BUSINESSADVANTAGE℠
MASTER GROUP CONTRACT

BusinessADVANTAGE is an open access product. That means Members decide at the time they need medical care whether they will go to a healthcare Provider within BlueChoice HealthPlan of South Carolina Inc.'s (BlueChoice®) Network, a Network Provider, or go to a non-Network Provider. Benefits are available in either case; however, Members using Network Providers receive higher benefits.

This Contract is entered into by and between BlueChoice, a corporation incorporated under the laws of the state of South Carolina, hereinafter the Corporation, and the Employer as identified on the Master Group Application.

In consideration of their mutual promises and other good and valuable consideration as set forth in the Master Group Application, the parties agree as follows:

The Employer hereby agrees:

1. To offer the Corporation's product known as BusinessADVANTAGE to those Employees eligible for health care coverage as part of an employee benefit plan or program,

2. To pay the Corporation in advance for the services and benefits provided hereunder, including the arrangement and administration thereof, by remitting to the Corporation monthly Premium in the amounts set forth in the Master Group Application and any subsequent amendments thereto, according to the terms and conditions set forth in this Contract.

3. To grant to the Corporation access to the Employees who are eligible for participation in the Corporation's product at such reasonable times and for such reasonable period of time as may be agreed to between the Corporation and the Employer, for purposes related to this Contract, provided that the available access time shall include at least one period annually.

The Corporation hereby agrees to provide benefits for the Covered Services described in the Certificate of Coverage, a copy of which is attached hereto and made part of this Contract, subject to the terms, conditions, and limitations of the Contract. This Contract shall be controlling in case of any dispute or question concerning the coverage or rules of eligibility, enrollment, and participation with the Corporation.

Both parties agree to abide by the terms of this Contract. All matter printed or written by the Corporation on the following pages forms a part of this Contract. This Contract supersedes any previous Contract between the parties.

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

Capitalized terms not otherwise defined in this Contract shall have the meaning prescribed in the Contract or Certificate of Coverage, or if not defined therein, as the context requires.

SECTION I
ELIGIBILITY FOR COVERAGE

I.01 Eligibility

1. Every Employee within the classification(s) set forth on the Master Group Application by the Employer who is Actively-at-Work and his or her Dependents are eligible for coverage on or after the Contract Effective Date provided the Employee has completed the period of continuous employment commonly referred to as the Waiting Period with the Employer, if applicable. The Waiting Period will never exceed 90 days. Neither an Employee nor the Employee's Dependents shall be covered until the Employee is Actively-at-Work. An Employee or Dependent cannot be denied coverage simply because of a Health Status Related Factor.

   The Employee must be permanently working an average of 30 hours per week, including paid leave, unless 1) the Employee is on an Employer-approved leave of absence equal to or less than 90 days or 2) the Employee's absence is otherwise protected by applicable law beyond the 90 day noted in subsection 1 above or FMLA, if applicable.

   An Employee's receipt of a federal premium subsidy, taking any action to enforce his/her rights under applicable law, Health Status Related Factors, race, color, national origin, disability, sex, gender identity sexual orientation will not affect eligibility or premiums for this coverage.

I.02 Election of Coverage

1. Any Employee eligible for coverage may elect coverage for himself or herself and any eligible Dependents by completing and filing with the Employer a Membership Application during the Employer's applicable annual open enrollment period. In addition, new Employees may enroll within 31 days of the date they first become Employees or after satisfaction of the Waiting Period, if one exists, whichever is later. Dependents may be enrolled within 31 days of the date on which they first become Dependents. The Employer shall notify the Corporation in writing within 30 days of the person's Enrollment Date or other changes to enrollment. Note: Persons also may enroll if eligible under terms of Special Enrollment.

2. The Employer shall furnish to the Corporation a list of eligible Employees and Dependents to be covered, together with such data, and in such timeframe, as may be required by the Corporation as a prerequisite to coverage under this Contract.

SECTION II
NONRENEWAL OR DISCONTINUATION OF THIS CONTRACT

II.01 General Provisions

Except as provided in this section, the Corporation must renew or continue in force such coverage at the option of the Employer. The Corporation may non-renew or discontinue health coverage offered in connection with a Group Health Plan in the small group market based only on one or more of the following:

1. **Nonpayment of Premium** – The Employer has failed to pay premium or contributions in accordance with the terms of the Contract or the Corporation has not received timely premium. This Contract and all certificates issued thereunder shall automatically terminate without notice on the 31st day following a premium due date retroactive to the last paid date, unless the full premium is received by the Corporation at its home office no later than the 31st day after its due date. The Contract shall continue in force during that 31-day period. We may charge you a fee if your premium payment is returned for non-sufficient funds (NSF). The NSF fee is $25. We may also charge you a $10 fee to reinstate the Contract.

   If the Employer had coverage with BlueChoice or any of its affiliated companies, and the Contract was canceled due to nonpayment of premiums, and the Employer reapplies for coverage within 12 months, the Employer will be required to pay all past due premiums before new coverage can be effective.

2. **Fraud** – The Employer has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Contract. It could also be intentional misrepresentation by an insured individual or the individual's representative. To the extent that coverage is terminated and premiums are affected, premiums will be recalculated back to the date the fraud or intentional misrepresentation occurred.

3. **Violation of Participation or Contribution Rules** – The Employer has failed to comply with a material plan provision relating to Employer contribution or group participation rules.

4. **Termination of Coverage** –

   A. The Corporation may discontinue offering the insurance product for coverage, provided the Corporation:

      1) Provides notice of the discontinuation to each Employer providing coverage under this insurance product, and the Members covered under the coverage, of the discontinuation at least 90 days before the date of the discontinuation

      2) Offers to each Employer providing coverage under this insurance product, the option to purchase any other Health Insurance Coverage currently being offered by the Corporation to a Group Health Plan in the small group market

      3) Acts uniformly without regard to the claims experience of those Employers or any Health Status Related Factor relating to any Member covered or new Member who may become eligible for coverage.

   B. The Corporation may elect to discontinue offering all Health Insurance Coverage in this small group market this state, if:

      1) Notice of the discontinuation is provided to the Director of Insurance and to each Employer and Member covered under the coverage of the discontinuation at least 180 days before the date of the discontinuation of coverage

      2) All Health Insurance Coverage issued or delivered in this state in such the small group market is discontinued and coverage under the Health Insurance Coverage in the market is not renewed. The Corporation may not provide for the issuance of any Health Insurance Coverage in the market in this state during the five-year period beginning on the date of the discontinuation of the last Health Insurance Coverage not so renewed.

5. **Movement Outside Service Area** – The Corporation may discontinue offering this particular type of coverage if there is no longer any Member in connection with this plan who lives, resides or works in the Local Service Area of the Corporation or in the area in which the Corporation is authorized to do business.

