CERTIFICATE OF COVERAGE

Primary Choice

Benefits are provided In-Network only.

No benefits are provided for services received Out-of-Network unless the service is due to an emergency or the service is not available at a Network Provider.

BlueChoice® HealthPlan
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FOREWORD
BlueChoice® HealthPlan of South Carolina, Inc.
Certificate Of Coverage

BlueChoice HealthPlan of South Carolina, Inc. (BlueChoice HealthPlan) is a health maintenance organization licensed by the state of South Carolina. This certificate of coverage is issued by BlueChoice HealthPlan and is an agreement with persons who have enrolled as Members (through their Employer) pursuant to a Master Group Contract. The Contract is delivered in and governed by the laws of the state of South Carolina. By enrolling in Primary Choice and accepting this certificate, the Member agrees to abide by the rules of BlueChoice HealthPlan as outlined in this certificate. The Member recognizes that except for Emergency Covered Services, only those Medically Necessary Covered Services provided by the Member's Primary Care Physician or Authorized by the Member's Primary Care Physician and BlueChoice HealthPlan are a benefit under this certificate. Members are entitled to the benefits described in this certificate in exchange for the Premium paid to BlueChoice HealthPlan by the Member or by the Employer on the Member's behalf.

The Contract may require that the Member contribute to the required Premium. Information regarding the Premium and any portion of the Premium that the Member must pay can be obtained from the Employer.

BlueChoice HealthPlan agrees with the Employer to provide benefits for Covered Services to Members, subject to the terms, conditions, exclusions and limitations of the Contract. The Contract is issued on the basis of the Employer's application and payment of the required Premium. The Employer's application is made a part of the Contract.

How To Use This Certificate

This certificate should be read in its entirety because many of the provisions are interrelated. Many words used in this certificate have special meanings. These words will appear capitalized and are defined. By using these definitions, the Member will have a clearer understanding of this certificate.

Contact BlueChoice HealthPlan

Throughout this certificate there are statements that encourage the Member to contact BlueChoice HealthPlan for further information. A question or concern regarding benefits for Covered Services or any required procedure may be addressed to BlueChoice HealthPlan through the Web site www.BlueChoiceSC.com or by calling (803) 786-8476 (in Columbia) or 1-800-868-2528 when outside Columbia.

Identification Card

When a Member seeks any type of medical service or supply, including Prescription Medication and insulin, the Member should show the identification (ID) card to Providers indicating the Member's enrollment in BlueChoice HealthPlan. Failure to show the ID card may result in the Member receiving a bill for healthcare services.

SECTION I
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.

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

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

Allowed Amount - the allowance for Covered Services as established by BlueChoice HealthPlan.

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

Authorized or Authorization - prior approval from the Corporation for a Provider of health care services to provide certain Covered Services to a Member. Covered Services provided must be in accordance with the Authorization in order to receive benefits under this Plan.

Autism Spectrum Disorder - the three following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

1. Autistic Disorder;
2. Asperger's Syndrome;
3. Pervasive Developmental Disorder -- Not Otherwise Specified

Behavioral Therapy – any behavioral modification using Applied Behavioral Analysis (ABA) techniques to target cognition, language, and social skills.

Behavioral Therapy does not include educational or alternative programs such as, but not limited to:

1. TEACCH,
2. Auditory Integration Therapy,
3. Higashi Schools/Daily Life,
4. Facilitated Communication,
5. Floor Time (DIR, Developmental Individual-difference Relationship-based model),
6. Relationship Development Intervention (RDI), Holding Therapy,
7. Movement Therapies,
8. Music Therapy, and
9. Pet Therapy.

Benefit Period - the period of time within which benefits are administered, including the determination of certain limitations. The Benefit Period is shown in the Schedule of Benefits.

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.

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.

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

Contract Effective Date - the date the Contract between the Employer and BlueChoice HealthPlan becomes effective.

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 Contract, subject to the terms, conditions, limitations and exclusions of the Contract.

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

1. Covered Services must be provided when the Contract is in effect;
2. Covered Services must be provided prior to the date of termination of Coverage;
3. Covered Services must be provided only when the recipient is a Member and meets all eligibility requirements specified in the Contract; and
4. Covered Services are provided by the Primary Care Physician or Authorized in advance by the Primary Care Physician and BlueChoice HealthPlan.

Creditable Coverage - with respect to an individual, coverage of the 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.

Dependent - members of a Subscriber's family who are eligible and enrolled for Coverage and for whom BlueChoice HealthPlan has received the required Premium. The term Dependent also includes a child for whom healthcare Coverage is required through a Qualified Medical Child Support Order, as determined by the Employer.

Designated Transplant Facility - a Hospital, named as a Designated Transplant Facility by BlueChoice HealthPlan, which has entered into an agreement with or on behalf of BlueChoice HealthPlan to render Medically Necessary and medically appropriate Covered Services for transplant services. 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.

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 Contract.

Emergency Medical Condition (Emergency) - a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (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.

Employee - any individual employed by an Employer or member of an association who is eligible for Coverage and who is so designated to BlueChoice HealthPlan by the Employer.

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

Enrollment Date - the date of enrollment under the Group Health Plan or, if earlier, the first day of the Waiting Period for the enrollment.

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.

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.

Group Health Plan - Health Insurance Coverage for eligible Employees and their Dependents and/or retirees of the same Employer and their Dependents. Benefits usually include coverage for hospital, medical or other healthcare services and supplies as defined under the terms of the contract with the health plan.

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 - the card most recently issued by BlueChoice HealthPlan showing the Member's identification number.

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 age 19; and (2) dependent upon the Employee for at least 51% of support and maintenance and who has fulfilled the requirements of the Employer as provided in the Contract.

Late Enrollee - an eligible Employee or Dependent who enrolls under this plan other than during:

1. the first period in which the individual is eligible to enroll under the plan if the initial enrollment period is a period of at least 30 days; or
2. a Special Enrollment Period.

