BlueChoice® HealthPlan
South Carolina

An independent licensee of the
Blue Cross and Blue Shield Association

MyChoice Open Access

Group Insurance Trust Open Access Coverage

MEMBER CERTIFICATE

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BLUECHOICE HEALTHPLAN GROUP INSURANCE TRUST COVERAGE
HEALTH COVERAGE

Important

BlueChoice HealthPlan of South Carolina, Inc. is a Health Maintenance Organization. BlueChoice HealthPlan's Group Insurance Trust Open Access Coverage is an open access product. That means you decide at the time you need medical care whether you will go to a health care provider within BlueChoice HealthPlan's network (i.e., a Participating Provider), or go to a non-network provider. Benefits are available in either case; however, by using network providers you receive higher benefits. A person enrolled in BlueChoice HealthPlan's Group Insurance Open Access Trust Coverage 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 health care 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 Reasonable and Customary Fee Schedule. BlueCross® BlueShield® of South Carolina underwrites these benefits and has arranged for BlueChoice HealthPlan to serve as the administrator of the Out-of-Network benefits. BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association.

This Certificate summarizes and explains the benefits available to you from BlueChoice HealthPlan. It includes as few legal and technical terms as possible. This Certificate becomes part of the Master Policy. The Master Policy is also the controlling document for determining all contractual rights. In the event of differences or errors, the provisions of the Master Policy control. If you wish to review the Master Policy, please submit a written request to the address listed in the *How to Get Help* section.

GENERAL INFORMATION

WHEN YOUR COVERAGE BEGINS AND ENDS

Eligibility: This coverage is available through a group trust product. Single-only certificates are available to persons: (1) at least two years of age and less than 64 ½ years of age; (2) who are not eligible for Medicare; and (3) who live in South Carolina. If you meet these requirements, BlueChoice HealthPlan Group Insurance Trust Coverage may be purchased for you by your parents, grandparents or legal guardians. You may also purchase it yourself if you are at least 18 years of age. Dependents cannot be added to the Certificate.

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

Important Notice Concerning Statements in Your Application for Coverage: The application is a part of the contract. Your Application will be mailed to you separately. We issued the certificate on the basis that the answers to all questions and any other material information shown on the application are correct and complete and that your health did not change between the time your application was signed and the effective date of this certificate (subject to the Patient Protection and Affordable Care Act). You have a duty to disclose updated medical and personal information from the date of the application until the effective date of the certificate. Please read the copy of the Application. If any information on it is not correct and complete as of the certificate effective date, or if any medical history has not been included, write to **BlueChoice HealthPlan, Post Office Box 6170, Columbia, South Carolina, 29260-6170**. If an intentional error on your Application misled us about the risk we assumed, we may have grounds to rescind the Certificate or require an additional premium in addition to the premium already required.

Listing the names of your providers in the application does not mean you have provided your medical history. If you do not provide your complete and correct medical history and personal information in the application and any updates and/or changes to your medical or personal information up to the effective date of this certificate, we may rescind the certificate or issue an endorsement to limit or exclude coverage had we known the true and correct facts at the time the certificate was issued subject to the *Incontestability* provision of the Master Policy.

Termination of Insurance: Your coverage will end at 12:01 a.m. Eastern Time: 1) on the next premium due date after we receive your written request, or 2) on the date the certificate lapses due to non-payment of premiums or is non-renewed, or 3) 30 days from the date of the notice of rescission, if rescinded, whichever occurs first. The company will provide you with a Certificate of Creditable Coverage when your coverage ends. If a duplicate certificate is needed at a later time, you must request the Certificate of Creditable Coverage within 24 months of your coverage ending. You may also request the Certificate of Creditable Coverage from the company even if your coverage is still in force. To request the Certificate of Creditable Coverage, please contact us at the address listed in the *How to Get Help* section.

Even if requested, we will not cancel this Certificate retroactively and refund any premium, whether or not you had any claims during that period of time except when coverage is rescinded.

EMERGENCY AND URGENT CARE SERVICES

Benefits are provided for services and supplies for stabilization and/or initial treatment of an Emergency Medical Condition provided on an outpatient basis at either a Hospital or an Alternate Facility. This plan provides coverage without the need for prior authorization regardless of the participating status of the provider. In order to be Covered, a Participating Physician must provide follow-up care.

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

PARTICIPATING PROVIDERS

Participating providers are hospitals, skilled nursing facilities, home health agencies, hospices, physicians and other medical professionals who have agreed with the company to:

- File all claims for covered services with the company.
- Collect only the copayment, deductible and coinsurance amounts, if any, for covered services. These amounts (part of the charge for covered services that the company does not pay) are shown in the Schedule of Benefits.
- Accept the Fee Schedule amount as payment in full for covered services.

You should contact the Company if you are billed by a participating provider for covered services other than any applicable coinsurance, copayment or deductible.

Verification of Participation Status. You are responsible for verifying the participation status of the Physician, Hospital or other Provider prior to receiving Covered Services. You may verify participation status by contacting Member Services through the website at www.BlueChoiceSC.com, or by calling 786-8476 in Columbia or 800-868-2528 when outside the Columbia area.

Enrolling for coverage does not guarantee the availability of a particular participating provider on the list of providers. This list of participating providers is subject to change.

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 and any applicable Pre-existing Condition Exclusion.

THE BLUECARD® PROGRAM

As a Blue Cross and Blue Shield licensee, BlueChoice HealthPlan participates in a national program called the BlueCard Program. *This program benefits you when you receive covered services for a condition while traveling outside the company's service area (state of South Carolina).* The "BlueCard" is your BlueChoice HealthPlan identification card. Your card tells participating hospitals and/or physicians which independent Blue Cross and Blue Shield licensee is yours.

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

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

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

HOW TO GET HELP

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

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

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

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

My Health Toolkit

Go to "My Health Toolkit" from www.BlueChoiceSC.com to:
- Check your eligibility.
- See how much you have paid toward your Deductible or Coinsurance Maximum.
- Check on Authorizations.
- Find out if we have processed your claims.
- Order a new ID card.
- See if our records show if you have other Health Insurance.
- Ask a Customer Service Representative a question through secure email.
- View your Explanation of Benefits (EOB).

Questions

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

From Columbia, dial 786-8476.
From anywhere else in the state, dial 800-868-2528, toll free.

If you can't call, write to:

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

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

COVERED SERVICES

WHAT'S COVERED: IN-NETWORK SERVICES

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.

Physician Services

Benefits are provided for preventive, diagnostic and treatment services when they are provided by Participating Physicians. This includes Medically Necessary office visits and medical or surgical care including Surgical Assistants provided in a Participating Physician's office or a Participating Hospital, Alternate Facility, Long-Term Acute Care Facility, Skilled Nursing Facility or Rehabilitation Hospital. The following services are Covered Services.

1. **Primary Care Physician Services.** All diagnostic and treatment services provided at the medical office of a Participating Primary Care Physician and at such other places as Authorized by BlueChoice HealthPlan, including preventive services, diagnostic procedures, therapeutic procedures, surgical procedures, medical supplies, consultation and treatment.

2. **Specialty Physician Services.** All diagnostic and treatment services provided at the medical office of a Participating specialty Physician and at such places as Authorized by BlueChoice HealthPlan including diagnostic procedures, therapeutic procedures, surgical procedures, medical supplies, consultation and treatment.

3. **Preventive Services. Health maintenance and preventive services including well-baby care** and periodic checkups; immunizations and injections; health education; and voluntary family planning provided by a Participating Primary Care Physician. Preventive health services will be covered without any cost-sharing from you when services are provided by a Participating Primary Care Physician. These preventive services include:

    A. Evidence-based services with a current "A" or "B" rating from the United States Preventive Services Task Force.
    B. Immunizations recommended for routine use by the Advisory Committee on Immunization Practices at the Centers for Disease Control and Prevention.
    C. Child preventive care and screenings provided for in the guidelines supported by the Health Resources and Services Administration (HRSA).
    D. For women, the preventive care and screenings provided for guidelines under development by the U.S. Department of Health and Human Services (HHS).

4. **Allergy Services.** Allergy testing and treatment, including test and treatment material (allergy serum) provided by a Participating Physician.

Inpatient Facility Services

Benefits are provided for a comprehensive range of benefits when a Member is hospitalized in a Participating Hospital, Skilled Nursing Facility or Long-Term Acute Care Facility. The admission must be ordered, provided or arranged under the direction of a Participating Physician except for an Emergency admission. BlueChoice HealthPlan must authorize the admission in advance except for an Emergency admission.

