BlueChoice® Individual Coverage

www.BlueChoiceSC.com

BlueChoice HealthPlan of South Carolina is an Independent Licensee of the Blue Cross and Blue Shield Association.

Contract - Plan 2

BlueChoice® Individual Coverage
Plan 2

BlueChoice Health Plan of South Carolina, Inc.
Post Office Box 6170
Columbia, South Carolina 29260-6170
786-8476 in Columbia

Individual Health Maintenance Organization Coverage
Contract Form. No. CHCPOL.01

Outline of Coverage

If you need information about this health coverage:

Call BlueChoice HealthPlan's Member Services department. From Columbia, dial 786-8476. From anywhere else in the state, dial 800-868-2528, toll free. You may also send your inquiries through the Web site at www.BlueChoiceSC.com.

Read Your Contract Carefully

This Outline of Coverage provides a very brief description of the important features of BlueChoice Individual Coverage. This is not the contract and only the actual contract provisions will control the contract. The contract itself sets forth in detail the rights and obligations of you and BlueChoice HealthPlan. Please refer to your contract, which accompanies this Outline of Coverage. It gives special instructions on how to obtain authorization and how to handle an emergency.

Individual Health Maintenance Organization Coverage

BlueChoice Individual Coverage is specifically designed for you to use your primary care physician and other medical professionals with whom BlueChoice HealthPlan has a contract. All care must be provided by or authorized in advance by your primary care physician and BlueChoice HealthPlan except in a medical emergency. You must select a primary care physician from BlueChoice HealthPlan's list of participating primary care doctors. There are no claim forms when contracting doctors are used and few out-of-pocket expenses. Deductibles, copayments, coinsurance provisions or limitations set for in the contract are applicable.

Important

Here is the most important thing you need to remember about BlueChoice Individual Coverage:

All care, except for emergency services, must be provided by your primary care physician or authorized in advance by your primary care physician and BlueChoice HealthPlan.

Benefits Descriptions - Plan 2

Services	**Benefits**
Primary Care Physician Services	100% after $15 Copayment per office visit
Routine, Preventive Office Services	100% after $15 Copayment per office visit
Inpatient Hospital Care	80% after Deductible
Outpatient Hospital Care	80% after Deductible
Specialist Physician Services	80% after Deductible
Urgent Care	100% after $35 Copayment per visit
Mental Health (office services only)	100% after $25 Copayment per visit; up to 20 visits per Benefit Period
Prescription Drugs (Prescription drugs are each subject to one copayment for up to a 31-day supply)	100% after $7 Copayment for Generic Drugs 100% after $30 Copayment for Preferred Drugs 100% after $50 Copayment for Non-Preferred Drugs
Specialty Pharmaceuticals	100% after $100 Copayment
Vision Care	One eye exam per Benefit Period
Dental Care	Up to $20 for one exam and $30 for one cleaning per Benefit Period
Deductible	$500 per Benefit Period
Lifetime Maximum	$2,000,000
Prescription Drug Maximum	Unlimited
Durable Medical Equipment Maximum	$5,000 per Benefit Period
Physical Therapy, Speech Therapy, & Occupational Therapy Maximum	$5,000 per Benefit Period
Coinsurance Maximum	$2,000 per Benefit Period

This is only a brief description of benefits. For a complete Schedule of Benefits, please refer to the contract.

Some Services And Supplies That Are Not Covered By BlueChoice Individual Coverage

There are some services and supplies that the person may receive which are not covered by BlueChoice Individual Coverage.

Listed below are a few examples of services and supplies which are not covered:

- Mental or emotional disorders, alcoholism and drug addiction except as provided under Mental Health Services. Treatment of Attention Deficit-Hyperactivity Disorder (ADHD) is not covered.
- Normal pregnancy and childbirth except for complications of pregnancy

For a complete listing of services and supplies that are not covered, please refer to the contract.

Pre-Existing Conditions

Pre-existing conditions are those conditions for which medical advice or treatment was received or recommended no more than 12 months prior to the effective date of your coverage. Services or supplies for pre-existing conditions are not covered until the earlier of:

1. A period of 12 months without medical care, treatment, or supplies related to the pre-existing condition ending after the effective date of coverage or
2. 12 months after the effective date of coverage.

Waiting Periods

After the effective date of your coverage under this contract, there are some waiting periods during which no coverage is provided for treatment of certain specified diseases or conditions or losses resulting therefrom. The waiting periods for this contract are stated below:

- Six months for adenoids
- Six months for appendix
- Six months for disorders of reproductive systems
- Six months for hemorrhoids
- Six months for hernia
- Six months for tonsils
- Six months for varicose veins

These waiting periods do not apply in case of an emergency if there is no previous medical history of the condition prior to the effective date of your coverage.

Guaranteed Renewable Except For Stated Reasons

The company shall renew or continue in force the contract at the person's option. The company may nonrenew or discontinue this contract based only on one of the following reasons:

- Failure to pay premiums
- Fraud or material misrepresentation
- Discontinuance of this type of coverage by the company
- The person no longer resides, works or lives in South Carolina
- The person reaches age 30

However, the company will not decline to renew the contract simply because of a health status-related factor. This is only a brief description. Please see the contract for more details on renewability, termination of coverage and conversion privileges.

Contract Term

This contract is renewable monthly up to age 30, subject to the renewal and termination provisions of this contract.

About Premiums

The company has the right to change the table of premiums on a class basis. If this table of premiums changes, the person will be notified at least 31 days in advance of the date that the change affects you. Note that the person's premium also changes as the person enters an older attained age group. If premiums change, the person pays the new rates the next time the premium is due.

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BlueChoice Individual Coverage
SCHEDULE OF BENEFITS – PLAN 2

In order to receive benefits, all care must be provided by the member's primary care physician or authorized in advance by the primary care physician and the company, unless otherwise noted. This applies to each and every individual service or treatment unless otherwise noted. Benefits are subject to all terms, conditions, limitations, exclusions and maximums in this contract.

