BlueChoice HealthPlan of South Carolina, Inc.
Individual Coverage

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

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

BlueChoice Individual Coverage
Outline of Coverage

If you need information about this health coverage:

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

Read Your Contract Carefully

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

Individual Health Maintenance Organization Coverage

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

Important

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

All care, except for treatment of an Emergency Medical Condition, vision care or dental care, must be provided by your primary care physician or authorized in advance by your primary care physician.

Benefits Descriptions

Services	Benefits – We Pay
Primary Care Physician Services (including Behavioral Health)	100% after $10, $15, $25 or $35 Copayment per office visit or 100% after the Deductible
Routine, Preventive Office Services	100% after $10, $15, $25 or $35 Copayment per office visit
Inpatient Hospital Care	100%, 80% or 70% after Deductible
Outpatient Hospital Care	100%, 80% or 70% after Deductible
Specialist Physician Services	100%, 80% or 70% after Deductible
Urgent Care	100% after $35 or $50 Copayment per visit or 100% after the Deductible
Behavioral Health	100%, 80% or 70% after Deductible
Prescription Drugs (Prescription drugs are each subject to one copayment for up to a 31-day supply)	100% after $7 or $8 Copayment or 100% after Deductible for Generic Drugs 100% after $15 or $30 Copayment or 100% after Deductible for Preferred Drugs 100% after $30, $50 or $60 Copayment or 100% after Deductible for Non-Preferred Drugs
Specialty Pharmaceuticals	100% after $100 Copayment or 100% after Deductible
Vision Care	One eye exam per Benefit Period
Dental Care	Up to $20 for one exam and $30 for one cleaning per Benefit Period
Deductible	$250, $500, $750, $1,500, $2,500, $3,000 or $5,000 per Benefit Period
Out-of-Pocket Maximum	$1,500, $2,000, $2,500, $5,000 or NA per Benefit Period

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

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

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

1. Normal pregnancy and childbirth except for complications of pregnancy.
2. Illness, accident, treatment or medical condition arising out of war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection, service in the armed forces or units auxiliary thereto.
3. Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.
4. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet. This exclusion does not include corrective surgery or treatment for metabolic or peripheral vascular disease.
5. Care in connection with the detection and correction by manual or mechanical means of structure imbalance distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment of subluxation of, or in the vertebral column.
6. Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any state or federal workman's compensation, employers liability or occupational disease law, any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family; and services for which no charge is normally made in the absence of insurance.
7. Dental care or treatment except as provided under Dental Care in the Schedule of Benefits and Covered Services.
8. Eyeglasses, hearing aids and examination for the prescription or fitting thereof; except as provided under Vision Care in the Schedule of Benefits and Covered Services.
9. Rest cures, custodial care, and transportation.
10. Any non-emergency, out-of-area care when care is available within the local service area. This is known as a territorial limitation.
11. Services, supplies or charges for wellness or alternative treatment programs, acupuncture, massage therapy, hypnotism and Transcutaneous Electrical Nerve Stimulation (TENS) unit therapy or any kind of pain management, unless and to the extent such services may be covered under, and you receive these services while participating in, an approved program listed under the Additional Covered Services section of the Policy.
12. Any treatment or Surgery for obesity (even if morbid obesity is present), weight reduction or weight control, such as gastric by-pass, insertion of stomach (gastric) banding, intestinal bypass, wiring mouth shut, liposuction or complications from it, unless and to the extent such services may be covered under, and you receive such services while participating in, an approved program listed under the Additional Covered Services section of the Contract. This includes any reversal or reconstructive procedures from such treatments. Treatment for obesity may be covered if a Member participates in the My Health Novel program.

Guaranteed Renewable Except For Stated Reasons

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

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

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

Contract Term

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

About Premiums

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

BLUECHOICE HEALTHPLAN INDIVIDUAL HEALTH COVERAGE CONTRACT

Your Right to Examine This Contract

You have 30 days to examine this contract. If you're not happy with it, you may return it to BlueChoice with a note that says you don't want it. If you do that, any premiums you have paid will be returned to you. However, if you use any of the benefits provided by this contract during this 30-day examination period, you may not then return the contract and receive a refund of the premium paid.

Contract Term

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

Guaranteed Renewable Except For Stated Reasons

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

1. You have failed to pay premiums in accordance with this contract or the company has not received timely premium payments.
2. You have performed an act or practice that constitutes fraud or made a material misrepresentation of material fact under the terms of the coverage.
3. The company is ceasing to renew this contract for everyone who has this type of contract. However, coverage may only be discontinued if the company:
   A. Provides notice to each covered individual of the discontinuance at least 90 days before the date the contract ends,
   B. Offers to each covered individual the option to purchase other individual coverage currently offered by the company, and
   C. Acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for coverage in exercising the option to discontinue the contract or offering the option to purchase other individual coverage.
4. You no longer reside, work or live in the company's service area or in the area in which the company is licensed to do business. This area is the state of South Carolina.
5. You reach the age of 30. A reminder that is coverage will end when you reach age 30 will be sent to you 31 days prior to your 30th birthday. See your rights under Conversion Privilege if your contract is nonrenewed for this reason.
6. At the time of renewal, the company may modify the BlueChoice Individual Coverage contract for everyone who has it as long as the modification is consistent with state law and effective on a uniform basis.

However, the company will not decline to renew your contract simply because of a health status-related factor. At the time of renewal, we may modify the Policy for everyone who has it as long as the modification is consistent with federal and state law and effective on a uniform basis.

About Premiums

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

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

Scott Graves
President
BlueCross BlueShield Division

TABLE OF CONTENTS

Important

BlueChoice HealthPlan of South Carolina, Inc. (BlueChoice) is a managed care organization and uses an HMO network. That means all Covered Services (except Emergency Medical Care and dental and vision care) must be received from your Primary Care Physician (PCP) or from a Provider authorized by your PCP. Unless otherwise specified, coverage is not provided for services not Authorized by your PCP or furnished by Out-of-Network Providers unless you are being treated for an Emergency Medical Condition at a Hospital Emergency Room, Freestanding Emergency Room or Urgent Care Center or receiving dental or vision care.

BlueChoice Individual Coverage generally requires the designation of a PCP. You have the right to designate any in-network PCP who is available to accept you. For children, you may designate a pediatrician as the PCP.

You do not need Authorization from BlueChoice or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from an in-network Provider who specializes in obstetrics or gynecology. The Provider, however, may be required to comply with certain procedures, including obtaining Authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For information on how to select a PCP, and for a list of the PCPs or in-network Providers who specialize in obstetrics or gynecology, contact Member Services through the website at www.https://www.BlueChoiceSC.com/find-care or by calling 803-786-8476 in Columbia or 800-868-2528 when outside the Columbia area.

GENERAL INFORMATION

Non-Discrimination. Your receipt of a federal Premium subsidy, taking any action to enforce your rights under applicable law, Health Status-Related Factors, race, color, national origin, present or predicted disability, sex, gender identity sexual orientation, expected length of life, degree of medical dependency or quality of life will not affect your eligibility or Premiums for this coverage.

Premiums may not be increased, coverage cannot be denied, and wellness incentives may not be reduced or withheld based on the lawful ownership, possession, use or storage of a firearm or ammunition.