1. **Inpatient Hospital.** Covered Services for inpatient Hospital care include room and board and related ancillary and diagnostic services and supplies. Medically Necessary services provided in a special care unit are Covered Services.
2. **Skilled Nursing Facility or Long-Term Acute Care Facility.** Covered Services include room and board for semi-private accommodations, rehabilitative treatment, and related ancillary and diagnostic services and supplies. Benefits are limited to 120 days per Benefit Period unless otherwise specified in the Schedule of Benefits.

Outpatient Facility Services

1. **Outpatient Surgery.** Services and supplies for outpatient surgery and observation stays are Covered Services when provided by or under the direction of a Participating Physician at a Participating Hospital or a Participating Alternate Facility.

2. **Outpatient Laboratory, Radiology, Diagnostic and Therapeutic Services.** Services and supplies for laboratory, radiology and other diagnostic tests and therapeutic treatments are Covered Services when provided under the direction of a Participating Physician at a Participating Hospital or Participating Alternate Facility.

3. **Screening Mammography**. Services and supplies for screening mammograms performed at a Participating Hospital or Participating Alternate Facility when ordered by a Participating Physician are Covered in full.

Physical, Speech and Occupational Therapy

Benefits are provided for physical therapy, occupational therapy and speech therapy. Benefits for physical therapy are limited to 20 visits per Benefit Period unless otherwise noted on the Schedule of Benefits. Benefits for speech therapy are limited to 20 visits per Benefit Period unless otherwise noted on the Schedule of Benefits. Benefits for occupational therapy are limited to 20 visits per Benefit Period unless otherwise noted on the Schedule of Benefits. See the Chiropractic Services section for benefits.

Benefits are not provided for unattended or non-supervised physical therapy, occupational therapy or speech therapy services, such as unattended electrical stimulation; or physical therapy, occupational therapy or speech therapy services that do not require the skills of a licensed therapist to perform, such as the application of hot or cold packs.

Behavioral Health Services

Unless otherwise specified in the Schedule of Benefits, benefits are provided for the following services:

Benefits for mental health or substance use disorder services, performed in an office setting, are limited to the number of visits shown on the Schedule of Benefits. Covered Services must be authorized in advance by Companion Benefit Alternatives (CBA) and provided by a Participating Provider. On behalf of BlueChoice HealthPlan, CBA manages behavioral health and substance abuse benefits for most of our members and their dependents. CBA is a separate company. Covered Services do not include medications, supplies or treatment of Attention Deficit Disorder (ADD) with or without hyperactivity (ADHD). Covered services do not include partial hospitalization or intensive outpatient services (see definitions). Services for treatment at a Residential Treatment Center are not Covered Services.

Prescription Medication

Coverage for Prescription Medication is provided when specifically indicated in the Schedule of Benefits. When Covered, benefits for Prescription Medication are provided when purchased at a Participating pharmacy, this includes certain classes of over-the-counter drugs designated by BlueChoice HealthPlan as Prescription Medication. Benefits for a Covered Prescription Medication dispensed to a Member shall not exceed the quantity, if applicable, as specified in the Schedule of Benefits.

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. Certain Prescription Medications require Prior Authorization and/or Step Therapy in order to be Covered, and have quantity limits as determined by BlueChoice HealthPlan.

Generics Now: If a Participating Physician prescribes a Brand-name Drug and there is an equivalent Generic Drug available, and the Member still requests the Brand-name Drug, then any difference between the cost of the Generic Drug and the higher cost of the Brand-name Drug will be the responsibility of the Member. This will be in addition to the Copayment appropriate to the Brand-name Drug being purchased. In no instance will the Member be charged more than the actual retail price of the drug.

Specialty Pharmaceuticals. Coverage for Specialty Pharmaceuticals is provided when specifically indicated on the Schedule of Benefits. When Covered, benefits for Specialty Pharmaceuticals are provided when purchased from a designated Participating Provider. Benefits for Covered Specialty Pharmaceuticals dispensed to a Member shall not exceed the quantity, if any, as specified in the Schedule of Benefits. The Member may obtain a list of Specialty Pharmaceuticals by contacting BlueChoice HealthPlan. See the section on How to Get Help.

BlueChoice HealthPlan receives financial credits directly from drug manufacturers and through a Pharmacy Benefit Manager (PBM). 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 preferred drug credit by BlueChoice HealthPlan. Copayments are flat amounts and likewise do not change due to receipt of these credits.

Ambulance Services

Professional ambulance services to a local hospital are covered in connection with an acute injury or medical emergency. Coverage is also provided in connection with an interfacility transport between acute care facilities, when medically necessary due to the requirement for a higher level of services. No benefits are provided for ambulance service used for routine, nonemergency transportation, including, but not limited to, travel to a facility for scheduled medical or surgical treatments, such as dialysis or cancer treatment, or transport from a facility to home or skilled nursing settings. All claims for ambulance services are subject to medical review. The Member is responsible for any outstanding balance as a result of all services rendered by a non-participating air or ground ambulance provider.

Home Health Services and Outpatient Private Duty Nursing

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

Benefits are provided for special or private duty nursing by an R.N. or an L.P.N. when provided on an outpatient basis and when such services are required for care and treatment that otherwise would require admission to a Hospital. Benefits for outpatient private duty nursing are limited to 60 days per Benefit Period unless otherwise specified in the Schedule of Benefits.

Hospice Services

Hospice care is a Covered Service when recommended by a Participating Physician and provided through a Participating Provider. Volunteer services are not Covered Services.

Transplants

1. Benefits are provided for Covered Services for certain human organ and tissue transplants, listed on the Schedule of Benefits. To be covered, such transplants must be provided from a human donor to a Member (the transplant recipient) and provided at a Designated Transplant Facility. All solid organ (complete organ or segmental, cadaveric or living donor) procurement services, including donor organ harvesting, typing, storage and transportation are covered.
2. The payment for charges for Covered Services incurred by a living donor are covered only if the donor and recipient are both covered by BlueChoice HealthPlan.
3. Transplants that are Experimental, Investigational or Unproven are not Covered Services. Transplants that are not Medically Necessary, as determined by the Corporation, are not Covered Services.
4. Benefits are provided on the same basis as any other condition or illness subject to the maximums stated in the Schedule of Benefits, if any.

Emergency and Urgent Care Services

Benefits are provided for services and supplies for stabilization and/or initial treatment of an Emergency Medical Condition provided on an outpatient basis at either a Hospital or an Alternate Facility. This plan provides coverage without the need for prior authorization regardless of the participating status of the provider. In order to be Covered, a Participating Physician must provide follow-up care.

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

Prosthetics and Durable Medical Equipment

Coverage is provided for prosthetic devices and Durable Medical Equipment when obtained from a vendor or Provider designated by BlueChoice HealthPlan, and when ordered by or provided by or under the direction of a Participating Physician for use outside a Hospital, Skilled Nursing Facility, Long-term Acute Care Facility, or Rehabilitation Hospital. Coverage is provided for prosthetic devices and Durable Medical Equipment that meets minimum specifications and is Medically Necessary. No benefits are provided for repair, replacement or duplicates, nor are benefits provided for services related to the repair or replacement of such devices and equipment, except when necessary due to a change in the Member's medical condition. Benefits are provided for:

1. The initial purchase of artificial limbs, artificial eyes, and other Medically Necessary prosthetic devices made necessary as a result of injury or sickness. (Prosthetic devices replace a limb or body part).
2. The rental or purchase, at the discretion of BlueChoice HealthPlan, of Durable Medical Equipment including, but not limited to, the following: braces, including necessary adjustments to shoes to accommodate braces (dental braces are excluded); oxygen and the rental of equipment for the administration of oxygen; standard wheelchairs; standard Hospital-type beds; and mechanical equipment necessary for the treatment of chronic or acute respiratory failure. Air conditioners, humidifiers, dehumidifiers, personal comfort items, eyeglasses, hearing aids and deluxe appliances are excluded. Cooling or heating devices used in the outpatient setting, including but not limited to, water circulating compression devices are not covered.