Deductible per Benefit Period	$500	
Maximum Coinsurance per Benefit Period	$2,000	
BENEFITS	**Member Pays**	**Plan Pays** *after copay/ deductible*
Physician Services		
Primary Care		
Office Services	$15 Copayment per visit	100%
Routine, Preventive Services	$15 Copayment per visit	100%
Hospital Services	$0	100%
Specialty Care		
(except mental health/substance abuse care)		
Office Services	Deductible, then 20%	80%
Hospital Services	Deductible, then 20%	80%
Mental Health Benefits (office services only)	$25 per visit	100%
Other Services		
Ambulance	Deductible, then 20%	80%
Durable Medical Equipment	Deductible, then 20%	80%
Home Health	Deductible, then 20%	80%
Hospice	Deductible, then 20%	80%
Medical Supplies	Deductible, then 20%	80%
OP Private Duty Nursing	Deductible, then 20%	80%
Physical, Speech & Occupational Therapy	Deductible, then 20%	80%
Prosthetic Devices	Deductible, then 20%	80%
Facility Services		
Inpatient Hospital	Deductible, then 20%	80%
Skilled Nursing Facility & Long-Term Acute Care Facility	Deductible, then 20%	80%
Outpatient Services	Deductible, then 20%	80%
Urgent Care Services – for services provided by a participating urgent care center	$35 Copayment per visit	100%
Emergency Room Services	Deductible, then 20%	80%
Dental Services		
One exam per Benefit Period	100% after $20	$20
One cleaning per Benefit Period	100% after $30	$30

BlueChoice Individual Coverage
SCHEDULE OF BENEFITS – PLAN 2

In order to receive benefits, all care must be provided by the member's primary care physician or authorized in advance by the primary care physician and the company, unless otherwise noted. This applies to each and every individual service or treatment unless otherwise noted. Benefits are subject to all terms, conditions, limitations, exclusions and maximums in this contract.

BENEFITS	Member Pays	Plan Pays *after copay/ deductible*
Vision Exam One complete eye exam for glasses per Benefit Period for services provided by participant in the Physicians Eye Network (PEN)	$0	100%
Prescription Medication Generic Drugs Preferred Drugs Non-Preferred Drugs **Retail pharmacy**: Prescription Medications are each subject to one Copayment for up to a 31-day supply. **Mail-order pharmacy:** Prescription Medications are each subject to two Copayments for up to a 90-day supply. Not all medications are available from the mail-order pharmacy.	 $7 $30 $50	 100% 100% 100%
Specialty Pharmaceuticals Not subject to the Prescription Medication Maximum	$100 Copayment	100%
PLAN MAXIMUMS		
Lifetime Benefit Maximum	$2,000,000	
Prescription Medication	None	
Durable Medical Equipment	$5,000 per Benefit Period	
Physical, Speech & Occupational Therapy	$5,000 per Benefit Period	
Organ Transplants (Covered Transplants)	**Maximum Benefit per Transplant**	
Kidney (single)	$60,000	
Pancreas and Kidney	$80,000	
Heart	$120,000	
Lung (single)	$130,000	
Liver	$225,000	
Pancreas	$80,000	
Heart and Lung	$175,000	
Bone Marrow/Stem Cell	$250,000	
Cornea	$25,000	
Lifetime Transplant Maximum Benefit	$250,000	

The Benefit Period is 12 consecutive months from the effective date of coverage.

BLUECHOICE® INDIVIDUAL COVERAGE CONTRACT

Your Right to Examine This Contract

You have 30 days to examine this contract. If you're 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 contract during this 30-day examination period, you may not then return the contract and receive a refund of the premium paid.

Contract Term

This contract is renewable monthly up to age 30, subject to the renewal and termination provisions of this contract.

Guaranteed Renewable Except For Stated Reasons

Except as provided in this section, the company shall renew or continue in force this contract at your option. The company may nonrenew or discontinue this contract based only on one or more of the following reasons:

1. You have failed to pay premiums in accordance with this contract or the company has not received timely premium payments.
2. You have performed an act or practice that constitutes fraud or made a material misrepresentation of material fact under the terms of the coverage.
3. The company is ceasing to renew this contract for everyone who has this type of contract. However, coverage may only be discontinued if the company:
   A. Provides notice to each covered individual of the discontinuance at least 90 days before the date the contract ends,
   B. Offers to each covered individual the option to purchase other individual coverage currently offered by the company, and
   C. Acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for coverage in exercising the option to discontinue the contract or offering the option to purchase other individual coverage.
4. You no longer reside, work or live in the company's service area or in the area in which the company is licensed to do business. This area is the state of South Carolina.
5. You reach the age of 30. See your rights under Conversion Privilege if your contract is nonrenewed for this reason.
6. At the time of renewal, the company may modify the BlueChoice Individual Coverage contract for everyone who has it as long as the modification is consistent with state law and effective on a uniform basis.

However, the company will not decline to renew your contract simply because of a health status-related factor.

About Premiums

Your initial premium is payable in advance of the effective date of this contract. From then on, subsequent premiums must be paid on or before the first day of each month.

The current premiums charged for each attained age group eligible for this contract are shown on the premium rate sheet. The company has the right to change this table of premiums on a class basis. If this table of premiums changes, you will be notified at least 31 days in advance of the date that the change affects you. Note that your premium also changes as you enter an older attained age group. If premiums change, you pay the new rates the next time your premium is due.

Mary P. Mazzola Spivey
President and Chief Operating Officer
BlueChoice® HealthPlan of South Carolina, Inc.

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BLUECHOICE® INDIVIDUAL COVERAGE
HEALTH COVERAGE

Important

BlueChoice HealthPlan of South Carolina, Inc. is a Health Maintenance Organization. BlueChoice Individual Coverage is specifically designed for you to use your primary care physician and other medical professionals with whom BlueChoice HealthPlan has a contract. All care must be provided by or authorized in advance by your primary care physician and BlueChoice HealthPlan. This applies to each and every individual service or treatment except for Dental and Vision Care as discussed below and Emergency Services.

GENERAL INFORMATION

WHEN YOUR COVERAGE BEGINS AND ENDS

Eligibility. BlueChoice Individual Coverage is available to persons at least six weeks of age and less than 30 years of age. If you are in this age category and live in the state of South Carolina, BlueChoice Individual Coverage may be purchased for you by your parents, grandparents or legal guardians. You may also purchase it yourself if you are at least 18 years of age.

Contract: When It's Valid. It takes three things to put this contract into effect. The first is your application. The second is your first payment. The third is for your application to be accepted by BlueChoice HealthPlan. The contract goes into effect on the first day of the month after the company accepts your application. Your coverage will become effective at 12:01 a.m. local time at your residence.

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

Termination of Your Coverage. Your coverage will end at 12:01 a.m. (1) on the date you request in writing or the date the company receives the request (whichever is later); or (2) on the date the contract lapses or is non-renewed. 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, you must contact the Company.