Local Service Area - the geographic area served by BlueChoice HealthPlan and approved by the appropriate regulatory body.

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.

Medical Child Support Order - any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which:

1. provides for child support with respect to a child of a Subscriber under the Contract or provides for health benefit coverage to such a child, is made pursuant to a State domestic relations law (including a community property law), and relates to benefits under the Contract; or
2. enforces a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act 0f 1993) with respect to a group health plan.

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 - an Employee or covered Dependent whose Notice of Election has been accepted by BlueChoice HealthPlan and for whom BlueChoice HealthPlan has received the required Premium.

Member's Effective Date - the date (beginning at 12:01 a.m.) on which the Member is enrolled and eligible for benefits under the terms of the Contract. See Section II.03 for further details.

Mental Health and Substance Use Disorders - mental health or psychiatric diagnostic categories of the most current Diagnostic and Statistical Manual of Mental Disorders, unless specifically excluded from Coverage. This definition includes but is not limited to bipolar disorder; major depressive disorder; obsessive compulsive disorder; paranoid and other psychotic disorders; schizoaffective disorder; schizophrenia; anxiety disorder; post-traumatic stress disorder; and depression in childhood and adolescence.

Mental Health Services - the treatment of those mental health or psychiatric diagnostic categories of the Diagnostic and Statistical Manual of Mental Disorders, IV, Revised unless specifically excluded from Coverage.

New Hire - any Employee who, on the Contract Effective Date, has less than 12 months of continuous full-time employment with the Employer.

Notice of Election - any mechanism agreed upon by BlueChoice HealthPlan and the Employer for transmitting the necessary enrollment information from its Employees to BlueChoice HealthPlan.

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.

Physician - a person, other than the Subscriber or a Dependent, licensed through a state law, who performs, within the scope of that license, a Covered Service and who customarily bills for such service.

Premium - the amount paid by the Employee or by the Employer on the Employee's behalf for benefits under the Contract.

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

Prescription Medication - those drugs listed on the Prescription Drug List, including insulin. Such drugs (and insulin) have been determined to be safe and effective by the Food and Drug Administration (FDA) and can, under Federal or State law, only be dispensed when ordered by a Physician who is duly licensed to prescribe them. The benefit for Prescription medication also includes syringes and related supplies for conditions such as diabetes. Specific classes of over-the-counter medications may be designated as Prescription Medication at the discretion of BlueChoice HealthPlan. If so designated, these classes of over-the-counter medications must be purchased at a Participating pharmacy with a prescription from a Participating Physician. The designated over-the counter medications will be listed in the Prescription Drug List.

Primary Care Physician - the personal Physician the Member selects from the list of Participating Primary Care Physicians to direct and coordinate the Member’s healthcare.

Provider - any person licensed in, or legally engaged in the practice of, or performing duties associated with, any of the following: medicine; surgery; dentistry; pharmacy; optometry; 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; or Skilled Nursing Facility. 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.

Qualified Medical Child Support Order (QMCSO) - any judgment, decree, or order (including approval of a settlement agreement), issued by a court of competent jurisdiction that creates or recognizes the right of a plan participant’s child to receive benefits under the Contract.

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 licensed institution, other than a Hospital, which meets all six of these requirements:

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

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

Serious Medical Condition - a health condition or illness that requires medical attention, and for which failure to provide the current course of treatment through the current Provider would place your health in serious jeopardy. This includes cancer, acute myocardial infarction and pregnancy.

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.

Special Enrollee - an eligible Employee or Dependent who enrolls under the plan during a Special Enrollment Period.

Special Enrollment Period - an enrollment period during which an Employee who is eligible, but not enrolled, for Coverage under the terms of the Contract, or a dependent of the Employee if the dependent is eligible but not enrolled for Coverage under such terms, may enroll for Coverage under the terms of the Contract. There are certain requirements that must be met. See Section II.04 for additional details.

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

Substance Abuse - the use of drugs or alcohol to the extent that medical services are required.

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.

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

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

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 an Employee must wait before benefits are provided under the Contract.

SECTION II
ELIGIBILITY FOR COVERAGE

II.01 Eligibility

1. Every Employee within the classification(s) set forth on the Master Group Application by the Employer who is Actively At Work and resides or works in the Local Service Area, and his or her Dependents shall be eligible for Coverage on or after the Contract Effective Date provided such Employee has completed the period of continuous employment commonly referred to as the Waiting Period with the Employer. Neither an Employee nor the Employee's Dependents shall be Covered until the Employee is Actively At Work.

2. To be eligible for membership as a family Dependent, the Dependent must:

   A. meet the Employer's eligibility requirements for Dependent Coverage; and
   B. be the Subscriber's legal spouse; or
   C. be the Subscriber's natural child, adopted child, foster child, step child, or child for whom the Subscriber has legal custody or legal guardianship, and is less than age 26 years unless the child of the Subscriber is an Incapacitated Dependent. Coverage of an Incapacitated Dependent will continue beyond the attainment of the limiting age, provided proof of such incapacity and dependency is furnished to BlueChoice HealthPlan by the Employee within 31 days of such child's attainment of that limiting age, as long as Coverage remains in force for the Employee. Further proof of continued incapacity and dependency may be required by BlueChoice HealthPlan, but not more frequently than annually after the two year period following the child's attainment of the limiting age.

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

4. A Dependent child who otherwise is eligible for Coverage shall not be denied enrollment for any of the following reasons:

   A. the child was born out of wedlock;
   B. the child is not claimed as a dependent on the Subscriber's federal tax return;
   C. the child does not reside with the Subscriber; or
   D. the child does not reside in the Local Service Area.

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

II.02 Election of Coverage

Any Employee eligible for Coverage on the Contract Effective Date may elect Coverage for himself or herself and all eligible Dependents by completing and filing with the Employer a Notice of Election during the initial enrollment period. In addition, new Employees may enroll within 31 days of the date they first become Employees or after satisfaction of the Waiting Period, if one exists, as specified by the Employer whichever is later. Dependents may be enrolled within 31 days of the date on which they first become Dependents. Note: Persons also may enroll if eligible during a Special Enrollment Period or as a Late Enrollee during a designated enrollment period.

