Blue Option

Outline of Coverage

Major Medical Expense Coverage
Policy Form No. Blue Option (Rev. 1/19)

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's 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.

BlueChoice has free language interpretation 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 HealthPlan or from any other person (including a 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 HealthPlan 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-provider 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 and certain prescription drugs must be Authorized in advance by BlueChoice HealthPlan.

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 are the Policy doesn't cover. Benefits are subject to all terms, conditions, limitations, and exclusions outlined the Policy.

Silver Plan Options

Plan Name	Deductible	Coinsurance	Copayment	Out-of-Pocket Maximum	Prescription Drugs
6002	$6,000 Individual $12,000 Family	20%	PCP $0 Specialist $35 Doctor's Care $0 Urgent Care $50 Emergency Room* $300 Inpatient Admissions* $300 Skilled Nursing Facility* $300 Residential Treatment Center* $300 Free Standing Ambulatory Surgical Center $200	$7,350 Individual $14,700 Family	**Retail**: Tier 1 $10 Tier 2 $10 Tier 3 $30 Tier 4 $75 Tier 5 $300 Tier 6 $300 **Mail-Order**: Tier 1 $20 Tier 2 $20 Tier 3 $60 Tier 4 $150 Tier 5 $600 Tier 6 $600
6250	$6,250 Individual $12,500 Family	25%	PCP $0 Specialist $35 Doctor's Care $0 Urgent Care $50 Free Standing Ambulatory Surgical Center $200	$7,350 Individual $14,700 Family	**Retail**: Tier 1 $10 Tier 2 $10 Tier 3 $30 Tier 4 $75 Tier 5 $300 Tier 6 $300 **Mail-Order**: Tier 1 $20 Tier 2 $20 Tier 3 $60 Tier 4 $150 Tier 5 $600 Tier 6 $600

Silver Plan Options

Plan Name	Deductible	Coinsurance	Copayment	Out-of-Pocket Maximum	Prescription Drugs
6251	$6,250 Individual $12,500 Family	25%	PCP $0 Specialist $35 Doctor's Care $0 Urgent Care $50 Free Standing Ambulatory Surgical Center $200	$7,750 Individual $15,500 Family	**Retail**: Tier 1 $10 Tier 2 $10 Tier 3 $30 Tier 4 $75 Tier 5 $300 Tier 6 $300 **Mail-Order**: Tier 1 $20 Tier 2 $20 Tier 3 $60 Tier 4 $150 Tier 5 $600 Tier 6 $600
2502	$2,500 Individual $5,000 Family	30%	PCP $25 Specialist $50 Doctor's Care $25 Urgent Care $50 Emergency Room* $250 Inpatient Admissions* $250 Skilled Nursing Facility* $250 Residential Treatment Center* $250 Lab/X-ray and Imaging* $250 Free Standing Ambulatory Surgical Center $200	$7,000 Individual $14,000 Family	**Retail**: Tier 1 $10 Tier 2 $10 Tier 3 30% Tier 4 30% Tier 5 30% Tier 6 30% **Mail-Order**: Tier 1 $20 Tier 2 $20 Tier 3 30% Tier 4 30% Tier 5 30% Tier 6 30%

Silver Plan Options

Plan Name	Deductible	Coinsurance	Copayment	Out-of-Pocket Maximum	Prescription Drugs
4200	$4,200 Individual $8,400 Family	0%	Not Applicable	$4,200 Individual $8,400 Family	**Retail**: Tier 1 0% Tier 2 0% Tier 3 0% Tier 4 0% Tier 5 0% Tier 6 0% **Mail-Order**: Tier 1 0% Tier 2 0% Tier 3 0% Tier 4 0% Tier 5 0% Tier 6 0%
7350	$7,350 Individual $14,700 Family	0%	PCP $25 Specialist $60 Doctor's Care $25 Urgent Care $50 Free Standing Ambulatory Surgical Center $200	$7,350 Individual $14,700 Family	**Retail**: Tier 1 $10 Tier 2 $10 Tier 3 $30 Tier 4 0% Tier 5 0% Tier 6 0% **Mail-Order**: Tier 1 $20 Tier 2 $20 Tier 3 $60 Tier 4 0% Tier 5 0% Tier 6 0%