CONVERSION PRIVILEGE

If you cease to be eligible because you have reached the limiting age of this policy, you are entitled to coverage under a direct pay conversion policy. The conversion policy is available without evidence of insurability and upon notice made and premium payment to BlueCross® BlueShield® of South Carolina. Such notice of election must be made to BlueCross BlueShield of South Carolina within 60 days of the loss of coverage under this policy. Coverage under such conversion contract will commence from the date of termination of coverage under this policy if the Notice of Election for conversion is made and premium paid within the first 31 days. If Notice of Election is made from the 32nd through the 60th day, the conversion

coverage will be effective on the date of the Notice of Election and the conversion policy may provide that it does not cover any expenses incurred prior to the date the Notice of Election was submitted.

Extension of Benefits after Termination of Coverage. If the company does not renew or terminates your contract and you are in the hospital or continuously disabled when your coverage under this contract ends, benefits will be provided while you remain continuously disabled for the same cause. Benefits are subject to the terms, conditions, exclusions and limitations of the contract. This coverage will continue until you are no longer disabled, you use up all of your benefits, or 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 "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 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.

EMERGENCY PROCEDURES

Coverage for treatment of an emergency medical condition continues only so long as the state of emergency exists as determined by the medical director of BlueChoice HealthPlan. Any follow-up care must be either provided by your primary care physician or authorized by your primary care physician and approved by BlueChoice HealthPlan. If you have an emergency inside or outside the local service area and have no control over where you are taken, you or a member of your family should notify BlueChoice HealthPlan within 24 hours or the next working day, whichever is later. BlueChoice HealthPlan must be promptly notified to assure payment for services.

For An Emergency That Occurs Within The BlueChoice HealthPlan Local Service Area:

1. Call your primary care physician and identify yourself as a BlueChoice HealthPlan member.
2. State "This is an emergency." Your call will be given priority. You may be given first-aid advice, be directed to your physician's office, hospital or another provider for needed treatment.
3. If contacting your primary care physician is impractical because of the severity of the emergency you should call 911 or go to the nearest hospital or physician for treatment.

For An Emergency That Occurs Outside The BlueChoice HealthPlan Local Service Area:

1. Go to the nearest hospital or physician for treatment and present your BlueChoice HealthPlan ID card.
2. Request the bill for services be sent to BlueChoice HealthPlan.
3. Notify BlueChoice HealthPlan within 24 hours or the next working day, whichever is later, if you are admitted to a hospital.
4. If you paid for treatment, forward all itemized bills to BlueChoice HealthPlan for consideration of payment.

Non-emergency care outside the local service area is not covered.

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 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 hospitals and/or physicians which independent Blue Cross and Blue Shield Licensee is yours.

If you need care while away from home, follow these easy steps:

1. Always carry your current BlueChoice HealthPlan ID card for easy reference and access to service.
2. In an emergency, go directly to the nearest hospital.
3. Call your primary care physician or BlueChoice HealthPlan for prior authorization and/or pre-certification, if necessary.
4. To find names and addresses of nearby doctors and hospitals, visit the BlueCard Doctor and Hospital Finder Web site (www.BCBS.com) or call BlueCard Access at 800-810-BLUE.
5. When you arrive at the participating doctor's office or hospital, simply present your BlueChoice HealthPlan ID card.

After you receive care, you should not have to complete any claim forms. Nor should you have to pay for medical services other than your usual out-of-pocket expenses (non-covered services, deductible, copayment, and coinsurance).

PRIMARY CARE PHYSICIANS AND PARTICIPATING PROVIDERS

Primary Care Physician. When you enrolled in BlueChoice Individual Coverage, you selected a primary care physician. Your primary care physician has access to the skills and support of specialists and other health personnel who are part of a comprehensive health care delivery network. In order to receive benefits, you should receive all covered services (except for emergency services) from the selected primary care physician, or the provider authorized by the primary care physician and the company.

Preventive or routine services are covered under the contract when provided or ordered by your primary care physician.

You may change to a different primary care physician at any time. Just call a Member Services representative at 786-8476 in Columbia or 800-868-2528, toll free from anywhere else in the state. You may also contact the company through the Web site: www.BlueChoiceSC.com. The change will be effective the first day of the month following receipt of the request or immediately if you request this.

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 services that the company does not pay) are shown in the Schedule of Benefits, and
- Accept the allowed 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.

COVERED SERVICES

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

1. Medically necessary and appropriate,
2. Not be experimental or investigational in nature,
3. Performed on or after your effective date and prior to cancellation of coverage, and
4. Rendered by your primary care physician or by a provider authorized in advance by your primary care physician and by the company.

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, copayments, deductibles, coinsurance and maximum payment amounts specified in this contract and the exclusions and limitations as stated in this contract. Covered services do not include treatment for complications arising from or related to the receipt by a member of any non-covered procedure, service, treatment or condition. Expenses for covered services will be paid according to the benefits stated in the Schedule of Benefits.

Benefits payable under this contract are not assignable to a non-participating provider, unless otherwise determined by the company in its sole discretion. Any benefits payable for covered services of such providers will be based on the provider's usual and customary charge which is representative of the average and prevailing charge for the same covered service in the same or similar geographic communities where the covered service is rendered, in the company's judgment.

1. Physician Services

Benefits do not include: treatment of infertility; impotence or sexual dysfunction; acupuncture; transsexual procedures; treatment of obesity, weight reduction or weight control disorders; refractive care such as radial keratotomy, keratmolieusis and lamellar keraplasty. Any hospital services associated with these services or procedures are also not covered. Charges for failure to keep a scheduled appointment; completion of claim forms or charges for providing medical information, and telephone consultations are not considered to be medical care and are not covered under this contract.

A. **Primary Care Physician Services.** All diagnostic and treatment services provided at the medical office of your primary care physician and at such other places as authorized by the company, including preventive services, diagnostic procedures, therapeutic procedures, surgical procedures, medical supplies, consultation, and treatment.

B. **Preventive Services.** Health maintenance and preventive services provided by the primary care physician including well-baby care and periodic check ups; immunizations and injections; health education and voluntary family planning.

C. **Specialty Physician Services.** All diagnostic and treatment services provided at the medical office of a specialist physician and at such places as authorized by the company including diagnostic procedures, therapeutic procedures, surgical procedures, medical supplies, consultation and treatment.

D. **Allergy Services.** Allergy testing and treatment, including test and treatment material (allergy serum).

E. **Limited Gynecological Access without Referral.** Coverage is provided for a female enrollee 13 years of age or older for a minimum of two visits annually without referral, for covered services provided by a participating gynecologist. For any continuing treatment resulting from gynecological complications diagnosed during the two visits in a benefit year, authorization is required in order to be covered. For purposes of this section, covered services include the full scope of medically necessary services provided by the participating gynecologist in the care of or related to the female reproductive system and breasts. Charges related to a normal pregnancy and childbirth are not covered.

