BlueChoice® HealthPlan
South Carolina

An independent licensee of the
Blue Cross and Blue Shield Association

BLUE OPTION℠ MEMBER POLICY

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 services are provided at an Urgent Care Center or Hospital Emergency Room.

BlueChoice has free language interpretation services available. We can also give you information in languages other than English or other alternate formats.

Blue Option (Rev. 1/19)

Individual Coverage

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BLUECHOICE® INDIVIDUAL COVERAGE
HEALTH COVERAGE

Important

BlueChoice HealthPlan of South Carolina, Inc. is a managed care organization. BlueChoice's individual coverage is specifically designed for you to use your primary care Physician and other medical professionals with whom BlueChoice HealthPlan has a contract. Some services require prior Authorization from BlueChoice HealthPlan. This Policy does not provide coverage for out-of-network Providers unless you are being treated for an Emergency Medical Condition at a Hospital Emergency Room or Urgent Care Center. We offer a variety of wellness programs, including a smoking cessation program to assist you in making a positive lifestyle change. Please call a Customer Service Advocate or go to our website for more information about our programs.

This Policy summarizes and explains the benefits available to you from BlueChoice HealthPlan. It includes as few legal and technical terms as possible. This Policy is also the controlling document for determining all contractual rights. In the event of differences or errors, the provisions of the Policy control.

Your Right to Examine This Policy

You have 30 days to examine this Policy. If you are not happy with it, you may return it to BlueChoice HealthPlan with a note that says you don't want it. If you do that, any Premiums you have paid will be returned to you. However, if you use any of the benefits provided by this Policy during this 30-day examination period, you may not then return the Policy and receive a refund of the Premium paid.

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 due to any of the following reasons:

- Failure to pay Premiums or if we have not received timely Premium payments.
- Fraud or material misrepresentation.
- We decide to discontinue offering Blue Option for everyone who has this Policy form. However, coverage may only be discontinued if we:
  - Provide notice to each individual covered by the Blue Option Policy of the discontinuance at least 90 days before the date the Policy is discontinue;
  - Offer to each individual covered by the Blue Option Policy, the option to purchase other individual health insurance coverage currently offered by us; and
  - In exercising the option to discontinue the Policy or offering the option to purchase other individual coverage, we act uniformly without regard to any Health Status-related Factor.
- 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.

Premiums:

The benefits described are available as long as the required Premium is paid on time. 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.

Your Rights and Responsibilities

As a Member, you have certain rights. You also have some responsibilities. As part of our ongoing efforts to keep you informed, we've listed your rights and responsibilities below.

You have the right to:

- Be treated with respect and recognition of your dignity and right to privacy.
- Get the information you need to make thoughtful decisions before choosing a Provider or treatment plan.
- Constructively share your opinion, concerns, or complaints.
- Receive information from BlueChoice regarding services provided or care received.

You have the responsibility to:

- Carefully read all health plan materials provided by BlueChoice after we accept you as a Member.
- Ask questions and make sure you understand the information given to you.
- Present your BlueChoice ID card prior to receiving services or care.
- Inform BlueChoice of any information that affects your coverage, including any other insurance you may have.
- Select a representative to act on your behalf in the event you are unable to represent yourself.
- Pay your cost share amounts, including your Premium.
- Tell us if you move.
- Promptly respond to requests for documentation to support eligibility.

Summary of Benefits and Coverage

A Summary of Benefits and Coverage (SBC) summarizes the benefit options of your insurance plan. All insurance companies are required to provide you with a SBC. You can find your SBC by going to www.BlueOptionSC.com/members/resources/summary-benefits-and-coverage.

You may also contact a customer service advocate and ask us to send you a copy of the SBC. We can send it to you electronically or mail a paper copy (free of charge).

GENERAL INFORMATION

WHEN YOUR COVERAGE BEGINS AND ENDS

Eligibility:
This coverage is available through an individual product. Individual and family policies are available to persons who live in South Carolina.

This product is considered to be duplication of Medicare coverage. If you are entitled to or enrolled in Medicare coverage, you cannot lawfully purchase this product.

To be eligible for or to enroll in the Catastrophic plan, you must be under the age of 30 years at the beginning of the plan year or have a certification in effect that you are exempt from the requirement under section 5000A of the Internal Revenue Code of 1986 regarding individuals without affordable coverage or with hardships. A catastrophic health plan does not provide a bronze, silver, gold or platinum level of coverage.

To be eligible for membership as a family Dependent, the Dependent must: A) be the individual's legal spouse; or B) be the individual's natural child, adopted child, foster child, step child, or child for whom the individual has legal custody or legal guardianship and is less than 26 years of age, unless the child of the individual is an Incapacitated Dependent. Coverage of an Incapacitated Dependent will continue beyond the attainment of the limiting age, provided proof of such incapacity and dependency is furnished to BlueChoice HealthPlan by you within 31 days of such child's attainment of that limiting age, as long as Coverage remains in force for you.

1. A Dependent child placed for adoption with the individual is subject to the same terms and conditions as apply to a natural child, irrespective of whether the adoption has become final.

2. A Dependent child who otherwise is eligible for Coverage shall not be denied enrollment for any of the following reasons: the child was born out of wedlock; the child is not claimed as a dependent on the individual's federal tax return; the child does not reside with the Subscriber; or the child does not reside in the local service area.

3. A person's eligibility for or receipt of Medicaid assistance shall not be considered in enrolling that person for Coverage or in making benefit payments.

Policy: When it is Valid.
Your coverage will become effective at 12:01 a.m. Eastern Time.

Effective Date of Coverage:
The date on which coverage for a Member begins under this Policy is called the effective date. If you enroll during the open enrollment, your Effective Date is January 1.

Enrollment:
The only time you may enroll in or change your coverage is once a year during the annual open enrollment period. However, if you have a triggering event, you may enroll at other times during the year. This is called a Special Enrollment. The triggering events are described on the next page.

Special Enrollment
Unless otherwise specified, a Special Enrollment must be requested within 60-days of the triggering event. You may be required to submit documentation (proof) of your Special Enrollment event. If requested, proof must be submitted within 30 days of application. If proof is not received, the application for Special Enrollment will be denied.

You and your Dependent (when specified below) may enroll if one of the following triggering events occurs:

1. **Loss of Minimal Essential Coverage** – You or a Dependent loses minimum essential coverage. Loss of minimum essential coverage does not include loss due to: 1) failure to pay premium (including COBRA premiums) even if the premium is unaffordable; 2) rescission; 3) voluntarily dropping coverage. Loss of minimal essential coverage includes:
   - Coverage through a job, or through another person's job. This also applies if you're now eligible for help paying for coverage because your employer stops offering coverage or the coverage isn't considered qualifying coverage.
   - Loss of qualifying COBRA contributions by an employer or former employer.
   - Medicaid or Children's Health Insurance Program (CHIP) coverage (including pregnancy related coverage and medically needy coverage).
   - Medicare.
   - Individual or group health plan coverage that ends during the year, including student health insurance if it was a qualifying health plan.
   - Coverage under your parent's health plan (if you're on it), including when you turn 26 or the maximum dependent age allowed in your state and lose coverage. A Dependent who reaches the age of 26 years may remain on your Policy until the end of the month in which he or she reaches 26.

2. **Gaining or Losing a Dependent** – You gain a Dependent or become a Dependent through marriage, birth, adoption, court order, placement for adoption or placement in foster care.

   A Special Enrollment is only granted when becoming or gaining a Dependent due to marriage when at least one of the spouses had coverage for at least one day in the 60 days prior to the marriage. You must also enroll in the same plan or you may choose another plan as long as it is the same metal level as your current plan, if your current plan is no longer available.

   You lose a Dependent or are no longer considered a Dependent through divorce or legal separation or death.

3. **Permanent Move** – You gain access to a **new** Health Plan **(a plan previously not available to you)** as a result of a permanent move. However, you must have had coverage at least one or more days in the 60 days prior to the move, unless you are moving from a foreign country or United State territory or as stated in regulations. Also, moving only for medical treatment or staying somewhere for vacation does not qualify you for a Special Enrollment Period.
4. **Domestic Abuse or Abandonment** – (i) You are a victim of domestic abuse or spousal abandonment, are enrolled in minimum essential coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment; or (ii) are a Dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim.

5. You apply for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and are determined ineligible for Medicaid or CHIP after open enrollment has ended.

Your effective date for special enrollment for loss of minimum essential coverage is the first of the following month. Your effective date for special enrollment for triggering events other than loss of minimum essential coverage is:

Triggering Event Occurs	**Effective Date**
Between the 1st and 15th of the month	**The 1st of the following month**
Between the 16th and the end of the month	**The 1st of the next month**

If you marry, the Effective Date of coverage is the first day of the next month after we receive notice of the special enrollment.

For a loss of Minimum Essential Coverage, the Effective Date depends on when you request coverage and the date the loss of coverage occurs. You have 60 days before and 60 days after the loss of Minimum Essential Coverage to make a plan selection. The Effective Date will always be the first day of the month after the plan selection, or the date you lose coverage.

For a newborn child of the individual, Coverage is effective at birth provided the newborn is enrolled by the individual within 60 days of the newborn's birth and any required Premium is paid.

For an adopted child of the individual, Coverage shall be retroactive from the moment of birth for a child with respect to whom a decree of adoption by the individual has been entered within 31 days after the date of the child's birth. If adoption proceedings have been instituted by the individual within 31 days after the date of the child's birth and the individual has temporary custody, Coverage shall be provided from the moment of birth.

For adopted children other than a newborn, Coverage shall commence upon temporary custody and will continue as long as you have custody.

Payment of Premium

You are responsible for all Premiums due for your coverage, including the Premiums for Dependents that are covered under your Policy. 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.

If you previously had coverage with BlueChoice HealthPlan of South Carolina, Inc. or any of its affiliated companies, the 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.

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*). 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.

Grace Period
Other than Premium for the initial month, a Grace period will be granted for the payment of Premiums. This means if your Premium is not paid on or before the date it is due, it may be paid during the Grace Period. If the Premium has not been paid by 12:01 a.m. of the day following the end of the Grace Period, your coverage will automatically terminate without further notice to you. The termination will be effective back to the Premium due date. Any claims paid after the last Premium paid date does not extend this coverage.

The Grace Period is 31-days. Benefits will not be allowed during the Grace Period until Premiums are paid.

Non-Discrimination
Your receipt of a federal Premium subsidy, taking any action to enforce your rights under applicable law, Health Status-Related Factors, race, color, national origin, present or predicted disability, sex, gender identity sexual orientation, expected length of life, degree of medical dependency or quality of life will not affect your eligibility or Premiums for this coverage.

Premiums may not be increased, coverage cannot be denied and wellness incentives may not be reduced or withheld based on the lawful ownership, possession, use or storage of a firearm or ammunition.

Termination of Insurance
Your coverage will end at 12:01 a.m. Eastern Time the earliest of:
1. 14 days after we receive your written request, or
2. The date the Policy lapses due to non-payment of Premiums as determined by the Grace Period, or
3. On the Policy Effective Date if rescinded, or
4. If you are determined to be no longer eligible for coverage, your coverage in the plan will end on the last day of the month following the month in which you received notice of your ineligibility, or
5. If you move out of the State of South Carolina.

