Provider at certain in-Network facilities, or specified out-of-Network post-Stabilization services resulting from an Emergency Medical Condition. The Blue Option Network is generally within the State of South Carolina.

For a complete description of Covered Services, please refer to the What Is Covered section of the Policy.

The BlueCard® Program. As a Blue Cross® and Blue Shield® Licensee, BlueChoice participates in a national program called the BlueCard Program. *This program benefits you when you receive Covered Services while traveling outside ours service area (state of South Carolina)*. The "BlueCard" is your BlueChoice identification card. Your card tells participating BlueCard hospitals and/or Physicians which independent Blue Cross and Blue Shield Licensee is yours.

If you need care for an urgent condition while away from home, follow these easy steps:

- Always carry your current BlueChoice ID card for easy reference and access to service. Need your member ID card? Log in to My Health Toolkit® and your digital ID card is always available. You can view, print or share your member ID card any time you need it. Download the mobile app and you'll have your digital ID card right in your pocket. You can get the app through the App Store or Google Play. Just search for My Health Toolkit.
- To find names and addresses of nearby doctors and hospitals, visit the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or call BlueCard Access at 800-810-BLUE.
- When you arrive at the Participating doctor's office or Hospital, simply present your BlueChoice ID card.

After you receive care, you should not have to complete any claim forms. Nor should you have to pay for medical services other than your usual out-of-pocket expenses (non-Covered Services, Deductible, Copayment, and Coinsurance). You should see your Primary Care Physician for any follow-up care.

OUT-OF-AREA SERVICES

Overview – BlueChoice has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area BlueChoice serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of our service area, you will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("non-Participating Providers") don't contract with the Host Blue. We explain below how we pay both kinds of Providers.

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 benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by us to provide the specific service or services.

A. BlueCard® Program

Under the BlueCard Program, when you receive covered healthcare services within the geographic area served by a Host Blue, we will remain responsible for doing what we agreed to in the contract. However the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

When you receive covered healthcare services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services, is calculated based on the lower of:

- The billed covered charges for your Covered Services; or
- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare Provider or Provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we have used for your claim because they will not be applied after a claim has already been paid.

B. Special Cases: Value-Based Programs

BlueCard® Program

If you receive covered healthcare services under a Value-Based Program inside a Host Blue's service area, you 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 us through average pricing or fee schedule adjustments.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If we have entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Members on your behalf, we will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

C. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

D. Non-Participating Providers Outside Our/Licensee Name Service Area (Optional)

1. Member Liability Calculation

When covered healthcare services are provided outside of our service area by non-Participating Providers, the amount you pay for such services will normally be based on either the Host Blue's non-Participating Provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the non-Participating Provider bills and the payment we will make for the covered healthcare services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. Exceptions

In certain situations, we may use other payment methods, such as billed charges for Covered Services, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment to determine the amount we will pay for services provided by non-Participating Providers. In these situations, you may be liable for the difference between the amount that the non-Participating Provider bills and the payment we will make for the covered healthcare services as set forth in this paragraph.

D. BCBS Global™ Core Program

If you are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of BCBS Global Core Program when accessing Covered Services. BCBS Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although BCBS Global Core assists you with accessing a network of inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when you receive care from Providers outside the BlueCard service are, you will typically have to pay the Providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or Hospital) outside BlueCard service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a Physician appointment or hospitalization, if necessary.

- **Inpatient Services**

  In most cases, if you contact the BCBS Global Core Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts. In such cases, the Hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services.

You must contact BlueChoice to obtain precertification for non-Emergency inpatient services.

- **Outpatient Services**

  Physicians, Urgent Care centers and other outpatient Providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

- **Submitting a BCBS Global Core Claim**

  When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a BCBS Global Core claim form and send the claim form with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from BlueChoice, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

Emergency Services:
Use of the Emergency Room is intended only for persons who are experiencing an Emergency Medical Condition, as defined in the Policy. We will review requests for benefits after an Emergency Room visit to determine meets the definition of an Emergency Medical Condition. Requests for services that do not meet this standard will be denied as not covered.

