CERTIFICATE OF COVERAGE

BusinessADVANTAGE℠

Benefits are provided both In-Network and Out-of-Network. Using In-Network Providers will result in higher benefits.

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INTRODUCTION

Open Access Benefits. Business Advantage is an open access product**.** That means Members decide at the time they need medical care whether they will go to a healthcare Provider within BlueChoice HealthPlan's Network, a Network Provider, or go to a non-Network Provider. Benefits are available in either case; however, Members using Network Providers receive higher benefits. A person enrolled in Business Advantage is automatically entitled to In-Network and Out-of-Network benefits as described below.

In-Network benefits apply when you receive Covered Services from a BlueChoice HealthPlan Participating Provider. In general, these benefits provide a higher level of Coverage with less out-of-pocket expense. Some benefits are only available when you receive them from a healthcare professional within BlueChoice HealthPlan's Network of Providers. Please see your Schedule of Benefits for this information. BlueChoice HealthPlan's Participating Providers handle all of the paperwork, so you have no bills or claim forms to submit. BlueChoice HealthPlan of South Carolina, Inc. underwrites these benefits.

Out-of-Network benefits apply when you receive Covered Services from any licensed Provider outside of the BlueChoice HealthPlan Network of Participating Providers. Some services covered by the In-Network benefits are not covered by the Out-of-Network benefits. Out-of-Network benefits provide a lower level of coverage, and you are responsible for completing claim forms and submitting itemized bills in order to receive benefits. You can also be billed for any amount in excess of the Allowable Charge. Payments that you make to an Out-of-Network Provider do not contribute to your Deductible, out-of-pocket expenses or any plan maximums. Blue Cross® and Blue Shield® of South Carolina underwrites these benefits and has arranged for BlueChoice HealthPlan to serve as the administrator of the Out-of-Network benefits.

Contact BlueChoice HealthPlan. Throughout this Certificate, there are statements that encourage you to contact BlueChoice HealthPlan for further information. A question or concern regarding benefits or any required procedure may be addressed to BlueChoice HealthPlan through the Web site at www.BlueChoiceSC.com or by calling Member Services at 786-8476 in Columbia or 1-800-868-2528 when outside the Columbia area.

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

Identification Card. When you or your enrolled Dependents 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 Business Advantage. If you do not show your ID card, the Providers have no way of knowing that you are a Member of Business Advantage and you may receive a bill for Covered Services.

The BlueCard® Program. The BlueCard Program is a national program in which all Blue Cross and Blue Shield Licensees participate, including BlueChoice HealthPlan. This national program enables BlueChoice HealthPlan Members living or traveling outside of South Carolina to receive the highest level of benefits when they obtain services from any physician or Hospital designated as a BlueCard PPO Provider**.** Doctors and Hospitals in the BlueCard program are considered to be Participating Providers.

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're unable to represent yourself.
- Pay your cost share amounts, including your premium.
- Tell us if you move.

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.BlueChoiceSC.com/BASBC.

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).

CERTIFICATE OF COVERAGE

This Certificate of Coverage is part of a group Contract that is a legal document between BlueChoice® HealthPlan and your Employer. The Master Group Contract, this Certificate of Coverage, the Schedule of Benefits, the Master Group Application, the Notices of Election and attached amendments, addenda, riders, or endorsements, if any, constitute the entire Contract between both BlueChoice HealthPlan and your Employer.

The Contract is delivered in and governed by the laws of the state of South Carolina and the federal government. By enrolling in Business Advantage and accepting this Certificate, the Member agrees to abide by the rules of BlueChoice HealthPlan as outlined in this Certificate.

Members are entitled to the benefits described in this Certificate in exchange for the Premium paid to BlueChoice HealthPlan by the Member or by the Employer on the Member's behalf. The Contract may require that the Member contribute to the required Premium. Information regarding the Premium and any portion of the Premium that the Member must pay can be obtained from your Employer.

This Certificate replaces and supersedes any Certificate that previously may have been issued to you by BlueChoice HealthPlan and governs Covered Services provided after the Effective Date of the Contract. Any subsequent Certificates issued to you by BlueChoice HealthPlan will in turn supersede this Certificate. From time to time, the Contract may be amended. When that happens, a new Certificate or amendment pages for this Certificate will be sent to you. Your Certificate should be kept in a safe place for your future reference.

How To Use This Certificate. It is important that you read the entire Certificate carefully and become familiar with its terms and provisions. Many of the provisions are interrelated, so reading just one or two sections may give you a misleading impression. Many words used in this Certificate have special meanings. These words will appear capitalized and are defined. The terms "you" and "your" as used throughout this Certificate mean the Subscriber and the Subscriber's enrolled Dependents**.**

Important For Benefits. All Inpatient Hospital Admissions, except for Emergency Admissions, certain outpatient services and certain prescription drugs must be Authorized in advance by BlueChoice HealthPlan. The admitting Physician, the Hospital or someone acting on your behalf must initiate the Authorization process by notifying BlueChoice HealthPlan prior to Admission or receipt of services and complying with specific Authorization requirements in order to qualify for maximum benefits. Failure to do so may result in denial of benefits.

Only Medically Necessary health services are covered under the Contract. The fact that a Physician has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for an injury, sickness or mental illness, does not mean that the procedure or treatment is covered under the Contract. BlueChoice HealthPlan may, at its discretion, delegate authority to other persons or entities to provide services in regard to the Contract.

Benefits payable under the Contract are not assignable to a non-Participating Provider. This means BlueChoice HealthPlan may send benefit payments to you and you will be responsible for paying the Provider.

BlueChoice offers a variety of wellness programs, including a smoking cessation program, to assist you in making positive lifestyle changes. Please contact a Customer Services Advocate or go to our website for more information about our programs.

SECTION 1
WHAT IS COVERED:

In-Network benefits apply when you receive Covered Services from a BlueChoice HealthPlan Participating Provider. In general, these benefits provide a higher level of Coverage with less out-of-pocket expense. BlueChoice HealthPlan's Participating Providers handle all of the paperwork so you have no bills or claim forms to submit. These benefits are paid based on BlueChoice HealthPlan's Fee Schedule. BlueChoice HealthPlan of South Carolina, Inc. underwrites these benefits. Preauthorization must be obtained on certain services to receive maximum benefits.

Out-of-Network benefits apply when you receive Covered Services from any licensed Provider outside of the BlueChoice HealthPlan Network of Participating Providers. Some Covered Services are only available at In-Network Providers. Out-of-Network benefits provide a lower level of Coverage, and you are responsible for completing claim forms, submitting itemized bills in order to receive benefits and may be balance billed by the Provider. These benefits are paid based on Allowable Charge. Blue Cross and Blue Shield of South Carolina underwrites these benefits and has arranged for BlueChoice HealthPlan to serve as the administrator of the Out-of-Network benefits.

Benefits for all services are subject to the provisions of the Contract. In order to be covered, services must be Medically Necessary and performed on or after the Member's Effective Date and prior to cancellation of Coverage. Benefits are subject to all (if any) limitations, Copayments, Deductibles, Coinsurance and maximum payment amounts specified in this Certificate including the Schedule of Benefits, and the exclusions and limitations as stated in this Certificate and in the Contract.

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 Certificate or after you no longer have this coverage except as described in **Extended Benefits for Total Disability** under the *When Coverage Ends* section of this Certificate 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.

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 Service – Professional ambulance services to a local Hospital in the United States 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 in the United States, when medically necessary due to the requirement for a higher level of services. No benefits are provided for ambulance service 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.

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.

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 Certificate.

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. Benefits received for Dental Care do not apply to your Deductible or Maximum Out-of-pocket. 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 is limited to care completed within six months of such accident and while the patient is still covered under this Certificate. **Benefits are subject to the Deductible and Coinsurance.**

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 Authorized every 90 days. If Authorization is not obtained, no benefits will be provided for the DME or the supplies.

Emergency Services
Use of the Emergency Room is intended only for persons who are experiencing an Emergency Medical Condition, as defined in this Certificate. We will review requests for benefits after an Emergency Room visit to determine if the illness or injury was sudden or unexpected or would be expected to cause a serious risk to your health, or your unborn child's health, if not treated immediately. Requests for services that do not meet this standard will be denied as not covered.

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 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 by an 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 by an Out-of-Network Provider**
   When Emergency Services are received from an Out-of-Network Provider, benefits will be provided for Emergency Services at the in-Network rate; but you may have additional cost-sharing or because an Out-of-Network Provider provided the services.
   Please note: At any In-Network Hospital or facility, you may be treated by and Out-of-Network Provider. Out-of-Network Providers may Balance Bill you, even when you are treated for an Emergency Medical Condition.