A Dependent who reaches the age of 26 years may remain on your Policy until the end of the month in which he or she reaches 26. The Dependent is eligible to enroll in his or her own Policy, without evidence of insurability when coverage ends because he or she has reached age 26. He or she must apply for this Policy within 60 days of turning age 26 and pay the appropriate Premium. The Policy will provide the coverage currently being issued by BlueChoice which is most nearly similar to, but not greater than, the terminated coverage.

Your spouse is no longer eligible for coverage under this Policy if you are legally divorced. Your ex-spouse is eligible to enroll in his or her own Policy, without evidence of insurability. He or she must apply for coverage within sixty days following the entry of the legal divorce, and pay the appropriate Premium. The Policy will provide the coverage currently being issued by BlueChoice which is most nearly similar to, but not greater than, the terminated coverage.

Rescission is a cancellation or discontinuance of coverage that has a retroactive effect. Coverage will not be rescinded for an individual once the individual is covered under this Policy, unless the individual, (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact. A cancellation or discontinuance is not a rescission if (a) the cancellation or discontinuance has only a prospective effect; or (2) the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required Premiums as determined by the grace period.

We will not cancel this Policy retroactively and refund any Premium, whether or not you had any claims during that period of time except when coverage is rescinded.

The Company will provide you with a Certificate of Creditable Coverage when your coverage ends. If a duplicate certificate is needed at a later time, you must request the Certificate of Creditable Coverage within 24 months of your coverage ending. You may also request the Certificate of Creditable Coverage from the Company even if your coverage is still in force. To request the Certificate of Creditable Coverage, please contact us at the address listed in the *How to Get Help* section.

Reinstatement
If any renewal Premium is not paid within the grace period, the Policy will lapse automatically without further notice to you. We may reinstate the Policy if:

a. You request reinstatement; and
b. The unpaid Premium is not more than 60 days overdue; and
c. You pay all overdue Premiums (note: you will be given a conditional receipt for the Premiums); and
d. We approve your request for reinstatement.

If your request is approved, the Policy will be reinstated on the date it lapsed. Lacking such approval, the Policy will be reinstated on the 45th day after the date of the conditional receipt unless we have previously written you of our disapproval. The Policy will be reinstated on the date the Policy lapsed, if requirements (a) through (d) above have been met. If your request is disapproved, we will refund the Premium submitted.

After the Policy is reinstated, both parties will have the same rights as existed just before the due date. Any amendments to the Policy will still apply and remain effective after reinstatement.

PRIMARY CARE PHYSICIANS AND PARTICIPATING PROVIDERS

Primary Care Physician.
We encourage you to select a Primary Care Physician. By having a Primary Care Physician, if you need assistance he or she can't provide, he or she will help you find an in-Network Specialist.

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.

Participating Providers.
Participating Providers are hospitals, skilled nursing facilities, home health agencies, hospices, Physicians and other medical professionals who have agreed with the Company to do the following:

- File all claims for Covered Services with the Company,
- Collect only the Copayment, Deductible and Coinsurance amounts, if any, for Covered Services. These amounts (part of the charge for Covered Service that the Company does not pay) are shown in the Schedule of Benefits, and
- Accept the fee schedule amount as payment in full for Covered Services.

You should contact the Company if you are billed by a Participating Provider for Covered Services other than any applicable Coinsurance, Copayment or Deductible.

Note: If you receive services at an In-network Hospital or from another In-network Provider, you may also receive ancillary services that are incidental to the primary benefit/service from an Out-of-network Provider. When this happens, you may be required to pay the full cost of those services or benefits you received from the Out-of-network Provider. For example, if you have surgery at an In-network Hospital, performed by an In-network Physician, but the anesthesiologist is not in the Blue Option network, charges billed by the Out-of-network anesthesiologist are not covered and will be your responsibility.

Verification of Participation Status.
You are responsible for verifying the participation status of the Physician, Hospital, or other Provider prior to receiving Covered Services. You may verify participation status by contacting Member Services through the website at www.BlueOptionSC.com/find-provider, or by calling 786-8476 in Columbia or 1-855-816-7636 when outside the Columbia area.

Enrolling for coverage does not guarantee the availability of a particular Participating Provider on the list of Providers. This list of Participating Providers is subject to change.

Referral Health Services by Non-Participating Providers. If specific Essential Health Benefits cannot be provided by or through a Participating Provider, you are eligible for coverage for Covered Services obtained through non-Participating Providers. These services must be Authorized in advance through referral documentation designated by BlueChoice HealthPlan and are subject to the provisions, limitations and exclusions of this Policy. It is your responsibility to obtain this required Authorization prior to receiving the services.

Preauthorization

Preauthorization is also called prior authorization, prior approval or precertification. It is important to understand what Preauthorization means. It means the service has been determined to be medically appropriate for the patient's condition. **A Preauthorization does not guarantee that we will pay benefits.**

Preauthorization must be obtained for certain categories of benefits; a failure to get preauthorization may result in benefits being denied. We will make our final benefit determination when we process your claims. Even when a service is preauthorized, we review each claim to make sure:

- The patient is a Member under the Policy at the time service is provided.
- The service is a Covered Service. Policy limitations or exclusions may apply.
- The service provided was Medically Necessary as defined by your Policy.

A Preauthorization may only be for a specific period of time or number of visits/treatments. If you have any questions about this, please contact the Member Services Department.

If your request for Preauthorization of services is denied, you can request further review; see the *Claim for Benefits, Appeals and External Reviews* section of this Policy. Preauthorization denials are considered denied claims for purposes of appeals and grievances.

Network Providers in South Carolina will be familiar with the requirement to obtain Preauthorization and will get the necessary approvals. If a Network Provider in South Carolina does not get Preauthorization, it cannot bill you for the penalty.

Prior Authorization.
All Inpatient Hospital Admissions, except for Emergency Admissions, certain outpatient services and certain prescription drugs must be Authorized in advance by BlueChoice HealthPlan. For Emergency Admissions, BlueChoice HealthPlan 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.

Concurrent Review.
BlueChoice HealthPlan will conduct concurrent review of all Inpatient Admissions. BlueChoice HealthPlan will remain in contact with the treating Physician throughout the course of treatment to review requests for extension of benefits based on the Medical Necessity of a continued Hospital stay. Each requested extension will be reviewed on a case-by-case basis.

Continuation of Care.
If a Provider's contract with BlueChoice HealthPlan ends or is not renewed for any reason other than suspension or revocation of the Provider's license, you may be eligible to continue to receive In-Network Benefits for Covered Services from that Provider if you are receiving treatment for a Serious Medical Condition at the time the Provider's contract ends.

In order to receive this continuation of care for a Serious Medical Condition, you must submit a request to us on the appropriate form. You may get the form for this request from BlueChoice HealthPlan by going to the website at www.BlueOptionSC.com or calling the Customer Service phone number on your BlueChoice HealthPlan ID card. You will also need to ask the treating Physician to include a statement on the form confirming that you have a Serious Medical Condition. After we receive your request, we will notify you and the Provider of the last date the Provider is part of our network and a summary of continuation of care requirements. We will review your request to determine if you qualify for the continuation of care. If additional information is necessary to make a determination, we may contact you or the Provider for such information.

If we approve your request, we will provide In-Network Benefits for charges for Covered Services from that Provider for 90 days or until the end of the Benefit Period, whichever is greater. During this time, the Provider will accept the BlueChoice network allowance as payment in full. Continuation of care is subject to all other terms and conditions of the Policy, including regular benefit limits.

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 Urgent Care Centers and Hospital Emergency Rooms, 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 Urgent Care Center or Hospital Emergency Room, 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.

Blue Cross and Blue Shield of South Carolina underwrites the BlueCard program.

HOW TO GET HELP

It is only natural to have questions about your coverage and BlueChoice HealthPlan is committed to helping you understand your coverage so you can make the most of your benefits.

Your Fastest Place for Answers – www.BlueOptionSC.com
You can find quick and easy answers to your health coverage questions any time day or night. When you go to www.BlueOptionSC.com, you will find useful tools that can help you better understand your coverage.

Here are some of the things you can do on our website:

- Learn more about our products and services.
- Stay informed with all the latest BlueChoice HealthPlan news, including press releases.
- Find links to other health-related websites.
- Locate a network Physician, Hospital or Pharmacy.
- Use My Health Toolkit®.

My Health Toolkit
Go to "My Health Toolkit" from www.BlueOptionSC.com to:

- Check your eligibility.
- See how much you have paid toward your Deductible or Coinsurance maximum.
- Check on Authorizations.
- Check the status of your claims.
- Order a new ID card.
- See if our records show if you have Other Health Insurance.
- Ask a Customer Advocate a question through secure e-mail.
- View your Explanation of Benefits (EOB).
- Pay your bill
- Rate your doctor

Questions

You can also call our Member Services department. Advocates are available to help you Monday through Friday, 8:30 a.m. to 5 p.m. Eastern Time.

From Columbia, dial 786-8476.
From anywhere else in the state, dial 855-816-7636, toll free.

If you can't call, write to the following address:

BlueChoice HealthPlan of South Carolina, Inc.
P.O. Box 6170
Columbia, South Carolina 29260

Be sure to put your ID number in your letter, along with your name, address and telephone number. When you write or call, BlueChoice HealthPlan will do everything it can to help you.

COVERED SERVICES

Benefits for all services are subject to the provisions of this Policy. In order to be covered under this Policy, services must be:

1. Medically necessary and appropriate,
2. Not be Experimental or Investigational in nature and
3. Provided by a Participating Provider.

This applies to all services except for treatment of an Emergency Medical Condition, dental care and vision care as described below.

Benefits are subject to all limitations, exclusions, Copayments, Deductibles, Coinsurance and Maximum Payment amounts specified in this Policy and the Schedule of Benefits. **There are no annual or lifetime dollar limits on Essential Health Benefits.** Expenses for Covered Services will be paid according to the benefits stated in the Schedule of Benefits.

Luxury or convenience items; services and supplies not needed for the diagnosis or treatment of an illness or injury; services, supplies and treatment for complications resulting from any non-covered procedure or condition; medical social services, visual therapy or private duty nursing (unless a part of an approved Home Health Care or Hospice program); and devices of any type, such as but not limited to: therapeutic devices, artificial appliances or similar devices, even with a prescription are not Covered Services. Dorsal Rhizotomy (cutting the back of the spinal nerve roots) in the treatment of spasticity (increased tone or tension in a muscle such as a leg) is also not a Covered Service.

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 after Termination of Coverage** under the *General Policy Provisions* section of this Policy are not Covered Services. In addition, any services or supplies a Member of your immediate family provides, including the dispensing of drugs, is not considered a Covered Service. A member of your family means spouse, parents, grandparents, brothers, sisters, aunts, uncles, children or in-laws.

Any and all travel expenses (including those related to a transplant) such as, but not limited to: transportation, lodging and repatriation are only covered if specifically listed below.

Benefits payable under this Policy are not assignable to a non-Participating Provider unless otherwise determined by the Company. Any benefits payable for Covered services of such Providers will be based on the Allowable Charge. If any service or item that is not an Essential Health Benefit is provided by a non-Participating Provider, it will not be covered.