WHEN YOUR COVERAGE BEGINS AND ENDS

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

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

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

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

CONVERSION PRIVILEGE

If you cease to be eligible because you have reached the limiting age of this policy, you are eligible to enroll in another Policy, without evidence of insurability. You must apply for coverage within 60 days of reaching the limiting age and pay the appropriate Premium. The Policy will provide the coverage currently being issued by BlueChoice which is most nearly similar to, but not greater than, the terminated coverage and complies with the Affordable Care Act provisions.

Extension of Benefits after Termination of Coverage. If the company does not renew or terminates your contract and you are in the hospital or totally disabled when your coverage under this Policy ends, benefits will be provided while you remain totally disabled for the same cause. Benefits are subject to the terms, conditions, exclusions and limitations of the Policy. This coverage will continue under this section ends at the earliest of:

1. The date you have full coverage for the disabling condition under a health plan with similar benefits and that plan makes reasonable provisions for continuity of care for the disabling condition;
2. You are no longer totally disabled;
3. You use up all of your benefits, or
4. Until the end of a period of 365 consecutive days.

Benefits will be paid only for charges related to treatment of the disabling condition. The term "disabled" means that you are receiving ongoing medical care by a physician and can perform none of the usual and customary duties or activities of a person in good health of the same age. A physician's statement of disability will be required.

Important Note: We recommend that you notify the company within 12 if you wish to exercise the extended benefits for total disability rights. Claims filed under this section must be accompanied by a Physician's statement of disability. The medical director of the company will have authority for determining if the requirements of total disability have been met. You should contact the company for the necessary forms.

EMERGENCY PROCEDURES

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

For An Emergency That Occurs Within the BlueChoice Local Service Area:

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

For An Emergency That Occurs Outside the BlueChoice Local Service Area:

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

Non-emergency care outside the Local Service Area is not covered.

The BlueCard® Program

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

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

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

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

PRIMARY CARE PHYSICIANS AND PARTICIPATING PROVIDERS

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

You do not need prior Authorization from BlueChoice or from any other person (including your PCP) in order to obtain access to a pediatrician for children or gynecological care (from a Provider who specializes in gynecology) for women from a health care professional in our Network. 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. For a list of Participating health care professionals who specialize in gynecology, contact BlueChoice at 786-8476 in Columbia or 855-816-7636, toll free from anywhere else.

Preventive or routine services are covered under the contract when provided or ordered by your PCP.

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

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

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

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

Note: If you receive services at an In-network Hospital, Hospital outpatient department, Critical Access Hospital, or Ambulatory Surgical Center, you may receive some services from an Out-of-network Provider. When this happens, those services may be covered as if they were provided In-Network, and you should not be billed for any Covered Services other than any applicable in-Network Coinsurance, Copayment or Deductible. However, if the out-of-Network Provider furnishes you with a notice and obtains your consent in advance, the services will not be covered by this Policy and you may be required to pay the full cost of those services or benefits you received from the out-of-Network Provider (except to the extent the services consist of "ancillary services" that must be covered on an in-Network basis in all cases, such as anesthesiology, pathology, radiology, neonatology, and laboratory services, or services for which there is no in-Network Provider available at the facility to furnish).

Verification of Participation Status. You are responsible for verifying the participation status of the Physician, Hospital, or other Provider prior to receiving Covered Services. You may verify participation status by contacting Member Services through the website at https://www.bluechoicesc.com/find-care, or by calling 786-8476 in Columbia or 1-855-816-7636 when outside the Columbia area.

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

Companion Benefit Alternatives, Inc. ("CBA") is responsible for managing Behavioral Healthcare Services (including Preauthorization) on behalf of BlueChoice.

Referral Health Services by Non-Participating Providers. If specific Essential Health Benefits cannot be provided by or through a Participating Provider, you are eligible for coverage for Covered Services obtained through non-Participating Providers. These services must be Authorized in advance through referral documentation designated by BlueChoice and are subject to the provisions, limitations and exclusions of this Policy. It is your responsibility to obtain this required Authorization prior to receiving the services.

Continuation of Care

If benefits under this Policy are no longer covered for a Provider due to a change in the Provider's terms of participation in the Network, such as the Network Provider's contract ends with BlueChoice or CBA is modified, or ends or is not renewed for any reason other than fraud or failure to meet specified quality standards, including suspension or revocation of the Provider's license, or the Contract is terminated, and you are a Continuing Care Patient of the Provider at the time, you may be eligible to continue to receive Network benefits for that Provider's services for a limited period of time. We will attempt to notify you if and when these situations arise with your Providers, and explain your right to elect continued Network coverage, but such continued Network coverage is not automatic; please contact us or have your Provider contact us in order to receive this continued Network coverage.

We recommend you use a form for this request. This form can be found by going to the website at www.BlueOptionSC.com or calling the Member Service phone number on your BlueChoice ID card. Your treating Physician should include a statement confirming that you have a Serious Medical Condition. Upon receipt of your request, we will confirm the last date the Provider is part of our Network and a summary of continuation of care requirements. If additional information is necessary, we may contact you or the Provider.

If you qualify for continued in-Network status under this section, we will provide in-Network benefits for you, for those services from that Provider, for the course of treatment relating to your status as a Continuing Care Patient, for 90 days or until the date you are no longer a Continuing Care Patient with respect to the Provider, whichever occurs earlier. Such continued Network status is subject to all other terms and conditions of the Policy, including regular benefit limits.

Special Out-of-Network Rules

If you receive treatment from an out-of-Network Provider as described below, your treatment may be covered under the same terms as if the treatment had been received from an in-Network Provider, and the Allowed Amount for purposes of determining your Cost Sharing liability will be the Recognized Amount. This exception applies only if one of the situations described below applies. You will still be liable for any in-Network Cost Sharing amounts under all other terms of this coverage. These are the only circumstances in which BlueChoice will allow for out-of-Network services without prior Authorization and approval.

- You are treated in the emergency department of a Hospital or a free-standing emergency department where the facility or a treating Provider is not in-Network, including post-Stabilization services provided as part of Outpatient observation or an Inpatient or Outpatient stay relating to Emergency Services furnished at an emergency department visit. In emergency situations, no prior Authorization is required. For post-Stabilization services, the provider or facility may furnish you a notice of treatment by an out-of-Network provider and an opportunity to consent to the treatment in advance, in which case this section will not apply and the post-Stabilization services will not be covered by this Policy (except for services furnished due to unforeseen, urgent medical needs).
- You seek non-Emergency treatment at an in-Network Hospital, Hospital outpatient department, Critical Access Hospital, or Ambulatory Surgical Center, but during your treatment, you receive services from a non-Network Provider. An example of this would be if you have surgery performed in a Network Hospital; your surgeon is in-Network, but the anesthesiologist out-of-Network. Except for certain ancillary services, when this occurs, the Provider may furnish you a notice of treatment by a non-Network Provider and an opportunity to consent to the treatment in advance, in which case this section will not apply and those services will not be covered by this Policy.
- It is Medically Necessary for you to be transported by an air ambulance company not in our Network.

If you need assistance because one of the above actions has occurred, please contact us using the information on the back of your ID card or as shown in the section above titled “How to Contact Us.”

COVERED SERVICES

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

1. Medically necessary and appropriate,
2. Not be Experimental or Investigational in nature,
3. Performed on or after your effective date and prior to cancellation of coverage, and
4. Provided by your PCP or by a provider authorized in advance by your PCP.