   Out-of-Network Emergency room – We will provide benefits for Emergency Medical Condition 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. As long as you are considered to have an Emergency Medical Condition, we will provide benefits at the in-Network rate and the Allowed Amount will be based on the fee schedule for In-Network Providers. Because the provider is Out-of-Network, you will be reimbursed at the in-Network rate and will need to forward this payment to the Provider. The Provider may balance-bill you for the difference between our Allowed Amount and the rate they charge. Non-Emergency care outside the Business Advantage 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 and three visits for Individual and Family Counseling **are provided under an agreement between First Sun EAP and the Employer. First Sun EAP is a separate company that does not offer BlueChoice HealthPlan products. These services are offered by First Sun EAP, not BlueChoice HealthPlan. BlueChoice HealthPlan has no responsibility for these services. For services, please call First Sun EAP at 1-800-968-8143. First Sun EAP staff are available 24 hours a day, seven days a week.**

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. 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. 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 Authorize hospice services before you are eligible for this care. The services must be provided according to a Physician prescribed treatment plan.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. 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.

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. The day you are admitted to the Hospital as an Inpatient and remain past midnight 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. 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). 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 within 31 days of birth and applicable premium must be paid in order for benefits to be paid. Maternity care does not include: surrogate parenting; artificial insemination and in-vitro fertilization.

No Preauthorization is 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 a 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 including: 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 Certificate; 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 and certain Outpatient Mental Health and/or Substance Use Disorders care must be Authorized before care is received.

Newborn Child Coverage – When you add your newborn to your policy within 31 days of his or her birth, coverage will be effective on the date of birth and benefits will be provided for the hospitalization and related professional services for the newborn 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 birth is not counted in the 48 hours after vaginal delivery (96 hours for Caesarean Section).

Out-of-country – We will provide out-of-country benefits based on the in-Network Provider allowance or the total charge, whichever is less. Out-of-country benefits consist of all Covered Services provided or supplies received outside the United States. However, services must be provided through Blue Cross Blue Shield Global Core®. Please note that these Global Core Providers may bill you the difference between the allowance and the total charge. To find a BlueCard Provider outside of the United States, , visit the BlueCard

Doctor and Hospital Finder website (www.BCBS.com), call the Blue Cross Blue Shield Global Core service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.. You can also visit www.bcbsglobalcore.com. .

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 peritoneal dialysis. Dialysis treatment includes home dialysis. Dialysis treatment is only covered when provided by an In-Network Provider.

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 (including any program developed by centers with multidisciplinary staffs intended to provide the interventions needed to allow the development of pain coping skills and freedom from analgesic medication dependence); excessive sweating; diagnosis or treatment of sexual dysfunction including, but not limited to, drugs, lab and x-ray test and counseling for such procedures; or treatment for varicose veins and/or venous incompetence, including but not limited to: endovenous ablation, vein stripping or sclerosing solutions injection. Benefits also do 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.

Prescription Drugs –Benefits are provided for the Prescription Drugs listed on the Covered Drug list. Prescription Drugs must be purchased at a participating pharmacy and prescribed by a Participating licensed physician. A list of Participating pharmacies can be found on the BlueChoice HealthPlan website at www.BlueChoiceSC.com/BAPharmacy.

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, there is a less-expensive equivalent generic or over-the-counter drug available and covered, and the Member still 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 an Employee 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.

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 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 In-Network only. 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 Health Plan of South Carolina.

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 or microprocessor components or bioelectric, microprocessor or computer programmed 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 benefit 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 be denied.

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 Contract terms and conditions.

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

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.

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.

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 and provided through a Provider we designate. Services include, but is 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 of 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 Certificate. 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 Certificate 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 Contract.
   - Single/double kidney, pancreas and kidney, heart, single/double lung, liver, pancreas, heart and single/double lung, and bone marrow transplants.

3. Benefits are 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. Benefits for allogeneic or syngeneic bone marrow transplants 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.

4. Benefits are available for allogeneic bone marrow transplantation in the treatment of developmental and non-malignant diseases of bone marrow. Benefits for allogeneic bone marrow transplants 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 at an 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 Provider.

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 adult 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 do 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 we serve, 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 ("nonparticipating 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 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 Services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for Covered 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 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.

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. Nonparticipating Providers Outside Our Service Area

When covered healthcare services are provided outside of our service area by non-participating healthcare Providers, information regarding the amount you pay for such services is contained in the Covered Services section of this policy.

E. BCBS Global™

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 when accessing Covered Services. BCBS Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the 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 area, 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 the 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, can 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 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.

SECTION 2
PROCEDURES FOR OBTAINING BENEFITS

With Business Advantage, you have benefits for Covered Services provided by any licensed healthcare professional. For coverage at the In-Network benefit level, services must be received from a Provider in the BlueChoice HealthPlan Network - a Participating Provider. Or, you may see a healthcare professional who is not in the BlueChoice HealthPlan Network and receive benefits for Covered Services at the lower, Out-of-Network level. Some services may not be covered if you receive them from an Out-of-Network Provider - a Non-Participating Provider. Please refer to your Schedule of Benefits and Sections 1 and 2 of this Certificate for additional details.

2.01 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 Web site at www.BlueChoiceSC.com/doctorhospitalfinder.aspx, or by calling 786-8476 in Columbia or 1-800-868-2528 when outside the Columbia area.

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

2.02 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 Web site at www.bluechoicesc.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 Contract, including regular benefit limits.

2.03 Referral Health Services by Non-Participating Providers

If specific Covered Services cannot be provided by or through a Participating Provider, you may be eligible for coverage at the In-Network benefit level for Covered Services obtained through non-Participating Providers. These services must be Authorized in advance and provided at a Provider designated by BlueChoice HealthPlan and are subject to the provisions, limitations and exclusions of this Contract. It is your responsibility to obtain this required Authorization prior to receiving the services.

2.04 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.

2.05 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.

2.06 Authorization Does Not Guarantee Benefits

The fact that BlueChoice HealthPlan Authorizes services or supplies does not guarantee that all charges will be covered. Benefit determination is made by BlueChoice HealthPlan in accordance with all of the terms, conditions, limitations and exclusions of this Contract - including eligibility.

2.07 Services Outside of South Carolina - The BlueCard Program

Follow these easy steps for health coverage when you're away from home in the United States:

1. Always carry your current BlueChoice HealthPlan ID card.
2. In an Emergency, go directly to the nearest Hospital.
3. To find names and addresses of nearby doctors and Hospitals, visit www.BlueChoiceSC.Com/doctorhospitalfinder.apsx or call BlueCard Access at 1-800-810-BLUE. This phone number can also be found on your Member identification card.
4. If you are admitted to the Hospital, call BlueChoice HealthPlan for pre- authorization. (Refer to the phone number on the back of your BlueChoice HealthPlan ID card).
5. When you arrive at the participating doctor's office or Hospital, simply present your BlueChoice HealthPlan ID card. As a Business Advantage Member, the doctor will recognize the PPO℠ logo.

After you receive care:

- You should not have to complete any claim forms.
- You should not have to pay up front for medical services other than the usual out-of-pocket expenses (non-Covered Services, Deductible, Copayment, and Coinsurance).
- BlueChoice HealthPlan will send you a complete explanation of benefits.

You also have Coverage when you are traveling outside the United States. Please call BlueChoice HealthPlan before you leave for additional information.

SECTION 3
HOW TO FILE A CLAIM

3.01 Participating Providers

Participating Providers have agreed with BlueChoice HealthPlan to do the following:

1. File all claims for Covered Services directly to BlueChoice HealthPlan;
2. Collect only the Copayment, Deductible and Coinsurance amounts, if any, for Covered Services. These amounts, which are part of the charge for Covered Services that you pay, are shown in the Schedule of Benefits; and
3. Accept the Fee Schedule (minus any applicable Coinsurance, Copayment or Deductible) as payment in full for Covered Services.

If you are billed by a Participating Provider for other than any applicable Coinsurance, Copayment or Deductible, you should contact BlueChoice HealthPlan.