II.02 Effective Date of Termination

1. If any of the following occurs, coverage will end for an Employee and/or his or her Dependent(s) on the last day of the month specified by the Employer, except as provided in this Article and the Continuation of Coverage section of the Certificate:

   - When a Dependent child reaches age 26.
   - The Employer notifies the Corporation that coverage of a Member is to be terminated.
   - This Contract is canceled by the Employer or non-renewed by the Corporation.

   If the Employer notifies the Corporation of the termination of an Employee's coverage other than on a timely basis, there will be no retroactive credit adjustment.

   i. It is the Employer's responsibility to ensure any retroactive Member termination forwarded to the Corporation is in compliance with federal law, specifically, that such termination was due to one of the following:

      a. A Member's fraudulent act, practice or omission
      b. A Member's intentional misrepresentation of material fact
      c. A Member's failure to timely pay required premiums or contributions toward the cost of coverage.

      The Employer is solely responsible for providing the Member with any notice related to retroactive terminations or rescissions that are required by law.

   ii. Other than as expressly required by law, if this Contract is terminated for any reason, the Employer is solely responsible for notifying all Members of such termination and coverage of Members will not continue beyond the termination date.

   iii. The Employer agrees to indemnify and hold the Corporation harmless for all damages, claims, causes of action, costs and expenses (including a reasonable attorney's fee) arising out of or relating to the Employer's failure to notify Members of termination of this Contract, or any other notification required to be given to Members by the Employer.

2. **Family and Medical Leave Act** – The Corporation will comply with any actions requested by the Employer based on an Employee's use of, or protection by, the Act.

   An Employee may be considered as remaining in the active employment for purposes of coverage under this Contract during a disability leave of absence if the Employer is subject to the Family and Medical Leave Act of 1993.

   If an Employee on leave pursuant to the Family and Medical Leave Act fails to pay the Employee portion of the premium within a 31-day grace period and his or her coverage ends, the coverage of the Employee will be reinstated without new Waiting Periods as long as the Employee returns to work immediately after the leave period, re-enrolls and pays his or her portion of the then current premium within 31 days.

3. Employees on Leave of Absence – Employees may be considered as remaining in active employment and eligible for coverage under this Contract during a leave of absence for a period not to exceed 90 days, including paid leave, from the date of cessation of active work.

SECTION III
COMPLIANCE WITH STATUTES

III.01 Corporation as Claim Fiduciary

If this Contract is an integral part of an Employee welfare benefit plan subject to the provisions of the Employee Retirement Income Security Act of 1974, as amended (ERISA), the Corporation is a claim fiduciary. As claim fiduciary, the Corporation shall have the discretionary authority to determine eligibility for benefits and to construe the terms of that part of the ERISA plan represented by this Contract. Any judicial review of a decision of the Corporation will be conducted under the arbitrary and capricious standard of review with deference given to the claim fiduciary's decision.

SECTION IV
PREMIUM PROVISIONS

IV.01 Premium Calculation

The monthly premium shall be calculated by multiplying the number of Enrollees in each premium class by the rates then in effect. A full Contract Month's premium shall be charged for Enrollees whose Enrollment Date falls on or before the 15th of that Contract Month. No premium shall be charged for Enrollees whose Enrollment Date falls after the 15th of that Contract Month.

IV.02 Changes in Enrollment

The Employer, as plan administrator, is solely responsible in a timely fashion for furnishing the information that the Corporation requires for the purpose of enrolling Employees under this Contract, processing applications and terminations and effecting changes in family and membership status.

The Employer is responsible for the accuracy of the information it transmits to the Corporation and understands that the Corporation will rely on this information. The Employer further agrees to indemnify the Corporation for all expenses it incurs, if any, as a result of the Employer's failure to transmit the information, failure to transmit it in the time period required by the Corporation and/or failure to transmit the correct information. As used here the term "expenses" includes, without limitation, any benefits the Corporation may be required to pay beyond those required according to the information the Employer furnished to the Corporation, attorney's fees, court costs, penalties and uncollected premiums.

Nothing contained in this Section will be construed to expand or otherwise alter the benefits provided for Members under this Contract.

IV.03 Changes in Premium Rates

The Company reserves the right to change the premium rates. Written notice of any such change in premium rates shall be given to the Contractholder at least 31 days prior to the Effective Date of the change. Payment of premium shall constitute the Contractholder's acceptance of the terms of this Contract (including this Plan of Benefits and the Schedule of Benefits) regardless of the absence of the Employer's signature.

IV.04 Payment of Premiums

Premiums required by this Contract are payable in advance of the premium due date on a monthly basis. The first premium is due and payable on the Effective Date of this Contract. Subsequent premiums are due and payable on the first of each Contract Month thereafter that this Contract is in effect. Premiums for this Contract must be paid by the Contractholder from the Contractholder's funds or from funds contributed by the insured persons, or from both. The Corporation will not accept payment of premiums from any health care Provider, health agency, health entity, public or private institution or any other person or entity that does not have an insurable interest.

At any time, the Corporation may notify the Employer that no premium is due for coverage for a certain period of time. The notification will include the reason for the waiver of premiums and the length of time the waiver is in effect. This can occur when the Corporation needs to refund money to the Employer or in situations involving a medical loss ratio rebate, for example. The Corporation is under no obligation to waive the Employer's premium and the fact that it may do so does not obligate it waive premium in the future.

IV.05 Grace Period

A 31-day grace period will be granted for the payment of premiums, other than premiums for the initial month, during which grace period this Contract will continue in force and the Employer will be liable to the Corporation for all premiums due and unpaid for the period this Contract continues in force. If premiums are not received by the end of the grace period, this Contract will automatically terminate retroactive to the end of the last paid. Any claims paid after the last paid date of coverage does not constitute a waiver of this section or extend this coverage in any way.

IV.06 Misstatement of Age

If the Corporation learn that a Member's age has been misstated, but not due to fraud or intentional misrepresentation of material fact, and the Member remains eligible for coverage, the Corporation will modify the premium for that Member to match the premium applicable to that Member's age.

SECTION V
STANDARD PROVISIONS

V.01 Incontestability

The validity of the Contract may not be contested after it has been in force for two years from its date of issue and no statement, except fraudulent misstatements, made by any person covered under the Contract relating to insurability may be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force prior to the contest for a period of two years during the person's lifetime nor unless it is contained in a written instrument signed by the person making the statement. The provision does not preclude the assertion at any time of defenses based upon the person's ineligibility for coverage under the Contract or upon other provisions in the Contract.

V.02 Entire Contract

A copy of the application, if any, of the Contractholder must be attached to the Contract when issued. All statements made by the Contractholder or by the persons insured are considered representations and not warranties, and no statement made by any person insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the person or, in the event of the death or incapacity of the insured person, to the individual's beneficiary or personal representative.

V.03 Issuance of Certificate
The Corporation will issue to the Contractholder for delivery to each person insured a certificate setting forth a statement as to the insurance protection to which that person is entitled, to whom the insurance benefits are payable, and a statement as to any family member's or Dependent's coverage.

