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. 1/21)

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 1-855-816-7636, toll free. You may also send your inquiries through the Web site at www.BlueOptionSC.com.

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, which accompanies this Outline of Coverage. It gives special instructions on how to obtain 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 obtain 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/find-care for the most current list of Participating Physicians.

Important

Here is the most important thing you need to remember about Blue Option:
All inpatient admissions, except for Emergency Admissions, certain outpatient services, Durable Medical Equipment when the purchase price or rental cost is $500 or more and certain prescription drugs must be Authorized in advance by BlueChoice.

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 Mental Health and/or Substance Use Disorders care must be Authorized in advance or no benefits will be provided. Inpatient Mental Health and/or Substance Abuse Disorders treatment is only covered when provided at a facility that has a current contract with BlueChoice HealthPlan of South Carolina, Inc. or Companion Benefit Alternatives. Companion Benefit Alternatives, Inc. is a separate company that Authorizes/manages Mental Health and Substance Use Disorder Services on behalf of BlueChoice.

For Emergency Admissions, BlueChoice should be notified no later than 24 hours after the Admission or the next working day if possible, or as soon as the patient's condition allows.

Benefits are provided in-network only. No benefits are provided for services received out-of-network unless the service is due to an Emergency Medical Condition and the service is provided at an Urgent Care Center or Hospital Emergency Room.

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 Option

Plan Benefits	Bronze 5550	Bronze 6500	Bronze 7300
Deductible:			
Individual	$5,550	$6,500	$7,300
Family	$11,00	$13,000	$14,600
Coinsurance	35%	20%	50%
Out-of-Pocket Maximum:			
Individual	$8,550	$8,550	$8,550
Family	$17,100	$17,100	$17,100
Copayments:			
PCP/Doctor's Care/Blue CareOnDemand℠	$60	$60	$65
Specialist	Not Applicable	$100	$100
Urgent Care	$75	$75	$75
Free Standing Ambulatory Surgery Center	$200	$200	$200
Emergency Room*	$500	$500	$500
Inpatient Admissions*	$500	$500	$500
Skilled Nursing Facility*	$500	$500	$500
Residential Treatment Center*	$500	$500	$500
Outpatient Professional Services for Diagnostic, Lab and X-rays*	$500	$500	$500
Prescription Drugs – Retail:			
Tier 1	35%	$40	$40
Tier 2	35%	$40	$40
Tier 3	35%	20%	50%
Tier 4	35%	20%	50%
Tier 5	35%	20%	50%
Tier 6	35%	20%	50%
Prescription Drugs – Mail Order:			
Tier 1	35%	$80	$80
Tier 2	35%	$80	$80
Tier 3	35%	20%	50%
Tier 4	35%	20%	50%
Tier 5	35%	20%	50%
Tier 6	35%	20%	50%

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

Bronze Plan Options

Plan Benefits	Bronze 8550	Bronze 6900 HD
Deductible:		
Individual	$8,550	$6,900
Family	$17,100	$13,800
	0%	
Coinsurance		0%
Out-of-Pocket Maximum:		
Individual	$8,550	$6,900
Family	$17,100	$13,800
Copayments:		
PCP/Doctor's Care/Blue	$70	
CareOnDemand		Not Applicable
Specialist	$100	Not Applicable
Urgent Care	$75	Not Applicable
Free Standing Ambulatory Surgery Center	$200	Not Applicable
Prescription Drugs – Retail:		
Tier 1	$40	0%
Tier 2	$40	0%
Tier 3	0%	0%
Tier 4	0%	0%
Tier 5	0%	0%
Tier 6	0%	0%
Prescription Drugs – Mail Order:		
Tier 1	$80	0%
Tier 2	$80	0%
Tier 3	0%	0%
Tier 4	0%	0%
Tier 5	0%	0%
Tier 6	0%	0%