3.02 Non-Participating Providers

Non-Participating Providers may agree to file claims directly to BlueChoice HealthPlan, but are not required to and any may refuse to file your claims. Written notice of claim must be given within twenty days after a covered loss starts or as soon as reasonably possible. The notice may be given to the company at its home office or to the company's agent. You are then responsible for filing a claim to BlueChoice HealthPlan's office, on a form provided by or satisfactory to BlueChoice HealthPlan, within 12 months of the date of service. Failure to provide this information within the time required shall invalidate coverage for the service unless it was not reasonably possible to have furnished the required information within 12 months. If you are legally incapacitated, failure to provide this information to BlueChoice HealthPlan within one year of the date of service shall invalidate coverage for the service.

You may use a form provided by BlueChoice HealthPlan or an American Medical Association insurance form, which is available at most Physicians' offices. Claim forms are available on the BlueChoice HealthPlan Web site at www.BlueChoiceSC.com. Some claims may require additional information before being processed. Actual benefit payment can be determined only at the time a claim is submitted and all facts are presented in writing. BlueChoice will pay completed claims received via paper within forty business days and completed electronic claims within twenty 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.

If you request claim forms from BlueChoice HealthPlan, BlueChoice HealthPlan must provide the forms within 15 days after receipt of the request. If BlueChoice HealthPlan fails to provide the forms within 15 days, you may satisfy the time requirements stated above by supplying BlueChoice HealthPlan with the following information:

1. Subscriber's name and address.
2. Patient's name, age and identification number (stated on the Identification Card).
3. The name and address of the Provider of services.
4. A diagnosis from the Physician.
5. Itemized bill that gives a CPT code or description of each charge.
6. Date service provided.
7. Charge for each service.

Claims should be mailed to:

BlueChoice HealthPlan
Post Office Box 6170
Columbia, SC 29260-6170

Questions about claims may be directed to Member Services at 786-8476 in Columbia or 1-800-868-2528 outside the Columbia area.

Non-Participating Providers can also bill you for charges in excess of the Allowable Charge.

Benefits payable under the Contract are not assignable to a non-Participating Provider, unless determined otherwise by BlueChoice HealthPlan in its discretion. This means BlueChoice HealthPlan may send benefit payments to you and you will be responsible for paying the Provider.

SECTION 4
WHAT IS NOT COVERED

4.01 Exclusions

No benefits are provided for the following unless otherwise specified in the Schedule of Benefits. Notwithstanding any provision of the Contract to the contrary, if the Contract 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.

Benefits are not provided for:

- Hospital, Residential Treatment Center or Skilled Nursing Facility charges when you don't get the required Authorization.

- Services and supplies that aren't Medically Necessary, not needed for the diagnosis or treatment of an illness or injury, or not specifically listed in *What Is Covered*.

- Services and supplies you received before you had coverage under this Group Contract or after you no longer have this coverage except as described in the *Extended Benefits for Total Disability* section of this Certificate.

- Services, supplies or Prescription Drugs for which you're entitled to benefits under Medicare or any other governmental program, except for Medicaid; or for which you're not legally responsible for paying.

- Benefits for injuries or diseases paid by Workers' Compensation or settlement of a Workers' Compensation claim.

- Any charges by the Department of Veterans Affairs (VA) for a service-related disability or care in any State or Federal Hospital for which you aren't legally responsible.

- Rest care or Custodial Care.

- Admissions or portions thereof for long-term or chronic care for medical or psychiatric conditions.

- All Admissions to Hospitals or freestanding Rehabilitation Facilities for physical rehabilitation when the services aren't done at a Provider we designate and/or you don't receive the required Preauthorization.

- Treatment resulting from war or acts of war (whether declared or undeclared), while participating in a riot or uprising, or while in the military service or its auxiliary units.

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

- Any service (other than substance abuse services), medical supplies, charges or losses resulting from a Member being Legally Intoxicated or under the influence of any drug or other substance, or taking some action the purpose of which is to create a euphoric state or alter consciousness unless taken on the advice of a Physician, even if the condition is not diagnosed prior to the injury. The Member, or the Member's representative, must provide any available test results showing drug/substance levels and/or blood alcohol levels upon our request of and, if the Member refuses to provide these test levels, no benefits will be provided.

- Services and supplies a Member receives from any intentionally self-inflicted injury (or injury resulting from attempted suicide) unless it results from a medical (physical or mental) condition, even if the condition is not diagnosed prior to the injury.

- 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 don't get the required prior Preauthorization, it's not done at a Provider we designate, or unless specifically listed in Covered Services.

- Services and supplies related to cosmetic Surgery, as determined by us. This means any plastic or reconstructive Surgery done mainly to improve the appearance of any body part, and from which no improvement in physiologic function is reasonably expected, unless performed either to correct functional disorder or as a result of an injury. Cosmetic Surgery excluded includes, but isn't limited to:
  - Surgery for sagging or extra skin;
  - Any augmentation, reduction, reshaping or injection procedures;
  - Rhinoplasty, abdominoplasty, liposuction and other associated Surgery; and
  - Any procedures using an implant that doesn't alter physiologic function or isn't incidental to a surgical procedure.

  Any services a Member receives due to complications of cosmetic Surgery also aren't covered.

- Reduction mammoplasty for macromastia unless the Member is within 20 percent of the ideal body weight.

- Any treatment or Surgery for obesity (even if morbid obesity is present), weight reduction, weight control such as gastric bypass, 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.

- Eyeglasses, contact lenses (except after cataract Surgery and as shown in the children's Vision Coverage sections), 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), 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.

- Home health care and hospice services, except as provided in *Covered Services* and with a Preauthorization.

- Any medical social services, visual therapy or Private Duty Nursing services, except when part of a preauthorized home health care plan 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.

- 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.

- Marriage counseling.

- Any services or supplies for the diagnosis or treatment of infertility. This includes, but isn't limited to: fertility drugs, lab and X-ray tests, reversals of tubal ligations or vasectomies, surrogate parenting, artificial insemination and in vitro fertilization.

- Any services or supplies for the diagnosis or treatment of sexual dysfunction. This includes, but isn't 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. A penile prosthesis will be considered for payment 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 Contract.

- 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.

- 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 (TEACCH) programs;
  3. Higashi schools/daily life;
  4. Facilitated communication;
  5. Floor time;
  6. Developmental Individual-Difference Relationship-based model (DIR);
  7. Relationship Development Intervention (RDI);
  8. Holding therapy;
  9. Movement therapies;
  10. Music therapy; and
  11. Animal-Assisted therapy.

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

- Any services, supplies or treatment for excessive sweating.

- Services and supplies related to non-surgical treatment of the feet, except when related to diabetes.

- 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.

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

- Services, supplies or treatment for venous incompetence and/or varicose veins, including but not limited to, endovenous ablation, vein stripping or sclerosing solutions injection.

- Bioelectric, microprocessor or computer-programmed prosthetic components.

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

- 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 all of the requirements specified in the Covered Services section of the Contract.

- Services or supplies 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 and usually known as TMJ).

- 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 isn't 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 children's vision Coverage sections; for dental care to Sound Natural Teeth for up to six months after an accident; and for cleft lip and palate services.

- 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: transportation, lodging and repatriation unless specifically included in Covered Services.

- Durable Medical Equipment when you don't get the required Preauthorization.

- Equipment available over the counter such as, but not limited to: air conditioners, whirlpool baths, spas, (de)humidifiers, wigs, fitness supplies, vacuum cleaners or air filters and common first aid supplies.

- Benefits will be denied for procedures, services or pharmaceuticals when you don't get the required Preauthorization.

- Prescription Drugs and pharmaceuticals under the medical portion of this coverage 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's 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's excessive in terms of the scope, duration or intensity of drug therapy that's needed to provide safe, adequate and appropriate care.
- Some medications classified as self-administered drugs; when obtained, purchased and/or administered at a doctor's office or in an Outpatient setting, these medications are not covered.
- That require Authorization and the Authorization is not received.
- That requires step therapy when a Step Therapy Program is not followed.
- That are received Out-of-network, unless due to an Emergency Medical Condition.
- That are not on the BlueChoice Covered 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.

- 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.

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

- Any services or supplies a member of your 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 or treatment for complications resulting from any non-covered procedure or condition.

4.02 Limitation

Benefits are limited to the extent a Member proves entitlement to any benefits under this Contract by filing or causing to be filed a claim and documentation in support of the claim.

SECTION 5
WHEN COVERAGE BEGINS

5.01 Eligibility

1. Every Employee within the class(es) set forth by the Employer who is Actively-at-work and his or her Dependents are eligible for coverage on or after the Contract Effective Date provided the Employee has completed the period of continuous employment commonly referred to as the Waiting Period with the Employer. The Waiting Period will never exceed ninety days. The Employee must be permanently working an average of 30 hours per week. Neither an Employee nor the Employee's Dependents shall be covered until the Employee is Actively-at-work. An Employee or Dependent cannot be denied coverage simply because of a Health Status Related Factor.