The following are Covered Services:

Ambulance Services –
Professional ambulance services to a local Hospital in the United States are covered in connection with an acute injury or Emergency Medical Condition. Coverage is also provided in connection with an interfacility transport between acute care facilities in the United States, when Medically Necessary due to the requirement for a higher level of services. No benefits are provided for international ambulance services or ambulance services used for routine, non-Emergency transportation, including, but not limited to, travel to a facility for scheduled medical or surgical treatments, such as dialysis or cancer treatment or transfer to a sub-acute place of care such as a skilled nursing facility. All claims for ambulance services are subject to medical review to determine if Medically Necessary. The Allowed Amount of ambulance services provided by out-of-Network Provides will be determined by us, in our discretion, using methods including, but not limited to, comparable cost of other transportation services over comparable distances.

Birth Control –
Benefits are provided for oral contraceptives and contraceptive devices. Birth control includes female sterilization.

Breastfeeding Support, Supplies and Counseling –
Benefits will be provided for breastfeeding support and counseling. Breastfeeding support includes benefits for breast pumps. Breast pumps must be purchased from a Provider we designate and are limited to one per year.

Cleft Lip and Palate –
Benefits will be provided for the care and treatment of a cleft lip and palate and any condition or illness that is related to or caused by a cleft lip and palate. Cleft lip and palate means a congenital cleft in the lip or palate or both. Care and treatment will include, but are not limited to:
1. Oral and facial Surgery, surgical management and follow-up care;
2. Prosthetic treatment such as obdurators, speech appliances and feeding appliances;
3. Orthodontic treatment and management;
4. Treatment and management for missing teeth (prosthodontics);
5. Ear, nose and throat (otolaryngology) treatment and management;
6. Hearing (audiological) assessment, treatment and management including surgically implanted hearing aids; and
7. Physical therapy assessment and treatment.

If a Member with a cleft lip and palate is also covered by a dental Policy, then teeth capping, prosthodontics and orthodontics will be covered by the dental Policy to the limit of coverage provided and any excess after that will be provided by this Policy.

Clinical Trials –
Benefits are provided for routine Member costs for items and services related to clinical trials when:
1. The Member has cancer or other life-threatening disease or condition; and
2. The referring Provider is a Network Provider that has concluded that the Member's participation in such trial would be appropriate; and
3. The Member provides medical and scientific information establishing that the Member's participation in such trial would be appropriate; and
4. The services are furnished in connection with an Approved Clinical Trial.

An Approved Clinical Trial is one that is approved or funded through the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHRQ), the Centers for Medicare & Medicaid Services (CMS), the Department of Defense (DOD), the

Department of Veterans Affairs (VA), a qualified non-governmental research entity identified in the guidelines issued by the NIH or is conducted under an Investigational new drug application reviewed by the Food and Drug Administration (FDA).

Dental Care –

Reimbursement up to $50 is provided for one oral examination every six months by or under the direction of a licensed dentist. Reimbursement up to $50 is also provided for one dental cleaning (prophylaxis) every six months by or under the direction of a licensed dentist. This service does not have to be Authorized. You will have to file a request for reimbursement to the Company to receive reimbursement. Other than preventive dental services listed above, there is no Coverage for other dental services related to the teeth and supporting structures. These reimbursements do not apply to your Deductible or your Maximum Out-of-Pocket expenses.

Dental Services to Sound Natural Teeth Related to Accidental Injury –

Care is for treatment, Surgery or appliances caused by accidental bodily injury (except dental injuries occurring through the natural act of chewing). It's limited to care completed within six months of such accident and while the patient is still covered under this Policy. Benefits are subject to the Deductible and Coinsurance. The first emergency visit does not require prior Authorization. The dentist should submit an outline of the plan of treatment to BlueChoice's review before any further treatment is provided.

Diabetes Management –

Benefits are provided for equipment, supplies, Outpatient self-management training and education including nutritional counseling for the treatment of Members with diabetes. A health care professional must follow minimal standards of care for diabetes as adopted and published by the Diabetes Initiative of South Carolina.

Diabetes self-management training and education will be provided on an Outpatient basis when done by a registered or licensed health care professional certified in diabetes education.

Durable Medical Equipment (DME) –

Benefits are provided toward the purchase price or total rental cost up to the purchase price of the DME when it's for therapeutic use outside of a Hospital for the treatment of your condition. If the equipment is not available for rent, we may approve the monthly payments toward the purchase of the equipment. We provide benefits for standard DME only. Benefits don't include manual or motorized wheelchairs or power operated scooters, unless Medically Necessary for mobility in the patient's home; or bioelectric, microprocessor or computer programed DME.

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 is not considered Durable Medical Equipment.

Prior Authorization is required before you get the DME if the purchase price or rental cost is $500 or more. In addition, supplies used with the DME must be prior Authorized every 90 days. If prior Authorization is not obtained, no benefits will be provided.

Emergency Services –

Use of the Emergency Room is intended only for persons who are experiencing an Emergency Medical Condition, as defined in this 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 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 additional cost-sharing because an Out-of-Network Provider provided the services.

   Out-of-Network Hospital Emergency Room – We will provide benefits for an Emergency Medical Condition 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 provided by an out-of-Network Hospital will be the greater of: A) the median amount for those Emergency Services, calculated using reimbursement rates of in-Network Providers who participate in the Blue Option Network; or B) the amount for those Emergency Services calculated using Medicare reimbursement rates, which is the same method we generally use to determine payment to out-of-Network Providers who do not participate in the Blue Option Network.

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

Employee Assistance Program (EAP Service) – Three visits for Life Management Services are provided under an agreement with First Sun EAP. 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.

Costs associated with these visits do not apply to your Deductible or your Maximum Out-of-Pocket expenses.

Genetic Counseling –
Benefits are provided for Genetic Counseling. If referred by a Participating Physician, routine breast cancer susceptibility gene (BRCA) testing is also covered for women whose family history is associated with an increased risk for deleterious mutations in the BRCA1 or BRCA2 genes.

Habilitation Services –
Benefits include Physical, Occupational and Speech Therapy for the purpose of assisting a Member with achieving developmental skills, such as a developmental speech delay, developmental communication disorder, or a developmental coordination disorder. Benefits are provided when a Physician prescribes therapy and it is performed by a licensed, professional physical, occupational or speech therapist. Preauthorization is required. If Preauthorization is not obtained, no benefits will be provided. Habilitation Services are limited to 15 visits per Member per Benefit Period.

Home Health Care Services –
Benefits are provided to an essentially homebound Member in a personal residence. Home health care must be provided by, or through a community home health agency on a part-time visiting basis and according to a Physician-prescribed course of treatment. We must pre-authorize the care based on established home health care treatment before you are eligible. If prior Authorization is not obtained, no benefits will be provided. Home Health Care Services are limited to 60 visits per Member per Benefit Period. Home health care includes:

1. Services by a registered nurse (RN) or licensed practical nurse (LPN);
2. Services provided by a home health aide or medical social worker;
3. Nutritional guidance;
4. Diagnostic services;
5. Administration of Prescription Drugs;
6. Medical and surgical supplies;
7. Oxygen and its use; and
8. Durable Medical Equipment (A separate prior Authorization is not needed when we approve the entire Home health care plan).

Hospice Services –
Benefits are provided for hospice services. We must prior Authorize hospice services before you are eligible for this care. The services must be provided according to a Physician prescribed treatment plan. If prior Authorization is not obtained, no benefits will be provided. Hospice Services are limited to 6 months per Member per episode. Hospice services include:

1. Services provided by a registered nurse (RN) or licensed practical nurse (LPN);
2. Physical, speech and occupational therapy (Benefit Period Maximum applies)
3. Services provided by a home health aide or medical social worker;
4. Nutritional guidance;
5. Diagnostic services;
6. Administration of Prescription Drugs;
7. Medical and surgical supplies;
8. Oxygen and its use;
9. Durable Medical Equipment (A separate Authorization is not needed when we approved the entire Hospice Service plan); and
10. Family counseling concerning the patient's terminal condition.

Hospital Services –
Include Inpatient Admissions, Outpatient care and ancillary services. Prior Authorization is required. If prior Authorization is not obtained, no benefits will be provided. Hospital services do not include: Admissions or portions thereof for long-term or chronic care due to medical conditions or Behavioral Health conditions, or 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) is not covered**.**

Room and board benefits are provided at the most prevalent semi-private room rate. When all rooms in a Hospital are private, the semi-private room rate will be considered the private room allowance.

College or School Infirmary –
When a Member receives care in a college or school infirmary that bills students for its services, benefits will be limited to the average semi-private room rate for South Carolina Hospitals.

The day you leave a Hospital, with or without permission, is treated as the day of discharge and will not be counted as an Inpatient care day, unless you return to the Hospital by midnight of the same day. The day you return to the Hospital is treated as the day of Admission and is counted as an Inpatient care day. The days during which you are not physically present for Inpatient care are not counted as Inpatient days.

Immunizations –
Benefits will be provided for immunizations as recommended by the Centers for Disease Control (CDC), the United States Preventive Services Task Force (USPSTF), and Health Resources and Services and Administration (HRSA). The recommendations may include age and/or frequency restrictions. Immunizations do not include those recommended prior to travel outside the United States. The CDC, USPSTF and HRSA are independent organizations that offers health information on behalf of BlueChoice HealthPlan.

Laboratory Services –
Benefits will be provided for procedures to identify the nature and/or extent of a condition or disease. We will reduce benefits for Inpatient diagnostic services to the level of benefits for Outpatient services when services could have been safely done on an Outpatient basis. Lab services do not include: pre-conception testing, pre-conception genetic testing or any services related to infertility. Diagnostic services include, but are not limited to:

1. Radiology, ultrasound and nuclear medicine;
2. Laboratory and pathology;
3. ECG, EEG and other electronic diagnostic medical procedures and physiological medical testing;
4. Surgical pathology — pathological examination of tissue removed surgically, by resection or biopsy. This does not include smear techniques;
5. High technology diagnostic services such as, but not limited to, MRIs, MRAs, PET scans and CT scans; and
6. Gastrointestinal endoscopies.

Mastectomy and Reconstruction –
Benefits include Hospitalization for at least 48 hours following a mastectomy. If you are released early, then we will provide benefits for at least one home care visit if the attending Physician orders it.

We will also provide benefits for Prosthetic Devices, reconstruction of the breast on which the mastectomy was performed and physical complications for all stages of mastectomy including lymphedemas. This includes Surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance as determined in consultation with the attending Physician and the patient.

Maternity Care –
Benefits will be provided for pre- and postnatal care, including the hospitalization and related professional services for at least 48 hours after a vaginal delivery (96 hours following a Cesarean section) or the date of discharge from the Hospital — whichever occurs first. The day of delivery or Surgery is not counted in the 48 hours after vaginal delivery (96 hours for Caesarean Section). Maternity care does not include: surrogate parenting; artificial insemination and in-vitro fertilization.

Prior Authorization is not required for hospitalization related to the delivery of a newborn child when the Hospital stay is 48 hours or less for a vaginal birth or 96 hours or less for a cesarean section. The day of delivery, Surgery or birth is not counted in the 48 or 96 hours. If you or the newborn are not released within these timeframes, you or your Provider should contact BlueChoice for Authorization for a continued stay. If you are in a network Hospital, the Hospital should contact us for this Authorization.

Medical Supplies –
Benefits will be provided for items you need for treatment of an illness or injury and must be dispensed by or under the direction of your primary care Physician. Supplies include syringes and related supplies for conditions such as diabetes, dressings for cancer or burns, catheters, external opening (ostomy) bags, test tapes, kidney (renal) dialysis supplies and surgical trays. Supplies and equipment that have non-therapeutic uses, over-the-counter supplies and bandages are not covered.