V.04 Written Notice of Claim
Written notice of claim must be given to the Corporation within 20 days after the occurrence or commencement of any loss covered by the Contract. Failure to give notice within the time does not invalidate nor reduce any claim if it can be shown not to have been reasonably possible to give the notice and that notice was given as soon as was reasonably possible.

V.05 Proof of Loss
The Corporation will furnish to the person making claim, or to the Contractholder for delivery to such person, such forms as are usually furnished by it for filing proof or loss. If the forms are not furnished before the expiration of 15 days after the Corporation received notice of any claim under the Contract, the person making the claim is considered to have complied with the requirements of the Contract as to proof of loss upon submitting within the time fixed in the Contract for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claims is made.

V.06 Time 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.

V.07 Legal Action
No action at law or in equity may be brought to recover on the Contract before the expiration of 60 days after written proof of loss has been filed in accordance with the requirements of the Contract and that no such action may be brought at all unless brought within six years after the time written proof of loss is required to be furnished.

V.08 Conformity with Statutes
Any provision of this Contract that, at any relevant time, is in conflict with the law of jurisdiction in which it is delivered, is hereby amended to conform to the minimum requirements of such laws. Notwithstanding anything herein to the contrary, no provision of this Contract shall be interpreted as prohibiting any provision, access, use or disclosure of information to the extent required by applicable law.

SECTION VI
GENERAL PROVISIONS

VI.01 Basis for Coverage
This Contract has been issued to the Contractholder on behalf of the eligible Employees and their eligible Dependents. The eligibility requirements, Contract Effective Date, Enrollee's Effective Date, and termination date of coverage stated in this Contract, are coincident to and consistent with the provisions set forth in the Contract. The Employees to be covered, any Employee Waiting Period that applies, premium classes and the plan of benefits are in accordance with the Contractholder's Master Group Application to the Corporation. Employee and Dependent premium shall be on a contributory or non-contributory basis as specified in the Contractholder's Master Group Application to the Company.

VI.02 Changes
No changes in this Contract shall be valid until approved by an executive officer of the Corporation and such approval is endorsed and attached to this Contract. No agent has the authority to change this Contract or waive any of its provisions.

VI.03 Records
The Contractholder shall give the Corporation all information and proof as the Corporation may reasonably require with regard to any matters pertaining to this Contract. All documents given to the Contractholder by Members in connection with their coverage, together with the Contractholder's payroll and any other records that may have a bearing on the coverage provided under this Contract, may be inspected by the Corporation, at any reasonable time.

This includes providing Subscriber and Member Social Security numbers during the enrollment process and anytime upon request.

VI.04 Clerical Error
Clerical error shall not deprive any person of coverage under this Contract. Failure to report the termination of any person's coverage shall not continue such coverage beyond the termination date. Upon discovery of a clerical error, an appropriate adjustment in premium or coverage may be made.

VI.05 Workers' Compensation Not Affected
The coverage provided under this Contract is not in lieu of and does not affect any requirements for coverage by Workers' Compensation Insurance or similar laws.

VI.06 Summary of Benefits and Coverage
The Corporation will have complied with federal law by providing applicable Summary of Benefits and Coverage (SBCs) to the Employer. It will be the Employer’s responsibility, and not the Corporation’s, to distribute the SBCs to its Employees (and Dependents who live at a different address when it is known) in accordance with federal law.

VI.07 Group Replacement Standards

South Carolina Group Replacement Standards, S.C. Code §38-71-760(m)(5), will apply only if this Contract becomes effective within 62 days after termination of prior Health Insurance Coverage. These Replacement Standards do not apply to changes in benefit options under this Contract.

a. If the Employee and/or Dependents had continuous coverage with the Employer's prior Group Health Plan and are now insured by this plan, credit will be given for Deductibles and Coinsurance to the extent that they were fully or partially met under similar provisions of the prior plan. The credit will apply for the same or overlapping Benefit Periods and for expenses actually incurred and applied against the Deductible and Coinsurance provisions of the prior plan during the 90 days before the Effective Date of this plan. This applies only if this Contract covers these expenses and these expenses are subject to similar Deductible and Coinsurance provisions.
b. Each person not eligible for coverage under this Contract because of the Actively-at-Work provision (unless due to a Health Status Related Factor) is nevertheless covered under this Contract, based on the following rules if the person had valid coverage (including Extension of Benefits) under the Employer's prior Group Health Plan on the date it ended. Each person must also be eligible for coverage under this Contract. Any reference in the following rules to a person who was or was not totally disabled is a reference to the person's status immediately before the date this Contract became effective.

   Rules

   1. The level of benefits the Contract provides is the Contract's regular benefits, with credit given for Deductibles and Coinsurance to the extent stated in paragraph (a) above, reduced by any benefits payable by the prior plan
   2. Coverage will be provided pursuant to the South Carolina Group Replacement Standards laws until the earliest of the following dates:
      a. The date the person becomes eligible under this Contract, satisfying the Actively-at-Work provision.
      b. The date the Member's coverage would end based on this Contract's provisions regarding individual termination of coverage.
      c. In the case of a person who was totally disabled at the time the prior plan was discontinued and replaced by a Group Health Plan with similar benefits, the minimum level of benefits provided by the succeeding carrier must be the applicable level of benefits of the succeeding carrier's plan. This Benefit may be reduced by any benefits paid by the prior plan.

   The Schedule of Benefits will indicate if this Contract is a "Qualified High Deductible Health Plan," in which case the below will be in lieu of the above a. and b.

   Each person not eligible for coverage under this Contract because of the Actively-at-Work provision (unless due to a Health Status Related Factor) is nevertheless covered under this Contract, based on the following rules if the person had valid coverage (including Extension of Benefits) under the Employer's prior Group Health Plan on the date it ended. Each person must also be eligible for coverage under this Contract. Any reference in the following rules to a person who was or was not totally disabled is a reference to the person's status immediately before the date this Contract became effective.

Rules

a. The level of benefits the Contract provides is the Contract's regular benefits reduced by any benefits payable by the prior plan.
b. Coverage will be provided pursuant to the South Carolina Group Replacement Standards laws until the earliest of the following dates:
    1. The date the person becomes eligible under this Contract, satisfying the Actively-at-Work provision.
    2. The date the Member's coverage would end based on this Contract's provisions regarding individual termination of coverage.
    3. In the case of a person who was totally disabled at the time the prior plan was discontinued and replaced by a Group Health Plan with similar benefits, the minimum level of benefits provided by the succeeding carrier must be the applicable level of benefits of the succeeding carrier's plan. This benefit may be reduced by any benefits paid by the prior plan.

VI.08 Right to Modify

The Corporation may modify this Contract at the time of coverage renewal as long as the modification is consistent and in accordance with state and federal law. Such modifications shall not be effective until the first day of the month following 30 days written notice to the Employer. Notice of a modification shall be given to the Employer when addressed to the Employer at the address shown in the Master Group Application. The Corporation has no responsibility to provide individual notice to each Employee that a modification to this Contract has been made.