II.03 Effective Date of Coverage

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

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

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

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

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

5. For an adopted child of the Employee:

   A. Coverage shall be retroactive from the moment of birth for a child with respect to whom a decree of adoption by the Employee has been entered within 31 days after the date of the child's birth;
   B. if adoption proceedings have been instituted by the Employee within 31 days after the date of the child's birth and the Employee has temporary custody, Coverage shall be provided from the moment of birth; and
   C. for adopted children other than a newborn, Coverage shall commence upon temporary custody and may continue for up to one year. Coverage may be extended by the court for an additional period of time.

II.04 Special Enrollment Periods

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

1. The Employee or dependent was covered under a group health plan or had Health Insurance Coverage at the time Coverage was previously offered to the Employee or dependent;

2. The Employee stated in writing at the time, that coverage under a group health plan or Health Insurance Coverage was the reason for declining enrollment, but only if BlueChoice HealthPlan required such a statement at the time and provided the Employee with notice of the requirement and the consequences of the requirement at the time.

3. The Employee's or dependent's coverage:

   A. was under a COBRA continuation provision and the coverage under the provision has exhausted;
   C. was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage, including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or employer contributions toward the coverage were terminated; or
   D. was one of multiple health insurance plans offered by an employer and the employee elects a different plan during an open enrollment period.

4. Under the terms of the plan, the Employee requests the enrollment not later than 30 days after the date of exhaustion of coverage described in 3 A above or termination of coverage or employer contribution described in 3 B above.

The following apply to a Dependent Special Enrollment Period.

5. If a group health plan makes coverage available with respect to a dependent of an individual, the individual is a participant under the plan, or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period, and the person becomes a dependent of the individual through marriage, birth, or adoption or placement for adoption, the health insurance issuer offering Health Insurance Coverage in connection with the group health plan shall provide for a dependent Special Enrollment Period during which the person may be enrolled under the plan as a dependent of the individual and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as dependent of the individual if such spouse is otherwise eligible for coverage.

6. A Dependent Special Enrollment Period must be not less than 31 days and begins on the later of:

   A. the date dependent coverage is made available; or
   B. the date of the marriage, birth, or adoption or placement for adoption.

7. If an individual seeks to enroll a dependent during the first 31 days of a Dependent Special Enrollment Period, the Coverage of the Dependent shall become effective:

   A. in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;
   B. in the case of a dependent's birth, or a dependent’s adoption or placement for adoption, within 31 days of birth, as of the date of the birth; or
   C. in the case of a dependent's adoption or placement for adoption beyond 31 days from the date of birth, the date of the adoption or placement for adoption.

8. A dependent spouse or minor dependent or dependent child of an Employee, if the dependent is eligible, but not enrolled for Coverage, shall be permitted to enroll under a Dependent Special Enrollment Period, under the terms of this plan if a court has ordered that Coverage be provided for the dependent under a Member's health insurance plan and a request for enrollment is made within 30 days after the issuance of the court order.

II.05 Special enrollment period in case of termination of Medicaid or Children's Health Insurance Program (CHIP) coverage or eligibility for assistance in purchase of employment-based coverage.

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

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

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

SECTION III
COVERED SERVICES

Benefits for all services are subject to the provisions of the Contract. In order to be Covered, all services must be Medically Necessary and performed on or after the Member's Effective Date and prior to cancellation of Coverage, and rendered by the Member's Primary Care Physician or rendered by a Provider Authorized in advance by the Member's Primary Care Physician and by BlueChoice HealthPlan.

Benefits are subject to all (if any) limitations, Copayments, Deductibles, and Coinsurance amounts specified in the Schedule of Benefits, and the exclusions and limitations as stated in this certificate and in the Master Group Contract.

Benefits payable are not assignable to a non-Participating Provider, unless otherwise determined by BlueChoice HealthPlan in its sole discretion. Any benefits payable for Covered Services of such Providers will be based on the Provider's usual and customary charge which is representative of the average and prevailing charge for the same Covered Service in the same or similar geographic communities where the Covered Service is rendered, in BlueChoice HealthPlan's judgment.

III.01 Physician Services

Benefits are provided for preventive, diagnostic, and treatment services when such services are provided by Participating Physicians. This includes Medically Necessary office visits and medical or surgical care including Surgical Assistants provided in a Physician's office or in a 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 the Member's 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 specialist Physician and at such places as Authorized by BlueChoice HealthPlan including diagnostic procedures, therapeutic procedures, surgical procedures, medical supplies, consultation and treatment. Routine care provided by a Participating gynecologist does not require referral or Authorization.

   Obstetrician and/or Gynecologist Services. Covered obstetrical or gynecological services from a Participating provider who specializes in obstetrical or gynecological care do not need prior authorization from BlueChoice HealthPlan or from any other person (including a primary care provider). The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

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

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

III.02 Inpatient Facility Services

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.

III.03 Maternity Care

Benefits are provided for professional and facility maternity care for a Subscriber or Dependent spouse only, unless otherwise specified in the Schedule of Benefits. Covered Services include those provided in a Hospital or Hospital-based birthing center. Services provided for home births are not Covered Services. Benefits include prenatal and postpartum care for Hospital services (including use of delivery room), and medical services (including operations and special procedures such as Cesarean section), and anesthesia. Benefits for inpatient care are provided for 48 hours after normal delivery, not including the day of delivery, or 96 hours after Cesarean section, not including the day of surgery. Coverage for the newborn child includes, but is not limited to, routine nursery care and/or routine well baby care during the initial period of Hospital confinement.

III.04 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 including radiation therapy, chemotherapy, and respiratory therapy.
3. **Screening Mammography.** Services and supplies for screening mammograms when ordered by the Member's Primary Care Physician or other Participating Provider.