Medical Supplies

Covered supplies must be purchased at or under the direction of a Participating Physician. Benefits for medical supplies are available for but not limited to the following:

1. dressings requiring skilled application for conditions such as cancer or burns;
2. catheters;
3. colostomy bags and related supplies;
4. necessary supplies for renal dialysis equipment or machines;
5. surgical trays; and
6. splints or such supplies as needed for orthopedic conditions.

Supplies and equipment that have non-therapeutic uses are not Covered Services.

Dental Care for Accidental Injury

Dental services performed by a Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.) to natural teeth required because of accidental injury are Covered Services. For purposes of this benefit, an accidental injury is defined as an injury caused by a traumatic force such as a car accident or blow by a moving object. No benefits are provided for injuries that occur while the Member is in the act of chewing or

biting. Only services directly related to the accidental injury are Covered Services. No Coverage is provided unless the dentist certifies to BlueChoice HealthPlan that services were performed to natural teeth that were injured as a result of an accident, and that the services were completed within six months of the accident. Services other than those provided during the initial visit must be Authorized by BlueChoice HealthPlan in order to receive benefits.

Dental Care

One oral examination every benefit year by or under the direction of a licensed dentist is covered. One dental cleaning (prophylaxis) every benefit year by or under the direction of a licensed dentist is covered. This service does not have to be authorized. You will have to file a claim to the company to receive reimbursement. Other than preventive dental services listed above, there is no Coverage for other dental services related to the teeth and supporting structures.

Vision Care

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

Chiropractic Services

Benefits are provided for office services provided by a chiropractor in connection with the detection and correction by manual means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference and the effects of such nerve interference, where such interference is the result of or related distortion, misalignment or subluxation of, or in, the vertebral column. Maintenance care is not Covered.

Benefits will also be provided for other Covered Services that are within the scope of the practice of chiropractic.

Benefits Mandated by State and/or Federal Law

1. **Limited Obstetrical and Gynecological Access without Referral.** Coverage is provided for a female enrollee 13 years of age or older for a minimum of two visits annually without referral, for Covered Services provided by a Participating obstetrician-gynecologist. For purposes of this section, Covered Services include the full scope of Medically Necessary services provided by the Participating obstetrician-gynecologist in the care of or related to the female reproductive system and breasts.

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

3. **Mammograms.** Coverage is provided for mammograms. Benefits are provided on the same basis as any other condition or illness. A mammogram is a radiological examination of the breast for purposes of detecting breast cancer when performed as a result of a Physician referral or by a health testing

service that utilizes radiological equipment approved by the Department of Health and Environmental Control. For benefit purposes, such examination may be made with the following minimum frequency:

A. once as a base-line mammogram for a female who is at least 35 years of age but less than 40 years of age;
B. once every two years for a female who is at least 40 years of age but less than 50 years of age;
C. once a year for a female who is at least 50 years of age; or
D. in accordance with the most recently published guidelines of the American Cancer Society.

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

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

6. **Reconstructive Surgery Following Mastectomy.** If a Member is receiving benefits in connection with a mastectomy and elects breast reconstruction in connection with such mastectomy, Coverage will be provided in a manner determined in consultation with the attending Physician and the Member. Benefits are provided on the same basis as any other condition or illness and include:

A. reconstruction of the breast on which the mastectomy was performed;
B. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
C. prostheses and physical complications in all stages of mastectomy including lymphedemas.

7. **Cleft Lip and Palate**

Benefits are provided for the Medically Necessary care and treatment of cleft lip and palate and any condition or illness related to or developed as a result of cleft lip and palate. Covered Services must be provided by or under the direction of a Participating Provider and include, but are not limited to, Medically Necessary:

A. oral and facial surgery, surgical management and follow-up care;
B. prosthetic treatment such as obdurators, speech appliances and feeding appliances;
C. orthodontic treatment and management;
D. prosthodontia treatment and management;
E. otolaryngology treatment and management;
F. audiological assessment, treatment, and management, including surgically implanted amplification devices; and
G. physical therapy assessment and treatment.

If a Member with a cleft lip and palate is covered by a dental policy, teeth capping, prosthodontics, and orthodontics are covered first by the dental policy up to the limit of coverage provided. Any additional benefits for Covered Services thereafter shall be provided under the terms of this Contract.

Benefits are provided on the same basis as for any other medical condition or illness as specified in the Schedule of Benefits.

The BlueCard® Program

When a Member obtains healthcare services through the BlueCard program while outside South Carolina, the amount the Member pays for Covered Services, other than a Copayment, is calculated based on the lower of:

1. the billed charges for Covered Services; or
2. the negotiated amount that the Blue Cross and/or Blue Shield Plan (Host Blue) where care is received passes on to BlueChoice HealthPlan.

This negotiated amount may consist of a simple discount that reflects the actual amount paid by the Host Blue. Sometimes an estimated amount is factored into the actual amount, expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with the healthcare Provider or with a specified group of Providers. The negotiated amount also may be the billed charges reduced to reflect an average expected savings with the healthcare Provider or with a specified group of Providers. The amount that reflects average savings may result in greater variation (more or less) from the actual amount paid than will the estimated amount. The negotiated amount also will be adjusted in the future to correct for over- or underestimation of past amounts. In any case, the amount the Member pays is considered a final amount.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim, or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, BlueChoice HealthPlan will calculate the Member's liability for any Covered Services in accordance with the applicable state statute in effect at the time the Member received care.

Discount Services

Benefits in the form of a discount for certain additional services are available to Members by networks with which BlueChoice HealthPlan contracts for various programs. The special network of providers shall offer these discounts to Members at the time the services are rendered. BlueChoice HealthPlan shall not be responsible for any costs associated with these programs including charges related to any injury or illness that results from member's use of Discount Services. The services available include, but are not limited to: LASIK surgery, hearing aids, massage therapists, acupuncturists and fitness clubs. All services and programs may not be available in all areas at all times.

WHAT'S COVERED: OUT-OF-NETWORK SERVICES

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. These benefits are paid based on Reasonable and Customary Fee Schedule. BlueCross BlueShield of South Carolina underwrites these benefits and has arranged for BlueChoice HealthPlan to serve as the administrator of the Out-of-Network benefits. Out-of-Network dialysis services are not a covered benefit.

Covered Health Services

Medical and surgical services including Surgical Assistants provided by a Physician for the treatment of a sickness or injury including office visits and Hospital visits.
Allergy testing and treatment, including test and treatment material (allergy serum).

Inpatient Facility Services

Benefits are provided for a comprehensive range of benefits when a Member is hospitalized in a Hospital, Skilled Nursing Facility or Long-Term Acute Care Facility. BlueChoice HealthPlan must authorize the admission in advance except for an emergency admission.

1. **Inpatient Hospital**. Covered Services include inpatient Hospital care including room and board and related ancillary and diagnostic services and supplies. Medically Necessary services provided in a special care unit are Covered Services.
2. **Skilled Nursing Facility or Long-Term Acute Care Facility**. Covered Services include room and board for semi-private accommodations, rehabilitative treatment, and related ancillary and diagnostic services and supplies. Benefits are limited to 120 days per Benefit Period unless otherwise specified in the Schedule of Benefits.

Outpatient Facility Services

1. **Outpatient Surgery**. Services and supplies for outpatient observation and surgery.
2. **Outpatient Laboratory, Radiology, Diagnostic and Therapeutic Services**. Services and supplies for laboratory, radiology, and other diagnostic tests and therapeutic treatments.

Ambulance Services

Professional ambulance services to a local hospital are covered in connection with an acute injury or medical emergency. Coverage is also provided in connection with an interfacility transport between acute care facilities, when medically necessary due to the requirement for a higher level of services. No benefits are provided for ambulance service used for routine, nonemergency transportation, including, but not limited to, travel to a facility for scheduled medical or surgical treatments, such as dialysis or cancer treatment, or transport from a facility to home or skilled nursing settings. All claims for ambulance services are subject to medical review. The Member is responsible for any outstanding balance as a result of all services rendered by a non-participating air or ground ambulance provider.

Home Health Services and Outpatient Private Duty Nursing

1. Benefits for home health services include part-time, intermittent nursing care by a registered nurse (RN) or by a licensed practical nurse (LPN) where appropriate, or physical, speech, or occupational therapy provided through a home health agency. Services by a home health aide are considered to be Custodial Care and are not Covered.
2. Benefits are provided for special or private duty nursing by a registered nurse or a licensed practical nurse when provided on an outpatient basis, and when such services are required for care and treatment that otherwise would require admission to a Hospital. Benefits for outpatient private duty nursing are limited to 60 days per Benefit Period.