VI.09 Plan Administration

1. The Employer shall be the administrator of the plan represented by this Contract and shall have the sole responsibility for compliance with all state and federal laws and regulations with respect to such plan. The Employer shall be solely responsible for administration of the plan and the Corporation shall have no duties with respect thereto except as specifically provided herein.

2. All statements made by the Employer or by any of the Employees shall be deemed representations and not warranties, and no statement made by an Employee may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the person or, in the event of the death or incapacity of the Employee, to the individual's beneficiary or personal representative.

VI.10 Identification Card and Certificate of Coverage

The Corporation shall issue to each Employee covered hereunder an identification (ID) card and a Certificate of Coverage describing the benefits to which the Employee is entitled. If any amendment to this Contract shall materially affect any benefits described in such certificate, a new certificate or an endorsement describing the change shall be issued. ID cards issued to Employees pursuant to this Contract are for identification purposes only. Possession of an ID card confers no rights to benefits under this Contract**.**

VI.11 Gag Clause Compliance Attestation

The Corporation will complete and submit Gag Clause Prohibition Compliance Attestations on behalf of the Employer's Group Health Plan, pursuant to section 9824 of the Internal Revenue Code of 1986, as amended (the "Code"), section 724 of ERISA, and section 2799A-9 of the Public Health Service Act ("PHSA"), and the applicable federal guidance issued thereunder, as follows.

1. The Corporation will complete and submit, by no later than December 31 of each calendar year that this Contract is in effect, the annual Gag Clause Prohibition Compliance Attestation on behalf of the Group Health Plan for that calendar year. Absent written direction from the Employer, the attestation will cover any and all agreements between the Group Health Plan (or Employer on behalf of the Group Health Plan) and any health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of health care providers.

2. The Employer represents and warrants that the Group Health Plan currently is, and at all times during the term of this Contract will be, compliant with the provisions of Code section 9824, ERISA section 724, and/or PHSA section 2799A-9, as applicable, with regard to any and all agreements between the Group Health Plan (or Employer on behalf of the Group Health Plan) and any health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of health care providers, if applicable.

3. The Employer will provide to the Corporation upon request, and in the timeframe and manner specified by the Corporation, if applicable, all information that the Corporation requires in order to complete and submit the Gag Clause Prohibition Compliance Attestation on behalf of the Group Health Plan. If the Employer fails to provide any such requested information, the Corporation may, in its discretion, use its best efforts to complete and submit a Gag Clause Prohibition Compliance Attestation on behalf of the Group Health Plan, in good faith, in accordance with this Contract.

4. The Employer acknowledges that the Corporation will rely entirely on the Employer's representations and warranties as described herein, and any information that the Employer provides to the Corporation, in completing and submitting each Gag Clause Prohibition Compliance Attestation on behalf of the Group Health Plan, in accordance with this Section.

5. The Employer agrees to defend, indemnify, and hold harmless the Corporation, its directors, officers, agents, employees, affiliates, successors, and assigns from and against any and all claims, demands, liabilities, damages, losses, suits, costs (including reasonable legal costs) and judgments arising out of or related in any way to the Corporation's completion and submission of one or more Gag Clause Prohibition Compliance Attestations on behalf of the Group Health Plan in accordance with this Contract, including but not limited to such submissions made where the Employer has failed to provide any or all requested information to the Corporation.

6. If this Contract terminates during a calendar year, and there is no successor agreement between the parties, this Section will survive such termination and remain in effect through December 31st of that calendar year. For the avoidance of doubt, if this Contract terminates during a calendar year, the Corporation will complete and submit an annual Gag Clause Prohibition Compliance Attestation on behalf of the Group Health Plan with regard to the portion of that calendar year that this Contract was in effect.

VI.12 Notification

The Employer is acting as an agent for eligible individuals or for enrolled Members for purposes of notification. Notifications received from, or given to, the Employer by the Corporation will fulfill all notice requirements of this Contract. The Employer shall be responsible to collect all ID cards of all Members who terminate coverage with the Corporation for whatever reason during the Benefit Period.

VI.13 Physical Examination

The Corporation, at its own expense, shall have the right and opportunity to examine the person of any Member whose injury or sickness is the basis of claim when and as often as it may reasonably require during the consideration of a claim or action hereunder.

VI.14 Independent Corporation

The Employer on behalf of itself and its participants hereby expressly acknowledges its understanding this Contract constitutes a contract solely between the Employer and the Corporation, 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 the Corporation to use the Blue Cross and/or Blue Shield service marks in the state of South Carolina, and that the Corporation is not contracting as the agent of the Association. The Employer on behalf of itself and its participants further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than the Corporation and that no person, entity or organization other than the Corporation shall be held accountable or liable to the Employer for any of the Corporation's obligations to the Employer created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of the Corporation other than those obligations created under other provisions of this Contract.

VI.15 Out-of-Area Services

Overview

BlueChoice has a variety of relationships with other Blue Cross and/or Blue Shield Licensees, referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever Members access healthcare services outside the geographic area we serve, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the geographic area BlueChoice serves, Members obtain care from healthcare providers that have a contractual agreement ("participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from healthcare providers in the Host Blue geographic area that do not have a contractual agreement ("nonparticipating providers") with the Host Blue. We remain responsible for fulfilling our contractual obligations to you. Our payment practices in both instances are described below.

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

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Members access Covered Services outside the geographic area we serve, the Host Blue will be responsible for contracting and handling all interactions with its participating healthcare providers. The financial terms of the BlueCard Program are described generally below.

Liability Calculation Method Per Claim

Unless subject to a fixed dollar copayment, the calculation of the Member liability on claims for Covered Services will be based on the lower of the participating provider's billed covered charges or the negotiated price made available to us by the Host Blue.

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to us by the Host Blue may be represented by one of the following:

i. An actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases; or

ii. An estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or

iii. An average price. An average price is a percentage of billed covered charges in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues determine whether or not they will use an actual, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over-or underestimation of past prices (i.e., prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid or anticipated to be paid to providers or refunds received or anticipated to be received from providers). However, the BlueCard Program requires that the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by us in determining your premium.

B. Special Cases: Value-Based Programs

BlueCard Program

BlueChoice has included a factor for bulk distributions from Host Blues in your premium for Value-Based Programs when applicable under this contract.

C. Return of Overpayments

Recoveries from a Host Blue or its participating and nonparticipating providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits/healthcare provider/hospital bill audits, credit balance audits, utilization review refunds and unsolicited refunds. Recoveries will be applied so that corrections will be made, in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to us, they will be credited to your account. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be charged to you as a percentage of the recovery.

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

In some instances, federal or state laws or regulations may impose a surcharge, tax or other fee that applies to insured accounts. If applicable, we will include any such surcharge, tax or other fee in determining your premium.

E. Nonparticipating Providers Outside Our Service Area

1. Member Liability Calculation. When covered healthcare services are provided outside of our service area by non-Participating Providers, the amount a Member pays for such services will generally be based on either the Host Blue's non-Participating Provider local payment or the pricing arrangements required by applicable law. In these situations, the Member may be responsible for the difference between the amount that the non-Participating Provider bills and the payment we will make for the Covered Services as set forth in the paragraph. Payments for out-of-network Emergency services are governed by applicable federal and state law.