Silver Plan Options

Plan Benefits	Silver 5550	Silver 7000	Silver 2000	Silver 3200
Deductible:				
Individual	$5,550	$7,000	$2,000	$3,200
Family	$11,100	$14,000	$4,000	$6,400
Coinsurance	20%	0%	50%	50%
Out-of-Pocket Maximum:				
Individual	$7,350	$7,000	$7,500	$7,900
Family	$14,700	$14,000	$15,000	$15,800
Copayments:				
PCP/Doctor's Care/Blue CareOnDemand	$45	$0	$35	$35
Specialist	$100	$50	$75	$80
Urgent Care	$50	$50	$50	$50
Free Standing Ambulatory Surgery Center	$200	$200	$200	$200
Emergency Room*	$500	$500	$400	$400
Inpatient Admissions*	$500	$500	$400	Not Applicable
Skilled Nursing Facility*	$500	$500	Not Applicable	Not Applicable
Residential Treatment Center*	$500	$500	Not Applicable	Not Applicable
Outpatient Professional Services for Diagnostic, Lab and X-rays*	$500	$500	Not Applicable	Not Applicable
Prescription Drugs – Retail:				
Tier 1	$15	$25	$20	$25
Tier 2	$15	$25	$20	$25
Tier 3	$35	$45	50%	$50
Tier 4	20%	0%	50%	$90
Tier 5	20%	0%	50%	$300
Tier 6	20%	0%	50%	$300
Prescription Drugs – Mail Order:				
Tier 1	$30	$50	$40	$50
Tier 2	$30	$50	$40	$50
Tier 3	$70	$90	50%	$100
Tier 4	20%	0%	50%	$180
Tier 5	20%	0%	50%	$600
Tier 6	20%	0%	50%	$600

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

Silver Plan Options

Plan Benefits	Silver 3500	Silver 6250	Silver 6850
Deductible:			
Individual	$3,500	$6,250	$6,850
Family	$7,000	$12,500	$13,700
Coinsurance	40%	25%	40%
Out-of-Pocket Maximum:			
Individual	$8,000	$7,800	$7,800
Family	$16,000	$15,600	$15,600
Copayments:			
PCP/Doctor's Care/Blue CareOnDemand	$40	$20	$25
Specialist	$80	$55	$60
Urgent Care	$50	$50	$50
Free Standing Ambulatory Surgery Center	$200	$200	$200
Emergency Room*	$350	Not Applicable	Not Applicable
Prescription Drugs – Retail:			
Tier 1	$25	$20	$25
Tier 2	$25	$20	$25
Tier 3	$70	$40	$45
Tier 4	$95	$90	$80
Tier 5	$300	$300	$300
Tier 6	$300	$300	$300
Prescription Drugs – Mail Order:			
Tier 1	$50	$40	$50
Tier 2	$50	$40	$50
Tier 3	$140	$80	$90
Tier 4	$190	$180	$160
Tier 5	$600	$600	$600
Tier 6	$600	$600	$600

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

Silver Plan Options

Plan Benefits	Silver 7350	Silver 4300 HD	Silver 6100 HD
Deductible:			
Individual	$7,350	$4,300	$6,100
Family	$14,700	$8,600	$12,200
Coinsurance	0%	0%	0%
Out-of-Pocket Maximum:			
Individual	$7,350	$4,300	$6,100
Family	$14,700	$8,600	$12,200
Copayments:			
PCP/Doctor's Care/Blue CareOnDemand	$40	Not Applicable	Not Applicable
Specialist	$80	Not Applicable	Not Applicable
Urgent Care	$50	Not Applicable	Not Applicable
Free Standing Ambulatory Surgery Center	$200	Not Applicable	Not Applicable
Prescription Drugs – Retail:			
Tier 1	$35	0%	0%
Tier 2	$35	0%	0%
Tier 3	$60	0%	0%
Tier 4	$75	0%	0%
Tier 5	$300	0%	0%
Tier 6	$300	0%	0%
Prescription Drugs – Mail Order:			
Tier 1	$70	0%	0%
Tier 2	$70	0%	0%
Tier 3	$120	0%	0%
Tier 4	$150	0%	0%
Tier 5	$600	0%	0%
Tier 6	$600	0%	0%