This applies to all services except for treatment of an Emergency Medical Condition, dental care and vision care as described below.

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

Benefits payable under this Policy are not assignable to a non-participating provider, unless otherwise determined by the company. Any benefits payable for covered services of such providers will be based on the Allowable Charge.

1. Physician Services

Benefits do not include: treatment of infertility, including fertility drugs, lab and X-ray test, reversals of sterilization, surrogate parenting, artificial insemination and in-vitro fertilization; acupuncture; treatment of obesity, weight reduction or weight control disorders (unless and to the extent such services may be covered under, and you receive such services while participating in, an approved My Health Novel Weight Management Program; refractive care such as radial keratotomy, keratmolieusis and lamellar keraplasty. Any hospital services associated with these services or procedures are also not covered. Charges for failure to keep a scheduled appointment; completion of claim forms or charges for providing medical information, and telephone consultations are not considered to be medical care and are not covered under this contract. Benefits are provided for preventive care, diagnostic services, and treatment of illness or injury when they are provided by a Physicians. This includes Medically Necessary office visits, and medical, surgical, or Behavioral Health care, including Surgical Assistants, provided in a Provider's office, Hospital, Alternate Facility, Long-Term Acute Care Facility, Skilled Nursing Facility, Residential Treatment Facility or Rehabilitation Hospital. The following services, unless and to the extent specified in the Schedule of Benefits, are Covered Services.

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

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

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

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

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

2. Facility Services

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

Inpatient

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

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

Outpatient

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

B. **Outpatient Laboratory, Radiology, Diagnostic and some Therapeutic Services.** Benefits will be provided for procedures to identify the nature and/or extent of conditions or diseases. Services and supplies for radiology and some therapeutic treatments are also Covered Services when provided under the direction of a Physician at a Hospital or Alternate Facility.

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

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

Benefits are available to treat an Emergency Medical Condition at a Hospital Emergency Room, free-standing Emergency Room or at an Urgent Treatment Center and only as long as your condition continues to be considered an Emergency. If you receive care for an Emergency Medical Condition and are treated in the Emergency Room at a Hospital, the charges for Emergency Services are paid as follows:

A. Emergency Care Benefits – In-Network and Out-of-Network

1. Benefits are provided for services and supplies for Stabilization and/or initial treatment of an Emergency Medical Condition. If possible, call your Primary Care Physician prior to seeking treatment. If it is not possible to call your Primary Care Physician or delaying medical care would make your condition dangerous, please go to the nearest Hospital. Your claim for Emergency Services will be reviewed to ensure it meets the definition of an Emergency Medical Condition. If your claim does not meet the criteria for an Emergency Medical Condition, benefits will be denied whether the service is provided by an In-Network Provider or not.

   If you are admitted to a Hospital due to an Emergency Medical Condition, you or someone acting on your behalf, must contact BlueChoice within 24 hours or the next working day, whichever is later at 800-950-5387. If the Admission occurs outside the Local Service Area or at an Out-of-Network Provider, you may be required to transfer to a Hospital within the Local Service Area once your condition has Stabilized 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 be provided by an In-Network Provider.

   Cost Sharing for Emergency Services for an Emergency Medical Condition is described in Special Out-of-Network Rules section.

2. Elective care, routine care, care for minor illness or injury, or care that reasonably could have been foreseen is not considered an Emergency Medical Condition and is not covered. Examples of non-Emergency Medical Conditions are: Prescription Drug refills, removal of stitches, requests for a second opinion, screening tests or routine blood work, follow-up care for chronic conditions such as high blood pressure or diabetes.

3. Urgent Care Services are Covered Services when provided by a Participating Physician or at a Participating Alternate Facility such as an Urgent Care center or after-hours facility. Urgent Care provided by a non-Participating Provider is covered when Authorized by BlueChoice in advance or within 24 hours of receiving the service. Follow-up care must be provided by a Participating Physician in order to be a Covered Service.

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

   We will provide benefits for off-label use of Prescription Drugs that haven't been approved by the FDA for the treatment of a specific type of cancer for which the drug was prescribed, provided the drug is recognized for treatment of that specific cancer in at least one standard reference compendium or the drug is found to be safe and effective in formal clinical studies. These results must have been published in peer-reviewed professional medical journals.

   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.

   We contract with a pharmacy benefit manager to manage the pharmacy Network, and/or Specialty Drug Network Providers, and to perform other administrative services, including negotiating prices with the pharmacies in this Network. OptumRx® is an independent company that offers a pharmacy network on behalf of BlueChoice HealthPlan of South Carolina Inc.

   The Company receives financial credits directly from drug manufacturers and through a Pharmacy Benefit Manager (PBM). The credits are used to help stabilize overall rates and to offset expenses. Reimbursements to pharmacies, or discounted prices charged at pharmacies, are not affected by these credits. Any **c**oinsurance percentage or Deductible amount that you must pay for prescription medications is based on the negotiated rate or lesser charge at the pharmacy and does not change due to receipt of any preferred drug credit by the Company. Copayments are flat amounts and likewise do not change due to receipt of these credits.

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

   Specialty pharmaceuticals are not covered under the prescription medication benefit.

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

The company receives financial credits directly from drug manufacturers and through a Pharmacy Benefit Manager. The credits are used to help stabilize overall rates and to offset expenses. Reimbursements to participating providers, or discounted prices charged by participating providers, are not affected by these credits. Any coinsurance percentage or deducible amount that a member must pay for specialty pharmaceuticals is based on the negotiated rate or lesser charge by the participating provider and does not change due to receipt of any financial credit by the company. Copayments are flat amounts and likewise do not change due to receipt of these credits.

6. **Ambulance Services.** Professional ambulance services to a local hospital in the United States are covered in connection with an acute injury or an Emergency Medical Condition. Coverage is also provided in connection with an interfacility transport between acute care facilities in the United States, when medically necessary due to the requirement for a higher level of services. No benefits are provided for international ambulance services or ambulance services used for routine, non-Emergency transportation, including but not limited to travel to a facility for scheduled medical or surgical treatments, such as dialysis or cancer treatment or transfer to sub-acute place of care such as a Skilled Nursing Facility. All claims for ambulance services are subject to medical review to determine if Medically Necessary. The Allowed Amount for ambulance services provided by Non-Participating Providers will be determined in accordance with the applicable fee schedule.

   Air Ambulance Transportation: Authorization is required for transportation as an Inpatient from one Hospital to a second Hospital using an air ambulance. All the following requirements must be met:
   - The first Hospital does not have needed Hospital or skilled nursing care for the member's illness or injury (such as burn care, cardiac care, trauma care, and critical care).
   - The second Hospital is the nearest medically appropriate Facility.
   - A ground ambulance transport endangers the Member's medical condition.
   - The transport is not related to a hospitalization outside the United States.

   Cost Sharing requirements for covered Out-of-Network air ambulance services is described in Special Out-of-Network Rules section.

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

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

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

10. **Behavioral Health Services.** Benefits for Behavioral Health Services are provided.

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

12. **Prosthetics and Durable Medical Equipment.** Benefits are provided for a prosthetic, other than a dental or cranial prosthetic, which meets minimum specifications for the body part it is replacing regardless of the functional activity level. If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost. The item must be a standard, non-luxury item as determined by us. Benefits are provided only for the initial temporary and permanent prosthesis. Services related to the repair or replacement of a prosthetic are only considered necessary when due to a change in the Member's medical condition. A penile prosthesis will be considered for benefits only after prostate Surgery. Prosthetic devices are limited to one device per Member per episode.