Mental Health & Substance Use Disorder Services –
We will provide benefits as shown in the Schedule of Benefits, for Mental Health and/or Substance Use Disorders. Mental Health and Substance Use Disorder Services does not include: Admissions for long-term or chronic care for psychiatric conditions; residential treatment received at: therapeutic schools, wilderness/boot camps, therapeutic boarding homes, half-way houses and therapeutic group homes; marriage counseling; 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; 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 this 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; and Services for animal assisted therapy, Vagal Nerve Stimulation (VNS), Eye Movement Desensitization and Reprocessing (EMDR) or rapid opiate detoxification.

All Inpatient, certain Outpatient 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 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 Health Plan.

Newborn Child Coverage –
Coverage for the newborn child shall include, but is not limited to, routine nursery care and/or routine well-baby care during the initial period of Hospital confinement. A newborn child must be enrolled and applicable Premium must be paid in order for benefits to be paid.

Physician Services (Primary Care Physician and Specialist) –
Benefits are provided for the following:

1. Office/Outpatient Medical Services – Medical care and consultation by a Physician in an Outpatient setting for the examination, diagnosis or treatment of an injury or illness.

2. Inpatient Services – Medical care and consultation provided by a Physician in an Inpatient setting for the examination, diagnosis or treatment of an injury or illness.
   a. Inpatient and Intensive Medical Care Visits – Visits are limited to one per day. Inpatient medical services also include diagnostic services and therapy services done concurrently with medical care.
   b. Consultation – If a consultation with another Physician is ordered by a patient's attending Physician, benefits are provided for one consultation per consulting Physician.

   We will not provide benefits for daily medical visits by more than one Physician unless the Member has a separate medical condition the attending Physician cannot treat. In this type of situation, benefits may be provided for one daily visit by each Physician.

3. Surgery – Benefits include pre- and post-operative care as well as daily care by the Physician who performed the Surgery if you are Inpatient. However, reduction mammoplasty for macrosastia is covered only when you are within 20% of your ideal body weight. Benefits do not include any Surgery for reversals of sterilization; obesity, weight reduction or weight control such as but not limited to, gastric by-pass, insertion of stomach (gastric) banding, intestinal bypass, wiring the mouth shut, liposuction, complications from any such procedure and reversal of or reconstruction procedures from such treatments.

   Benefits are provided for medical visits by another Physician when you have a condition the Physician who performed the Surgery cannot treat.

   a. Multiple Surgical Procedures – When multiple surgical procedures are performed through the same incision or body opening during one operation, benefits are provided only for the primary procedure unless more than one body system is involved or the procedures are required for management of multiple trauma.

      If two or more surgical procedures are performed through different incisions or body openings during one operation, benefits are provided for the additional procedures at 50 percent of the Allowable Charge for each procedure.

      If a procedure is performed in two or more steps or stages, benefits will be limited to the Allowed Amount for the entire procedure.

      If two or more Physicians, other than an assistant at Surgery or anesthesiologist, perform procedures in conjunction with one another, we will prorate the Allowed Amount between them when so required by the Physician in charge of the case. This benefit is subject to the above paragraphs.

      When more than one skin lesion is removed at one time, we provide full benefits for the largest lesion, 50 percent of the Allowed Amount is covered for the removal of the second largest lesion and 25 percent of the Allowed Amount is covered for removing any other lesions.

      We designate certain surgical procedures that are normally exploratory in nature, as "Independent Procedures." The Allowable Charge is covered when such a procedure is performed as a separate and single procedure. However, when an Independent Procedure is performed as an integral part of another surgical service, only the Allowable Charge for the major procedure will be covered.

   b. Surgical Assistant – Services of one Physician who actively assists the operating Physician when an eligible Surgery is performed in a Hospital, and when such surgical assistant service is not available by an intern, resident or house Physician. We will provide a predetermined percent not more than 20 percent of the Allowable Charges, not to exceed the Physician’s actual charge.

c. Anesthesia – Services provided by a Physician or a certified registered nurse anesthetist, other than the attending surgeon or his assistant.

4. Chemotherapy – The treatment of malignant disease by chemical or biological antineoplastic agents that have received full, unrestricted market approval from the FDA.

5. Dialysis Treatment – The treatment of acute renal failure or chronic irreversible renal insufficiency to include hemodialysis or retinol dialysis. Dialysis treatment includes home dialysis. Dialysis treatment must be Authorized by BlueChoice HealthPlan.

6. Radiation Therapy – The treatment of disease by X-ray, radium or radioactive isotopes.

Physician Services benefits do not include services or supplies for: pre-conception testing or pre-conception genetic testing; infertility; acupuncture; hypnotism; TENS unit or services for chronic pain management programs; excessive sweating; diagnosis or treatment of sexual dysfunction, including, but not limited to, drugs, lab and x-ray test and counseling for such procedures. Benefits also does not include Physician charges for drugs, appliances, supplies, blood and blood products, or any type of fee or charge for handling medical records, filing a claim or missing a scheduled appointment.

Note: If you receive services at an in-Network Hospital or from another in-Network Provider, you may also receive ancillary services that are incidental to the primary benefit/service from an Out-of-network Provider. When this happens, you may be required to pay the full cost of those services or benefits you received from the Out-of-network Provider. For example, if you have surgery at an in-Network Hospital, performed by an in-Network Physician, but the anesthesiologist is not in the Blue Option network, charges billed by the Out-of-network anesthesiologist are not covered and will be your responsibility.

Prescription Drugs –
Benefits are provided for the Prescription Drugs listed on the Covered Drug List and which tier the Prescription Drug is on. Prescription Drugs must be purchased at a Participating pharmacy and prescribed by a Participating licensed Physician. A list of Participating pharmacies and the Covered Drug List that shows the tier each drug is in can be found on the Blue Option website at https://www.BlueOptionSC.com/prescription-drugs.

Prescription Drug benefits are limited to 31-day supply when purchased at retail Pharmacy and a 90-day supply when purchased through the Mail-Order Pharmacy.

Benefits are provided only for the most cost-effective Prescription Medication available at the time dispensed whenever medically appropriate and in accordance with all legal and ethical standards.

There may be additional requirements or limits on some medications on the Covered Drug List. These requirements and limits may include:

- **Prior Authorization (PA):** If your drug needs prior authorization, your doctor will have to get approval before we will cover your drug. There are different reasons a drug might require prior authorization. One is to make sure it's being used for the condition(s) it was approved for by the United States Food and Drug Administration (FDA). Another is because there are drugs that usually work just as well, but cost less.
- **Quantity Limits (QL):** If your drug has a quantity limit, we will only cover a certain amount of the drug in a specified period of time, usually a month. This is to make sure you are using the drug safely and based on the FDA guidelines. If we determine a Member has used multiple Doctors or Pharmacies to obtain quantities of Prescription Drugs in excess of what is allowed or recommended, we reserve the right to

require the use of a designated Provider for prescribing the medication and/or a specific Pharmacy to fill all prescriptions for that medication.

- **Step Therapy (ST):** If your drug has a step therapy requirement, we will only cover second choice drugs if you have already tried a first choice drug and it didn't work for you. The reason for a particular step therapy requirement may be because there are drugs that usually work just as well, but will cost you less. It may also be because some drugs are approved by the FDA specifically as second-choice drugs or as add-ons to other medication.

The BlueChoice Covered Drug List includes drugs on different Tiers, each with its own copayment and/or Coinsurance levels. Drugs are chosen for each level based on their value, which takes into consideration their clinical benefit (how well they work) and also their cost.

We will provide benefits for off-label use of Prescription Drugs that haven't been approved by the FDA for the treatment of a specific type of cancer for which the drug was prescribed, provided the drug is recognized for treatment of that specific cancer in at least one standard reference compendium or the drug is found to be safe and effective in formal clinical studies. These results must have been published in peer-reviewed professional medical journals.

If a Participating Physician prescribes a non-generic drug for which there is a less-expensive equivalent generic or over-the-counter drug available, and the Member requests the non-generic drug, then any difference between the cost of the Covered generic or over-the-counter drug and the higher cost of the non-generic drug will be the responsibility of the Member. This will be in addition to any Copayment or Coinsurance appropriate to the non-generic drug being purchased. In no instance will the Member be charged more than the actual retail price of the drug.

BlueChoice HealthPlan receives financial credits directly from drug manufacturers and through a pharmacy benefit manager. The credits are used to help stabilize overall rates and to offset expenses. Reimbursements to Pharmacies, or discounted prices charged at Pharmacies, are not affected by these credits. Any Coinsurance percentage that a Member must pay for Prescription Medications is based on the negotiated rate or lesser charge at the pharmacy, and does not change due to receipt of any drug credit by BlueChoice HealthPlan. Copayments are flat amounts and likewise do not change due to receipt of these credits.

Formulary Exception Request (standard or expedited): If a drug is not covered, it may be helpful to discuss other covered alternatives with your Physician; or, if not medically viable, you may request a formulary exception. An exception request may be made by the Member, the Member's designee, or the Member's prescribing Provider (or other prescriber, as appropriate) to request and gain access to clinically appropriate drugs not otherwise covered by the health plan by contacting our Pharmacy Benefit Manager (PBM). You may also contact the Prior Authorization line at 855-582-2022 to acquire an exception request form. After completing the necessary information, the form can be faxed to 855-245-2134. Our Pharmacy Benefit Manager will work with the prescribing physician to obtain any medical records or other necessary information to process the request. We must act on a standard request within 72 hours and on an expedited request within 24 hours after we receive your request for a formulary exception. Expedited requests are available only when you have exigent circumstances: a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or when you are undergoing a current course of treatment using a non-formulary drug. For a standard formulary exception, we will notify you no later than 72 hours following receipt of the request, and if approved, will provide coverage of the approved non-formulary drug for the duration of the prescription, including refills. For an expedited formulary exception, the determination will be made no later than 24 hours following receipt of the request and, if approved, will provide coverage of the non-formulary drug only for the duration of the exigent circumstances. If your formulary exception request is denied, you can ask for an exception review. The request can be made by you or your prescribing Provider. You can ask for an exception review by contacting us to begin the process at:

CVS/Caremark
Appeals Department, MC 109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax: 1-866-443-1172

The independent review organization will make a determination on your exception review and we will notify you or your designee, along with the prescribing Provider, of the coverage determination. If the original request was a standard formulary exception request, we will notify you no later than 72 hours following receipt of the request, and if approved, will provide coverage of the approved non-formulary drug for the duration of the prescription. If the original formulary exception request was an expedited request, the determination will be made no later than 24 hours following receipt of the request and, if approved, will provide coverage of the non-formulary drug only for the duration of the exigency. If you still disagree with the decision in your case, see the Appeals section of this Policy.

Preventive Screenings –
A limited number of services are provided as preventive care with no cost sharing. Benefits will be provided as follows:

- The United States Preventive Services Task Force (USPSTF) recommended Grade A or B screenings.
- Screenings recommended for children and women by Health Resources and Services and Administration (HRSA).
- Preventive prostate screenings and lab work according to the American Cancer Society (ACS) guidelines.
- Pediatric oral and vision care as recommended by the United States Preventive Services Task Force (USPSTF) Grade A or B screenings and Health Resources and Services Administration (HRSA).

Virtual colonoscopies may be covered but are subject to medical management guidelines and are subject to Preauthorization.