2. Exceptions
   In some exception cases, at your direction, we may pay claims from nonparticipating healthcare providers outside of our service area based on the provider's billed charge. This may occur in situations where a Member did not have reasonable access to a Participating Provider, as determined by us in our sole and absolute discretion or by applicable state law. In other exception cases, at your direction, we may pay such claims based on the payment we would make if we were paying a non-Participating provider inside of our service area, as described elsewhere in this contract. This may occur where the Host Blue's corresponding payment would be more than our in-service area non-Participating provider payment. We may choose to negotiate a payment with such a provider on an exception basis.

Unless otherwise stated, in any of these exception situations, the Member may be responsible for the difference between the amount that the non-Participating healthcare provider bills and payment we will make for the covered services as set forth in this paragraph.

F. Blue Cross Blue Shield Global®

- **General Information**

  If Members are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard service area"), they may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists Members with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when Members receive care from providers outside the BlueCard service area, the Members will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

- **Inpatient Services**

  In most cases, if Members contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require Members to pay for covered inpatient services, except for their cost-share amounts. In such cases, the hospital will submit Member claims to the service center to initiate claims processing. However, if the Member paid in full at the time of service, the Member must submit a claim to obtain reimbursement for Covered Services. **Members must contact BlueChoice to obtain Authorization for non-emergency inpatient services.**

- **Outpatient Services**

  Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require Members to pay in full at the time of service. Members must submit a claim to obtain reimbursement for Covered Services.

- **Submitting a Blue Cross Blue Shield Global Claim**

  When Members pay for Covered Services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Members should complete a Blue Cross Blue Shield Global claim form and send the claim form with the provider's itemized bill(s) to the service center address on the form to initiate claims processing. The claim form is available from BlueChoice, the service center or online at www.bcbsglobalcore.com. If Members need assistance with their claim submissions, they should call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

SECTION VII
DEFINITIONS

Words or phrases that are capitalized in this Contract, the Certificate or Schedule of Benefits have specific defined meanings. Any term that has a different medical and nonmedical meaning and that is undefined in this Contract, Certificate or the Schedule of Benefits is intended to have the medical meaning.

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

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

Eligible Employee: Any individual who is eligible for coverage and who is so designated to BlueChoice HealthPlan by the Employer

Employee: Any individual employed by the Employer.

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

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.

Small Employer: An Employer, as defined in Section 3(5) of the Employee Retirement Income Security Act of 1974, an Employer who employed no more than 50 Employees on business days during the preceding calendar year and who employs at least one Employee on the first day of the Benefit Period:

a. In determining the number of eligible Employees, entities that are treated as a single Employer under subsection (b), (c), (m) or (o) of Section 414 of the Internal Revenue Code of 1986 will be considered one employer
b. In the case of an Employer that was not in existence throughout the prior calendar year, the determination of whether such Employer is a Small Employer, or a Large Employer, will be based on the average number of employees that the employer reasonably expected to employ on business days in the current calendar year; and
c. Any reference in this Contract to an Employer includes a reference to any predecessor of the Employer.

The holder of this Contract is a Member of Blue Cross® and Blue Shield® of South Carolina, hereinafter called Company, and is entitled to vote in person or by proxy at any and all meetings of said Company. This is a non-assessable Contract and the Contractholder is not subject to any contingent liability. The annual meeting of the Members shall be held at the Home Office of the Company on the third Thursday in April at 11:00 a.m., Eastern Time.

GROUP MEDICAL POINT OF SERVICE INSURANCE CONTRACT

BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA
(A Corporation incorporated under the laws of the state of South Carolina and hereinafter referred to as the Company)
I-20 East at Alpine Road
Columbia, South Carolina 29219

GROUP NAME:	as shown on the BlueChoice® HealthPlan Master Group Application, hereinafter called the Employer
CONTRACT EFFECTIVE DATE:	as shown on the BlueChoice HealthPlan Master Group Application

In consideration of the Application made by the Employer listed above, a copy of which is attached hereto and made part of this Contract, and in consideration of payment by the Employer of the premium as herein provided, the Company hereby agrees to provide the benefits for Covered Services as described in the Certificate of Coverage, a copy of which is attached hereto and made part of this Contract, for a period of one year beginning at 12:01 a.m. Eastern Time, on the date indicated above, hereinafter called the Contract Effective Date and from year to year thereafter, unless this Contract is terminated as provided herein. The premium shall be due and payable by the Employer in advance of the Contract Effective Date and thereafter as provided herein. This Contract is issued and delivered in the state of South Carolina, is governed by the laws thereof and is subject to the terms and provisions recited over the signatures hereto affixed.

This Contract, subject to its benefits, conditions, limitations and exclusions, defines and describes the non-Network health care portion of the Employer's managed care plan. This Contract, when combined with the BusinessADVANTAGE Contract, provides comprehensive coverage. This Contract covers all eligible enrolled persons according to the terms described within this Group Medical Point of Service Plan.

Scott Graves
President
BlueCross BlueShield Division

INTRODUCTION

ADMINISTRATOR.
Since BlueChoice HealthPlan of South Carolina Inc. is a wholly-owned subsidiary of the Company and as such has executed an Administrative Agreement with the Company, the Company has authorized BlueChoice HealthPlan to act as the Administrator for the Contract. The Administrator shall collect premiums and process all claims occurring under this Contract and pay benefits when due in accordance with the terms, conditions, limitations and exclusions of this Contract.

IMPORTANT FOR BENEFITS.
The Company has arranged for the Administrator to conduct Authorization review for Inpatient Admissions, certain Outpatient Services and certain Prescription Medications. The Member must initiate the review process by notifying the Administrator and complying with specific Authorization requirements to qualify for maximum benefits under this Contract. Failure to do so may result in denial of benefits.

SECTION 1
ELIGIBILITY AND ELECTION OF COVERAGE

ELIGIBILITY

Every Employee within the classification(s) set forth on the Master Group Application by the Employer who is Actively-at-Work and his or her Dependents are eligible for coverage on or after the Contract Effective Date provided the Employee has completed the period of continuous employment commonly referred to as the Waiting Period with the Employer, if applicable. The Waiting Period will never exceed 90 days. Neither an Employee nor the Employee's Dependents shall be covered until the Employee is Actively-at-Work. An Employee or Dependent cannot be denied coverage simply because of a Health Status Related Factor.

The Employee must be permanently working an average of 30 hours per week, including paid leave, unless 1) the Employee is on an Employer approved leave of absence equal to or less than 90 days, or 2) the Employee's absence is otherwise protected by applicable law beyond the 90 day noted in subsection 1 above or FMLA, if applicable.

An Employee's receipt of a federal premium subsidy, taking any action to enforce his/her rights under applicable law, Health Status Related Factors, race, color, national origin, disability, sex, gender identity or sexual orientation will not affect eligibility or premiums for this coverage.

