BlueChoice® Individual Coverage
Plan 3

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

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

Outline of Coverage

If you need information about this health coverage:

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

Read Your Contract Carefully

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

Individual Health Maintenance Organization Coverage

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

Important

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

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

Benefits Descriptions - Plan 3

Services	Benefits
Primary Care Physician Services	100% after $15 Copayment per office visit
Routine, Preventive Office Services	100% after $15 Copayment per office visit
Inpatient Hospital Care	80% after Deductible
Outpatient Hospital Care	80% after Deductible
Specialist Physician Services	80% after Deductible
Urgent Care	100% after $35 Copayment per visit
Mental Health (office services only)	100% after $25 Copayment per visit; up to 20 visits per Benefit Period
Prescription Drugs (Prescription drugs are each subject to one copayment for up to a 31-day supply)	100% after $7 Copayment for Generic Drugs 100% after $30 Copayment for Preferred Drugs 100% after $50 Copayment for Non-Preferred Drugs
Specialty Pharmaceuticals	100% after $100 Copayment
Vision Care	One eye exam per Benefit Period
Dental Care	Up to $20 for one exam and $30 for one cleaning per Benefit Period
Deductible	$750 per Benefit Period
Lifetime Maximum	$2,000,000
Prescription Drug Maximum	$3,000 per Benefit Period
Durable Medical Equipment Maximum	$5,000 per Benefit Period
Physical Therapy, Speech Therapy, & Occupational Therapy Maximum	$5,000 per Benefit Period
Coinsurance Maximum	$2,500 per Benefit Period

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

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

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

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

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

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

Pre-Existing Conditions

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

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

Waiting Periods

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

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

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

Guaranteed Renewable Except For Stated Reasons

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

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

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

Contract Term

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

About Premiums

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

BlueChoice Individual Coverage
SCHEDULE OF BENEFITS – PLAN 3

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

Deductible per Benefit Period	$750	
Maximum Coinsurance per Benefit Period	$2,500	
BENEFITS	**Member Pays**	**Plan Pays** *after copay/ deductible*
Physician Services		
Primary Care		
Office Services	$15 Copayment per visit	100%
Routine, Preventive Services	$15 Copayment per visit	100%
Hospital Services	$0	100%
Specialty Care (except mental health/substance abuse care)		
Office Services	Deductible, then 20%	80%
Hospital Services	Deductible, then 20%	80%
Mental Health Benefits (office services only)	$25 per visit	100%
Other Services		
Ambulance	Deductible, then 20%	80%
Durable Medical Equipment	Deductible, then 20%	80%
Home Health	Deductible, then 20%	80%
Hospice	Deductible, then 20%	80%
Medical Supplies	Deductible, then 20%	80%
OP Private Duty Nursing	Deductible, then 20%	80%
Physical, Speech & Occupational Therapy	Deductible, then 20%	80%
Prosthetic Devices	Deductible, then 20%	80%
Facility Services		
Inpatient Hospital	Deductible, then 20%	80%
Skilled Nursing Facility & Long-Term Acute Care Facility	Deductible, then 20%	80%
Outpatient Services	Deductible, then 20%	80%
Urgent Care Services – for services provided by a participating urgent care center	$35 Copayment per visit	100%
Emergency Room Services	Deductible, then 20%	80%
Dental Services		
One exam per Benefit Period	100% after $20	$20
One cleaning per Benefit Period	100% after $30	$30

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SCHEDULE OF BENEFITS – PLAN 3

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BENEFITS	Member Pays	Plan Pays *after copay/ deductible*
Vision Exam One complete eye exam for glasses per Benefit Period for services provided by participant in the Physicians Eye Network (PEN)	$0	100%
Prescription Medication Generic Drugs Preferred Drugs Non-Preferred Drugs **Retail pharmacy**: Prescription Medications are each subject to one Copayment for up to a 31-day supply. **Mail-order pharmacy:** Prescription Medications are each subject to two Copayments for up to a 90-day supply. Not all medications are available from the mail-order pharmacy.	 $7 $30 $50	 100% 100% 100%
Specialty Pharmaceuticals Not subject to the Prescription Medication Maximum	$100 Copayment	100%
PLAN MAXIMUMS		
Lifetime Benefit Maximum	$2,000,000	
Prescription Medication	$3,000 per Benefit Period	
Durable Medical Equipment	$5,000 per Benefit Period	
Physical, Speech & Occupational Therapy	$5,000 per Benefit Period	
Organ Transplants (Covered Transplants)	Maximum Benefit per Transplant	
Kidney (single)	$60,000	
Pancreas and Kidney	$80,000	
Heart	$120,000	
Lung (single)	$130,000	
Liver	$225,000	
Pancreas	$80,000	
Heart and Lung	$175,000	
Bone Marrow/Stem Cell	$250,000	
Cornea	$25,000	
Lifetime Transplant Maximum Benefit	$250,000	

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

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance online at contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-396-0190 . (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)