   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, disability, sex, gender identity or sexual orientation will not affect your eligibility or premiums for this coverage.

2. To be eligible for Membership as a family Dependent, the Dependent must:
   a. Meet the Employer's eligibility requirements for Dependent Coverage; and
   b. Be the Subscriber's legal spouse; or
   c. Be the Subscriber's natural child, adopted child, foster child, step child, or child for whom the Subscriber has legal custody or legal guardianship and is less than 26 years of age (unless otherwise specified on the Master Group Application), unless the child of the Subscriber 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 the Employee within 31 days of such child's attainment of that limiting age, as long as Coverage remains in force for the Employee.

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

4. 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 Subscriber's federal tax return; the child does not reside with the Subscriber; or the child does not reside in the Local Service Area.

5. 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.

5.02 Election of Coverage

Any Employee eligible for Coverage may elect Coverage for himself or herself and all eligible Dependents by completing and filing with the Employer a Notice of Election. In addition, new Employees may enroll within 31 days of the date they first become Employees or after satisfaction of the Waiting Period, if one exists, whichever is later. Dependents may be enrolled within 31 days of the date on which they first become Dependents. Persons also may enroll if eligible under terms of a Special Enrollment Period.

5.03 Effective Date of Coverage

Unless otherwise provided in this Certificate, Coverage shall commence as stated in this section. In all cases, the required Premium must be paid before Coverage begins.

1. For an Employee not Actively-at-work at the time this Coverage would otherwise commence, Coverage for the Employee and eligible Dependents will commence on the date corresponding to the Contract Effective Date in the first month following the date the Employee becomes Actively-at-work. A Health Status Related Factor may not be used to determine Actively-at-work.

2. For an Employee eligible prior to and on the Contract Effective Date who elects Coverage, Coverage begins on the Contract Effective Date if a Notice of Election is filed prior to the Effective Date and the Employee is Actively-at-work.

3. For an Employee who becomes eligible after the Contract Effective Date and who elects Coverage, Coverage begins on the first day of the next month following eligibility. This date will be the Member's Effective Date, provided the Notice of Election is received by BlueChoice HealthPlan prior to the Member's Effective Date and the Employee is Actively-at-work.

4. For a newborn child of the Employee, Coverage is effective at birth provided the newborn is enrolled by the Employee within 31 days of the newborn's birth and any required Premium is paid during such 31 day period.

5. For an adopted child of the Employee:
    a. Coverage shall be retroactive from the moment of birth for a child with respect to whom a decree of adoption by the Employee has been entered within 31 days after the date of the child's birth; if adoption proceedings have been instituted by the Employee within 31 days after the date of the child's birth and the Employee has temporary custody, Coverage shall be provided from the moment of birth;
    b. For adopted children other than a newborn, Coverage shall commence upon temporary custody and will continue as long as you have custody.

5.04 Special Enrollment Periods

An Employee or Dependent(s) eligible for coverage but not yet enrolled may enroll or change from one Health Plan to another if each person seeking enrollment meets one of the requirements listed below:

1. You or a Dependent had coverage at the time enrollment was previously offered, but lost eligibility for coverage or employer contributions toward the coverage, and the Employee requests the enrollment no later than 31 days after the date coverage ended.

2. The Employee or Dependent gains or loses coverage under a Medicaid plan or under a State Children's Health Insurance Program (S-CHIP) and the Employee requests coverage under the Group Health Plan no more than 60 days after the date the Employee or Dependent is determined to be eligible or ineligible for such assistance.

3. You or a Dependent loses Minimum Essential Coverage. This doesn't include loss due to failure to pay premiums on a timely basis (including COBRA premiums) or rescission of coverage.

4. You gain a Dependent or become a Dependent through marriage, birth, adoption or placement for adoption.

Marriage
If you marry, the Effective Date of coverage is the first day of the next month after we receive notice of the special enrollment. If you're eligible under this plan, but aren't enrolled and you marry, then you're also eligible to enroll in the plan. You must request coverage within 31 days of the marriage.

Loss of Minimum Essential Coverage
If you or a Dependent loses Minimum Essential Coverage, the Effective Date of coverage is the first day of the next month after we receive notice of the special enrollment. If you're eligible under this plan, but aren't enrolled, you're also eligible for this special enrollment. In this situation, you must request coverage within 31 days of the qualifying event.

Birth, Adoption, or Placement for Adoption
If you or your spouse gives birth, adopts a child or a child is placed with you or your spouse for the purpose of adoption while this policy is in force, then the child is covered. If you're eligible under this plan, but aren't enrolled and you or your spouse has a child, adopts a child or is in the process of adopting a child, you and your spouse can receive coverage as long as you meet the eligibility requirements of the Contract. In both of these situations, you must request coverage within 31 days of the child's birth, adoption or placement for adoption and pay any premium that may be due.

For an adopted child, coverage will start when you pay the appropriate premium, if any, as follows:
1. From the moment of birth for a child you or your spouse legally adopts within 31 days of the child's birth;
2. From the moment of birth for a child for whom you or your spouse has temporary custody and have begun adoption proceedings within 31 days of the child's birth; or
3. When the adopted child isn't a newborn, upon temporary custody with you or your spouse. Coverage will continue as long as you or your spouse has custody of the child.

Your Effective Date for special enrollment for triggering events, except birth, adoption, placement for adoption, marriage or loss of Minimum Essential Coverage is the first day of the next month after we receive notice of the special enrollment.

5.05 Special enrollment period in case of termination of Medicaid or Children's Health Insurance Program (CHIP) coverage or eligibility for assistance in purchase of employment-based coverage.

An Employee who is eligible but not enrolled for Coverage under the terms of the Contract, or a Dependent of the Employee if the Dependent is eligible but not enrolled for Coverage under such terms, may enroll for Coverage during a Special Enrollment Period. To be eligible to participate in the Special Enrollment Period, either of the following conditions must be met.

1. Termination of Medicaid or CHIP Coverage: The Employee or Dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and coverage of the Employee or Dependent under such plan is terminated due to loss of eligibility for such coverage and the Employee requests enrollment under this group health Contract not later than 60 days after the termination date of such coverage; or

2. Eligibility for Premium Assistance under Medicaid or CHIP: The Employee or Dependent becomes eligible for premium assistance, with respect to coverage under this group health Contract, under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), and the Employee requests enrollment under this group health Contract not later than 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

SECTION 6
WHEN COVERAGE ENDS

6.01 Conditions for Termination of a Member's Coverage Under the Contract

Subject to continuation and conversion privileges stated in this section, Coverage of the Member, including Coverage for Health Services provided after the date of termination for medical conditions arising prior to the date of termination, shall automatically terminate on the earliest of the dates specified below.

1. The date the entire Contract is terminated, as specified in the group Contract. The Employer is responsible for notifying Subscribers of the termination of the Contract.

2. The date specified by BlueChoice HealthPlan in written notice to the Subscriber that all Coverage will terminate because the Member or the Member's representative has performed an act or practice that constitutes fraud or made an intentional misrepresentation. If the intentional misrepresentation is made by a person with respect to any person's prior health condition, BlueChoice HealthPlan has the right also to deny Coverage to that person or to impose as a condition of continued Coverage the exclusion of the condition misrepresented.

3. The date BlueChoice HealthPlan receives written notice from the Subscriber or the Employer instructing BlueChoice HealthPlan to terminate Coverage of the Subscriber or any Member or the date requested in such notice, if later.

4. Unless a later date is specified in the Contract, the date on which the Member ceases to be eligible as a Subscriber or enrolled Dependent.

In no event will a Member's Coverage be terminated because of his or her health status or requirements for Health Services.

Coverage will not be rescinded for an individual once the individual is covered under this Contract, 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 of contributions towards the cost of the Coverage. The Employer will be responsible for sending the individual any notice related to retroactive terminations or rescissions that are required by law.

BlueChoice HealthPlan will provide the Employee or Dependent a Certificate of Creditable Coverage at the time coverage ends or at the time the COBRA or state continuation coverage ends. If a duplicate certificate is needed at a later time, the Employee or Dependent must request the Certificate of Creditable Coverage within 24 months of the coverage ending or the COBRA or state continuation coverage ending, whichever occurs first. The Employee or Dependent may also request the Certificate of Creditable Coverage from BlueChoice HealthPlan even if their coverage is still in force. To request the Certificate of Creditable Coverage, the Employee or Dependent must contact BlueChoice HealthPlan.