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

Catastrophic Plan Options

Plan Benefits	Catastrophic
Deductible:	
Individual	$8,550
Family	$17,100
Coinsurance	0%
Out-of-Pocket Maximum:	
Individual	$8,550
Family	$17,100
Copayments:	
PCP/Doctor's Care/Blue CareOnDemand	$25
Copayments for PCP/Doctor's Care/Blue CareOnDemand are limited to the first three visits, then it is subject to Deductible.	
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

Emergency Room care – In order for Emergency Room care to be covered, care must be for an Emergency Medical Condition. If Emergency Room Care is received for an Emergency Medical Condition outside of the Network, the Member will be responsible for any amounts above the allowable amount up to the billed amount.

Mental Health/Substance Abuse

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

Inpatient hospital (includes maternity care and Mental Health/Substance Abuse)

Skilled Nursing Facility/Residential Treatment Centers

Facility Services / Outpatient Hospital

Outpatient services (includes Ambulatory Surgical Center and maternity care)

Freestanding Ambulatory Surgical Center (centers not affiliated with Hospital)

Outpatient Surgery Physician/Surgical services

Mental Health/Substance Abuse

Emergency Room – In order for Emergency Room care to be covered, care must be for an Emergency Medical Condition. If Emergency Room Care is received for an Emergency Medical Condition outside of the Network, the Member will be responsible for any amounts above the allowable amount up to the billed amount.

Prescription Medication

Tier 1
Tier 2
Tier 3
Tier 4
Tier 5
Tier 6

Other Services

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	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. One comprehensive vision per Benefit Period One standard contact lens fitting per Benefit Period **$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)**	(Authorization not required) $0 $49
Preventive Dental Care (any licensed dentist) One dental exam every six months, a maximum of two per Benefit Period One dental cleaning every six months, a maximum of two per Benefit Period	 Balance over $50 Balance over $50
• Life Management Services (3 visits) 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 1-800-968-8143. First Sun EAP staff is available 24 hours a day, seven days a week.	$0

A Summary of Benefits and Coverage, also known as an SBC, is available to you online by using this link www.BlueOptionSCcom/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 service is due to an Emergency Medical Condition and the service is provided at an Urgent Care Center or Hospital Emergency Room.

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 for an Emergency Medical Condition or an urgent condition 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

BlueCard® is applicable to services received as a result of an Emergency Medical Condition or an urgent condition. .

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 on an Outpatient basis at a Hospital Emergency Room or at an Urgent Treatment Center, and only for as long as your condition continues to be considered an Emergency. If you receive care for an Emergency Medical Condition and are treated in the Emergency Room at a Hospital, 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. 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 greater of: 1) the median amount for those Emergency Services, calculated using reimbursement rates of Network Providers who participate in the Blue Option Network; or 2) the amount for those Emergency Services calculated using Medicare reimbursement rates, which is the same method BlueChoice generally uses to determine payment to Out-of-network Providers who do not participate in the Blue Option Network.

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:

- Services for which no charge is normally made in the absence of insurance.
- Services, supplies or Prescription Drugs for which you are entitled to benefits under Medicare or other governmental programs (except Medicaid).
- Injuries or diseases paid by Workers' Compensation or settlement of a Workers' Compensation claim.
- Treatment provided in a government Hospital that you are not legally responsible for.
- Rest care or Custodial Care.
- 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.

- 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.

- 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 are also not covered.

- 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.

- 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.

- 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.

- Services and supplies related to non-surgical treatment of the feet, except when related to diabetes. Non-surgical, diabetic foot treatment does not include non-FDA approved technologies.

- 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.

- 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

- Services, supplies or Prescription Drugs received from a non-network Provider, unless the service is due to an Emergency Medical Condition and it is received in a Hospital Emergency Room or Urgent Care center.

- Hospital, Skilled Nursing Facility or Residential Treatment Center charges when prior Authorization is not obtained.

- 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*.

- Habilitation services after 30 visits per Member per Benefit Period.

- Home Health Care services after 60 visits per Member per Benefit Period.

- Hospice care received after six months per episode per Member.