Benefits are available to treat an Emergency Medical Condition only when provided at a Hospital or Freestanding Emergency Room or at an Urgent Treatment Center, and only (1) for as long as your condition continues to be considered an Emergency, or (2) for certain post-Stabilization services described below. If you receive such care related to an Emergency Medical Condition, the charges for Emergency Services are paid as follows:

1. Emergency Care Benefits – In-Network and Out-of-Network

   A. Benefits are provided for services and supplies for Stabilization and/or initial treatment of an Emergency Medical Condition, as well as post-Stabilization services and supplies rendered as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which Emergency Services are furnished. Benefits will not be provided, however, for post-Stabilization services and supplies where the Provider meets specified advance patient notice and consent requirements (unless the post-Stabilization services are not furnished in connection with unforeseen, urgent medical needs). If possible, call your Primary Care Physician prior to seeking treatment. If it is not possible to call your Primary Care Physician or delaying medical care would make your condition dangerous, please go to the nearest Hospital. Your claim for Emergency Services will be reviewed to ensure it meets the definition of an Emergency Medical Condition. If your claim does not meet the criteria for an Emergency Medical Condition, benefits will be denied whether the service is provided by an In-Network Provider or not.

If you are admitted to a Hospital due to an Emergency Medical Condition, you or someone acting on your behalf must contact BlueChoice HealthPlan within 24 hours or the next working day, whichever is later at 1-800-950-5387. If the Admission occurs outside the Local Service Area or at an Out-of-Network Provider, you may be required to transfer to a Hospital within the Local Service Area once your condition has Stabilized in order to receive benefits. If an Admission occurs within 24 hours after an Emergency visit as a result of the Emergency Medical Condition, the Emergency Copayment, if any, will be waived and the applicable Copayment for Admission will be assessed.

In order to be covered, any follow-up care must be provided by an In-Network Provider.

The Allowed Amount for benefits for Emergency Services for an Emergency Medical Condition when provided by an Out-of-network Provider will be the lesser of: 1) the billed charges, or (2) our median contracted rate for the same or similar Emergency Services furnished by Network Providers in the same or similar specialty in the same geographic region; provided that, except in connection with air ambulance services, if a different amount is 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 Allowed Amount.

B. Elective care, routine care, care for minor illness or injury, or care which reasonably could have been foreseen is not considered an Emergency Medical Condition and is not covered. Examples of non-Emergency Medical Conditions are Prescription Drug refills, removal of stitches, requests for a second opinion, screening tests or routine blood work, follow-up care for chronic conditions such as high blood pressure or diabetes and symptoms you have had for 24 to 48 hours, such as cough, sore throat, rash or stuffy nose.

C. Urgent Care Services are Covered Services when provided by a Participating Physician or at a Participating Alternate Facility such as an urgent care center or after-hours facility. Urgent care provided by a non-Participating Provider is Covered when Authorized by BlueChoice HealthPlan in advance or within 24 hours of receiving the service. Follow-up care is a Covered Service when provided by a Participating Physician.

Exclusions and Limitations of the Policy

No benefits are provided for the following, unless otherwise specified in the Schedule of Benefits. Notwithstanding any provision of the Policy to the contrary, if the Policy generally provides benefits for any type of injury, then in no event shall an exclusion or limitation of benefits be applied to deny coverage for such injury if the injury results from an act of domestic violence or a medical condition (including both physical and Mental Health condition), even if the medical condition is not diagnosed before the injury.

Excluded Services

Except as specifically provided in the Policy, even if Medically Necessary, no benefits will be provided for:

1. Services for which no charge is normally made in the absence of insurance.

2. Services, supplies or Prescription Drugs for which you are entitled to benefits under Medicare or other governmental programs (except Medicaid).

3. Injuries or diseases paid by Workers' Compensation or settlement of a Workers' Compensation claim.

4. Treatment provided in a government Hospital that you are not legally responsible for.

5. Illness contracted or injury sustained as the result of war or act of war (whether declared or undeclared); participation in a riot or insurrection; service in the armed forces or an auxiliary unit.

6. Treatment, services or supplies received as a result of suicide, attempted suicide or intentionally self-inflicted injuries unless it results from a medical (physical or mental) condition, even if the condition is not diagnosed prior to the injury.

7. Any plastic or reconstructive Surgery done mainly to improve the appearance or shape of any body part and for which no improvement in physiological or body function is reasonably expected, also known as Cosmetic Surgery. Cosmetic Surgery includes, but is not limited to, Surgery for saggy or extra skin (regardless of reason); any augmentation, reduction, reshaping or injection procedures of any part of the body; rhinoplasty, abdominoplasty, liposuction and other associated types of Surgery; and any procedures using an implant that doesn't alter physiologic or body function or isn't incidental to a covered surgical procedure. Cosmetic Surgery does not include reconstructive Surgery incidental to or following Surgery resulting from trauma, infection or other diseases of the involved part. Complications arising from Cosmetic Surgery is also not covered.