III.05 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.

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.

III.05A Chiropractic Services

Benefits will be provided at the level shown in the Schedule of Benefits. 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.

III.06 Mental Health and Substance Use Disorders

Benefits for treatment of Mental Health and Substance Use Disorders, as defined in this Contract, are the same as for any other medical condition. Covered Services must be Authorized in advance by Companion Benefit Alternatives and provided by a Participating Provider.

III.07 Prescription Medication

Coverage for Prescription Medication is provided unless specifically excluded pursuant to Section V. When Covered, benefits for Prescription Medication are provided when purchased at a Participating pharmacy and prescribed by a Participating Physician. 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 and benefit maximum, if applicable, as specified in the Schedule of Benefits. A list of Participating pharmacies can be found on the BlueChoice HealthPlan website.

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.

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

For information about Prescription Medications, please refer to the Prescription Drug List which can be found on the BlueChoice HealthPlan website. The Prescription Drug List shows the coverage levels, called Tiers, for most Covered drugs. Each Tier has its own copayment and/or coinsurance levels. Once you have identified the Tier which is applicable to your Prescription Medication, you can refer to your Schedule of Benefits to determine how much you will pay for a Prescription Medication based on its Tier. A list of any drugs that are not covered by this plan is also on the Prescription Drug List.

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

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

III.08 Ambulance Service

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

III.09 Home Health Services and Outpatient Private Duty Nursing

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

III.10 Hospice Services

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

III.11 Transplant Services

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 subject to the following:
   A. When both the transplant recipient and the donor are Members, benefits will be provided for both.

   B. When the transplant recipient is a Member and the donor is not, benefits will be provided for both.

   C. When the transplant recipient is not a Member and the donor is, no benefits will be provided to either the donor or the recipient.

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.

III.12 Emergency and Urgent Care Services

1. Emergency Care Benefits

   A. Benefits are provided for services and supplies for stabilization and/or initial treatment of an Emergency Medical Condition. If the Member is admitted to a Hospital due to an Emergency Medical Condition, the Member or someone acting on behalf of the Member, must contact BlueChoice HealthPlan within 24 hours or the next working day, whichever is later. If the Admission occurs outside the Local Service Area, the Member may be required to transfer to a Hospital within the Local Service Area when medically appropriate in order to receive benefits. If an Admission occurs within 24 hours after an Emergency visit as a result of the Emergency Medical Condition, the Emergency Copayment, if any, will be waived and the applicable Copayment for Admission will be assessed. In order to be Covered, any follow-up care must either be provided by the Primary Care Physician or Authorized by the Primary Care Physician and BlueChoice HealthPlan.
   B. Elective care, routine care, care for a minor illness or injury, or care which reasonably could have been foreseen before departure from the Local Service Area is not considered Emergency care and is not Covered.

2. Urgent Care Benefits

   Urgent Care is a Covered Service 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 the Primary Care Physician and BlueChoice HealthPlan. Follow-up care is a Covered Service when provided by the Primary Care Physician.

III.13 Prosthetics and Durable Medical Equipment

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

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 aid body functioning or replace a limb or body part; and

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.

III.14 Medical Supplies

Covered supplies must be dispensed by or under the direction of the Member's Primary Care Physician. Supplies and equipment that have non-therapeutic uses are not Covered Services. 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.

III.15 Dental Care For Accidental Injury

Benefits are provided for dental services performed by a Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry (DMD) to natural teeth required because of accidental injury subject to the benefit limitation, if any, shown in the Schedule of Benefits. 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. Services not directly related to the accidental injury are not 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 have prior approval from BlueChoice HealthPlan in order to receive benefits.

III.16 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:

1. oral and facial surgery, surgical management and follow-up care;
2. prosthetic treatment such as obdurators, speech appliances and feeding appliances;
3. orthodontic treatment and management;
4. prosthodontia treatment and management;
5. otolaryngology treatment and management;
6. audiological assessment, treatment, and management, including surgically implanted amplification devices; and
7. 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 Coverage. Benefits, are provided on the same basis as for any other medical condition or illness as specified in the Schedule of Benefits.

III.17 Required Benefits

1. **Limited Obstetrical and Gynecological Access without Referral.** Coverage is provided for a female Member 13 years of age or older for a minimum of two visits per Benefit Period without referral, for Covered Services provided by a Participating obstetrician-gynecologist. For any continuing treatment resulting from obstetrical and/or gynecological complications diagnosed during the two visits in a Benefit Period, Authorization is required in order to be Covered. Written communication should be sent by the obstetrician-gynecologist to the patient's Primary Care Physician regarding the condition being treated within a reasonable time after each visit. 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 Mastectomy.** 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 includes 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. **Mammogram.** Coverage is provided for a mammogram. 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 which 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 Member who is at least 35 years of age but less than 40 years of age;
   B. once every two years for a female Member who is at least 40 years of age but less than 50 years of age;
   C. once a year for a female Member 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 Smear.** 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. Benefits are provided for such examination once a year or more often if recommended by a medical doctor.

5. **Prostate Examination.** Coverage is provided for prostate cancer examination, screening 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 is provided in a manner determined in consultation with the attending Physician and the Member. Benefits will be 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. **Autism Spectrum Disorder.** Any Member diagnosed with Autistic Spectrum Disorder at age eight or younger is eligible for this Coverage. Coverage will end on the Member's 16th birthday.

   Treatment of Autism Spectrum Disorder is Covered for eligible Members. Benefits for the treatment of Autism Spectrum Disorder are outlined in the Schedule of Benefits.

   Behavioral Therapy for Autism Spectrum Disorder is also Covered for eligible Members. Benefits for Behavioral Therapy are subject to a maximum benefit and are outlined in the Schedule of Benefits.