2. Facility Services

A. **Inpatient Hospital.** Room and board for semi-private accommodations and related ancillary and diagnostic services and supplies. Medically necessary services provided in a special care unit are covered.

B. **Skilled Nursing Facility or Long-Term Acute Care Facility.** Room and board for semi-private accommodations, rehabilitative treatment and related ancillary and diagnostic services and supplies. Benefits are limited to 120 days per Benefit Period.

C. **Outpatient Facility Services.** Surgery, Laboratory, Radiology, Diagnostic Services and Screening Mammography.

3. Emergency and Urgent Care Services. Benefits are provided for services and supplies for stabilization and/or initial treatment of an emergency medical condition provided on an outpatient basis at either a hospital or an alternate facility. In order to be Covered, a Participating Physician must provide follow-up care. When an inpatient admission occurs within 24 hours after an emergency visit as a result of the emergency medical condition, the emergency copayment, if any, will be waived and the applicable copayment for admission will be assessed.

Urgent Care Services are Covered Services when provided by a Participating Physician or at a Participating Alternate Facility such as an Urgent care center or after hours facility. Urgent care provided by a non-Participating Provider is Covered when Authorized by BlueChoice HealthPlan. Follow-up care is a Covered Service when provided by a Participating Physician.

4. Prescription Medications. Benefits for prescription medication are provided when purchased at a participating pharmacy and prescribed by a participating physician. Benefits for a covered prescription medication dispensed to you shall not exceed the quantity and benefit maximum specified in the Schedule of Benefits. Benefits are provided only for the most cost-effective prescription medication available at the time dispensed and include generic drugs and prescription medication as shown on the preferred drug list whenever medically appropriate and in accordance with all legal and ethical standards. Certain prescription medications require prior authorization in order to be covered, and have dosage limits as determined by the company. Benefits are not provided for over-the-counter drugs, vitamins or drugs for non-covered therapies, services or conditions.

The company receives financial credits directly from drug manufacturers and through a Pharmacy Benefit Manager (PBM). These credits are based on the volume of claims processed for preferred drugs utilized by all of the company's members. The credits are used to help stabilize overall rates and to offset expenses. Reimbursements to pharmacies are not affected by these credits. Any coinsurance percentage that you 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 preferred drug credit by

the company. Copayments are flat amounts and likewise do not change due to receipt of PBM credits.

If a participating physician prescribes a brand-name drug and indicates on the prescription that substitution of a generic drug is permitted, and there is an equivalent generic drug available, and the member still requests the brand-name drug then any difference between the cost of the generic drug and the higher cost of the brand-name drug will be the responsibility of the member. This will be in addition to the copayment appropriate to the brand-name drug being purchased. In no instance will the member be charged more than the actual retail price of the drug.

Specialty pharmaceuticals are not covered under the prescription medication benefit.

5. **Specialty Pharmaceuticals.** Benefits for specialty pharmaceuticals are provided when purchased from a designated participating provider and prescribed by a participating physician. Benefits for covered specialty pharmaceuticals dispensed to a member shall not exceed the quantity and benefit maximum, if any, as specified in the Schedule of Benefits. The member may obtain a list of specialty pharmaceuticals by contacting the company. See Section entitled How To Get Help.

   The company 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 participating providers, or discounted prices charged by participating providers, are not affected by these credits. Any coinsurance percentage that a member must pay for specialty pharmaceuticals is based on the negotiated rate or lesser charge by the participating provider, and does not change due to receipt of any financial credit by the company. Copayments are flat amounts and likewise do not change due to receipt of these credits.

6. **Ambulance Services.** Professional ambulance services to a local hospital are covered in connection with an acute injury or medical emergency. Coverage is also provided in connection with an interfacility transport between acute care facilities, when medically necessary due to the requirement for a higher level of services. No benefits are provided for ambulance service used for routine, nonemergency transportation, including, but not limited to, travel to a facility for scheduled medical or surgical treatments, such as dialysis or cancer treatment. All claims for ambulance services are subject to medical review.

7. **Home Health Services.** Benefits for home health services include part-time or intermittent nursing care by a registered nurse (R.N.), or by a licensed practical nurse (L.P.N.) where appropriate or physical, speech or occupational therapy provided through a home health agency. Services by a home health aide are considered to be custodial care and are not covered.

8. **Hospice Services.** Hospice care when recommended by a primary care physician and furnished through a participating provider. Charges for volunteer services are not covered.

9. **Medical Supplies.** Benefits for medical supplies are limited to the following: dressings requiring skilled application for conditions such as cancer or burns; catheters; colostomy bags and related supplies; necessary supplies for renal dialysis equipment or machines; surgical trays; and splints or such supplies as needed for orthopedic conditions. Supplies and equipment that have non-therapeutic uses are not covered.

10. Mental Health Services. Benefits for mental health services, performed in an office setting, are limited to 20 visits per Benefit Year. Covered Services must be authorized in advance by Companion Benefit Alternatives and provided by a Participating Provider. Covered Services do not include treatment of Attention Deficit-Hyperactivity Disorder (ADHD). Covered services do not include partial hospitalization or intensive outpatient services (see definitions) Services for treatment at a Residential Treatment Center are not Covered Services.

11. Outpatient Private Duty Nursing. Special or private duty nursing by an R.N. or an L.P.N. when provided on an outpatient basis when such services are required for care and treatment that otherwise would require admission to a hospital. Benefits for outpatient private duty nursing are limited to 60 days per benefit year.

12. Prosthetics and Durable Medical Equipment. Coverage is provided for prosthetic devices and durable medical equipment when obtained from a vendor or provider designated by BlueChoice HealthPlan, and when ordered by or provided by or under the direction of the primary care physician for use outside a hospital or skilled nursing facility. Coverage is provided for prosthetic devices and durable medical equipment that meet minimum specifications and are medically necessary. No benefits are provided for repair, replacement or duplicates, nor are benefits provided for services related to the repair or replacement of such devices and equipment, except when necessary due to a change in the member's medical condition. Benefits are provided for:

A. The initial purchase of artificial limbs, artificial eyes and other medically necessary prosthetic devices made necessary as a result of injury or sickness. Prosthetic devices aid body functioning or replace a limb or body part.