These services are covered only when provided by a Participating Provider. Preventive care (except Preventive Pap Smear) must meet the age and/or condition guidelines/recommendations of the USPSTF, CDC, HRSA or ACS to be covered at no cost to the Member. These organizations and agencies are independent organizations that offer health information and recommendations; they are not affiliated with BlueChoice HealthPlan.

Prosthetics –
Benefits are provided for a prosthetic, other than a dental or cranial prosthetic, which meets minimum specifications for the body part it is replacing regardless of the functional activity level. The item must be a standard, non-luxury item as determined by us. Specialty items such as bionics/bioelectric, microprocessor components or computer programed Prosthetics are not covered. Benefits are provided only for the initial temporary and permanent prosthesis. No benefits are provided for repair, replacement or duplicates, nor for services related to the repair or replacement of such prosthetics, except when necessary due to a change in the Member's medical condition, and with prior Authorization from us. Repair or replacement for routine wear and tear is not a Covered Service. Prosthetics do not include; adjustable cranial orthosis (band or helmet) for positional plagiocephaly or craniosynostoses in the absence of cranial vault remodeling Surgery or a penile prosthesis necessary due to any medical condition or organic disease. A penile prosthesis will be considered for benefits only after prostate Surgery. Prosthetic devices are limited to one device per Member per episode.

Rehabilitation Services –
Include:

Cardiac Rehabilitation –
Benefits are provided for Phase 1 and 2 cardiac rehabilitation when provided within 30 days following a cardiac event.

Physical, Occupational and Speech Therapy –
Benefits are provided when a Physician prescribes therapy and it is performed by a licensed, professional physical, occupational or speech therapist. Physical, Occupational and Speech Therapy service are limited to 15 visits per Member per Benefit Period for all services combined.

Pulmonary Rehabilitation –
Benefits are provided when pulmonary rehabilitation is in conjunction with a covered lung transplant.

Prior Authorization is required for Inpatient Rehabilitation.

Residential Treatment Center (RTC) –
Benefits include room and board, general nursing service, therapy services and other ancillary services. Prior Authorization is required. If Prior Authorization is not obtained, benefits will not be provided.

Benefits for a Residential Treatment Center are provided at the semi-private room rate. When you are admitted to a Residential Treatment Center in which all rooms are private, the most prevalent semi-private room rate, as determined by us, will be considered the private room rate.

The day you go to the Residential Treatment Center is the Admission day. The day you leave the Residential Treatment Center, with or without permission, is the discharge day. Please note that services provided on the day of discharge are provided according to the Policy terms and conditions.

Benefits are not provided for days in which you are not physically present in the Residential Treatment Center.

Residential Treatment Center benefits are limited to 60 days per Member per Benefit Period.

Skilled Nursing Facility –
Benefits include room and board, special diets, general nursing services, therapy services and other ancillary services. You must be admitted within 14 days after being discharged from a Hospital following an Authorized hospitalization. Prior Authorization is required. If prior Authorization is not obtained, benefits will not be provided.

Benefits for Skilled Nursing Facility are provided at the semi-private room rate. When you are admitted to a Skilled Nursing Facility in which all rooms are private, the most prevalent semi-private room rate, as determined by us, will be considered the private room.

The day you leave the Skilled Nursing Facility, with or without permission, is the discharge day. The day you go to the Skilled Nursing Facility is the Admission day. Benefits are not provided for days in which you are not physically present in the Skilled Nursing Facility.

Skilled Nursing Facility benefits are limited to 60 days per Member per Benefit Period.

Telehealth –
Benefits will be provided for Telehealth services which are initiated by either a Member or Provider and are provided by Network Providers who have been credentialed as eligible Telehealth Providers.

Telemedicine –
Benefits will be provided for Telemedicine when provided through a Provider we designate. Services include, but are not limited to, consultation, diagnosis and treatment where the services would otherwise be covered if you were "in person." Telemedicine visits are considered office visits and will count toward any limits for office visits.

Telemedicine services will be covered when the services performed are Covered Services under this Policy and under the following circumstances:
1. The medical care is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the Member's need; and,
2. The medical care can be safely furnished, and there is no equally effective, more conservative and less costly treatment available.

The following examples are services that are not Telemedicine services and will not be covered:
1. Telephone conversations;
2. E-mail messages;
3. Facsimile transmissions; or
4. Internet-based audio-video communication that is not secure and HIPAA-compliant (e.g., Skype).

Transplants (Human Organ and/or Tissue) –
We provide benefits for covered transplants only when you obtain prior Authorization and use a Provider we designate.

Organ transplant coverage includes all expenses for medical and surgical services a Member receives for human organ and/or tissue transplants while the Member is covered under this Policy. This includes donor organ procurement. Organ transplants do not include transplants involving mechanical or animal organs.

1. The only living donor transplants covered under this Policy are kidney transplants for Members with dialysis-dependent kidney failure and liver transplants. All other living donor transplants are not covered. Benefits will be subject to the following conditions:
   a. When both the transplant recipient and the donor are Members, benefits will be provided for both.
   b. When the transplant recipient is a Member and the donor is not, benefits will be provided for both.
   c. When the transplant recipient is not a Member and the donor is, no benefits will be provided to either the donor or the recipient.

2. Benefits are provided for the specified transplants listed below. These benefits are subject to all other provisions of the Policy.
   - Single/double kidney, pancreas and kidney, heart, single/double lung, liver, pancreas, heart and single/double lung, and bone marrow transplants.

3. Benefits may be available when a malignancy is present for high-dose chemotherapy followed by hematopoietic stem support, either autologous (the patient is the donor) bone marrow transplant, peripheral stem cell or allogeneic bone marrow transplant.

4. Benefits may be available for allogeneic bone marrow transplantation in the treatment of developmental and non-malignant diseases of bone marrow.

   Benefits for allogeneic or syngeneic bone marrow transplants as described in items 3 and 4 above are available only if there are at least six of eight histocompatibility complex antigen matches between the patient and the donor and the mixed lymphocyte culture is nonreactive.

5. The following services related to tissue transplants, except fetal tissue, are covered:
   a. Blood transfusions (but not whole blood and blood plasma);
   b. Autologous parathyroid transplants;
   c. Corneal transplants;
   d. Bone and cartilage grafting; or
   e. Skin grafting.

   The following transplants are not Covered Services:

   - 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.

Urgent Care Services –
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.

Vision Care (for ages 19 years and older) –
One routine vision examination or one exam for contact lenses per Member per Benefit Period when Provided by a PEN Provider is covered. One standard contact lens fitting per Member per Benefit Period. Any additional charge for a contact lens fitting is the Member's responsibility. One pair of eyewear from a designated selection per Member every other Benefit Period when purchased from a PEN Provide.

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.

(Physicians EyeCare Network (PEN) is an independent company that provides vision services on behalf of BlueChoice HealthPlan, Inc. of South Carolina.)

Any other vision or eye examination (other than a routine vision screening by the Member's Primary Care Physician) is not covered unless Medically Necessary. Benefits received for vision care services dot not apply to your Deductible or Out-of-pocket.

Vision Care for Children –
Pediatric vision services are covered for children through age 18 years. One comprehensive vision examination per Dependent child per calendar year when provided by a PEN Provider is covered, subject to a $25 Copayment.

One pair of glasses (lenses and frames) per Dependent child per calendar year, subject to a $50 Copayment is covered.

Covered lenses include single vision, lined bifocal, lined trifocal or lenticular lenses. Covered frames are from a standard selection.

In lieu of eyeglasses, elective contact lens services and materials are covered once per Calendar Year for one of the following modalities: Standard (one pair annually), Monthly (six-month supply), Bi-weekly (three-month supply), Dailies (three-month supply).
Necessary contact lenses are covered in full for members who have specific conditions for which contact lenses provide better visual correction.

Items not covered under the contact lens coverage include insurance policies or service agreements, artistically painted or non-prescription lenses, additional office visits for contact lens pathology or contact lens modification, polishing or cleaning

Additional items excluded under this plan include two pairs of glasses instead of bifocals, replacement of lenses, frames or contacts, medical or surgical treatment and orthoptics, vision training or supplemental testing.

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 Service Area

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 the 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 Authorization 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 service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

SERVICES AND SUPPLIES THAT ARE NOT COVERED

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 this 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, 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 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 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 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 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*.

- 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 the Covered Services Section.

- 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 this 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.

- Services, supplies or charges for any kind of pain management, including but not limited to, wellness or alternative treatment programs, acupuncture, massage therapy, hypnotism and Transcutaneous Electrical Nerve Stimulation (TENS) unit therapy. We may, in our discretion under certain limited circumstances, approve services for a Multi-disciplinary Pain Management Program, as defined herein. A Multi-disciplinary Pain Management Program is a program that includes Physicians of different specialties and non-Physician Providers, who specialize in the assessment and management of patients with a range of painful diagnoses and chronic pain, the purpose of which is intended to provide the interventions needed to allow the patients to develop pain coping skills and discontinue analgesic medication. Services, supplies or charges for a Multi-disciplinary Pain Management Program must be Authorized in advance. Pre-authorization approval shall be on a case by case basis, in our discretion, and contingent upon such program, and the Providers offering such program, complying with our Provider credentialing and medical policy requirements, which may change from time to time based on new evidence-based medical information available to us. The member is solely responsible for seeking Authorization in advance, regardless of the State of location of the provider offering the Multi-disciplinary Pain Management Program.

- 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 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.

- 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 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.

- 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 this 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 Covered Services.
  - 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.
  - That require Authorization and the Authorization is not received.
  - Some 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 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.

SUBROGATION

If you receive medical benefits under this Policy for an injury caused by the act or omissions of a liable third party and receive a settlement, judgment, or other payment relating to the injury from a liable third party, any other person, firm, corporation, organization or business entity, you agree to reimburse us for not more than the amount that we have paid relating to the injury. This agreement is a condition to receiving benefits under this Policy. Our right to subrogation or reimbursement applies to any judgment and/or settlement proceeds, whether or not liability is admitted.

Our interest in subrogation or reimbursement extends to all benefits relating to your injury even if claims for those benefits have not been submitted to us for payment at the time you receive the settlement, judgment or payment.

You have the right to petition the Director of Insurance, or his designee, to determine if our subrogation action is inequitable or unjust. If the Director makes the determination that allowing subrogation is inequitable or unjust, then it is not allowed. This determination by the Director may be appealed to the Administrative Law Judge Division as provided by law.

We will pay attorney's fees and costs from the amount recovered.

If you choose not to pursue an action to recover damages, you agree to transfer all rights to recover damages in full for such benefits to us. At our expense, we lawfully stand in the place of you to recover the amount of money we have paid for your medical benefits from any third party who is liable, responsible, or otherwise makes a payment for your injury. We may seek recovery for its payment of claims from the liable third party, any liability or other insurance covering the liable third party or from your own uninsured motorist insurance and/or underinsured motorist insurance.

In all situations involving subrogation, you shall not do anything to hinder or slow our right to seek reimbursement. You shall cooperate with us, sign any documents, and do all things necessary to protect and secure our subrogation and reimbursement rights.

Each time a claim is filed with a diagnosis that could be related to an accident or injury, you may receive a notice stating that we need information to complete processing the claim along with a questionnaire regarding the claim. For your files to be updated, you must return the questionnaire with the requested information.

CLAIM FOR BENEFITS, APPEALS AND EXTERNAL REVIEWS

The terms listed below are important and need to be understood.