Under certain circumstances, Members who cease to be eligible for Coverage under the Contract may be eligible to continue Coverage under the Contract or to convert to another policy. Members should refer to the following paragraphs in this section for additional details.

6.02 Payment and Reimbursement Upon Termination

Termination of the Contract shall not affect any request for reimbursement for Covered Services rendered prior to the Effective Date of termination, when such request is furnished as required in Section 3, How To File a Claim, of this Certificate.

6.03 Extended Coverage for Incapacitated Dependent

The Coverage of an Incapacitated Dependent under this Contract will not be terminated merely by the attainment of the limiting age, but may be continued provided proof of such incapacity and dependency is furnished to BlueChoice HealthPlan by the Employee within 31 days of such child's attainment of that limiting age, as long as Coverage remains in force for the Employee. Further proof of continued incapacity and dependency may be required by BlueChoice HealthPlan, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

6.04 Extended Benefits for Total Disability

1. If coverage under this Contract is terminated under this section, all rights to receive benefits provided in this Contract on the date of such termination shall automatically cease, except that an Employee or Dependent confined to a Hospital, Long-Term Acute Care Hospital, Rehabilitation Hospital, or Skilled Nursing Facility or totally disabled on the date of such termination is entitled to receive benefits specified

in Sections 1 and 2, for each day of that Admission or total disability. Benefits are subject to all exclusions, limitations, Coinsurance, Copayments and Deductibles stated in this Contract including the Schedule of Benefits. Benefits provided are limited to services directly related to the illness or injury causing the confinement or the total disability. In all situations except BlueChoice HealthPlan's withdrawal from the small group market, the extension of benefits liability of BlueChoice HealthPlan ends at the earliest of:

A. The date the individual has full coverage for the disabling condition under a Group Health Plan with similar benefits and that plan makes reasonable provisions for continuity of care for the disabling condition;
B. The date of recovery of the individual from the total disability; or
C. A period of 365 days from the date of termination of coverage under this section; or
D. The date benefits to which the individual is entitled are exhausted.

2. As used in this paragraph with respect to an Employee, the terms "totally disabled" and "total disability" mean disability to the extent that the Employee is receiving ongoing medical care by a Physician and is unable to perform any of the usual and customary duties of his/her own employment or occupation during the first year of disability or for the length of the Benefit Period if less than one year. After the first year of disability, total disability is defined as the complete inability of the Employee to engage in any employment or occupation, for wage or profit, for which the Employee is qualified by reason of education, training or experience. With respect to a Dependent, the terms mean disability to the extent that the Dependent is receiving ongoing medical care by a Physician and is unable to perform any of the usual and customary duties or activities of a person in good health of the same age and sex.

Important Note: The Member must notify BlueChoice HealthPlan if they wish to exercise the Extended Benefits for Total Disability rights. BlueChoice HealthPlan will then determine if the Member is eligible for the Benefits. Premium payments are waived for Members receiving Extended Benefits for Total Disability. There are no continuation rights or any conversion rights available to any Member at the end of the Extended Benefits period.

Claims filed under this section must be accompanied by a Physician's statement of disability. The medical director of BlueChoice HealthPlan will have sole authority for determining if the requirements of total disability have been met.

6.05 Continuation Coverage Under Federal Law (COBRA)

A Member whose Coverage would otherwise end under the Contract may be eligible to elect continuation Coverage in accordance with federal law under COBRA (Consolidated Omnibus Budget Reconciliation Act) or continuation Coverage in accordance with state law. Continuation Coverage under COBRA applies only to Employers that are subject to the provisions of COBRA. Members should contact the Employer's Human Resources to determine if he or she is eligible to continue Coverage under COBRA.

6.06 Continuation Coverage Under State Law

An Employee who leaves the employ of the Employer while the Contract is in force shall have the right to continue Coverage under the group Contract for the fractional Contract Month remaining at termination plus six additional Contract Months upon payment in advance to the Employer of the full group Premium for this continuance of Coverage period including any portion thereof usually paid by the former Employer. This continuance is available only if the Member has been continuously covered under the Employer's group

coverage for at least six months and has been terminated for any reason other than non-payment of Premium. The Member is not entitled to have Coverage continued if the Member is entitled under federal law (COBRA) to continuation of Coverage for a period of greater duration than provided herein. Continuation of Coverage is subject to this Contract, or a successor policy, remaining in force and the Member paying the entire Premium, including any portion usually paid by the former Employer, before the date each month that the group Contract Month begins. Continuation is not available if the Member becomes eligible for other group health coverage or Medicare benefits.

6.07 Conversion Privilege For A Former Spouse

An Enrolled Dependent who ceases to be eligible due to divorce from the Subscriber will be able to purchase another policy from BlueChoice without written proof of insurability. The spouse must apply for the policy and send us the required Premium within 60 days following the decree of divorce. The new policy will be a policy that complies with the Affordable Care Act provisions. Any probationary or Waiting Periods set forth in the policy shall be considered as being met to the extent Coverage was in force under the prior policy.

SECTION 7
COORDINATION OF BENEFITS AND SUBROGATION

7.01 Purpose of Coordination of Benefits (COB)

A person may be covered for benefits under more than one health plan. In this case, BlueChoice HealthPlan will coordinate benefits with the other plans to prevent duplicate payments and overpayments. This nationally accepted cost-containment program provides that the benefits under this Contract plus any benefits due from other group coverage, will not exceed the amount of actual expenses charged for services. If a person's other group coverage is responsible for making payments first, BlueChoice HealthPlan cannot pay until information is provided concerning how much the other coverage paid. The person must report to BlueChoice HealthPlan any other group benefit plan for which the person is eligible.

The rules determining which group coverage should pay primary (first) are as follows using the first of the following rules that apply:

1. **Non-Dependent/Dependent**. The Group Health Plan provided where a person works is primary for that person. If the same person is covered as a Dependent under a spouse's group plan, the spouse's plan is secondary.

2. **Dependent Child and Parents Not Separated or Divorced**. When a husband and wife work at different places, both of which have group health coverage, the plan of the parent whose birthday falls earlier in the year is primary for their children.

3. **Dependent Child and Parents Separated or Divorced**. In the case of divorce or legal separation, the plan that should pay primary for the child are determined in the following order:
   a. The plan of the parent with custody of the child.
   b. The plan of the spouse of the parent with the custody of the child.
   c. The plan of the parent not having custody of the child.

d. If the specific terms of a court decree state that one of the parents is responsible for the healthcare expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first.
e. If the specific terms of a court decree state that the parents shall share joint custody without specifying that one of the parents is responsible for the healthcare expenses of the child, the plans covering the child shall follow the rules in paragraph 2 of this section.

4. **Active or Inactive Employee**. The benefits of a Plan that covers a person as an Employee who is neither laid off nor retired (or as that Employee's Dependent) are determined before those of a Plan that covers that person as a laid off or retired Employee (or as that Employee's Dependent).

5. **Longer or Shorter Length of Coverage**. If a person works at several places and each place has a Group Health Plan, the plan he or she has been covered under the longest is primary.

6. **Continuation Coverage** - If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:
   a. First, extended benefits payable under the continuation coverage;
   b. Second, the benefits of a Plan covering the person as an Employee, Member, or subscriber (or as that person's Dependent).

7. **Medicare**. This Plan is secondary to Medicare except where federal law mandates this plan to be the primary plan.

When a Group Health Plan does not have a coordination of benefits provision, that plan is primary.

Benefits are <u>not</u> coordinated between the two portions of this Open Access product.

7.02 Effect On The Benefits Of This Plan

1. **When This Section Applies**. This Section 7.02 applies when, in accordance with Section 7.01, This Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" in paragraph 2.B. immediately below.

2. **Reduction in this Plan's Benefits**. The benefits of This Plan will be reduced when the sum of A and B below exceeds those Allowable Expenses in a Claim Determination Period:

   a. Benefits payable for the Allowable Expense under This Plan in the absence of this COB provision; and
   b. Benefits payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made.

      In such case, the benefits of this Plan are reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of this Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

3. If this Contract is secondary to Medicare as mandated by Federal Law, and if the person did not elect to enroll in Medicare, Benefits under this Contract may be reduced by the amount that would have been paid by Medicare had the person elected such coverage.

7.03 Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. BlueChoice HealthPlan has the right to decide what information is needed in order to apply these COB rules. Such information may be obtained from, or given to any other entity or person without the consent of any person. Each person claiming benefits under this plan must give BlueChoice HealthPlan any facts necessary to administer the benefits of this plan.