Silver Plan Options

Plan Name	Deductible	Coinsurance	Copayment	Out-of-Pocket Maximum	Prescription Drugs
7750	$7,750 Individual $15,500 Family	0%	PCP $25 Specialist $60 Doctor's Care $25 Urgent Care $50 Free Standing Ambulatory Surgical Center $200	$7,750 Individual $15,500 Family	**Retail**: Tier 1 $10 Tier 2 $10 Tier 3 $30 Tier 4 0% Tier 5 0% Tier 6 0% **Mail-Order**: Tier 1 $20 Tier 2 $20 Tier 3 $60 Tier 4 0% Tier 5 0% Tier 6 0%
3500	$3,500 Individual $7,000 Family	30%	PCP $0 Specialist $60 Doctor's Care $0 Urgent Care $50 Free Standing Ambulatory Surgical Center $200	$7,350 Individual $14,700 Family	**Retail**: Tier 1 $0 Tier 2 $0 Tier 3 30% Tier 4 30% Tier 5 30% Tier 6 30% **Mail-Order**: Tier 1 $0 Tier 2 $0 Tier 3 30% Tier 4 30% Tier 5 30% Tier 6 30%

Silver Plan Options

Plan Name	Deductible	Coinsurance	Copayment	Out-of-Pocket Maximum	Prescription Drugs
3501	$3,500 Individual $7,000 Family	40%	PCP $0 Specialist $60 Doctor's Care $0 Urgent Care $50 Free Standing Ambulatory Surgical Center $200	$7,500 Individual $15,000 Family	**Retail**: Tier 1 $0 Tier 2 $0 Tier 3 40% Tier 4 40% Tier 5 40% Tier 6 40% **Mail-Order**: Tier 1 $0 Tier 2 $0 Tier 3 40% Tier 4 40% Tier 5 40% Tier 6 40%
6900	$6,900 Individual $13,800 Family	40%	PCP $0 Specialist $35 Doctor's Care $0 Urgent Care $50 Free Standing Ambulatory Surgical Center $200	$7,350 Individual $14,700 Family	**Retail**: Tier 1 $5 Tier 2 $5 Tier 3 $30 Tier 4 $90 Tier 5 40% Tier 6 40% **Mail-Order**: Tier 1 $10 Tier 2 $10 Tier 3 $60 Tier 4 $180 Tier 5 40% Tier 6 40%

Silver Plan Options

Plan Name	Deductible	Coinsurance	Copayment	Out-of-Pocket Maximum	Prescription Drugs
3000	$3,000 Individual $6,000 Family A separate Prescription Drug Deductible of $0 per Member per Benefit Period applies to Prescription Drugs	50%	PCP $20 Specialist $50 Doctor's Care $20 Urgent Care $50 Emergency Room* $300 Inpatient Admissions* $300 Skilled Nursing Facility* $300 Residential Treatment Center* $300 Free Standing Ambulatory Surgical Center $200 **Retail**: Tier 5/6 Drugs** $300 **Mail-Order**: Tier 5/6 Drugs** $600	$7,350 Individual $14,700 Family	**Retail**: Tier 1 $10 Tier 2 $10 Tier 3 $40 Tier 4 $80 Tier 5 50% Tier 6 50% **Mail-Order:** Tier 1 $20 Tier 2 $20 Tier 3 $80 Tier 4 $160 Tier 5 50% Tier 6 50%
1501	$1,500 Individual $3,000 Family	50%	PCP $40 Specialist $80 Doctor's Care $40 Urgent Care $50 Free Standing Ambulatory Surgical Center $200	$7,500 Individual $15,000 Family	**Retail**: Tier 1 $20 Tier 2 $20 Tier 3 $60 Tier 4 $80 Tier 5 50% Tier 6 50% **Mail-Order**: Tier 1 $40 Tier 2 $40 Tier 3 $120 Tier 4 $160 Tier 5 50% Tier 6 50%