B. The rental or purchase, at the discretion of BlueChoice HealthPlan, of durable medical equipment including, but not limited to, the following: braces, including necessary adjustments to shoes to accommodate braces (dental braces are excluded); oxygen and the rental of equipment for the administration of oxygen; standard wheelchairs; standard Hospital-type beds; and mechanical equipment necessary for the treatment of chronic or acute respiratory failure. Air-conditioners, humidifiers, dehumidifiers, personal comfort items, eyeglasses, hearing aids and deluxe appliances are excluded.

13. Physical, Occupational and Speech Therapy. Benefits are provided for physical therapy, occupational therapy, and speech therapy when recommended by a Participating Physician and provided through a Participating Provider.

Benefits are limited to the dollar maximum shown in the Schedule of Benefits.

14. Therapeutic Services. Chemotherapy, Dialysis treatment, and Radiation therapy.

15. Cleft Lip and Palate. Medically necessary care and treatment of cleft lip and palate and any condition or illness related to or developed as a result of cleft lip and palate. Covered services must be provided by or under the direction of a participating provider and include, but are not limited to, medically necessary:

A. Oral and facial surgery, surgical management and follow-up care,
B. Prosthetic treatment such as obdurators, speech appliances and feeding appliances,
C. Orthodontic treatment and management,

D. Prosthodontia treatment and management,
E. Otolaryngology treatment and management,
F. Audiological assessment, treatment, and management, including surgically implanted amplification devices, and
G. Physical therapy assessment and treatment.

If a Member with a cleft lip and palate is covered by a dental policy, teeth capping, prosthodontics, and orthodontics are covered first by the dental policy up to the limit of coverage provided. Any additional benefits for covered services thereafter shall be provided under the terms of this contract. Benefits are provided on the same basis as for any other medical condition or illness.

16. **Hospitalization for Mastectomies.** If coverage is provided for hospitalization for a mastectomy, then benefits will be provided for hospitalization for at least 48 hours following the mastectomy unless the attending physician releases the patient prior to the expiration of 48 hours. In the case of an early release, coverage shall include at least one home care visit if ordered by the attending physician. Benefits will be provided on the same basis as any other condition or illness.

17. **Mammograms.** Coverage is provided for mammograms. Benefits will be provided on the same basis as any other condition or illness. A mammogram is a radiological examination of the breast for purposes of detecting breast cancer when performed as a result of a Physician referral or by a health testing service which utilizes radiological equipment approved by the Department of Health and Environmental Control. For benefit purposes, such examination may be made with the following frequency:

A. Once as a base-line mammogram for a female who is at least 21 years of age,
B. Once a year for a female who is at least 21 years of age, or
C. In accordance with the most recently published guidelines of the American Cancer Society.

18. **Pap Smears.** Coverage is provided for an annual Pap smear. Benefits will be provided on the same basis as any other condition or illness. A Pap smear is an examination of the tissues of the cervix or the uterus for the purposes of detecting cancer when performed under the recommendation of a medical doctor. Such examination may be made once a year or more often if recommended by a medical doctor.

19. **Prostate Examinations.** Coverage is provided for prostate cancer examinations, screenings and laboratory work for diagnostic purposes in accordance with the most recent published guidelines of the American Cancer Society. Benefits will be provided on the same basis as any other condition or illness.

20. **Reconstructive Surgery Following Mastectomy.** If you are receiving benefits in connection with a mastectomy and elect breast reconstruction in connection with such mastectomy, coverage will be provided in a manner determined in consultation with the attending physician and you. Benefits will be provided on the same basis as any other condition or illness and include reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications in all stages of mastectomy, including lymph edemas.

21. **Transplant Services.** Benefits are provided for covered services for organ and tissue transplants as shown in the Schedule of Benefits. To be covered, such transplants must be provided from a human donor to you (the transplant recipient) and provided at or arranged by a Designated Transplant Facility while you are covered under this contract. All solid organ procurement services, including donor organ harvesting, typing, storage and transportation are covered. Benefits are provided on the same basis as any other condition or illness subject to the maximum benefit amounts shown in the Schedule of Benefits. All transplant-related benefits (except Prescription Drugs) provided during a Transplant Benefit Period apply toward the Transplant Lifetime Maximum.

    Benefits are also provided for medical expenses of a live donor to the extent that benefits remain and are available under your (the transplant recipient) policy, after benefits for your expenses have been paid. Experimental transplants are not covered services.

22. **Dental Care**. One oral examination every benefit year by or under the direction of a licensed dentist is covered. One dental cleaning (prophylaxis) every benefit year by or under the direction of a licensed dentist is covered. This service does not have to be authorized. You will have to file a claim to the company to receive reimbursement.

23. **Vision Care.** One comprehensive vision examination for eyeglasses by a designated participating provider per benefit year is covered in full. Any additional charge for a contact lens examination and/or fitting is your responsibility. This service does not have to be authorized. You will have to file a claim to the company to receive reimbursement.

24. **BlueCard®.** When you obtain health care services through the BlueCard® program outside the geographic area BlueChoice HealthPlan serves, the amount you pay for covered services is calculated on the lower of (1) the billed charges for your covered services, or (2) the negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to us.

    Often, this "negotiated price" will consist of a simple discount, which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over or underestimation of past prices. However, the amount you pay is considered a final price.

    Statutes in a small number of states may require the Host Blue to use a basis for calculating Member liability for covered services that did not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard® method noted above in paragraph one of this section or require a surcharge, BlueChoice HealthPlan would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

SERVICES AND SUPPLIES THAT ARE NOT COVERED

Charges for some services and supplies you may get will not be covered under this contract. Benefits will not be paid for charges for services, supplies or treatment of:

1. Pre-existing conditions or diseases except as provided in the Pre-existing Condition Exclusion.
2. Mental or emotional disorders, alcoholism and drug addiction except as provided under Mental Health Services.
3. Normal pregnancy and childbirth except for complications of pregnancy.
4. Illness, accident, treatment or medical condition arising out of war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection, service in the armed forces or units auxiliary thereto.
5. Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.
6. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet. This exclusion does not include corrective surgery or treatment for metabolic or peripheral vascular disease.
7. Care in connection with the detection and correction by manual or mechanical means of structure imbalance distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment of subluxation of, or in the vertebral column.
8. Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any state or federal workman's compensation, employers liability or occupational disease law, any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family; and services for which no charge is normally made in the absence of insurance.
9. Dental care or treatment except as provided under Dental Care in the Schedule of Benefits and Covered Services.
10. Eyeglasses, hearing aids and examination for the prescription or fitting thereof; except as provided under Vision Care in the Schedule of Benefits and Covered Services.
11. Rest cures, custodial care, and transportation.
12. Any non-emergency, out-of-area care when care is available within the local service area. This is known as a territorial limitation.