7.04 Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. In such event, BlueChoice HealthPlan may pay that amount to the entity that made such payment. That amount will then be treated as though it were a benefit paid under this plan. BlueChoice HealthPlan will not pay that amount again. Payment made includes the reasonable cash value of any benefit provided in the form of services.

7.05 Right of Recovery

If the amount of the payment made under this plan is more than permitted under this COB provision, BlueChoice HealthPlan may recover the excess from one or more of:

1. The person(s) paid or person(s) for whom payment was made;
2. Insurance companies; and/or
3. Other entities.

The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

7.06 Subrogation

If you receive medical benefits under this coverage 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 benefits that we've paid relating to the injury. This agreement is a condition to receiving benefits under this coverage. 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 haven't 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 isn't allowed. This determination by the Director may be appealed to the Administrative Law Judge Division as provided by law.

We'll 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 your place to recover the amount of money we've paid for your medical benefits from any third party who's liable, responsible, or otherwise makes a payment for your injury. We may seek recovery for our 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 right.

Each time a claim is filed with a diagnosis that could be related to an accident or injury, you may receive either 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.

SECTION 8
REVIEWS AND APPEALS

8.01 Information and Records

BlueChoice HealthPlan 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. BlueChoice HealthPlan shall in every case hold such records as confidential except as authorized by a Member or as required by law. BlueChoice HealthPlan shall not release confidential medical records to the Employer except as authorized by a Member or as required by law.

The submission of a claim shall be deemed written proof of loss and written authorization from the Member 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 a Member's claim shall be deemed to be acting as the agent of the Member.

8.02 ERISA

If the Contract is an integral part of an employee welfare benefit plan subject to the provisions of the Employee Retirement Income Security Act of 1974, as amended (ERISA), BlueChoice HealthPlan is a claim fiduciary. As claim fiduciary, BlueChoice HealthPlan shall have the discretionary authority to determine eligibility for benefits and to construe the terms of that part of the ERISA plan represented by the Contract. Any construction or interpretation of the plan, determination of eligibility for benefits, or any other decision regarding the plan by the claims fiduciary shall be binding and conclusive so long as the decision is not arbitrary or capricious or in violation of applicable statutory law.

8.03 Claims Processing

The United States Department of Labor has developed new standards for processing benefit claims of participants and beneficiaries who are covered under employee benefit plans governed by the Employee Retirement Income Security Act of 1974 (ERISA). Even if you are not covered by ERISA, BlueChoice HealthPlan has made the decision to apply these standards to all enrollees. The terms listed below are important and need to be understood, as do the new time periods for claims and for appeals.

1. **Initial Claims**

A. Urgent Claims

An urgent claim is 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 you would be subject to severe pain that could not adequately be managed without the care or treatment. We will defer to the attending Provider with respect to the decision as to whether a claim constitutes "urgent care."

If your claim is determined to be an urgent claim, a notice will be sent as soon as possible, taking into account the medical exigencies, but in no case later than 72 hours after receipt of the claim. You may be given notice orally, in which case a written notice will be provided within three days of the oral notice. If your urgent claim is determined to be incomplete, you will be sent a notice to this effect within 24 hours of receipt of your claim, at which point you will have 48 hours to provide additional information.

If you request an extension of urgent care benefits beyond an initially determined period and make the request at least 24 hours prior to the expiration of the original determination, you will be notified within 24 hours of the receipt of the request.

B. Pre-Service Claims

A pre-service claim is a claim for services that have not yet been provided and for which your benefits plan requires prior Authorization.

We must give our decision, based on Medical Necessity, in writing or electronic form within 15 calendar days.

An extension of 15 calendar days may be provided if we determine that, for reasons beyond our control, an extension is necessary. If an extension is required, we will notify you within the initial 15-day time period that an extension is necessary. When we require an extension due to incomplete

information, we are entitled to the rest of the initial determination period to reach a benefit determination after the additional information is received form you or the Provider.

We will let you know within five calendar days if we receive incomplete information from you and additional information is required to make a determination. You have 60 calendar days to send us the required information. If we do not receive the required information within the 60-day time period, we may deny the claim.

C. Post-Service Claims

A post-service claim is a claim for services that already have been provided, or where your benefits plan does not require prior Authorization.

When you submit a post-service claim and your claim is denied, a notice will be sent within a reasonable time period, but not longer than 30 days from receipt of the claim. If BlueChoice HealthPlan determines that an extension is necessary due to matters beyond the control of the plan, this time may be extended 15 days. You will be sent notice prior to the extension that indicates the circumstances requiring the extension and the date by which the plan expects to provide a determination. If the extension is necessary in order to request additional information, the extension notice will describe the required information, and you will be given 60 calendar days to submit the information..

D. Concurrent Care Claims

A concurrent care claim is a claim that arises when there is a reduction or termination of ongoing care.

You will be notified if there is to be any reduction or termination in Coverage for ongoing care sufficiently in advance of such reduction so that you will be able to appeal the decision before the Coverage is reduced or terminated, unless such a reduction or termination is due to a plan amendment or termination of your benefits plan.

Notice of Determination: If your claim is filed properly, and your claim is in part or wholly denied, you will be sent notice of an adverse benefit determination that will:

- State the specific reason(s) for the adverse benefit determination;
- Reference the specific plan provisions on which the determination is based;
- Describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary;

- Describe the plan's claims review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review, if you are enrolled in an ERISA plan;
- Disclose any internal rule, guideline, or protocol relied upon in making the adverse determination (or state that such information is available free of charge upon request); and
- If the denial is based on medical necessity, experimental treatment or other similar limit, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request).

If your claim is approved, you will be sent notification if your claim is an urgent or pre-service claim. You will not be sent an approval notice for post-service claims.

2. **REQUEST FOR REVIEW AND APPEALS**

You have 180 days from the receipt of an adverse benefit determination to file an appeal. After the end of this period, disposition of the claim shall be considered final.

Requests for appeals should be sent to:

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

The appeal must state that you are requesting a formal appeal and include all pertinent information regarding the claim in question that you wish to be considered in the appeal. Request to cover services and supplies which are specifically excluded in the Contract will be treated as appeals; however, such requests aren't eligible for external review.

The following guidelines apply for each type of claim (including the appropriate claim with regard to a Concurrent Care decision), unless both parties agree to the extension:

A. Urgent Claims

You may request an expedited review process for an Urgent Care Claim either orally or in writing, and all necessary information pertaining to the appeal will be transmitted by telephone, facsimile or other expeditious method. We must complete the appeal process within 72 hours after we receive your appeal.

B. Pre-Service Claims

We must complete the appeal process within 30 calendar days after receiving the appeal.

C. Post-Service Claims

We must complete the appeal process within 60 calendar days after receiving the appeal.

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. No deference will be afforded to the initial determination. Individuals involved in the decision-making for claims and appeals aren't compensated or rewarded based on the outcome of the appeals.

The Member will be considered to have exhausted the internal appeal process if the Corporation 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 Corporation's control;
D. In the context of an ongoing good-faith exchange of information; and
E. Not reflective of a pattern or practice of non-compliance.

You may write to us and request an explanation of our basis for stating we meet the above standard.

External Reviews

You will be notified in writing of your right to request an external review. You should file a request for external review within four months of receiving that notice. You 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
Post Office Box 100105
Columbia, SC 29202-3105
800-768-3467

Standard External 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 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 based on our determination that the service is 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.

We will respond within five business days of your 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 your records to it or telling you in writing that your situation doesn't meet the requirements for an external review and explaining the reasons.

You have five business days from the date you receive our response to submit additional information to the IRO in writing. The IRO must consider this additional information when conducting its review. The IRO will also forward this information to us within one business day of its receipt.

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

If your request is not accepted for external review, the IRO will inform you and us 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, we must process the claim subject to applicable Policy exclusions, limitations and other provisions within five business days of our receipt of the notification.

Expedited External Reviews
You can request an expedited external review within 15 days after receiving a notice of a denied claim only if you meet the requirements stated above for a Standard Review and your Physician certifies you have a Serious Medical Condition, or the claim denial concerns a health care service for which you received Emergency Medical Care, and you have not been discharged. 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 expedited 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, but it remains 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.

3. **LEGAL ACTIONS**

You may not bring a lawsuit to recover benefits under this plan until you have exhausted the administrative process described in this section. No action may be brought at all unless brought no later than six years after the time written proof of loss is required to be furnished.