Silver Plan Options

Plan Name	Deductible	Coinsurance	Copayment	Out-of-Pocket Maximum	Prescription Drugs
4000	$4,000 Individual $8,000 Family	30%	PCP $15 Specialist $40 Doctor's Care $15 Urgent Care $50 Emergency Room* $300 Inpatient Admissions* $300 Skilled Nursing Facility* $300 Residential Treatment Center* $300 Free Standing Ambulatory Surgical Center $200	$6,600 Individual $13,200 Family	**Retail**: Tier 1 $15 Tier 2 $15 Tier 3 $50 Tier 4 30% Tier 5 30% Tier 6 30% **Mail-Order**: Tier 1 $30 Tier 2 $30 Tier 3 $100 Tier 4 30% Tier 5 30% Tier 6 30%
3001	$3,000 Individual $6,000 Family A separate Prescription Drug Deductible of $0 per Member per Benefit Period applies to Prescription Drugs	35%	PCP $30 Specialist $80 Doctor's Care $30 Urgent Care $50 Emergency Room* $300 Free Standing Ambulatory Surgical Center $200	$7,350 Individual $14,700 Family	**Retail**: Tier 1 $20 Tier 2 $20 Tier 3 $50 Tier 4 $75 Tier 5 35% Tier 6 35% **Mail-Order**: Tier 1 $40 Tier 2 $40 Tier 3 $100 Tier 4 $150 Tier 5 35% Tier 6 35%

Silver Plan Options

Plan Name	Deductible	Coinsurance	Copayment	Out-of-Pocket Maximum	Prescription Drugs
2000	$2,000 Individual $4,000 Family	50%	PCP $0 Doctor's Care $0 Urgent Care $50 Free Standing Ambulatory Surgical Center $200	$7,350 Individual $14,700 Family	**Retail**: Tier 1 $0 Tier 2 $0 Tier 3 50% Tier 4 50% Tier 5 50% Tier 6 50% **Mail-Order**: Tier 1 $0 Tier 2 $0 Tier 3 50% Tier 4 50% Tier 5 50% Tier 6 50%
5001	$5,000 Individual $10,000 Family	30%	PCP $35 Specialist $75 Doctor's Care $35 Urgent Care $50 Emergency Room* $300 Free Standing Ambulatory Surgical Center $200	$7,350 Individual $14,700 Family	**Retail**: Tier 1 $10 Tier 2 $10 Tier 3 $30 Tier 4 $75 Tier 5 30% Tier 6 30% **Mail-Order**: Tier 1 $20 Tier 2 $20 Tier 3 $60 Tier 4 $150 Tier 5 30% Tier 6 30%

Silver Plan Options

Plan Name	Deductible	Coinsurance	Copayment	Out-of-Pocket Maximum	Prescription Drugs
1500	$1,500 Individual $3,000 Family A separate Prescription Drug Deductible of $0 per Member per Benefit Period applies to Prescription Drugs	50%	PCP $15 Specialist** $15 Doctor's Care $15 Urgent Care $50 Emergency Room* $250 Free Standing Ambulatory Surgical Center $200 **Retail**: Tier 5/6 Drugs** $300 **Mail-Order**: Tier 5/6 Drugs** $600	$7,100 Individual $14,200 Family	**Retail**: Tier 1 $15 Tier 2 $15 Tier 3 50% Tier 4 50% Tier 5 50% Tier 6 50% **Mail-Order:** Tier 1 $30 Tier 2 $30 Tier 3 50% Tier 4 50% Tier 5 50% Tier 6 50%
4500 HD	$4,500 Individual $9,000 Family	0%	Not Applicable	$4,500 Individual $9,000 Family	**Retail**: Tier 1 0% Tier 2 0% Tier 3 0% Tier 4 0% Tier 5 0% Tier 6 0% **Mail-Order**: Tier 1 0% Tier 2 0% Tier 3 0% Tier 4 0% Tier 5 0% Tier 6 0%

Silver Plan Options

Plan Name	Deductible	Coinsurance	Copayment	Out-of-Pocket Maximum	Prescription Drugs
5004 HD	$5,000 Individual $10,000 Family	0%	Not Applicable	$5,000 Individual $10,000 Family	**Retail**: Tier 1 0% Tier 2 0% Tier 3 0% Tier 4 0% Tier 5 0% Tier 6 0% **Mail-Order**: Tier 1 0% Tier 2 0% Tier 3 0% Tier 4 0% Tier 5 0% Tier 6 0%
2503	$2,500 Individual $5,000 Family	50%	PCP $0 Doctor's Care $0 Urgent Care $50 Free Standing Ambulatory Surgical Center $200 Copayments for PCP/Doctor's Care are limited to the first two visits, then it is subject to Deductible and Coinsurance.	$7,350 Individual $14,700 Family	**Retail**: Tier 1 $25 Tier 2 $25 Tier 3 50% Tier 4 50% Tier 5 50% Tier 6 50% **Mail-Order:** Tier 1 $50 Tier 2 $50 Tier 3 50% Tier 4 50% Tier 5 50% Tier 6 50%