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

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

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

    A. Oral and facial surgery, surgical management and follow-up care
    B. Prosthetic treatment such as obturators, speech appliances and feeding appliances
    C. Orthodontic treatment and management
    D. Prosthodontia treatment and management
    E. Otolaryngology treatment and management
    F. Audiological assessment, treatment, and management, including surgically implanted amplification devices
    G. Physical therapy assessment and treatment

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

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

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

A. Once as a base-line mammogram for a female who is at least 21 years of age,
B. Once a year for a female who is at least 21 years of age, or
C. In accordance with the most recently published guidelines of the American Cancer Society. The American Cancer Society is an independent organization that offers health information and recommendations; it is not affiliated with BlueChoice.

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

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

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

21. **Transplant Services.** Benefits are provided for covered services for organ and tissue transplants as shown in the Schedule of Benefits. To be covered, such transplants must be provided from a human donor to you (the transplant recipient) and provided at Blue Distinction® Centers for Transplants Designations while you are covered under this contract. All solid organ procurement services, including donor organ harvesting, typing, storage and transportation are covered. Benefits are provided on the same basis as any other condition or illness.

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

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

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

24. OUT-OF-AREA SERVICES

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 Primary Care Physician ("PCP")/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. Blue Cross Blue Shield Global® Core

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 Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core 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 Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the 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 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 service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. You must contact us 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 Blue Cross Blue Shield Global Core 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 Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from us, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

25. **My Health Novel Weight Management Program.** If you wish to make healthy lifestyle changes to manage your weight and reach your health goals, log onto My Health Toolkit to complete an assessment to determine if you are eligible to participate in a weight management program offered through My Health Novel. Members who are eligible to participate will be matched to programs based on their risk factors, interests and preferred method of participation (i.e., in person or on-line).

26. **Pain Management Program.** We may, in our discretion under certain limited circumstances, approve services for a multi-disciplinary Pain Management Program that includes Physicians of different specialties and non-Physician Providers who (i) specialize in the assessment and management of patients with a range of painful diagnoses and chronic pain and (ii) provide the interventions needed to allow the patients to develop pain coping skills and discontinue analgesic medication. Services, supplies or charges for a multi-disciplinary Pain Management Program must be Authorized in advance. Pre-authorization approval shall be on a case-by-case basis, in our discretion, and contingent upon such program satisfying our medical policies. The Member is solely responsible for seeking Authorization in advance, regardless of the State of location of the provider offering the Multi-disciplinary Pain Management Program.

27. **Diabetes Education and Preventive Care.** Diabetes education and preventive care received from a Participating Provider.

28. Clinical Trials. Benefits are provided for routine Member costs for items and services related to clinical trials when:

a. The Member has cancer or other life-threatening disease or condition; and
b. The referring Provider is a Network Provider that has concluded that the Member's participation in such trail would be appropriate; and
c. The Member provides medical and scientific information establishing that the Member's participation in such trail would be appropriate; and
d. The services are furnished in connection with an Approved Clinical Trail.

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).

SERVICES AND SUPPLIES THAT ARE NOT COVERED

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

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

8. Eyeglasses, hearing aids and examination for the prescription or fitting thereof; except as provided under Vision Care in the Schedule of Benefits and Covered Services.
9. Rest cures, custodial care, and transportation.
10. Any non-emergency, out-of-area care when care is available within the local service area. This is known as a territorial limitation.
11. Services, supplies or charges for wellness or alternative treatment programs, acupuncture, massage therapy, hypnotism and Transcutaneous Electrical Nerve Stimulation (TENS) unit therapy or any kind of pain management, unless and to the extent such services may be covered under, and you receive these services while participating in, an approved program listed under the Additional Covered Services section of the Policy.
12. Any treatment or Surgery for obesity (even if morbid obesity is present), weight reduction or weight control, such as gastric by-pass, insertion of stomach (gastric) banding, intestinal bypass, wiring mouth shut, liposuction or complications from it, unless and to the extent such services may be covered under, and you receive such services while participating in, an approved program listed under the Additional Covered Services section of the Contract. This includes any reversal or reconstructive procedures from such treatments. Treatment for obesity may be covered if a Member participates in the My Health Novel program.

DEFINITIONS AND RELATED COVERAGE REQUIREMENTS

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

Adverse Benefit Determination: Any denial, reduction or termination of, or failure to provide or make (in whole or in part) payment for a claim for Benefits, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in a Plan, and including, a denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for a Benefit which results from the application of any utilization review as well as a failure to cover an item or services for which Benefits are otherwise provided because it is determined to be Investigational or Experimental or not Medically Necessary or appropriate. An Adverse Benefit Determination includes any rescission of coverage.

Allowed Amount: The amount BlueChoice or a licensee of the Blue Cross and Blue Shield Association agrees to pay a Provider as payment in full (less any applicable Coinsurance, Copayment, and/or Deductible) for a service, procedure, supply or equipment, except as provided in the Special Out-of-Network Rules Section.

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

Ambulatory Surgical Center: A facility that is licensed for Outpatient Surgery only and does not provide overnight accommodations or around-the-clock care. The care must be provided under the supervision of a Physician. It also must provide nursing services by or under the supervision of an on duty registered nurse (RN). The facility must not be an office or clinic for the private practice of a Physician.

Authorized or Authorization: Prior approval from your PCP for a Provider of healthcare services to provide certain Covered Services. This approval must be on file with the company before the service is considered Authorized. Each individual service or treatment, except for emergency services, dental care, and vision care requires such prior approval. Services or supplies provided must be in accordance with the approval given.

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

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

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

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

Coinsurance: A percentage of the Allowed Amount that you pay. This percentage applies to the negotiated rate or lesser charge when we've negotiated rates with that Provider. For example, if the Coinsurance for a particular benefit is 20 percent, you pay 20 percent of the Allowed Amount and we pay 80 percent.

Company: BlueChoice HealthPlan of South Carolina, Inc.

Continuing Care Patient: An individual who, with respect to a Provider or facility, either (a) is undergoing a course of treatment for a Serious and Complex Condition from the Provider or facility, (b) is undergoing a course of institutional or inpatient care from the Provider or facility, (c) is scheduled to undergo nonelective surgery from the Provider, including receipt of postoperative care from such Provider or facility with respect to such a surgery, (d) is pregnant and undergoing a course of treatment for the pregnancy from the Provider or facility, or (e) is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such Provider or facility.

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

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

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

Cost Sharing: The general term that refers to the share of costs for services covered by a plan or health insurance that you must pay out of your own pocket (sometimes called "out-of-pocket" costs). Some examples of types of Cost Sharing include Copayments, Deductible and Coinsurance. Other costs, including your premiums, penalties you may have to pay or the cost of care not allowed by a plan or policy are usually not considered Cost Sharing.

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
4. Covered Services must be provided by the Primary Care Physician or Authorized in advance by the Primary Care Physician and BlueChoice HealthPlan, unless otherwise provided in this Certificate or the Schedule of Benefits.