PRE - EXISTING CONDITION EXCLUSION

Pre-existing conditions are those conditions for which medical advice or treatment was received or recommended no more than 12 months prior to the effective date of your coverage. Services or supplies for pre-existing conditions are not covered until the earlier of:

1. A period of 12 months without medical care, treatment or supplies related to the pre-existing condition ending after the effective date of coverage or
2. 12 months after the effective date of coverage.

WAITING PERIODS

After the effective date of your coverage under this contract, there are some waiting periods during which no coverage is provided for treatment of certain specified diseases or conditions or losses resulting therefrom. The waiting periods for this contract are stated below:

- Six months for adenoids
- Six months for appendix
- Six months for disorders of reproductive systems
- Six months for hemorrhoids
- Six months for hernia
- Six months for tonsils
- Six months for varicose veins

These waiting periods do not apply in case of an emergency if there is no previous medical history of the condition prior to the effective date of your coverage.

DEFINITIONS AND RELATED COVERAGE REQUIREMENTS

Here are words and terms you need to know to help you understand your health coverage:

Allowed Amount: The allowances agreed upon by participating providers and BlueChoice HealthPlan.

Alternate Facility: A non-hospital healthcare facility, or an attached facility designated as such by a hospital, that provides one or more of the following services on an outpatient basis pursuant to the law of jurisdiction in which treatment is received: prescheduled surgical services, emergency covered services, urgent care services or prescheduled rehabilitative, laboratory or diagnostic service.

Authorized or Authorization: Prior approval from your primary care physician and the company for another provider to provide services to you. This approval must be on file with the company. Each individual service or treatment, except for emergency services, dental care, and vision care requires such prior approval. Services or supplies provided must be in accordance with the approval given.

Benefit Year: The period of time within which benefits are administered, including the determination of certain limitations. A benefit year begins on the effective date of your coverage under this contract and lasts for 365 days. Then a new benefit year begins.

BlueChoice HealthPlan: The trade name for BlueChoice HealthPlan of South Carolina, Inc.

Brand-Name Drug: A prescription medication that is manufactured under a registered trade name or trademark. A brand-name drug may be a preferred drug or a non-preferred drug.

Coinsurance: The percent of certain covered medical expenses payable by a member. Coinsurance is based on the negotiated rate or lesser charge of the provider.

Company: BlueChoice HealthPlan of South Carolina, Inc.

Contract Holder: The parent, grandparent or legal guardian who obtained this contract to cover the member and who is the owner of the contract and payer of the premiums. Contract Holder is responsible for assuring that the member obtains all required authorizations for services and selects a primary care physician. (Note: The member is the Contract Holder if the member was 18 years old or older at the time of his or her application for this contract.)

Contracting Pharmacy: A pharmacy that has a written agreement with BlueChoice HealthPlan.

Copayment: The fixed amount payable by the member before contract benefits begin for certain covered medical expenses. Copayment amounts are shown on the Schedule of Benefits. The copayment amount is due at the time the service is performed.

Creditable Coverage: Health coverage subject to Health Insurance Portability and Accountability Act of 1996 (HIPAA). There must be no more than a 63-day break between two different health coverages. When your coverage under this contract ends, you have the right to receive a certification showing the period of coverage you had under this contract. This period of coverage is called Creditable Coverage. It may be that credit for this period of coverage will be given, if a future employer with a group health insurance plan has a

pre-existing condition exclusion period, so long as there is no more than a 63-day break in coverage between this coverage and any succeeding coverage. If you leave the future group health insurance, the time of coverage under this contract may help reduce a pre-existing condition exclusion period with the South Carolina Health Insurance Pool.

Crisis Intervention and Evaluation: Those health services that are medically necessary to provide immediate treatment of acute mental health conditions on a short-term basis.

Deductible: The amount of covered charges which the member must pay in a benefit year before the company will pay any part of certain covered medical expenses. The deductible amount is shown on the Schedule of Benefits. The deductible is based on the negotiated rate or lesser charge of the provider.

Durable Medical Equipment (DME): Medical equipment that can withstand repeated use, is not disposable, is used to service a medical purpose, is generally not useful to a person in the absence of a sickness or injury and is appropriate for use in the home. Such equipment must be necessary for, or be used in, the course of treatment of disease and/or disorders. Durable Medical Equipment also includes a feeding pump and nutritional supplements when administered through a feeding pump.

Effective Date: The date (beginning at 12:01 a.m.) on which you became enrolled and eligible for benefits under the terms of this contract.

Emergency Medical Condition (Emergency): A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; or (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Experimental, Investigational or Unproven Services: Medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that at the time provided, or sought to be provided, are determined by BlueChoice HealthPlan to be:

1. Not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use or not identified in the American Hospital Formulary Service, or the United States Pharmacopoeia Drug Information, or
2. Subject to review and approval by any Institutional Review board for the proposed use, or
3. The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight, or
4. Not supported by at least two or more peer-reviewed, full-length articles in respected national professional medical journals with results of good quality-controlled clinical studies indicating the service is safe, effective and accepted for the treatment of the specific medical condition for which it was prescribed.

Charges for these services are not covered under your contract.

Generic Drug: A prescription medication that has the same active ingredients as the brand-name drug but is not manufactured under a registered brand name or trademark.

Health-Status-Related Factor: Any of the following factors: health status; medical condition, including both physical and mental illnesses; claims experience; receipt of healthcare; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; or disability.

Hospital: A short-term, acute care (1) general hospital, (2) children's hospital, (3) eye, ear, nose and throat hospital, (4) maternity hospital, or (5) any other type of short-term acute care hospital licensed by the state in which it operates, that for compensation from its patients and on an inpatient basis, is engaged primarily in providing diagnostic and therapeutic facilities for the medical or surgical diagnosis and treatment of injured or sick persons, by or under the supervision of a staff of physicians duly licensed to practice medicine, and which provides continuous 24 hour-a-day services by licensed, registered, graduate nurses physically present and on duty. A hospital may participate in a teaching program. This means that you may be seen or treated by a medical student, intern or resident participating in such a teaching program.

Identification Card: You will get a BlueChoice HealthPlan card with your contract. It will show your identification number. When you seek any type of medical services or supplies, including prescription medication, be sure to show your identification (ID) card so the participating providers know you have BlueChoice HealthPlan coverage. If you do not show your card, the providers have no way of knowing that you are a member of BlueChoice HealthPlan and you may receive a bill for healthcare services.

Intensive Outpatient Services: A structured treatment setting provided a minimum of three hours/day, three days/week. Services provided include multi-disciplinary group and individual therapy. Services are typically provided in a fully licensed and accredited facility.