8. Eyeglasses, contact lenses (except after cataract Surgery), except as shown in the Covered Services section, and hearing aids and exams for the prescription or fitting of them. Any Hospital or Physician charges related to refractive care such as radial keratotomy (Surgery to correct nearsightedness), or keratomileusis (laser eye Surgery or LASIK), lamellar keratoplasty (corneal grafting) or any such procedures that are designed to alter the refractive properties of the cornea.

9. Services or supplies related to an abortion, except:
   - for an abortion performed when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused or arising from the pregnancy; or
   - when the pregnancy is the result of rape or incest.

10. Services, care or supplies used to detect and correct, by manual or mechanical means, structural imbalance, distortion or subluxation in your body for the purpose of removing nerve interference and its effects when this interference is the result of or related to distortion, misalignment or subluxation of, or in, the spinal column.

11. Services and supplies related to non-surgical treatment of the feet, except non-FDA approved technologies for non-surgical foot treatment related to diabetes.

12. Physician services directly related to the care, filling, removal or replacement of teeth; the removal of impacted teeth; and the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth. This includes but is not limited to: apicoectomy (dental root resection), root canal treatment, alveolectomy (Surgery for fitting dentures) and treatment of gum disease. Exception is made as shown in the Covered Services section, for dental treatment to Sound Natural Teeth for up to six months after an accident and for Medically Necessary Cleft Lip and Palate services.

13. Separate charges for services or supplies from an employee of a Hospital, laboratory or other institution; or an independent health care professional whose services are normally included in facility charges.

Other Services the Policy Does not Cover

14. Services, supplies or Prescription Drugs received from a non-network Provider, unless the services are (1) due to an Emergency Medical Condition and received in a Hospital or Freestanding Emergency Room or Urgent Care center, (2) medically necessary air ambulance services, or (3) except where the Provider satisfies advance patient notice and consent requirements as described herein, services rendered by an out-of-Network Provider at certain in-Network facilities, or specified out-of-Network post-Stabilization services resulting from an Emergency Medical Condition.

15. Services, procedures, charges, supplies, equipment or pharmaceuticals for which prior Authorization is required and not obtained.

16. Services and supplies that are not Medically Necessary, not needed for the diagnoses or treatment of an illness or injury or not specifically listed in *Covered Services*.

17. Any Covered Service provided in excess of applicable limits described in this Policy or the Schedule of Benefits.

18. Services and supplies you received before you had coverage under this Policy or after you no longer have this coverage except as described in Extension of Benefits under *Eligibility* in the *When Your Coverage Ends* section of this Policy.

19. Any charges by the Department of Veterans Affairs (VA) for a service-related disability.

20. Admissions or portions thereof for long-term care, including: 1) rest care; 2) care to assist a Member in the performance of activities of daily living (including, but not limited to, walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation and taking medication); 3) custodial or long-term care; or; 4) therapeutic schools, wilderness/boot camps, therapeutic boarding homes, half-way houses and therapeutic group homes(this exclusion does not apply to otherwise Covered Services furnished in these settings).

21. All Admissions to Hospitals or freestanding Rehabilitation Facilities for physical Rehabilitation when the services are not done at a Designated Provider and/or you do not receive the required prior Authorization.

22. Any loss that results from you committing, or attempting to commit a crime, felony or misdemeanor or from engaging in an illegal occupation.

23. Investigational or Experimental Services, as determined by us, including but not limited to the following:

    Relating to transplants:
    - Uses of allogeneic bone marrow transplantation (between two related or unrelated people) or syngeneic bone marrow transplantation (from one identical twin to the other) along with other forms of stem cell transplant (with or without high doses of chemotherapy or radiation) in cases in which less than four of the six complex antigens match; cases in which mixed leukocyte culture is reactive; and AIDS and HIV infection;
    - Adrenal tissue to brain transplants;
    - Islet cell transplants;
    - Procedures that involve the transplantation of fetal tissues into a living recipient.

Relating to other conditions or services:

- Dorsal Rhizotomy (cutting spinal nerve roots) in the treatment of spasticity (increased tone or tension in a muscle such as a leg).

24. Services and supplies related to transplants involving mechanical or animal organs, human organ and/or tissue transplant procedures when you do not get the required prior Authorization and it is not done at a Designated Provider, or unless specifically listed in *Covered Services*.