Creditable Coverage: Health coverage subject to Health Insurance Portability and Accountability Act of 1996 (HIPAA). There must be no more than a 63-day break between two different health coverages. When your coverage under this contract ends, you have the right to receive a certification showing the period of coverage you had under this contract. This period of coverage is called Creditable Coverage. It may be that credit for this period of coverage will be given, if a future employer with a group health insurance plan has a pre-existing condition exclusion period, so long as there is no more than a 63-day break in coverage between this coverage and any succeeding coverage. If you leave the future group health insurance, the time of coverage under this contract may help reduce a pre-existing condition exclusion period with the South Carolina Health Insurance Pool.

Critical Access Hospital: A facility that is designated by the state in which it is located, and certified by the United States Department of Health and Human Services, as a critical access hospital.

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

Deductible: The amount you are responsible for paying for Covered Services before we begin to pay each Benefit Year, as listed in the Schedule of Benefits. The deductible is based on the negotiated rate or lesser charge of the provider.

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care Provider that have exclusive medical use. These items must be reusable and may include wheelchairs, Hospital-type beds, walkers, Prosthetic Devices, orthotic devices, oxygen, and respirators. To be considered DME, the device or equipment's use must be limited to the patient for whom it was ordered.

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

Emergency Medical Care: Health care services you receive in a Hospital Emergency Room or independent free-standing emergency department to evaluate and treat an Emergency Medical Condition.

Emergency Medical Condition (Emergency): A medical condition, including a Behavioral Health condition or Substance Use Disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) so 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 the following:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part.

Emergency Services – with respect to an Emergency Medical Condition,

- a medical screening examination that is within the capability of the emergency department of a Hospital or independent freestanding emergency department, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
- such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or independent freestanding emergency department (as required under SSA) to Stabilize the patient.

Excluded Services: Health care services that the Contract and the Certificate doesn't provide or cover.

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

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

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

Hospital: An acute-care facility that meets the following requirements:
1. Is licensed and operated according to the law
2. Primarily and continuously provides or operates medical, diagnostic, therapeutic and major surgical facilities for the medical and Behavioral Health care and treatment of injured or sick people on an Inpatient basis. Care must be provided under the supervision of a staff of duly licensed Physicians
3. Provides 24-hour nursing services by or under the supervision of registered nurses (RNs)

The term "Hospital" does not include long-term, chronic-care institutions or institutions (even when these are affiliated with or part of a Hospital) that are, other than incidentally:
1. Convalescent, rest or nursing homes or facilities
2. Facilities primarily affording custodial, educational or rehabilitory care

Identification Card: The card most recently issued by BlueChoice showing the Member's identification number.

Inpatient: A registered bed patient in a Hospital, Skilled Nursing Facility, Rehabilitation Facility or Mental Health or Substance Use Disorder Facility for whom a room and board charge is made.

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

Investigational or Experimental Services: The use of services or supplies that are not recognized in the United States as standard medical care for the treatment of conditions, diseases, illnesses or injuries. We may use the following criteria to determine whether a service or supply is Investigational or Experimental:

1. The service does not have final unrestricted market approval from the FDA or final approval from any other governmental regulatory body for the use in treatment of a specified condition.
2. The service does not have scientific evidence that permits conclusions concerning the effective of the technology on health outcomes.
3. The service has not been demonstrated to improve the net health outcome.
4. The service has not been found to be as beneficial as any established alternatives.
5. The service does not show improvement outside the investigational settings.

If a service meets one or more of these criteria, it is Investigational or Experimental. We may consider opinions of professionals in a particular field and/or opinions and assessments of nationally recognized organizations, but they are not determinative or conclusive.

Our Medical Director, in making such determinations, may consult with or use medical and/or science industry references, including but not limited to the following sources of information:
1. FDA-approved market rulings
2. *The United States Pharmacopoeia and National Formulary*
3. The annotated publication titled, *Drugs, Facts, and Comparisons*, published by J. B. Lippincott Company
4. Available peer-reviewed literature
5. Appropriate consultation with professionals and/or Specialists on a local and national level.

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

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

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

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

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 Health Care Field, published annually.

Managed Care Organization: Means a licensed insurance company, a hospital or medical services plan contract, a health maintenance organization, or any other entity which is subject to regulation by the department, and which operates a managed care plan.

Managed Care Plan: means a plan operated by a managed care organization which provides for the financing and delivery of health care and treatment services to individuals enrolled in the plan through its own employed health care providers or contracting with selected specific providers that conform to explicit selection standards, or both. A managed care plan also customarily has a formal organizational structure for continual quality assurance, a certified utilization review program, dispute resolution, and financial incentives for individual enrollees to use the plan's participating providers and procedures.

Maximum Payment: The maximum amount we will pay (as determined by us) for a particular benefit. The Maximum Payment will not be affected by any financial credits received from drug manufacturers, through a pharmacy benefit manager, or otherwise. The Maximum Payment will be one of the following, unless otherwise required by applicable law:

1. The actual charge submitted to us for the service, procedure, supply or equipment by a Provider
2. An amount based upon the reimbursement rates established by the plan sponsor
3. An amount that has been agreed upon in writing by a Provider and us or a member of the Blue Cross and Blue Shield Association
4. An amount established by us, based upon factors including, but not limited to, (i) governmental reimbursement rates applicable to the service, procedure, supply or equipment, or (ii) reimbursement for a comparable or similar service, procedure, supply or equipment, taking into consideration the degree of skill, time and complexity involved, geographic location and circumstances giving rise to the need for the service, procedure, supply or equipment
5. The lowest amount of reimbursement we allow for the same or similar service, procedure, supply or equipment when provided by a Participating Provider/contracting Provider
6. The Medicare reimbursement rates.

Medically Necessary or Medical Necessity: Health care services that a Physician, exercising prudent clinical judgment, would provide to prevent, evaluate, diagnose or treat an illness, injury, disease or its symptoms, and that are:

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

For the purpose of determining Medically Necessary/Medical Necessity:

- We have the discretion to utilize and rely upon medical and Behavioral Health standards, policies, guidelines, criteria, protocols manuals or publications, either developed by us or, in our discretion, determined to be generally accepted by the medical and Behavioral Health community; and
- "Generally Accepted Standards of Medical Practice" means United States standards that are based on credible scientific evidence published in peer-reviewed medical and/or behavioral health literature generally recognized by the United States Medical and/or Behavioral Health community, Physician or Behavioral Health specialty society recommendations and any other relevant factors Determined in our discretion; and

Our use of, including but not limited to, Corporate Administrative Medical (CAM) Policies, Technology Evaluation Center (TEC) Assessments and Clinical Protocols, and MCG Health, LLC Care Guidelines reflect and are clinically appropriate health care services and generally accepted standards of medical and Behavioral Health practice.

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

Mental Health: Conditions defined, described or classified as mental health disorders or conditions in the latest publication of The American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders.*

Multi-disciplinary Pain Management Program: A program that includes Physicians of different specialties and non-Physician Providers, who specialize in the assessment and management of patients with a range of painful diagnoses and chronic pain, to provide the interventions needed to allow the patients to develop pain coping skills and discontinue analgesic medication.

Negotiated Arrangement: An agreement negotiated between a Blue Cross and/or Blue Shield Licensee and one or more Host Blues for any National Account that is not delivered through the BlueCard Program.