   Services must be provided by or under direction of a Participating Provider. Prior Authorization requests and treatment plans must be approved by Companion Benefit Alternatives. Companion Benefit Alternatives is a separate company that provides utilization management for behavioral health services on behalf of BlueChoice HealthPlan of South Carolina.

III.18 Preventive Services

The Corporation will pay for preventive health services required under PPACA as follows:

1. Evidence based services that have a rating of A or B in the current United States Preventive Services Task Force (USPSTF) recommendations;
2. Immunizations as recommended by the Center for Disease Control and Prevention (CDC); and
3. Preventive care and screenings for children and women as recommended by the Health Resources and Services Administration (HRSA).

These Benefits are provided without any cost-sharing by the Member when the services are provided by a Participating Provider. Any other covered preventive screenings will be provided as specified in the Schedule of Benefits.

III.19 Clinical Trials

The Corporation will pay for routine Member costs for items and services related to clinical trials when:

1. The Member has cancer or other life-threatening disease or condition; and
2. the referring Provider is a Participating Provider that has concluded that the Member's participation in such trial would be appropriate; and
3. the Member provides medical and scientific information establishing that the Member's participation in such trial would be appropriate; and
4. the services are furnished in connection with an Approved Clinical Trial.

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

III.20 Vision Care

One comprehensive vision examination for eyeglasses by a designated Participating Provider per Member per Benefit Period is covered in full. A contact lens examination is covered in full with a Copayment. Any additional charge for a contact lens fitting is the Member's responsibility. One pair of eyeglasses (frames and lenses) from a designated selection from a designated Participating Provider every other Benefit Period covered in full. Any other vision or eye examination (other than a routine vision screening by the Member's Primary Care Physician) is not covered unless Medically Necessary.

III.21 Overview

BlueChoice has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees"). Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you obtain healthcare services outside of our service area, the claims for these services may be processed through one of these Inter-Plan Arrangements.

When you receive care outside of our service area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some providers ("nonparticipating
providers") don't contract with the Host Blue. We explain below how we pay both kinds of providers.

We cover only limited healthcare services received outside of our service area. As used in this section "Out-of-Area Covered Healthcare Services" include Emergency care and Urgent Care obtained outside the geographic area we serve. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless authorized by BlueChoice.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits except when paid as medical benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by us to provide the specific service or services.

A. BlueCard® Program

Under the BlueCard® Program, when you receive Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, we will remain responsible for doing what we agreed to in the contract. However the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

The BlueCard Program enables you to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the Member copayment amount, as stated in your Plan Summary.

Emergency Care Services: If you experience a Medical Emergency while traveling outside the BlueChoice service area, go to the nearest Emergency or Urgent Care facility.

When you receive Out-of-Area Covered Healthcare Services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for the Out-of-Area Covered Healthcare Services, if not a flat dollar copayment, is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price we have used for your claim because they will not be applied after a claim has already been paid.

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

B. Nonparticipating Providers Outside Our Service Area

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

C. BlueCard Worldwide® Program

If you are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you may be able to take advantage of the BlueCard Worldwide® Program when accessing Covered Services. The BlueCard Worldwide Program {is unlike the BlueCard Program available in the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands in certain ways. For instance, although the BlueCard Worldwide Program assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you should call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

In most cases, if you contact the BlueCard Worldwide Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts. In such cases, the hospital will

submit your claims to the BlueCard Worldwide Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. **You must contact BlueChoice to obtain precertification for non-emergency inpatient services.**

- **Outpatient Services**

Physicians, urgent care centers and other outpatient providers located outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

- **Submitting a BlueCard Worldwide Claim**

When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a BlueCard Worldwide International claim form and send the claim form with the provider's itemized bill(s) to the BlueCard Worldwide Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from BlueChoice, the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com. If you need assistance with your claim submission, you should call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

III.23 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.

SECTION IV
PRIMARY CARE PHYSICIAN AND OTHER PARTICIPATING PROVIDERS

IV.01 Primary Care Physician

1. When enrolling for Coverage, each Member must select a Primary Care Physician in order to receive benefits. All family Members do not need to select the same Primary Care Physician. The Primary Care Physician has access to the skills and support of specialists and other health personnel who are part of a comprehensive healthcare delivery network.

2. The Member should receive all Covered Services (except for Emergency Covered Services) from the selected Primary Care Physician, or the Provider Authorized by the Primary Care Physician and BlueChoice HealthPlan.

3. Preventive or routine services are Covered under the Plan when provided or ordered by the Primary Care Physician.

4. A Member may change to a different Primary Care Physician, by submitting the change on a Notice of Election form or by contacting a Member Services representative. The change will be effective the first day of the month following receipt of the request.

IV.02 Participating Providers

Participating Providers are Hospitals, Skilled Nursing Facilities, home health agencies, hospices, Physicians and other Providers of Covered Services who have agreed with BlueChoice HealthPlan to do the following:

1. file all claims for Covered Services with BlueChoice HealthPlan;

2. collect only the Copayment, Deductible and Coinsurance amounts, if any, for Covered Services. These amounts (part of the charge for Covered Services that BlueChoice HealthPlan does not pay) are shown in the Schedule of Benefits; and

3. accept the Allowed Amount as payment in full for Covered Services.

If the Member is billed by a Participating Provider for Covered Services other than any applicable Coinsurance, Copayment, or Deductible, the Member should contact BlueChoice HealthPlan.

SECTION V
EXCLUSIONS AND LIMITATIONS

V.01 Exclusions

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 contract, will not be denied if the injury results from an act of domestic violence or a medical condition (including both physical and mental conditions), even if the medical condition was not diagnosed before the injury.

1. Any services or supplies for which the Member is not legally obligated to pay.

2. Any services or supplies for treatment of military service-related disabilities when the Member is legally entitled to other coverage.

3. Any services or supplies for which benefits are paid by workers' compensation, occupational disease law or other similar legislation.

4. 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.

5. Any charges for services provided prior to the Member's Effective Date or after the termination of Coverage.

6. Custodial care or respite care.

7. Treatment of Mental Health or Substance Use Disorders, including therapeutic schools; wilderness/boot camps; therapeutic boarding homes; half-way houses; and therapeutic group homes.