Bronze Plan Options

Plan Name	Deductible	Coinsurance	Copayment	Out-of-Pocket Maximum	Prescription Drugs
5500	$5,500 Individual $11,000 Family	50%	Not Applicable	$6,600Individual $13,200 Family	**Retail**: Tier 1 50% Tier 2 50% Tier 3 50% Tier 4 50% Tier 5 50% Tier 6 50% **Mail-Order**: Tier 1 50% Tier 2 50% Tier 3 50% Tier 4 50% Tier 5 50% Tier 6 50%
7150	$7,150 Individual $14,300 Family	0%	PCP $45 Specialist $90 Doctor's Care $45 Urgent Care $50 Free Standing Ambulatory Surgical Center $200	$7,150 Individual $14,300 Family	**Retail**: Tier 1 0% Tier 2 0% Tier 3 0% Tier 4 0% Tier 5 0% Tier 6 0% **Mail-Order**: Tier 1 0% Tier 2 0% Tier 3 0% Tier 4 0% Tier 5 0% Tier 6 0%

Bronze Plan Options

Plan Name	Deductible	Coinsurance	Copayment	Out-of-Pocket Maximum	Prescription Drugs
6350 HD	$6,350 Individual $12,700 Family	0%	Not Applicable	$6,350 Individual $12,700 Family	**Retail**: Tier 1 0% Tier 2 0% Tier 3 0% Tier 4 0% Tier 5 0% Tier 6 0% **Mail-Order**: Tier 1 0% Tier 2 0% Tier 3 0% Tier 4 0% Tier 5 0% Tier 6 0%
7350	$7,350 Individual $14,700 Family	0%	PCP $45 Specialist $90 Doctor's Care $45 Urgent Care $50 Free Standing Ambulatory Surgical Center $200	$7,350 Individual $14,700 Family	**Retail**: Tier 1 $30 Tier 2 $30 Tier 3 0% Tier 4 0% Tier 5 0% Tier 6 0% **Mail-Order**: Tier 1 $60 Tier 2 $60 Tier 3 0% Tier 4 0% Tier 5 0% Tier 6 0%

Bronze Plan Options

Plan Name	Deductible	Coinsurance	Copayment	Out-of-Pocket Maximum	Prescription Drugs
6500	$6,500 Individual $13,000 Family	50%	Emergency Room $300 Free Standing Ambulatory Surgical Center $200	$6,850 Individual $13,700 Family	**Retail**: Tier 1 50% Tier 2 50% Tier 3 50% Tier 4 50% Tier 5 50% Tier 6 50% **Mail-Order**: Tier 1 50% Tier 2 50% Tier 3 50% Tier 4 50% Tier 5 50% Tier 6 50%
6000 HD	$6,000 Individual $12,000 Family	0%	Not Applicable	$6,000 Individual $12,000 Family	**Retail**: Tier 1 0% Tier 2 0% Tier 3 0% Tier 4 0% Tier 5 0% Tier 6 0% **Mail-Order**: Tier 1 0% Tier 2 0% Tier 3 0% Tier 4 0% Tier 5 0% Tier 6 0%

Bronze Plan Options

Plan Name	Deductible	Coinsurance	Copayment	Out-of-Pocket Maximum	Prescription Drugs
5501	$5,500 Individual $11,000 Family	50%	Not Applicable	$7,900 Individual $15,800 Family	**Retail**: Tier 1 50% Tier 2 50% Tier 3 50% Tier 4 50% Tier 5 50% Tier 6 50% **Mail-Order**: Tier 1 50% Tier 2 50% Tier 3 50% Tier 4 50% Tier 5 50% Tier 6 50%
7900	$7,900 Individual $15,800 Family	0%	Not Applicable	$7,900 Individual $15,800 Family	**Retail**: Tier 1 0% Tier 2 0% Tier 3 0% Tier 4 0% Tier 5 0% Tier 6 0% **Mail-Order**: Tier 1 0% Tier 2 0% Tier 3 0% Tier 4 0% Tier 5 0% Tier 6 0%