Out-of-Pocket Limit: The most you pay in Cost Sharing for Covered Services in a Benefit Period before your Plan begins to pay 100 percent of the Allowed Amount. This limit never includes your premium, balance billed charges, or payment for health care services that are not covered under the Contract.

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

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

Participating Provider: A Provider of Covered Services who has entered into a written agreement with BlueChoice or CBA to provide Covered Services to Members. The participating status of a provider may change from time to time. Providers who take part in the BlueCard program are considered to be Participating Providers in the context of this Policy.

Physician: A person (other than an intern, resident or house Physician), duly licensed as a medical doctor, dentist, oral surgeon, podiatrist, osteopath, chiropractor, optometrist, ophthalmologist, Physician's assistant, licensed independent social worker or licensed doctoral psychologist legally entitled to practice within the scope of his or her license and who normally bills for his or her services.

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

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

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

1. Syringes and related supplies for conditions such as diabetes
2. Specific classes of over-the-counter medications designated as Prescription Medication at the discretion of BlueChoice. If so designated, these classes of over-the-counter medications must be purchased at a Participating pharmacy with a prescription from a Participating Physician. The designated over-the counter medications will be listed in the Prescription Drug List.

Primary Care Physician (PCP): A family doctor, general Physician, OB-GYN, pediatrician, osteopath or internal medicine Physician.

Prosthetic Devices: Artificial replacement body parts needed to ease or correct a condition caused by an illness, injury or birth defect, disease or anomaly. A Physician must order the appliance or device. Prosthetics don't include bioelectric microprocessor or computer programmed prosthetic components.

Provider: Any of the following: a facility, Hospital, Skilled Nursing Facility, Rehabilitation/Habilitation Facility, Mental Health or Substance Use facility, Residential Treatment Center, Physician, psychologist, other Mental Health clinicians and an Ambulatory Surgical Center licensed as required by the state where located, performing within the scope of the license and acceptable to us. Providers also include:

1. Durable Medical Equipment suppliers
2. Independent clinical laboratories
3. Occupational, Physical and Speech therapists
4. Pharmacies
5. Home health care Providers
6. Hospice services Providers
7. Behavioral Health Providers

Recognized Amount: The lesser of the Out-of-Network Provider's billed charges or BlueChoice's median contracted rate for In-Network Providers for the same or similar item or service furnished in the same or similar specialty in the same geographic region; provided that, except in connection with air ambulance services, if there is a recognized amount specified for this purpose under an applicable All-Payer Model Agreement under Section 1115A of the Social Security Act, or if not, under applicable state law, then such amount, as applicable, will instead serve as the Recognized Amount.

Rehabilitation Facility: A Hospital or other free-standing medical facility, to provide services directed toward restoring full function and independent living for patients with neurological or other physical illnesses or injuries. These services consist of a multi-disciplinary therapeutic program that includes physical therapy, occupational therapy and other therapeutic interventions on an Inpatient or Outpatient basis.

Residential Treatment Center: A licensed and accredited institution, other than a hospital, that meets all six of these requirements:

1. Maintains permanent and full-time facilities for bed care of resident patients
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
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)
4. Keeps a daily medical record for each patient
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
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, which specify the amount of coverage provided and any applicable maximums, Copayments, Coinsurance, and Deductibles.

Serious and Complex Condition: In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm, or in the case of a chronic illness or condition, a condition that (a) is life-threatening, degenerative, potentially disabling, or congenital, and (b) requires specialized medical care over a prolonged period of time.

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: A licensed and accredited institution, other than a Hospital, that has a written agreement with BlueChoice or with another BlueCross and/or BlueShield Plan that meets all six of these requirements:

1. Maintains permanent and full-time facilities for bed care of resident patients
2. Has the services of a Physician 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
3. Has a Physician or registered nurse (RN) on full-time duty who is in charge of patient care, along with one or more RNs or LPNs on duty at all times (24/7)
4. Keeps a daily medical record for each patient

5. Is primarily providing continuous skilled nursing care for sick or injured patients during the recovery stage of their illnesses or injuries and isn't, other than incidentally, a rest home or a home for Custodial Care for the aged
6. Is operating lawfully as a Skilled Nursing Facility in the area where it is located.

In no event will the term "Skilled Nursing Facility" include an institution that mainly provides care and treatment for substance or alcohol use.

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

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

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

Substance Use Disorders: Conditions defined, described or classified as substance use disorders in the latest publication of The American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders.*

Surgery: 1) The performance of generally accepted operative and cutting procedures including endoscopic examinations and other invasive procedures; 2) the correction or treatment of fractures and dislocations; and 3) other procedures as reasonable and as approved by us. This includes the usual, necessary and related pre- and post-operative care.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency room care.

Urgent Treatment Center: A medical facility where ambulatory patients can be treated on a walk-in basis, without appointment, and receive immediate, non-Emergency care. It doesn't include a Hospital Emergency room.

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

HOW TO GET HELP

Resolution of a Question

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

You can also call our Member Services department. From Columbia, dial 786-8476. From anywhere else in the state, dial 800-868-2528, toll free. If you can't call, write to the following address:

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

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

Complaints, Appeals and Grievances

A complaint is any dissatisfaction you have regarding services or benefits you receive from us. To file a complaint, you may e-mail, call or write a Member Services representative. If the complaint involves a representative of BlueChoice, the request should be addressed to the chief operating officer of BlueChoice. If a complaint is related to the quality of care received by a Member, it is considered a grievance. You should submit a description of the problem in writing at the address above.

The terms listed below are important and need to be understood.

Urgent Claims: 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.

Pre-Service Claims: A claim for services that have not yet been provided and for which your benefits plan requires prior Authorization.

Post-Service Claims: A claim for services that already have been provided, or where your benefits plan does not require prior Authorization.

Concurrent Care Claims: A claim that arises when there is a reduction or termination of ongoing care.

Notice of Adverse Benefit Determination: A notice which will be sent to you if your claim is filed properly, and your claim is in part or wholly denied.

Internal Claims Appeals: You have 180 days from the receipt of an adverse benefit determination to file an appeal. The disposition of the claim shall be considered final after the end of this period.

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 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, or his or her subordinate. No deference will be afforded to the initial determination. Individuals involved in the decision-making for claims and appeals are not compensated or rewarded based on the outcome of an appeal.

If your claim involves a medical judgment question, BlueChoice will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on appeal. Upon request, BlueChoice will provide you with the identification of any medical expert whose advice was obtained on behalf of the plan in connection with your appeal.

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

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

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

Urgent Claims: The Company will defer to the attending Provider with respect to the decision as to whether a claim constitutes "Urgent Care." You may request an expedited review of any urgent claim. This request may be made orally, and BlueChoice HealthPlan will communicate with you by telephone, facsimile, or similarly rapid communication method. You will be notified of the determination as quickly as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim.

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.

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

External Review by an Independent Review Organization

Requests to cover services, benefits, or supplies which are specifically excluded in the Policy are not eligible for external review. The Member will be notified in writing of the right to request an external review. The Member should submit a written request for external review within four months of receiving that notice. The Member will be required to authorize the release of any medical records that may be needed for the external review. If you need assistance during the external review process, you can contact the South Carolina Department of Insurance at:

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

Standard Review: You can request an external review if we deny your claim, either in whole or in part. You may be held financially responsible for the covered benefits. You can request an external review without completing the grievance and appeal process above if:

1. Your Physician has certified in writing that you have a serious medical condition; or
2. The denial of coverage was due to the service being Investigational or Experimental and your Physician certifies:
   a. Your condition is a serious disability or you have a life-threatening disease; and
      i. Standard health care services or treatments have not been effective in improving your condition; or
      ii. Standard health care services or treatments are not medically appropriate; or
      iii. The recommended or requested service or treatment is more beneficial than the standard health care service or treatment covered by us; and
   b. Medical and scientific evidence shows that treatment that was denied is more beneficial to you than available standard health services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of the standard services or treatments.