Hospice Services

Hospice care is Covered when recommended by a Physician and provided through a licensed hospice Provider. Volunteer services are not Covered Services.

Medical Supplies

Covered supplies must be purchased at or under the direction of a Participating Physician. Benefits for medical supplies are available for but not limited to the following:

1. Dressings requiring skilled application for conditions such as cancer or burns;
2. Catheters;
3. Colostomy bags and related supplies;
4. Necessary supplies for renal dialysis equipment or machines;
5. Surgical trays; and
6. Splints or such supplies as needed for orthopedic conditions.

Supplies and equipment that have non-therapeutic uses are not Covered Services.

Chiropractic Care

Benefits are provided for office services provided by a chiropractor in connection with the detection and correction by manual means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference and the effects of such nerve interference, where such interference is the result of or related distortion, misalignment or subluxation of, or in, the vertebral column. Maintenance care is not Covered.

Benefits will also be provided for other Covered Services that are within the scope of the practice of chiropractic.

HOW TO FILE A CLAIM

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.

Non-Participating Providers

Non-Participating Providers may agree to file claims directly to BlueChoice HealthPlan, but are not required to any may refuse to file your claims. You are then responsible for filing a claim to BlueChoice HealthPlan''s office, on a form provided by or satisfactory to BlueChoice HealthPlan, within six 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 six 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 website 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.

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 800-868-2528 outside the Columbia area.

Non-Participating Providers can also bill you for charges in excess of the Reasonable and Customary Fee Schedule.

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

SERVICES AND SUPPLIES THAT ARE NOT COVERED

No benefits are provided for the following, unless otherwise specified in the Schedule of Benefits. Treatment of an injury which is generally covered by this Certificate will not be denied if the injury results from being a victim of an act of domestic violence.

1. Any services or supplies determined to be not Medically Necessary.
2. Any services or supplies for which the Member is not legally obligated to pay.
3. Any services or supplies for treatment of military service-related disabilities when the Member is legally entitled to other coverage.
4. Any services or supplies for which benefits are paid by Workers' Compensation, occupational disease law or other similar legislation.
5. Treatment of an illness contracted or injury sustained while engaged in the commission or an attempt to commit an assault or a felony; treatment of an injury or illness incurred while engaged in an illegal act or occupation; treatment of an injury or illness due to voluntary participation in a riot or civil disorder.
6. Any charges for services provided prior to the Member's Effective Date or after the termination of Coverage.
7. Custodial care or respite care.
8. Residential treatment of Mental Health or Substance Use Disorders, including residential treatment centers; therapeutic schools; wilderness/boot camps; therapeutic boarding homes; half-way houses; and therapeutic group homes.
9. Inpatient Hospital treatment of Mental Health or Substance Use Disorders.
10. Any services or procedures for transsexual surgery or related services provided as a result of complications of such transsexual surgery.
11. All services and supplies related to pregnancy except for life-threatening complications of pregnancy to either the mother or fetus. An elective abortion is not considered to be a complication of pregnancy.
12. Services, supplies or drugs for the treatment of infertility including, but not limited to, artificial insemination and in-vitro fertilization; fertility drugs; reversal of sterilization procedures; and surrogate parenting.
13. Pre-conception testing or pre-conception genetic testing.
14. Any drugs, services, treatment or supplies determined by the medical staff of the Corporation, with appropriate consultation, to be Experimental, Investigational or Unproven Services. NOTE: Benefits are provided for off-label uses of pharmaceuticals that have been approved by the U.S. Food and Drug Administration (FDA) (but not approved for the prescribed use) provided that the drug is not contraindicated by the FDA for the off-label use prescribed, and that the drug has been proven safe, effective and accepted for the treatment of the specific medical condition for which the drug has been prescribed, as evidenced by the results of good quality-controlled clinical studies published in at least two or more peer-reviewed full length articles in respected national professional medical journals.
15. Drugs for which there is an over-the-counter equivalent, except for over-the-counter drugs considered to be Prescription Medication. All vitamins, except prenatal vitamins; drugs not approved by the Food and Drug Administration; drugs for the treatment of non-Covered therapies, services, or

conditions such as drugs prescribed for obesity or weight control, cosmetic purposes, hair growth, fertility or sexual dysfunction.

16. Plastic or cosmetic surgical procedures or services performed to improve appearance or to correct a deformity without restoring a bodily function, unless such services are Medically Necessary and due to physical trauma, prior surgery or congenital anomaly.

17. Early Intensive Behavioral Interventions for Autism Spectrum Disorders, typified by Applied Behavioral Analysis (ABA) or other behavioral/educational therapies.

18. Services, therapy or medications for the treatment of Attention Deficit Disorder with or without hyperactivity (ADHD).

19. Psychological or educational testing to determine job or occupational placement, school placement or for other educational purposes, or to determine if a learning disability exists.

20. Relationship counseling including marriage counseling for the treatment of pre-marital, marital or relationship dysfunction.

21. Counseling and psychotherapy services for the following conditions:

    A. Feeding and eating disorders in early childhood and infancy;
    B. Tic disorders except when related to Tourette's syndrome;
    C. Elimination disorders;
    D. Mental disorders due to general medical condition;
    E. Sexual function disorders;
    F. Sleep disorders;
    G. Medication induced movement disorders; or
    H. Nicotine dependence unless listed elsewhere as covered.

22. Medical supplies, services or charges for the diagnosis or treatment of dissociative disorders, sexual and gender identity disorders, personality disorders, learning disorders, developmental speech delay, communication disorders, developmental coordination disorders, mental retardation or vocational rehabilitation.

23. Services for Animal Assisted Therapy, Repetitive Transcranial Magnetic Stimulation (rTMS), Vagal Nerve Stimulation for depression and other DSM disorders, Eye Movement Desensitization and Reprocessing (EMDR), behavioral therapy for solitary maladaptive habits, or Rapid Opiate Detoxification.

24. Any rehabilitation therapy or services for the treatment of mental retardation or developmental coordination disorder; or vocational rehabilitation.

25. Any service or supply for the diagnosis or treatment of sexual dysfunction including, but not limited to, surgery, drugs, laboratory and X-ray tests, counseling or penile implant necessary due to any medical condition or organic disease.

26. Services or supplies related to dysfunctional conditions of the muscles of mastication, malpositions or deformities of the jaw bone(s), orthognathic deformities or temporomandibular joint (TMJ) disorders including, but not limited to, surgical treatment, appliances and orthodontia.

27. For dental work or treatment which includes Hospital or professional care in connection with:

    A. an operation or treatment for the fitting or wearing of dentures, regardless if needed due to injury of natural teeth due to an accident;

B. orthodontic care or treatment of malocclusion;

C. operations on or treatment of or to the teeth or supporting bones and/or tissues of the teeth except for removal of malignant tumors or cysts;

D. any treatment of an injury to natural teeth due to an accident not received within 6 months of the accident date;

E. removal of teeth, whether impacted or not; and

F. any operation, service, prosthesis, supply or treatment for the preparation for, and the insertion or removal of, a dental implant.

This exclusion does not apply to facility and anesthesia services that are Medically Necessary because of a specific organic medical condition including but not limited to congestive heart failure, asthma or chronic obstructive pulmonary disease that requires Hospital-level monitoring.

28. Hearing aids or examinations for the prescription or fitting of hearing aids.

29. Charges incurred as the result of a missed scheduled appointment and charges for the preparation, reproduction, or completion of medical records, itemized bills, or claims forms.

30. Services or supplies not specifically listed as a Covered Service or in the Schedule of Benefits.

31. Transplant services other than those described in Covered Services.

32. Medical and surgical expenses for care and treatment of a living human organ transplant donor.

33. Complications arising during, from or related to the receipt by a Member of non-Covered Services. "Complications", as used in this exclusion, includes any medically necessary services or supplies which, in the Plan's judgment, would not have been required by the Member had the Member not received non-Covered Services. This includes Complications arising from discount value-added services.

34. Items that do not provide a direct medical treatment, are generally available without a physician's prescription, and may be useful to a Member in the absence of disease, including but not limited to the purchase or rental of air conditioners, home air filtration systems, motorized transportation equipment, escalators or elevators, swimming pools, waterbeds, exercise equipment, or other similar items or equipment.