Bronze Plan Options

Plan Name	Deductible	Coinsurance	Copayment	Out-of-Pocket Maximum	Prescription Drugs
7901	$7,900 Individual $15,800 Family	0%	PCP $50 Specialist $100 Doctor's Care $50 Urgent Care $50 Free Standing Ambulatory Surgical Center $200	$7,900 Individual $15,800 Family	**Retail**: Tier 1 $35 Tier 2 $35 Tier 3 $60 Tier 4 $75 Tier 5 $300 Tier 6 $300 **Mail-Order**: Tier 1 $70 Tier 2 $70 Tier 3 $120 Tier 4 $150 Tier 5 $600 Tier 6 $600

Catastrophic Plan Option

Deductible	Coinsurance	Copayment	Out-of-Pocket Maximum	Prescription Drugs
$7,900Individual $15,800 Family	0%	PCP $25 Doctor's Care $25 Copayments for PCP/Doctor's Care are limited to the first three visits, then it is subject to Deductible.	$7,900 Individual $15,800 Family	**Retail and Mail-Order**: Tier 1 0% Tier 2 0% Tier 3 0% Tier 4 0% Tier 5 0% Tier 6 0%

* Benefit is also subject to the Deductible and Coinsurance in addition to the Copayment.
** Benefit is also subject to Coinsurance in addition to the Copayment

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COVERED SERVICES

Professional Services (performed outside the office setting)
Hospital services / Emergency Room care Mental Health/Substance Abuse Laboratory Outpatient X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)
Maternity 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
Facility Services / Outpatient Hospital Outpatient services (includes Ambulatory Surgical Center and maternity care) Outpatient Surgery Physician/Surgical services Mental Health/Substance Abuse Emergency Room
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
Pediatric Vision Care – Physician EyeCare Network (PEN)

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,	15 combined visits per Benefit Period
Habilitative Services – Occupational Therapy, Physical Therapy,	15 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 EyeCare Network (PEN) Providers Only (Refer to Provider Directory) (Physicians EyeCare Network (PEN) is an independent company that provides adult vision services on behalf of BlueChoice HealthPlan, Inc. of South Carolina.) One routine eye exam or one exam for contact lenses per Benefit Period One standard contact lens fitting per Benefit Period One pair of eyewear from a designated selection every other Benefit Period **Please consult your PEN Provider for information on discounts for which you may be eligible if you elect to receive eyewear/contact lenses outside the standard designated selection.** **(For Members outside of the South Carolina service area, $71 will be allowed towards the routine eye exam and $120 credit will apply to the purchase of eyewear. Claims must be filed by the Member.)**	(Authorization not required) $0 $45 $0
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
• **Employee Assistance Program (EAP Services)** • Life Management Services (3 visits) **Benefits are provided under an agreement between First Sun EAP and the Employer. 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 are 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.BlueOptionSC.com/members/resources/summary-benefits-and-coverage. 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 HealthPlan 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 the Company's service area (state of South Carolina).* The "BlueCard" is your BlueChoice HealthPlan 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 HealthPlan ID card for easy reference and access to service.
- 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 HealthPlan 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.

Non-Participating Healthcare Providers Outside Our Service Area
When covered healthcare services are provided outside of our service area by non-Participating healthcare Providers, information regarding the amount you pay for such services is contained in the Covered Services section of this Policy.

For non-network Emergency services, we will pay an amount equal to the greatest of (1) the amount we have negotiated with in-network (Participating) Providers for the Emergency service the Member received (and, if more than one amount is negotiated, the median of the amounts, excluding any applicable in-network Member copayment or Coinsurance) (2) 100% of the allowable amount for Emergency services provided by the non-network Provider under this contract, or Policy (i.e., the amount we would pay in the absence of any cost-sharing that would otherwise apply for services of non-network Providers) or (3) the amount that would be paid under Medicare, in compliance with 45 CFR 147.138(b)(3).

The amounts described above in (1), (2), and (3) exclude any cost share amounts that apply to Emergency services provided by Participating Providers.

Emergency Services:
If you experience an Emergency Medical Condition, seek immediate medical attention. Benefits are only available to treat an Emergency Medical Condition provided on an Outpatient basis at a Hospital Emergency Room, 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 Services provided in-Network**
   When Emergency Services are received from an in-Network Provider, benefits are provided as any other in-Network service under this Policy.