25. Reduction mammoplasty for macrosastia unless you are within 20% of your recommended body weight in accordance with BlueChoice's medical guidelines.

26. Any treatment or Surgery for obesity (even if morbid obesity is present), weight reduction or weight control, such as gastric by-pass, insertion of stomach (gastric) banding, intestinal bypass, wiring mouth shut, liposuction or complications from it, unless and to the extent such services may be covered under, and you receive such services while participating in, an approved program listed under the Additional Covered Services section of this Policy. This includes any reversal or reconstructive procedures from such treatments. Treatment for obesity may be covered if a Member participates in the My Health Novel program.

27. Any medical social services, visual therapy or private duty nursing, except when part of an Authorized home health care or hospice services program.

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

31. Biofeedback, unless Authorized.

32. Bionic/bioelectric, microprocessor or computer programmed prosthetic components.

33. Any services, supplies or drugs for the diagnosis or treatment of infertility. This includes, but is not limited to: fertility drugs, lab and X-ray tests, reversals of sterilization, surrogate parenting, artificial insemination and in-vitro fertilization.

34. Medical supplies, services or charges for the diagnosis or treatment of learning disorders, communication disorders, motor skills disorders, relational problems, intellectual disabilities, and vocational rehabilitation, except as specified on the Schedule of Benefits.

35. Counseling and psychotherapy services for the following conditions are not covered: 1) TIC disorders, except when related to Tourette's disorder; 2) mental disorders due to a general medical condition; 3) medication induced movement disorders; or 4) nicotine dependence, except when a part of an approved wellness program.

36. Any behavioral, educational or alternative therapy techniques to target cognition, behavior, language, and social skills modification, including:
    a. Applied behavioral analysis (ABA) therapy;
    b. Teaching, Expanding, Appreciating, Collaborating and Holistic (TEACCH) programs;
    c. Higashi schools/daily life;
    d. Facilitated communication;
    e. Floor time;
    f. Developmental Individual-Difference Relationship-based model (DIR);
    g. Relationship Development Intervention (RDI);
    h. Holding therapy;

i. Movement therapies;
j. Primal therapy;
k. Group socialization;
l. Art therapy;
m. Music therapy; and
n. Animal Assisted therapy.

37. Services, supplies or charges for wellness or alternative treatment programs, acupuncture, massage therapy, hypnotism and Transcutaneous Electrical Nerve Stimulation (TENS) unit therapy or any kind of pain management, unless and to the extent such services may be covered under, and you receive these services while participating in, an approved program listed under the Covered Services section of this Policy.

38. Any services, supplies or treatment for excessive sweating.

39. Orthomolecular therapy including infant formula, nutrients, vitamins and food supplements, even if the Physician orders or prescribes them. Enteral feedings when not a sole source of nutrition.

40. An assistant at surgery, when not Medically Necessary or when the assistant at surgery does not have surgical privileges at the Facility or Hospital.

41. Physician charges for drugs, appliances, supplies, blood and blood products.

42. Physician charges for virtual office visits including but not limited to telephonic, internet, electronic mail or video chat consultations unless listed in the Schedule of Benefits.

43. Telemonitoring, except as shown in Covered Services.

44. Telehealth services which are initiated by either a Member or Provider (including, but not limited to a medical doctor) in which the method of web-based or video communication is not secure, does not occur in real-time and/or are not provided by Network Providers who have been credentialed as eligible Telehealth Providers.

45. Telemedicine services which do not comply with all the requirements specified in the Covered Services section of this Policy.

46. Any service or supply related to dysfunctional conditions of the chewing muscles, wrong position or deformities of the jaw bone(s), orthognathic deformities or temporomandibular joint syndrome (headache, facial pain and jaw tenderness caused by jaw problems usually known as TMJ).

47. Luxury or convenience items whether or not a Physician recommends or prescribes them.

48. Any and all travel expenses (including those related to a transplant) such as, but not limited to: immunizations prior to travel, transportation, lodging and repatriation, unless specifically included in Covered Services.

49. Routine, non-Emergency ambulance transportation, including, but not limited to, travel to a facility for scheduled medical or surgical treatments, such as dialysis or cancer treatment or transfer to a sub-acute place of care such as a Skilled Nursing Facility.

50. Replacement of Prosthetic Devices due to damage or wear and tear, unless Medically Necessary.

51. Items purchased that exceed the minimum specifications for the Member's needs. We will pay only the amount that we would have paid for the items that meets the Member's minimum specifications. The Member will be responsible for any difference in the cost.