35. Manual or motorized wheelchairs or power-operated vehicles such as scooters for mobility outside of the home setting. Coverage for these devices to assist with mobility in the home setting is subject to the establishment of Medical Necessity by the Corporation.

36. External infusion insulin pumps and continuous glucose monitoring systems.

37. Bioelectric, computer programmed prosthetic devices.

38. Services, treatment or medications related to the management of all types of blood clotting or coagulation disorders, such as, but not limited to Hemophilia, unless the member has received treatment at least once in a given Benefit year at a Hemophilia Treatment Center (HTC) as designated by the U.S. Centers for Disease Control and Prevention.

39. Any service or supply provided by a member of the patient's family or by the patient, including the dispensing of drugs. A member of the patient's family means the patient's spouse, parent, grandparent, brother, sister, child or spouse's parent.

40. Charges for acupuncture, hypnotism, biofeedback therapy, and TENS units. Services for chronic pain management programs or any program developed by centers with multidisciplinary staffs intended to

provide the interventions necessary to allow the patient to develop pain coping skills and freedom from dependence on analgesic medications.

41. Services, supplies, treatment or medication for the management of morbid obesity, obesity, weight reduction, weight control or dietary control (collectively referred to as "Obesity-related treatment") including, but not limited to, gastric bypass or stapling, intestinal bypass and related procedures or gastric restrictive procedures.

    Also, the treatment or correction of complications from Obesity-related treatment are non-covered services, regardless of Medical Necessity, prescription by a physician or the passage of time from a Member's obesity-related treatment. This includes the reversal of Obesity-related treatments, and reconstructive procedures necessitated by weight loss.

42. Orthomolecular therapy including infant formula, nutrients, vitamins and food supplements. Enteral feedings when not a sole source of nutrition.

43. Nutrition counseling, lifestyle improvements, or physical fitness programs. This exclusion does not include diabetic nutrition education.

44. Radial keratotomy, myopic keratomileusis, LASIK surgery, INTACS surgery and any surgery which involves corneal tissue for the purpose of altering, modifying or correcting myopia, hyperopia or stigmatic error. This exclusion does not include the treatment and management of keratoconus unresponsive to contact lens therapy.

45. Treatment of weak, strained or flat feet, including orthopedic shoes or other orthotic supportive devices, for services and supplies for cutting, removal or treatment of corns, calluses or nail care. This exclusion does not include corrective surgery, or treatment for metabolic or peripheral vascular disease.

46. Communications, travel time, transportation, except for use of professional ambulance services as defined in Covered Services under item 6, Ambulance Services.

47. Adjustable cranial orthoses (band or helmet) for positional plagiocephaly or craniosynostoses in the absence of cranial vault remodeling surgery.

48. Services, supplies or treatment for varicose veins, including but not limited to endovenous ablation, vein stripping, or the injection of sclerosing solutions.

49. Growth hormone therapy for patients over 18 years of age. Growth hormone therapy for patients 18 years of age or younger is excluded unless required for documented growth hormone deficiency.

50. Pulmonary Rehabilitation, except in conjunction with a Covered lung transplant.

51. Charges for services or supplies from an independent healthcare professional whose services are normally included in facility charges.

52. Physician charges for virtual office visits including but not limited to telephonic, Internet, electronic mail or video chat consultations.

53. Pre-operative anesthesia assessment.

54. Massage therapy.

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, including surgery, of certain specified diseases or conditions or losses resulting there from. The waiting periods for this contract are stated below:

- Six months for acne treatment
- Six months for adenoids
- Six months for allergy testing
- Six months for gastrointestinal reflux surgery
- Six months for hemorrhoids
- Six months for hernia (all types)
- Six months for disorders of reproductive systems
- Six months for sinus surgery
- Six months for strabismus
- Six months for tonsils

PRE - EXISTING CONDITION EXCLUSION

THIS SECTION IS APPLICABLE ONLY TO MEMBERS WHO ARE 19 YEARS OF AGE OR OLDER

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.

Credit for Prior Coverage

Credit for Prior Coverage, which is calculated on a day-by-day basis, can reduce or eliminate the Pre-existing Condition Exclusion unless the condition is excluded by Endorsement.

A period of prior coverage does not count if there is at least a 31-day period where you were not covered under any Health Insurance Coverage. Your Waiting Period for Health Insurance Coverage is not counted toward or against the 31-day period.

Credit for Prior Coverage will be determined when you provide us with a Certificate or other acceptable evidence that shows you had prior Health Insurance Coverage. You have the right to request a Certificate of Creditable Coverage from any prior plan or issuer. If necessary, BlueChoice HealthPlan will request the certificate with your written authorization.

We will notify you of any Pre-existing Condition Limitations period and the basis for the determination. You have the right to submit additional evidence showing you have Credit for Prior Coverage; BlueChoice HealthPlan will then calculate your revised Pre-Existing Limitation Period. We have the right to reconsider our decision if we determine you did not have the full credit for the prior coverage you say you did.

COORDINATION OF BENEFITS

All of the Benefits provided under this Certificate are subject to this section.

Definitions

1. **Plan** – Any program providing benefits for services or treatment, and for which those benefits are provided by: 1) group insurance and group subscriber coverage; 2) uninsured arrangements of group coverage; 3) group coverage through HMOs and other prepayment coverage, group practice and individual practice plans; 4) medical benefits coverage in group and individual "no fault" and traditional automobile "fault" type contracts; and 5) group hospital indemnity benefits payments in excess of $100 per day.

   For purposes of this section, the term "Plan" will also include Medicare Part B when a Member Certificate is secondary to Medicare as mandated by federal law, and the person covered under this Certificate did not elect coverage under Medicare Part B.

   The term "Plan" will be construed separately with respect to each policy, contract or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract or other arrangement which reserves the right to coordinate benefits or services of other Plans in determining its benefits and that portion which does not.

2. **Covered Services** – Any necessary, reasonable and/or customary service or supply specified in this Certificate for which benefits will be provided when provided by a Provider. Payment under this Certificate cannot exceed the amount that would normally be paid in the absence of this section. Personal comfort items provided at the patient's request, such as television, air conditioning and telephone that are listed separately on the Hospital's or Skilled Nursing Facility's regular statement of charges, are not considered Covered Services. If benefits are reduced under a primary plan because the covered person did not comply with the Plan's provisions, such as Second Surgical Opinions, precertification of admissions or services, and preferred Provider arrangements, the amount of the reduction will not be covered for benefits under this Certificate. When the Plan provides benefits in the form of services, the reasonable cash value of each service provided will be considered a paid benefit.

Effects on Benefits

1. If you are also covered for comparable benefits or services under another Plan that should pay first, benefits payable under this Plan will be reduced so that, for Covered Services incurred, benefits available under all Plans will not exceed the total Allowable Charge of such Covered Services. You will receive a notice stating a claim has been denied or that we need information to complete processing the claim. For the files to be updated, you must return the notice with the requested information.

2. The rules establishing the order of benefits determinations are as follows:

   A. The benefits of a Plan that does not contain a Coordination of Benefits provision or other provisions of similar intent will be determined before the Benefits under the Certificate.

   B. The benefits of a Plan which covers a named insured primarily, will be determined before the benefits of a Plan which covers such persons as a Dependent, or secondarily.

C. When the prior rules do not establish an order of benefit determination, the benefits of a Plan that has covered the person for the longer period of time will be determined before the benefits of a Plan that has covered the person for the shorter period of time.

D. If a Plan contains order of benefit determination rules that declare that Plan to be excess to or always secondary to all other Plans, this Certificate will coordinate benefits as follows:

1) If this Certificate is primary, it will pay or provide benefits on a primary basis;

2) If this Certificate is secondary, it will pay or provide Benefits first, but the amount of benefits payable will be determined as if this Certificate were the secondary Plan. The liability of this Certificate will be limited to such payment;

3) If the other Plan does not furnish the information needed by this Certificate to determine Benefits within a reasonable time after such information is requested, this Certificate will assume that the benefits of the other Plan are the same as those provided under this Certificate and will pay benefits accordingly. When information becomes available as to the actual benefits of the other Plan, any Benefit payment made under this Certificate will be adjusted accordingly;

4) If the other Plan reduces its benefits so that the covered person receives less in benefits than he or she would have received had this Certificate paid or provided benefits as the secondary Plan and the other Plan paid or provided its benefits as the primary Plan and the governing State law allows the right of subrogation, then this Certificate will advance an amount equal to such difference to or on your behalf.