Urgent Claims –
any claim for medical care or treatment where making a determination under the normal timeframes could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.

Pre-Service Claims –
A claim for services that have not yet been provided and for which your benefits plan requires prior Authorization.

Post-Service Claims –
A claim for services that already have been provided, or where your benefits plan does not require prior Authorization.

Concurrent Care Claims –
A claim that arises when there is a reduction or termination of ongoing care.

Notice of Adverse Benefit Determination – a notice which will be sent to you if your claim is filed properly, and your claim is in part or wholly denied.

Internal Claims Appeals
You have 180 days from the receipt of an adverse benefit determination to file an appeal. The disposition of the claim shall be considered final after the end of this period.

Requests for appeals should be sent to:

BlueChoice HealthPlan
Appeals Department
Mail Code AX-325
PO Box 6170
Columbia, SC 29260-6170

You will have the opportunity to present testimony, submit written comments, documents, or other information in support of your appeal and you will have access to all documents that are relevant to your claim. If BlueChoice HealthPlan considers or presents additional evidence in connection with your appeal or uses new or additional reasons as the basis of the adverse determination, you will be notified of the new evidence or rationale in advance of the date of the appeal decision. Your appeal will be conducted by someone other than the person who made the initial decision, or his or her subordinate. No deference will be afforded to the initial determination. Individuals involved in the decision-making for claims and appeals are not compensated or rewarded based on the outcome of an appeal.

If your claim involves a medical judgment question, BlueChoice HealthPlan will consult with an appropriately qualified healthcare practitioner with training and experience in the field of medicine involved. If a healthcare professional was consulted for the initial determination, a different healthcare professional will be consulted on appeal. Upon request, BlueChoice HealthPlan will provide you with the identification of any medical expert whose advice was obtained on behalf of the plan in connection with your appeal.

You will be considered to have exhausted the internal appeal process if the Company fails to strictly adhere to the internal appeal process, unless the violation was:

a. De minimus;
b. Non-prejudicial;
c. Attributable to good cause or matters beyond the Company's control;
d. In the context of an ongoing good-faith exchange of information; and
a. Not reflective of a pattern or practice of non-compliance.

An explanation of the Company's basis for stating it meets the above standard may only be requested by the Member in writing.

A final decision on your appeal will be made within the time periods specified below.

Urgent Claims:
The Company will defer to the attending Provider with respect to the decision as to whether a claim constitutes "Urgent Care." You may request an expedited review of any urgent claim. This request may be made orally, and BlueChoice HealthPlan will communicate with you by telephone, facsimile, or similarly rapid communication method. You will be notified of the determination as quickly as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim.

Pre-Service Claims:
When you request a review of a pre-service claim, you will be notified of the determination within a reasonable period of time, taking into account the medical exigencies, but not longer than 30 days from the date your request is received.

Post-Service Claims:
When you request a review of a post-service claim, you will be notified of the determination within a reasonable period of time, but no later than 60 days from the date your request is received.

External Review by an Independent Review Organization

The Member will be notified in writing of the right to request an external review. The Member should file a request for external review within four months of receiving that notice. The Member will be required to authorize the release of any medical records that may be needed for the external review. If you need assistance during the external review process, you can contact the South Carolina Department of Insurance at the following address and telephone number:

South Carolina Department of Insurance
P.O. Box 100105
Columbia, SC 29202-3105
1-800-768-3467

Standard Review:
You can request an external review if we deny your claim, either in whole or in part. You may be held financially responsible for the covered benefits. You can request an external review without completing the grievance and appeal process above if:

1) Your Physician has certified in writing that you have a serious medical condition; or
2) The denial of coverage was due to the service being Investigational or Experimental and your Physician certifies:
    a. Your condition is a serious disability or you have a life-threatening disease; and
        i. Standard health care services or treatments have not been effective in improving your condition; or

ii. Standard health care services or treatments are not medically appropriate; or
iii. The recommended or requested service or treatment is more beneficial than the standard health care service or treatment covered by us; and

b. Medical and scientific evidence shows that treatment that was denied is more beneficial to you than available standard health services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of the standard services or treatments.

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

The Member has five business days from the date the Member receives the Company's response to submit additional information to the independent review organization in writing. The independent review organization must consider this additional information when conducting its review. The independent review organization will also forward this information to the Company within one business day of its receipt.

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

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

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

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

Expedited Review:
You can file a request for an expedited external review within 15 days after receiving a notice of a denied claim if you meet the requirements under Standard Review listed above in paragraph 2. You can also request an expedited external review if the denial concerns an Admission, availability of care, continued stay or health care service for which you received Emergency Medical Care, but have not been discharged from a facility, if you may be held financially responsible for the Emergency Medical Care. You can request an expedited external review at the same time as requesting an expedited internal review.

When we receive your request for an expedited external review, the South Carolina Department of Insurance will assign your review to an IRO and we will forward our records by overnight delivery, or tell you in writing that your situation doesn't meet the requirements for an external review and explain the reasons.

The IRO must make its decision as fast as possible but within no more than 72 hours after it receives the request for expedited review. If the IRO's decision is to allow benefits, we must approve the benefit as covered, subject to applicable Policy exclusions, limitations and other provisions.

All requests for external review will be at our expense.

If your Physician certifies that you have a "serious medical condition," you are entitled to an expedited external review. A serious medical condition, as used in this provision, means one that requires immediate medical attention to avoid serious impairment to body functions, serious harm to an organ or body part, or that would place your health in serious jeopardy or jeopardize your ability to regain maximum function.

GENERAL POLICY PROVISIONS

1. Entire Policy: Changes

This Policy, your Application, and any amendments, riders or endorsements make up the whole Policy between you and the Company. No change in this Policy is valid unless it comes to you as an amendment, rider or endorsement signed by the Company. No one else has the authority to change this Policy or to waive any of its provisions.

2. Time Limit on Certain Defenses

Premium The Application is a part of your Policy. If a statement on your Application or enrollment records is an intentional misrepresentation of material facts related to your eligibility for coverage, or you perform an act or practice that constitutes fraud, we may have grounds to rescind the Policy. A rescission does not include a retroactive cancellation or discontinuance of your coverage due to the failure to timely pay Premiums. If the Policy is rescinded, we will provide 30 days written notice and refund your Premiums minus any amounts paid for claims. After this Policy has been in force for two years, we cannot use any statement made in any Application (unless fraudulent) to void the Policy or deny any claim incurred after the two-year period.

Premium After two years from the issue date only fraudulent misstatements in the Application may be used to void the Policy or deny any claim for loss incurred or disability that starts after the two year period.

3. Extension of Benefits after Termination of Coverage.

If the Company does not renew or terminates your Policy and you are in the Hospital or continuously and totally disabled when your coverage under this Policy 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 Policy. 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.

4. How to File Claims; Notice of Claim and Proof of Loss

Show your ID card when you get healthcare services or supplies, so that people who file claims for you can see the information on it. Written notice of claim must be given within 20 days after a covered loss starts or as soon as reasonably possible. The notice may be given to us at our home office or to our agent. Notice should include the name of the Covered Person and the Policy number. Written proof of loss must be furnished to us at our said office within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event, except in the absence of legal capacity, will written proofs of loss be furnished later than one year from the time the proof is otherwise required.

5. Claim Forms

When we receive notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not given to the claimant within 15 days, the claimant will meet the proof of loss by giving us a written statement of the nature and extent of the loss.

6. Payment of Claims

All benefits provided in this Policy will be paid promptly upon receipt of due proof of loss. We will pay benefits as described in this Policy directly to the Provider when the Member receives covered services from a Network Provider. If a Member receives covered services from a non-Network Provider, we will pay benefits directly to the Member. The Member is then responsible for any payment to the non-Network Provider. No assignment of benefits is allowed to a non-Network Provider. Any payment of benefits or refund due after the death of a Member will be paid to the Member's estate.

7. Time of Payment of Claims

BlueChoice will pay completed claims received via paper within 40 business days and completed electronic claims within 20 business days following the later of 1) date the claim is received; or 2) the date on which the insurer receives all of the information needed in the format required for the claim to constitute a "clean" claim as defined in the South Carolina Health Care Financial Recovery and Protection Act.

8. Physical Examinations

The Company may require a physical exam, at its expense, of the Member as often as is reasonably necessary while a claim is pending.

9. Legal Actions

No action at law or equity can be brought against the Company until 60 days after a claim (notice and proof of loss) has been received or until the grievance procedure set forth below has been exhausted. No such action can be brought against the company more than six years after a claim was received.

10. Conformity with State Statutes

Any provision of this Policy that, on its effective date, is in conflict with the statutes of the federal government or the state of South Carolina on such date is hereby amended to conform to the minimum requirements of such statutes.

11. Non-Assessable

This is a non-assessable Policy. You - the Policy holder - are not subject to any assessment for any contingent liability. This means that if, for any reason, the company owes money, you are not responsible for paying it.

12. Other Valid Coverage: Proration

This Policy is not meant to duplicate other valid coverage you have with insurance policies; see the Medicare Coverage Provision on page 42.

If you have other valid coverage and BlueChoice HealthPlan has not been notified of this coverage by you in writing, the company will "prorate" benefit payments when your claim is received. The company will carefully consider all of the valid health insurance that covers your claims. Then, the company will determine its responsibility for your loss in proportion to the responsibility that should be accepted by other insurance companies. The company will pay the portion of your claim for which it is responsible.

If your claim is prorated, you will receive a refund of the portion of the Premiums you have paid for coverage that the company did not accept as its responsibility. This refund will be based on Premiums paid during the time both policies were in effect.

13. Right of Recovery

We have the right to recover any overpayments or mistakes made in payment. The recovery can be from any person to or for with respect to which such payments were made. Recovery will be by check, wire transfer or as an offset against existing or future benefits payable under this Policy, and any from other insurance companies or any other organizations.

14. Independent Corporation

The Member hereby expressly acknowledges its understanding that this Policy constitutes a Policy solely between the Member and BlueChoice HealthPlan of South Carolina, Inc. (BlueChoice HealthPlan), which is an independent corporation operating under a license from the Blue Cross® and Blue Shield® Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting BlueChoice HealthPlan to use the Blue Cross and Blue Shield service marks in the State of South Carolina, and that BlueChoice HealthPlan is not contracting as the agent of the Association. The Member further acknowledges and agrees that it has not entered into this Policy based upon representations by any person other than BlueChoice HealthPlan and that no person, entity or organization other than BlueChoice HealthPlan shall be held accountable or liable to the Member for any of BlueChoice HealthPlan's obligations to the Member created under this Policy. This paragraph shall not create any additional obligations whatsoever on the part of BlueChoice HealthPlan other than those obligations created under other provisions of this Policy.

15. Information and Records

BlueChoice HealthPlan is entitled to obtain such Authorization from you for medical and Hospital records from any Provider of services as is reasonably required in the administration of benefits described in this Policy. You agree that benefits for any professional or facility Covered Services are contingent upon receipt of such information or records. BlueChoice HealthPlan shall in every case hold such records as confidential except as authorized by you or as required by law.

The submission of a claim shall be deemed written proof of loss and written Authorization from you to BlueChoice HealthPlan to obtain any medical or financial records and documents useful to BlueChoice HealthPlan. BlueChoice HealthPlan is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at the time the claim is processed. Any party submitting medical or financial reports and documents to BlueChoice HealthPlan in support of your claim shall be deemed to be acting as your agent.