52. Durable Medical Equipment when you do not get the required prior Authorization and any charges in excess of the purchase price.

53. Repair, replacement or duplicate Durable Medical Equipment/Prosthetics, except when Medically Necessary due to a change in the Member's medical condition and Authorized by us. Repair or replacement for routine wear and tear is not covered.

54. Equipment or supplies that have non-therapeutic uses and equipment and supplies that are available over the counter such as, but not limited to, air conditioners, air filters, whirlpool baths, spas, (de)humidifiers, wigs, fitness supplies, vacuum cleaners or common first aid supplies.

55. Manual or motorized wheelchairs or power operated scooters, unless Medically Necessary for mobility in the patient's home.

56. Benefits will be denied for procedures, services or pharmaceuticals when you do not get the required prior Authorization.

57. Any type of fee or charge for handling medical records, filing a claim or missing a scheduled appointment.

58. Any services or supplies you or a member of your immediate family provides, including the dispensing of drugs. A member of your family means spouse, parent, grandparent, brother, sister, aunt, uncle, children or in-law.

59. Any service, supply or treatment for complications resulting from any non-covered procedure or condition or drug.

60. Adjustable cranial orthosis (band or helmet) for positional plagiocephaly or craniosynostoses in the absence of cranial vault remodeling Surgery.

61. Services, supplies or treatment for varicose veins and or venous incompetence, including but not limited to endovenous ablation, vein stripping or sclerosing solutions injection, and to the extent otherwise provided in this Policy or Schedule of Benefits.

62. Pre-conception testing or pre-conception genetic testing.

63. Prescription and/or Specialty Drugs:
    - That are used for or related to non-Covered Services or conditions, such as, but not limited to, weight control, obesity, erectile dysfunction, cosmetic purposes (such as Tretinoin or Retin-A, Kybella for chin fat), hair growth and hair removal. Also excludes all vitamins (except for prenatal vitamins due to pregnancy or otherwise covered as Preventive Care).
    - That are used for infertility.
    - That are more than the number of days supply allowed as shown in Covered Services.
    - That are refills in excess of the number specified on your Physician's prescription order.
    - That are for more than the recommended daily dosage defined by BlueChoice unless prior Authorization is sought and approved.

- When administered or dispensed in a Physician's office, Skilled Nursing Facility, Residential Treatment Center, Hospital or any other place that is not licensed to dispense Prescription Drugs.
- That are available over the counter or when there is an over-the-counter drug equivalent containing the same active ingredients as the prescription version including any over-the-counter supplies, devices or supplements.
- When not consistent with the diagnosis and treatment of an illness, injury or condition or that is excessive in terms of the scope, duration or intensity of drug therapy that is needed to provide safe, adequate and appropriate care.
- That require Authorization and the Authorization is not received.
- That are classified as self-administered drugs when obtained, purchased and/or administered at a doctor's office or in an Outpatient setting.
- That requires step therapy when a Step Therapy Program is not followed.
- That are received out-of-Network, unless due to an Emergency Medical Condition that is treated at an Urgent Care Center or Hospital Emergency Room.
- That are not on the Prescription Drug List
- That are medications or drugs for which some or all the cost sharing is paid by a drug manufacturer in any form of direct support (cash, reimbursement, coupon, voucher, debit card, etc.) that reduces or eliminates immediate out-of-pocket costs for a specific prescription brand drug. Although the drug remains a covered prescription drug, cost sharing amounts provided by the drug manufacturer will not be counted toward the member's annual limitation on cost sharing.
- That are new to the market and under clinical review by BlueChoice shall be listed on the Covered List as excluded until the clinical review has been completed and a final determination has been made as to whether the Drug should be covered.
- That are Prescription Drugs and pharmaceuticals that could be covered under both the medical and Prescription Drug portion of this coverage. In that case, coverage is provided under the Prescription Drug benefit only.

64. Any of the following services associated with a Clinical Trial:
    - Services that are not considered routine patient care costs/services, including the following:
        - The investigational drug, service, item or service that is provided solely to satisfy data collection and analysis needs.
        - An item or service that is not used in the direct clinical management of the individual.
        - A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
    - An item or service provided by the research sponsors free of charge for any person enrolled in the trial.
    - Travel and transportation expenses, unless and otherwise covered this Certificate, including but not limited to the following:
        - Fees for personal vehicle, rental car, taxi, medical van, ambulance, commercial airline, train.
        - Mileage reimbursement for driving a personal vehicle.
        - Lodging.
        - Meals.