SECTION 9
GENERAL CONTRACT PROVISIONS

9.01 Conformity With Statutes

Any provision of the Contract which, on the Contract Effective Date, is in conflict with the statutes of the jurisdiction in which it is delivered is hereby amended to conform to the minimum requirements of such statutes.

9.02 Workers' Compensation Not Affected

The Contract is not in lieu of and does not affect any requirements for coverage for Workers' Compensation Insurance.

9.03 Relationship With Providers

The Employer and Members 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.

9.04 Relationship Between Parties

The Contract constitutes a Contract solely between the Employer and BlueChoice HealthPlan of South Carolina, Inc. BlueChoice HealthPlan of South Carolina, Inc. is an independent corporation operating under a license with the Blue Cross and Blue Shield Association permitting BlueChoice HealthPlan of South Carolina, Inc. to use the Blue Cross and Blue Shield service mark in the state of South Carolina. BlueChoice HealthPlan of South Carolina, Inc. is not contracting as the agent of the Association.

9.05 Coverage Exceptions

No person or entity has any authority to make any oral changes or amendments to the Contract. BlueChoice HealthPlan may, in certain circumstances for purposes of overall cost savings or efficiency provide benefits for services that otherwise would not be Covered Services. The fact that BlueChoice HealthPlan does so in any particular case shall in no way be deemed to require it to do so in other similar cases.

9.06 Policies and Procedures

BlueChoice HealthPlan may adopt reasonable policies, procedures, rules, and interpretations to promote the orderly and efficient administration of the Contract with which the Employer and the Members shall comply.

9.07 Fees

We may charge you a fee to reinstate your Policy and a fee if your Premium payment is returned for non-sufficient funds (NSF). The reinstatement fee is $10. The NSF fee is $25.

SECTION 10
COMPLIANCE WITH MEDICAL CHILD SUPPORT ORDER

10.01 Group Health Plan Coverage Pursuant to a Medical Child Support Order

A Medical Child Support Order is a judgment, decree, or order (including an approval of a property settlement) that 1) is made pursuant to State domestic relations law (including a community property law) or certain other State laws relating to medical child support; and 2) provides for child support or health benefit coverage for a child of a participant under a Group Health Plan and relates to benefits under the plan. If the Contract is an integral part of an employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended, the Contract shall provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order.

10.02 Information to be Included in a Qualified Medical Child Support Order

A Medical Child Support Order becomes a Qualified Medical Child Support Order only if such order clearly specifies:

1. The name and the last known mailing address (if any) of the participant Employee and the name and mailing address of each Alternate Recipient covered by the order;
2. A reasonable description of the type of Coverage to be provided by the plan to each such Alternate Recipient, or the manner in which such type of Coverage is to be determined;
3. The period to which such order applies; and
4. Each plan to which such order applies.

NOTE: An Alternate Recipient is any child of a participant in a Group Health Plan who is recognized under a medical child support order as having a right to enrollment under the plan with respect to such participant.

Additionally, a Medical Child Support Order becomes a Qualified Medical Child Support Order only if such order does not require a plan to provide any type or form of benefit or any option not otherwise provided under the plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993).

10.03 Procedural Requirements

1. **Establishment of Procedures for Determining Qualified Status of Orders.** The Employer as the plan administrator of the Group Health Plan shall establish reasonable procedures to determine whether a Medical Child Support Order is a Qualified Medical Child Support Order and to administer the provision of benefits under such qualified order.

   Such procedures shall:

   A. Be in writing;
   B. Provide for the notification of each person specified in a Medical Child Support Order as eligible to receive benefits under the plan (at the address included in the Medical Child Support Order) of such procedures promptly upon receipt by the plan of the Medical Child Support Order; and
   C. Permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

2. **Timely Notifications and Determinations**. In the case of any Medical Child Support Order received by a Group Health Plan:

   A. The Employer as the plan administrator shall promptly notify the Employee and each Alternate Recipient of the receipt of such order and the plan's procedures for determining whether a Medical Child Support Orders is a Qualified Medical Child Support Order; and
   B. Within a reasonable period after receipt of such order, the Employer/plan administrator shall determine whether such order is a Qualified Medical Child Support Order and notify the Employee and each Alternate Recipient of such determination.

3. **Actions Taken by** Plan Administrators. If a plan administrator acts in accordance with these procedural requirements in treating a Medical Child Support Order as being (or not being) a Qualified Medical Child Support Order, then the plan's obligation to the participant and each Alternate Recipient shall be discharged to the extent of any payment made pursuant to such act.

10.04 Participation of Alternate Recipients

1. A person who is an Alternate Recipient under any Medical Child Support Order shall be considered a participant under the plan only for purposes of the reporting and disclosure requirements of ERISA.

2. A person who is an Alternate Recipient under a Qualified Medical Child Support Order shall be considered a beneficiary under the plan for purposes of any provision of ERISA.

3. Any payment for benefits made by a Group Health Plan pursuant to a Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

4. If an Employee remains Covered under a Group Health Plan but fails to enroll an Alternate Recipient under this plan after receiving notice of the Qualified Medical Child Support Order from the Employer/plan administrator, the Group Health Plan shall enroll the Alternate Recipient and deduct the additional Premium from the participant Employee's paycheck.

5. Except for any Coverage continuation rights otherwise available under this Contract, Coverage for the Alternate Recipient shall end on the earliest of:

   A. The date the Employee's Coverage ends;
   B. The date the Qualified Medical Child Support Order is no longer in effect;
   C. The date the Employee obtains other comparable health coverage through another insurer or plan to cover the Alternate Recipient; or
   D. The date the Employer eliminates family health coverage for all Employees under all of the Employer's Group Health Plans.

SECTION 11
CONTACT US

11.01 Resolution of a Question

Questions or concerns about Coverage may be directed to Member Services through the Web site at:

www.BlueChoiceSC.com

or by calling:

786-8476 in Columbia; or
1-800-868-2528 outside the Columbia area.

Representatives are available between 8:30 a.m. and 6 p.m., Monday through Friday, to answer questions or discuss concerns.

Members may also write to:

BlueChoice HealthPlan
Member Services (AX-435)
P. O. Box 6170
Columbia, SC 29260-6170

Please include your ID number, name, address, and telephone number in your correspondence.

11.02 Complaints and Grievances

Our goal is for Members to be completely satisfied with the benefits and services associated with their BlueChoice HealthPlan coverage. However, if you are dissatisfied, we want to hear from you. A complaint is any dissatisfaction you have regarding services or benefits you receive from us. To file a complaint, you may e-mail, call or write a Member Services representative (see above for addresses). If the complaint involves a representative of BlueChoice HealthPlan, the request should be addressed to the chief operating officer of BlueChoice HealthPlan of South Carolina, Inc. 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 Member Services representative.

SECTION 12
DEFINITIONS

This section defines the terms used throughout this Certificate and is not intended to describe Covered and non-Covered Services. The terms defined in this section or in the following sections of this Certificate shall have their defined meaning whenever they are capitalized in this Certificate. Any term in this Certificate which has a different medical and non-medical meaning and which is undefined in this Certificate 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 such as a car accident or blow by a moving 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 doesn't include indirect or direct loss that results in whole or partially from a disease or other illness.

Actively-at-Work: To be considered Actively-at-work, the Employee must: 1) have begun work and not be absent from work because of leave of absence or temporary lay-off, unless the absence is due to a Health Status-related Factor; and 2) be performing the normal duties of his or her occupation at one of the Employer's places of business or at a location to which the Employee must travel to do his or her job. If the Employee does not meet this requirement, coverage will begin on the first day of the next Contract Month after the Employee has returned to active, full-time work.

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 maximum amount that we may pay for a Covered Service.

Ambulatory Surgical Center: A facility that's 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.

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).

Authorize or Authorization: Prior approval by BlueChoice HealthPlan for a Provider of healthcare services to provide certain Covered Services to a Member. Such approval must be on file with BlueChoice HealthPlan before the service is considered Authorized.

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 Preauthorization. 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 a required prior Authorization was not obtained.

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

Behavioral Therapy: Behavioral modification using applied behavioral analysis (ABA) techniques to target cognition, language and social skills.