16. Relationship With Providers

You acknowledge and agree that BlueChoice HealthPlan shall not be liable for injuries resulting from negligence, malpractice, misfeasance, nonfeasance, or any other act or omission on the part of any Provider, employees thereof, or of any other person, in the course of performing services for Members.

17. Medical Loss Ratio

Individual Policies must meet certain medical loss ratio requirements as required by federal law. If all individual coverage policies issued by BlueChoice HealthPlan of South Carolina does not meet the medical loss ratio requirement, we will issue medical loss ratio rebates. These rebates may be in form of a lump-sum check, credit or debit card reimbursement, pre-paid debit or credit cards or Premium credits. A Premium credit means you will not be required to pay your Premium or a portion of your Premium for a specified period of time. However, after the specified time, you must again pay your Premiums.

Each year by a date determined by Health and Human Services, you will receive notice if you are due a Medical Loss Ratio rebate for the previous year. Every Member's rebate will be in the same form, unless the Member is no longer active. If the Member is no longer active, the rebate will always be in the form of a lump-sum check.

18. Policies and Procedures

The Company may adopt reasonable policies, procedures, rules, and interpretations to promote the orderly and efficient administration of the Policy with which Members shall comply.

19. Fees

We may charge you a fee if your Premium payment is returned for non-sufficient funds (NSF). The NSF fee is $25.

20. Medicare Coverage

If you are enrolled in another insurance coverage, such as Medicare, that offers medical coverage for any of the benefits under this Policy, BlueChoice may reduce benefits under this Policy to avoid paying benefits between the two plans that are greater than the cost of the health care service. If you and/or your Dependents become eligible for Medicare, you should apply and enroll in Medicare Part A and B, and use Providers who accept Medicare in order to ensure that you receive full benefit coverage. Based on Medicare Secondary Payor legislation, regulations and Centers for Medicare & Medicaid Services guidance, BlueChoice assumes you will enroll in Medicare once you are eligible, and BlueChoice may take into account the benefits that you or your Dependent are eligible for under Medicare, regardless of whether you have actually enrolled for that coverage. In other words, even if you have not enrolled in Medicare, BlueChoice may reduce your claim by the benefits that you are eligible for under Medicare, and then pay the remaining claim amount under the terms of this Policy and in accordance with Medicare coordination rules. As a result, your Maximum out-of-pocket costs may be higher if you do not enroll in Medicare.

The coordination of benefits (COB) process ensures that claims are paid correctly by identifying the health benefits available to a Medicare beneficiary, coordinating the payment process, and ensuring that the primary payer (Medicare) pays first. It also ensures that the amount paid by plans in dual coverage situations does not exceed 100% of the total claim, to avoid duplicate payment. Even if you have not enrolled in Medicare Part B, we will coordinate benefits and reduce your claim(s) by the benefits that you would be eligible for under Medicare Part B. This may result in physicians billing you for services that were only partially covered under your Blue Option plan.

DEFINITIONS

This section defines the terms used throughout this Policy and is not intended to describe covered and non-Covered Services. The terms defined in this section have their defined meaning whenever they are capitalized. Any term in this Policy which has a different medical and non-medical meaning and which is undefined is intended to have the medical meaning.

Accidental Injury:
An injury directly and independently caused by a specific accidental contact with another body or object. All injuries you receive in one accident, including all related conditions and recurrent symptoms of these injuries, will be considered one injury. Accidental Injury does not include indirect or direct loss that results in whole or in part from a disease or other illness.

Admission:
The period of time between a Member's entry as a registered bed-patient in a Hospital or Skilled Nursing facility and the time the Member leaves or is discharged from the Hospital or Skilled Nursing Facility. The Admission may be on an inpatient or outpatient basis as determined by the Provider.

Allowed Amount or Allowable Charge:
The amount we or a member of the Blue Cross and Blue Shield Association agrees to pay a Participating Provider/contracting Provider or non-Participating Provider/non-contracting Provider as payment in full for a service, procedure, supply or equipment. For a non-Participating Provider/non-contracting Provider, (i) the Allowed Amount shall not exceed the Maximum Payment and (ii) in addition to the Member's liability for benefit year Deductibles, Copayments and/or Coinsurance, the Member may be balance billed by the non-Participating Provider/non-contracting Provider for any difference between the Allowed Amount and the billed charge.

Ambulatory Surgical Center:
A facility that is licensed for Outpatient Surgery only and doesn't provide overnight accommodations or around-the-clock care. The care must be provided under the supervision of a Physician. It also must provide nursing services by or under the supervision of an on duty registered nurse (RN). The facility must not be an office or clinic for the private practice of a Physician.

Application:
The electronic or paper form to transmit the necessary information from the Member to us when applying for this Policy. The form becomes a part of this Policy.

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

Authorized or Authorization:
All inpatient, certain outpatient services and certain Prescription Drugs must be Authorized prior to the services being received. If prior Authorization is not received, benefits may be reduce or denied. Services or supplies provided must be in accordance with the approval given in order to receive benefits from this plan.

Balance Billing:
When a Provider bills you for the difference between the Provider's charge and the Allowed Amount or for the penalties for not obtaining Authorization. For example, if the Provider's charge is $100 and the Allowed Amount is $70, the Provider may bill you for the remaining $30. A Network Provider may ***not*** Balance Bill you for Covered Services, unless the required Authorization was not obtained.

Behavioral Health:
Comprehensive term to include Mental Health and Substance Use Disorder services.

Benefit Percentage:
The percentage of the Allowed Charges we pay once you have met the Benefit Period Deductible and/or Copayment. For example, if you pay 20 percent as Coinsurance; the 80 percent we pay is the Benefit Percentage.

Benefit Period:
A period beginning January 1st and continuing through December 31st. Your first Benefit Period begins on our effective date of coverage and lasts until December 31st.

Benefit Period Maximum:
The maximum number of days or visits that benefits will be provided for a Covered service in a Benefit Period.

BlueCard® Program:
The national program in which all Blue Cross and Blue Shield Licensees participate, including BlueChoice HealthPlan. This national program benefits BlueChoice HealthPlan Members who receive Covered Services outside BlueChoice HealthPlan's Local Service Area.

BlueChoice or BlueChoice HealthPlan:
Trade name for BlueChoice HealthPlan of South Carolina, Inc.

Certificate of Creditable Coverage:
A document from a previous health insurance plan or insurer that says you had prior Health Insurance Coverage with them. You should receive a Certificate of Creditable Coverage after your prior Health Insurance Coverage ends.

Coinsurance:
A percentage of the Allowed Amount that you pay. This percentage applies to the negotiated rate or lesser charge when we have negotiated rates with that Provider. For example, if you pay 20 percent of the Allowed Amount and we pay 80 percent.

Company:
BlueChoice HealthPlan.

Copayment:
A set amount (for example, $50 for an office visit) for some services.

Covered Services:
The services that are covered under the insurance Policy. See the Covered Services section.

Custodial Care:
Care that we determine is provided primarily to assist the patient in the activities of daily living and does not require a person with medical training to provide the services. Custodial Care includes, but is not limited to, activities such as bathing, eating, dressing, toileting, continence, transferring, preparation of special diets and supervision over self-administered medications.

Deductible:
The amount you are responsible for paying for Covered Services before we begin to pay each year. The Deductible may not apply to all Covered Services. If you have family coverage, the family Deductible is either aggregate or embedded. Your Schedule of Benefits will show whether your Deductible is aggregate or embedded. An **Aggregate Deductible** means the entire family Deductible must met before benefits begin to pay each year. An **Embedded Deductible** means that benefits will begin paying for a Member once that Member meets the single Deductible for that year. Coupons for medical services and/or Prescription Drugs may not be used to satisfy the Deductible.

Dependent:
Your legal spouse and any children (natural or adopted, step, folder or under your legal guardianship) through age 25.

Durable Medical Equipment (DME):
Equipment ordered by a health care Provider that has exclusive medical use. These items must be reusable and may include: wheelchairs, hospital-type beds, walkers, Prosthetic Devices, orthotics devices, oxygen, respirators, etc. To be considered DME the device or equipment's use must be limited to the patient for whom it was ordered.

Emergency:
An unexpected and usually dangerous situation that calls for immediate action.

Emergency Medical Condition:
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm. This includes illness or injury to an unborn child.

Essential Health Benefits:
Items and services within the following 10 benefit categories:
1) ambulatory patient services,
2) Emergency services,
3) hospitalization,
4) maternity and newborn care,
5) Mental Health and substance use disorder services, including Behavioral Health treatment,
6) prescription drugs,
7) rehabilitative and habilitative services and devices,
8) laboratory services,
9) preventive and wellness services and chronic disease management, and
10) pediatric services, including oral and vision care.

Excluded Services:
Health care services that this Policy doesn't provide benefits for or cover.

Genetic Information:
Information about your genetic tests or the genetic tests of your family Members, or any request of or receipt by you or your family members of genetic services. Genetic Information does not include the age or sex of any individual.

Habilitation Services:
Healthcare services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of impatient and /or outpatient settings. All services must be provided by a licensed physical, occupational or speech therapist.

Health Insurance Coverage:
Benefits for medical care provided directly, through insurance, reimbursement or otherwise. It does not include benefits or coverage provided under:

1. Coverage for accident or disability income insurance, or any combination of the two;
2. Coverage issued as a supplement to liability insurance;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Workers' Compensation or similar insurance;
5. Automobile medical payment insurance;
6. Credit-only insurance;
7. Coverage for on-site medical clinics;
8. Other similar insurance coverage that's specified in regulations where benefits for medical care are secondary or incidental to other insurance benefits;
9. If offered separately:
    a. Limited scope dental or vision benefits;
    b. Benefits for Long-term Care, nursing home care, home health care, community-based care or any combination of them;
    c. Such other similar, limited benefits as specified in regulations;
10. If offered as independent, non-coordinated benefits:
    a. Coverage only for a specified disease or illness;
    b. Hospital indemnity or other fixed indemnity insurance;
11. If offered as a separate insurance Policy:
    a. Medicare supplemental Health Insurance;
    b. Coverage to supplement coverage provided under Military, TRICARE; and
    c. Coverage to supplement coverage under a group health plan.

Health Status-Related Factor:
Any one of these: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, Genetic Information, evidence of insurability, and including conditions arising out of acts of domestic violence or disability.

Hospital:
An acute-care facility that:

1. Is licensed and operated according to the law; and
2. Primarily and continuously provides or operates medical, diagnostic, therapeutic and major surgical Facilities for the medical care or Behavioral Health care and treatment of injured or sick people on an Inpatient basis. The care must be provided under the supervision of a staff of duly licensed Physicians; and
3. Provides 24-hour nursing services by or under the supervision of registered nurses (RNs).

The term Hospital does not include long-term, chronic-care institutions or institutions (even when affiliated with or a part of the Hospital) that are, other than incidentally:

1. Convalescent, rest or nursing homes or Facilities; or
2. Facilities primarily affording custodial, educational or rehabilitory care.

Incapacitated Dependent:
A child who is: (1) incapable of self-support because of developmental disability, mental illness or physical incapacity which began before the child reached the limiting age; and (2) mainly dependent upon you for support and maintenance. The child must have developed the handicap before he or she reached the age at which coverage would otherwise terminate. Coverage of an Incapacitated Dependent will continue beyond the attainment of the limiting age, provided proof of such incapacity and dependency is furnished to BlueChoice HealthPlan by you within 31 days of such child's attainment of that limiting age, as long as Coverage remains in force for you. For the child to remain covered, we must receive a Physician's written report at least every two years.