8. Any services or procedures for transsexual surgery or related services provided as a result of complications of such transsexual surgery.

9. All services and supplies related to pregnancy of a Dependent child 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.

10. 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.

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

12. 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 US 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.

13. 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.

14. 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.

15. 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.

16. 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.

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

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

19. Counseling and psychotherapy services for the following conditions: Feeding and eating disorders in early childhood and infancy; Tic disorders except when related to Tourette's syndrome; Elimination disorders; Mental disorders due to general medical condition; Sexual function disorders; Sleep disorders; Medication induced movement disorders; Nicotine dependence unless listed elsewhere as covered.

20. Services for Animal Assisted Therapy, rTMS, Eye Movement Desensitization and Reprocessing (EMDR), behavioral therapy for solitary maladaptive habits, or Rapid Opiate Detoxification.

21. Group counseling or psychotherapy.

22. 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.

23. 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.

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

- an operation or treatment for the fitting or wearing of dentures, regardless if needed due to injury of natural teeth due to an accident;
- orthodontic care or treatment of malocclusion;
- 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;

- any treatment of an injury to natural teeth due to an accident not received within 6 months of the accident date;
- removal of teeth, whether impacted or not; and
- 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.

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

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

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

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

29. 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.

30. 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.

31. 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.

32. 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.

33. Services or care in connection with the detection and correction by manual or mechanical 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. This exclusion does not apply if the Member has the optional Chiropractic Services benefit.

34. Charges for acupuncture, hypnotism, biofeedback therapy, massage therapy and/or 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.

35. 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.

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

37. 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.

38. 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.

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

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

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

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

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

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

45. Charges for services or supplies from an independent healthcare professional whose services are normally included in facility charges. Charges for Pre-operative anesthesia assessment.

46. Drugs specifically listed on the Prescription Drug List as excluded.

47. Over-the-counter drugs, except for over-the-counter drugs that are considered to be Prescription Medication (and listed on the Prescription Drug List).

48. Prescription Medications which are new to the market and which are under clinical review by the Corporation shall be listed on the Prescription Drug List as excluded until the clinical review has been completed and a final determination has been made as to the whether the drug should be Covered.

V.02 Limitation

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

V.03 Method of Counting Creditable Coverage

BlueChoice HealthPlan will count a period of Creditable Coverage without regard to the specific health benefits covered during the period.

Credit for prior coverage will be determined through a certificate indicating prior coverage or other acceptable evidence of coverage presented by the Employee. The Employee or Dependent has the right to request a Certificate of Creditable Coverage from any prior plan or issuer. This is based on the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal law. BlueChoice HealthPlan will request the certificate if necessary with written authorization from the Member.

The Member has the right to submit additional evidence of prior Creditable Coverage. BlueChoice HealthPlan has the right to reconsider its decision if it determines that the Member did not have the claimed prior Creditable Coverage.

SECTION VI
TERMINATION OF COVERAGE

VI.01 Conditions For Termination of Member's Coverage

Subject to continuation and conversion privileges stated in Section VIII of this certificate, Coverage of the Member, including benefits for Covered Services rendered after the date of termination for medical conditions arising prior to the date of termination, shall automatically terminate on the earliest of the dates specified below:

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

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

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

4. The date on which the Member ceases to be eligible as a Subscriber or enrolled Dependent.

5. The date on which the Subscriber's employment is terminated.

6. If the Subscriber fails to remit required contributions for coverage when due, coverage will terminate at the end of the period for which contribution was made.

7. The date the Subscriber dies.

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

Coverage will not be rescinded for an individual once the individual is Covered under this Contract, unless the individual, (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact. A cancellation or discontinuance is not a rescission if (a) the cancellation or discontinuance has only a prospective effect; or (2) the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums of contributions towards the cost of the Coverage. The Employer will be responsible for sending the individual any notice related to retroactive terminations or rescissions that are required by law.

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

HealthPlan even if their coverage is still in force. To request the Certificate of Creditable Coverage, the Employee or Dependent must contact BlueChoice HealthPlan.

Under certain circumstances, Members who cease to be eligible for Coverage under the Contract may be eligible to continue Coverage under the Contract or to convert to another policy, as described in Section VIII of this certificate.

VI.02 Payment and Reimbursement Upon Termination

Termination of the Contract shall not affect any request for reimbursement of eligible expenses for Covered Services rendered prior to the effective date of termination, when such request is furnished as required in Section IV of this certificate.

VI.03 Extended Benefits For Total Disability

1. If coverage under this Contract is terminated under this section, all rights to receive benefits provided in this Contract on the date of such termination shall automatically cease, except that an Employee or Dependent confined to a Hospital**,** Long-Term Acute Care Hospital, Rehabilitation Hospital or Skilled Nursing Facility or totally disabled on the date of such termination is entitled to receive benefits specified in Section I and II, for each day of that Admission or total disability. Benefits are subject to all exclusions, limitations, Coinsurance, Copayments and Deductibles stated in this Contract including the Schedule of Benefits. Benefits provided are limited to services directly related to the illness or injury causing the confinement or the total disability. In all situations except BlueChoice HealthPlan's withdrawal from the large group market, small group market or both markets, the extension of benefits liability of BlueChoice HealthPlan ends at the earliest of:

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

2. As used in this paragraph with respect to an Employee, the terms "totally disabled" and "total disability" mean disability to the extent that the Employee is receiving ongoing medical care by a Physician and is able to perform none of the usual and customary duties of his/her own employment or occupation during the first year of disability or for the length of the benefit period if less than one year. After the first year of disability, total disability is defined as the complete inability of the Employee to engage in any employment or occupation, for wage or profit, for which the Employee is qualified by reason of education, training or experience. With respect to a Dependent, the terms mean disability to the extent that the Dependent is receiving ongoing medical care by a Physician and can perform none of the usual and customary duties or activities of a person in good health of the same age and sex.