Legal Guardian: The guardian of a minor child (other than an institution or agency) appointed by a court of any state.

Local Service Area: The geographic area, approved by State authorities, which is served by the company. For purposes of defining an out-of-area emergency, local service area means the area within 30 miles of your home, place of employment or primary care physician’s office.

Long-Term Acute Care Facility: A facility that meets the definition of a hospital providing care to patients whose average length of stay is greater than twenty-five consecutive days as set out in the American Hospital Association Guide to the Health Care Field, published annually.

Medically Necessary or Medical Necessity: Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice, and
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease, and
3. Not primarily for the convenience of the patient, physician or other health care provider, and
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 these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Member: A person 1) who resides in the state of South Carolina, 2) who is at least six weeks of age and less than 30 years of age, and 3) who is enrolled in BlueChoice Individual Coverage.

Non-Preferred Drug: A prescription medication that has not been chosen by the company, or its designated pharmacy benefit manager, to be a preferred drug. This includes any brand-name drug with an "A" rated generic drug available.

Partial Hospitalization Services: A highly structured treatment setting provided a minimum of six hours/day, five days/week. Services provided include multidisciplinary group and individual therapy under medical supervision. Services are typically provided in a fully licensed and accredited facility. A full range of skilled nursing is provided and a MD is available 24 hours/day.

Participating: The relationship whereby a provider of covered services has entered into a written agreement with the company to provide covered services to members. The participating status of a provider may change from time to time.

Preferred Drug: A prescription medication that has been reviewed for cost and clinical effectiveness and quality. Preferred drugs are brand-name drugs and generic drugs that are preferred by the company, or its designated pharmacy benefit manager, for dispensing to members when appropriate.

Preferred Drug List: A listing of prescription medications approved for a specified level of benefits by the company. This list shall be subject to periodic review and modification by the company.

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. Syringes and related supplies for conditions such as diabetes are also considered to be prescription medications.

Primary Care Physician: The personal physician the member selects from BlueChoice HealthPlan's list of doctors to direct and coordinate all of that member's healthcare.

Provider: Any person licensed in, or legally engaged in the practice of, or performing duties associated with, any of the following: medicine; surgery; dentistry; pharmacy; optometry; osteopathy; podiatry; chiropractic; radiology; nursing; physiotherapy; pathology; anesthesiology; anesthesia; laboratory analysis; rendering assistance to a physician; psychiatry; psychology; physical therapy; or home health care, hospital long-term acute care facility or skilled nursing facility. A provider may participate in a teaching program. This means that you may be seen or treated by a medical student, intern, or resident participating in such a teaching program.

Skilled Nursing Facility: An institution primarily engaged in providing skilled nursing care, rehabilitation services and related care that is recognized under Medicare as a Skilled Nursing Facility. A Skilled Nursing Facility is not a facility or institution which is primarily a place for rest or residence.

Specialty Pharmaceuticals: Prescription medications that treat a complex clinical condition with complex delivery of care and distribution requirements. They include but are not limited to infusible specialty drugs for chronic disease; injectable and self-injectable specialty drugs for acute and chronic diseases; and specialty oral drugs.

Substance Abuse: The use of drugs or alcohol to the extent that medical services are required for detoxification.

Transplant Benefit Period: For transplants other than bone marrow/stem cell transplants, the period begins on the Admission Date on which a transplant is performed and continues for 12 consecutive months. For bone marrow, the period begins on the first date of mobilization therapy, the date of bone marrow/stem cell harvest, or the inpatient Admission date for the transplant procedure, whichever occurs first, and continues for 12 consecutive months.

Transplant Lifetime Maximum: The maximum amount of benefits provided in a lifetime for each Member for any or all of the transplants listed in the Schedule of Benefits. Once the Transplant Lifetime Maximum has been met, no additional transplant benefits are available for that Member.

You, Your: These terms refer to the member when describing covered services and benefits. They refer to the contract holder when describing contract rights and obligations. They refer to both the member and the contract holder when referencing the subrogation, proration, non-renewal and termination rights of the company.

HOW TO GET HELP

Resolution of a Question

Questions or concerns about coverage may be directed to BlueChoice HealthPlan Member Services through the Web site at www.BlueChoiceSC.com.

You can also call our Member Services department. From Columbia, dial 786-8476. From anywhere else in the state, dial 800-868-2528, 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.

Complaints, Appeals and Grievances

A complaint is any dissatisfaction you have regarding services or benefits you receive from us. To file a complaint or to appeal a decision regarding the provision of benefits under this contract, you may contact a representative of BlueChoice HealthPlan stating the issue to be reviewed and attaching pertinent medical records or other information in support of the appeal. You also may request a description of any pertinent records that the company reviewed in making the original decision to deny the claim in whole or in part. If the complaint involves a representative of BlueChoice HealthPlan, the request should be addressed to the chief operating officer of BlueChoice HealthPlan Corporation. If a complaint is related to the quality of care received by a Member, it is considered a grievance. You should submit a description of the problem in writing to a BlueChoice HealthPlan representative.

If the problem is an appeal of the denial of an authorization, you may request that the individual who reviews the request be a person who did not make the initial decision of denial. You may request that the reviewer be a provider licensed in the same specialty as the attending medical provider. If you believe the determination to deny authorization warrants immediate appeal, you may request an expedited appeal. For an expedited appeal, a decision shall be made and the Member shall be notified of the decision within two business days of the company's receipt of all information necessary to complete the appeal. If the result of the expedited appeal does not resolve the difference in opinion, the Member may resubmit the appeal through the standard appeal process.

All claims, questions, grievances, or appeals must be submitted within six months after the later of the date services were rendered or the date the claim for services was denied. After the expiration of this period, disposition of the claim shall be considered final. Any question or appeal a Member has concerning an Authorization must be made to BlueChoice HealthPlan within six months from the date the Authorization was approved or denied by BlueChoice HealthPlan or the decision shall be considered final.

External Review by an Independent Review Organization

In certain situations, you may be entitled to an additional review of your appeal at our expense. An external review may be used to reconsider your appeal if we have denied it, either in whole or in part; the payment would be greater than $500.00; and a requested service or payment for service has been denied, reduced, or terminated. These situations include a decision by us that your requested service:

A. Does not meet our requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or
B. Is experimental or investigational, and it involves a condition that is life-threatening or seriously disabling.