The Company will respond within five business days of the Member's request for an external review, by either notifying the South Carolina Department of Insurance of a request for external review and requesting the South Carolina Department of Insurance to assign the review to an independent review organization (IRO) and forwarding the Member records to it or telling the Member in writing that the situation doesn't meet the requirements for an external review and explaining the reasons. The South Carolina Department of Insurance will assign an IRO for based upon a rotational system. The rotational system will be independent and impartial and in no event will the IRO be assigned by BlueChoice or the Member. BlueChoice will verify that no conflict of interest exists with the assignment given by the South Carolina Department of Insurance. If a conflict does exist, BlueChoice will contact the South Carolina Department of Insurance for a change in IRO.

The Member has five business days from the date the Member receives the Company's response to submit additional information to the independent review organization in writing. The independent review organization must consider this additional information when conducting its review. The independent review organization will also forward this information to the Company within one business day of its receipt.

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

If the Member's request is not accepted for external review, the IRO will inform the Member and the Company in writing of the reason(s) your request was not accepted.

The IRO will provide written notice of its decision within 45 days after it receives the request.

If the IRO's decision is to allow benefits, the Company must process the claim subject to applicable Policy exclusions, limitations and other provisions within five business days of our receipt of the notification.

Expedited Review: You can file a request for an expedited external review after receiving a notice of a denied claim if you meet the requirements under Standard Review listed above in paragraph 2. You can also request an expedited external review if the denial concerns an Admission, availability of care, continued stay or health care service for which you received Emergency Medical Care, but have not been discharged from a facility, if you may be held financially responsible for the Emergency Medical Care. You can request an expedited external review at the same time as requesting an expedited internal review.

When we receive your request for an expedited external review, the South Carolina Department of Insurance will assign your review to an IRO and we will forward our records by overnight delivery or tell you in writing that your situation doesn't meet the requirements for an external review and explain the reasons.

The IRO must make its decision as fast as possible but within no more than 72 hours after it receives the request for expedited review. If the IRO's decision is to allow benefits, we must approve the benefit as covered, subject to applicable Policy exclusions, limitations and other provisions.

We will pay the for external review.

If your Physician certifies that you have a "serious medical condition," you are entitled to an expedited external review. A serious medical condition, as used in this provision, means one that requires immediate medical attention to avoid serious impairment to body functions, serious harm to an organ or body part, or that would place your health in serious jeopardy or jeopardize your ability to regain maximum function.

GENERAL CONTRACT PROVISIONS

1. Entire Contract; Changes

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

2. Time Limit on Certain Defenses

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

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

3. Grace Period

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

If you do not pay your premium by the date it is due, the Company gives you a grace period of 31 days. This Policy remains in force during the grace period.

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

4. Reinstatement

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

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

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

Show your ID card when you get health care services or supplies, so that people who file claims for you can see the information on it. Written notice of claim must be given within 20 days after a covered loss starts or as soon as reasonably possible. The notice may be given to us at our home office or to our agent. Notice should include the name of the Covered Person and the Policy number. Written proof of loss must be furnished to us at our said office within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event, except in the absence of legal capacity, will written proofs of loss be furnished later than one year from the time the proof is otherwise required.

6. Claim Forms

When we receive notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not given to the claimant within 15 days, the claimant will meet the proof of loss by giving us a written statement of the nature and extent of the loss.

Since Network Providers file claims on your behalf, claim forms may not be sent to you for filing proof of loss.

7. Payment of Claims

All benefits provided in this Policy will be paid promptly upon receipt of due proof of loss. We will pay benefits as described in this Policy directly to the Provider when the Member receives covered services from a Network Provider. If a Member receives covered services from a non-Network Provider, we may pay benefits directly to the Member. The Member is then responsible for any payment to the non-Network Provider. No assignment of benefits is allowed to a non-Network Provider. Any payment of benefits or refund due after the death of a Member will be paid to the Member's estate.

8. Time of Payment of Claims

BlueChoice will pay completed claims received via paper within 40 business days and completed electronic claims within 20 business days following the later of 1) date the claim is received; or 2) the date on which the insurer receives all of the information needed in the format required for the claim to constitute a "clean" claim as defined in the South Carolina Health Care Financial Recovery and Protection Act.

9. Physical Examinations

The company may require a physical exam, at its expense, of the member as often as is reasonably necessary while a claim is pending.

10. Legal Actions

No action at law or equity can be brought against the Company until 60 days after a claim (notice and proof of loss) has been received or until the grievance procedure has been exhausted. No such action can be brought against the Company more than six years after a claim was received.

11. Conformity with State and Federal Statutes

Any provision of this Policy that, any relevant time, is in conflict with the statutes of the federal government or the state of South Carolina is hereby amended to conform to the minimum requirements of such statutes. Notwithstanding anything herein to the contrary, no provision of this Policy shall be interpreted as prohibiting any provision, access, use, or disclosure of information to the extent required by applicable law.

12. Non-Assessable

This is a non-assessable contract. You - the contract holder - are not subject to any assessment for any contingent liability. This means that if, for any reason, the company owes money, you are not responsible for paying it.

13. Other Valid Coverage: Proration

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

If you have other valid coverage and BlueChoice HealthPlan has not been notified of this coverage by you in writing, the company will “prorate” benefit payments when your claim is received. The company will carefully consider all of the valid health insurance that covers your claims. Then, the company will determine its responsibility for your loss in proportion to the responsibility that should be accepted by other insurance companies. The company will pay the portion of your claim for which it is responsible.

If your claim is prorated, you will receive a refund of the portion of the premiums you have paid for coverage that the company did not accept as its responsibility. This refund will be based on premiums paid during the time both policies were in effect.

14. Subrogation Rights

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

15. Independent Corporation

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

16. Information and Records

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

The submission of a claim shall be deemed written proof of loss and written authorization from the member to the company to obtain any medical or financial records and documents useful to the company. The company is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at the time the claim is processed. Any party submitting medical or financial reports and documents to the company in support of a member's claim shall be deemed to be acting as the agent of the member.

17. Relationship with Providers

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

18. Policies and Procedures

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

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

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

BLUECHOICE HEALTHPLAN INDIVIDUAL HEALTH COVERAGE
CLINICAL TRIAL AMENDMENT

This Amendment is subject to all the provisions of the BlueChoice HealthPlan Individual Health Coverage Contract, which are not otherwise specified in the provision of this Amendment.

This Amendment is effective upon receipt.

The following additions/revisions should not be construed as a complete replacement of the sections of the Outline of Coverage and/or the Contract unless otherwise noted.

The Contract is amended as follows:

Covered Services, 28, Clinical Trials, is deleted in its entirety and replaced by the following:

Benefits are provided routine patient care costs and services related to an Approved Clinical Trial for a qualified individual. The individual must be eligible to participate according to the trial protocol and EITHER of the following conditions must be met:

- The referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate, or
- The individual provides medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

In addition to qualifying as an individual, the clinical trial must also meet certain criteria for patient care costs and services to be covered.