2. **Emergency Services at an out-of-Network Provider**
   When Emergency Services are received from an Out-of-Network Provider, benefits will be provided for Emergency Services, but you may have the following additional cost-sharing or other requirements because an Out-of-Network Provider provided the services:

   Out-of-Network Hospital Emergency Room – We will provide benefits for Emergency Medical Care received in an Emergency Room at an Out-of-Network Hospital. However, benefits for Covered Services are subject to any In-Network Copayment, Deductible, and Coinsurance as shown in the Schedule of Benefits. And, the Out-of-Network Provider may Balance Bill you

   The Allowed Amount for benefits for Emergency Services for an Emergency Medical Condition when services are provided to you by an out-of-Network Hospital will be the greater of: A) the median amount for services as if you were treated by in-Network Providers who participate in the Blue Option Network; or B) the Medicare reimbursement rate for the same or similar service, procedure, supply, or equipment.

We will review requests for benefits after an Emergency Room visit to determine if the illness or injury was sudden or unexpected or would be expected to cause a serious risk to your health, or your unborn child's health, if not treated immediately. Requests for services that do not meet this standard will be denied as not covered.

Non-Emergency care outside the Blue Option Network is not covered; any follow-up care must be provided by an in-Network Provider.

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 is also not covered.

- Eyeglasses, contact lenses (except after cataract Surgery), except as shown in the Covered Services section of the Policy, 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:
  - to 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.

- 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 pediatric Vision sections, 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 this 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 15 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 15 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 the 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 the 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 psychiatric conditions.
- Psychiatric 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* of the Policy.

- 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, weight control such as gastric by-pass, insertion of stomach (gastric) banding, intestinal bypass, wiring mouth shut, liposuction or complications from it. 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, educational or play therapy; biofeedback; psychological or educational diagnostic testing to determine job or occupational placement or for other educational purposes, or to determine if a learning disorder exists; therapy for learning disorders, intellectual disability, dissociative disorder, sexual disorder, personality disorder and vocational rehabilitation unless specifically included in your Schedule of Benefits.

- Bioelectric, microprocessor or computer programmed prosthetic components.

- Marriage counseling.

- 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: feeding and eating disorders in early childhood and infancy; tic disorder except for Tourette's disorder; elimination disorder; mental disorders due to general medical conditions; sexual function disorder; sleep disorder; medication induced movement disorder; and nicotine dependence unless specifically covered in the Policy.

- 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.

- Charges for acupuncture, massage therapy, hypnotism and TENS unit, or services for chronic pain management programs. This includes any program developed by centers with multidisciplinary staffs intended to provide the interventions needed to allow the patient to develop pain coping skills and freedom from analgesic medications dependence.

- 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.

- 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 the 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: immunization prior to travel, transportation, lodging and repatriation, unless specifically included in Covered 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.
- Equipment 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 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.
- Services for Animal Assisted Therapy, Vagal Nerve Stimulation (VNS), Eye Movement Desensitization and Reprocessing (EMDR), Behavioral Therapy for solitary maladaptive habits or Rapid Opiate Detoxification.
- 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.
- Prescription Drugs and pharmaceuticals under the medical portion of the Policy when benefits are available under the Prescription Drug benefit.

- 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.
  - More than the number of days supply allowed as shown in the Covered Services section of the Policy.
  - Refills in excess of the number specified on your Physician's prescription order.
  - More than the recommended daily dosage defined by BlueChoice, unless prior Authorization is sought and approved.
  - That are not provided in compliance with any applicable place of service requirements.
  - 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.
  - Some medications classified as self-administered drugs; when obtained, purchased and/or administered at a doctor's office or in an Outpatient setting, these medications are not covered.
  - That require Authorization and the Authorization is not received.
  - 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
  - Any medications or drugs in which the costs and associated services for said drugs or medications are in any way paid for through or under a pharmaceutical manufacturer or other discount card or coupon program on behalf of the member (excluding Members who qualify or enroll in patient assistance programs designed to assist Members based on financial need or hardship).
  - Prescription Drugs that are new to the market and under clinical review by the Corporation shall be listed on the Prescription Drug 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.
  - 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
- 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.