In no event will this Certificate advance more than it would have paid as the primary Plan less any amount it previously paid. In consideration of such advance, this Certificate will be subrogated to all your rights against the other Plan. Such advance under this Certificate will also be without prejudice to any claim it may have against the other Plan in the absence of such subrogation.

3. If this Certificate is secondary to Medicare as mandated by federal law, and if the person did not elect coverage under Medicare Part B, Benefits under this Certificate may be reduced by the amount that would have been paid by Medicare Part B had the person elected such coverage.

Right to Receive and Release Necessary Information
For the purpose of determining the applicability of and implementing the terms of this section or any provision of similar purpose of any other Plan, we may, without the authorization of or prior notice to any person, release to or obtain from any insurance company or other organization or person any information, with respect to any person, which it deems to be necessary for such purposes. Any person claiming benefits under this Plan will furnish such information to us as may be necessary to implement this section.

Facility of Payment
Whenever payments which should have been made under this Plan according to this section have been made under any other Plan, we will have the right to pay over to any organization making such other payments any amounts it determines to be warranted in order to satisfy the intent of this section, and amounts paid will be considered paid benefits under this Plan and, to the extent of such payments for Covered Services, we will be fully discharged from liability under this Certificate.

Right of Recovery
If the amount of the payments we made is more than it should have paid under this COB provision, it may receive the excess from one or more of the following: the Member it has paid or for who it has paid, the other Plan, or other person or organization.

You, or in the case of a minor, the Certificate holder, will, upon request, execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to us or any other Plan.

CLAIM FOR BENEFITS, APPEALS AND EXTERNAL REVIEWS

The terms listed below are important and need to be understood, as do the new time periods for claims and for appeals.

Initial Claims

1. 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, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.

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 24 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.

2. Pre-Service Claims

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

If your pre-service claim is improperly filed or does not follow the procedures established in this Certificate of Coverage, you will be sent notification within five days of receipt of the claim. If your pre-service claim is filed properly, a claims determination will be sent within a reasonable period of time appropriate to the medical circumstances, but no later than 15 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 another 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 render 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 at least 45 days to submit the information. BlueChoice HealthPlan then will make its determination within 15 days from the date it receives your information or, if earlier, the deadline to submit your information.

3. Post-Service Claims

A post-service claim is a claim for services that already have been rendered, 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 render 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 at least 45 days to submit the information. BlueChoice HealthPlan then will make its determination within 15 days from the date it receives your information or, if earlier, the deadline to submit your information.

4. 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;
- 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).

Claim 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

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.

If your claim involves a medical judgment question, BlueChoice HealthPlan will consult with an appropriately qualified healthcare practitioner with training and experience in the field of medicine involved. If a healthcare professional was consulted for the initial determination, a different healthcare professional

will be consulted on appeal. Upon request, BlueChoice HealthPlan will provide you with the identification of any medical expert whose advice was obtained on behalf of the plan in connection with your appeal.

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

1. Urgent Claims

You may request an expedited review of any urgent claim. This request may be made orally, and BlueChoice HealthPlan will communicate with you by telephone, facsimile or similarly rapid communication method. You will be notified of the determination as quickly as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim.

2. Pre-Service Claims

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

3. Post-Service Claims

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

Notice of Appeals Determination: You will be sent a notice if your claim on appeal is approved. If 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 determination;
- reference the specific plan provisions on which the benefit determination is based;
- state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- describe any voluntary appeal procedures offered by the plan and your right to obtain information about such procedures;
- disclose any internal rule, guideline, or protocol relied upon in making the adverse determination (or state that such information will be provided 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).

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.

External Review by an Independent Review Organization

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

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

After your internal appeals are completed, you will be notified in writing of your right to request an external review. If you need assistance during the external review process, you have the right to contact the South Carolina Department of Insurance. The Director of the South Carolina Department of Insurance or his designee may be contacted at the following address and telephone number:

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

Standard Review: You should file a request for review within 60 days of receiving that notice. You will be required to authorize the release of any medical records that may need to be reviewed for the purpose of reaching a decision during the external review.

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

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

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

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

GENERAL CONTRACT PROVISIONS

1. Entire Contract: Changes

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

2. Time Limit on Certain Defenses

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

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

3. Payment of Premium

Premiums are due and payable in full on or before the monthly due date. The benefits described are available as long as the required premium is paid.

Other than premiums for the initial month, a 31-day grace period will be granted for the payment of premiums, during which grace period the certificate will continue in force and the certificate holder will be liable for all premiums due and unpaid for the period the certificate continues in force. If premiums are not received by the end of the grace period, the certificate will automatically terminate as of the premium due date without further notice to the certificate holder. Any claims paid after the last premium paid date does not extend the coverage.

The company bases initial premiums, age, sex, where the member lives, and various rating factors related to a specific medical condition or symptoms of the member at the time the certificate is issued. The Premium Rate Sheet that is included with the certificate shows the premium as of the effective date. Premiums change based upon the member's age and may change if the member changes his or her place of residence. The company may also change premium rates with at least a 31-day prior written notice to the certificate holder.

If the member's age, sex or residence has been misstated and if the amount of the premiums is based on these factors, an adjustment in premiums, coverage, or both, will be made based on the member's true age, sex or residence. No misstatement of age will continue insurance that has been otherwise validly terminated or terminate coverage otherwise validly in force.

When the company pays a claim, the company may deduct any premium due from the claim payment.

4. Reinstatement

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

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

5. Extension of Benefits after Termination of Coverage

If the company does not renew or terminates your contract and you are in the hospital or continuously and totally disabled when your coverage under this contract ends, benefits will be provided while you remain continuously and totally disabled for the same cause. Benefits are subject to the terms, conditions, exclusions and limitations of the contract. This coverage will continue until you (1) have full coverage for the disabling condition under a group health plan with similar benefits and that plan makes reasonable provisions for continuity of care for the disabling condition; (2) are no longer totally disabled; (3) you use up all of your benefits, or (4) until the end of a period of 365 consecutive days, whichever occurs first. Benefits will be paid only for charges related to treatment of the disabling condition.

The term "totally disabled" means that you are receiving ongoing medical care by a physician and can perform none of the usual and customary duties or activities of a person in good health of the same age. A child who is Totally Disabled is receiving ongoing medical care by a Physician and unable to perform the normal activities of a child in good health of the same age and sex. A physician's statement of disability will be required.

Important Note: We recommend that you notify the company if you wish to exercise the extended benefits for total disability rights. Claims filed under this section must be accompanied by a Physician's statement of disability. The medical director of the company will have authority for determining if the requirements of total disability have been met. You should contact the company for the necessary forms.

6. How to File Claims; Notice and Proof of Loss

Show your ID card when you get healthcare services or supplies, so that people who file claims for you can see the information on it. All claims, questions, grievances, or appeals must be submitted within 180 days after the later of the date services were rendered or the date the claim for services was denied. After the expiration of this period, disposition of the claim shall be considered final.

7. Right of Recovery

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

8. Subrogation Rights

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

9. Independent Corporation

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

10. Information and Records

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

The submission of a claim shall be deemed written proof of loss and written authorization from the member to the company to obtain any medical or financial records and documents useful to the company. The company is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at

the time the claim is processed. Any party submitting medical or financial reports and documents to the company in support of a member's claim shall be deemed to be acting as the agent of the member.

11. Relationship With Providers

The member acknowledges and agrees that the company shall not be liable for injuries resulting from negligence, malpractice, misfeasance, nonfeasance, or any other act or omission on the part of any provider, employees thereof, or of any other person, in the course of performing services for members.

12. Policies and Procedures

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

13. Right to Transfer to an Group Insurance Trust Contract of Equal or Lesser Benefits with BlueChoice HealthPlan

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

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 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 is intended to have the medical meaning.

Admission - the period of time between a Member's entry as a registered bed-patient into a Hospital, Long-Term Acute Care Facility or Skilled Nursing Facility and the time the Member leaves or is discharged from the Hospital, Long-Term Acute Care Facility or Skilled Nursing Facility.

Alternate Facility - a non-Hospital healthcare facility, or an attached facility designated as such by a Hospital, that provides one or more of the following services on an outpatient basis pursuant to the law of jurisdiction in which treatment is received: prescheduled surgical services, Emergency Covered Services, Urgent Care Services or prescheduled rehabilitative, laboratory or diagnostic services.