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

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

SECTION VII
GENERAL PROVISIONS

VII.01 Conformity With Statutes

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

VII.02 ERISA

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

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

A. **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 72 hours after receipt of the claim. You may be given notice orally, in which case a written notice will be provided within 3 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 your 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, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review, if you are enrolled in an ERISA plan;
- disclose any internal rule, guideline, or protocol relied upon in making the adverse determination (or state that such information is available free of charge upon request); and
- if the denial is based on medical necessity, experimental treatment or other similar limit, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request).

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

B. REQUEST FOR REVIEW AND APPEALS

You will have 180 days from the receipt of an adverse benefit determination to file an appeal. 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. The Corporation will defer to the attending Provider with respect to the decision as to whether a claim constitutes "urgent care." 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: 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);
- 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).
- include a statement regarding your right to bring action under section 502(a) of ERISA, if you are enrolled in an ERISA plan.

You also will be sent a notice if your claim on appeal is approved.

C. **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.

The Member will be considered to have exhausted the internal appeal process if the Corporation fails to strictly adhere to the internal appeal process, unless the violation was:

A. De minimus;
B. Non-prejudicial;
C. Attributable to good cause or matters beyond the Corporation’s control;
D. In the context of an ongoing good-faith exchange of information; and
E. Not reflective of a pattern or practice of non-compliance.

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

VII.03 Compliance with Medical Child Support Order

If the Contract is an integral part of an employee welfare benefit plan subject to ERISA, the Contract shall provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order. The Employer as the plan administrator of the group health plan shall establish reasonable procedures to determine whether a Medical Child Support Order is a Qualified Medical Child Support Order and to administer the provision of benefits under such qualified order.

VII.04 Workers' Compensation Not Affected

The Contract is not in lieu of and does not affect any requirements for coverage for workers' compensation insurance.

VII.05 Relationship With Providers

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

VII.06 Relationship Between Parties

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

VII.07 Coverage Exceptions

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

VII.08 Policies and Procedures

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

VII.09 Medical Loss Ratio

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

VII.10 Summary of Benefits and Coverage

The Company will have complied with Federal Law by providing applicable Summary of Benefits and Coverage (SBCs) to the Employer. It will be the Employer's responsibility to distribute the SBCs to their Employees (and Dependents who live at a different address when it is known).

SECTION VIII
CONTINUATION OF COVERAGE AND CONVERSION

VIII.01 Continuation Coverage Under Federal Law (COBRA)

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

VIII.02 Continuation Coverage Under State Law

An Employee who leaves the employ of the Employer while this Contract is in force shall have the right to continue Coverage under the group policy for the fractional policy month remaining at termination plus six additional policy months upon payment in advance to the Employer of the full group Premium for this continuance of Coverage period including any portion thereof usually paid by the former Employer. This continuance is available only if the Member has been continuously Covered under the Employer's group Coverage for at least six months and has been terminated for any reason other than non-payment of premium. The Member is not entitled to have Coverage continued if the Member is entitled under federal law (COBRA) to continuation of Coverage for a period of greater duration than provided herein. Continuation of Coverage is subject to this Contract, or a successor policy, remaining in force and the Member paying the entire Premium, including any portion usually paid by the former Employer, before the date each month that the group policy month begins. Continuation is not available if the Member becomes eligible for other group health coverage or Medicare benefits.

VIII.03 Conversion Privilege For Divorced Spouse

An Enrolled Dependent who ceases to be eligible due to divorce from the Subscriber shall be entitled to have issued to him or her, without evidence of insurability, upon notice of election made to BlueChoice HealthPlan within 60 days following the decree of divorce, and upon payment of the appropriate Premium, a direct pay conversion policy. A policy shall be provided through BlueChoice HealthPlan or an indemnity carrier designated by BlueChoice HealthPlan with coverage similar to but not greater than the terminated coverage. Any probationary or Waiting Periods set forth in the policy shall be considered as being met to the extent coverage was in force under the prior policy.

IX. Continuation of Care

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

In order to receive this continuation of care for a Serious Medical Condition, you must submit a request to us on the appropriate form. You may get the form for this request from BlueChoice HealthPlan by going to the Web site at www.bluechoicesc.com or calling the Customer Service phone number on your BlueChoice HealthPlan ID card. You will also need to ask the treating physician to include a statement on the form confirming that you have a Serious Medical Condition. After we receive your request, we will notify you and the Provider of the last date the Provider is part of our network and a summary of continuation of care requirements. We will review

your request to determine if you qualify for the continuation of care. If additional information is necessary to make a determination, we may contact you or the Provider for such information.

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

SECTION IX
COORDINATION OF BENEFITS AND SUBROGATION

IX.01 Coordination of Benefits

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

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

2. **Longer/Shorter Length of Coverage** - If a person works at several places and each place has a group health plan, the plan he or she has been covered under longest is primary.

3. **Active/Inactive Employee** - The benefits of a plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee’s dependent).

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

5. **Dependent Child/Separated or Divorced Parents** - In the case of divorce or legal separation, the benefits of a plan for the child are determined in this order:

   A. the plan of the parent with custody of the child;
   B. the plan of the spouse of the parent with custody of the child; then
   C. the plan of the parent not having custody of the child.
   D. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the healthcare expenses of the child, the plans covering the child shall follow the rules in Paragraph 4 of this section.

6. When a group health plan does not have a coordination of benefits provision, that plan is primary.

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

If the amount of the payments under this plan is more than permitted under this coordination of benefits provision, BlueChoice HealthPlan may recover the excess from one or more of the following: the person paid or for whom payment was made; insurance companies; or any other organization.