ELECTION OF COVERAGE

Any Employee eligible for coverage may elect coverage for himself or herself and any eligible Dependents by completing and filing with the Employer a Membership Application during the Employer's applicable annual open enrollment period. In addition, new Employees may enroll within 31 days of the date they first become Employees or after satisfaction of the Waiting Period, if one exists, whichever is later. Dependents may be enrolled within 31 days of the date on which they first become Dependents. Note: Persons also may enroll if eligible under terms of Special Enrollment.

The Employer shall furnish to the Administrator a list of eligible Employees and Dependents to be covered, together with such data, and in such timeframe, as may be required by the Administrator as a prerequisite to coverage under this Contract.

SECTION 2
NONRENEWAL OR DISCONTINUATION OF THIS CONTRACT

GENERAL PROVISIONS.

Except as provided in this section, the Company must renew or continue in force such coverage at the option of the Employer. The Company may non-renew or discontinue health coverage offered in connection with a Group Health Plan based only on one or more of the following reasons:

1. **Nonpayment of Premiums –** The Employer has failed to pay premium or contributions in accordance with the terms of the Contract or the Company has not received timely premium payments. This Contract and all certificates issued thereunder shall automatically terminate without notice on the 31st day following a premium due date retroactive to the last paid date, unless the full premium is received by the Administrator at its home office no later than the 31st day after its due date. The Contract shall continue in force during that 31-day period. We may charge you a fee if your premium payment is returned for non-sufficient funds (NSF). The NSF fee is $25. We may also charge you a $10 fee to reinstate the Contract.

If the Employer had coverage with BlueChoice HealthPlan of South Carolina Inc. or any of its affiliated companies, and the Contract was canceled due to nonpayment of premiums, and the Employer reapplies for coverage within 12 months, the Employer will be required to pay all past-due premiums before new coverage can be effective.

2. **Fraud –** The Employer has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Contract, intentional misrepresentation by the insured individual or the individual's representative. If coverage is denied and premiums are affected, premiums will be recalculated back to the date the fraud or intentional misrepresentation occurred.

3. **Violation of Contribution or Participation Rules –** The Employer has failed to comply with a material plan provision relating to Employer contribution or group participation rules.

4. **Termination of Coverage –**

   A. The Company discontinues offering the insurance product for this coverage, if it:

      1) Provides notice of the discontinuation to each Employer providing coverage under this insurance product, and the Employees and Dependents covered under the coverage, of the discontinuation at least 90 days before the date of the discontinuation of the coverage
      2) Offers to each Employer providing coverage under this insurance product, the option to purchase any other Health Insurance Coverage currently being offered by the Company to a Group Health Plan in the small group market
      3) Acts uniformly without regard to the claims experience of those Employers or any Health Status Related Factor relating to any Enrollee covered or new Enrollee who may become eligible for coverage.

   B. The Company may elect to discontinue offering all Health Insurance Coverage in the small group market this state, if:

      1) Notice of the discontnuation is provided to the Director of Insurance and to each Employer, Employee and Dependent covered under the coverage of the discontinuation at least 180 days before the date of the discontinuation of coverage

      2) All Health Insurance Coverage issued or delivered in this state in the small group market is discontinued and coverage under the Health Insurance Coverage in the market is not renewed. The Company may not provide for the issuance of any Health Insurance Coverage in the market in this state during the five-year period beginning on the date of the discontinuation of the last Health Insurance Coverage not so renewed.

5. **Movement Outside Service Area –** The Company may discontinue offering the product for this coverage if there is no longer any Enrollee in connection with this plan who lives, resides or works in the area in which the Company is authorized to do business.

EFFECTIVE DATES OF TERMINATION

1. If any of the following occurs, coverage will end for an Employee and/or his or her Dependent(s) on the last day of the month specified by the Employer, except as provided in this Article and the *Continuation of Coverage* section of the Certificate:
   - When a Dependent child reaches age 26.
   - The Employer notifies the Administrator that coverage of a Member is to be terminated.
   - This Contract is canceled by the Employer or non-renewed by the Administrator.

   If the Employer notifies the Administrator of the termination of an Employee's coverage other than on a timely basis, there will be no retroactive credit adjustment.

   i. It is the Employer's responsibility to ensure any retroactive Member termination forwarded to the Administrator is in compliance with federal law, specifically that such termination was due to one of the following:
      a. A Member's fraudulent act, practice or omission
      b. A Member's intentional misrepresentation of material fact
      c. A Member's failure to timely pay required premiums or contributions towards the cost of coverage.

      The Employer is solely responsible for providing the Member with any notice related to retroactive terminations or rescissions that are required by law.

   ii. Other than as expressly required by law, if this Contract is terminated for any reason, the Employer is solely responsible for notifying all Members of such termination, and coverage of Members will not continue beyond the termination date.

   iii. The Employer agrees to indemnify and hold the Company harmless for all damages, claims, causes of action, costs and expenses (including a reasonable attorney's fee) arising out of or relating to the Employer's failure to notify Members of termination of this Contract or any other notification required to be given to Members by the Employer.

2. **Family and Medical Leave Act** – The Administrator will comply with any actions requested by the Employer based on an Employee's use of, or protection by, the Family and Medical Leave Act.

   An Employee may be considered as remaining in the active employment for purposes of coverage under this Contract during a disability leave of absence if the Employer is subject to the Family and Medical Leave Act of 1993.

   If an Employee on leave pursuant to the Family and Medical Leave Act fails to pay the Employee portion of the premium within a 31-day grace period and his or her coverage ends, the coverage of the Employee will be reinstated without new Waiting Periods as long as the Employee returns to work immediately after the leave period, re-enrolls and pays his or her portion of the then current premium within 31 days.

3. **Employees on Leave of Absence** – Employees may be considered as remaining in active employment and eligible coverage under this Contract during a leave of absence for a period not to exceed 90 days, including paid leave, from the date of cessation of active work.

SECTION 3
STANDARD PROVISIONS

INCONTESTABILITY
The validity of the Contract may not be contested after it has been in force for two years from its date of issue, and no statement, except fraudulent misstatements, made by any person covered under the Contract relating to insurability may be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force prior to the contest for a period of two years during the person's lifetime nor unless it is contained in a written instrument signed by the person making the statement. The provision does not preclude the assertion at any time of defenses based upon the person's ineligibility for coverage under the Contract or upon other provisions in the Contract.

ENTIRE CONTRACT
A copy of the application, if any, of the Contractholder must be attached to the Contract when issued. All statements made by the Contractholder or by the persons insured are considered representations and not warranties, and no statement made by any person insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the person or, in the event of the death or incapacity of the insured person, to the individual's beneficiary or personal representative.

ISSUANCE OF CERTIFICATE
The Administrator, on behalf of the Company, will issue to the Contractholder for delivery to each person insured a certificate setting forth a statement as to the insurance protection to which that person is entitled, to whom the insurance benefits are payable, and a statement as to any family member's or Dependent's coverage.