Application – a form for transmitting the necessary information from You to BlueChoice HealthPlan when applying for Coverage under this Group Insurance Trust.

Authorized or Authorization - prior approval from the Company for another provider to provide services to You. This approval must be on file with the Company. Each individual service or treatment, except for Emergency Covered Services, dental services, and vision care requires such prior approval. Services or supplies provided must be in accordance with the approval given in order to receive benefits from this plan.

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

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

BlueChoice HealthPlan - trade name for BlueChoice HealthPlan of South Carolina, Inc.

Brand-name Drug - a Prescription Medication that is manufactured under a registered trade name or trademark. A Brand-name Drug may be a Preferred Drug or a Non-preferred Drug.

Certificate - this document, issued to a Member, that summarizes the benefits and exclusions that becomes part of the Group Insurance Trust Master Policy.

Certificate holder - You or a parent or a legal guardian who purchased this insurance Certificate to cover the Member and who is the owner of the Certificate and payer of the premiums.

Certificate of Creditable Coverage - a document from a previous health insurance plan or insurer that says you had prior Health Insurance Coverage with them. You should receive a Certificate of Creditable Coverage after your prior Health Insurance Coverage ends. By presenting a Certificate of Creditable Coverage when you enroll in this new health plan, you may be able to reduce the length of or eliminate this plan's Pre-existing Condition exclusion period.

Company - BlueChoice HealthPlan.

Coinsurance - the percent, if any, indicated in the Schedule of Benefits, of a Covered Service payable by a Member to a Provider of such service. Coinsurance is based on the negotiated rate or lesser charge of the Provider.

Coinsurance Maximum - the maximum amount of Covered Services incurred during the Benefit Period for which benefits are not payable by BlueChoice HealthPlan. The Coinsurance Maximum is made up of Coinsurance amounts payable by the Member, as indicated in the Schedule of Benefits. Copayment and Deductible amounts do not apply toward the Coinsurance Maximum.

Copayment - the fixed amount indicated in the Schedule of Benefits that is payable by the Member to the Provider of a Covered Service each time the Member receives such service.

Coverage or Covered - the entitlement by a Member to receive benefits for Covered Services provided under the Certificate, subject to the terms, conditions, limitations and exclusions of the Certificate.

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

1. Covered Services must be provided when the Certificate 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 Certificate; and
4. Covered Services must be Authorized when required under this Contract.

Creditable Coverage - coverage of an individual under any of the following:

1. A Group Health Plan;
2. Health Insurance coverage;
3. Medicare Part A or B;
4. Medicaid, other than coverage consisting solely of 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 Employee Health Benefits Program;
9. A public health plan (any plan established or maintained by a State, the U.S. government, a foreign country or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage); or
10. A health benefit plan under the Peace Corps Act;
11. Short Term Health; or
12. A State Children's Health Insurance Program (S-CHIP).

Creditable Coverage does not include coverage consisting solely of those benefits excepted from the definition of Health Insurance Coverage.

Custodial Care - care provided primarily for maintenance of the patient or care designed essentially to assist the patient in meeting his or her activities of daily living. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets, and supervision over self-administration of medications that do not require the technical skills or professional training of medical or nursing personnel in order to be performed safely and effectively. Custodial Care is not primarily provided for therapeutic value in the treatment of a sickness, injury, disease, or condition.

Deductible - the amount, if any, indicated in the Schedule of Benefits, that the Member must pay each Benefit Period before benefits are Covered by BlueChoice HealthPlan.

Designated Transplant Facility - a Blue Cross and Blue Shield Association Blues Distinction® Center for Transplant (BDCT) designated facility. In the event a particular transplant type is not specified in the BDCT network, then a BlueCard participating facility must be utilized. A Designated Transplant Facility may or may not be located within BlueChoice HealthPlan's geographic area.

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

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

Emergency Covered Services - those healthcare services and supplies necessary for the treatment of an Emergency Medical Condition, subject to the terms and conditions of this Certificate.

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

Expense Incurred – the liability incurred by a Member for a service as of the date the service is rendered.

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

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

service is safe, effective and accepted for the treatment of the specific medical condition for which it was prescribed.

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

Generic Drug - a Prescription Medication that has the same active ingredients as the Brand-name Drug but is not manufactured under a registered brand name or trademark.

Genetic Information - information about genes, gene products, and inherited characteristics that may derive from the Member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes of chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

Health Insurance Coverage - benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer, except:

1. coverage only for accident, or disability income insurance, or any combination of accident and disability income insurance;
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, under which 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 healthcare, community-based care, or any combination of these;
    C. other similar, limited benefits;
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 supplemental to the coverage provided under military, TRICARE or CHAMPUS; and
    C. similar supplemental coverage under a group 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 - a short-term, acute care (1) general Hospital, (2) children's Hospital, (3) eye, ear, nose and throat Hospital, (4) maternity Hospital, or (5) any other type of short-term acute care Hospital licensed by the state in which it operates, that for compensation from its patients and on an inpatient basis, is engaged primarily in providing diagnostic and therapeutic facilities for the medical or surgical diagnosis and treatment of injured or sick persons, by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which provides continuous 24-hour-a-day services by licensed, registered, graduate nurses physically present and on duty. A Hospital may participate in a teaching program. This means that a Member may be seen or treated by a medical student, intern, or resident participating in such a teaching program.

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

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

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

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

Long-Term Acute Care Facility - a facility that meets the definition of a Hospital providing care to patients whose average length of stay is greater than 25 consecutive days as set out in the American Hospital Association Guide to the Healthcare Field, published annually.

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

1. in accordance with generally accepted standards of medical practice; and
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
3. not primarily for the convenience of the patient, physician, or other health care provider; and
4. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Member - a person 1) who resides in the state of South Carolina, 2) who is at least two years of age and less than 64 ½ years of age, and 3) who is enrolled in BlueChoice HealthPlan Group Trust product.

Mental Health Services - the treatment of those mental health or psychiatric diagnostic 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* unless specifically excluded from Coverage. As used in this health plan, Mental Health Services does not include services for the treatment of Substance Abuse.

Non-preferred Drug - a Prescription Medication that has not been chosen by BlueChoice HealthPlan, or its designated Pharmacy Benefit Manager, to be a Preferred Drug. This includes any Brand-name Drug with an "A" rated Generic Drug available.

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

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

Physician - a person (other than an intern, resident or house Physician) duly licensed as a medical doctor, oral surgeon, osteopath, chiropractor, optometrist, ophthalmologist, dentist, podiatrist 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

Pre-Existing Condition - a physical or mental condition present before the Effective date, whether or not any medical advice, diagnosis, care or treatment was received or recommended before that day. Genetic Information may not be treated as a Pre-existing Condition in the absence of a diagnosis of the condition related to the information. Pregnancy may not be treated as a Pre-existing Condition.

Preferred Drug - a Prescription Medication that has been reviewed for cost, clinical effectiveness, quality and the availability of generic or over-the-counter alternatives. The Preferred Drug List is subject to periodic review and updates by BlueChoice HealthPlan without prior notice to members.

Preferred 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 Preferred Drug list is always available on the BlueChoice HealthPlan website.

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

1. Syringes and related supplies for conditions such as diabetes also are considered to be Prescription Medications and

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 Preferred Drug List.

Specialty Pharmaceuticals are not Covered under the Prescription Medication benefit.

Primary Care Physician - a Participating Physician whose practice predominantly includes family practice, internal medicine, pediatrics, gynecology, or obstetrics/gynecology; or a nurse-practitioner.

Provider - any person licensed in, or legally engaged in the practice of, or performing duties associated with, any of the following: medicine; surgery; dentistry; pharmacy; optometry; obstetrics; osteopathy; podiatry; chiropractic; radiology; nursing; physiotherapy; pathology; anesthesiology; anesthesia; laboratory analysis; psychiatry; psychology; physical therapy; Substance Abuse treatment; home healthcare; an Alternate Facility; Hospital; Long-Term Acute Care Facility; Skilled Nursing Facility; or Rehabilitation Hospital. A Provider may participate in a teaching program. This means that a Member may be seen or treated by a medical student, intern, or resident participating in such a teaching program.

Reasonable and Customary Fee Schedule - the allowance established by BlueChoice HealthPlan for Covered Services performed by non-Participating Providers. In the event the Reasonable and Customary Fee Schedule does not apply for a specific service or supply, the allowance will be the actual charge as submitted or the Fee Schedule for Participating Providers, whichever is less.