Extension of Benefits after Termination of Coverage

If BlueChoice does not renew or terminates your contract and you are in the hospital or continuously and totally disabled when your coverage under this contract ends, benefits will be provided while you remain continuously and totally disabled for the same cause. Benefits are subject to the terms, conditions, exclusions and limitations of the contract. This coverage will continue until you (1) have full coverage for the disabling condition under a health plan with similar benefits and that plan makes reasonable provisions for continuity of care for the disabling condition; (2) are no longer totally disabled; (3) you use up all of your benefits, or (4) until the end of a period of 365 consecutive days, whichever occurs first. Benefits will be paid only for charges related to treatment of the disabling condition.

The term "Totally Disabled" means that you are receiving ongoing medical care by a physician and can perform none of the usual and customary duties or activities of a person in good health of the same age. A child who is Totally Disabled is receiving ongoing medical care by a Physician and unable to perform the normal activities of a child in good health of the same age and sex. A physician's statement of disability will be required.

Important Note: We recommend that you notify BlueChoice if you wish to exercise the extended benefits for total disability rights. Claims filed under this section must be accompanied by a Physician's statement of disability. The medical director of BlueChoice will have authority for determining if the requirements of total disability have been met. You should contact BlueChoice for the necessary forms.

Renewability Provision

Guaranteed Renewable Except For Stated Reasons: BlueChoice shall renew or continue in force the Policy at the person's option. We may nonrenew or discontinue this Policy based only on one of the following reasons:

- Failure to pay Premiums
- Fraud or material misrepresentation
- Discontinuance of this type of coverage by BlueChoice
- Discontinuance of individual health insurance in the state of South Carolina by BlueChoice.
- The person no longer resides, works or lives in South Carolina.

However, we will not decline to renew the Policy simply because of a Health Status-Related Factor or because a Member's health changes. At the time of renewal, we may modify the Policy for everyone who has it as long as the modification is consistent with federal and state law and effective on a uniform basis.

Individual Transfer Right

Any person purchasing an individual accident, health or accident and health insurance policy, will have the right to transfer to any individual policy of equal or lesser benefits offered for sale by BlueChoice at the time transfer is sought.

Premiums

If you previously had coverage with BlueChoice HealthPlan of South Carolina, Inc. or its affiliated companies, your policy was cancelled due to nonpayment of premiums and you re-apply for coverage within 12 months, you will be required to pay all past due premiums before you can activate new coverage or begin using benefits.

Premiums are due and payable in full on or before the monthly due date. The benefits described are available as long as the required Premium is paid. If you enroll in our automatic draft for your Premiums, and later decide to cancel the automatic draft, it must be cancelled at least three business days prior to the draft. We will not accept payment of your Premiums from any health care Provider, health agency, health entity, public or private institution or any other person or entity which does not have an insurable interest.

Other than Premiums for the initial month, a Grace Period will be granted for the payment of Premiums. During this Grace Period the Policy will continue in force. The Policyholder will be liable for all Premiums due and unpaid for the period the Policy continues in force. If Premiums are not received by the end of the Grace Period, the Policy will automatically terminate without further notice to the Policyholder. The termination will be effective back to the Premium due date. Any claims paid after the last Premium paid date does not extend the coverage.

BlueChoice bases Premiums on coverage selected, age, residence, tobacco use and regulatory fees and taxes required by the Affordable Care Act. Premiums may only be changed at the beginning of your Benefit Period. At least 31 days prior to your new Benefit Period, you will receive notice of your new Premium.

If the Member's age, residence or tobacco use has been misstated and if the amount of the Premiums is based on these factors, an adjustment in Premiums, coverage, or both, will be made based on the Member's true age, residence or tobacco use. No misstatement of age, residence or tobacco use will continue insurance that has been otherwise validly terminated or terminate coverage otherwise validly in force.

When BlueChoice pays a claim, BlueChoice may deduct any Premium due from the claim payment.

At any time, BlueChoice may notify the Member that no Premium is due for coverage for a certain period of time. The notification will include the reason for the waiver of Premiums and the length of time the waiver is in effect. This can occur when BlueChoice needs to refund money to the Member or in situations involving a medical loss ratio rebate (see the **Medical Loss Ratio** Section in the *General Policy Provisions* in the Policy). BlueChoice is under no obligation to waive the Member's Premium and the fact that it may do so does not obligate it waive Premium in the future.