WRITTEN NOTICE OF CLAIM
Written notice of claim must be given to the Administrator within 20 days after the occurrence or commencement of any loss covered by the Contract. Failure to give notice within the time does not invalidate nor reduce any claim if it can be shown not to have been reasonably possible to give the notice and that notice was given as soon as was reasonably possible.

PROOF OF LOSS
The Administrator will furnish to the person making claim, or to the Contractholder for delivery to such person, such forms as are usually furnished by it for filing proof or loss. If the forms are not furnished before the expiration of 15 days after the Administrator received notice of any claim under the Contract, the person making the claim is considered to have complied with the requirements of the Contract as to proof of loss upon submitting within the time fixed in the Contract for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

TIME PAYMENT OF CLAIMS
The Administrator 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.

LEGAL ACTION
No action at law or in equity may be brought to recover on the Contract before the expiration of 60 days after written proof of loss has been filed in accordance with the requirements of the Contract and that no such action may be brought at all unless brought within six years after the time written proof of loss is required to be furnished.

NOTIFICATION
The Employer is acting as an agent for eligible individuals or for Enrollees for purposes of notification. Notifications received from or given to the Employer by the Administrator will fulfill all notice requirements of this Contract.

SECTION 4
GENERAL PROVISIONS

BASIS FOR COVERAGE
This Contract has been issued to the Contractholder on behalf of the eligible Employees and their eligible Dependents. The eligibility requirements, Contract Effective Date, Enrollee's Effective Date, and termination date of coverage stated in this Contract, are coincident to and consistent with the provisions set forth in the Contract. The Employees to be covered, any Employee Waiting Period which applies, premium classes and the plan of benefits are in accordance with the Contractholder's Master Group Application to the Company. Employee and Dependent premium shall be on a contributory or non-contributory basis as specified in the Contractholder's Master Group Application to the Company.

CHANGES
No changes in this Contract shall be valid until approved by an executive officer of the Company or the chief operating officer of the Administrator and such approval is endorsed and attached to this Contract. No other individual or agent has the authority to change this Contract or waive any of its provisions.

RECORDS
The Contractholder shall give the Administrator all information and proof as the Administrator may reasonably require with regard to any matters pertaining to this Contract. All documents given to the Contractholder by Members in connection with their coverage, together with the Contractholder's payroll and any other records that may have a bearing on the coverage provided under this Contract may be inspected by the Company or the Administrator at any reasonable time.

CLERICAL ERROR
Clerical error shall not deprive any person of coverage under this Contract. Failure to report the termination of any person's coverage shall not continue such coverage beyond the termination date. Upon discovery of a clerical error, an appropriate adjustment in premium or coverage may be made.

WORKERS' COMPENSATION NOT AFFECTED
The coverage provided under this Contract is not in lieu of and does not affect any requirements for coverage by Workers' Compensation Insurance or similar laws.

CONFORMITY WITH STATUTES
Any provision of this Contract that, at any relevant time, is in conflict with the law of jurisdiction in which it is delivered, is hereby amended to conform to the minimum requirements of such laws. Notwithstanding anything herein to the contrary, no provision of this Contract shall be interpreted as prohibiting any provision, access, use or disclosure of information to the extent required by applicable law.

SUMMARY OF BENEFITS AND COVERAGE

The Company will have complied with federal law by providing applicable Summary of Benefits and Coverage (SBCs) to the Employer. It will be the Employer's responsibility, and not the Corporation's, to distribute the SBCs to its Employees (and Dependents who live at a different address when it is known) in accordance with federal law.

GROUP REPLACEMENT STANDARDS

South Carolina Group Replacement Standards, S.C. Code §38-71-760(m)(5), will apply only if this Contract becomes effective within 62 days after termination of prior Health Insurance Coverage. These Replacement Standards do not apply to changes in benefit options under this Contract.

a. If the Employee and/or Dependents had continuous coverage with the Employer's prior Group Health Plan and are now insured by this plan, credit will be given for Deductibles and Coinsurance to the extent that they were fully or partially met under similar provisions of the prior plan. The credit will apply for the same or overlapping Benefit Periods and for expenses actually incurred and applied against the Deductible and Coinsurance provisions of the prior plan during the 90 days before the Effective Date of this plan. This applies only if this Contract covers these expenses and these expenses are subject to similar Deductible and Coinsurance provisions.

b. Each person not eligible for coverage under this Contract because of the Actively-at-work provision (unless due to a Health Status Related Factor) is nevertheless covered under this Contract, based on the following rules if the person had valid coverage (including Extension of Benefits) under the Employer's prior Group Health Plan on the date it ended. Each person must also be eligible for coverage under this Contract. Any reference in the following rules to a person who was or was not totally disabled is a reference to the person's status immediately before the date this Contract became effective.

   Rules

   1. The level of benefits the Contract provides is the Contract's regular benefits, with credit given for Deductibles and Coinsurance to the extent stated in paragraph (a) above, reduced by any benefits payable by the prior plan.
   2. Coverage will be provided pursuant to the South Carolina Group Replacement Standards laws until the earliest of the following dates:
      a. The date the person becomes eligible under this Contract, satisfying the Actively-at-Work provision.
      b. The date the Member's coverage would end based on this Contract's provisions regarding individual termination of coverage.
      c. In the case of a person who was totally disabled at the time the prior plan was discontinued and replaced by a Group Health Plan with similar benefits, the minimum level of benefits provided by the succeeding carrier must be the applicable level of benefits of the succeeding carrier's plan. This benefit may be reduced by any benefits paid by the prior plan.

   The Schedule of Benefits will indicate if this Contract is a "Qualified High Deductible Health Plan," in which case the below will be in lieu of the above a. and b.

   Each person not eligible for coverage under this Contract because of the Actively-at-Work provision (unless due to a Health Status Related Factor) is nevertheless covered under this Contract, based on the following rules if the person had valid coverage (including Extension of Benefits) under the Employer's prior Group Health Plan on the date it ended. Each person must also be eligible for coverage under this Contract. Any reference in the following rules to a person who was or was not totally disabled is a reference to the person's status immediately before the date this Contract became effective.

Rules

a. The level of benefits the Contract provides is the Contract's regular benefits reduced by any benefits payable by the prior plan.
b. Coverage will be provided pursuant to the South Carolina Group Replacement Standards laws until the earliest of the following dates:
    1. The date the person becomes eligible under this Contract, satisfying the Actively-at-Work provision.
    2. The date the Member's coverage would end based on this Contract's provisions regarding individual termination of coverage.
    3. In the case of a person who was totally disabled at the time the prior plan was discontinued and replaced by a Group Health Plan with similar benefits, the minimum level of benefits provided by the succeeding carrier must be the applicable level of benefits of the succeeding carrier's plan. This benefit may be reduced by any benefits paid by the prior plan.