Definitions and Related Coverage Requirements, is amended by the addition of the following:

Approved Clinical Trial: Is a phase I, phase II, phase III or phase IV clinical trial conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition that meets ANY of the following criteria:

- It is a Federally funded trial: The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH)
  - Centers for Disease Control and Prevention (CDC)
  - Agency for Health Care Research and Quality (AHRQ)
  - Centers for Medicare and Medicaid Services (CMS)
  - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA)
  - A qualified non-governmental research entity identified in NIH guidelines for center support grants

  Or ANY of the following:
  - Department of Energy

- Department of Defense
- Department of Veteran's Affairs

If BOTH of the following conditions are met:

- Study or investigation has been reviewed and approved through a system of peer review comparable to the system of peer review of studies and investigations used by the National Institutes of Health
- Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

The contract and Outline of Coverage are amended as follows:

Services and Supplies That Are Not Covered, is amended by the addition of the following:

12. Any of the following services associated with a Clinical Trial:
    - Services that are not considered routine patient care costs/services, including the following:
        - The investigational drug, service, item or service that is provided solely to satisfy data collection and analysis needs.
        - An item or service that is not used in the direct clinical management of the individual.
        - A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
    - An item or service provided by the research sponsors free of charge for any person enrolled in the trial.
    - Travel and transportation expenses, unless and otherwise covered this Certificate, including but not limited to the following:
        - Fees for personal vehicle, rental car, taxi, medical van, ambulance, commercial airline, train.
        - Mileage reimbursement for driving a personal vehicle.
        - Lodging.
        - Meals.

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 (TDD: 711).

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 by emailing 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 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 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (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, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 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)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ą́ąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíį́ bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)

Vann du adda ebbah es du am helfa bisht, ennichi questions hend veyyich *deah health plan*, hend diah's recht fa hilf un information greeya in eiyah aykni shprohch unni kosht. Fa shvetza mitt en interpreter, roof deah nummah oh 1-833-584-1829. (Pennsylvania Dutch)

Summary of the South Carolina Life and Accident and Health Insurance Guaranty Association Act and Notice Concerning Coverage Limitations and Exclusions

Residents of South Carolina who hold life insurance, annuities, or health insurance policies should know that the insurance companies and health maintenance organizations (HMOs) licensed in this state to write these types of insurance are required by law to be members of the South Carolina Life and Accident and Health Insurance Guaranty Association (SCLAHIGA). The purpose of SCLAHIGA is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, SCLAHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through SCLAHIGA is limited. Consumers should shop around for insurance coverage and exercise care and diligence when selecting insurance coverage.

Disclaimer

Under South Carolina law, the South Carolina Life and Accident and Health Insurance Guaranty Association (SCLAHIGA) may provide coverage of certain direct life insurance policies, accident and health insurance policies, annuity contracts and contracts supplemental to life, accident and health insurance policies and annuity contract claims (covered claims) if the insurer becomes impaired or insolvent. South Carolina law does not require the SCLAHIGA to provide coverage for every policy. **COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.**

Coverage is generally conditioned upon residence in this state. Other conditions that may preclude or exclude coverage are described in this notice. Even if coverage is provided, there are significant limits and exclusions. Please read the entire notice for further details on limitations and exclusions.

Insurance companies and insurance agents are prohibited by law from using the existence of the SCLAHIGA or its coverage to sell you an insurance policy. You should not rely on the availability of coverage under SCLAHIGA when selecting an insurer. The South Carolina Life and Accident and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

If you think the law has been violated, you may file a written complaint with the SCLAHIGA or the South Carolina Department of Insurance at the addresses listed below

South Carolina Life and Accident and Health Insurance Guaranty Association Attention: Executive Director P.O. Box 8625 Columbia, SC 29202	**South Carolina Department of Insurance** Attention: Office of Consumer Services 1201 Main Street, Suite 1000 Columbia, SC 29201 Electronic complaint submission via www.doi.sc.gov/complaint

Please attach copies of all pertinent documentation. You may submit a written complaint or a complaint electronically to the Department through submission of the electronic form on the Department's website at www.doi.sc.gov/complaint. You should receive a response to your complaint within 10 days.

This safety-net coverage is provided for in the South Carolina Life and Accident and Health Insurance Guaranty Association Act (the Act). The following summary of the Act's coverages, exclusions and limits does not cover all provisions of the Act; nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the SCLAHIGA.

COVERAGE

Generally, individuals will be protected by the SCLAHIGA if they live in this state and hold a covered life, accident, health or annuity policy, plan or contract issued by an insurer (including a health maintenance organization) authorized to conduct business in South Carolina. The beneficiaries, payees or assignees of insured persons may also be protected if they live in another state unless circumstances described under the Act exclude coverage.

EXCLUSIONS FROM COVERAGE

Persons who hold a covered life, accident, health or annuity policy, plan or contract are r1ot protected by SCLAHIGA if:

- They are eligible for protection under the laws of another state (This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.);
- The insurer was not authorized to do business in this state; or
- They acquired rights to receive payments through a structured settlement factoring agreement.

SCLAHIGA also does not provide coverage for:

- A portion of a policy or contract or part thereof not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner;
- A policy or contract of reinsurance, unless assumption certificates have been issued;
- Interest rate or crediting rate yields or similar factors employed in calculating value changes that exceed an average rate;
- Any policy or contract issued by assessment mutuals, fraternals, and nonprofit hospital and medical service plans;
- Benefits payable by an employer, association or other person under: (a) a multiple employer welfare arrangement; (b) a minimum premium group insurance plan; (c) a stop-loss group insurance plan; or (d) an administrative services contract;
- A portion of a policy or contract to the extent that it provides for (a) dividends or experience rating credits; (b) voting rights; or (c) payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;
- A portion of a policy or contract to the extent that the assessments required by Section 38-29-80 with respect to the policy or contract are preempted by federal or state law;
- An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner or policy owner, including without limitation: (a) Claims based on marketing materials; (b) Claims based on side letters, riders or other documents that were issued by *the* member insurer without meeting applicable policy or contract form filing or approval requirements; (c) Misrepresentations of or regarding policy or contract benefits; (d) Extra-contractual claims; or (e) A claim for penalties or consequential or incidental damages;
- An unallocated annuity contract;
- A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Medicare Part C or D or Medicaid; or
- Interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes impaired or insolvent insurer, whichever is earlier.

LIMITS ON AMOUNTS OF COVERAGE

The South Carolina Life and Accident and Health Insurance Guaranty Association Act also limits the amount that SCLAHIGA is obligated to pay for covered claims. The benefits for which SCLAHIGA may become liable shall in no event exceed the lesser of the following:

- With respect to one life, regardless of the number of policies or contracts: $300,000 in life insurance death benefits, or not more than $300,000 in net cash surrender and net cash withdrawal values for life insurance;
- For health insurance benefits: (a) $300,000 for coverages not defined as disability income insurance or health benefit plans or long-term care insurance, including any net cash surrender and net cash withdrawal values; (b) $300,000 for disability income insurance; (c) $300,000 for long-term care insurance; (d) $500,000 for health benefit plans; or
- $300,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.