After your internal appeals are completed, you will be notified in writing of your right to request an external review. If you need assistance during the external review process, you have the right to contact the South Carolina Department of Insurance. The Director of the South Carolina Department of Insurance or his designee may be contacted 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 should file a request for review within 60 days of receiving that notice. You will be required to authorize the release of any medical records that may need to be reviewed for the purpose of reaching a decision during the external review.

Within five business days of your request for an external review, we must respond by either:

A. Assigning your review and forwarding the records we relied upon in making our decision to an independent review organization or
B. Telling you in writing that your situation does not meet the requirements for an external review and the reasons for our decision.

The independent review organization will take action on your request for review within 45 days after it receives the request.

Expedited reviews: Expedited reviews are available if your physician certifies that you have a serious medical condition, meaning one that requires immediate medical attention to avoid serious impairment to bodily functions, serious harm to an organ or body part, or that would place your health in serious jeopardy. You may also receive an expedited review if our denial involves an emergency admission or care, you have not been discharged from a facility after receiving that care; and you will be held financially responsible.

GENERAL CONTRACT PROVISIONS

1. Entire Contract; Changes

The contract, your enclosed application, and any amendments, riders or endorsements make up the whole contract between you and the company. No change in this contract 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 contract or to waive any of its provisions.

2. Time Limit on Certain Defenses

It is possible to make a mistake in filling out an application for an HMO contract. During the first two years this contract is in force, the company cannot deny a claim because of an error in the application, unless your error misled the company about the risk it assumed when the application was accepted. If it is found that your error on the application was misleading in this manner, the company may have grounds to void the contract, in which case your premiums will be refunded, minus any benefits paid for claims for you.

After the contract has been in force for two years, the company cannot deny a claim because of an error in your application unless you make fraudulent misstatements in an effort to deceive the company. If the contract is declared void for this reason, your premiums will be refunded, minus any benefits paid for claims for the member.

3. Grace Period

Unless the company has notified you of its intent not to renew this contract, the following information about the grace period applies to this contract.

If you do not pay your premium by the date it is due, the company gives you a grace period of 10 days. This contract remains in force during the grace period.

However, the company is entitled to the premium due during the grace period and may collect any unpaid premium by deducting it from any claims payment due to you. If you do not pay your premium by the end of the grace period, you have cancelled your contract as of the end of the grace period.

4. Reinstatement

BlueChoice HealthPlan may reinstate this contract, at its option, if you ask for reinstatement after your coverage has lapsed because you didn’t pay your premium. You should ask for reinstatement by writing the Member Advocates at BlueChoice HealthPlan.

No agent has the authority to accept a premium for reinstatement or to reinstate this contract. If the company approves reinstatement, this contract will be reinstated as of the date it lapsed. You should receive written notice from the company about approval or disapproval of your request. If you don’t get a written notice of disapproval by the 45th day after you request reinstatement, your coverage is automatically reinstated. The company will charge a fee for reinstatement.

5. How to File Claims; Notice 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. All claims, questions, grievances, or appeals must be submitted within six months after the later of the date services were rendered or the date the claim for services was denied. After the expiration of this period disposition of the claim shall be considered final. Any question or appeal a Member has concerning an Authorization must be made to BlueChoice HealthPlan within six months from the date the Authorization was approved or denied by BlueChoice HealthPlan or the decision shall be considered final.

6. Payment of Claims

All benefits provided in this contract will be paid promptly upon receipt of due proof of loss.

7. 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.

8. 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.

9. Conformity with State Statutes

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

10. Non-Assessable

This is a non-assessable contract. You - the contract 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.

11. Other Valid Coverage: Proration

This contract is not meant to duplicate other valid coverage you have with insurance policies. “Other valid coverage” is defined as health insurance coverage that is similar to the coverage provided by this contract, coverage provided by hospital or medical service organizations, coverage provided by union welfare plans or employee benefit organizations, but not group or individual health insurance with this company.

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.

12. Subrogation Rights

BlueChoice HealthPlan - the company - is subrogated to your rights against a liable third party causing you injury to the extent of benefits paid for medical expenses. This means that if a liable third party causes you to be injured and the company pays your medical bills, it has the right to get the money back from the liable third party responsible for your injury or from you if they have paid it to you. If you sue the liable third party or if you accept a settlement from the liable third party, the company still has the right to get the money back. And the company can get the money back from benefits available to you under uninsured motorists provisions of automobile insurance contract. As a member of BlueChoice HealthPlan, you should help the company recover this money, at no expense to you. Attorney fees and costs will be paid by the company from the amounts recovered. The Director of the Department of Insurance or his designee, upon being petitioned by the contractholder, may determine that the exercise of subrogation by the company is inequitable and commits an injustice; if this determination is made, subrogation is not allowed. This determination by the Director or his designee may be appealed to the Administrative Law Judge Division as provided by law.

13. Independent Corporation

The Member hereby expressly acknowledges its understanding that this contract constitutes a contract 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 contract 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 contract. 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 contract.

14. Information and Records

The company is entitled to obtain such authorization from the member for medical and hospital records from any provider of services as is reasonably required in the administration of benefits hereunder. The member agrees that benefits for any professional or facility-covered services are contingent upon receipt of such information or records. The company shall in every case hold such records as confidential except as authorized by a member or as required or permitted by law. The company shall not release confidential medical records except as authorized by you or by law.

The submission of a claim shall be deemed written proof of loss and written authorization from the member to the company to obtain any medical or financial records and documents useful to the company. The company 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 the company in support of a member's claim shall be deemed to be acting as the agent of the member.

15. Relationship With Providers

The member acknowledges and agrees that the company 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.

16. Sole Discretion

The company has sole and exclusive discretion in interpreting the benefits provided under the contract and the other terms, conditions, limitations and exclusions set out in the contract and in making factual determinations related to the contract and its benefits. No person or entity has any authority to make any oral changes or amendments to the contract. The company may, in certain circumstances for purposes of overall cost savings or efficiency and in its sole discretion, provide benefits for services that otherwise would not be covered services. The fact that the company does so in any particular case shall not in any way be deemed to require it to do so in other similar cases.

17. Policies and Procedures

The company may adopt reasonable policies, procedures, rules, and interpretations to promote the orderly and efficient administration of the contract with which members shall comply.

18. Right to Transfer to an Individual Contract of Equal or Lesser Benefits with BlueChoice HealthPlan

Any person enrolled in BlueChoice Individual Coverage has the right to transfer to any individual contract of equal or lesser benefits offered for sale by BlueChoice HealthPlan at the time the transfer is sought. Any special provision excluding coverage for a specified condition may remain after transfer, and any waiting period or preexisting condition period specified in the contract to which the transfer is made may be required to be served after the transfer.

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