- Rehabilitative Occupational Therapy, Physical Therapy and Speech Therapy after 30 visits per Member per Benefit Period.

- Skilled Nursing Facility benefits beyond 60 days per Member per Benefit Period.

- Residential Treatment Center benefits beyond 60 days per Member per Benefit Period.

- 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.

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

- Admissions or portions thereof for long-term or chronic care for medical or Behavioral Health conditions, except when Medically Necessary and approved by us.

- Behavioral Health or Substance Use Disorder residential treatment received at: therapeutic schools; wilderness/boot camps; therapeutic boarding homes; half-way houses; and therapeutic group homes.

- 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.

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

- 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).

• 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*.

• Reduction mammoplasty for macrosastia unless you are within 20% of your ideal body weight.

• 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 the Policy. This includes any reversal or reconstructive procedures from such treatments.

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

• Recreational or educational therapy; psychological or educational diagnostic testing to determine job or occupational placement, for other educational purposes, or to determine if a learning disorder exists; and vocational rehabilitation unless specifically included in the Covered Services Section.

• Biofeedback, unless Authorized.

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

• Any services or supplies 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.

• Any services or supplies for the diagnosis or treatment of sexual dysfunction. This includes, but is not limited to: drugs, lab and X-ray tests, counseling, sexual procedures not Medically Necessary or penile prostheses necessary due to any medical condition or organic disease. If benefits are available for Durable Medical Equipment, a penile prosthesis will be considered for benefits only after Medically Necessary prostate Surgery.

• Counseling and psychotherapy services for: tic disorder except for Tourette's disorder; mental disorders due to general medical conditions; learning disorders; intellectual disabilities; sexual function disorder; medication induced movement disorder; and nicotine dependence unless specifically covered in this Policy.

• Services for Animal Assisted Therapy.

• Vagal Nerve Stimulation (VNS),

- Rapid Opiate Detoxification.

- Any behavioral, educational or alternative therapy techniques to target cognition, behavior, language, and social skills modification, including:
  1. Applied behavioral analysis therapy;
  2. Teaching, Expanding, Appreciating, Collaborating and Holistic programs (TEACCH);
  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.

- 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 Additional Covered Services section of the Policy.

- Any services, supplies or treatment for excessive sweating.

- 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.

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

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

- 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.

- Telemonitoring, except as shown in Covered Services.

- 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.

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

- 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).

- Devices of any type, even with a prescription (other than contraceptive devices), such as but not limited to: therapeutic devices, artificial appliances or similar devices.

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

- 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.

- Non-Emergency ambulance services.

- More than one Prosthetic Devices per episode.

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

- 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.

- 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.

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

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

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

- 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, parents, grandparents, brothers, sisters, aunts, uncles, children or in-laws.

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

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

- Services, supplies or treatment for varicose veins and or venous incompetence, including but not limited to endovenous ablation, vein stripping or sclerosing solutions injection, unless Medically Necessary under our medical management guidelines and Preauthorization is obtained.

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

- The following 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).
  - 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, Hospital or any other place that is not licensed to dispense Prescription Drugs.
  - When there is an over-the-counter drug equivalent containing the same active ingredients as the prescription/Rx 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 certain medications 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 Covered Drug List
  - That are medication or drugs for which some or all of 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 the Corporation 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 included.
  - That are Prescription Drugs and pharmaceuticals under the medical portion of this Policy when benefits are available under the Prescription Drug benefit.

Extension of Benefits after Termination of Coverage

If the Company 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 the Company 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 the Company will have authority for determining if the requirements of total disability have been met. You should contact the Company for the necessary forms.

Renewability Provision

Guaranteed Renewable Except For Stated Reasons: The Company 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 the Company
- Discontinuance of individual health insurance in the state of South Carolina by the Company.
- 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 your physical or mental changes or your Dependent’s physical or Mental 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 HealthPlan of South Carolina 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. 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.

The Company 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 the Company pays a claim, the Company may deduct any Premium due from the claim payment.

At any time, the Company 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 the Company 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). The Company 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.