GAG CLAUSE COMPLIANCE ATTESTATION

The Corporation will complete and submit Gag Clause Prohibition Compliance Attestations on behalf of the Employer's Group Health Plan, pursuant to section 9824 of the Internal Revenue Code of 1986, as amended (the "Code"), section 724 of ERISA, and section 2799A-9 of the Public Health Service Act ("PHSA"), and the applicable federal guidance issued thereunder, as follows.

1. The Corporation will complete and submit, by no later than December 31 of each calendar year that this Contract is in effect, the annual Gag Clause Prohibition Compliance Attestation on behalf of the Group Health Plan for that calendar year. Absent written direction from the Employer, the attestation will cover any and all agreements between the Group Health Plan (or Employer on behalf of the Group Health Plan) and any health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of health care providers.

2. The Employer represents and warrants that the Group Health Plan currently is, and at all times during the term of this Contract will be, compliant with the provisions of Code section 9824, ERISA section 724, and/or PHSA section 2799A-9, as applicable, with regard to any and all agreements between the Group Health Plan (or Employer on behalf of the Group Health Plan) and any health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of health care providers, if applicable.

3. The Employer will provide to the Corporation upon request, and in the timeframe and manner specified by the Corporation, if applicable, all information that the Corporation requires in order to complete and submit the Gag Clause Prohibition Compliance Attestation on behalf of the Group Health Plan. If the Employer fails to provide any such requested information, the Corporation may, in its discretion, use its best efforts to complete and submit a Gag Clause Prohibition Compliance Attestation on behalf of the Group Health Plan, in good faith, in accordance with this Contract.

4. The Employer acknowledges that the Corporation will rely entirely on the Employer's representations and warranties as described herein, and any information that the Employer provides to the Corporation, in completing and submitting each Gag Clause Prohibition Compliance Attestation on behalf of the Group Health Plan, in accordance with this Section.

5. The Employer agrees to defend, indemnify, and hold harmless the Corporation, its directors, officers, agents, employees, affiliates, successors, and assigns from and against any and all claims, demands, liabilities, damages, losses, suits, costs (including reasonable legal costs) and judgments arising out of or related in any way to the Corporation's completion and submission of one or more Gag Clause Prohibition Compliance Attestations on behalf of the Group Health Plan in accordance with this Contract, including but not limited to such submissions made where the Employer has failed to provide any or all requested information to the Corporation.

6. If this Contract terminates during a calendar year, and there is no successor agreement between the parties, this Section will survive such termination and remain in effect through December 31st of that calendar year. For the avoidance of doubt, if this Contract terminates during a calendar year, the Corporation will complete and submit an annual Gag Clause Prohibition Compliance Attestation on behalf of the Group Health Plan with regard to the portion of that calendar year that this Contract was in effect.

BLUE CROSS® AND BLUE SHIELD® ASSOCIATION

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

Out-of-Area Services

Overview

BlueChoice has a variety of relationships with other Blue Cross and/or Blue Shield Licensees, referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever Members access healthcare services outside the geographic area we serve, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the geographic area BlueChoice serves, Members obtain care from healthcare providers that have a contractual agreement ("participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from healthcare providers in the Host Blue geographic area that do not have a contractual agreement ("nonparticipating providers") with the Host Blue. We remain responsible for fulfilling our contractual obligations to you. Our payment practices in both instances are described below.

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

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Members access Covered Services outside the geographic area we serve, the Host Blue will be responsible for contracting and handling all interactions with its participating healthcare providers. The financial terms of the BlueCard Program are described generally below.

Liability Calculation Method Per Claim

Unless subject to a fixed dollar copayment, the calculation of the Member liability on claims for Covered Services will be based on the lower of the participating provider's billed covered charges or the negotiated price made available to us by the Host Blue.

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to us by the Host Blue may be represented by one of the following:

(i) An actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases; or

(ii) An estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or

(iii) An average price. An average price is a percentage of billed covered charges in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues determine whether or not they will use an actual, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over-or underestimation of past prices (i.e., prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid or anticipated to be paid to providers or refunds received or anticipated to be received from providers). However, the BlueCard Program requires that the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by us in determining your premiums.

B. Special Cases: Value-Based Programs

BlueCard Program

BlueChoice has included a factor for bulk distributions from Host Blues in your premium for Value-Based Programs when applicable under this contract.

C. Return of Overpayments

Recoveries from a Host Blue or its participating and nonparticipating providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits/healthcare provider/hospital bill audits, credit balance audits, utilization review refunds and unsolicited refunds. Recoveries will be applied so that corrections will be made, in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to us, they will be credited to your account. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be charged to you as a percentage of the recovery.

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

In some instances, federal or state laws or regulations may impose a surcharge, tax or other fee that applies to insured accounts. If applicable, we will include any such surcharge, tax or other fee in determining your premium.

E. Nonparticipating Providers Outside Our Service Area

1. Member Liability Calculation. When covered healthcare services are provided outside of our service area by non-Participating Providers, the amount a Member pays for such services will generally be based on either the Host Blue's non-Participating Provider local payment or the pricing arrangements required by applicable law. In these situations, the Member may be responsible for the difference between the amount that the non-Participating Provider bills and the payment we will make for the Covered Services as set forth in the paragraph. Payments for out-of-network Emergency services are governed by applicable federal and state law.

2. Exceptions
   In some exception cases, at your direction, we may pay claims from nonparticipating healthcare providers outside of our service area based on the provider's billed charge. This may occur in situations where a Member did not have reasonable access to a Participating Provider, as determined by us in our sole and absolute discretion or by applicable state law. In other exception cases, at your direction, we may pay such claims based on the payment we would make if we were paying a non-Participating provider inside of our service area, as described elsewhere in this contract. This may occur where the Host Blue's corresponding payment would be more than our in-service area non-Participating provider payment. We may choose to negotiate a payment with such a provider on an exception basis.

   Unless otherwise stated, in any of these exception situations, the Member may be responsible for the difference between the amount that the non-Participating healthcare provider bills and payment we will make for the covered services as set forth in this paragraph.

F. Blue Cross Blue Shield Global™

- **General Information**

  If Members are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard service area"), they may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists Members with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when Members receive care from providers outside the BlueCard service area, the Members will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

- **Inpatient Services**

  In most cases, if Members contact the service center for assistance, hospitals will not require Members to pay for covered inpatient services, except for their cost-share amounts. In such cases, the hospital will submit Member claims to the service center to initiate claims processing. However, if the Member paid in full at the time of service, the Member must submit a claim to obtain reimbursement for Covered Services. **Members must contact BlueChoice to obtain Authorization for non-emergency inpatient services.**

- **Outpatient Services**

  Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require Members to pay in full at the time of service. Members must submit a claim to obtain reimbursement for Covered Services.

- **Submitting a Blue Cross Blue Shield Global Claim**

  When Members pay for Covered Services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Members should complete a Blue Cross Blue Shield Global claim form and send the claim form with the provider's itemized bill(s) to the service center address on the form to initiate claims processing. The claim form is available from BlueChoice, the service center or online atwww.bcbsglobalcore.com. If Members need assistance with their claim submissions, they should call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.