Behavioral Therapy doesn't include educational or alternative programs such as, but not limited to:
1. TEACCH
2. Auditory integration therapy
3. Higashi schools/daily life
4. Facilitated communication
5. Floor time (DIR, developmental individual-difference relationship-based model)
6. Relationship development intervention (RDI), holding therapy
7. Movement therapies
8. Music therapy
9. Animal-Assisted therapy

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 12-month period that begins on the Effective Date of the group coverage or a calendar year. If the group coverage has a calendar year Benefit Period, the first Benefit Period may not be 12 months. It begins again each year on that date. Your Benefit Period is shown in your Schedule of Benefits.

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 South Carolina.

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 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've negotiated rates with that Provider. For example, you pay 20 percent of the Allowed Amount and we pay 80 percent.

Contract (Master Group Contract): The legal agreement between BlueChoice HealthPlan and the Employer including all sections of this Certificate of Coverage, the Master Group Contract, the Master Group Application, attached amendments, addenda, riders, or endorsements, if any, which constitute the entire Contract between both parties.

Copayment: A set amount (for example, $50 for an office visit) for some services. Please refer to your Schedule of Benefits to see if Copayments apply to your coverage.

Covered Service: A healthcare service for which benefits are provided under this Contract subject to the terms, conditions, limitations and exclusions of the Contract, including but not limited to, the following conditions:

1. Covered Services must be provided when the Contract is in effect;
2. Covered Services must be provided prior to the date of termination of Coverage;
3. Covered Services must be provided only when the recipient is a Member and meets all eligibility requirements specified in the Contract; and
4. Covered Services must be Authorized when required under this Contract.

Creditable Coverage: Benefits or coverage provided under:

1. A Group Health Plan;
2. Health Insurance Coverage;
3. Medicare Part A or B;
4. Medicaid, other than coverage having only benefits under Section 1928;
5. Military, TRICARE or CHAMPUS;
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool, including the South Carolina Health Insurance Pool (SCHIP);
8. The Federal Employees Health Benefits Plan (FEHBP);
9. A public health plan, as defined in regulations;
10. A health benefit plan of the Peace Corps;
11. Short Term Health; or
12. A State Children's Health Insurance Program (S-CHIP).

This term doesn't include coverage for coverage excepted under Health Insurance Coverage. We'll count a period of Creditable Coverage without regard to specific health benefits covered during that time.

Custodial Care: Care that we determine is provided primarily to furnish to or assist the patient in the activities of daily living and doesn't 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're responsible for paying for Covered Services before we begin to pay each Benefit Period. The Deductible may not apply to all Covered Services. Coupons for medical services and/or Prescription Drugs may not be used to satisfy any portion of the Deductible.

Dependent: Your legal spouse and any children through age 25 who are covered under the Contract. A Dependent child can be a natural or adopted child, stepchild, foster child or a child who's under your legal guardianship.

This also includes any child of a divorcing/divorced Employee who's recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment under this health plan. This means we provide coverage for Dependents of an Employee who's a Member of this Group Health Plan even though this Employee is the noncustodial parent when a QMCSO exists.

Designated Transplant Facility: A Hospital, named as such by BlueChoice HealthPlan, which has entered into an agreement with or on behalf of BlueChoice HealthPlan to render Medically Necessary and medically appropriate covered transplant services. A Designated Transplant Facility may or may not be located within BlueChoice HealthPlan's geographic area.

Durable Medical Equipment (DME): Equipment and supplies 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, orthotic 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.

Effective Date: 12:01 a.m. on the date that coverage begins.

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

Emergency Medical Care: Health care services you receive in a Hospital Emergency room to evaluate and treat an Emergency Medical Condition.

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.

Employee: Any individual employed by an Employer or Member of an association who is eligible for Coverage and who is so designated to BlueChoice HealthPlan by the Employer.

Employer: An Employer or association with whom BlueChoice HealthPlan has a Contract, by virtue of which Employees of the Employer or Members of the association, as the case may be, and their Dependents are eligible for the benefits described herein.

Enrollment Date: The date of enrollment in the Group Health Plan or the first day of the Waiting Period for enrollment, whichever is earlier.

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 Plan doesn't provide or cover.

Fee Schedule: The negotiated amount to be paid by BlueChoice HealthPlan to Participating Providers for Covered Services.

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 doesn't include the age or sex of any individual.

Group Health Plan: A policy or contract which combines the coverage of group accident insurance and of group health insurance.

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 Inpatient 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 doesn't 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 or CHAMPUS; and
    c. Coverage to supplement coverage under a Group Health Plan.

Health Insurance Marketplace or Marketplace: The process through which you're able to purchase a Qualified Health Plan.

Health Status Related Factor: Any of the following factors in relation to the Member:

1. Health status;
2. Medical condition, including both physical and mental illnesses;
3. Claims experience;
4. Receipt of healthcare;
5. Medical history;
6. Genetic Information;
7. Evidence of insurability, including conditions arising out of domestic violence; or
8. 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 and Behavioral Health care and treatment of injured or sick people on an Inpatient basis. 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" doesn't include long-term, chronic-care institutions or institutions (even when these are affiliated with or part of a Hospital) that are, other than incidentally:
1. Convalescent, rest or nursing homes or facilities; or
2. Facilities primarily affording custodial, educational or rehabilitory care.

In-Network Coverage: Benefits for covered health services or supplies obtained from Providers who have entered into a written agreement with BlueChoice HealthPlan to provide Covered Services to Members.

Incapacitated Dependent: A child who is: (1) incapable of self-sustaining employment because of a mental or physical handicap; and (2) mainly dependent upon the Employee or the Employee's spouse for support and maintenance. The child must have developed the handicap before he or she reached the age at which coverage would other terminate.

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 Services: 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.

Legally Intoxicated: The Member's blood alcohol level was at or in excess of the amount established under applicable state law to create a presumption and/or inference the Member was under the influence of alcohol, when measured by law enforcement or medical personnel.

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

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; or
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 Physician, 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;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;
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: An enrolled Employee or covered Dependent.

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
5. Any other health benefits coverage, such as a state health benefits risk pool, as recognized by the HHS Secretary

Minimum Essential Coverage doesn't include Health Insurance Coverage consisting of excepted benefits, such as dental-only coverage.

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

Out-of-Network Coverage: Benefits for non-Emergency, self-referred Covered Services or supplies obtained from non-Participating Providers.

Out-of-Pocket Limit: The most you pay for Covered Services in a Benefit Period before your Plan begins to pay 100 percent 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.

Outpatient: A Member who receives services or supplies in a setting that doesn't require an overnight stay.

Participating: The status of a Provider of Covered Services who has entered into a written agreement with BlueChoice HealthPlan to provide Covered Services to Members and to join BlueChoice HealthPlan's Network of Providers. 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 Certificate of Coverage.

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.

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 Web site.

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
2. Specific classes of over-the-counter medications designated as Prescription Medication at the sole discretion of 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 (PCP): A 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 don't 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 facility, Residential Treatment Center, Physician, psychologist, other mental health clinicians and an Ambulatory Surgical Center licensed as required by the state where located, performing within the scope of the license and acceptable to us. 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

Qualified Health Plan: A health plan that has been certified by the U.S. Department of Health and Human Services (HHS) to be offered through the Marketplace.

Qualified Individual: An individual who seeks to enroll in a Qualified Health Plan offered through the Marketplace, resides in – or intends to reside in – the state that established the Marketplace, and is determined to be eligible by the Marketplace.

Rehabilitation Facility: A Hospital or other freestanding medical facility that has a written agreement with BlueChoice, 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 multi-disciplinary therapeutic program that includes physical therapy, occupational therapy and other therapeutic interventions 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 and occupational therapy and speech therapy in a variety of Inpatient and/or Outpatient settings. All services must be provided by a licensed physical, speech or occupational 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 as an attachment to this Contract that specify the amount of coverage provided, applicable Copayments, Coinsurance, Deductibles and limitations.

Skilled Nursing Facility: A licensed institution, other than a Hospital, that has a written agreement with BlueChoice or with another BlueCross and/or BlueShield 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's in charge of patient care, along with one or more 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 isn't, other than incidentally, a rest home or a home for Custodial Care for the aged; and
6. Is operating lawfully as a 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 or alcohol abuse.

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

Specialist: A Physician who isn't a Primary Care Physician.

Subscriber: The individual whose employment or other status, except for family dependency, is the basis for eligibility for enrollment under this Contract, and who is in fact enrolled.

Substance Use Disorders: 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 as 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; and 3) other procedures as reasonable and as 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 Accountability Act's security rules by an eligible Provider who's at a different location than 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 health care 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 doesn't include a Hospital Emergency room.

Waiting Period: The period that must pass before you or your family members are eligible to be covered for benefits under the terms of the Contract with your Employer.