IX.02 Subrogation

As a condition of receiving benefits under this Contract, the Member agrees to transfer to BlueChoice HealthPlan all rights to recover damages in full for not more than the amount of insurance benefits paid by BlueChoice HealthPlan when an injury or illness for which benefits were paid by BlueChoice HealthPlan occurs through the act or omission of a liable third party. BlueChoice HealthPlan shall be subrogated, unless prohibited by law, to the rights of recovery of such Member against such liable third party. If the Director of Insurance or his designee, upon being petitioned by the Member, determines that the exercise of subrogation by BlueChoice HealthPlan is inequitable and commits an injustice to the Member, subrogation is not allowed. Reasonable attorney's fees and costs must be paid by BlueChoice HealthPlan from the amount received.

Alternatively, if a Member receives any recovery by way of payment, reimbursement, judgment settlement, or otherwise from another person, firm, corporation, organization, or entity, the Member agrees to reimburse BlueChoice HealthPlan in full, in first priority, for any benefits paid by it even though the Member has not been made whole for all of his or her losses. The obligation to reimburse BlueChoice HealthPlan in full, in first priority, exists regardless of whether the payment, reimbursement, judgment, or settlement specifically designates the recovery or a portion thereof as including medical expenses.

BlueChoice HealthPlan's right of full recovery may be from, but is not limited to, funds the Member receives or is entitled to receive from the third party, any liability coverage or other insurance covering the third party or Member, uninsured motorist coverage under insured motorist coverage, any medical payments, no fault, malpractice and school insurance coverage which are paid or are payable. BlueChoice HealthPlan may enforce its rights by requiring the Member to cooperate and to assert a claim to any coverage to which the Member may be entitled. The Member shall cooperate with BlueChoice HealthPlan and shall execute all documents and do all things necessary to protect and secure BlueChoice HealthPlan's right of subrogation and reimbursement.

SECTION X
HOW TO GET HELP

X.01 Resolution of a Question

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

www.BlueChoiceSC.com

or by calling:

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

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

Members may write to:

BlueChoice HealthPlan
Member Services Department
P. O. Box 6170
Columbia, SC 29260-6170

Please include your ID number, name, address, and telephone number with your request.

X.02 Complaint, Grievance and Appeal Procedures

1. To file a complaint or to appeal a decision regarding the provision of benefits under this Contract, the Member may contact a representative of BlueChoice HealthPlan stating the issue to be reviewed and attaching pertinent medical records or other information that the Member offers in support of the appeal. The Member also may request a description of any pertinent records that BlueChoice HealthPlan reviewed in making the original decision to deny the claim in whole or in part. If the complaint involves a representative of BlueChoice HealthPlan, the request should be addressed to the chief operating officer of BlueChoice HealthPlan of South Carolina, Inc. If a complaint is related to the quality of care received by a Member, it is considered a grievance. The Member should submit a description of the problem in writing to a BlueChoice HealthPlan representative.

2. A BlueChoice HealthPlan representative will notify the Member of receipt of the complaint or appeal and will arrange for a review by an appropriate representative of BlueChoice HealthPlan. A complaint or appeal shall be resolved within 30 days from the date received. This period may be extended in the event of a delay in obtaining the documents or records necessary for the resolution of the matter.

3. If the problem is an appeal of the denial of an Authorization, the Member may request that the individual who reviews the request be a person who did not make the initial decision of denial. The Member may request that the reviewer be a Provider licensed in the same specialty as the attending medical Provider. If the Member believes the determination to deny Authorization warrants immediate appeal, the Member may request an expedited appeal. For an expedited appeal, a decision shall be made and the Member shall be notified of the decision within two business days of BlueChoice HealthPlan's

receipt of all information necessary to complete the appeal. If the result of the expedited appeal does not resolve the difference in opinion, the Member may resubmit the appeal through the standard appeal process.

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

X.03 External Review by an Independent Review Organization

In certain situations, a Member may be entitled to an additional review of the appeal at BlueChoice HealthPlan's expense. An external review may be used to reconsider the appeal if BlueChoice HealthPlan has denied it either in whole or in part; if the payment would be greater than $500; and if a requested service or payment for service has been denied, reduced, or terminated. These situations include a decision by BlueChoice HealthPlan that the requested service

1. does not meet the requirements for medical necessity, appropriateness, healthcare setting, level of care, or effectiveness; or
2. is experimental or investigational, and involves a condition that is life-threatening or seriously disabling.

After all internal appeals are completed, the Member will be notified in writing of the right to request an external review. The Member should file a request for review within 60 days of receiving that notice. The Member 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. If a Member needs assistance during the external review process, he or she has the right to contact the South Carolina Department of Insurance. The Director of the South Carolina Department of Insurance or his designee may be contacted at the following address and telephone number:

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

Within five business days of the request for an external review, BlueChoice HealthPlan must respond by either:

1. assigning the review and forwarding records used in making the decision to an independent review organization; or
2. telling the Member in writing that the situation does not meet the requirements for an external review and the reasons for this decision.

The independent review organization will take action on the request for review within 45 days after receipt of the request.

Expedited reviews are available if the Member's Physician certifies that the Member has 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 the Member's health in serious jeopardy. The Member also may receive an expedited review if the denial involves an Emergency Admission or Emergency care; if the Member has not been discharged from a facility after receiving that care; and if the Member will be held financially responsible.

X.04 Legal Actions

No action at law shall be brought to recover on this Contract until a Member has exhausted the review procedures set forth above in this section, or until the expiration of 60 days after written proof of loss has been filed with BlueChoice HealthPlan nor shall such action be brought after the expiration of six years from the date written proof of loss is required to be furnished.

X.05 Information and Records

BlueChoice HealthPlan is entitled to obtain such authorization from the Member for medical and Hospital records from any Provider of services as is reasonably required in the administration of benefits hereunder. The Member agrees that benefits for any professional or facility Covered Services are contingent upon receipt of such information or records. BlueChoice HealthPlan shall in every case hold such records as confidential except as authorized by a Member or as required by law. BlueChoice HealthPlan shall not release confidential medial records to the Employer except as authorized by a Member or as required by law.

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)