Rehabilitation Hospital - a licensed facility that is engaged primarily in providing rehabilitation care to patients on an inpatient basis. Rehabilitation care consists of the combined use of medical, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a registered nurse.

Residential Treatment Center - a non-acute, 24 hour-a-day residential treatment setting for Mental Health Services and Substance Use Disorders including Therapeutic schools; wilderness/boot camps; therapeutic boarding homes; half-way houses; and therapeutic group homes.

Schedule of Benefits - the pages so titled and a part of this Certificate that specify the amount of Coverage provided and any applicable maximums, Copayments, Coinsurance, and Deductibles.

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

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

Substance Abuse - the continued use, abuse and/or dependence of legal or illegal substance(s), despite significant consequences or marked problems associated with the use as defined, described or classified in the latest publication of The American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*. As used in this health plan, Substance Abuse does not include services for treatment of Mental Health Services.

Surgical Assistant - any person legally engaged in, the practice of rendering first assistant- at- surgery to a Physician and who hold the certification of Medical Doctor, Doctor of Osteopathy, Physician's Assistant-Certified, Clinical Nurse Specialist, or Nurse Practitioner.

Trustee - a person or entity, whether as original, substitute or successor, designated by BlueChoice HealthPlan as the group policyholder and party to any trust documents executed between it and BlueChoice HealthPlan.

Urgent Care - Covered Services required in order to treat an unexpected illness or injury that is not life-threatening. Such Covered Services must be required in order to prevent a significant deterioration of the Member's health if treatment were delayed.

Waiting Period - the period of time that You must wait before benefits are provided under the Certificate.

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

Family Coverage Amendment

This Amendment is subject to all the provisions of the Master Group Policies Group Insurance Trust I (GIT One Policy 10/10) and Group Insurance Trust II (GIT Two Policy 10/10), which are not otherwise specified in the provisions of this Amendment.

This Amendment to the Contract is effective upon approval.

The Contract is revised as follows:

Article II – Eligibility for Coverage is deleted in its entirety and the following substituted therefore:

This Contract is a group trust product. Certificates are issued to individuals: 1) from 19 years of age to 64½ years of age; 2) who are not Medicare eligible; and 3) who live in South Carolina. The Corporation determines an individual's entitlement to coverage as a Member under the group Master Policy.

Nothing contained in this Amendment will be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the Contract other than as stated above.

BlueChoice HealthPlan of South Carolina, Inc.
An independent licensee of the Blue Cross and Blue Shield Association

Mary P. Mazzola Spivey
President and Chief Operating Officer

BlueChoice HealthPlan of South Carolina, Inc.

An independent licensee of the Blue Cross and Blue Shield Association

Optional Family Coverage Member Certificate Endorsement

The Certificate to which this Endorsement is attached is amended to add coverage for Dependents.

If you chose the Optional Family Coverage Endorsement, it will be shown in your Application, which is a part of your Certificate.

(The following additions/revisions should not be construed as a complete replacement of the sections in your Member Certificate unless otherwise noted.)

This supplement to your Member Certificate is effective on your Member Certificate Effective Date. The Effective Date of your Member Certificate is the date shown in the Schedule of Benefits after this Optional Endorsement is selected.

For purposes of this Endorsement, the following Definitions are added to the Certificate:

Dependent: The Certificate holder's lawful spouse and children through age 26. Dependent Children are natural or adopted children, stepchildren, foster children, children who are under your legal guardianship or for whom a court order requires you to provide Health Insurance.

Incapacitated Dependent - an unmarried child who is: (1) incapable of self-support because of mental retardation, mental illness or physical incapacity which began before the child reached the limiting age; and (2) dependent upon the Employee for at least 51% of support and maintenance and who has fulfilled the requirements of the Eligibility section of this certificate.

Coverage for Dependents is subject to the following:

Eligibility, Coverage and When Your Coverage Ends

Coverage is available to Dependents of the Certificate holder. If coverage ends for the Certificate holder, coverage for the Dependents will also end, unless coverage is extended as described in this Endorsement. Coverage may also be extended for currently covered Dependents if the Certificate holder dies or becomes eligible for Medicare. If coverage ends for the Certificate holder due to death or Medicare eligibility, the spouse, if covered under the same Certificate, would become the Certificate holder. If the spouse is not covered, each covered Dependent child will be issued his or her own Certificate. Death or Medicare eligibility of the Certificate holder is the only time a Dependent child under the age of 19 is eligible for a Certificate without family coverage.

All provisions of the Certificate apply to Dependents as they apply to the Certificate holder.

Adding a Child: If you or your spouse gives birth or a child is placed with you or your spouse for the purpose of adoption while the Certificate is in force for you, then the child is covered from the moment of birth or adoption for Medically Necessary Covered Services and supplies, but only if you submit an application and any premium that may be due within 31 days of the birth or adoption. For newborns enrolled within 31 days of birth and newly adopted children enrolled within 31 days of eligibility, this includes any necessary care and treatment of medically diagnosed birth defects, diseases and anomalies or complications due to a premature birth.

Failure to send us a completed application within 31 days of the birth or adoption will result in no coverage for that Dependent Child. Coverage being effective on the first or the 15th of month after we receive the application for that Dependent child.

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 date 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 is not 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.

To add any other Dependent child as a Member outside the open enrollment period, you must: 1) submit an application for our approval, and 2) pay any additional premium that may be required. Coverage will be effective on the first or the 15th of month after we receive the application for that Dependent child on the effective date of the open enrollment.

Incapacitated Dependent Child: The limiting age doesn't apply to a child who becomes and continues to be: 1) incapable of self-sustaining employment because of mental or physical handicap or disability; and 2) mainly dependent upon the Certificate holder or Certificate holder's spouse for support and maintenance. The child must have developed the handicap or disability before he or she reached the age at which coverage would otherwise terminate. To keep coverage for an Incapacitated Dependent child you must give us written proof of the disability from a Physician within 31 days of the Dependents 26th birthday. For the child to remain covered, we must receive a Physician's written report every two years within 31 days of the child's birthday. If the Certificate holder coverage ends for any reason, except in the case of death or Medicare eligibility, coverage for an Incapacitated Dependent Child will also end.

Termination of Insurance for Your Covered Spouse: Your Spouse's coverage will end at 12:01 a.m. Eastern Standard Time: 1) on the next premium due date after we receive your request in writing, 2) on the date the Certificate lapses due to non-payment of premiums or is non-renewed, or 3) on the premium due date following the date of a divorce, whichever occurs first.

We will pay benefits to the end of the period for which we accepted premiums.

Termination of Insurance for Your Other Covered Dependents: Coverage will end for a child at 12:01 a.m. Eastern Standard Time on the earlier of:

1. The next premium due date after we receive your request in writing;
2. The date the Certificate lapses due to non-payment of premiums or is non-renewed; or
3. The premium due date following the date he or she reaches age 26.

An Incapacitated child's coverage, however, will not end simply because he or she has reached age 26.

We will pay benefits to the end of the period for which we accepted premiums.

Pre-Existing Condition Limitations: The Pre-existing Condition Limitation is not applicable to a dependent who obtains coverage prior to age 19.

Deductible, Out-of-Pocket Maximum and Maximum Benefits
The application of the Deductible and out-of-pocket maximum for family coverage is shown in the Schedule of Benefits. Any applicable Benefit Year maximum will apply to each Member each Benefit Year.

Continuation of Coverage
If the Member has been continuously insured under the Certificate for at least six months and coverage is terminated for any reason other than nonpayment of the required premium, then the Member is entitled to continue coverage under the Certificate through the end of the month the Certificate is cancelled plus an additional six months. The Member is not entitled to have this coverage continued if the Member was entitled under federal law to continuation of his or her coverage for a period of greater than six months.

Continuation of Coverage for Your Former Spouse: If a spouse covered under this Certificate is no longer eligible because of a divorce, then he/she may obtain a similar policy from us without proof of good health, but only if the spouse sends us written notification and the required premium within 60 days after the legal divorce

The new policy will provide coverage from us similar to, but not greater than, this coverage. Credit will be given for any Waiting Periods met under this Certificate. The premium will apply to the age of such Member at the time of continuation. The new policy Effective Date will be the date coverage ceased for such Member under this Certificate.

Any exclusion or limitation Riders on this Certificate will be carried forward to the new policy.

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)