Inpatient:
A registered bed patient in a Hospital, Skilled Nursing Facility, Rehabilitation Facility or Mental Health or Substance Use Disorder Facility for whom a room and board charge is made.

Investigational or Experimental:
Surgical or medical procedures, supplies, devices or drugs which, at the time provided, or sought to be provided, are in our judgement, not recognized as conforming to generally accepted medical practice in the United States, or the procedure, drug or device:

1. Has not received final approval in the United States to market from appropriate government bodies;
2. Is one about which the peer-reviewed medical literature in the United States does not permit conclusions concerning its effect on health outcomes;
3. Is not demonstrated in the United States to be as beneficial as established alteratives;
4. Has not been demonstrated in the United States to improve net health outcomes; or
5. Is one in which the improvement claimed is not demonstrated in the United States to be obtainable outside the Investigational or Experimental setting.

Long-term Care:
Services that are not reasonably expected to result in measurable functional improvement in a reasonable and predictable period of time.

Maximum Out-of-pocket:
The most you pay for Covered Services in a year before this Plan begins to pay 100% of the Allowed Amount. This limit never includes your Premium, Balance-Billed charges, health care your Plan doesn't cover or coupons for medical and/or prescription coverage.

Maximum Payment:
The maximum amount we will pay (as determined by us) for a particular benefit. The Maximum Payment will not be affected by any credit. The Maximum Payment will be one of the following as determined by us in our discretion:

1. The actual charge submitted to us for the service, procedure, supply or equipment by a Provider;
2. An amount based upon the reimbursement rates established by the plan sponsor in its benefits checklist;
3. An amount that has been agreed upon in writing by a Provider and us or a member of the Blue Cross and Blue Shield Association;
4. An amount established by us, based upon factors including, but not limited to, (i) governmental reimbursement rates applicable to the service, procedure, supply or equipment, or (ii) reimbursement for a comparable or similar service, procedure, supply or equipment, taking into consideration the degree of skill, time and complexity involved, geographic location and circumstances giving rise to the need for the service, procedure, supply or equipment;

5. The lowest amount of reimbursement we allow for the same or similar service, procedure, supply or equipment when provided by a Participating Provider/contracting Provider; or
6. The Medicare reimbursement rates.

Medically Necessary:
Health care services that a Provider, exercising prudent clinical judgment, would provide to prevent, evaluate, diagnose or treat an illness, injury, disease or its symptoms, and that are:
1. In accordance with generally accepted standards of medical practice; or
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; or
3. Not primarily for the convenience of the patient, caregiver, Physician or other health care Provider; or
4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For the purpose of determining Medically Necessary/Medical Necessity:
- We have the discretion to utilize and rely upon medical and behavioral health (which includes substance use and mental health) standards, policies, guidelines, criteria, protocols, manuals or publications, either developed by us or, in our discretion, determined to be generally accepted by the medical and behavioral health community; and
- "Generally Accepted Standards of Medical Practice" means United States standards that are based on credible scientific evidence published in peer-reviewed medical and/or behavioral health literature generally recognized by the relevant United States Medical and or behavioral health community, Physician or behavioral health specialty society recommendations, and/or any other relevant factors determined in our discretion; and
- Our use of, including but not limited to, Corporate Administrative Medical ("CAM") Policies, Technology Evaluation Center ("TEC") Assessments, Utilization Management Level of Care Criteria and Clinical Protocols, and MCG Health, LLC Care Guidelines reflect and are clinically appropriate health care services and generally accepted standards of medical and behavioral health practice.

Member:
A person insured under this Policy.

Mental Health:
Conditions defined, described or classified as psychiatric disorders or conditions in the latest publication of The American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*.

Minimum Essential Coverage:
Any of the following: 1) coverage under certain government-sponsored plans; 2) employer-sponsored plans, with respect to any employee; 3) plans in the individual market; 4) grandfathered health plans; and 5) any other health benefits coverage, such as a state health benefits risk pool, as recognized by the Health and Human Services Secretary.

Network:
The facilities, Providers and suppliers we have contracted with to provide health care services.

Outpatient:
Receiving services or supplies in a setting that does not require an overnight stay.

Participating:
The relationship whereby a Provider of Covered Services has entered into a written agreement with BlueChoice HealthPlan to provide Covered Services to Members. The Participating status of a Provider may change from time to time. Providers who take part in the BlueCard program are considered to be Participating Providers in the context of this Policy.

Physician and other Clinicians:
A person (other than an intern, resident or house Physician) duly licensed as a medical doctor, dentist, oral surgeon, podiatrist, osteopath, chiropractor, optometrist, ophthalmologist, Physician's assistant, licensed independent social worker or licensed doctoral psychologist, legally entitled to practice within the scope of his or her license and who normally bills for his or her services.

Policyholder:
You, or a parent or a legal guardian who purchased this insurance Policy to cover the Member and who is the owner of the Policy and payer of the Premiums.

Premium:
The amount that must be paid for your health insurance or plan.

Prescription Drug Deductible:
The amount you are responsible for paying for Covered Prescription Drug Services before we begin to pay each year. This Deductible is separate from the medical Deductible and does not count toward the medical Deductible. The medical Deductible does not apply toward the Prescription Drug Deductible.

Prescription Drug List:
A listing of Prescription Medications approved for a specified level of benefits by BlueChoice HealthPlan. This list shall be subject to periodic review and modification by BlueChoice HealthPlan. The most up-to-date version of the Prescription Drug List is always available on the BlueChoice HealthPlan website.

Prescription Medication:
A drug, including insulin, which has been determined to be safe and effective by the Food and Drug Administration (FDA) and which can, under Federal or State law, only be dispensed when ordered by a Physician who is duly licensed to prescribe such medication. The benefit for Prescription medication also includes:

1. Syringes and related supplies for conditions such as diabetes; and
2. Specific classes of over-the-counter medications designated as Prescription Medication by BlueChoice HealthPlan. If so designated, these classes of over-the-counter medications must be purchased at a Participating pharmacy with a prescription from a Participating Physician. The designated over-the counter medications will be listed in the Prescription Drug List.

Primary Care Physician:
A Participating family doctor, general Physician, OB/GYN, pediatrician, osteopath or internal medicine Physician.

Prosthetic Devices:
Artificial replacement body parts needed to ease or correct a condition caused by an illness, injury or birth defect, disease or anomaly. A Physician must order the appliance or device. Prosthetics do not include bioelectric, microprocessor or computer programmed prosthetic components.

Provider:
Any of the following: A facility, Hospital, Skilled Nursing Facility, Rehabilitation/Habilitation facility, Mental Health or Substance Use Disorder facility, Residential Treatment Facility, Physician, Psychologist, and other Mental Health Clinicians, clinic and an Ambulatory Surgical Center licensed as required by the state where located, performing within the scope of the license, and acceptable to us or as listed. Providers also include:

1. Durable Medical Equipment supplier
2. Independent clinical laboratory
3. Occupational, Physical and Speech therapist
4. Pharmacy
5. Home Health Care Provider
6. Hospice Services Provider
7. Behavioral Health

Rehabilitation Facility:
A Hospital or other freestanding medical facility that has a written agreement with us to provide services directed toward restoring full function and independent living for patients with neurological or other physical illnesses or injuries. These services consist of a multidisciplinary therapeutic program that includes physical therapy, occupational therapy and other therapeutic on an Inpatient or Outpatient basis.

Rehabilitation Services:
Health care services that help a person improve skills and functioning that have been lost or impaired due to an illness or injury. These services may include physical, occupational and speech therapy services in a variety of inpatient and/or outpatient settings. The services must be provided by a licensed physical, occupational or speech therapist.

Residential Treatment Center:
A licensed institution, other than a Hospital, which meets all six of these requirements:

1. Maintains permanent and full-time Facilities for bed care of resident patients; and
2. Has the services of a Psychiatrist (Addictionologist, when applicable) or Physician extender available at all times and is responsible for the diagnostic evaluation, provides face-to-face evaluation services with documentation a minimum of once/week and PRN as indicated; and
3. Has a Physician or registered nurse (RN) present onsite who is in charge of patient care along with one or more registered nurses (RNs) or licensed practical nurses (LPNs) onsite at all times (24/7); and
4. Keeps a daily medical record for each patient; and
5. Is primarily providing a continuous structured therapeutic program specifically designed to treat Behavioral Health disorders and is not a group or boarding home, boarding or therapeutic school, half-way house, sober living residence, wilderness camp or any other facility that provides Custodial Care; and
6. Is operating lawfully as a residential treatment center in the area where it is located.

Schedule of Benefits:
The pages issued to you as a part of this Policy that specify the amount of coverage provided, your Copayments, Coinsurance, Deductibles and limitations.

Skilled Nursing Facility:
A licensed institution, other than a Hospital, that has a written agreement with us or another Blue Cross and/or Blue Shield plan, which meets all six of these requirements:

1. Maintains permanent and full-time Facilities for bed care of resident patients; and
2. Has the services of a Physician available at all times; and
3. Has a registered nurse (RN) or Physician on full-time duty who is in charge of patient care along with one or more registered nurses (RNs) or licensed practical nurses (LPNs) on duty at all times; and
4. Keeps a daily medical record for each patient; and
5. Is primarily providing continuous skilled nursing care for sick or injured patients during the recovery stage of their illnesses or injuries and is not, other than incidentally, a rest home or a home for Custodial Care for the aged; and
6. Is operating lawfully as a skilled nursing home in the area where it is located.

In no event, will the term "Skilled Nursing Facility" include an institution that mainly provides care and treatment for Substance Use Disorder or Mental Health Services.

Sound Natural Tooth:
Teeth that are free of active or chronic decay, have at least 50 percent bony support, are functional in the arch and have not been excessively weakened by multiple dental procedures. Also includes teeth that have been restored to normal function.

Specialist:
A Physician who is not a Primary Care Physician.

Substance Use Disorder:
The continued use, abuse and/or dependence of legal or illegal substance(s), despite significant consequences or marked problems associated with the use as defined, described or classified in the latest publication of The American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*.

Surgery:
1) The performance of generally accepted operative and cutting procedures including endoscopic examinations and other invasive procedures; 2) the correction or treatment of fractures and dislocations, including the placement of casts; and 3) other procedures deemed as reasonable and approved by us. This includes the usual necessary and related pre- and post-operative care.

Telemedicine:
Providing medical care using an interactive two-way telecommunications system (like real-time audio and video) that is compliant with the Health Insurance Portability and Accountable Act's security rules by an eligible Provider who is at different location from you.

Telemonitoring:
Services where a Member transmits, whether by facsimile, e-mail, telephone or any other format, his or her specific health data (e.g. blood pressure, weight, etc.) to a Provider. Telemonitoring services are not covered.

Tier:
The level(s) of coverage specified on the Prescription Drug List with respect to Prescription Medication. The Prescription Drug List includes drugs on different Tiers, each with its own Copayment and/or Coinsurance levels. Drug are chosen for each level based on their value, which takes into consideration their clinical benefit (how well they work) and also their cost.

Urgent Care:
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency room care.

Urgent Treatment Center:
A medical facility where ambulatory patients can be treated on a walk-in basis, without appointment, and receive immediate non-Emergency care. It does not include a Hospital Emergency room.